OPEN-ENDED PHARMACEUTICAL ALIBI: THE ARMY'S QUEST TO LIMIT THE DURATION OF CONTROLLED SUBSTANCES FOR SOLDIERS

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> *[R]evising, updating or drafting policy that will affect more than 700,000 Soldiers must be thoroughly vetted to prevent unintended consequences . . . .*[1]

I. Introduction

They called him the Wizard.[2] As an Army psychologist in Baghdad during the bloodiest period of Operation Iraqi Freedom (OIF), Captain Peter Linnerooth had an extraordinary ability to connect with suffering Soldiers.[3] He spent over 60 hours each week counseling Soldiers, helping them summon the strength to cope with their haunted lives and confront nightmares over the obliteration of military vehicles by roadside bombs, the grisly bodies of slain comrades, and the death wail of Iraqi children.[4] Healing others took a personal toll. When he returned home to Minnesota, Peter's own post-traumatic stress came with him. He began taking antidepressants and struggled to find normalcy as he moved

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[1] U.S. Dep't of Army, Army 2020 Generating Health & Discipline in the Force Ahead of the Strategic Reset Report 2012, at 85 (2012) [hereinafter Gold Book].

[2] Sharon Cohen, *Vet Who Saved Many in Iraq Couldn't Escape Demons*, ASSOCIATED PRESS, Mar. 18, 2013, http://news.yahoo.com/vet-saved-many-iraq-couldnt-escape-demons-190136480.html.

[3] Mark Thompson, *Dr. Peter J. N. Linnerooth, 1970-2013*, TIME, Jan. 11, 2013, http://nation.time.com/2013/01/11/dr-peter-j-n-linnerooth-1970-2013/.

[4] Cohen, *supra* note 2.

from job-to-job following his exit from active duty military service.[5] His marriage crumbled, and he sought escape through prescription medications, eventually overdosing on pills in his first unsuccessful suicide attempt.[6] In the end, the Wizard could help every Soldier but himself.[7] At age 42, Captain Peter Linnerooth, a veteran of the "Surge" in OIF, a Bronze Star recipient, a father, drew his weapon for the last time, took aim at himself, and ended his life.[8]

Though the tragic tale gained nationwide attention, the conclusion of Peter's story is not unique. Starting in 2008, active-duty and reserve Soldiers, as well as veterans,[9] started committing suicide at an alarming rate. During 2008, the suicide rate for active-duty Soldiers surpassed that of the United States public, a line not crossed since the Vietnam War.[10] As the suicide toll continued to mount,[11] the Army scrambled to quell the rise, commissioning multi-year medical studies[12] and panels of distinguished Soldiers[13] to analyze how best to tackle a problem of epidemic proportions that gripped the nation.

In 2010, one of the panels found what appeared to be a breakthrough. The panel reported a shocking correlation between suicide and prescription drug use, determining that "prescription drugs were involved in almost one third of the active duty suicides" in Fiscal Year (FY) 2009.[14] With this startling link in hand, the panel concluded that a limitation on prescription duration could mitigate the possible deadly connection between prescription drug use and suicide, and it

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[5] *Id.*
[6] *Id.*
[7] *Id.*
[8] *Id.*
[9] According to a 2012 Department of Veteran Affairs study, twenty-two veterans a day commit suicide. This number includes all veterans, not just veterans from the wars in Iraq or Afghanistan. U.S. DEP'T OF VETERANS AFFAIRS, SUICIDE DATA REPORT, 2012, at 15 (2012), *available at* http://www.va.gov/opa/docs/suicide-data-report-2012-final.pdf.
[10] U.S. DEP'T OF ARMY, ARMY HEALTH PROMOTION, RISK REDUCTION, SUICIDE PREVENTION REPORT 2010, at 14, 16 (2010) [hereinafter RED BOOK]; Mike Mount, *Army Suicide Rate Could Top Nation's This Year*, CNN (Dec. 9, 2008, 2:44 P.M.), http://www.cnn.com/2008/HEALTH/09/09/army.suicides/.
[11] GOLD BOOK, *supra* note 1, at 54.
[12] Lizette Alvarez, *Army and Agency Will Study Rising Suicide Rate Among Soldiers*, N.Y. TIMES, Oct. 29, 2008, http://www.nytimes.com/2008/10/30/us/30soldiers.html.
[13] *See* RED BOOK, *supra* note 10.
[14] *Id.* at 56.

recommended prohibiting Soldiers from using lawfully prescribed drugs after one year from the prescription date.[15]

In February 2011, the United States Army Medical Command (MEDCOM) implemented the panel's recommendation, but changed the prohibition on use to six-months, not one year, from the prescription date.[16] This change was a stark departure from existing expiration requirements under federal regulations. Specifically Food and Drug Administration (FDA) regulations require pharmaceutical manufacturers to conduct stability-testing of their drugs to provide an expiration date[17] based on drug efficacy.[18] However, under federal law and regulations, there is no expiration as to the *legality* of use by individuals prescribed a controlled substance.[19]

Implemented through an obscure regulation, MEDCOM Regulation 40-51 (MEDCOM policy), this prohibition fundamentally changed the nature of controlled substances usage in the Army. The MEDCOM policy redefined drug expiration, tying it to prescription date rather than drug efficacy, and it further prohibited the use of "expired" drugs, purportedly making illicit any use outside of the designated time window.

In implementing the change, the MEDCOM policy did so in an unusual way. The Army did not implement a punitive regulation of

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[15] *Id.* at 57.

[16] U.S. Army Medical Command, Reg. 40-51, Medical Review Officers and Review of Positive Urinalysis Drug Testing Results para. 8e (17 Apr. 2013) [hereinafter MEDCOM Reg. 2013].

[17] Expiration Dating, 21 C.F.R. § 211.137(a) (2014) ("To assure that a drug product meets applicable standards of identity, strength, quality, and purity at the time of use, it shall bear an expiration date determined by appropriate stability testing described in § 211.166."); Drugs; Location of Expiration Date, 21 C.F.R. § 201.17 ("When an expiration date of a drug is required, e.g., expiration dating of drug products required by § 211.137 of this chapter, it shall appear on the immediate container and also the outer package, if any, unless it is easily legible through such outer package.").

[18] This designation marks the final date "up to which the manufacturer will guarantee that medicine has full potency." Heidi Mitchell, *Are Expired Medications Ok to Take?*, WALL ST. J., Aug. 25, 2014, http://www.wsj.com/articles/are-expired-medications-ok-to-take-1409005882. However, depending on storage conditions, drugs may often be safely used well past the expiration date. *Id.* In fact, one study run by the FDA and commissioned by the Department of Defense found that eighty-eight percent of a large stockpile of pharmaceuticals stored under excellent conditions could be effectively used five years past the manufacturer's expiration date. *Id.*

[19] *See infra* Part IV.

general applicability to all Soldiers; instead, the Army delegated implementation to MEDCOM.[20] Then MEDCOM changed the standard for medical review officers (MRO) to determine whether a positive urinalysis test for a prescribed controlled substance is authorized or illegitimate.[21] The MEDCOM policy only applied to MROs and was not explicitly punitive.[22]

As with some novel policies implemented in unusual ways, the MEDCOM policy had a major flaw; a violation of the ban could not be construed as a crime under the Uniform Code of Military Justice (UCMJ).[23] Because the MEDCOM policy was not punitive, only applied to a subset of MEDCOM providers, and failed to acknowledge an existing case law-created defense—innocent use—for taking lawfully prescribed controlled substances,[24] commanders lacked a criminal hook to hold Soldiers accountable for policy violations. In short, the MEDCOM policy's unusual implementation method precluded achieving the very goal for which the policy was created.

This article proceeds in ten parts to examine the MEDCOM policy, detail its flaws and unintended consequences, and propose an alternative way to legally reach the Army's goal of limiting controlled substance use by Soldiers. Part II of this article traces the history of drug demand reduction programs in the military. Part III examines the Army's suicide study and implementation of the MEDCOM policy change. Part IV summarizes federal law and regulations regarding the expiration of prescribed controlled substances. Part V describes the current MEDCOM policy and the process of urinalysis testing. Part VI dissects the MEDCOM policy's legality and two possible challenges under either the Takings Clause of the United States Constitution or the Administrative Procedure Act. Part VII examines two legal doctrines that may preclude judicial review for potential litigants claiming an unlawful taking of their prescription drugs: the *Mindes* test and judicial deference to military decisions. Part VIII details how the MEDCOM policy fails to articulate a crime that is punishable under the UCMJ. Part

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[20] All Army Activities Message, 062/2011, 232349Z Feb. 11, U.S. Dep't of Army, subject: ALARACT Changes to Length of Authorized Duration of Controlled Substance Prescriptions in MEDCOM Regulation 40-51, para. 2B [hereinafter ALARACT 062/2011].

[21] MEDCOM REG. 2013, *supra* note 16, para. 9e.

[22] *Id.* para. 3.

[23] UCMJ (2012).

[24] *See infra* Part VIII.

IX suggests a general order from the Secretary of the Army as the best means to implement a ban on the legal use of prescribed controlled substance after a set date, and the appendix contains a proposed general order. Part X briefly examines policy alternatives and concludes the paper.

II. Drug Demand Reduction Programs in the Military

A. The Impetus for Drug Testing Programs

Following a series of drug abuse scandals in the mid-twentieth century, the Department of Defense (DoD) instituted a Drug Demand Reduction Program (DDRP) to combat illegal drug use in the military.[25] During the Vietnam War, one researcher found that almost half of all Soldiers serving in Vietnam illegally used opiates.[26] In response, the Army implemented the first mandatory urinalysis drug-testing program in the military, along with an amnesty and drug-treatment program.[27] Under the amnesty program, over 14,000 Soldiers admitted to being heroin users.[28] Drug abuse in the military was largely considered an Army problem until 1981, when fourteen Sailors were killed in a major Navy mishap on an aircraft carrier and marijuana metabolites were found in the bodies of six of the deceased Sailors.[29] The incident made apparent a wider drug abuse problem in the military, and DoD mandated a DDRP in each military service to deter and detect illicit drug use.[30]

B. The Army's Current Drug Testing Regime

The Army's current DDRP is designed to ensure force readiness and deter drug use while also encouraging and providing drug abuse treatment.[31] The Department of Defense mandates that each military

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[25] Elaine Casey, *History of Drug Use and Drug Users in the United States*, SCHAFFER LIBRARY OF DRUG POLICY, http://www.druglibrary.org/schaffer/history/casey1.htm (last visited May 19, 2015).
[26] *Id.*
[27] *Id.*
[28] *Id.*
[29] RED BOOK, *supra* note 10, at 3.
[30] *Id.* at 2; *see also* U.S. Dep't of Def., Instr. 1010.01, Military Personnel Drug Abuse Testing Program (13 Sep. 2012).
[31] U.S. Dep't of Army, Reg. 600-85, The Army Substance Abuse Program para. 4-1(b) (28 Dec. 2012) [hereinafter AR 600-85].

service, including the Army, annually test 100 percent of a unit's end strength,[32] which is the total number of servicemembers assigned to a unit, for illegal drug use through a urine test (urinalysis).[33] Because the program focuses on end-strength and not the testing of individuals, every year at least some Soldiers are not tested, especially those Soldiers in transit to new duty stations.[34]

Following collection, urinalysis samples are sent to specialized DoD drug laboratories for testing.[35] Each urine sample is then screened against a mandatory drug panel of illegal drugs (e.g., cocaine, marijuana, etc.) and drugs the legality of which depends on whether the Soldier had a prescription (e.g., oxycodone, morphine, etc.).[36] Following a subsequent confirmation test, samples that screened positive for prescription drugs are sent to an MRO at each base who determines whether the latter category of drugs have an "authorized" or "illegitimate" basis for use,[37] and positive tests for illegal drugs are "sent directly to the unit commander for action."[38]

III. Rise of the Prescription Expiration Policy

A. The *Red Book* Study

The MEDCOM policy change was an attempt to stem the flood of suicides in the Army. In 2008, the rate of suicide in the Army surpassed the age-adjusted suicide rate for civilians in the United States and brought nation-wide attention to the issue.[39] The Army's Vice Chief of Staff subsequently commissioned a panel to examine the problem and recommend measures to bring down the suicide rate.[40] In 2010, the Army released its multi-year study of suicide in the Army, the *Army Health Promotion, Risk Reduction, Suicide Prevention Report* (*Red*

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[32] RED BOOK, *supra* note 10, at 33, 51-52.
[33] *Id.* at 51-52.
[34] *Id.* For example, in FY 2011, the Army did not test 89,310 Soldiers. GOLD BOOK, *supra* note 1, at 111.
[35] U.S. Dep't. of Def., Status of Drug Use in the Department of Defense Personnel, Fiscal Year 2011 Drug Testing Statistical Report 6-7 (2012).
[36] RED BOOK, *supra* note 10, at 53-54.
[37] MEDCOM REG. 2013, *supra* note 16, para. 8.
[38] *Id.* app. B-2.
[39] RED BOOK, *supra* note 10, at 14-16.
[40] *Id.* at 1-4.

Book).[41] One of the study's notable findings was that there is a strong correlation between prescription drug use and suicide. In FY 2009, for example, "prescription drugs were involved in almost one third of the active-duty suicides."[42] Prescription drugs were connected to other troubling deaths as well. From FY 2006 to FY 2009, prescription drugs were found in the system of thirty-five percent (139 of 397) of Soldiers who died from undetermined or accidental causes.[43]

The *Red Book* also uncovered a startling increase in prescription drug use across the force. Pursuant to the Army's drug testing protocol, controlled substances that may be prescribed by a healthcare provider are reviewed to determine if the use is "authorized" or "illegitimate."[44] In examining a subset of positive urinalysis samples for oxycodone, a powerful narcotic often referred to by the brand name OxyContin,[45] the *Red Book* found that positive samples for oxycodone nearly doubled in a three-year span, rising from 1,909 positive samples in FY 2006 to 3,756 in FY 2009.[46] OxyContin was not the only controlled substance to increase during that same time; other controlled substances tested by the urinalysis program had similar increases as well.[47] As the rate of urinalysis samples testing positive for controlled substances increased, so too did the number of Soldiers lawfully prescribed controlled substances.[48] The rate of "authorized" use for controlled substances skyrocketed from thirty-three percent of samples in FY 2005 to eighty percent of samples in FY 2009,[49] which raised concerns that open-ended medical prescriptions and "MRO authorizations may be masking opiate and other legal drug dependence and illicit drug use."[50] To segregate illegitimate users from authorized users, the *Red Book* recommended restricting access to prescription drugs through an Army-imposed expiration on prescribed controlled substances of one year from the prescription date.[51]

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[41] GOLD BOOK, *supra* note 1, at 5.
[42] RED BOOK, *supra* note 10, at 56.
[43] *Id.* at 56-57.
[44] *Id.* at 54.
[45] *Oxycodone*, DRUGS.COM, http://www.drugs.com/oxycodone.html (last visited May 19, 2015).
[46] RED BOOK, *supra* note 10, at 55.
[47] *Id*. During the same time period, for example, the number of positive urinalysis samples for amphetamines doubled. *Id*.
[48] *Id.* at 55-57.
[49] *Id.* at 57.
[50] *Id.* at 56.
[51] *Id.* at 57.

B. Announcement of the Army's Policy

With only a minor change, the *Red Book*'s recommendation for a prescription drug expiration date was implemented in February 2011.[52] In an All Army Activities (ALARACT) message from Headquarters, Department of the Army, the Army announced that lawfully prescribed drugs would expire six months after the prescription date, not one year as recommended by the *Red Book*.[53] The difference in time between the *Red Book*'s recommendation and the MEDCOM policy that was implemented is likely due to a faulty interpretation of federal regulations. The ALARACT states, "Federal regulations limit the duration of controlled substance prescriptions to six-months (e.g., a prescription must be filled within six-months of the date the prescription is written)."[54] As discussed *infra*,[55] no federal law or regulation mandates an expiration date for the lawful use of a prescribed drug. Confusingly, the parenthetical correctly states a federal regulatory requirement that prescriptions must be filled within six months of the prescription's issuance, but this statement is imprecise because the federal regulation only applies to Schedule III through V, not Schedule II, controlled substances.[56] Taken as a whole, the ALARACT's characterization of federal requirements was misleading regarding the time limit for the lawful use of controlled substances and inaccurate about the filling deadlines for prescriptions.

IV. Prescriptions Under Federal Law and Regulation

A. Introduction

The MEDCOM expiration policy was a startling addition to the federal process for prescribing and issuing controlled substances. Federal laws and regulations impose strict requirements on the provision of controlled substances to patients. Under the Controlled Substances

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[52] ALARACT 062/2011, *supra* note 20, para. 2b.
[53] *Id.* para. 3.
[54] *Id.*
[55] *See infra* Part IV.
[56] *Controlled Substance Schedules*, DRUG ENFORCEMENT ADMINISTRATION, http://www.deadiversion.usdoj.gov/schedules/ (last visited May 19, 2015) [hereinafter *Schedules*].

Act of 1970 (CSA), specified drugs are prohibited from personal use without prescriptions from authorized practitioners.[57] Drugs prescribed for personal use are classified into schedules based on their accepted medical use, relative abuse potential, and likelihood of causing dependence in a patient.[58] Schedule I substances have no accepted medical use and a high potential for abuse.[59] These are commonly referred to as "street" drugs, such as heroin, marijuana, and cocaine.[60] Schedules II through Schedule V drugs have an accepted medical use and are separated into different schedules based on their relative abuse potential: from Schedule II drugs with the highest abuse potential and psychological effect to Schedule V drugs with low abuse potential and psychological effect.[61]

B. Receiving and Filling Prescriptions

Only a physician (who is authorized to practice medicine in the jurisdiction in which he or she is located) or an authorized researcher may issue patients a prescription for a controlled substance on Schedules II through V.[62] For physicians, the controlled substance must be issued for "a legitimate medical purpose" in "the usual course of his professional practice."[63] This requirement prevents doctors from writing prescriptions disconnected from a patient's medical condition.[64] In writing the prescription, physicians are not required by federal regulations to delineate an expiration date.[65] Once written, a pharmacist is the only individual authorized to fill a prescription.[66] Upon receipt of a valid prescription, a pharmacist may then fill the prescription and

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[57] Controlled Substances Act of 1970, Pub. L. No. 91-513, 84 Stat. 1285 (1970) (codified as amended at 21 U.S.C. § 801 et seq. (1990)) [Hereinafter CSA].
[58] *Schedules*, *supra* note 56.
[59] *Id.*
[60] MEDCOM REG. 2013, *supra* note 16, app. B-2.
[61] *Schedules*, *supra* note 56.
[62] 21 U.S.C. § 353(b)(1)(B) (2012); Persons Entitled to Issue Prescriptions, 21 C.F.R. § 1306.03(a) (2014).
[63] Purpose of Issue of Prescription, 21 C.F.R. § 1306.04 (2014).
[64] *See, e.g.*, *Doctor Found Guilty of Illegal Distribution of Drugs*, DRUG ENFORCEMENT ADMINISTRATION, http://www.dea.gov/divisions/la/2014/la081514.shtml (last visited May 19, 2015).
[65] The physician's prescription must have the date of the prescription; the full name and address of the patient; the drug name, strength, dosage form, and quantity prescribed; the directions for use; and the name, signature, address, and registration number of the prescribing practitioner. Purpose of Issue of Prescription, *supra* note 63.
[66] 21 C.F.R. § 1306.06.

provide it to a patient for use.[67] With limited exceptions,[68] this process applies for all prescriptions.[69]

C. Labeling of Controlled Substance Packages

Federal regulations impose strict labeling requirements for all filled prescriptions. Pharmacists are required to appropriately label all packages containing a controlled substance.[70] But among the eight required labeling fields, no field requires a pharmacist to specify an expiration date for the prescription.[71] Once filled, no federal law or regulation mandates an expiration date for the use of a lawfully

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[67] *Id.*

[68] In three situations, the strict requirements for issuing and filling a prescribed drug are relaxed. First, a physician may administer in the course of his or her professional practice a controlled substance for immediate administration to a patient. Requirement of Prescription, 21 C.F.R. § 1306.11 (2014); Requirement of Prescription, 21 C.F.R. § 1306.21(b) (2014). Second, in an emergency, physicians can provide an oral prescription for a controlled substance to a pharmacist, but the prescription must be promptly reduced to writing and provided to the filling pharmacist within seven days. 21 C.F.R. § 1306.11(d). Finally, in certain institutional settings, such as a hospital, the prescription may be written by the treating physician and filled and administered by the institution. *Id.* §§ 1306.11(c), 1306.21(c).

[69] In addition to mandating prerequisites for the filling of a prescription, federal regulations also dictate which controlled substances may or may not be refilled. Unlike Schedule III through V drugs, Schedule II drugs may not be refilled. Refilling of Prescriptions; Issuance of Multiple Prescriptions, 21 C.F.R. § 1306.12(a) (2014). Instead, each "re-filling" of a Schedule II drug must be done by a new prescription. However, an individual practitioner may issue multiple individual prescriptions to a patient as long as the total supply does not exceed 90 days. *Id.* § 1306.12(b)(1). Among other things, such prescriptions must be provided in the usual course of practice; state the earliest fill date (with the exception of the first prescription if for immediate filling); and not create an "undue risk of diversion or abuse." *Id.* § 1306.12(b)(1)(a)-(e). Prescriptions for controlled substances on Schedule III through V, however, are authorized refills, but prescriptions for substances on Schedules III and IV, but not V, must be "filled or refilled" no "more than six months after the date on which such prescription was issued." 21 C.F.R. § 1306.22. Notably, this requirement is different from the MEDCOM policy's requirement because it is six months to *fill* the prescription for the controlled substance, not *use* it.

[70] Pharmacists must ensure the date of the prescription was filled; the pharmacy name and address; the serial number of the prescription; the name of the patient; the prescribing physician's name; and directions for use and cautionary statements, if any, are on the label. Labeling of Substances and Filling of Prescriptions, 21 C.F.R. § 1306.14(a) (2014); Labeling of Substances and Filling of Prescriptions, 21 C.F.R. § 1306.24(a) (2014).

[71] *Id.*

prescribed controlled substance.[72] As noted, the only expiration date for a controlled substance is tied to a manufacturer's guarantee of the drug's efficacy.[73]

V. The Army's Medical Review Program

A. Purpose of the Medical Review

For all positive urinalysis samples for prescription drugs, the Army requires that MROs review the Soldier's medical records to determine if a valid medical reason exists for the positive sample.[74] In other words, "a positive laboratory test result [for a prescription drug] does not automatically identify [a Soldier] . . . as an illegal drug user."[75] In making their finding, MROs follow a rigid process, a Medical Review (MR), set forth in the MEDCOM policy, which determines if a Soldier's use of a controlled substance is "authorized" or "illegitimate."[76] With the exception of adding an expiration date for prescribed controlled substances and changing the education requirements for MROs, the MR process has remained largely unchanged since 2005.[77]

B. Medical Review Officer Appointment and Qualification

The MR process begins with the appointment of an MRO at Army installations with a Military Treatment Facility (MTF). Each MTF commander is responsible for appointing an MRO.[78] The MRO must be

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[72] E-mail from Major Meghan Raleigh, M.D., to author (Nov. 20, 2014, 14:41 EST) (on file with author) [hereinafter Raleigh E-mail]; *see also* United States v. Bell, 1994 CCA Lexis 32 (A.F. Ct. Crim. App. 1994).

[73] *See* Expiration Dating, *supra* note 17.

[74] MEDCOM REG. 2013, *supra* note 16, para. 2.

[75] U.S. Dep't of Health and Human Serv., Medical Review Officer Manual for Federal Agency Workplace Drug Testing Programs 1 (31 May 2014) [hereinafter HHS MRO Manual].

[76] MEDCOM REG. 2013, *supra* note 16, para. 9e.

[77] *See* MEDCOM Reg. 2013, *supra* note 16; U.S. Army Medical Command, Reg. 40-51, Medical Review Officers and Review of Positive Urinalysis Drug Testing Results (13 May 2011) [hereinafter MEDCOM Reg. 2011]; U.S. Army Medical Command, Reg. 40-51, Medical Review Officers and Review of Positive Urinalysis Drug Testing Results (21 July 2010) [hereinafter MEDCOM Reg. 2010]; U.S. Army Medical Command, Reg. 40-51, Medical Review Officers and Review of Positive Urinalysis Drug Testing Results (30 Mar. 2005) [hereinafter MEDCOM Reg. 2005].

[78] MEDCOM REG. 2013, *supra* note 16, paras. 6b, 7c.

a physician, nurse practitioner, or physician assistant;[79] have knowledge of pharmaceuticals; and have been trained and certified by MEDCOM on the MR system.[80]

C. Medical Review Process

The MR process is decentralized and conducted by individual MROs at each MTF. Following referral of a positive urinalysis sample from the DoD's specialized labs,[81] the MRO determines the schedule of the controlled substance found in the sample.[82] For positive urinalysis samples with drugs on Schedule I, no MR is required unless requested by the referring agency, and the sample is automatically deemed "illegitimate" use.[83] For all other positive samples, the MRO must review the urinalysis test to determine if a valid medical reason for the positive result exists.[84] In making this determination, the MRO reviews the Soldier's electronic or written health record, prescription bottles, and any statements from the Soldier's physician or dentist documenting the drug prescribed or administered and the date of the procedure.[85]

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[79] This is a substantial change from previous MEDCOM 40-51 policies, which required a medical doctor or doctor of osteopathy to perform MRs. *Compare* MEDCOM REG. 2011, *supra* note 77, para. 6b, *with* MEDCOM REG. 2005, *supra* note 77, para. 7a ("In accordance with Federal law, only physicians possessing an M.D. or D.O. degree from an accredited university may serve as an MRO."). This is also a substantial departure from federal civilian agency requirements for MROs. HHS MRO MANUAL, *supra* note 75, at 1.

[80] MEDCOM REG. 2013, *supra* note 16, para. 7.

[81] A unit commander, an Army Substance Abuse Program employee, or a base area code manager may refer a positive urinalysis to an MRO. MEDCOM REG. 2013, *supra* note 16, para. 9a.

[82] MEDCOM REG. 2013, *supra* note 16, paras. 6c(3), 9a.

[83] The drugs are heroin metabolites, cocaine metabolites, or amphetamine and methamphetamine designer drugs. MEDCOM REG. 2013, *supra* note 16, app. B-2. Notably, this paragraph fails to point out marijuana, PCP, and LSD are part of the current drug testing panel and do not require MRO review. This appears to be a drafting error because the following sections of the regulation detail metabolite cut-off percentages for these drugs and explicitly states that such urinalysis positives do not require MRO review before the commander releases the information to law enforcement agencies. MEDCOM REG. 2013, *supra* note 16, app. C. Previous editions had similar drafting errors. MEDCOM REG. 2011, *supra* note 77, app. B (omitting LSD); MEDCOM REG. 2010, *supra* note 77, app. B (omitting LSD).

[84] The drugs are amphetamines, opiates, steroids, synthetic opiates, benzodiazepines, and any other specially requested drug tests. MEDCOM REG. 2013, *supra* note 16, para. 6c(3).

[85] *Id.* para. 9b.

If the test result is validated through the Soldier's medical records (i.e., the Soldier's medical records contain a valid prescription for the applicable drug or drug metabolite),[86] the MRO then uses the date of the urine sample as a proxy for the date of the Soldier's drug use and examines this date in relation to when the prescription was written.[87] Pursuant to the MEDCOM policy, any Schedules II through V drug "will expire six months after [the] last date prescribed," and the use of expired drugs is prohibited under the policy.[88] Thus, a drug sample that tests positive more than six months after the date prescribed is designated as "illegitimate,"[89] whereas a positive test within six months of the prescription is deemed "authorized."[90]

If the test result cannot be validated through the Soldier's medical records, the MRO must arrange for an interview, either in person or over the phone, with the Soldier to determine if there is a valid reason for the positive sample.[91] Before beginning the interview, Soldiers are apprised of their Article 31(b) rights,[92] advised that the MRO is acting as an investigating officer with no patient-provider confidentiality, and given the option whether to provide testimony or evidence to the MRO.[93] If the Soldier provides proof of a valid prescription not captured in the Soldier's military medical records and the use (i.e., the date that the urine sample was provided) was within six months of the prescription date, the use is "authorized."[94] If not, the use is deemed "illegitimate."[95] Notably, the MRO could, on his or her own accord, contact the Soldier's civilian or military healthcare provider to determine if a valid medical reason exists for the positive sample, but this is not required under the MEDCOM policy.[96]

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[86] *Id.* para. 6c(3).
[87] *Id.* para. 8e.
[88] *Id.*
[89] *Id.* para. 8e. Illegitimate use is any use for which there is no valid "prescription(s) or valid medical explanation for a drug(s) that would account for the positive urinalysis test result." *Id.* para. 9e(2).
[90] *Id.* para. 9e(1). Authorized use is defined as one having "a prescription(s) or valid medical explanation for a drug(s) that caused the positive urinalysis result." *Id.*
[91] *Id.* para. 6c(3).
[92] UCMJ art. 31(b) (2012).
[93] *Id.* para. 6c(4).
[94] *Id.* para. 9e(1).
[95] *Id*. para. 8e.
[96] *See* MEDCOM REG. 2013, *supra* note 16.

D. Change in the Medical Review Process

Across the four editions of MEDCOM Regulation 40-51 from 2005 to 2013,[97] the only major policy change was the addition of an "expiration date" for lawfully prescribed controlled substances in 2011.[98] Before this addition, the previous MEDCOM policy held that the use of a prescription at any time was legitimate so long as the use was not beyond a "clearly labeled expiration date."[99] In other words, if a prescribed controlled substance had no "clearly labeled expiration date," a Soldier could lawfully take prescribed controlled substances at any time for his or her medical condition.[100] Because there is no requirement under federal law to put an expiration date on controlled substance labels issued by a pharmacist to a patient nor is there a requirement for such a labeling on prescription drugs in the MEDCOM policy,[101] it is unclear when—if ever—the "clearly labeled expiration date" provision would apply.[102]

Following the *Red Book*'s finding of a dramatic rise in prescription drug abuse by Soldiers and its correlation to suicide,[103] "senior Army leadership . . . directed a change in Army policy."[104] The old MR standard allowing the use of a prescribed controlled substance at any time was castigated by MEDCOM, the agency which wrote and implemented that very same MR standard, as an "open-ended pharmaceutical alibi for the duration of that Soldier's career, long after the clinical indication for the medication had been resolved."[105] The *Red Book*'s findings were based on an examination of 42,028 MRs conducted from FY 2001 to 2009 under the previous MR standard.[106] From that population of positive urinalysis samples, 13,301 samples were deemed "unauthorized" (i.e., drugs used without a valid medical prescription),

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[97] *See supra* note 77.
[98] MEDCOM REG. 2011, *supra* note 77, para. 9e.
[99] MEDCOM REG. 2010, *supra* note 77, para. 8f.
[100] *Id.*
[101] *See* MEDCOM REG. 2013, *supra* note 16.
[102] MEDCOM REG. 2010, *supra* note 77, para. 8f.
[103] RED BOOK, *supra* note 10, at 55-56.
[104] Memorandum from Office of The Surgeon General to Medical Review Officers Serving in the Army Healthcare System, Dep't of Army et al., subject: Interim Guidance for Medical Review Officers re: MEDCOM Regulation 40-51, 13 May 2011 para. 1 (2 Sep. 2011) [hereinafter Interim Guidance].
[105] *Id.* para. 2.
[106] RED BOOK, *supra* note 10, at 55.

23,222 samples were deemed "authorized" (i.e., used with a valid medical prescription), and 5,505 samples were characterized as "unresolved."[107] The *Red Book*'s recommendation for a prescription expiration date was aimed squarely at those 23,222 Soldiers who had a lawful prescription but may not have had a medical basis for the long-term use of a controlled substance.[108] As the *Red Book* put it, "How many of these authorized positive UAs [urinalysis tests] are actually the result of dependence?"[109] To eliminate this "alibi," MEDCOM instituted the new expiration standard, mandating that Schedules II through V prescriptions "will expire six months after [the] last date prescribed."[110]

E. Interim Guidance from the Army's Medical Command

As detailed *infra*,[111] the new expiration policy failed to give commanders a framework to dispose of cases with Soldiers who "illegitimately" used a lawfully prescribed controlled substance. As a result, four months after the major policy change in 2011, MEDCOM issued interim guidance that provided two exceptions to the six-month use window.[112] But just as with the MEDCOM policy itself, the interim guidance failed to provide commanders with a legal framework to dispose of cases.

One of the exceptions provided for use consistent with a provider's instructions when the "clinical indication for treatment with the medication in question is still present."[113] In such cases, the use would be deemed legitimate. However, because MROs are not required to conduct medical examinations of individual Soldiers,[114] and because a mere check of military medical records cannot definitively indicate whether a medical problem has continued or reemerged, the exception failed to segregate drug dependent Soldiers from those with long-term medical conditions, obviating the underlying purpose of the policy change.

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[107] *Id.*
[108] *Id.* at 55-56.
[109] *Id.* at 56.
[110] MEDCOM REG. 2013, *supra* note 16, para. 8e.
[111] *See infra* Part VIII.
[112] Interim Guidance, *supra* note 104, para. 5.
[113] *Id.* para. 3.
[114] *See* MEDCOM REG. 2013, *supra* note 16.

The second exception in the interim guidance expanded the MRO's role as an investigator in order to determine a Soldier's knowledge of the policy change.[115] The interim guidance tasked the MRO with verifying whether the Soldier received notice of the policy change through other sources, such as a "primary care provider, Commander, First Sergeant, or ASAP personnel."[116] If the Soldier was not on notice of the policy change, then the use was deemed a "valid medical use."[117] In such cases, the MRO was required to inform the Solider that subsequent uses of a controlled substance after six months from the prescription date would be considered illegitimate use.[118]

Neither the interim guidance nor the MEDCOM policy itself provides an administrative or criminal mechanism for commanders to dispose of cases tied to the unauthorized use of lawfully prescribed controlled substances.[119] Presumably, the knowledge requirement of the second exception is meant to establish an element of a disobedience or wrongful use offenses, but as detailed *infra*,[120] the exception does not assist commanders in establishing the other necessary criminal elements. In willful disobedience offenses, problems arise because civilian doctors cannot issue lawful commands, intentional defiance of the order by a Soldier is hard to prove, and a military medical provider issuing the command must outrank the Soldier receiving it.[121] In "other lawful orders" offenses, the problem lies in Army medical providers not having a special status to issue orders to Soldiers.[122] And in wrongful use cases, the innocent use defense provides a complete defense for those Soldiers who lawfully used their prescribed controlled substances.[123]

Furthermore, neither of the exceptions is applicable anymore. The latest MEDCOM Regulation 40-51, issued in April 2013, did not incorporate the 2011 interim guidance's exceptions,[124] and under the

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[115] *Id.* para. 5C.
[116] *Id.*
[117] *Id.*
[118] *Id.* para. 5C.
[119] *See infra* Part VIII.
[120] *See infra* Part VIII.B, E.
[121] *See infra* Part VIII.E.
[122] *Id.*
[123] *See infra* Part VIII.B.
[124] *See* MEDCOM REG. 2013, *supra* note 16.

terms of the interim guidance's approval,[125] the interim guidance exceptions are consequently no longer in effect.

VI. Legality of the Medical Command Policy

A. Introduction

As with most major policy changes, MEDCOM's policy revision had unintended consequences. By adding new restrictions on controlled substance use, the Army was inadvertently exposed to other litigation risks. Specifically, the Army's policy could be construed as an unconstitutional taking under the Fifth Amendment to the United States Constitution or as a violation of the Administrative Procedure Act. At first blush, both claims have merit, but neither claim is likely to be successful in court. Ultimately, MEDCOM's policy has a strong likelihood of being upheld as a lawful exercise of the Army's discretion to act on matters concerning the health and welfare of the force—even if it is unenforceable under the UCMJ as it is written.

B. Takings Analysis

By prohibiting the use—which is the only true value—of a prescription drug, the MEDCOM policy has effectively nullified a Soldier's property interest in that drug. Specifically pursuant to the Controlled Substance Act, individuals who lawfully obtain and posses a controlled substance for their own use are classified as "ultimate users."[126] By definition, the ultimate user has all the essential rights of a property owner—to obtain, posses, and use a controlled substance—and, hence, is the property owner of the prescribed medicine.[127]

In impairing the use of personal property, the policy is subject to attack under the Takings Clause of the Fifth Amendment to the United States Constitution.[128] Pursuant to this Clause, private property may not

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[125] Memorandum from MEDCOM Chief of Staff to MEDCOM Regional Commands, Dep't of Army et al., subject: Interim Guidance Approval para. 2 (27 Dec. 2011) ("This approval [of the Interim Guidance] will remain in effect until the next update of MEDCOM Regulation 40-51.").
[126] 21 U.S.C. § 802(27) (2012).
[127] *Id.*
[128] U.S. CONST. amend. V.

be taken by the federal government without just compensation.[129] Fifth Amendment jurisprudence delineates two types of takings: eminent domain and regulatory takings. Based on the inherent authority of a sovereign,[130] eminent domain is the government's authority to seize private property for the public good.[131] The MEDCOM policy, however, does not call for the "intentional appropriation"[132] of controlled substances for public use, so the eminent domain doctrine does not apply.

In addition to eminent domain, courts have held that a government regulation alone may result in a taking of private property.[133] Such regulations are lawful if based on the sovereign's police powers to prevent the use of private property in ways detrimental to public safety or health.[134] While regulations that impose limited burdens on an individual's property rights do not necessarily invoke the Takings Clause,[135] the Supreme Court has not developed a "formula to determine where regulation ends and taking begins."[136] Nonetheless, the Court has found that a regulatory taking occurs when a government policy goes "too far," amounting to a de facto taking of property.[137]

The MEDCOM policy results in a de facto taking of a Soldier's prescription medication because it destroys the only true value of a controlled substance. The value of a controlled substance lies wholly in its use to treat an underlying ailment for which the controlled substance was prescribed. Unlike with personal property, controlled substances sales are "regulated transactions"; individuals may not sell or transfer their controlled substances to another individual.[138] In preventing the use of a lawfully prescribed controlled substance, the MEDCOM policy amounts to a "total deprivation" of a Soldier's property rights, and consequently, it is also a regulatory taking.[139]

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[129] *Id*.
[130] Boom Co. v. Patterson, 98 U.S. 403, 406 (1878).
[131] Eversleigh v. United States, 24 Cl. Ct. 357, 359 (1991).
[132] Vansant v. United States, 75 Ct. Cl. 562, 566 (1932).
[133] Reg'l Rail Reorg. Act Cases, 419 U.S. 102, 125-56 (1974).
[134] *Id.*
[135] United States *ex rel.* Tenn. Valley Auth. v. Powelson, 319 U.S. 266, 284 (1943).
[136] Penn. Cent. Transp. Co. v. N.Y. City, 438 U.S. 104, 124 (1978).
[137] Pa. Coal Co. v. Mahon, 260 U.S. 393, 415 (1922).
[138] CSA, *supra* note 57, § 802(39).
[139] Lucas v. S.C. Coastal Council, 505 U.S. 1003, 1017 (1992).

The MEDCOM policy's regulatory taking, however, is lawful because it has two possible public safety bases: 1) to protect Soldiers from the lethal threat of intentional and unintentional overdoses and 2) to separate drug-addicted Soldiers from those Soldiers who still have a legitimate medical need to use prescription medications. And, while done improperly by the current policy's own terms,[140] MEDCOM, as discussed *infra*,[141] has the statutory authority to promulgate a general regulation restricting controlled substance use—at least for MEDCOM Soldiers—pursuant to Article 92 of the UCMJ.[142] As such, MEDCOM may take; the question is whether it must also pay.

The unique legal status of Soldiers also impacts their property rights, which differ from those in civilian life. "Though the Army zealously enforces respect for the right of its individual members to enjoy their property, this right is by no means absolute, and may be restricted when military necessity requires."[143] Over the last century, the Army has regulated Soldiers' ownership and use of personal property. For example, a military court upheld the prohibition on operating a privately owned vehicle by Soldiers in West Germany.[144] To an extent, this restriction is similar to the total loss of use for controlled substances; the value of a car, in most cases, lies in its utility for transportation, which was impaired (if not eliminated) by the restriction. Indeed, most Army posts prohibit items deemed as drug paraphernalia, restricting Soldiers from possessing personal property like rolling papers and smoking pipes.[145] In upholding such regulations, military courts often stress that property-right limitations must be "reasonably necessary" to a legitimate duty.[146] In short, when an order is "found to be reasonably in furtherance of a service's duty to protect the morale, discipline, and usefulness of its members, it may be enforced although in deprivation of an established private right or interest."[147]

Under the Fifth Amendment, any lawful taking by the government requires just compensation to the affected property owner,[148] but the

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[140] *See infra* Part VIII.C.
[141] *See infra* Part IX.C.
[142] UCMJ art. 92 (2012).
[143] United States v. Jordan, 30 C.M.R. 424 (A.B.R. 1960).
[144] United States v. Smith, 26 C.M.R. 20 (C.M.A. 1958).
[145] *See, e.g.*, Memorandum from Commanding General, Fort Hood to Fort Hood et al., subject: Prohibited Substances (15 Dec. 2014) (banning all drug paraphernalia).
[146] United States v. Jordan, 30 C.M.R. 424, 428 (A.B.R. 1960).
[147] United States v. Dykes, 6 M.J. 744, 747 (N.C.M.R. 1978).
[148] U.S. CONST. amend. V.

economic value of a controlled substance is difficult to quantify. The Supreme Court has construed just compensation to mean fair economic compensation for the property at the time of the loss.[149] Generally, the value of a taken item is determined by resort to the fair market value.[150] But controlled substances prescribed to an "ultimate user" may not be sold to another person pursuant to the Controlled Substances Act, and therefore, they have no economic value to any other person.[151] Put simply, controlled substances have no market value. When there is no fair-market value, courts sometime resort to an item's value in the primary market for that item, i.e., the market cost for the government to buy the items from pharmaceutical manufacturers and wholesalers.[152] This latter market, though, is completely inaccessible to Soldiers, undermining its application to a value determination.[153] Courts, consequently, will have a hard time in determining a Soldier's economic loss resulting from the Army's lawful regulatory taking.

Whatever valuation model is used, Soldiers suffering from a taking will likely fall into two groups. First, some Soldiers who are prohibited from using expired controlled substances will likely have continuing medical conditions that require renewed prescriptions. These Soldiers, in practice, would have no loss because controlled substances, by their very nature, are fungible. Consequently, they can simply obtain a new prescription.

Second, some Soldiers prevented from using expired prescriptions will be denied renewed prescriptions due to a lack of a presenting medical condition requiring medication. Among this group, some Soldiers will only suffer a de minimis loss amounting to the leftover prescriptions following a six-month treatment regimen. For this subgroup, the Army presumably can take proactive measures to minimize any loss by ensuring providers practice controlled substance prescription minimization (i.e., only prescribing an amount of controlled substances adequate to treat the medical condition over a six-month

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[149] United States *ex rel.* TVA v. Powelson, 319 U.S. 266, 284 (1943); United States v. Reynolds, 397 U.S. 14, 16 (1970).
[150] United States v. Miller, 317 U.S. 369, 374 (1943).
[151] CSA, *supra* note 57, § 802(10), (27).
[152] Only Drug Enforcement Agency (DEA) registrants may purchase and issue prescriptions (e.g., researchers, pharmacists, and physicians). *Registration Applications Questions and Answers*, DRUG ENFORCEMENT AGENCY, http://www.deadiversion.usdoj.gov/drugreg/faq.htm (last visited May 19, 2015).
[153] *Id.*

period). To the extent courts do not consider leftover prescription drugs to be de minimis or for Soldiers with large amounts of leftover or costly prescriptions, those Soldiers could (at least theortically) file a claim for the loss in federal court.

Soldiers faced with a denial of replacement medications may file suit for their loss under the Little Tucker Act.[154] This Act waives sovereign immunity for claims against the United States founded on the destruction of private property.[155] But jurisdiction alone is not enough to file a claim; the Soldier must also have another source of law providing a cause of action that mandates monetary compensation by the Federal Government.[156] An uncompensated taking under the Fifth Amendment is one such cause of action.[157] Accordingly, Soldiers may file a claim against the United States to recover money damages for the regulatory taking of their private property in federal court.[158] For cases in which damages sought are less than $10,000, which should encompass almost all claims filed against the MEDCOM policy, a Soldier may file in either federal district court or the Court of Federal Claims. As detailed *supra*,[159] the applicable court would face the daunting task of determining the value, if any, of the Soldier's loss.

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[154] 28 U.S.C. § 1346(a)(2) (2012). It is unlikely that other potential causes of action—a Federal Tort Claims Act (FTCA) or a *Bivens* claim—would apply. While the FTCA does provide for the waiver of sovereign immunity for some torts caused by federal employees, the FTCA does not apply to constitutional torts. F.D.I.C. v. Meyer, 510 U.S. 471, 479 (1994). Alternatively, a Soldier's *Bivens* claim is also unlikely to succeed. *See* Bivens v. Six Unknown Named Agents of Fed. Bureau of Narcotics, 403 U.S. 388 (1971). A *Bivens* claim allows a person to sue federal officials for deprivations of her or his constitutional rights. *Id.* at 397. Federal officials, including Army Soldiers, have absolute immunity if they were acting within the scope of employment and "special factors counsel[] hesitation." *Id.* In *Chappell*, the Supreme Court held that "the unique disciplinary structure of the Military Establishment and Congress's activity in the field" were two such special factors. Chappell v. Wallace, 462 U.S. 296, 304 (1983). Furthermore, the Supreme Court in *Stanley* held there is no *Bivens* remedy for injuries that "arise out of or are in the course of activity incident to service." United States v. Stanley, 483 U.S. 669, 684 (1987). Considering the special-factors analysis and the official policy that would make any injury incident to service, a *Bivens* claim is unlikely to be a successful claim in federal district court.

[155] 28 U.S.C. § 1346(a)(2) (2012).

[156] United States v. Mitchell, 463 U.S. 206, 216-17 (1983).

[157] *See* LaChance v. United States, 15 Cl. Ct. 127, 130 (1988) (stating that a Fifth Amendment taking without just compensation claim would have been sufficient for jurisdiction).

[158] 28 U.S.C. § 1346(a)(2) (2012).

[159] *See supra* Part VI.B.

C. Administrative Procedures Act Analysis

As with all new federal regulations, the MEDCOM policy is subject to challenge for failure to follow the Administrative Procedures Act (APA).[160] The APA, in part, lays out the process for federal agencies to make rules.[161] Unlike Little Tucker Act claims, the APA does not provide subject matter jurisdiction over monetary claims.[162] Instead, the APA provides that an individual suffering a "legal wrong" or an adverse affect by an agency action may petition a federal district court for review of the process by which the federal agency made its decision.[163]

The Department of the Army is not per se excluded from review under the APA although the specific functions of courts-martial, military commissions, and a commander's decisions in the field in a time of war are.[164] The MEDCOM policy does not fall under any of these exclusions, so it is not exempted from reviewability pursuant to the exceptions. Under the APA, "[n]otice of a proposed rule, opportunity for public comment, and publication of the final rule are central tenents of the rule making process . . . ."[165] The MEDCOM policy, then, is potentially subject to APA review because it invokes all three of these central tenents—the Army has put in a place a rule without publication in the Federal Register or public comment regarding restrictions on a Soldier's use of controlled substances.[166]

Notably, however, the informal and formal rulemaking provisions of the APA provide a specific exception for "military affairs functions,"[167] and the designation of an agency act as a "military function" is "normally dispositive" to the outcome.[168] While the APA does not define this

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[160] 5 U.S.C. § 551 et seq. (2012).
[161] *Id*.
[162] Crocker v. United States, 37 Fed. Cl. 191 (1997).
[163] 5 U.S.C. § 702 (2012). The term legal wrong includes an action by an agency that is outside of the agency's authority (i.e., outside of the law or regulation). *Id*.
[164] 5 U.S.C. §§ 551(1)(F), (G) (2012).
[165] United States v. Ventura-Melendez, 321 F.3d 230 (1st Cir. 2003).
[166] Roger P. Freeman, *Construction and Application of "Military Function" Exception to Notice and Comment Requirements of Administrative Procedure Act*, 133 A.L.R. FED. 537 (2013).
[167] 5 U.S.C. § 553(a)(1) (2012). The same exception also applies to adjudications. 5 U.S.C. § 554 (2012).
[168] Freeman, *supra* note 166.

term,[169] the failure to include an outright exemption of military departments may indicate that the term was not intended to cover all of a military department's activity.[170] For example, Army Corps of Engineers work on navigable waters has been designated as a civil, not military, function.[171] Nonetheless, DoD has a long-standing assertion, to which courts traditionally defer,[172] that nearly all of its activities fall under the exception.[173]

To be sure, while the Attorney General's Manual on the APA, which is considered an authoritative source on the APA's interpretation, indicates a narrow interpretation of the term,[174] recent cases have been more expansive in detailing the reach of the military functions exception.[175] The Supreme Court, in dicta on a case resting in part on APA jurisdiction, expressed "great deference to the professional judgment of military authorities concerning the relative importance of a particular military interest" and to "professional military judgments" regarding the "control of a military force,"[176] indicating an expansive view of the scope of the military-functions exemption. In the more recent case of *Ventura-Melendez*, the First Circuit upheld the United States Navy's live-fire security zone that prohibited ship traffic, including civilian fisherman, around a naval range in Puerto Rico and the subsequent arrest of civilian protestors who breached the zone.[177] In other words, pursuant to the military functions exception, the court exempted a rule promulgated by the Navy that reached civilian, not just military, conduct from the APA's rulemaking requirements. Given the considerable deference in this attenuated case and the expansive views espoused by the Supreme Court, the MEDCOM policy, which is more closely aligned with military interests and effectively applies to military

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[169] *Id.*

[170] Major Thomas R. Folk, *The Administrative Procedure Act and the Military Departments*, 108 MIL. L. REV. 135, 140 (1985).

[171] *Id.*

[172] Udall v. Tallman, 380 U.S. 1, 16-18 (1965).

[173] *House Committee on Government Operations, Survey and Study of Administration, Organization, Procedure, and Practice in the Federal Agencies*, 85th Cong. pt. 3 (1957).

[174] *See* S. REP. NO. 79-752, at 13-14 (1945), *reprinted in* ADMINISTRATIVE PROCEDURE ACT: LEGISLATIVE HISTORY 1944-45, at 184, 198-99 (1946); U.S. DEP'T OF JUSTICE, ATTORNEY GENERAL'S MANUAL ON THE APA 26-28 (1947).

[175] *See* McDonald v. McLucas, 371 F.Supp. 837 (S.D.N.Y. 1973) (changing personnel status from missing-in-action to deceased terminated civilian spouse's survivor's benefits); Bridges v. Davis, 443 F.2d 970 (9th Cir. 1971) (barring civilians from military posts).

[176] Winter v. NRDC, Inc., 555 U.S. 7, 24 (2008).

[177] United States v. Ventura-Melendez, 321 F.3d 230, 233 (1st Cir. 2003).

personnel only, can readily meet the requirements of the "military functions" exception. The MEDCOM policy regulates Soldier conduct for the good order and safety of the unit and amounts to the protection of military interests and is almost certain to be deemed a military function, exempting the action from the reach of the APA.

In addition to the military-functions exception, the MEDCOM policy is also exempt under the agency management and personnel provision of the APA. Federal agencies do not have to follow APA rulemaking procedures for rules aimed at internal management and personnel matters provided the regulations do not regulate persons outside of the agency.[178] The MEDCOM policy is only aimed at a Soldier's use of controlled substances, which is a purely internal personnel matter. The narrow applicability to active-duty Soldiers means non-agency persons are not subject to the MEDCOM policy, and challenges to Army personnel policies similar in scope have been held by courts to be outside the APA's purview.[179] Consequently, the Army had no legal duty to follow the APA's rulemaking requirements for the MEDCOM policy change.

VII. Legal Doctrines Precluding Judicial Review

A. Introduction

While claims for violating the APA are unlikely to be successful, a constitutional taking claim pursuant to the Little Tucker Act could potentially win on the merits if the Army does not, according to a court's determination, provide just compensation. A meritorious claim, though, is not enough. Depending on the venue in which Soldiers file their claim—federal district court or the Court of Federal Claims[180]—two other legal doctrines, the non-reviewability of military decisions and judicial deference to the military, will likely preclude compensation as a result of the MEDCOM policy.

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[178] 5 U.S.C. § 553(a)(2) (2012); Joseph v. United States Civil Serv. Comm'n, 554 F.2d 1140, 1153 n.23 (D.C. Cir. 1977).

[179] In two separate cases, one before a federal district court and another before a military appellate court, the courts held that "internal personnel rules" found in Army policies are exempt from the APA's rulemaking provisions. *See* Pruner v. Dep't. of the Army, 755 F. Supp. 362 (D. Kan. 1991); United States v. Morse, 34 M.J. 677 (A.C.M.R. 1992).

[180] Federal district courts and the Court of Federal Claims have concurrent jurisdiction over takings claims that do not exceed $10,000. 28 U.S.C. § 1346(a) (2012). For claims exceeding $10,000, the Court of Federal Claims has exclusive jurisdiction. *Id*.

B. *Mindes* Test

In applicable jurisdictions, the doctrine of non-reviewability of military decisions will preclude servicemembers from bringing a claim in federal district court. This doctrine is set forth in the *Mindes* test, which is employed to determine justiciability of administrative claims against the military.[181] The *Mindes* test involves two distinct steps. First, a court determines if a plaintiff has exhausted all administrative remedies[182] and has alleged a violation by the military of the United States Constitution, a federal statute, or the military's own regulations.[183] The *Mindes* test's second step requires weighing the Soldier's allegations against the reasons for precluding review;[184] the four factors balanced as part of this step are: 1) the nature and weight of the plaintiff's claim; 2) the potential injury to the plaintiff if review is denied; 3) the extent of interference in military matters; 4) and the degree to which military expertise and discretion are involved.[185]

At first blush, the initial step of the *Mindes* test would appear to preclude some, but not all, Soldiers' claims of unconstitutional taking by the MEDCOM policy because a Soldier must prove he or she has exhausted all administrative remedies. However, there are no administrative remedies for constitutional taking claims flowing from the MEDCOM policy. For example, Article 138 claims by Soldiers require a discretionary act by their commanders; however, any injury inflicted by the MEDCOM policy is independent of a commander's actions.[186] Similarly, the takings claim is independent of the final administrative review process provided by the Army Board of Correction for Military Records, which Soldiers must normally exhaust before judicial review.[187] The Army also has no claims process to handle such cases; instead, the Army refers takings claims to federal courts.[188] Normally, the burden of successfully navigating the administrative appeals process and the amount of time required to exhaust administrative remedies would

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[181] Mindes v. Seaman, 453 F.2d 197 (5th Cir. 1971).

[182] The Supreme Court's invalidation of a judicial requirement of exhaustion in the civilian context is unlikely to apply to the military. *See* E. Roy Hawkens, *The Exhaustion Component of the* Mindes *Justiciability Test is Not Laid to Rest by Darby v. Cisneros*, 166 MIL. L. REV. 67 (2000).

[183] *Mindes*, 453 F.2d at 201.

[184] *Id.* at 201-02.

[185] *Id.*

[186] 10 U.S.C. § 938 (2012).

[187] 10 U.S.C. § 1553 (2012).

[188] U.S. DEP'T OF ARMY, REG. 27-20, CLAIMS para. 1-4(e)1 (8 Feb. 2008).

preclude a number of claims moving forward, but not for taking claims. Thus, the first step of *Mindes* is met.

The second step of the *Mindes* test tilts towards non-reviewability of the MEDCOM policy. The first and second factor requires examination of the importance of the Soldier's challenge and harm to the Soldier if review is denied. The *Mindes* court separated out constitutional challenges based on their relative weight; for example, the *Mindes* court's comparison of "haircut regulation questions to those arising in court-martial situations which raise issues of personal liberty" implies, at least by juxtaposition, that some constitutional claims are not as strong as others. While property rights are covered in several sections of the Constitution,[189] the property rights at issue in this policy are, as discussed *supra*,[190] relatively limited. The policy only applies to whatever leftover medicine remains after six-months of use, and no lawful secondary market exists for the resale of these items. Because Soldiers are not precluded from receiving a new prescription for a persistent medical condition, any injury to a Soldier will be modest, at best.[191] In short, the policy only marginally infringes on a Soldier's property, and the weight of this claim and potential harm to the Soldier skew toward non-reviewability.

The third *Mindes* factor—potential interference with military matters—is the only factor that favors a Soldier's claim. The court's review of these claims competes with no essential military functions since, in the absence of a framework to dispose of use-violation cases, as detailed *infra*,[192] a determination of "authorized" or "illegitimate" use of a lawfully prescribed controlled substance has little practical effect. Striking down the expiration mandates at most a revision of the MEDCOM policy to excise that portion of the policy. However, the MEDCOM policy, to the extent it is followed voluntarily by Soldiers, might have an impact on the correlation noted by the *Red Book* between prescription drug use and suicide.[193] As detailed *infra*,[194] the underlying

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[189] *See*, e.g., U.S. CONST. art. I, § 8; amend. V.
[190] *See supra* Part VI.B.
[191] The worst potential injury is if the Soldier is refused a new prescription by a healthcare provider. In such cases, however, the underlying medical condition, or at least treatment through a prescription drug, no longer exists, and the Soldier would arguably have no legitimate basis to continue using the prescription drug.
[192] *See infra* Part VIII.
[193] *See* RED BOOK, *supra* note 10, at 56.
[194] *See infra* Part X.

data supporting this correlation is not as strong as initially believed, indicating that the ultimate effect of a judicial ruling on Soldiers may be modest. Indeed, before the 2011 change to the MEDCOM policy, the Army did not have an expiration date for its controlled substances,[195] so reverting to the prior regulatory provision requires no substantial revision to ensure conformity with a judicial ruling. Furthermore, striking the MEDCOM policy would not require judicial oversight during implementation, a persistent worry for federal judges.[196]

Finally, the last factor is strongly in favor of the MEDCOM policy. Determining how to deal with the scourge of suicide and controlled substance abuse in the ranks is quintessentially a military decision. While substance abuse is a problem in civil society, the problem of military suicides is multifactorial and befalls servicemembers at a greater per-capita rate than civilians.[197] As a "separate society" confronting a challenging problem, the military is the institution best suited to determine appropriate solutions to a distinctive military problem.[198] A court would be loathe to overrule military action in this field.

Viewing all four factors, a federal judge is likely to hold the *Mindes* test precludes review. As a balancing test, a purely numerical approach—three factors for precluding review and one factor in favor of review—is unlikely to persuade a judge to rule in favor of either side. Instead, a judge will probably focus on the harm to the plaintiff and the impact on the Army. Thus, the relatively minor injury to the Soldier's property rights and the Army's strong desire to take action against the suicide problem plaguing the ranks will likely lead a judge to preclude review in *Mindes*-test jurisdictions.

While the *Mindes* test is likely to bar judicial review, the *Mindes* test does not apply universally across all federal courts. Two-thirds of federal appellate courts follow the test,[199] but the Supreme Court has

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[195] *See* MEDCOM REG. 2010, *supra* note 77; MEDCOM REG. 2005, *supra* note 77.
[196] Gilligan v. Morgan, 413 U.S. 1, 10 (1973).
[197] RED BOOK, *supra* note 10, at 14, 16.
[198] Parker v. Levy, 417 U.S. 733, 743 (1974).
[199] Penagaricano v. Llenza, 747 F.2d 55 (1st Cir. 1984) (applying *Mindes*); Williams v. Wilson, 762 F.2d 357 (4th Cir. 1985) (applying *Mindes*); Schultz v. Wellman, 717 F.2d 301 (6th Cir. 1983) (applying *Mindes*); Nieszner v. Mark, 684 F.2d 562 (8th Cir. 1982) (applying *Mindes*); Wenger v. Monroe, 282 F.3d 1068 (9th Cir. 2002) (applying *Mindes*); Lindenau v. Alexander, 663 F.2d 68 (10th Cir. 1981) (applying *Mindes*); Stinson v. Hornsby, 821 F.2d 1537 (11th Cir. 1987) (applying *Mindes*).

never addressed it.[200] The Court of Federal Claims has not adopted the *Mindes* test.[201] Since the vast majority of active-duty Army installations are in *Mindes* jurisdictions,[202] the test would likely apply to most cases and preclude judicial review in federal district court. For those Soldiers filing claims in a jurisdiction that does not follow *Mindes* or in the Court of Federal Claims, the doctrine of judicial deference to the military would, nonetheless, likely preclude compensation.

C. Judicial Deference to the Military

The Supreme Court has consistently applied a high level of deference to review of military actions.[203] This deference has been characterized by some legal commentators as the "highest degree of deference,"[204] and it has even been criticized by others as "judicial abdication."[205] The Court itself, however, has clearly stated this deference does not bar all claims: "[T]his Court has never held . . . that military personnel are barred from all redress in civilian courts for constitutional wrongs suffered in the course of military service."[206] Lower courts have struggled in applying this "highest degree of deference" rule because it does not produce meaningful standards to apply in cases.[207] The juridical underpinning of deference to military authorities—separation of powers considerations and institutional inability—are no more help than the Court's own decisions in determining an appropriate standard of

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[200] Hawkens, *supra* note 182, at 69.

[201] The Court of Federal Claims treats nonjusticiable claims under *Mindes* as a motion for failure to state a claim upon which relief can be granted. Bond v. United States, 47 Fed. Cl. 641, 647 (2000).

[202] Troy C. Wallace, *Command Authority: What Are the Limits on Regulating the Private Conduct of America's Warriors?*, ARMY LAW., May. 2010, at 13, 19 n.105 (noting *Mindes* jurisdictions include Alabama, Arizona, California, Colorado, Florida, Georgia, Louisiana, Maryland, New Mexico, North Carolina, Oklahoma, South Carolina, Texas, and Virginia).

[203] *See*, *e.g.*, Parker v. Levy, 417 U.S 733 (1974); Rostker v. Goldberg, 453 U.S. 57 (1981); Chappell v. Wallace, 462 U.S. 296 (1983).

[204] The Honorable Sam Nunn, *The Fundamental Principles of the Supreme Court's Jurisprudence in Military Cases*, 29 WAKE FOREST L. REV. 557, 557 (1994).

[205] C. Thomas Dienes, *When the First Amendment is Not Preferred: The Military and Other 'Special Contexts'*, 56 U. CIN. L. REV. 779, 779 (1988). Major John P. Jurden, *Spit and Polish: A Critique of Military Off-Duty Personal Appearance Standards*, 184 MIL. L. REV. 1, 26 (2005).

[206] *Chappell*, 462 U.S. at 304-05.

[207] Seth Harris, *Permitting Prejudice to Govern: Equal Protection, Military Deference, and Exclusion of Lesbian and Gay Men from the Military*, 17 N.Y.U. REV. L. & SOC. CHANGE 171, 208 (1990).

review.[208] Nonetheless, existing court precedent makes it highly unlikely that a Soldier's taking claim would be reviewable in federal court.

The Supreme Court's separation of powers basis for military deference is predicated on a textual reading of the Constitution. Because of the Constitution's grant of plenary authority over the military to the political branches, the Court has held these branches alone are vested with setting military policy, providing little space for judicial review.[209] "Judicial deference . . . is at its apogee when legislative action under the congressional authority to raise and support armies and make rules and regulations for their governance is challenged."[210] Indeed, the Court has reasoned that a more expansive use of judicial review of military policy might lead to continuing judicial oversight of the military, which in and of itself would violate the separation of powers principle.[211]

The second basis for deference is the judiciary's institutional inability to evaluate military decisions. The Court has concluded that the military is a "specialized society separate from civilian society,"[212] with different constitutional parameters that "render permissible within the military that which would be constitutionally impermissible outside it."[213] The Supreme Court, whose current Justices have no previous military service,[214] are outsiders looking in at any military action, making review of this separate society particularly difficult. In this vein, the Court has stated it would give "great deference to the professional judgment of military authorities concerning the relative importance of a particular military interest" and to the "essentially professional military judgments" concerning the "composition, training, equipping, and control of a military force."[215] The Supreme Court has not been coy in its basis for deference in this area: "[it is] difficult to conceive of an area of governmental activity in which the courts have less competence,"[216] and

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[208] Jurden, *supra* note 205, at 23-24.
[209] U.S. CONST. art. I, § 8, cls. 12-14; art. II, § 2, cl. 1; *Chappell*, 462 U.S. at 301-02.
[210] Rostker v. Goldberg, 453 U.S. 57, 70 (1981).
[211] Gilligan v. Morgan, 413 U.S. 1, 10 (1973).
[212] Parker v. Levy, 417 U.S. 733, 743 (1974).
[213] *Id.*
[214] Andrew Cohen, *None of the Supreme Court Justices Has Battle Experience*, THE ATLANTIC, Aug. 13, 2012, *available at* http://www.theatlantic.com/national/archive/2012/08/none-of-the-supreme-court-justices-has-battle-experience/260973/ [herinafter A. Cohen].
[215] *Gilligan*, 413 U.S. at 10.
[216] *Id.*

the Court is "ill-equipped to determine the impact upon discipline that any particular intrusion upon military authority might have."[217]

This unique level of deference does not amount to judicial abdication. Even with great deference in place, courts have, on occasion, reviewed and struck down unlawful military policies.[218] The Supreme Court has held that in doffing their civilian clothes Soldiers "may not be stripped of their basic rights"[219] even if those rights are more limited than in the civilian context.[220] Indeed, the military appellate courts in particular have been wont to strike down military orders that too broadly sweep into the private affairs of servicemembers.[221]

In the unlikely event that a Soldier's taking without just compensation claim makes it to trial in either the Court of Federal Claims[222] or federal district court, under the high-level of deference espoused by the Supreme Court, the claim's chances of success are remote. Because no federal statutory or regulatory authority delineates the expiration of a lawfully prescribed controlled substance, MEDCOM does not directly conflict with any specific congressional dictate, and separation of powers is minimally relevant. The issue underlying the policy—suicide—is a multifactorial one that is plaguing the "separate society" of the military at a greater rate than comparable civil society,[223] indicating a uniquely military problem. Given the lack of military experience in current Justices of the Supreme Court and existing precedent lending support to great deference to the military on martial matters, there is little doubt that institutional incompetence would compel a court to bar compensation and defer to the Army's judgment that the MEDCOM policy is necessary to confront the suicide epidemic.

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[217] United States v. Stanley, 483 U.S. 669, 683 (1987); Jurden, *supra* note 205, at 27 ("Indeed, *Parker*'s lasting legacy seemingly is that courts routinely dispense with the need for the military to demonstrate a nexus between their regulations and the purposes they seek to promote.").

[218] Youngstown Sheet & Tube Co. v. Sawyer, 343 U.S. 579 (1952).

[219] Earl Warren, *The Bill of Rights and the Military*, 37 N.Y.U. L. REV. 181, 188 (1962).

[220] Parker v. Levy, 417 U.S. 733, 743 (1974).

[221] *See*, e.g., United States v. Milldebrandt, 25 C.M.R. 139 (C.M.A. 1958) (invalidating order for servicemember to report personal financial transactions to commander while on leave); United States v. Smith, 1 M.J. 156 (C.M.A. 1975) (striking down regulation prohibiting all loans between servicemembers without prior command approval).

[222] The Court of Federal Claims applies the Supreme Court's great deference standard to the military's discretionary decisions, but the Court of Federal Claims will review a military decision to ensure the military's own procedures are followed in a particular case. Bond v. United States, 47 Fed. Cl. 641, 650 (2000).

[223] Mount, *supra* note 10; RED BOOK, *supra* note 10, at 14, 16.

VIII. Problems for Commanders in Disposing of Cases

A. Introduction

The fundamental problem with the MEDCOM policy is that it provides few options for a commander to dispose of policy violations. Unless withheld by superior authority, commanders have near unfettered discretion to dispose of breaches of the UCMJ.[224] The key, of course, is that the alleged act must be a crime. Violations of MEDCOM Regulation 40-51 cannot be appropriately labeled as criminal. As set forth *infra*,[225] violating the policy is not a breach of a general regulation, wrongful use of a controlled substance, or within the orbit of the general article of Article 134. The only potential criminal violation is failure to follow a personal order from a military healthcare provider to the patient regarding the use of prescribed drugs. Such violations, however, will have problems of evidentiary proof and are unlikely to be of widespread applicability.[226] In the absence of a potential disobedience crime, the only legal option left to a commander is to take no UCMJ action against a Soldier who violated the policy.

Outside of criminal mechanisms, commanders are also limited in employing administrative remedies for policy violations. Normally, commanders faced with cases difficult to prove beyond a reasonable doubt may employ administrative measures, which have a lesser standard of proof, to dispose of the case.[227] Such measures cannot be applied here, however, because, with the exception of MROs assigned to MEDCOM, Soldiers have not violated an Army policy. The MEDCOM policy only applies to MROs, not all Soldiers,[228] and Soldiers have no duty to obey a regulation that explicitly does not apply to them. Consequently, commanders struggling with how to deal with breaches of

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[224] MANUAL FOR COURTS-MARTIAL, UNITED STATES, R.C.M. 306 (2012) [hereinafter MCM].
[225] *See infra* part VIII.B, C, D.
[226] *See infra* Part VIII.E.
[227] *See, e.g.*, U.S. DEP'T OF ARMY, REG. 635-200, ACTIVE DUTY ENLISTED ADMINISTRATIVE SEPARATIONS (6 June 2011) (RAR 6 Sep. 2011) [hereinafter AR 635-200]; U.S. DEP'T OF ARMY, REG. 600-37, UNFAVORABLE INFORMATION (19 Dec. 1986) [hereinafter AR 600-37].
[228] MEDCOM REG. 2013, *supra* note 16, para. 3.

the MEDCOM policy may at most counsel their Soldiers on the importance of responsible prescription drug use.

B. Wrongful Use

Violating the MEDCOM policy cannot be construed as wrongful use of a controlled substance under the UCMJ.[229] For use of a controlled substance to be wrongful, the MCM sets forth four elements: 1) an accused used a controlled substance; 2) an accused knew he used a controlled substance; 3) an accused knew the controlled substance was contraband; and 4) the use was wrongful.[230] The first three elements are easily met for policy violations determined through a urinalysis. For the first element, use of a controlled substance can be proven through urinalysis test results and expert testimony,[231] and, for the second element, the Soldier's knowledge of the substance used can be inferred through the Soldier's prescription from a medical provider, testimony of the prescribing medical provider, or receipt of the controlled substance by the Soldier from a pharmacist. Finally, the Soldier's knowledge that the controlled substance is contraband, a substance that is "illegal to use"[232] without a legitimate prescription, can be shown through testimony of the prescribing medical provider or pharmacist who filled the prescription.

However, the last element poses an insurmountable problem for deeming such violations as wrongful use. Taken to its logical extreme, the MEDCOM policy would eliminate the innocent-use defense.[233] The use of a controlled substance is wrongful if and only if it is "without legal justification or authorization."[234] In cases with no "evidence to the contrary," the wrongfulness of a Soldier's use of a controlled substance may be inferred based on the circumstances.[235] However, if the

[229] MCM, *supra* note 224, pt. IV, ¶ 37.
[230] *Id*. pt. IV, ¶ 37b(2); U.S. DEP'T OF ARMY, PAM. 27-9, MILITARY JUDGES' BENCHBOOK para. 3-37-2c (10 Sep. 2014) [hereinafter BENCHBOOK].
[231] *See* United States v. Campbell, 52 M.J. 386 (C.A.A.F. 2000).
[232] MCM, *supra* note 224, pt. IV, ¶ 37.b.(2); BENCHBOOK, *supra* note 230, para. 3-37-2c n.3.
[233] *See* United States v. Walters, 22 C.M.R. 255 (C.M.A. 1973); United States v. West, 34 C.M.R. 449 (C.M.A. 1964).
[234] MCM, *supra* note 224, pt. IV, ¶ 37.c.(5); United States v. Harper, 22 M.J. 157, 162 (C.M.A. 1986).
[235] United States v. Ford, 23 M.J. 331, 332 (C.M.A. 1987); *see also* BENCHBOOK, *supra* note 230, para. 3-37-2 n.6.

controlled substance used by a Soldier was "duly prescribed"[236] by a physician and the prescription was not obtained by fraud, the use is considered innocent.[237] In such cases, the permissive inference of wrongfulness fails, and the prosecution "must affirmatively prove" the wrongfulness of use.[238]

Once the innocent use defense is raised, the prosecution must prove wrongfulness by establishing the accused fraudulently obtained and used the prescription or by "establishing that the drug was not prescribed for legitimate medical purposes, and the accused was aware of this fact."[239] Or to put it another way, the accused must have known that the doctor medically should not have prescribed the drug. Without more evidence, mere violation of MEDCOM's policy does not establish fraudulent obtainment or use or establish an illegitimate medical purpose for the prescription.[240] To put it simply, the word "wrongful" cannot be construed to make such use in violation of a (probably non-binding MEDCOM policy), in fact, legally "wrongful." And given the defense of innocent use is provided by case law, a regulation employed as a mechanism to make such use wrongful will fail in court, especially in light of the wide latitude given to this defense by military courts.[241]

C. General Regulation

A violation of the MEDCOM policy may appear punishable for failure to follow a general regulation; however, the policy does not meet

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[236] "[D]uly prescribed means no more than prescribed by a physician for legitimate medical purposes." United States v. Moore, 24 C.M.R. 647, 649 (A.F.B.R. 1957).

[237] *Id.*

[238] *Id.*

[239] *Id.*

[240] The limited case-law pertaining to illegitimate medical purposes focuses on the basis for which a doctor prescribes a drug. For example, courts have held using anabolic steroids prescribed by a German doctor for bodybuilding and morphine prescribed by a Korean doctor for drug addiction are for nonmedical purposes and, therefore, are wrongful uses. United States v. Commander, 39 M.J. 972, 978 (A.F.C.M.R. 1994); United States v. Moore, 24 C.M.R. 647, 649 (A.F.B.R. 1957); United States v. Pariso, 65 M.J. 722, 724 (A.F. Ct. Crim. App. 2007); United States v. Gerds, 2012 CCA Lexis 450, at *9 (A.F. Ct. Crim. App. Nov. 29, 2012).

[241] Indeed, the *Lancaster* court held that the use of leftover prescription drugs for an ailment different than the one prescribed, but that still treated the same underlying symptom for which the drug was originally prescribed, is not per se wrongful use, indicating the scope of the innocent-use defenses. United States v. Lancaster, 36 M.J. 1116 (A.F.C.M.R. 1993).

the requisite elements for such a violation.[242] As set forth in the *MCM*, a violation of a general regulation requires three elements: 1) a lawful general regulation; 2) that an accused had a duty to obey; and 3) the accused violated the regulation.[243] While the third element can be easily meet through urinalysis evidence furnished by an MRO, the first two elements cannot be established. Under the *MCM* and case-law, lawful general regulations must: 1) be issued by competent authority;[244] 2) prohibit specific conduct;[245] 3) apply to a specified group, which includes the alleged violator;[246] 4) establish criminal sanctions, not mere policy guidance;[247] 5) not conflict with regulations from superior authority;[248] and 6) not already be prohibited by the punitive articles of the UCMJ.[249]

Under these six criteria, MEDCOM Regulation 40-51 is not a lawful general regulation and Soldiers, outside of those serving as MROs, do not have a duty to obey it. The policy does not establish any criminal sanctions, which is required for general regulations. Within the fourteen pages of the policy,[250] no specific acts are deemed punitive, and explicit enunciations of the punitive nature of the regulation or specified paragraphs within the regulation are required for general regulations to rise above "mere policy guidance."[251] By the policy's own terms, the MEDCOM policy only applies to the exceedingly small subset of Soldiers serving as MROs, not to all Soldiers in the Army.[252] Consequently, only those Soldiers in MRO billets would be among a specified group for which the general regulation applied and having a corresponding duty to obey the terms of the regulation. All other Soldiers in the Army would not be in the specified group and would have no obligation to obey a MEDCOM policy.

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[242] MCM, *supra* note 224, pt. IV, ¶ 16.a.(1).
[243] *Id.*
[244] The *MCM* enumerates several individuals with authority to issue general regulations, including the Secretary of the Army, a general court martial convening authority, and a general officer in command. *Id.*
[245] *See* United States v. Baker, 40 C.M.R. 216 (C.M.A. 1969).
[246] *See* United States v. Jackson, 46 C.M.R. 1128 (A.C.M.R. 1973).
[247] *See* United States v. Green, No. 20010446, 2003 CCA Lexis 137 (A. Ct. Crim. App. June 6, 2003).
[248] *See* United States v. Green, 22 M.J. 711 (A.C.M.R. 1986).
[249] *See* United States v. Curry, 28 M.J. 419 (C.M.A. 1989).
[250] *See* MEDCOM REG. 2013, *supra* note 16.
[251] *See Green*, 2003 CCA Lexis 137.
[252] MEDCOM REG. 2013, *supra* note 16, para. 3.

The MEDCOM policy, however, does pass the other elements required for general regulations. First, the policy provides a specific prohibition on conduct, requiring Soldiers to not use their prescribed controlled substances after six months from the prescription date.[253] Second, the policy does not conflict with regulations from superior authority. In fact, the policy implements guidance from Headquarters, Department of the Army in ALARACT 062/2011.[254] Third, the policy does not prohibit conduct already specified in the punitive articles of the UCMJ. As set forth *infra*,[255] a violation of the MEDCOM policy standing alone does not meet the elements of any crime set forth in the UCMJ. Fourth, competent authority issued the policy because the commanding general of MEDCOM is both a general court martial convening authority (GCMCA) and a general in command.[256] Of course, this order would only extend to the GCMCA's MROs because, pursuant to the MEDCOM policy's own terms, it only extends to those individuals in MEDCOM serving in MRO billets.[257]

D. Article 134, UCMJ—General Article

The "General Article" provides for criminalizing behavior that is not otherwise covered in Article 134 if 1) a Soldier did or failed to do something and 2) the Soldier's conduct was prejudicial to good order and discipline or service discrediting.[258] The key proof issue for such crimes is the second element.[259] For good order and discipline charges, a

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[253] *Id*. para. 8e.

[254] ALARACT 062/2011, *supra* note 20, para. 2A.

[255] *See supra* Part VIII.B, D, E.

[256] Headquarters, U.S. Dep't of Army, Gen. Order No. 1994-4 (18 Feb. 1994). Even though the MEDCOM Commanding General did not personally sign the regulation, it is issued under his name, which has been held sufficient for a valid regulation. United States v. Bartell, 32 M.J. 295 (C.M.A. 1991) (upholding a general order signed "by direction").

[257] MEDCOM REG. 2013, *supra* note 16, para. 3. Whether a Medical Corps Soldier who is assigned to a non-Medical Corps billet (i.e., a brigade surgeon) even has a duty to obey a punitive policy issued by a General Court-Martial Convening Authority who is outside of that Soldier's chain of command (i.e., The Surgeon General) is beyond the scope of this article.

[258] MCM, *supra* note 224, pt. IV, ¶ 60.a.

[259] The preemption doctrine would not bar charging a violation of the MEDCOM policy as a crime. This doctrine prohibits using Article 134 for crimes properly charged under Articles 80 to 132, the punitive articles. MCM, pt. IV, ¶ 60.c.(5)(a). Preemption requires that Congress intended the punitive articles to cover a class of offenses completely. United States v. Kick, 7 M.J. 82, 85 (C.M.A. 1979). While violating the MEDCOM

Soldier's conduct must be "directly prejudicial" to a unit's good order and discipline, not "remote or indirect."[260] While seemingly broad in scope, not every irregular or improper act is a punishable offense.[261] As for service discrediting charges, the Soldier's conduct must have a "tendency to bring the service into disrepute or . . . tend[] to lower it in public esteem."[262] The public does not need actual knowledge of a Soldier's act for it to be service discrediting.[263]

Existing societal norms regarding the use of prescribed controlled substance make a violation of the general article of Article 134 an untenable charge. Because use of a prescribed controlled substance from a healthcare provider for the treatment of a medical ailment is an accepted and established practice in the United States and in the Army,[264] a Soldier's use of a prescribed drug after six months from the prescription date would not have a directly prejudicial impact on a unit's discipline. From the battlefield to the garrison, Soldiers regularly interact with other Soldiers who are using prescribed controlled substances for their medical ailments.[265] Without more, mere violation of a medical policy that only applies to MROs[266]—and does not apply to all Soldiers—would have no impact on the good order and discipline of a unit.

Furthermore, a member of the American public would not look askance at any Soldier for the use of a prescribed controlled substance

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policy does not likely breach any punitive articles of the UCMJ, with the possible exception of a disobedience crime, the closest criminal analogue is wrongful use. The legislative history of Article 112a does not reflect Congress's intent to cover all drug offenses that might be prosecuted under Article 134, so the Article 134 charge would not be preempted. *See* United States v. Erickson, 61 M.J. 230 (C.A.A.F. 2005).

[260] MCM, *supra* note 224, pt. IV, ¶ 60c(2).

[261] United States v. Sadinsky, 34 C.M.R. 343 (C.M.A. 1964).

[262] MCM, *supra* note 224, pt. IV, ¶ 60.c.(3).

[263] United States v. Phillips, 70 M.J. 161 (C.A.A.F. 2011).

[264] *NABP, Stakeholders Release Consensus Document on the Challenges and "Red Flag" Warning Signs Related to Prescribing and Dispensing Controlled Substances*, REUTERS, Mar. 12, 2015, http://www.reuters.com/article/2015/03/12/nabp-consensus-doc-idUSnPn5Nyr3C+91+PRN20150312 (setting forth guidelines for health care practitioners "to ensure that all controlled substances are prescribed and dispensed for a legitimate medical purpose, as well as to provide guidance on which red flag warning signs warrant further scrutiny.").

[265] *See, e.g.*, *Blanchfield Army Community Hospital Pharmacy Limits Controlled Substances*, U.S. DEP'T OF ARMY, http://www.campbell.amedd.army.mil/pao/PR1125%20.pdf (last visited May 19, 2015).

[266] MEDCOM REG. 2013, *supra* note 16, para. 3.

after six-months from the prescription date. Members of the public, which all Soldiers were members of before joining the Army, have no expiration date for their use of lawfully prescribed controlled substances[267] and, logically, would not reasonably consider a Soldier's use of a controlled substance for a legitimate medical condition after six-months from prescription as anything but normal.

E. Personal Order

In a limited number of cases, violating a personal order to comply with the expiration prohibitions from the MEDCOM policy may be a lawful basis for punishment. Orders-violation crimes come in two types: willful disobedience to orders from superior commissioned officers and failure to obey an "other lawful order."[268] Both disobedience crimes are related to the violation of a personal order and would not be based on violating the MEDCOM policy.[269] The willful violation of a lawful order requires four elements: 1) an accused received a lawful command from a superior commissioned officer, 2) that an accused knew at the time that the officer was his superior commissioned officer; 3) an accused had a duty to obey the order; and 4) that an accused willfully disobeyed the order.[270] Willful disobedience is defined as "intentional defiance of authority";[271] mere forgetfulness is not enough.[272] Unlike willful disobedience crimes, violations of "other lawful orders" do not require a command from a superior officer nor willful disobedience. All other elements for these crimes are the same.

Though theoretically possible, willful disobedience crimes are unlikely to appear in practice because of issues proving the first and fourth elements. For the first element, violations will most likely ensnare enlisted Soldiers, warrant officers, and junior company-grade officers because a majority of military medical providers are captains and above in the Medical Corps (MC).[273] Consequently, senior company-grade

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[267] Raleigh E-Mail, *supra* note 72.
[268] MCM, *supra* note 224, pt. IV, ¶ 14.a.(2), 16.a.(2).
[269] *See* United States v. Ranney, 67 M.J. 297 (C.A.A.F. 2009).
[270] MCM, *supra* note 224, pt. IV, ¶ 14.b.(2).
[271] BENCHBOOK, *supra* note 230, para. 3-14-2c.
[272] MCM, *supra* note 224, pt. IV, ¶ 14.c.(2).(f).
[273] *Medical Corps Officer Careers & Jobs*, U.S. DEP'T OF ARMY, http://www.goarmy.com/careers-and-jobs/browse-career-and-job-categories/medical-and-emergency/medical-corps-officer.html (last visited June 5, 2015).

officers and above that violate the personal order of a military medical provider who is junior to them in grade or rank cannot meet the first element. The relative ranks of MC officers to their military patients are not the only problem with the first element. Civilian doctors employed by the Army are not superior commissioned officers. Because civilian doctors do not have UCMJ authority to command Soldiers regarding the expiration of prescription drugs, [274] they cannot issue a personal order in accordance with Article 90(2). Finally, the requirement for "intentional defiance" sets a high-bar for the Government in proving a Soldier's intent, making it difficult to establish in court. Thus, violators of personal orders are limited to junior Soldiers and officers who receive commands from their military medical providers and subsequently display indicia of "intentional defiance" to the personal order. Logically, cases meeting these conditions will be exceedingly rare.

Assuming that the person issuing the order and the person receiving the order are in the same military service, because military and civilian doctors do not have a special status to issue orders, Soldiers cannot be prosecuted for violating the "other lawful orders" of their military medical providers. While willful obedience crimes require superior rank, other lawful orders crimes do not require a Soldier issuing an order to be superior in rank to the Soldier receiving the order, eliminating the relative rank issue between patient and provider. However, a military medical provider lacks a special status under the law that would require another Soldier to obey him or her, unlike, for example, military police Soldiers in the performance of their duties have when dealing with superiors.[275]

IX. A Better Tool to Meet the Army's Intent

A. Introduction

While legal, the problem with the MEDCOM policy is that it is an inappropriate tool to regulate prescription drug use. A better policy tool exists. Instead of promulgating the policy through an obscure MEDCOM regulation, pursuant to Article 92 of the UCMJ, [276] the Secretary of the Army has the authority to issue a general order

[274] MCM, *supra* note 224, pt. IV, ¶ 16.b.(2).(a).
[275] *Id*. ¶ 16c(2)(c)(i).
[276] UCMJ art. 92 (2012).

regulating prescribed controlled substance use in the Army, providing commanders a criminal and administrative means to deal with Soldiers who violate the general order. The appendix contains a proposed general order from the Secretary of the Army. Issuing the order from the service secretary, instead of a general court martial convening authority, ensures a uniform system across the Army that all Soldiers have a duty to obey. The Army would not be blazing a novel legal trail by regulating prescription drug use through a general order. In fact, the Secretary of the Navy recently issued a general order barring the use of prescribed controlled substances by Sailors and Marines for the purpose of becoming intoxicated.[277]

B. Scope of the General Order

Because of gaps in the current MEDCOM policy, the general order should not merely recite the current policy restrictions. The Army has two basic means to control a Soldier's prescription drug usage: 1) enforcing limits on the amount of controlled substances a military provider may prescribe or 2) limiting the time for which Soldiers may take their prescriptions. The current MEDCOM policy relates only to the latter; it does not provide guidance or restrictions to military providers on prescription dosages. In part, the failure to address the first pathway is due to the policy mechanism employed. Because the prohibition is contained in a regulation regarding the evaluation of urinalysis test results, there is no logical way to implement a policy minimizing prescription dosages.[278] However, by failing to address this pathway, the Army loses the ability to limit any constitutional taking concerns and decrease ongoing prescription drug costs. Accordingly, the general order should include a mandate, with limited exceptions, that military providers only prescribe the minimum dosage necessary to treat the underlying medical condition.

The general order should also cover a glaring hole in medical surveillance from the current MEDCOM policy—prescriptions from civilian providers. Because there is no Army-wide policy requiring Soldiers to submit civilian prescriptions to their chain-of-command, MROs are left the burdensome task of tracking down Soldiers with

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[277] U.S. DEP'T OF NAVY, SEC'Y OF NAVY INSTR. 5300.28D, MILITARY SUBSTANCE ABUSE PREVENTION AND CONTROL para. 5c (23 May 2011).
[278] *See* MEDCOM REG. 2013, *supra* note 16.

positive urinalysis results for Schedules II through V controlled substances to determine if they were issued any prescriptions from civilian providers.[279] Employing MROs in this investigative method is a poor, and perhaps inappropriate, use of an MRO's time. This surveillance provision would also be particularly helpful for posts without an MTF, such as Fort Drum, New York, [280] or assignments in areas, such as recruiting detachments,[281] that may lack a nearby Army post and where Soldiers may receive almost wholly civilian-provided healthcare. The Navy has also pioneered in the area of prescription drug surveillance. In 2009, the Chief of Naval Operations issued an order requiring Sailors to turn in their prescriptions for controlled substances prescribed by civilian providers regardless of who paid for the prescription drugs.[282] Along with improving medical surveillance in the ranks, the general order would improve continuity of care as Soldiers move from post-to-post because military providers would have a more complete picture of their patients' medical history. Implementing the expiration policy along with these two other measures—improving medical surveillance of civilian-provided prescriptions and limiting dosage to the minimum required to treat the underlying condition—has a higher likelihood of reducing the use of controlled substances in the Army and suicides.

C. Lawfulness of the General Order

All orders from a commander, including the Secretary of the Army, are presumed lawful even if the order interferes with a Soldier's private rights or personal affairs.[283] An order's lawfulness turns on the purpose for which the order was issued.[284] Lawful orders must be "reasonably

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[279] *Id.* para. 9d.

[280] *U.S. Army Medical Treatment Facilities*, U.S. DEP'T OF ARMY, http://evans.amedd.army.mil/newcomer/milhosp2.htm (last visited May 19, 2015).

[281] *U.S. Army Recruiting Command Organization Chart*, U.S. DEP'T OF ARMY, http://www.usarec.army.mil/downloads/hq/USAREC_org_chart.pdf (last visited May 19, 2015).

[282] U.S. DEP'T OF NAVY, CHIEF, NAVAL OPERATIONS INSTR. 5350.4D, NAVY ALCOHOL AND DRUG ABUSE PREVENTION AND CONTROL para. 6i (4 Jun. 2009) ("Members shall report all prescription medications received from non-military Medical Treatment Facilities (MTFs) to their chain of command and ensure they are entered into their military health record.").

[283] MCM, *supra* note 224, pt. IV, ¶ 14.c.(2).(a); United States v. Hughey, 46 M.J. 152, 154 (C.A.A.F. 1997).

[284] Jurden, *supra* note 205, at 26.

necessary" to the completion of a military mission or promote the morale, discipline, and usefulness of the unit.[285] Additionally, such orders must be "directly connected with the maintenance of good order in the service."[286] Courts routinely defer to military determinations that internal policies are rationally related to their aims.[287] In fact, lawfulness is not even an element of disobedience offenses; the lawfulness of an order is a matter of law determined by a military judge.[288] This statutory hurdle exists, at least in part, because "[o]bedience to lawful orders is at the very heart of military discipline."[289] Indeed, the seminal Supreme Court case on military obedience, *Parker v. Levy*, held that the necessity of obedience to orders and discipline in the military allows the restriction of constitutionally guaranteed rights even though such action would be impermissible in a civilian setting.[290]

D. Challenges to the General Order

A Soldier accused of violating an order can challenge the order's legality, but the Soldier bears the burden of rebutting the presumption of an order's lawfulness.[291] Lawful orders have five main elements: 1) the order was issued by competent authority; 2) the order contains a specific mandate to do or not do something; 3) a rational relation between the order and a military duty; 4) the order cannot require the commission of an illegal act; and 5) the order cannot impermissibly intrude on a Soldier's constitutional or statutory rights.[292] The general order readily meets four of the five elements:

1. Element One: Competent Authority

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[285] MCM, *supra* note 224, pt. IV, ¶14.c.(2).(a).(iii).
[286] *Id.* at ¶ 14.c.(2).(a).(iii).
[287] Jurden, *supra* note 205, at 27 ("Jurisprudence in the wake of *Parker v. Levy* virtually has obliterated the need for the military truly to articulate a rational basis for the internal regulations it promulgates."); *see, e.g.*, United States v. Young, 1 M.J. 433 (C.M.A. 1976).
[288] 10 U.S.C. § 851(b) (2012); United States v. New, 55 M.J. 95, 105 (C.A.A.F. 2001).
[289] Colonel Michael J. Hargis et al., *Annual Review of Developments in Instructions 2005*, ARMY LAW., Apr. 2006, at 80, 80.
[290] Parker v. Levy, 417 U.S. 733, 757 (1974).
[291] *See* United States v. Hughey, 46 M.J. 152, 154 (C.A.A.F. 1997).
[292] United States v. Deisher, 61 M.J. 313, 317 (C.A.A.F. 2005).

The *MCM* specifically provides that a Secretary of a Military Department, such as the Secretary of the Army, may issue a general order.[293]

2. Element Two: Specific Mandate

The order is a specific mandate for three actions: 1) all Soldiers to not use a prescribed controlled substance after 180 days from the prescription's fill date, 2) all Soldiers to turn in all prescriptions from civilian providers to military healthcare personnel, and 3) for military healthcare personnel to only provide sufficient prescription drug dosages to treat the underlying medical condition. Because the order is "specific, definite, and certain" as to the permissible and impermissible acts, the order does not suffer from vagueness.[294]

3. Element Three: Rational Relation

The general order easily meets the requirement of a rational relation between the order and military duty because it has multiple military purposes that are directly tied to the good order and discipline of the force. The order attacks the correlation between prescription drug use and suicide, major problems that the Army has not successfully reigned in. The order ensures the proper use of controlled substances in the ranks, engendering trust among Soldiers. It protects Soldiers and civilians from the unlawful diversion of controlled substances by Soldiers or third parties, ensuring the Army's place as a responsible institution in local communities. The order improves the fitness of the force by enhancing medical knowledge regarding military patients and improving continuity of care as Soldiers move from post to post. Finally, in an era of diminishing funds,[295] the order reduces costs for prescription drugs, freeing money, albeit probably small amounts, for other uses. All of these justifications are rationally related to the three mandates in the general order.

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[293] MCM, *supra* note 224, pt. IV, ¶ 92.

[294] United States v. Womack, 29 M.J. 88, 90 (C.M.A. 1989).

[295] Michelle Tan, *Chief: Sequestration Could Create 'Hollow Army'*, ARMY TIMES (Jan. 22, 2015 5:25 P.M.), http://www.armytimes.com/story/military/capitol-hill/2015/01/22/odierno-sequestration-hollow-army/22156079/.

4. Element Four: Ban on Illegal Acts

None of the three mandates in the general order require commission of an illegal act.[296]

5. Element Five: Intrusions on Private Rights

The three mandates in the general order circumscribe a Soldier's property rights only to the extent a court finds that the MEDCOM policy results in a taking of property without just compensation. The Fifth Amendment only provides for the right to just compensation for property seized by the government;[297] this is not a broader constitutional right to own property.[298] The potential population of Soldiers whose property was taken by the MEDCOM policy is likely small. At most, this general order would only apply to the subset of Soldiers who were denied a new prescription for a controlled substance because their medical providers had concluded that they lack an underlying medical condition necessitating the prescription drug. For all other Soldiers impacted by the MEDCOM policy, there is no intrusion on the property rights set forth in the Fifth Amendment. For those Soldiers whose property a court determines was taken without just compensation, as outlined *supra*,[299] the order's three acts rationally relate to military duties and thus do not impermissibly interfere with private rights. In the military, constitutional rights are balanced against the necessity for military duties to maintain an effective fighting force; as long as an order is rationally related to the military purpose, what might be constitutional violations in the civilian community may be permissible.[300] Military purposes include, among other things, ensuring the health of the force, preventing conduct detrimental to the service, and protecting civilians from harm.[301]

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[296] *See supra* Part VI, IX.C.

[297] U.S. CONST. amend. V.

[298] *See* Kelo v. City of New London, 545 U.S. 469 (2005) (upholding a city's right to seize private property for private commercial development).

[299] *See supra* Part IX.D.3.

[300] Womack, 29 M.J. at 90 ("[T]he Armed forces may constitutionally prohibit or regulate conduct which might be permissible elsewhere."); United States v. Padgett, 48 M.J. 273, 276 (C.A.A.F. 1998) ("An order purporting to regulate personal affairs is not lawful unless it has a military purpose.").

[301] United States v. Dumford, 30 M.J. 137, 138 n.2 (C.M.A. 1990) ("We have absolutely no doubt that preventing a servicemember who has HIV from spreading it to the civilian population is a public duty of the highest order and, thus, is a valid military objective."); United States v. New, 55 M.J. 95, 107 (C.A.A.F. 2001) ("[W]e held that the order in

Though constitutional rights are more limited in the military, there are nonetheless bounds. "While an order may reasonably limit the exercise of an individual service person's rights, it may not arbitrarily or unreasonably interfere with the private rights or personal affairs of military members."[302] One legal commentator, however, has argued that the rational relationship bar is so low that "almost any order . . . can be justified . . . in furtherance of a service's duty to protect the morale, discipline, and usefulness of its members."[303] Low bar notwithstanding, military courts have occasionally struck down regulations that sweep too far into the personal affairs of Soldiers. For example, an order directing a Soldier to report all private financial transactions,[304] a regulation prohibiting private loans without command consent,[305] and a regulation prohibiting alcohol "in the system" at all times during the duty day[306] were all struck down by military courts for sweeping too far into the private affairs of Soldiers.

Even though the general order may regulate private rights for a limited subset of Soldiers, the order's narrow tailoring ensures minimal intrusion on individual rights. Given the deference to the military's justifications for the order, a court is unlikely to strike down the general order. If challenged, the issue would be largely one of first impression. The only marginally related decision of authority, *United States v. Spencer*, was a case regarding medical surveillance that is distinguishable from the proposed order. Unlike *Spencer*, in which an order to turn over all civilian medical records to a military clinic was held to be overbroad, the proposed order only requires the turn-in of prescriptions from civilian providers, which has a clear nexus to the Army's specific ability to evaluate the medical necessity of the use of controlled substances.[307]

The proposed general order in the appendix also meets the requirements set forth in case law discussed *supra*.[308] Based on the

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McDaniels [an order for a Marine not to drive his vehicle because he had been diagnosed with narcolepsy] was within military authority because it protected other persons.").

[302] United States v. Wine, 28 M.J. 688, 689 (A.F.C.M.R. 1989).

[303] Captain Frederic L. Borch, III, *Trial Defense Service Note: The Lawfulness of Military Orders*, ARMY LAW., Dec. 1986, at 47.

[304] *See* United States v. Milldebrandt, 25 C.M.R. 139 (C.M.A. 1958).

[305] *See* United States v. Smith, 1 M.J. 156 (C.M.A. 1975).

[306] *See* United States v. Wilson, 30 C.M.R. 165 (C.M.A. 1961)

[307] *See* United States v. Spencer, 29 M.J. 740 (A.F.C.M.R. 1989).

[308] *See supra* Part VIII.C.

totality of the document,[309] the general order provides clear criminal sanctions, not mere policy guidance,[310] by explicitly prohibiting Soldiers from using expired controlled substances, requiring Soldiers to turn in civilian-provided prescriptions, and mandating that military healthcare providers prescribe no more than the minimum adequate amount of controlled substances to treat the underlying medical condition. The applicable population for the three requirements—active-duty Soldiers—are clearly specified in the order. No punitive articles of the UCMJ cover the three limitations in the order.[311] And finally, the general order does not detract from the effectiveness of other regulations because the highest officer in the Department would issue it.[312]

X. Conclusion

At a minimum, MEDCOM must issue clarifying guidance to MROs on the proper standards for adjudicating cases. Given the oblique way in which the interim guidance was rescinded (i.e., publishing a new MEDCOM Regulation 40-51 that did not include the two exceptions), MROs, at least in some cases, are applying two different MR standards for cases, resulting in inequitable treatment for similarly situated Soldiers. This issue is illustrated by two recent cases at Fort Carson, Colorado. In both cases, the Soldiers had used their lawfully prescribed controlled substance outside of the six-month window established in the current MEDCOM policy.[313] In one case, an MRO deemed a Soldier's use of a controlled substance authorized because the Soldier's medical provider had documented that the Soldier still had a medical need for the treatment and had, accordingly, given the Soldier permission to continue to use it.[314] This rationale reflects the first exception to the interim guidance, which, by the time of the case in late 2013, was no longer applicable.[315] In the second case, another MRO at Fort Carson determined a Soldier's use was illegitimate because there was no

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[309] United States v. Nardell, 21 C.M.R. 322, 327 (C.M.A. 1972).
[310] *See* United States v. Green, No. 20010446, 2003 CCA Lexis 137 (A. Ct. Crim. App. June 6, 2003).
[311] *See supra* Part VIII.
[312] *See* United States v. Green, 22 M.J. 711 (A.C.M.R. 1986).
[313] Based on the author's experience as a Trial Counsel with the 2d Brigade, 4th Infantry Division, MROs at Fort Carson would apply different standards for review of positive samples for prescribed controlled substances.
[314] *Id.*
[315] Interim Guidance, *supra* note 104, para. 3.

prescription within six months of the urinalysis.[316] This determination reflects the current standard from the MEDCOM policy.[317] Because two MROs from the same post with similar cases reached two different results, it is possible that this type of error is happening Army-wide. The Army must take immediate action to fix this problem. Clarifying the standard of review, however, still leaves commanders in the lurch for determining how to dispose of cases for which traditional administrative and criminal tools simply do not work.

Lending more credence for change, support for the policy across other branches of the Army is crumbling. Late in 2014, the Army's Criminal Investigation Command took the step of disavowing the policy.[318] The new approach unfounded any criminal offense for which a Soldier was titled because of a violation of the MEDCOM policy.[319] This approach incorporates the innocent-use defense; only if a Soldier does not have a prescription for the controlled substance or if the Soldier has a prescription and obtained more of the medication illegally will a Soldier be titled for wrongful use of a controlled substance under Article 112a of the UCMJ.[320] The MEDCOM policy's loss of support by the Army's lead military criminal investigative organization for drug crimes should sound its death knell.

Though beyond the scope of this paper, the Army must also unwind any previous adverse action taken against Soldiers under the flawed MEDCOM policy. At the unit-level, commanders must vacate previous administrative actions, such as letters of reprimand,[321] based on violations of the MEDCOM policy. The Office of the Judge Advocate General should review for post-trial relief all court-martial convictions from 2011 to 2015 to identify erroneous convictions based on the MEDCOM policy.[322] For Soldiers no longer in the military, the Army Board of Correction for Military Records and other administrative

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316 *Id.*
317 MEDCOM REG. 2013, *supra* note 16, para. 9e.
318 Based on the author's experience as a Trial Counsel with the 2d Brigade, 4th Infantry Division and in the 63rd Graduate Course at The Judge Advocate General's Legal Center and School, CID revised its "titling" policy for Soldiers who violated the MEDCOM policy. This change resulted in all previous "foundings" of violations of article 112a of the UCMJ for breach of the MEDCOM policy being "unfounded."
319 *Id.*
320 *Id.*
321 *See, e.g.*, AR 600-37, *supra* note 227.
322 *See* U.S. DEP'T OF ARMY, REG. 27-10, MILITARY JUSTICE para. 5-39 (3 Oct. 2011).

review boards must undo any previous administrative actions taken against Soldiers pursuant to the MEDCOM policy.[323]

The simplest fix for the troubled MEDCOM policy is to revert to the prior standard, which did not mandate an expiration date for the use of lawfully prescribed controlled substances.[324] The change would align Army policy with federal regulatory and statutory standards for prescription drug use and eliminate any litigation risk based on an unconstitutional regulatory taking. Of course, this change would obviate the goal of reducing the correlation between suicides and prescription drug use by Soldiers.

Given the changes in data supporting the *Red Book's* findings in 2010, this rollback deserves a thorough review. Since the MEDCOM policy went into effect in early 2011, the number of suicides in the Army, at least for the active-duty force, peaked in 2012 and has subsequently fallen.[325] In 2014, there were 135 suicides by active-duty Soldiers compared to the 165 suicides that marked the apex of the epidemic in 2012.[326] Following the *Red Book* and *Gold Book*'s recommendation, the Army instituted numerous policy changes to decrease the number of suicides, including new suicide prevention campaigns and programs that encourage Soldiers to voluntarily surrender prescription drugs at "take back days" at military pharmacies to minimize the presence of extraneous controlled substances in the home.[327] In short, given all the changes the Army implemented, it is

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[323] *See, e.g.*, U.S. DEP'T OF ARMY, REG. 15-185, ARMY BOARD FOR CORRECTION OF MILITARY RECORDS (31 Mar. 2006).

[324] Because neither physicians nor pharmacists are required to provide expirations for controlled substances, the previous standard's exception for use unless beyond a "clearly labeled expiration date" should be rescinded. *See* MEDCOM REG. 2013, *supra* note 16, para. 8f.

[325] Lolita C. Baldor, *Military Suicides Up Slightly in 2014*, ASSOCIATED PRESS, Jan. 13, 2015, *available at* http://www.militarytimes.com/story/military/pentagon/2015/01/16/defense-department-suicides-2013-report/21865977/; Lisa Ferdinando, Army News Serv., *Number of Suicides in Army Drops in 2013*, U.S. DEP'T OF ARMY (Feb. 3, 2014), http://www.army.mil/article/119301/.

[326] *Id.*

[327] Patricia Kime, *DoD: Military Suicide Rate Declining*, MILITARY TIMES (Jan. 16, 2015, 4:01 P.M.), http://www.militarytimes.com/story/military/pentagon/2015/01/16/defense-department-suicides-2013-report/21865977/.

unclear what effect, if any, the MEDCOM policy itself had on the recent drop in active-duty Soldier suicides.[328]

Prescription drug use across the Army is also far less than originally estimated in 2010. In 2008, DoD survey data indicated a sharp rise in prescription drug use by servicemembers, growing from two percent in 2002 to eleven percent in 2008.[329] In 2013, DoD reviewed its methodology from 2008 and issued a disclaimer that methodology changes to the 2008 survey made the results questionable.[330] A subsequent DoD survey found a drop, not an increase, in prescription drug use from 2002, dipping from 2 percent in 2002 to 1.3 percent in 2011.[331] Given the connection between suicide and prescription drug use was based on an observed correlation, not established causation, and the retraction of survey data indicating a pervasive prescription drug problem in the military, the basis for the prescription expiration is not as strong as originally believed.

If the Army desires to retain this policy, the current MEDCOM regulation must be rescinded and a general order instituted in its place. While individual commanders could issue personal orders to each and every Soldier in their commands to not use prescribed controlled substances six-months after the prescription date, the potential for minor, but legally significant, differences in orders from different commanders and proving the elements of a disobedience crime for a mobile population are precisely the reason why the Army must have one order, enshrined in a general order, applicable to all Soldiers at all times. As it stands, the current MEDCOM policy provides an insufficient basis by which a commander can determine how to dispose of cases. Further, even if the policy had a sufficient legal basis for commanders to act on cases, it also has significant policy gaps; the policy does not improve medical surveillance of Soldiers with prescriptions from civilian providers, nor does it limit the dosages prescribed by uniformed providers to Soldiers to minimize leftover prescriptions. In sum, the MEDCOM policy is, in multiple respects, an inadequate tool for the stated policy ends.

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328 *See* RED BOOK, *supra* note 10; GOLD BOOK, *supra* note 1.
329 U.S. DEP'T OF DEFENSE, 2011 DEPARTMENT OF DEFENSE HEALTH RELATED BEHAVIORS SURVEY OF ACTIVE DUTY MILITARY PERSONNEL, at ES-5 (2013).
330 *Id.* at ES-16.
331 *Id.* at ES-5.

The appendix contains a proposed general order from the Secretary of the Army that solves the MEDCOM policy's program gaps and legal problems. The general order lawfully imposes a mandatory expiration date, addressing the suicide correlation found by the *Red Book*. The general order applies Army-wide and provides commanders a lawful basis to dispose of cases by Soldiers alleged to have violated the policy, imperiling any Soldiers who may be using prescription drugs as cover for their drug dependency. The general order improves medical surveillance of prescription drug use by mandating Soldiers turn-in all civilian provider prescriptions and requiring uploading those prescriptions into medical databases, improving continuity of care across the Army. The general order also cuts down on potential distribution of prescription drugs to others, including civilians in the local community, by limiting the dosage prescribed to ensure only a minimum amount of leftover drugs following a treatment regime; such a policy supports the Army's reputation and obligation as a responsible institution in the community. Given the Army's historical experience with drug use in the ranks, especially during the Vietnam conflict, the general order bolsters fellow Soldiers' trust and confidence that their comrades are appropriately using prescription controlled substances. And finally, a modest fiscal benefit may result from reducing the number of prescription controlled substances paid for by the Army.

Implementing a new policy will cause some turmoil. Commanders and MROs will need training on the new standard, and in the short run, the change will likely increase the administrative processing times for positive urinalysis samples. Military healthcare providers will likely have an increase in visits for prescription refills and processing civilian prescriptions turned in by Soldiers. However, the onus of the administrative burden will fall squarely on the person best positioned to shoulder it—the Soldier with a prescription. That Soldier will have the individual responsibility to take the prescription in accordance with the Army's expiration policy and to provide proof of any prescriptions from civilian providers. In the long run, this should reduce the processing time for MROs, who would no longer have to contact Soldiers about civilian prescriptions, enable commanders to adequately supervise and control prescription drug use in their formations, and ensure military healthcare providers have an adequate opportunity to monitor the safe use of prescription drugs by their patients.

In a valiant effort to stem the tide of suicides, the Army has taken many measures to reduce unnecessary, tragic deaths like Captain Peter

Linnerooth's.[332] Each of these measures, however, must be done in a fair and legal manner. The current MEDCOM policy is neither. Suffering from unintended consequences, glaring policy gaps, and insufficient legal analysis, the MEDCOM policy cannot stand.

[332] *See* RED BOOK, *supra* note 10; GOLD BOOK, *supra* note 1.

Appendix

GO 2015-__

GENERAL ORDER
NO. 2015–__

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, DC,

1. Purpose. This General Order regulates prescribed controlled substance use in the Army to ensure the good order and discipline of units. Prescribed controlled substances are those items listed on the Drug Enforcement Agency's Schedules II through V.

2. Applicability. This General Order applies to all Soldiers on active-duty in the United States Army.

3. Statement of Military Purpose and Necessity. This General Order ensures the good order and discipline of Army units by setting conditions for the safe use of prescribed controlled substances by Soldiers pursuant to a legitimate medical need. The suicide epidemic plaguing our Soldiers is correlated with the long-term use of prescription controlled substances. Given the rise of prescription drug use in the Army and civil society over the last decade, this General Order will also cut down on the potential diversion of controlled substances to other Soldiers and civilians by limiting the supply of prescription drugs, ensuring the Army's reputation as a responsible institution in our local communities. And as the Army's experience in Vietnam has illustrated, illegal drug use is a scourge in our ranks that undermines the trust and confidence among Soldiers that is so critical to our military effectiveness. As a mobile population, this General Order ensures Soldiers will receive improved continuity of medical care because military medical providers will have a better understanding of their patients's medical history. And in an era of fiscal constraint, this General Order will reduce medical costs and thereby ensure funding to train, deploy, and defeat our enemies.

4. Prohibited activities.

a. All controlled substances lawfully prescribed to Soldiers by healthcare providers, including civilian healthcare providers, will expire 180 days after the prescription's fill date. Soldiers are not authorized to use expired controlled substances.

b. Soldiers will provide a copy of all current controlled substances prescribed by a civilian provider to their servicing military healthcare provider. The military healthcare provider will ensure the Soldier's prescription is entered into the appropriate military healthcare databases and will ensure the Soldier understands the Army's expiration policy for prescribed controlled substances. For Soldiers assigned to areas without access to military healthcare providers, those Soldiers will provide a copy of their current controlled substance prescriptions from civilian providers to the Office of the Surgeon General of the Army.

c. Uniformed military healthcare providers may only prescribe the minimum necessary controlled substances to treat a Soldier's underlying medical condition. At most, a uniformed military healthcare provider can issue a prescription for a controlled substance adequate for 180 days of treatment.

5. Punitive Order. Paragraph four of this General Order is punitive. Soldiers who violate paragraph four may be punished under the Uniform Code of Military Justice.

6. Individual Duty. All Soldiers to whom this General Order applies are charged with the individual responsibility to know and understand the prohibitions specified in paragraph four.

7. Commanders and supervisors.

a. This General Order imposes a time limitation on prescriptions; however, it will not be construed as a limitation on access to medical care. Commanders of Soldiers with medical conditions necessitating long-term treatment will ensure their continued access to medical services, including controlled substance prescriptions, in accordance with a medical provider's instructions for care.

b. Commanders and military and civilian supervisors will encourage, but not require, Soldiers with expired controlled substances to turn in all unused drugs for safe disposal to either their local military law enforcement organization or the pharmacy at the closest Military Treatment Facility (MTF).

c. Commanders and military and civilian supervisors must ensure that all their assigned Soldiers know and understand this policy.

d. Installation commanders will ensure the local military law enforcement organization complies with all controlled substance take-back requirements under federal laws and regulations.

e. MTF commanders will ensure all on-site pharmacies have established a controlled substances take-back program in accordance with federal laws and regulations.

8. Effective date. This General Order will be effective ninety days from the date of publication to provide Soldiers time to turn in their civilian prescriptions for inclusion in their military healthcare records.

9. Waiver authority. For Soldiers with conditions necessitating long-term treatment or in areas that prevent timely access to medications (e.g., on a contingency operation), the commander of the nearest MTF, or his designee, may issue an exception to this policy. If there is no local MTF, an O-5 medical service or medical corps officer assigned to the local command may issue an exception to this policy. This exception must be annotated in Soldiers's healthcare records by their servicing military healthcare provider or a designated medical service officer.

John M. McHugh
Secretary of the Army