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regulatory environment, mounting financial pressure on private practices, financial incentives for hospitals to employ physicians, and cultural changes leading to physician priorities inconsistent with private practice.

Duty of Care has been the keystone of medical practice since Hippocrates first wrote about medical ethics around 400 B.C. Modern American medical ethics arising from Hippocratic ideals include the duty to not abandon patients. Malpractice jurisprudence largely has paralleled these ethical concepts, through Common Law, statutory codification, and the National Practitioner Database ("NPDB"), which formalizes certain duty of care principles and creates substantial consequences for breaches of duty.

Hospitals' contract enforcement may preclude physicians from meeting their duty of care. Patients, non-parties to these agreements, are not in privity with physicians. Likewise, increased union participation resulting from increasing physician and collective bargaining agreement provisions may conflict with physician-members' duty of care. Neither the Courts nor legislatures have addressed this issue directly. The NPDB's statutory language limits its ability to address these concerns.

Contract-duty conflict resolution requires narrowing the duty of care or changing the legal environment. With its ancient roots, ethical-legal construct retrenchment is unlikely. Opportunities for change include modifying physician-hospital contract precedents, enacting new legislation, modifying NPDB implementation and altering collective bargaining agreements. Finally, hospitals can act independently to minimize conflicts arising from physician employment.

Methadone's Regulatory Thicket

Methadone is an effective treatment for opioid use disorder, which makes it a key tool to address the opioid crisis. Paradoxically, regulations—particularly at the federal level, which is the focus of this Article—greatly limit access to methadone when it is used to treat opioid use disorder. As policymakers consider how to support treatment, it is important to understand which changes regulators can make on their own and which changes would require an act of Congress.

This Article analyzes four sets of regulations that are barriers to treatment for opioid use disorder with methadone. First, patient care regulations limit who may provide treatment, who may receive it, how much methadone patients may take home, and more. Second, the prohibition on prescribing methadone—as opposed to dispensing it directly—requires patients to travel to their opioid treatment program, rather than a pharmacy, to collect their medicine. Third, methadone's categorization as a Schedule II controlled substance limits it further. Fourth, entry barriers and operating costs depress the supply of treatment providers.

Working through each group or regulations, this Article finds that in almost every instance, federal regulators have clear statutory authority to amend or remove these barriers. It also explains how agencies can make changes. This includes determining which changes to make, a complex policy decision. This Article clarifies that federal agencies have discretion to lower barriers and improve access to methadone treatment for opioid use disorder. How will they use it?