Thereafter, the Government forwarded the record to me for final agency action. Having considered the record, I conclude that it establishes two separate grounds for revoking Respondent's registration. I further reject Respondent's request that his registration should be suspended and not revoked pending the completion of his appeal. I make the following findings.

Findings

Respondent is the holder of DEA Certificate of Registration, BL8586147, which authorizes him to dispense controlled substances in schedules II through V. Respondent's registration was last renewed on March 6, 2006, and was to expire on March 31, 2009. However, on February 13, 2009, Respondent submitted an application to renew the registration. I therefore find that Respondent's registration has remained in effect pending the issuance of this Decision and Final Order. *See* 5 U.S.C. 558(c).

I further find that on May 13, 2009, the United States District Court for the Southern District of Georgia entered a judgment in which it found Respondent guilty on 129 counts of violating 21 U.S.C. 841(a)(1), which prohibits "knowingly or intentionally * * * distribut[ing], or dispens[ing] * * * a controlled substance" except as authorized by the Controlled Substances Act (CSA). *See United States* v. *Ly,* No. CR407–00286–001 (S.D. Ga. May 13, 2009) (judgment). According to the indictment, the counts were for distributing hydrocodone (combined with acetaminophen), a schedule III controlled substance; alprazolam, a schedule IV controlled substance; and amphetamine sulfate, a schedule II controlled substance. For his crimes, the District Court sentenced Respondent to 97 months in prison; the Court also imposed an assessment of $12,900, a fine of $200,000, and a term of supervised release of five years following his release from prison.

I further find that on August 6, 2009, the Georgia Composite Medical Board issued a final decision which revoked Respondent's State medical license based on his convictions.

Discussion

Under Section 304(a) of the CSA, "[a] registration * * * to dispense a controlled substance * * * may be suspended or revoked by the Attorney General upon a finding that the registrant * * * has been convicted of a felony under this subchapter." 21 U.S.C. 824(a)(2). The Attorney General may also revoke a registration "upon a finding that the registrant * * * has had his State license or registration suspended, revoked, or denied by competent State authority and is no longer authorized by State law to engage in the * * * dispensing of controlled substances." *Id.* § 824(a)(3).

As found above, Respondent has been convicted of 129 counts of violating 21 U.S.C. 841(a)(1), a felony under subchapter I (the CSA). *See id.* § 801 (note). These convictions provide reason alone to revoke his registration.

Moreover, under the CSA, a practitioner must be currently authorized to handle controlled substances in "the jurisdiction in which he practices" in order to maintain a DEA registration. *See* 21 U.S.C. 802(21) ("[t]he term 'practitioner' means a physician * * * licensed, registered, or otherwise permitted, by * * * the jurisdiction in which he practices * * * to distribute, dispense, [or] administer * * * a controlled substance in the course of professional practice"). *See also id.* § 823(f) ("The Attorney General shall register practitioners * * * if the applicant is authorized to dispense * * * controlled substances under the laws of the State in which he practices."). As these provisions make plain, possessing authority under State law to handle controlled substances is an essential condition for holding a DEA registration.

Accordingly, DEA has held repeatedly that the CSA requires the revocation of a registration issued to a practitioner whose State license has been suspended or revoked. *David W. Wang,* 72 FR 54297, 54298 (2007); *Sheran Arden Yeates,* 71 FR 39130, 39131 (2006); *Dominick A. Ricci,* 58 FR 51104, 51105 (1993); *Bobby Watts,* 53 FR 11919, 11920 (1988). Respondent's loss of his State authority thus provides an additional ground for revoking his DEA registration.

I further reject Respondent's request that his registration only be suspended during the pendency of his appeal. As explained above, because Respondent does not have authority under Georgia law to prescribe controlled substances, he no longer meets the statutory requirement for holding a registration. Moreover, in the event that Respondent's confidence in the merits of his appeal is borne out, he can apply for a new registration upon persuading the Board to re-license him. However, given that it is entirely speculative whether both of these events will occur, there is no reason to continue his registration in the interim. Accordingly, Respondent's registration will be revoked and his pending application to renew his registration will be denied.

Order

Pursuant to the authority vested in me by 21 U.S.C. 823(f) & 824(a), as well as 28 CFR 0.100(b) & 0.104, I order that DEA Certificate of Registration, BL8586147, issued to Hung Thien Ly, M.D., be, and it hereby is, revoked. I further order that any pending application of Hung Thien Ly, M.D., to renew or modify his registration, be, and it hereby is, denied. This Order is effective September 15, 2010.

Dated: August 3, 2010.

Michele M. Leonhart,

Deputy Administrator.

[FR Doc. 2010–20209 Filed 8–13–10; 8:45 am]

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DEPARTMENT OF JUSTICE

Drug Enforcement Administration

[Docket No. 09–28]

Dewey C. Mackay, M.D.; Revocation of Registration

On February 26, 2009, I, the Deputy Administrator of the Drug Enforcement Administration (DEA), issued an Order to Show Cause and Immediate Suspension of Registration to Dewey C. MacKay, M.D. (Respondent), of Brigham City, Utah. The Show Cause Order proposed the revocation of Respondent's DEA Certificate of Registration, AM9742380, which authorizes him to dispense controlled substances as a practitioner, as well as the denial of any pending applications to renew or modify the registration, on the ground that his "continued registration is inconsistent with the public interest, as that term is defined in 21 U.S.C. 823(f) and 824(a)(4)." ALJ Ex. 1, at 1. The Order also immediately suspended Respondent's registration on the ground that his continued registration during the pendency of the proceeding "constitutes an imminent danger to public health and safety." *Id.*

The Show Cause Order alleged that "[f]rom June 2005 to the present," Respondent "issued numerous purported prescriptions for controlled substances without a legitimate medical purpose and outside the usual course of professional practice." *Id.* at 1–2. As evidence of his allegedly "unlawful prescribing practices," the Order alleged that: (1) On four occasions, M.R., a patient of his who cooperated with the DEA, visited Respondent and, while she "did not exhibit any verifiable medical indication warranting the prescribing of controlled substances," Respondent "issued prescriptions for controlled substances to her" and did so even after

M.R. told him that "she shared her controlled substances with another person"; (2) Respondent issued prescriptions for opioids "to at least four patients after engaging in unwelcome and inappropriate sexual activity * * * and without conducting any type of reasonable physical evaluation," that "this prescribing pattern indicates" that he issued "prescriptions for controlled substances in exchange for receiving sexual favors" and that the prescriptions were "without a legitimate medical purpose and outside the scope of professional practice"; (3) a "qualified medical expert" reviewed M.R.'s medical file and concluded that Respondent's "evaluation of M.R. was inadequate to justify the prescribing of controlled substances for her conditions," and that the expert had also reviewed nine of Respondent's patient files "selected at random" and concluded that his "actions encouraged the abuse of controlled substances and allowed their misuse"; (4) the same expert "determined that, with respect to four patients who died while under [his] care, the controlled substances [Respondent] prescribed were present in their systems and contributed to their deaths" and that "there was no justification for [his] long-term prescribing of controlled substances to these individuals"; and (5) since the execution of a search warrant at his office on June 5, 2008, Respondent had "continued to prescribe opioids in extraordinarily large amounts," which was "consistent with [Respondent's] prior practice of prescribing controlled substances without a legitimate medical purpose and outside the usual course of professional conduct." *Id.* at 2.

By letter of March 6, 2008, counsel for Respondent timely requested an expedited hearing in the matter, ALJ Ex. 2, at 1; and the matter was placed on the docket of the Agency's Administrative Law Judges (ALJ). Thereafter, Respondent objected to the Government's having scheduled the hearing to be held in Arlington, Virginia on April 28, 2009, on the ground that it would deny him Due Process; he also moved to have the venue of the hearing changed to Utah. ALJ Ex. 12. While the Government had initially argued against changing the location, ALJ Ex. 33, at 1; following Respondent's filing of his motion, it retreated from its earlier position and withdrew its objection to holding the hearing in Salt Lake City, Utah. ALJ Ex. 17. However, the ALJ denied Respondent's motion on the ground that he had failed to provide "sufficient justification" to change the location of the hearing. ALJ Ex. 18, at 5. Thereafter, Respondent also moved for the ALJ to recuse himself on the ground that he had "demonstrated partiality and bias against both [him] and [his] counsel" based, in part, on his pre-hearing rulings and several exchanges which occurred during two conference calls. ALJ Ex. 19, at 7–8. On March 30, 2009, the ALJ denied both motions. ALJ Ex. 18, at 2, 5–6; ALJ Ex. 20.

Thereafter, on April 7, 2009, the United States District Court for the District of Utah set aside the Order of Immediate Suspension, and further ordered that the hearing be held in the District of Utah. ALJ Ex. 33, at 1. The hearing was then rescheduled for April 28–30, 2009. *Id.* at 2. The District Court also rejected Respondent's request for an Order that the ALJ recuse himself. ALJ Dec. at 2.

Following additional procedures, the ALJ conducted a hearing in Salt Lake City, Utah, from April 28, 2009 through May 1, 2009. At the hearing, both parties elicited testimony and introduced documentary evidence for the record. The Government also introduced audio-recordings into the record. Following the hearing, both parties submitted briefs detailing their proposed findings of fact, conclusions of law, and argument.

On July 31, 2009, the ALJ issued his recommended decision (ALJ). With respect to the first of the five public interest factors, *see* 21 U.S.C. 823(f), (the recommendation of the appropriate State licensing board or professional disciplinary authority), the ALJ found that the record contained no evidence of a recommendation of any such licensing board or disciplinary authority and thus concluded that this factor "does not weigh for or against a determination as to whether continuation of the Respondent's DEA certification is consistent with the public interest." ALJ at 94. As to the third factor (Respondent's conviction record under Federal or State laws relating to the manufacture, distribution or dispensing of controlled substances), the ALJ noted that the record "contains no evidence that the Respondent has ever been convicted of any crime related to the manufacture, distribution, or dispensing of controlled substances" and concluded that this "weighs in the Respondent's favor." *Id.* at 96. The ALJ noted, however, that the "probative value" of this finding is "somewhat diminished by the myriad of considerations that are factored into a decision to initiate, pursue, and dispose of criminal proceedings by Federal, State, and local prosecution authorities." *Id.*

The ALJ then considered together factors two (Respondent's experience in dispensing controlled substances), four (Respondent's compliance with applicable State, Federal or local laws relating to controlled substances), and five (such other conduct which may threaten the public health and safety). *Id.* More specifically, the ALJ concluded that Respondent violated numerous provisions of Utah State law.

First, the ALJ concluded that Respondent met with K.D. and wrote her controlled substance prescriptions after "touching her in inappropriate, intimate, even sexual ways," thereby violating Utah Code Ann. § 58–1–501(2)(k), which makes sexual abuse and exploitation "unprofessional conduct." *Id.* at 101. Next, with respect to patients K.D., M.R. and M.P., the ALJ concluded that Respondent "routinely" violated Utah Code Ann. § 58–1–501(2)(m)(i) in that he "routinely issued prescriptions without first obtaining information 'sufficient to establish a diagnosis, to identify conditions, and to identify contraindications to the proposed treatment.'" *Id.* He further found that "Respondent's recordkeeping was not merely sloppy or scant, [but that] the records reflect things that never happened, do not monitor medication efficacy, and do not comply with the documentation levels even minimally required by Utah Admin. Code R156–37–602(1)[1] and/or the *Model Policy,* which has been incorporated into Utah law by Utah Administrative Code R156–1–502."[2] *Id.* at 104.

Next, with respect to K.D., the ALJ found that Respondent had continued to prescribe controlled substances to her "after she confided her concerns that she felt she was addicted to prescription drugs and wanted treatment," and that doing so violated Utah's regulation which prohibits "knowingly prescribing controlled substances to a drug-dependent person." *Id.* at 104–05 (citing Utah Admin. Code R156–37–502(6)). The ALJ also found that even if Respondent considered himself to be prescribing narcotics for maintenance

[1] This provision provides, in pertinent part:

Records of * * * prescribing * * * controlled substances shall be kept according to State and Federal law. Prescribing practitioners shall keep records reflecting the examination, evaluation and treatment of all patients. Patient medical records shall accurately reflect the prescription or administration of controlled substances in the treatment of the patient, the purpose for which the controlled substance is utilized and information upon which the diagnosis is based.

[2] Under a regulation of the Utah Division of Occupation and Professional Licensing, it is "unprofessional conduct" for a "prescribing practitioner" to "fail[] * * * to follow the *Model Policy for the Use of Controlled Substances for the Treatment of Pain,* 2004, established by the Federation of State Medical Boards." Utah Admin. Code R156–1–502(6).

purposes to K.D., he violated 21 CFR 1306.07, as Respondent lacked the "requisite special registration" to so prescribe controlled substances. *Id.* at 105.

The ALJ further found that "[b]ecause the controlled substance prescriptions that * * * Respondent wrote were not preceded by even cursory physical examinations or even the minimum level of treatment and progress information," he violated 21 CFR 1306.04(a). *Id.* Finally, the ALJ determined that "[b]ecause * * * Respondent routinely ignored obvious indications of abuse of controlled substances by his patients and took no real steps to address that abuse," Respondent violated his "obligations to guard against and provide effective controls against the diversion of controlled substances in accordance with 21 CFR 1301.71(a) and Utah Administrative Code R156–37–502(2)." *Id.* The ALJ thus concluded that "under the Fourth public interest factor, consideration of the Respondent's disregard of State and Federal laws related to controlled substances in the course of his controlled substance prescribing practices militates in favor of the revocation of his Certificate of Registration." *Id.*[3]

As for the fifth factor, the ALJ indicated that "Respondent's trading of physical intimacy for controlled substance prescriptions with K.D., the abysmal and misleading character of his patient-care documentation, the virtual ignoring of blatant indications of diversion exhibited by some of his patients, his practice of prescribing controlled substances without examining or even minimally questioning his patients beyond ascertaining which controlled substances they desired * * * are [all] practices that impact upon the public health and safety." *Id.* at 106. The ALJ also cited Respondent's repeated requests of K.D. during her undercover visits as to whether she was wearing a wire and working for DEA. *Id.* at 107. As he noted, "these repeated inquiries" not only "reflect[] * * * Respondent's poor judgment and naiveté," they also "demonstrate consciousness of guilt." *Id.* Furthermore, the ALJ determined that "Respondent's persistence in conducting his practice in this manner [in trying to ascertain whether the patient was working for DEA instead of asking the appropriate medical questions to formulate a basis for prescribing the controlled substances which he prescribed] reflects an astounding absence of any kind of remorse or acceptance of responsibility." *Id.* at 108.

The ALJ also found that Respondent's "unprofessional conduct" in not following the documentation requirements imposed by the *Model Policy* "constitutes sufficient justification, even standing alone, to support a revocation of the Respondent's DEA registration as contrary to the public interest." *Id.* at 108–09. Moreover, the ALJ further found that Respondent's failure "to react to multiple 'red flags' of drug abuse and/or misuse demonstrated by his patients" violated Utah Administrative Code R156–37–502 by "'fail[ing] to maintain controls over controlled substances which would be considered by a prudent practitioner to be effective against diversion * * * of controlled substances.'" *Id.* at 109.

The ALJ thus concluded that "the Government ha[d] established that the Respondent has committed acts that are inconsistent with the public interest." *Id.* at 114. Because Respondent "has not accepted responsibility for his actions, expressed remorse for his conduct at any level, or presented evidence that could reasonably support a finding that the Deputy Administrator should continue to entrust him with a registration," the ALJ recommended that I revoke Respondent's registration and deny any pending applications to renew his registration. *Id.*

On August 24, 2009, Respondent filed Exceptions to the ALJ's decision. Therein, Respondent argues that the record lacks substantial evidence to support the allegations that nine patients were "improperly treated," that he engaged in "sexual impropriety," and that his "care caused the death of a patient." Resp. Exceptions, at 2. Respondent also contends that "the ALJ disregard[ed] reliable testimony of [Respondent's] witnesses and afford[ed] the Petitioner's (or 'DEA') witnesses an unsupportable amount of deference," that he engaged in "a one sided assessment of the evidence rather than weighing disputed evidence offered in response by [Respondent], and * * * ignore[d] evidence that [was] not disputed, that [was] supportive of [Respondent]," and that the "recommended decision [was] rife with bias and written in the tone of an advocate rather than an impartial ALJ." *Id.* at 2–3. Respondent further claims that the ALJ did not, in fact, "weigh" the statutory factors. *Id.* at 7–8.

On August 25, 2009, the ALJ forwarded the record to me for final agency action. Having carefully reviewed the record as whole, as well as Respondent's Exceptions,[4] I concur with the ALJ's ultimate conclusion that Respondent has committed acts which render his continued registration inconsistent with the public interest and that he has failed to provide evidence sufficient to establish why he can be entrusted with a registration. Accordingly, I will adopt the ALJ's recommendation, revoke Respondent's registration and deny any pending applications to renew his registration.

However, before proceeding to make my factual findings, the record in this matter contains a motion to recuse the ALJ, which is accompanied by the affidavits of Respondent's two counsels. *See* ALJ Ex. 19. Under 5 U.S.C. 556(b)(3), "[o]n the filing in good faith of a timely and sufficient affidavit of personal bias or other disqualification of a presiding or participating employee, the agency shall determine the matter as a part of the record and decision in the case."

Respondent's motion is based largely on exchanges that occurred during what appears to have been a somewhat heated conference call, the ALJ's having rejected several of his motions, and the Government's alleged tainting of the ALJ by sending him a letter which references an allegation of sexual impropriety on Respondent's part. ALJ Ex. 19, at 1–9; *see also* ALJ Ex. 10, at 1. I conclude, however, that Respondent's affidavits are insufficient to establish that the ALJ was personally biased against Respondent or his counsels.

As for the ALJ's conduct of the conference call, the allegations that he cut off one of the lawyers and asked him if he had ever practiced administrative law (which, according to the ALJ, happened when he attempted to explain to Respondent's lawyers the limited scope of discovery in the proceeding, *see* ALJ at 3 n.3.), is hardly so far outside of the norms of judicial conduct as to overcome the presumption of impartiality that attaches to the ALJ's conduct of the proceeding. *See Liteky* v. *United States,* 510 U.S. 540, 555–556 (1994) ("*Not* establishing bias or partiality * * * are expressions of impatience, dissatisfaction, annoyance, and even anger, that are within the bounds of what imperfect men and women, even after having been confirmed as Federal judges sometimes display. A judge's ordinary efforts at courtroom administration—even a stern and short-tempered judge's ordinary

[3] The ALJ also apparently considered this conduct relevant in assessing Respondent's experience in dispensing control substances (which it is) although he did not explicitly state as much.

[4] I have carefully considered Respondent's exceptions pertaining to the ALJ's evaluation of the evidence in making my factual findings.

efforts at courtroom administration-remain immune.").[5]

Nor is the contention made persuasive by the ALJ's having ruled against Respondent on several issues. As the Supreme Court has further explained, "judicial rulings alone almost never constitute a valid basis for a bias or partiality motion." *Id.* at 555 (citing *United States* v. *Grinnell Corp.,* 384 U.S. 563, 583 (1966)). Notably, Respondent did not challenge any of these rulings in his exceptions. Finally, the allegation that the ALJ was impermissibly tainted because the Government sent a letter to the ALJ seeking a subpoena which set forth that a patient had "alleged that [he] subjected her to inappropriate sexual activity," ALJ Ex. 10, ignores that in every case an ALJ is required to read the Order to Show Cause and the allegations contained therein (as well as other documents such as pre-hearing statements which disclose what a potential witness may testify to). A judge, however, is presumptively able to distinguish between what is an allegation and what has been proved with evidence.

I therefore hold that the ALJ properly denied Respondent's recusal motion. I further note that when Respondent sought injunctive relief on the same issue in the District Court, the Court denied the motion.

Findings of Fact

Respondent currently holds DEA Certificate of Registration AM9742380, which authorizes him to dispense controlled substances in schedules II though V as a practitioner.[6] ALJ Ex. 6, at 10. While Respondent's registration was to expire on January 31, 2008, on December 18, 2007, Respondent filed a renewal application. Because Respondent's renewal application was timely filed, in accordance with the Administrative Procedure Act, I find that Respondent's registration has remained in effect pending the issuance of this Decision and Final Order. *See* 5 U.S.C. 558(c).

Respondent holds a physician's license issued by the State of Utah and is a board-certified orthopedic surgeon. RX 12. Sometime around 2001, Respondent underwent cardiac bypass surgery, which apparently resulted in damage to his hand. Tr. 1307. Thereafter, Respondent gradually reduced the number of surgeries he performed, and in 2006, ceased performing surgeries altogether. *Id.* at 1308–09. As his surgical practice decreased, Respondent commenced seeing chronic pain patients, *id.,* and by February 2007, eighty-five percent of his practice involved pain patients. *Id.* at 504, 1307.

According to P.E., his former office manager, who had worked for him from March 1986 until February 2007, Respondent, as a pain management doctor, was seeing an average of 90 to 100 patients a day, and he would see the patients for three to five minutes each. *Id.* at 506–07. *See also id.* at 1583 (testimony of Investigator that T.S., an employee of Respondent stated during an interview that Respondent "saw between 85 and 90 patients per day" and that he "did not perform any physical examinations" because he was a pain management doctor). By contrast, Dr. Perry Fine, who testified for Respondent as an expert in pain management, stated that in an eight-hour day (with a 30-minute lunch break), he could see "maybe 24, 30 patients at the most." *Id.* at 782. P.E. further testified that it "was not part of the routine procedure" to take the patient's vital signs "on each visit" and that when there was "a lull in the patient flow," Respondent would "pick up the charts and write the prescriptions before the patients arrived." *Id.* at 513; *see also id.* at 538 & 542 (testimony of former employee J.N.).

DEA initiated an investigation of Respondent upon receiving information from the Box Elder Narcotics Strike Force, which had, in its own investigation, interviewed several individuals, conducted several undercover operations, and determined that Respondent was issuing unlawful controlled substance prescriptions. *Id.* at 940–41; *see also* 21 CFR 1306.04(a). In addition to interviewing several former patients of Respondent, DEA executed search warrants on or about June 5, 2008, and on January 22, 2009, when it obtained various patient records. Tr. 1065. DEA also obtained the cooperation of two persons (M.R. and K.D.), who agreed to perform undercover visits with Respondent. *Id.* at 942, 944.

The four undercover visits of M.R. occurred on October 9, November 27, December 24, 2007 and January 29, 2008. The four undercover visits of K.D. occurred on November 3, November 24, December 1, and December 22, 2008. In addition there was a recorded telephone conversation between K.D. and Respondent on November 20, 2008. During the course of the investigations, DEA Investigators obtained various patient records which were entered into evidence. Before proceeding to analyze the evidence pertaining to the specific patients, a review of the parties' evidence regarding what practices satisfy the longstanding requirement of Federal law that a prescription "must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice," 21 CFR 1306.04(a), is warranted.

The Parties Evidence Regarding the "Usual Course of Professional Practice"

Both parties put on extensive evidence on the issue of whether Respondent's prescriptions were issued in the usual course of professional practice and were for a legitimate medical purpose. Dr. Bradford D. Hare testified for the Government, and Dr. Perry Fine for Respondent.[7] Both Drs. Hare and Fine also submitted written affidavits, regarding their reviews of the medical files of additional patients as well as the requirements for writing legitimate prescriptions for controlled substances under Federal and State law.

Dr. Bradford D. Hare, who has practiced medicine since 1975, is an anesthesiologist who is board-certified in pain medicine and has nearly thirty years of experience in the specialty of pain management. Tr. 34–35. Dr. Hare holds both an M.D. and a Ph.D. in pharmacology, which he received from the University of Utah. *Id.* at 35; GX 23, at 1. At the time of the hearing, Dr. Hare practiced pain management at the University of Utah's Pain Treatment Center, where he is also the Director of the Fellowship Program at the University's Pain Management Center.[8] Tr. 37; GX 23, at 2. He also holds the positions of Vice Chairman of Pain Management Services, Department of Anesthesiology, and Associate Professor of Anesthesiology and Pharmacology, both at the University of Utah. GX 23, at 2. Dr. Hare has published extensively in professional journals and in book chapters, and has made numerous presentations on pain management. GX 23, at 12–25. He also serves as a consultant to the Utah Division of

[5] To make clear, having reviewed the transcript, there is no evidence that the ALJ conducted himself with anything other than the temperament which is expected of a judicial officer.

[6] In accordance with 5 U.S.C. 556(e), I have taken official notice of the registration records of the Agency pertaining to Respondent. In accordance with this provision and DEA's regulation, Respondent "is entitled * * * to an opportunity to show the contrary" by filing a motion for reconsideration within twenty (20) days of the date this order is served by being placed in the mail.

[7] Dr. Lynn Webster, although qualified as an expert witness in medicine and pain medicine, did not present substantial testimony on pain medicine and testified only about the death of Respondent's patient D.W.

[8] Dr. Hare continues to see patients two days a week and also teaches on the clinical staff of the University of Utah Operating Room Anesthesiology Staff. GX 23, at 5; Tr. 37.

Professional Licensing (DOPL) and currently is a member of its Diversion Committee. *Id.* at 2–3. Dr. Hare was qualified as expert witness in pain management practice in Utah and in prescribing controlled substances in pain management practice. *Id.* at 40–41.

Dr. Hare testified that Utah has adopted the Federation of State Medical Boards May 2004 Model Policy for the Use of Controlled Substances for the Treatment of Pain (hereinafter, *Model Policy*), the essential provisions of which are set forth below.[9] Dr. Hare testified that in the usual course of professional practice, prior to prescribing a controlled substance for treating pain, a patient presents a medical complaint which the physician then evaluates. *Id.* at 43–44. According to Dr. Hare, the evaluation and proper diagnosis requires both taking a medical history and performing a physical examination. *Id.* at 44.

Taking the medical history includes asking the patient questions about what causes the pain, when did it occur, what treatments the patient has had, and what things alleviate or increase the pain. *Id.* The history should also include the patient's "medication history" and any "history of substance abuse" as required by the *Model Policy*. *Id.* at 54. Moreover, the patient's medical records should be obtained and reviewed. *Id.* at 46.

Dr. Hare testified that the physical examination includes taking the patient's vital signs, blood pressure, temperature, and heart rate; listening to the patient's heart and lungs; performing a neurological examination, which "involves checking reflexes * * * [and] the sensation particularly from one side of the body to the other" and which merges into the musculoskeletal examination; and a musculoskeletal examination, which is used to determine the patient's strength and whether he/she has lost strength due to the complaint. *Id.* at 49–51. Dr. Hare further testified that even if a patient brings her medical records to the initial visit, and those records show that another physician has recently performed a physical exam, a physician should still conduct his own examination because he might make different findings than the previous physician or find that a new problem has developed. *Id.* at 52. However, the physician need not repeat diagnostic tests such as x-rays, MRIs and labs. *Id.* at 53.

The diagnosis "dictate[s] the type of treatment that [was] most appropriate." *Id.* at 44–45. For instance, there are various types of pain such a neuropathic, diabetic neuropathic, and musculoskeletal. *Id.* While "there are some types of pain where opioid medications are a primary type of treatment[,] [t]here are other types of pain [such] as neuropathic pain * * * where one would not start with * * * opioids." *Id.* Moreover, musculoskeletal pain "responds best to physical therapy * * * better than pain medicine." *Id.*

Dr. Hare stressed that the *Model Policy* requires certain documentation for using controlled substances to treat pain with controlled substances, such as a proper medical history which includes a patient's history of substance abuse and information regarding prior medications. *Id.* at 54. Dr. Hare also testified that in the "usual course of professional practice for pain management," a physician must document in the patient's medical record the steps discussed above "prior to issuing a controlled substance prescription." *Id.* at 55. He further testified that the "usual course of professional practice" includes establishing a treatment plan at the first visit, as well as asking the patient for a pain rating which is typically done using "a zero to ten scale" and which is repeated at subsequent visits. *Id.* at 56–57.

To evaluate the effectiveness and appropriateness of the treatment plan, at follow-up visits, the physician should ask whether the prescribed treatment, including any medications, helped, and whether the medication is causing side effects. *Id.* at 56–58. A physician should document the patient's response to these questions; if the physician decides to change the medication, the reason for the change should be documented. *Id.* at 58–59. Moreover, if the patient develops additional problems such as anxiety or the inability to sleep, the physician should document the problem, the treatment plan for the particular problem, and the reason for prescribing any additional drug. *Id.* at 59. While Dr. Hare testified that it is "never appropriate under * * * any circumstances" for a physician to touch a patient in a sexual manner, he then added that "there could be the situations where there's a romantic involvement, but * * * just like in any other professional setting, if something like that would occur, it has to be put out in public." *Id.* at 60.

Dr. Perry Fine is a physician who is board-certified in anesthesiology, and holds subspecialty certifications in pain management as well as hospice and palliative care. *Id.* at 614; RX 11, at 1. Dr. Fine is a professor of anesthesiology at the University of Utah and is also on the faculty of its Pain Research Center. Tr. 610. After completing a residency in anesthesiology at the University of Utah and a pain medicine fellowship at the University of Toronto, he joined the faculty of the University of Utah. *Id.* at 611. At the time of the hearing, Dr. Fine served on the Board of Directors of both the American Academy of Pain Medicine and the American Pain Foundation. *Id.* at 615. He has also published extensively on pain management and anesthesiology and has done numerous presentations. RX 11, at 9–57. Dr. Fine was also qualified

[9] The *Model Policy* states that:

The Board will consider prescribing * * * controlled substances for pain to be for a legitimate medical purpose if based on sound clinical judgment. All such prescribing must be based on clear documentation of unrelieved pain. To be within the usual course of professional practice, a physician-patient relationship must exist and the prescribing should be based on a diagnosis and documentation of unrelieved pain.

GX 9, at 3. The *Model Policy* then states that "[t]he Board will judge the validity of the physician's treatment of the patient based on available documentation, rather than solely on the quantity and duration of medication administration." *Id.*

With respect to evaluation of a patient, the *Model Policy* provides that:

A medical history and physical examination must be obtained, evaluated, and documented in the medical record. The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of pain on physical and psychological function, and history of substance abuse. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.

Id.

As for the physician's treatment plan, the *Model Policy* states:

The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

Id. at 4.

The *Model Policy* also states that "[t]he physician should periodically review the course of pain treatment and any new information about the etiology of the pain or the patient's state of health." *Id.* Continuing, the *Model Policy* states that "[o]bjective evidence of improved or diminished function should be monitored * * *. If the patient's progress is unsatisfactory, the physician should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities." *Id.*

Finally, the *Model Policy* states that "[t]he physician should keep accurate and complete records to include[:] 1. the medical history and physical examination, 2. diagnostic, therapeutic and laboratory results, 3. evaluations and consultations, 4. treatment objectives, 5. discussion of risks and benefits, 6. informed consent, 7. treatments, 8. medications (including date, type, dosage and quantity prescribed), 9. instructions and agreements and 10. periodic reviews." *Id.*

as an expert in pain management practice and prescribing. Tr. 611–12.

Based on some of the records he reviewed, Dr. Fine maintained that Respondent's "prescribing practices * * * were done in the usual and customary routine of a physician-patient relationship," *id.* at 622, whatever that means. Dr. Fine testified that, based on the evidence he reviewed, Respondent "saw these patients * * * in a professional medical environment. He'd established a relationship with them, with recurrent visits and follow-up appointments, to evaluate the effective therapy, and to fulfill the obligations of prescribing controlled substances." *Id.* He also maintained that in several of the cases he reviewed, Respondent had consulted with other clinicians and that his "interpretation of that is that certainly met with approval within that local community standard." *Id.* at 624. Dr. Fine also testified that there is "no" test for pain, and that "[t]here are really only two ways to evaluate whether a patient has pain or not. One is what they tell you, and the other is by behaviors." *Id.* at 627–28. Dr. Fine then explained that there are "a number of tools we use to try and have patients rate their pain intensity," including "verbal descriptor scales, numerical scales, [and] pictorial scales." *Id.* at 628.[10] He also maintained that what a patient tells a physician is "certainly a large component of what constitutes * * * at least on a first-run basis, what we would consider to be the most valid or reliable indicator of a patient's pain experience." *Id.*

On cross-examination, Dr. Fine acknowledged that in the "usual course of professional practice" in pain management, "the patient presents with * * * an essentially, a compelling case, based upon their history and physical findings, and whatever corroborating laboratory or imaging studies may be required, depending upon the patient's circumstances." *Id.* at 704. Moreover, "within the course of their professional conduct," the physician must make "a reasonable effort to * * * try and understand what risks there might be of misuse, abuse, diversion, addiction, tolerance, dependence, all the various pharmacological and sort of social responsibility issues that come with prescribing." *Id.* at 704–05. A treatment plan is then initiated which "is appropriate to the level of risk, and monitors that patient accordingly." *Id.* at 705.

While Dr. Fine acknowledged that obtaining and documenting a patient's history is part of the usual course of professional practice for prescribing a controlled substance, he then maintained that "in the usual course of medical education, the details of the pain history are not spelled out under law, so much as spelled out under best practices." *Id.* at 706. Continuing, he maintained that "what we hope, of course, is that best practices become standard over the course of time" but then claimed that "for physicians" in the middle of their careers, "the opportunity to inculcate that level of skill or expertise simply has been lacking." *Id.* He then asserted that while "ideally, and under best practices," the "usual course of professional practice" requires that "a medical history documents activities that [the patient reports] exacerbate or mitigate the pain," this is "not necessarily so." *Id.* at 707. He then maintained that in a medical record, "you would rarely see a line item that said what exacerbates the pain, what relieves the pain." *Id.* at 708.

Continuing his answer, Dr. Fine then stated that physicians "might describe the pain in other ways. They may give it a numerical score. They may just say the patient has pain; they may not even say that." *Id.* When then asked if the usual course of professional practice requires documenting the frequency and intensity of the reported pain, he responded, "That's highly desirable. I teach that; I wish everybody did it * * *. It's simply not yet the standard of care." *Id.*

As to Utah's adoption of the *Model Policy* as part of its regulations, Dr. Fine opined that "I think it holds up a standard that would be desirable * * *. But very few physicians in the State would make that grade." *Id.* at 708–09. When asked whether the CSA's "usual course of professional practice" standard is an objective standard or what most physicians do, Dr. Fine answered:

> I think it's a desirable standard that's been put forth for very good reason, and supported by people who have expertise in pain medicine and want to both optimize the health and well-being of individual patients, and limit the * * * adverse consequence of problematic prescribing. But I daresay that in terms of in practice, how it's actualized, we could not call that standard in the way * * * [i]n a tort sense, what constitutes a standard of practice in the community, in the region, in the nation.

Id. at 709.

However, when asked whether it would be in the usual course of professional practice "if most physicians prescribe controlled substances without ever performing a physical exam," [11] Dr. Fine answered that "it is certainly a requirement, in terms of meeting reasonable standards of practice and standards of care, that some form of physical examination in proportion to or pursuant to the problem in front of the physician" be done. *Id.* at 710–11. Dr. Fine then acknowledged that documenting the findings of a physical exam is part of the usual course of professional practice. *Id.* at 712. However, he then maintained that, notwithstanding the *Model Policy's* statement that "the effect of pain on physical and psychological function" should be documented, this is only "a highly desirable evaluative point. But not necessarily what most people do most of the time." *Id.* He then asserted that the "usual course of professional practice" standard does not "get[] to that granular a level." *Id.* at 713.

When asked whether the "usual course of professional practice" required documenting a patient's history of substance abuse, Dr. Fine acknowledged that "a history of substance abuse, active addiction, * * * chemical dependency, or known diversion is highly problematic" and that there is "a professional obligation to at least acknowledge [that] and have a plan that manages that." *Id.* at 713–14. He also acknowledged that the "usual course of professional practice" requires that a physician document in a patient's medical record one or more recognized medical indications for prescribing a controlled substance. *Id.* at 714.

Dr. Fine further testified that a physician's recitation of a patient's complaint does not, by itself, constitute a diagnosis. *Id.* at 725. While he then acknowledged that the usual course of professional practice requires that a physician document a diagnosis before prescribing a controlled substance, he then maintained that "chronic pain is a legitimate diagnosis, for which there is no corroborative test other than what the patient says" and that a physician "is under absolutely no obligation to rule out every single potential cause of that problem." *Id.* In his affidavit, Dr. Fine further stated, "[i]n large part, chronic pain diagnosis and treatment relies on a patient's self-reporting to the physician, and a doctor is absolutely entitled to rely on the patient's self-report of pain." RX 36, at 3. He also stated:

> It is my medical opinion that an experienced orthopaedic surgeon, such as [Respondent], who had seen a patient routinely over a period of time, would not necessarily need to conduct a comprehensive

[10] According to Dr. Fine, behaviors are used to assess pain in "pre-verbal children or mentally incapable children or adults, or in patients with advanced dementing illness who can't verbally report." Tr. 628.

[11] While this question is not very clear, Dr. Fine's answer was clear.

physical examination or exhaustive work-up on every visit from the patient during the maintenance phase of treatment. Much of the diagnosis and treatment of chronic pain involves observational analysis by the physician including affect and pain related behavior during interview, watching the patients' [sic] gait, ability to sit down, ability to get up, ability to ambulate, etc.

Id.

Dr. Fine also testified that with chronic pain, "the diagnosis * * * oftentimes sound[s] like it came out of the patient's mouth." Tr. 726. He maintained that this is justified because the "International Classification of Diagnoses" [12] includes a code for "arm pain" even though "there could be a hundred different causes of arm pain." *Id.* However, Dr. Fine then admitted that while "arm pain" could be a diagnosis, the physician would have to do a physical exam and, in his own words, "before you do that, you take more history" before prescribing a controlled substance. *Id.* at 726–27.

As to the usual course of professional practice for follow-up visits, Dr. Fine testified that in his own practice, he utilizes "the four As" to evaluate his patients and that this is "what we teach" to doctors around the country. *Id.* at 764–67. He further testified that these guidelines were published some four to five years earlier, *id.* at 767, and they were now "very commonly used." *Id.* at 764. "The four As" stand for "analgesia, activities, adverse effect, [and] aberrant drug-related behaviors." *Id.* at 765. Dr. Fine clarified that "analgesia" means "analgesic efficacy"; that "activities" is "really about [a patient's] functional capacities"; that "adverse effects" are the effects caused by taking a controlled substance; and "aberrant behavior * * * would include anything that indicated misuse, abuse, drug-seeking behavior, * * * missed appointments * * * not following through with recommendations for physical therapy, behavioral therapy, [and] referrals." *Id.* at 765–66.

When then asked whether it is "the usual course of practice to fail to ask a patient about the efficacy of [an] opioid that is being prescribed over a period of four months, when [the physician] see[s] that patient each month?"; Dr. Fine answered: "I can't speak to DEA requirements. I would say that it certainly would be a reasonable expectation in the course of conventional medical practice." *Id.* at 768–69. He then acknowledged that during at least one of the follow-up visits, he would expect the physician to ask his patient if the medicine was helping, if her pain had worsened, if there were any activities which increased her pain, and if anything reduced her pain.[13] *Id.* at 769.

As to whether the "usual course of professional practice" included documenting a change to an existing controlled-substance prescription, Dr. Fine testified that "[i]t's recommended" and that "it would be a good practice." *Id.* at 722. However, he indicated that he would "have trouble elevating [that] to an absolute requirement or necessity." *Id.*

As to whether, when a patient presents a new pain complaint, the "usual course of professional practice" requires obtaining the history of the injury and performing a physical exam on that area, Dr. Fine stated that "[t]aking * * * a reasonable history and examination of any new problem would be considered a reasonable practice * * * [t]hat's necessary * * * to do a professional job as a doctor." *Id.* at 724. However, the physician could "refer the patient to someone else if [the condition is] beyond [his] expertise." *Id.* Here again, the evaluation should "include a history, physical examination and laboratory tests or imaging studies," although Dr. Fine maintained that the "obligation is not to do any of those * * * with any rigor outside of the necessity of making that which is necessary to make a reasonable diagnosis." *Id.* at 724–25.

After acknowledging that it would be a "sign of doctor-shopping" if a pharmacy called and reported that a patient had filled "the same exact prescription for Oxycontin from two other doctors in the last week," Dr. Fine stated that "in our practice, we run" DOPL (State prescription monitoring) reports "as a matter of course," and do so even if there is no concern that a particular patient is seeking drugs from other physicians. *Id.* at 718–19. Dr. Fine testified that if a report showed that a patient is getting a controlled substance from multiple physicians, it "may be" an indication of doctor shopping, but the report "doesn't signal a diagnosis or a conclusion in and of itself." *Id.* at 719. He later testified that checking the DOPL database when regularly prescribing large amounts of opioid analgesics would "reflect best practices, but a minority, a small minority of practitioners * * * were using the database on a regular basis." *Id.* at 813.

As to whether "it is in [the] usual course of professional practice" to discuss with a patient why she is seeking a refill before a prior prescription should have run out, Dr. Fine testified that a physician should "inquire, to try and understand the motivation for that." *Id.* at 721. He also acknowledged that if a patient routinely seeks early refills with no explanation, this is a "red flag" for diversion or abuse. *Id.* He also acknowledged that if a physician obtains information that a patient is sharing controlled substances with others, the "usual course of professional practice" requires the physician to address the issue with the patient. *Id.* at 721–22.

Dr. Fine agreed that the "usual course of professional practice" included, in the event of a documented history of overdose, that the physician should be "taking certain steps to ensure that narcotics are not going to be * * * abused." *Id.* at 738. However, he also indicated that where the documented history indicated an overdose from methadone, it would not necessarily signal an addiction but could instead be simple misuse of medication or an accident: "Again, it's a differential diagnosis." *Id.* at 737. He did agree that, if a physician knew of an overdose event and did not include it anywhere in the patient's medical record, this would not be in the "usual course of professional practice." *Id.* at 745–46.

The Government then asked Dr. Fine several hypothetical questions regarding the propriety of a physician prescribing to a patient with whom he engages in sexual relations. Dr. Fine testified that it is not within the "usual course of professional practice" for a physician to "invite a patient to a motel room for a topless massage," and after giving her a topless massage, to issue her a prescription for a controlled substance. *Id.* at 751. Although he initially answered "no" to the question whether it would be outside of the course of professional practice to go to the home of his patient, have her take off her clothes, digitally penetrate her vagina, and then issue her a controlled substance prescription, Dr. Fine eventually acknowledged that it is also not within the usual course of professional practice to continue to issue controlled substances to this person. *Id.* at 753.

As a follow-up, the Government asked Dr. Fine whether, if it was true that Respondent had engaged in the above described acts, this would change his opinion as to whether Respondent's "prescribing of controlled substances was in the usual course of professional practice?" *Id.* at 762–63. While Dr. Fine

[12] Apparently, Dr. Fine was referring to the International Classification of Diseases, a publication of the World Health Organization.

[13] Dr. Fine testified that a physician is not obligated to see a patient every time that he writes a controlled substance prescription for her. *Id.* at 757.

answered "yes," he then stated: "[b]eyond that, it would require far more granularities towards understanding the relationship." *Id.* at 763. While Dr. Fine did not have "much favorable" to say "about sexual impropriety," he then stated "my personal opinions are not what matters. What matters is what really happened, and what the standards are as viewed by the Code of Ethical Conduct within the jurisdiction. And that would not be viewed as within the Code of Ethical Conduct." *Id.* Dr. Fine then acknowledged that he would change his opinion about the propriety of Respondent's prescribing of controlled substances to the person he had met at a hotel room and given the topless massage to (and on another occasion, digitally penetrated) if these events did, in fact, occur. *Id.* at 763–64.

While the ALJ acknowledged his "impressive credentials," the ALJ found that "Dr. Fine's testimony was marked by a significant level of consistent equivocation regarding the appropriate standards." ALJ at 83. More specifically, the ALJ observed that although Dr. Fine "acknowledg[ed] that State law and regulations inform[ed] his expert opinions, [his] testimony reflected a persistent, intentional reluctance to explain the correct standard of care and patient file documentation." *Id.* The ALJ further noted that while Dr. Fine was "repeatedly and directly queried about the correct practices in clear and concise terms, [he] consistently declined to provide direct answers." *Id.* at 87. Continuing, the ALJ explained that "[f]or hours on the witness stand, Dr. Fine adhered to the logically inconsistent position that although he teaches correct standards of care and has even created mnemonic tools to assist practitioners in remembering them, these standards are * * * only some sort of best-practices guidelines based on his anecdotal awareness that some practitioners may fall below the proper standard." *Id.* Relatedly, the ALJ found that "[w]hen repeatedly queried about the proper standard [for] prescribing medications and documenting patient files, he persistently answered with variations upon a theme that there are substandard physicians practicing medicine who do not adhere to the correct standard." *Id.* at 88–89.

As the ALJ also noted, when asked to give an opinion (based on his review of the transcripts of the undercover visits) as to the propriety of Respondent's prescribing during these visits, Dr. Fine testified that he "discounted them as not being particularly useful," and that without video recordings of the visit, he really could not compare what happened with "what was documented [in the patient's record] as supposedly occurring on that date"; and he therefore could not draw any "further conclusions." *Id.* at 878–79.

As the ALJ found, Dr. Fine "intentionally avoid[ed] direct answers that did not favor the Respondent's position." ALJ at 88. Moreover, the ALJ found that Dr. Fine's testimony was "evasive" and "bias[ed] in favor of assuming the correctness of the actions of any doctor." *Id.* at 90. Having personally observed Dr. Fine's testimony, the ALJ findings are entitled to substantial deference. *See Universal Camera Corp.* v. *NLRB,* 340 U.S. 474 (1951). His conclusion that Dr. Fine's testimony should be given less weight than Dr. Hare's is well supported by the record. ALJ at 90.

The Patient Specific Evidence

M.R.

M.R. was a patient of Respondent from May 2004 through January 29, 2008. GX 25, at 21, 34. At her initial visit, M.R., who was then twenty-three years old, presented with "wrist pain." *Id.* at 34. Under the heading "PHYSICAL EXAM," the record reads as follows: "She has wrist pain. Neurologically intact." [14] *Id.* According to the M.R.'s record, at this visit Respondent recommended that she use ibuprofen. *Id.*

At the hearing, M.R. testified that the wrist pain she reported was false and that she simply went to Respondent to obtain prescriptions for Lortab (a schedule III controlled substance which contains hydrocodone and acetaminophen, *see* 21 CFR 1308.13), which she had used recreationally "off and on," because she liked "the buzz" and "the high" and wanted to "have that high all the time." Tr. 272–74. M.R. had previously received Lortab prescriptions from a Dr. D. of Logan, Utah. *Id.* at 274. She apparently obtained prescriptions from Dr. D. and Respondent at the same time and was ultimately discharged from Dr. D.'s practice for doctor-shopping. *Id.*

According to M.R., Respondent's initial physical examination of her consisted solely of his grabbing both of her wrists and holding them for about ten seconds, after which he handed her a prescription. *Id.* at 272. M.R. indicated that Respondent did not ask about the severity of her pain or do any further examination such as a range-of-motion test or take an x-ray. *Id.* at 273. As noted above, the medical record for the visit indicates only that she would use ibuprofen, a non-controlled drug. GX 25, at 34. However, the medical record indicates that at M.R.'s second visit (June 23, 2004), Respondent diagnosed her as having "BILATERAL WRIST PAIN," with his physical examination finding that she had "diffuse tenderness over the dorsum of the wrist" and also "low back pain where she had an epidural." *Id.* On this date, although the current medication is listed as ibuprofen, the "PLAN" indicated that M.R. "was given a *refill* of LORTAB 7.5 (60)." *Id.* (emphasis added).

M.R. testified that Respondent never discussed alternative treatments to the use of opioids, although the record of the initial visit and every visit thereafter, indicates that M.R. was to "continue conservative treatment." *Id.* at 275; GX 25, at 21–34. M.R. also testified that, while she complained of wrist pain two or three times, she "never really" had to "mention anything, just walk in and he'd give [me] a refill. He didn't ask." Tr. 277. M.R. further testified that a bit later she complained of back pain to Respondent, but this pain was also a feigned condition; M.R. also admitted that she was engaged in drug-seeking behavior. *Id.* at 277, 282. At the time, Respondent had her stand, bend over, and then stand up straight again, in a sequence that perhaps lasted ten seconds. *Id.* at 277. At the third visit, however, Respondent increased both the strength and quantity of the Lortab to 90 tablets of 10 mg. strength. GX 25, at 34.

In M.R.'s medical record, bilateral wrist pain was reported as the diagnosis through September 20, 2006. GX 25, 26–34. In this period, Respondent prescribed Lortab, as well as both Xanax (alprazolam) and Valium (diazepam), which are schedule IV controlled substances (*see* 21 CFR 1308.14(c)); the progress notes for the visits, however, contain no indication of a new medical complaint or diagnosis which supported prescribing either Xanax or Valium. *See id.* at 26–29.

The entry for October 18, 2006, indicated that M.R.'s chief complaint

[14] Respondent frequently employed the phrase "neurologically intact" in his patients' progress notes. According to Dr. Fine this means that Respondent could have performed a number of types of tests or alternatively made some rather casual observations to make this determination:

> In the most specific sense of the word, you would do a very detailed examination of the cranial nerves. Motor findings, for which there are many, many different tests. Anything from gross muscle-strength testing to electromyography.
>
> Sensory examination, which in fact may include multiple modalities. And coordination. Those would be the main * * * contributors.
>
> On the other—that's at the most micro-level. At the macro-level, it simply might be the observation—for instance, my standing here observing you, and having interacted with you, saying to the best of my ability, you are neurologically intact.

Tr. 732.

was "bilateral wrist pain." *Id.* at 26. Under the Physical Exam heading, Respondent indicated only that "she continues to have bilateral wrist pain and chronic low back pain. She is having low back pain." *Id.* Respondent indicated his "IMPRESSION" as both Bilateral Wrist Pain and Low Back Pain and issued a refill for Lortab 10 mg. He also prescribed Valium. *Id.* at 26. Respondent also indicated that he would get "x-rays of the low back on her return." *Id.*

The entry for the next appointment (November 20, 2006), replicated verbatim the entry for the previous visit with the exception of the statement regarding x-rays, which was not included. *Id.* However, there is no indication that x-rays were obtained. *See id.* The entry for M.R.'s December 20, 2006 visit was identical to that of November 20 except for the notation that Respondent would no longer prescribe Valium. *Id.*

The entry for the following visit, January 15, 2007, listed both wrist pain and low back pain under "IMPRESSIONS," and under "PHYSICAL EXAM," noted that "[s]he continues to have low back pain. She has diffuse tenderness L4 to S1. She is also having wrist pain." *Id.* at 25. However, the entry for M.R.'s next visit, February 12, 2007, completely omitted all mention of wrist pain. *Id.* Moreover, it repeated verbatim the notation under the physical exam section of January 15, adding only the adjective "chronic" before "low back pain" in both the diagnosis and physical exam sections. *Id.* The same complaint, physical exam, and impression are repeated for subsequent visits until March 29, 2007, when Respondent added to the physical exam findings that M.R. was "neurologically intact" and indicated as his impression both "CHRONIC LOW BACK PAIN" and "DEGENERATIVE DISC DISEASE LUMBOSACRAL SPINE." *Id.* at 24. At this visit, Respondent also resumed prescribing Valium for M.R. *Id.*

Between March 29, 2007, and January 29, 2008, M.R. saw Respondent eight times. The progress notes for these visits contain the same complaint, history, physical exam findings (although the last three visits also added "degenerative disc disease" to this section), impressions, and treatment plan (invariably 90 tablets of Lortab 10 with one refill and "she will continue conservative treatment" and "will follow up as needed").[15] *Id.* at 21–24.

[15] Under the entry for M.R.'s last visit (January 29, 2008), there is a handwritten notation which states: "5–25–08 I will no longer see pt. DCM").

M.R.'s medical record contains two signed Controlled Substance Contracts, one dated March 29 (with no year indicated) and another dated December 10, 2005. *Id.* at 4, 19. Although not identical, both contracts stated that controlled substances "have a high potential for misuse, addiction, and are closely controlled by the State and Federal government." *Id.* Both contracts also included a paragraph stating that the patient understands that if she violates the contract, "treatment may be terminated" and that the violation "may also be reported to other physicians, medical facilities and legal authorities." *Id.* The contracts also included a clause by which the patient promised to "help" herself through "better health habits such as exercise, weight control, minimal use of alcohol and to stop smoking." *Id.* The record also contained entries in the progress notes to the effect that Respondent asked M.R. if she was obtaining controlled substances from other physicians on three occasions, February 27 and April 3, 2006, and also February 12, 2007. *Id.* at 25, 28, 29.

M.R. estimated that at 95% of her appointments with Respondent, he just issued her a prescription without any discussion of her medical condition. Tr. 286. With respect to her purported back condition, M.R. testified that "I just told him that my back hurt." *Id.* at 279. When asked whether Respondent had physically examined her back, M.R. answered: "One time he did have me stand up and then just bend over, and I was standing straight back up again. That was it. Nothing more than that ever." *Id.* M.R. further explained that the exam lasted "[n]o longer than 10 seconds. Long enough to stand up, bend over, and stand back up again." *Id.* Moreover, Respondent took neither x-rays nor ordered other diagnostic tests of her back. *Id.* at 280. Indeed, M.R. testified that she "didn't really need to complain" to Respondent about having back pain, "because he didn't ask if you were in pain." *Id.*

As for the Valium prescriptions, M.R. testified that "[t]he first time I got them, I'm sure I asked for them. But after that he just asked if I needed a refill and I'd say yes and I'd get my refill. That was it." Tr. 285.

At the time that M.R. agreed to wear a wire on undercover visits for DEA, she had been charged with six felony counts of obtaining prescriptions under false pretenses. *Id.* at 302–03. M.R. acknowledged that she had worn the wire hoping to reduce the charges, which were eventually dismissed. *Id.* at 291–92. The ALJ found M.R.'s testimony "credible insofar as it describes the manner in which Respondent interacted with her during their treatment relationship and during the times he prescribed controlled substances to her." ALJ at 13. Here again, the ALJ personally observed M.R. testify and was in the best position to observe her demeanor. Moreover, having reviewed the recordings and transcripts of M.R.'s undercover visits, I find that they support her credibility. Accordingly, I adopt the ALJ's credibility findings with respect to M.R.[16]

M.R.'s Undercover Visits

On October 9, 2007, M.R. made her first undercover visit to Respondent, and brought along a DEA undercover officer (UC) who used the cover name of "Rebecca." *See* GX 10, at 10. The visit began with M.R. asking Respondent to "see" Rebecca. *Id.* Respondent said he would require a referral from Rebecca's "regular doctor" and that he would also require "old records." *Id.* However, after declining to see her, he asked, "what do you need to come in for?" *Id.* at 10–11. The UC stated that a Dr. Stack had been giving her medications in May or June but that she "can't get it from him anymore," that she couldn't "function without" the medication, and that at present she has "been just having to kinda rely on friends to help [her] out." *Id.* at 11. After the UC stated that she

[16] In his exceptions, Respondent argues that I should reject M.R.'s testimony (and the ALJ's credibility finding with respect to her) because: (1) She violated her controlled substance contract in which she agreed not to seek drugs from other doctors, (2) "she could not remember specifics from" an undercover visit which had occurred only one year earlier but could remember whether he had performed physicals exams at visits which occurred four years previously, (3) that she had been charged with six felony counts, and that after she assisted the investigations, the charges were dismissed and that she "has everything to gain by testifying for the DEA, and motive to falsely implicate" him, and (4) that she admitted under oath that she lied to Respondent about being in pain in order to obtain narcotics. *See* Resp. Exceptions at 11–16.

Respondent's contentions ignore that the ALJ observed M.R. testify and was thus able to observe her demeanor. In any event, his first and fourth reasons beg the question of what one would expect a drug-seeking patient to do. More importantly, as discussed in my legal conclusions, it is clear that at a certain point Respondent clearly knew that M.R. was not a legitimate patient and cannot claim to have been duped.

As for the contention that she could not recall "specifics"—a reference to whether Respondent asked her a particular question at one of the undercover visits—that a witness does not remember every single aspect of a year-old conversation does not render her entire testimony incredible. Finally, as for the contention that M.R. had reason to lie about Respondent because she was facing six felony counts, similar arguments are made to the factfinder (whether judge or jury) in nearly every criminal case and appellate courts rarely find them reviewable, let alone persuasive. In addition, much of her testimony is supported by the transcripts of the undercover visits. I thus reject his exceptions to M.R.'s testimony.

had gotten Lortab and OxyContin from Dr. Stack, Respondent asked her whether she had insurance and whether she had a job. *Id.* Respondent then stated that because the UC did not "fit the * * * rules," she was not his "first choice" as a patient. *Id.* Continuing, he stated that he was "not a hundred percent opposed trying to help" the UC and added that "there's no way [the UC] can afford OxyContin" without a job or insurance. *Id.* at 11–12. Respondent told the UC to get a job, "then give us a call, and we'll see if we can help." *Id.* at 12. A bit later he commented that without the UC having a job or insurance, it would be "irresponsible" for him to prescribe OxyContin. *Id.* at 12–13.

Immediately thereafter, the UC said, "I do have money today. Could you do a Lortab for me today?" *Id.* After doing an apparent double-take, Respondent insisted that the UC needed to make an appointment, get a referral and bring her records before he could prescribe for her. *Id.*

Although M.R. had no interaction with Respondent other than in her effort to refer Rebecca, she emerged from the appointment with a prescription for ninety Lortab 10mg. GX 14, at 1. Her medical record for that date indicates the Lortab prescription, with one refill. GX 25, at 22. While the record also bears the previously noted refrain used by Respondent for his physical examination findings—"She has chronic low back pain. She has diffuse tenderness L4–S1. Neurologically intact"—nothing in the transcripts or recording indicates that Respondent conducted a physical examination of her back that would reveal tenderness. *See id.* Moreover, the recording and transcripts make clear that Respondent never asked about M.R.'s pain level, medical condition, side effects from the medication or whether M.R. was continuing with whatever "conservative treatment" he had noted in the numerous progress notes.[17]

At the second undercover visit (November 27, 2007), Respondent asked M.R., "How are you today?" GX 11, at 3. M.R. replied, "Good. How are you?" *Id.* Respondent did not inquire about M.R.'s pain, and there is no evidence that he performed a physical examination although he indicated having done so in M.R.'s medical record. GX 25, at 22. Respondent asked M.R., "You want a refill again?"; she replied: "Yeah." GX 11, at 3. M.R. then mentioned her friend Rebecca and asked whether, if she provided information on her job and insurance, Respondent could issue a prescription for her. *Id.* at 3–4. Respondent declined, saying that "[t]he law requires her to have a face-to-face with the doctor." *Id.* at 4.

M.R. then stated that she "ended up having to share a little bit with [Rebecca] last time my prescription." *Id.* After M.R. asked whether that was "okay to do?"; Respondent answered: "It's against the law." *Id.* M.R. then asked, "Oh, is it?" Respondent replied: "Just don't, uh, don't tell me about it." *Id.*

M.R. again asked for a prescription for Rebecca, this time offering $140, but Respondent stated: "No, it's * * * not a money thing, it's the law thing." *Id.* at 5. Later, Respondent said that he "wouldn't mind seeing" the UC, but then he remembered that she had gone to Dr. Stack, who "poisoned a lot of people [and is] in jail." *Id.* at 6–7. Respondent commented that "anybody that's * * * been coming from that office, we've been staying away from." *Id.* at 7. Again, without any discussion of M.R.'s medical condition or any apparent physical examination, M.R. emerged from the appointment with a prescription for ninety Lortab 10mg. GX 14, at 2.

At M.R.'s third undercover visit (on December 24, 2007), Respondent opened the visit by noting that she was in after only one month, but that after this visit, he wanted her to not come back for two months because he was giving her a prescription plus a refill. GX 12, at 3, 9. Respondent then asked, "Lortab ten?" and M.R. answered, "Yeah." *Id.* After the sound of paper tearing from a pad, Respondent asked, "You been doing okay?" *Id.* M.R. replied, "Yeah. I'm doing good." *Id.* at 4, 9. After Respondent and M.R. exchanged Christmas greetings, Respondent concluded the visit and told M.R. to "[t]ake care." *Id.* at 4, 9–10. Once again, without any meaningful inquiry regarding her pain, Respondent issued M.R. a prescription for ninety Lortab 10mg., with one refill. GX 14, at 3. M.R.'s patient record does not record a visit for December 24, but an entry for December 20, 2007 carried over the information from the prior visit verbatim, including the description of a physical exam. GX 25, at 22.

On the fourth undercover visit (January 29, 2008), Respondent began the appointment by asking, "How are you today?" GX 13, at 8. M.R. answered, "Good. How are you?" *Id.* Respondent said, "Good," then asked "Lortab, ten #90?" and "You want a refill on it?" *Id.* Respondent inquired whether M.R. was "getting pills from any other doctor" and whether she was "abusing them, selling them, [or] buying them?" *Id.* When M.R. responded in the negative, Respondent further asked whether M.R. was "doing anything illegal?"; she answered, "No." *Id.* at 9. Respondent never inquired about her pain level, about side effects, or about her functional capacity, and the recording does not indicate that a physical examination was performed, yet M.R. emerged from the visit with another prescription for ninety Lortab 10s and one refill. GX 14, at 4. Respondent also never mentioned that M.R. was back a month earlier than he had indicated for her, yet he wrote another prescription for a controlled substance with one refill. M.R.'s medical record for that date again repeats verbatim the record from the prior visit, including a physical exam that found "diffuse tenderness L4 to S1." GX 25, at 21.

Dr. Hare reviewed both M.R.'s medical record and the transcripts of the visits; his opinion was set forth in a letter which was entered into evidence. *See* GX 44. Dr. Hare noted that at M.R.'s initial visit, "[n]o history was obtained at that time, even in regards to the occurrence of the wrist pain and its characterization." GX 44, at 1. He also noted that "[n]o further tests were ordered and the physical examination was only that she was 'neurologically intact,' no details of any neurological exam were listed." *Id.* Dr. Hare remarked that about one month after the initial Lortab 7.5 prescription, Respondent increased M.R.'s prescription from 60 to 90 tablets and the strength to Lortab 10mg. "with no indication of benefit from the prior prescriptions." *Id.* Moreover, "[e]ven though the pain apparently persisted unchanged, no further tests were ordered." *Id.* According to Dr. Hare, while the note indicated that M.R. was "told to continue 'conservative treatment' * * * this was not initiated by [Respondent] nor described by him, i.e. immobilization, ice, etc." *Id.*

With respect to M.R.'s February 27, 2006 visit, Dr. Hare found that "the note for bilateral wrist pain is essentially the same with the exception that the patient is said to be on Valium 5 mg. but [there] is no indication that she had been previously prescribed this medication by Dr. MacKay. At the time of this visit though, she was given a prescription for Valium 5 mg. tablets." *Id.* Moreover, at the next visit, Respondent indicated that M.R. was taking Valium 10 mg. and gave her a prescription for this strength of the drug. *Id.* at 2.

Dr. Hare then observed that on May 24, Respondent switched M.R. "from Valium to Xanax, even though there was no description of the reasons for the

[17] As his treatment "PLAN," the record for this visit reads (as many entries do), that M.R. "will continue conservative treatment" and that she "will follow up as needed." GX 25, at 22.

Valium previously.[18] There was no follow up as to efficacy and there was no reason for switching to Xanax." *Id.* Dr. Hare then noted that M.R. "remained on Lortab and Xanax throughout the next several visits but then was switched back to Valium on August 30, 2006 for reasons that aren't described and no diagnosis is included." *Id.*

Next, Dr. Hare noted that on January 15, 2007, M.R.'s chief complaint changed from wrist pain to low back pain, and on subsequent visits the wrist pain (which she had purportedly complained of for nearly three years at that point) was no longer a problem. *Id.* As for M.R.'s complaint of back pain, Dr. Hare observed that:

> there is no additional physical examination other than describing "tenderness" to define this problem nor were there any other tests such as x-rays, MRI's, or other diagnostic tests done to better understand this complaint. The patient was just treated with continuing doses of Lortab as had been previously prescribed for wrist pain. With the substitution of Low Back Pain, the notes otherwise seem to be largely the same as they were when the patient had wrist pain.

Id.

Dr. Hare then explained that the March 29, 2007 "note indicated that the patient has 'degenerative disc disease, lumbosicral [sic] spine' and yet there is no physical exam or other diagnostic tests done to identify this as a problem. This diagnosis remains in his notes throughout the remainder of his care for her." *Id.* Dr. Hare also observed that "[f]rom March 29, 2007 through January 29, 2008 the clinic notes are almost identical, verbatim. There is no apparent change in her condition and there is no indication that she is getting any benefit from [Respondent's] treatment. There is no further testing of any sort done nor are any consultations sought despite the persistence of pain." *Id.*

Dr. Hare concluded that neither M.R's. complaint of bilateral wrist pain or low back pain "was adequately evaluated." *Id.* He further explained that "[n]o history was obtained, inadequate physical examination was done, no tests were ordered to better understand these problems and despite the lack of information [Respondent] chose to treat these problems aggressively with controlled substances." *Id.* at 2–3. Dr. Hare concluded that "the continuing prescriptions of controlled substances were not warranted." *Id.* at 3.

As for Respondent's recordkeeping, Dr. Hare observed that:

> [Respondent's] clinic notes appear to be computer generated, basically "rubber stamped," or "fill in a blank," type notes that do not really reflect the patients [sic] change in condition. There is no indication that the patient was getting any benefit from [Respondent's] treatment [and] there is no indication of updated physical examinations or further evaluations for the above described problems. Without some indication that the patient has improved with treatment, *there is not justification for the continued prescribing of controlled substances.* The clinic notes reflect a number of inaccuracies in terms of current medications and previous prescriptions, another indication that these notes were computer generated and did not necessarily reflect the patient's current status.

Id. (emphasis added).

Ultimately, Dr. Hare concluded that Respondent's evaluation of M.R. "was inadequate to justify the prescribing of controlled substances for her conditions." *Id.* Noting that there was no medical justification in M.R.'s chart for the benzodiazepines (Valium and Xanax) Respondent prescribed, Dr. Hare observed that "that there can be dangerous and detrimental interactions between Benzodiazepines and Opioid medications" such that, absent any description that would "justify the prescribing of Valium and Xanax," Dr. Hare concluded that Respondent's prescribing was "below the standard of care for the evaluation of the patient for the above described medical conditions and the treatment he prescribed." *Id.*

In his testimony, Dr. Hare explained that in the usual course of professional practice, a physician documents the reasons for a change from one benzodiazepine to another (*e.g.,* a switch from Valium to Xanax, or vice versa), yet M.R.'s patient record has no such documentation. Tr. 148. He also testified that the physical examination and history were not consistent with the usual course of professional practice, which requires more detail. *Id.* at 157. He further noted that there was a DOPL report in M.R.'s file for January to April 2007, which showed that she was also receiving hydrocodone (Lortab) from Dr. D. (as found above), yet Respondent apparently did not alter his prescribing practice for her. *Id.* at 161–63. He testified that he "did not believe the medical records support the long-term prescribing of controlled substances to this patient" and that there was "insufficient evaluation for both her wrists and her low-back problems to allow such prescribing." *Id.* at 164.

Dr. Fine did not offer any testimony specific to M.R. even though he reviewed her patient file and the transcripts of her undercover visits. Tr. 619 & 872. As found above, Dr. Fine was unwilling to express an opinion on the validity of Respondent's prescribing to M.R. during the undercover visits because he was unable to view "a full audiovisual recording of these visits [and] compare them to the [patient] records." *Id.* at 878–79. He indicated that without knowing the context of the physician-patient relationship he just couldn't "make sense out of" the transcripts. *Id.* at 875.

I conclude that Dr. Fine's testimony is patently disingenuous. As did the ALJ, I find credible Dr. Hare's testimony regarding Respondent's prescribing to M.R.

K.D.

K.D. first saw Respondent in November 2004, complaining of a neck injury that was caused by a July 2003 auto accident.[19] GX 26, at 118. Previously, a Dr. M. had diagnosed her as having cervical spine disease and a pinched nerve. Tr. 345. K.D. testified that at her initial visit, Respondent did not take her heart rate, blood pressure, or weigh her, and he performed no physical examination beyond looking at her neck. *Id.* at 349; 345–46. Moreover, he did not ask about the severity of her pain or order diagnostic tests such as x-rays. *Id.* at 346, 348. According to K.D.'s records, Respondent found that "[s]he has diffuse pain in the neck areas, into the shoulders and headaches[,] * * * diffuse tenderness in the cervical spine C3 to C7[,] * * * tenderness in the trapezius area[,]" and that she was "neurologically intact." GX 26, at 118.

In contrast to K.D.'s testimony, Respondent noted in her record that "[x]-rays of the cervical spine taken are essentially normal with some straightening and loss of the lordotic curve." *Id.* He then diagnosed her as having "cervical strain July 2003 motor vehicle accident with flare up residuals." *Id.* Respondent indicated that K.D.'s treatment plan would include "physical therapy"; he also prescribed 60 Lortab 7.5 mg. (hydrocodone), 60 Soma, 60 Fioricet, and indicated that she would "continue conservative treatment" with a "follow up in three weeks."[20]

[18] In testimony, Dr. Hare indicated that Valium was an anti-anxiety drug which could be used as a muscle-relaxant for a few days to a week. Tr. 146. Xanax is also an anti-anxiety drug but a "shorter acting, shorter lasting drug than Valium." *Id.* at 147.

[19] On cross-examination, K.D. clarified that she had experienced more than three months of pain prior to consulting Respondent. Tr. 441.

[20] The progress notes for K.D's first three visits list her name as "Terri" rather than Kerri, the name which is used throughout the rest of this voluminous record. *See generally* GX 26. It is further noted that the cover of the file is labeled with the type-written name of Terri, with the letter K handwritten over the T. No argument has been raised that these progress notes were for a different patient.

As early as her third visit, K.D. reported that "her prescriptions and purse [were] stolen." *Id.* at 117. Respondent then gave her a new prescription for 60 Lortab. *Id.*

Respondent treated K.D. with various narcotics which, over the course of his prescribing to her, were of increasing strength and quantities. More specifically, through September 2006, Respondent usually prescribed Lortab; however, at some visits he prescribed Percocet 5 mg., or Percocet 10 mg., which are schedule II controlled substance containing oxycodone. GX 26, at 113–118. However, on November 6, 2006, Respondent gave her a prescription for sixty tablets of OxyContin 40 mg.; he also noted that "[t]he METHADONE made her itch to the point that she could not tolerate it over the weekend." *Id.* at 108. Yet there is no indication in her record that he had previously prescribed methadone for her.

At the next visit, Respondent refilled her OxyContin 40 mg. prescription and gave her a prescription for Lortab 10. *Id.* at 107. Subsequently, he wrote more prescriptions for OxyContin 40 mg. and Percocet 10 mg., although at times he indicated that the latter was for hydrocodone 10/325, a different controlled substance. *Id.* at 105–06. Subsequently, on March 9, 2007, Respondent stopped writing Percocet prescriptions and started issuing prescriptions for oxycodone 15 mg. (as well as OxyContin 40 mg.). *Id.* at 104. This prescribing pattern generally continued through the course of K.D.'s visits with Respondent. *Id.* at 91–105. However, in July 2007, Respondent gave her a prescription for Demerol, another schedule II controlled substance. *Id.* at 102. Moreover, in November 2007, Respondent again increased the quantity of oxycodone IR (from 120 tablets of 15 mg. strength to 90 tablets of 30 mg. strength, which was eventually increased to 120 tablets). On various occasions, he also gave her prescriptions for Lortab. In addition, Respondent prescribed several schedule IV controlled substances to K.D. including Ambien, Xanax and Valium. *Id.* at 91–98, 100–01; Tr. 348.

K.D. testified that Respondent did not ask her about her pain at every visit and that, if her pain was discussed, it was because she raised the subject and not because Respondent asked her about her pain or its severity. *Id.* at 348–49. She further testified that Respondent never performed physical examinations at subsequent visits and that she received at least one controlled substance prescription per visit. *Id.* at 349.

At an appointment in the summer of 2006, K.D. asked Respondent about getting a referral to a physical therapy practice with a masseuse on its staff. *Id.* at 360. Respondent asked K.D. if she "would like a massage" and then asked for her cell phone number. *Id.* at 350. He then stated that he would get a motel room in another town, and call for her. *Id.* Several weeks later, Respondent called K.D. and told her where to meet him. *Id.*

On or about September 23, 2006, K.D. met Respondent at the motel and, after entering his room, removed both her top and bra. *Id.* Respondent massaged her for 30–45 minutes. *Id.* at 351. After K.D. put on her clothes, Respondent explained that because he had diabetes he was unable "to perform certain sexual activities." *Id.* at 351. He then took out his prescription pad and asked her "what prescriptions [she] needed." *Id.* Respondent then gave her a prescription for ninety tablets of Percocet 7.5 mg., a schedule II controlled substance. *Id.; see also* GX 39 (prescription signed by Respondent dated September "9–25–06").[21] Not surprisingly, K.D. and Respondent did not discuss her pain or medical condition. *Id.* at 353.[22]

K.D. also met Respondent on four or five other occasions "at a friend's house." *Id.* at 354. During each encounter, Respondent again gave her a massage and afterward, gave her a controlled substance prescription. *Id.* at 354, 355. Prior to one of these encounters, which occurred in March 2008, K.D. called Respondent to tell him that she was back in town and wanted more drugs. *Id.* at 355. Respondent agreed to meet K.D. at her friend's house after he got off from work, and upon meeting her, asked her if she "would like a full body massage." *Id.* K.D. agreed and removed all of her clothes and laid down on a bed. *Id.*

After massaging her upper body and legs, Respondent rubbed her vaginal area and digitally penetrated her. *Id.* at 356. After five minutes or so of this latter activity, K.D. faked an orgasm to end the session. *Id.* K.D. got dressed, and Respondent then gave her a prescription for oxycodone IR 30 mg., as well as $75 to $100 "to fill" her prescription. *Id.* at 357; GX 38, at 1 (signed RX). K.D. then filled the prescription. *Id.* at 358. During the encounter (as well as the others that occurred outside of Respondent's office), there was no discussion of her condition or her pain. *Id.* at 361.

K.D. testified that she agreed to the March 2008 meeting so she "would get [her] pain medication." *Id.* at 396. She also stated that, while she had regular appointments at which she obtained medications, she agreed to meet Respondent outside of his office to obtain additional narcotics. *Id.*

K.D.'s medical record does not reflect either an office visit or the issuance of a prescription as having occurred on March 10, 2008, the date of the prescription. Rather, her record contains an entry for January 31, 2008, during which K.D. reported that she was "moving out of state to take care of her mother" and "will not be coming back," and at which Respondent indicated that his physical exam found that "[s]he has chronic low back pain" with "diffuse tenderness L4 to S1," "degenerative disc disease" and was "[n]eurologically intact." GX 26, at 98. Respondent gave her prescriptions for both 150 oxycodone IR (30 mg.) and Ambien. *Id.* K.D.'s record then contains an entry for an office visit which occurred on April 9, 2008, during which Respondent again found that she had "chronic low back pain" and "diffuse tenderness L4 to S1." *Id.* at 97. At the visit, Respondent gave her prescriptions for sixty tablets of OxyContin 40 mg., 120 tablets of oxycodone IR (30 mg.), 30 tablets of Ambien, and Fioricet. *Id.* at 97.

K.D.'s medical record contains a letter from Respondent to her, dated December 20, 2007, which stated that she had told Respondent that her insurance company would not approve her OxyContin prescription. GX 26, at 50. Respondent wrote that "we gave you

[21] The label attached by the dispensing pharmacy indicates, however, that the prescription was actually filled on September 23, 2006. GX 39.

The Government also entered into evidence a confirmation receipt, which showed that Respondent took a room at the Bestrest Inn, a motel in Ogden, Utah, on September 23, 2006, *see* GX 16; motel personnel told a DEA Investigator that Respondent had purchased the room for that night. Tr. 1146. An Investigator further testified that K.D. had provided investigators with an account of the visit that was generally consistent with the layout of the motel. *Id.* at 1019. The Government also entered into evidence a floor plan of the hotel, on which K.D. identified the room she had been in with Respondent as one of four rooms. GX 15; Tr. 1019–21.

[22] K.D.'s medical record has entries for September 22, 24, and 25, 2006. The September 22 entry indicates that a prescription for ten Lortab 10s was called in to a pharmacy. GX 25, at 109. The September 24 entry indicates that K.D. "called over the weekend needing more medication. She was given a prescription for PERCOCET 7.5/500 mg. (90), AMBIEN 10 mg. (30) and FIORCET (60)." *Id.* The entry for September 25 indicates that "[p]atient failed to show for appointment." *Id.* A DOPL report for KD for the period shows only that she filled a prescription from Respondent for hydrocodone 10 mg/APAP on September 22 and a prescription from Respondent for Endocet 7.5 on September 23, a drug which is the same formulation as Percocet. GX 37, at 3.

Methadone to try and help you,"[23] but the "State of Utah reported that [the OxyContin prescription] was indeed filled at WalMart Pharmacy in Harrisville." *Id.* Respondent wrote, "This represents an abuse situation and I will no longer be able to see you." *Id.* However, as found above, Respondent continued to prescribe controlled substances to K.D. notwithstanding this incident and did so on numerous occasions thereafter.[24]

K.D.'s medical record also contains a January 23, 2008 fax from the Box Elder Narcotics Task Force. *Id.* at 43–49. The fax included a document, which stated that K.D. was obtaining controlled substances from five prescribers (and twelve different pharmacies), as well as a DOPL report for the period of December 20, 2006 to December 20, 2007, which showed the same. *Id.* at 43, 46–49. In another fax, which is dated January 25, 2008, Respondent wrote to the Box Elder Narcotics Strike Force that: "We talked about her. I did talk to her as per our conversation. She promises 1 doctor, 1 pharmacy, as of the first part of Jan. Let's monitor her closely for [indecipherable]." *Id.* at 42.[25]

K.D.'s medical record contains a signed Controlled Substances Contract, which is dated September 23, 2005. *Id.* at 36. While one of the terms of the contract was that Respondent would not replace a prescription which was "lost, misplaced, stolen or * * * use[d] up sooner than prescribed," *id.,* K.D. testified that on May 12, 2008, where the medical record indicated that her medications had been stolen, Respondent restricted her to using one pharmacy. *Id.* at 380; GX 26, at 97. According to K.D., "I had run out of my medication early, and I called [Respondent] and told him. And he instructed me to make a false police report, and tell the police that my medication had been stolen, and to bring that." Tr. 381; *see* GX 43 (police report of May 12, 2008).[26]

In addition, K.D. testified that there were several falsifications in her medical record. While an entry for July 11, 2008, indicates that K.D. was having a "right knee scope by a physician in Ogden" and that she received another thirty tablets of oxycodone 30 mg. IR from Respondent, K.D. testified that she never had arthroscopic surgery on her right knee and that she had neither knee problems nor complained of such. Tr. 375–76. Moreover, while many of the notes for her visits list her chief complaint as "chronic low back pain," GX 26, K.D. testified that she has never suffered from chronic low back pain and never told Respondent that she did. Tr. 374. While K.D. maintained that some of the prescriptions she obtained from Respondent were necessary to treat her pain, she maintained that she used a "huge percentage" of them "for recreational use." *Id.* at 391–92.

K.D. became addicted to pain medication, *id.* at 392, and asked Respondent to take her off of OxyContin and give her methadone instead. *Id.* at 393. Respondent, however, told her that methadone hurts people, and he continued to write her prescriptions for OxyContin. *Id.*

On four occasions in November and December 2008, K.D., who had agreed to cooperate with DEA Investigators, visited Respondent while wearing a recording device. With regard to these activities, K.D. testified that nothing was promised her in exchange for her testimony, and that, at the time of the hearing, she was incarcerated in a county jail for violating her probation which had been imposed because she had violated a protective order involving her ex-husband. *Id.* at 390–91.

Moreover, while K.D. was generally required to give the Investigators the prescriptions she obtained, after the first undercover visit (November 7, 2008), the Investigator had her go into a pharmacy and fill a prescription for oxycodone 40 mg. Tr. 1064. The pharmacy, however, only partially filled the prescription. *Id.* While K.D. turned over the drugs to the Investigators, she later went back and filled the rest of the prescription without telling them. *Id.*

K.D. also admitted that in November 2008, she had sold on the street seventy tablets of OxyContin for $2400, which she had obtained using a prescription issued by Respondent.[27] *Id.* Moreover, on cross-examination, K.D. admitted that after the visit on December 22, 2008 (during which she received a prescription for 120 tablets of oxycodone IR 30 mg.), she called Respondent's office, told them she had lost the prescription, and obtained a replacement which she then filled.[28] *Id.* at 408; *see* GX 37 (DOPL report), at 9. K.D. stated that she considered this prescription to be "legitimate," because she was having pain that day. Tr. 406. The following week, K.D. was given a drug test which she flunked. *Id.* at 1171. She was re-incarcerated and DEA stopped using her as an informant.[29] *Id.*

K.D.'s undercover visits were recorded; the recordings along with transcripts for three of the visits were admitted into evidence by the Government. On November 3, 2008, after an initial discussion regarding a domestic violence incident with her ex-husband, Respondent asked K.D.: "Now, are you getting pills from other doctors?" GX 19, at 6. K.D. answered, "No, I've been in Kansas." *Id.* She indicated that for the past two months she had "been in a lot of pain." *Id.* at 7. After replying "I'll bet you have," Respondent asked, "What do you want to do?" *Id.* K.D. said, "I want my, all my—I need all my meds. I need my oxycontin, my [roxicet], my juraset." After a brief discussion of whether her insurance company had approved the OxyContin, Respondent asked: "Okay, so you want—got you down for 40 mg., 90 of them?" *Id.* K.D. answered affirmatively. *Id.* Respondent than asked: "And then what else?" *Id.* at 8. K.D. told him 120 Roxicet 30 mg., 60 Fioricet, and Ambien. *Id.* at 8. Continuing, K.D. complained that "I can't believe you forgot this, this is just not cool * * * You forgot what I take." *Id.* Respondent asserted that, to the contrary, "I make the patient tell me, to make sure they understand what they're

[23] This prescription is reflected in an entry of December 13, 2007, in which Respondent wrote, "That prescription was torn up by a pharmacist instead she was given methadone, 10 mgs." GX 26, at 55, 99. K.D. testified that she had used up her OxyContin too quickly so Respondent was going to give her methadone; she had not reported to Respondent that the prescription was torn up by the pharmacist. Tr. 377.

[24] K.D. testified that Respondent never told her that he was dismissing her from his practice; rather, he told her that she must use just one doctor. Tr. 379.

[25] Another DOPL report, dated April 8, 2008, showed that K.D. filled a prescription from Respondent for various controlled substances from Respondent including oxycodone on March 10, 2008, as well as for Ambien (Zolpidem), which was written by another physician. GX 26, at 41.

[26] K.D.'s medical record also indicates that Respondent discussed with her whether she was getting narcotics from other physicians and/or more than one pharmacy on six occasions: August 24, 2005; February 1 and November 6, 2006; February 5 and March 5, 2007; and January 16, 2008. *Id.* at 54, 61, 63, 65, 69–70, 72. However, given the numerous instances in which Respondent falsified records, these notations are of questionable accuracy.

[27] DEA learned of this in January 2009, apparently from K.D. Tr. 1142. As of the hearing, the matter had not been further investigated or referred to either Federal or State prosecutors. *Id.* at 1142–43.

[28] K.D. was then residing in a work-release facility. Tr. 1141.

[29] The ALJ provided an extensive explanation for why he found K.D.'s testimony credible. ALJ at 28–31. Among other things, the ALJ noted that other evidence corroborated her testimony regarding the March 2008 encounter at the motel.

It is disturbing that K.D. was able to obtain an extra prescription from Respondent which she apparently sold on the street while she was cooperating with the investigation. However, K.D. freely admitted having done so during her testimony. Again, the ALJ personally observed K.D.'s testimony and found her testimony to generally be credible. I find no reason to reject this finding. *See* Resp. Exceptions at 26.

getting," and added that "[i]t's just my little trick." *Id.*

Respondent then asked K.D. if she was "a plant from the police or the DEA?"; a lengthy conversation ensued in which Respondent complained that his office had been under investigation for sixteen months. *Id.* at 9–12. During this part of the conversation, K.D. asked if she was going to get in trouble, and Respondent answered: "Just as long as you're not abusing drugs. You're not getting narcotics from any other doctor?" *Id.* at 10. He also complained that DEA had "actually sent people in with wires" and had interviewed 100 of his patients to find out if he was "selling pills to them." *Id.* at 11–12. Respondent further asserted that his former partner had "turned" him "in," *id.* at 12, because he "sued me, and then to cover up this lawsuit he had filed against me, * * * he called the DEA in on me." *Id.* at 13. After venting about the lawyers involved in the suit, *id.* at 13–14, Respondent complained that the Government had seized all of his records and various assets and labeled him a terrorist. *Id.* at 16. After a discussion regarding K.D.'s mother, who had been put in an " 'old folks' home," *id.* at 20–23, the visit ended. During the visit, Respondent gave prescriptions for 90 tablets of OxyContin 40 mg., 120 tablets of oxycodone IR 30 mg., 30 tablets of Ambien, and 60 tablets of Fioricet. GX 17, at 1–4. As is clear from the transcript and recording, Respondent did not physically examine K.D. and did not ask about her pain level, the efficacy of the previously prescribed medications, possible side effects, or her functional capacities.

K.D.'s patient record for November 3, 2008, states, however, that Respondent conducted a physical examination during which he found: "She has chronic low back pain. She has degenerative disc disease and diffuse tenderness L4 to S1." GX 26, at 92. The record also states that K.D. "stated that she has been suffering." *Id.* Finally, the record states that K.D. "will continue conservative treatment" although neither the recording nor the transcript contain evidence that her continuation of such treatments was discussed. *Id.*

K.D.'s next undercover visit occurred on November 24, 2008. GX 20. K.D.'s meeting with Respondent began with a discussion of her insurance and whether the insurer had approved a full prescription. GX 20, at 4. K.D. complained that she had "bought twenty at first, and then, yeah—they, they held it back first, 'cause they only approved that twenty. And then, I had to go back and call and—twenty a year—which is complete bulls* * *" *Id.* Respondent then asked whether she had gotten the full prescription; K.D. answered, "yes." *Id.* Respondent stated that he could not write a refill in "less than four weeks" so that it would be the first of December before he could again write the prescription. *Id.* K.D. insisted, "I just need my meds." *Id.* Respondent replied that he could give her sixty oxycodone tablets instead to carry her through Thanksgiving, and that she could then come back and he would not charge her for the new prescription. *Id.* at 4–5.

Respondent then asked: "And you're not working with the DEA, or wearing a wire, right?" *Id.* at 5. K.D. answered, "no," and Respondent complained about the "pressure" DEA was applying. *Id.* Respondent explained that it was this pressure "that's why I, I just can't do it. 'Cause the * * * law says * * * four weeks." *Id.* K.D. then replied: "Does that mean you're not seeing me no more, either?" *Id.* Respondent asked, "What?" and K.D. repeated, "That means you're not seeing me no more, either? You can't see me no more? Can't talk to me no more? I can't believe you!" *Id.* Respondent replied, "I can't, I can't, yeah. It's * * * crazy." *Id.* at 6. K.D. said, "That's—this is insane to me," and Respondent replied, "Yeah." *Id.* K.D. stated "you'll be okay, though. I think"; Respondent answered, "I think so" plus some inaudible comment. *Id.*

Next, K.D. asked when she had to come back and whether Respondent would charge her. *Id.* Respondent stated that while he would bill K.D.'s insurance he would not charge her a co-pay. *Id.* Respondent and K.D. then agreed that her next visit would be "next Monday," which was December 1. *Id.; see also id.* at 9. Respondent then affirmed that he would not charge her the co-pay and added, "I'll give you sixty of the oxy 30s to get by and we'll * * * fill everything next week." *Id.* at 7.

The conversation turned to Respondent's dispute with his former partner and the latter's purported motivation for reporting him to the Agency. *Id.* K.D. then made an appointment with Respondent's office assistant for an appointment on December 1, 2008. *Id.* at 9. At the visit, Respondent gave K.D. a prescription for sixty tablets of oxycodone IR 30 mg. GX 17, at 5.

Once again, K.D.'s medical record indicates that Respondent performed a physical exam at this visit, during which he found that "[S]he has chronic low back pain. She has degenerative disc disease and diffuse tenderness L4 to S1." GX 26, at 92. However, neither the transcript nor the recording of the visit contain any evidence suggesting that a physical exam was performed. In addition, the progress note states that K.D. "denie[d] getting narcotics from any other physician" although neither the transcript nor the recording indicate that Respondent asked her anything of the sort. *Id.* The progress note also states that K.D. "will continue conservative treatment" although no alternative form of treatment was discussed in the course of the visit. *Id.*

K.D.'s third undercover visit took place on December 1, 2009. After a few inaudible exchanges between them, Respondent asked K.D., "today, what do you need?" GX 21, at 5. K.D. responded: "Everything. My Oxycontin, my Roxicet, my Fioricet, my Ambien, and I have been so stressed out, so I was going to see if I could get some Xanax, too. I don't know if I can do that with the Ambien, or if I have to substitute them." *Id.* Respondent made an inaudible comment, and K.D. indicated that she was "going through some sh-t." *Id.* Respondent then asked her, "how many Ambien, or, uh, Xanax do you want?" *Id.* They settled on thirty. *Id.* Respondent then warned K.D. that with Xanax, Ambien, Klonopin and Soma, she would "run the risk of over sedating." *Id.*

After K.D. stated that the Christmas holidays stressed her out, Respondent asked her how she was doing at her job. *Id.* at 6. K.D. replied: "I'm not making any money. I just barely went back to work, and I am just * * * freaking out * * * I have no more—I have—I'm just stressed out." *Id.* To this Respondent replied, "I told you about all my money, didn't I?" *Id.* He then stated: "They took * * * over a million dollars from me. And they haven't said anything, or given it back, or done anything." *Id.* When K.D. asked, "So I—I can't get Christmas help from you this year?"; Respondent offered to "give [her] every dollar in my wallet, but it's only three dollars." *Id.*

A bit later, Respondent asked K.D. for her "newest phone number" and stated that "if anything goes better for me, I'll * * * give you a call." *Id.* at 7. K.D. then complained that the back of her neck was swollen and stated, "I need a massage." *Id.* Respondent replied, "Right through there, yeah," and K.D. responded, "That means no more massages? No more help—at all?" *Id.* Respondent laughed. *Id.* A bit later, Respondent said, "Well, let's see if things get any better for us here." *Id.* at 8.

After Respondent assured K.D. that he would call her if things got better for him, she asked if one of his employees "get[s] mad that I close the door?" *Id.* Respondent answered: "She does. She

thinks your [sic] doing nasty things in here." *Id.* K.D. replied: "no, I would never do that * * * Well, not in the office. That's why she gets all—yeah, I can tell she does not like that. But I don't like to talk about my, and your personal business in front—yeah, I mean like [inaudible.]" *Id.* Respondent's reply was inaudible. *Id.* K.D. then stated that when she closed the door, the employee "kind of gave [her] a dirty look" and didn't like her "at all." *Id.* at 9. Respondent said that his employee did not "trust" K.D. and that his "mother said never trust anybody with a tattoo." *Id.* K.D. then acknowledged that she has two tattoos. *Id.*

Respondent inquired whether K.D. "still live[d] in that same place?" *Id.* K.D. answered, "yeah," and added that she was going to be kicked out because the house was being foreclosed on. *Id.* She then explained that while her "stuff" was still at the house she was actually "living at one of those little Budget Inn places." *Id.* at 9–10. After K.D. and Respondent discussed that neither of them had gone shopping due to money problems, Respondent said, "I am going to give you all the money I have * * * My three dollars." *Id.* at 11. K.D. noted that this would allow her to get "two gallons" of gas and thanked Respondent, who apparently again complained about the investigation. *Id.* K.D. said, "So you better * * * call me," and Respondent replied, "We'll win." *Id.* After K.D. told Respondent that he was "a friend," the two exchanged farewell wishes. *Id.* at 11–12.

At the visit, Respondent gave K.D. prescriptions for 90 tablets of OxyContin 40 mg., 120 tablets of oxycodone 30 mg., 30 tablets of Xanax, and 60 tablets of Fioricet. GX 17, at 6–7. The progress note for this visit again states that K.D. "comes in for follow up of chronic low back pain," and that Respondent had performed a physical examination and found that that K.D. "has degenerative disc disease and diffuse tenderness L4 to S1," GX 26, at 91, although neither the transcript nor the recording suggests that Respondent performed even a perfunctory physical examination. Moreover, the note states that K.D. "denies getting narcotics from any other physician" and that she "stated that this controls her pain well" although neither the transcript nor the recording provides any evidence that Respondent and K.D. discussed either issue during this visit. *Id.* The record also states that K.D. "will continue conservative treatment" although no discussion of such treatments took place in the course of the visit. *Id.*

On either December 18 or 22, 2008, K.D. made a fourth undercover visit; an audio recording of the visit was entered into evidence. GX 48.[30] The ALJ found that this visit shared many of the same characteristics of the other three visits. ALJ at 24. Respondent asked K.D. to tell him what she needed, and K.D. requested several controlled substances. GX 48. K.D. took the opportunity to thank Respondent for a $250.00 gift.[31] *Id.* During the visit, Respondent agreed to postdate prescriptions for K.D. because of an issue related to her insurance. *Id.* The visit ended with Respondent again bemoaning the investigation. *Id.*

K.D.'s patient record contains no entry for December 22, 2008. *See generally* GX 26. An entry for December 18, 2008, however, shares many of the features of the other entries, such as a Physical Exam section that reads: "She has chronic low back pain. She has degenerative disc disease and diffuse tenderness L4 to S1. Neurologically intact." GX 26, at 91. Consistent with the other undercover visits, the audio recording reflects no indication that any tests were conducted that would support any of the findings set forth in the treatment notes. The note also indicates that K.D. "denies getting narcotics from any other physician" and "stated this controlled her pain well." *Id.* Again, however, the recording contains no indication that Respondent and K.D. discussed how the prescriptions were affecting her pain level and functionality.

At the visit, K.D. "was given OXYCONTIN 40 (90), OXYCODONE 30 mg. IR (120), FIORCET [sic] (60) and XANAX 1 mg. (30)." *Id.; see also* GX 17, at 8 (RX for 120 oxycodone IR 30 mg.), 9 (RX for 90 OxyContin 40 mg.), 10 (RX for 30 Xanax 1 mg.), and 11 (RX for 60 Fioricet). The note also states that "She will continue conservative treatment." *Id.*

An addendum of the same date states that Respondent wrote "all four" prescriptions for K.D., but that she returned "stating that she did not get the ROXICET prescription." *Id.* Respondent wrote, "I will give her the benefit of the doubt this time and rewrite the ROXICET. I will check a DOPL in a few weeks to see if she doubled her prescription refill." *Id.* As found above, K.D. admitted in testimony that on that day, she had returned to Respondent's office without telling her DEA handlers, obtained an additional prescription, which she then filled at a drugstore across the street from Respondent's practice. Tr. 408.

In a letter of March 25, 2009, Dr. Hare provided an extensive analysis of Respondent's prescribings to K.D. GX 46. Therein, Dr. Hare found that Respondent's initial evaluation of K.D. for neck pain "consisted of a very brief history and a rather superficial examination," in which he stated that she was "neurologically intact" without providing "details as would be expected of the neurologic exam (reflexes sensory and strength examination)." *Id.* Respondent prescribed Lortab 7.5 and Soma, as well as Fioricet, which the patient was reportedly taking. *Id.*

Dr. Hare noted that at K.D.'s third visit (December 17, 2004), "the patient reported that her medications were stolen and [Respondent] promptly reissued her medications." *Id.* Dr. Hare observed that Respondent saw K.D. at two to three week intervals, yet he prescribed in a way that would "suggest one month medication supplies." *Id.* Next, Dr. Hare observed that in May 2005, K.D. reported that she had been assaulted by her husband and brought a police report (GX 26, at 81–82), which indicated that K.D. had a problem with substance abuse, and yet, despite this and the "early refills," Respondent "did not seem fazed and continued to prescribe for her without concern." *Id.* Moreover, "the next year [Respondent] gradually escalated her doses and sometime changed from Lortab to Percocet with no explanation." *Id.*

Next, Dr. Hare observed that on September 11, 2006, K.D.'s chief complaint changed to low back pain and that "there is no mention of her neck pain any longer." *Id.* He also noted that in Respondent's physical exam findings, "tenderness in the back [was] substituted for cervical tenderness." *Id.* He further noted that while oxycodone 15 mg. was substituted for her previous medications because they (Lortab and Percocet) were upsetting her stomach, shortly thereafter she was "again

[30] While the prescriptions Respondent gave K.D. are dated 12–22–08, on two of them the date of 12–18–08 was crossed out. GX 17, at 8 & 11. Other evidence suggests that the visit occurred on December 18, including the discussion of the need to post-date the prescriptions and K.D.'s patient record. *See* GX 26, at 91. The transcript was not entered into evidence. ALJ at 24 n. 41.

[31] In discussing this visit, the ALJ found that "[i]n the Respondent's version of the transcript, K.D. alludes to swelling on her neck, says she is [in] pain, and makes something of an effort to induce the Respondent to provide a massage." ALJ at 24 (citing RX 13, at 5). It is not clear why the ALJ cited RX 13 as evidence of the December 22 visit, as he had previously noted that it was a transcript of the December 1 visit. *See id.* at n.40. Moreover, having carefully read RX 13, it is noted that it tracks verbatim, with only minor differences, the Government's transcript of the December 1 visit. *Compare* RX 13 with GX 21. Furthermore, while the ALJ noted that in the recording of the December 22 visit, K.D. thanked Respondent for a $250 gift, RX 13 contains no such discussion. I thus find that RX 13 is a transcript of the December 1st, and not the December 22nd, visit.

receiving Lortab and then * * * Percocet." *Id.* at 2.

Dr. Hare noted that the following month (October 20, 2006), a handwritten note signed by one of Respondent's staff stated that a pharmacy had called and reported that K.D. was "getting multiple prescriptions from multiple doctors." *Id.* Dr. Hare observed that the entry for the November 1, 2006 visit indicates that Respondent discussed the matter with the patient and that K.D. "claimed this was a matter of identity theft by a roommate," and that on November 6, 2006, Respondent reportedly "set up a plan for 'one physician prescribing and one pharmacy for refills.'" *Id.* Dr. Hare noted, however, that Respondent "[i]mmediately began prescribing a significantly larger dose [sic] the pain medication for her," which "consisted of OxyContin 40" mg. *Id.* Dr. Hare also noted that K.D.'s record stated that methadone was causing side effects but that "there is no indication in her notes that she had ever received [m]ethadone from" Respondent. *Id.* Dr. Hare also observed that K.D. saw Respondent "approximately every three weeks for refills of what were apparently 30 day prescriptions for" narcotic controlled substances and that "there were continued incidents of her over using her medications or early refills for various reasons." *Id*

Dr. Hare next noted that in March 2007, despite K.D's. having reported re-injuring her neck in a recent motor vehicle accident, the chief complaint is still listed as low back pain, and there is no mention of neck pain. *Id.* On March 9 and 27, Respondent indicated his concern that K.D. had run out of Percocet early, and, in mid-April, when K.D. again complained of back pain and that because of an "'awful week'" and "'extreme pain'" she had overused her medication, Respondent gave her new prescriptions which "'must last four weeks.'" Ten days later, K.D. reported her medication as stolen, and Respondent, indicating that there had been problems in the past, placed her on probation. *Id.* Dr. Hare observed that Respondent had also placed K.D. on probation in November 2006 "but he does not seem to recall those past problems." *Id.*

In June 2007, Respondent began to list degenerative disc disease as a diagnosis "but he had not done any further evaluation of her that could confirm such a diagnosis." *Id.* Although K.D. "complained of some neck pain, numbness, tingling, and weakness in her arms for about a two week period, [Respondent] did not perform any additional neurologic examination which would be appropriate in diagnosing a new neurologic issue." *Id.* The following month "there apparently is no longer any problem with her neck or any neurologic issues." *Id.* Dr. Hare noted that Respondent had prescribed various drugs including Demerol (also a schedule II controlled substance) and opined that "there is really no explanation for these prescriptions in terms of trying to address a specific problem." *Id.*

Next, Dr. Hare noted that in October 2007, K.D. had again run "out of her medications early after about two weeks." *Id.* at 2. Dr. Hare again observed that an October 11 note referred to refilling a methadone prescription, but that her record contains "no indication * * * that she ha[d] ever been prescribed this medication before and certainly not in the immediate past." *Id.* at 3. Dr. Hare further noted that Respondent gave her a prescription for Valium but that "there was no explanation for" this. *Id.*

Dr. Hare found that in December 2007, K.D. told Respondent that her insurance company would not cover OxyContin, that a pharmacist had torn up the prescription, and that she "need[ed] a different medication." *Id.* Dr. Hare noted that a DOPL report a few weeks later indicated that K.D. had, in fact, filled that prescription. *Id.* Dr. Hare noted that in January 2008, the medical record states that "'the patient denies getting refills from other doctors but she has been using several pharmacies,'" yet Respondent "again remark[ed] about putting her on probation with one doctor and one pharmacy handling her prescriptions." *Id.* Dr. Hare then observed that "[t]his is at least the third or fourth time she is put on probation with no consequence." *Id.*

Next, Dr. Hare observed that an entry for late January indicated that K.D. "was moving out of state and * * * will not be coming back for treatment at his office." *Id.* However, "[h]e continued to prescribe for her" and actually increased the amount of oxycodone and gave "no explanation." *Id.* Dr. Hare further noted that Respondent "was aware of the patient's deception in filling the OxyContin prescription in December and yet he continued to prescribe for her." *Id.* Dr. Hare also noted that while Respondent sent K.D. a letter on December 20, 2007, in which he described an "abuse situation," he continued to see K.D. and prescribed controlled substances to her at three separate visits in January 2008.

Next, Dr. Hare observed that "[e]venthough [sic] his records would indicate that he terminated care with her in January," in March 2008, Respondent again prescribed to K.D. *Id.* Dr. Hare noted that "[t]here are no clinical records for this visit" (in fact, this prescription was issued after one of the massage encounters).

Id. Dr. Hare noted that on May 23, 2008, only eleven days after receiving new prescriptions, K.D. reported that she had run out of her medications early, and Respondent gave her new prescriptions. *Id.* Dr. Hare noted that on May 29, 2008, K.D. again claimed that her medications were stolen and that Respondent "state[d] he will see her early and refill her medications for a month[,] but that they will need to last that full time." The record indicates "she will not come in earlier than 30 days or I will not see her again." *Id.* Dr. Hare noted, however, that there were still more early refills including one for OxyContin, which occurred only "17 days after her last prescription." *Id.* at 4.

Dr. Hare then summarized the numerous problems he found with respect to Respondent's prescribing practices. *Id.* More specifically, "[t]here is an inadequate history and physical evaluation to justify prescribing chronic controlled substance prescriptions and particularly in escalating amounts." *Id.* Relatedly, when Respondent made a major diagnosis change from cervical spine pain to low back pain, "there was no significant additional evaluation done to try to delineate the problem or other means for treatment suggested." *Id.*

Moreover, there was frequently no justification in her chart for prescribing particular drugs and/or Respondent's changing K.D.'s medications. *Id.* Nor was there "documentation or indication of patient improvement even with dramatic increases in the medications, such as OxyContin and Oxycodone." *Id.*

Next, there were "many signs and outright indications" of overuse and abuse such as K.D.'s "reports of stolen medications and other excuses for early refills on many occasions." *Id.* Moreover, even though Respondent documented an "abuse situation," he "ignored these overt signs of problems * * * and continued prescribing to her without any apparent concern." *Id.* In addition, Respondent never performed toxicology screens on K.D. *Id.* He also never enforced his rule that "one doctor [was] to prescribe and one pharmacy [was] to fill" the prescriptions. *Id.*

Dr. Hare observed that while Respondent had indicated that K.D. would "continue conservative treatment," there was no evidence (such as notes from a physical therapist) that such treatments "ever occurred." *Id.* Dr. Hare also found that the progress "notes are remarkably identical from visit to

visit for long periods of time even with inaccuracies, i.e.[,] the current medications which are listed as Hydrocodone and Fioricet for many, many months even when the patient has not been on these medications." *Id.* Moreover, the "notes do not contain any new information, such as the response to treatment of the side effects to the medications, or other important issues." *Id.* Dr. Hare opined that "[t]his would be consistent with record falsification." *Id.*

In an addendum, Dr. Hare noted that he had reviewed the transcripts and recordings of K.D.'s undercover visits. *Id.* at 5. Dr. Hare found that during these visits, K.D. "requested medications which for the most part were granted as written prescriptions." *Id.* Moreover, "during those visits," "[n]o medical history was obtained [and] no physical examination was done. The conversations were almost entirely social [with] little pertaining to patient care." *Id.* Continuing, Dr. Hare opined that "[a]s the chart notes for these visits indicate a physical exam the same as the other notes, this raises the question as to whether physical exams were ever performed. The notes corresponding to the recordings are falsified. It is likely the other[] clinic notes were also falsified." *Id.*

In summary, Dr. Hare concluded that that Respondent's care for K.D. "was deficient in many parameters," that his prescribing of controlled substances for her was "done poorly and in a substandard fashion," and his prescribing "encouraged overuse of medications and possible diversion of these medications." *Id.* at 4–5. Dr. Hare also found that "[t]here was [a] clear indication that the patient was overusing and likely abusing her medications and yet this never seemed to deter [Respondent] in his prescribing." *Id.* Finally, Dr. Hare concluded that, although he "assume[d]" Respondent was paid for his services, "a deviation from standard care such as this would suggest other 'rewards' for [him] such as drugs or sexual favors."[32] *Id.*

Based on his review of K.D.'s medical record and the transcripts and recordings of her four undercover visits as well as her numerous early refills, lost prescriptions, and stolen prescriptions, Dr. Hare testified that he was concerned that she was abusing her medications. Tr. 165–66. He also testified that several times Respondent obtained a DOPL report which showed that K.D. was using multiple doctors to obtain controlled substances, and yet in each instance, Respondent reacted as if it were "the first time it ever happened, and the whole process start[ed] over again." *Id.* at 168. Dr. Hare testified that K.D.'s medical records "were really quite superficial on the initial evaluation, very little in the way of history or physical exam was done," there was "essentially nothing to follow-up to chart her progress," and "nothing to explain changes in medication." *Id.* at 169. When asked whether the prescriptions were issued "within the usual course of professional practice and for a legitimate medical purpose," Dr. Hare testified that "the evaluation * * * and the record don't support the long-term prescribing of controlled substances" and that "the records indicate an ongoing problem of drug misuse, abuse." *Id.*

With respect to the undercover visits, Dr. Hare testified that the findings of the physical exams were repeated "verbatim" and that there was no indication that Respondent actually performed a physical examination at "any of those visits." *Id.* at 173. He also opined that the long term prescribing of controlled substances was not supported by a legitimate medical purpose. *Id.* at 174. He further testified that in the usual course of professional practice, a physician engaged in pain management would have done "an adequate evaluation of the patient to set the base" and would have to "closely monitor the patients" when there are "multiple indications of abuse" such as in K.D.'s case. *Id.* at 175. Moreover, he then opined that if "the patient didn't comply to [sic] the plan, then the patient should be discharged from care." *Id.* at 176.

Although Dr. Fine testified that he had reviewed both K.D.'s medical record and a letter by Dr. Hare regarding his review of K.D.'s medical record, *Id.* at 618, Dr. Fine offered no testimony on direct examination about his review of K.D.'s record. As he did with M.R., on cross-examination, Dr. Fine declined to offer an opinion about the transcripts of the undercover visits claiming he needed a video recording to put the visit in context. *Id.* at 873–74. However, in response to the Government's hypothetical questions regarding the propriety of prescribing controlled substances to a patient with whom he had a sexual relationship, he acknowledged that this conduct was unethical and outside of the usual course of professional practice. *Id.* at 763–64.

Other Evidence

Dr. Hare also reviewed the files of ten additional patients of Respondent—D.W. (GX 47), P.A. (GX 28), J.B. (GX 29), T.D (GX 30), S.G. (GX 31), J.H. (GX 32), S.J., A.M. (GX 33), S.N. (GX 34), and W.S. (GX 36)—and provided a letter summarizing his review. GX 45. Dr. Hare also testified about several of these patients individually. Dr. Fine similarly reviewed Respondent's medical records for these patients, provided an affidavit that was entered into evidence, and testified about the results of his review. *See* RX 36. Moreover, several of the patients either submitted affidavits in support of Respondent or testified on his behalf. However, for reasons explained in the DISCUSSION section of this decision, in light of my findings with respect to M.R. and K.D., I find it unnecessary to make findings regarding these patients.

Respondent also submitted nineteen affidavits from fellow physicians within his community in support of his continued registration. RX 9. Three of these individuals—Dr. Carlos Dribble, Dr. Thomas Matthews, and Dr. Richard Dunn—also testified, offering their opinion that it is in the "best interest" of the local community that Respondent retain his registration. *See, e.g.,* Tr. 1215 (Dr. Dibble); *id.* at 1229 (Dr. Matthews); *id.* at 1246 (Dr. Dunn). However, while several of the physicians who provided affidavits and two of the physicians who testified had family members who had been patients of Respondent, only one, Dr. Beard, had been a patient of Respondent, and this was years earlier for fractures, and not pain management. RX 9N, at 28. While these individuals stated that they had referred patients in the past and would continue to refer patients in the future, none of their testimony was based on personal knowledge of Respondent's prescribing practices with respect to M.R. and K.D.

Finally, I further note that Respondent did not testify in this proceeding.

Discussion

Section 304(a) of the Controlled Substances Act (CSA) provides that a registration to "dispense a controlled substance * * * may be suspended or revoked by the Attorney General upon a finding that the registrant * * * has committed such acts as would render his registration under section 823 of this title inconsistent with the public interest as determined under such section." 21 U.S.C. 824(a)(4). With respect to a practitioner, the Act requires the consideration of the

[32] Dr. Hare also opined that the conversations with K.D. "became inappropriately personal with her personal phone number and place of residence given to Respondent" and that "[o]n one occasion he gave her $250 in cash." GX 46, at 5. Dr. Hare explained that "[t]his would appear to cross the line of professional behavior and suggest an inappropriate relationship with a patient receiving controlled substances." *Id.*

following factors in making the public interest determination:

(1) The recommendation of the appropriate State licensing board or professional disciplinary authority.

(2) The applicant's experience in dispensing * * * controlled substances.

(3) The applicant's conviction record under Federal or State laws relating to the manufacture, distribution, or dispensing of controlled substances.

(4) Compliance with applicable State, Federal, or local laws relating to controlled substances.

(5) Such other conduct which may threaten the public health and safety.

Id. § 823(f).

"These factors are * * * considered in the disjunctive." *Robert A. Leslie, M.D.,* 68 FR 15227, 15230 (2003). I "may rely on any one or a combination of factors, and may give each factor the weight [I] deem[] appropriate in determining whether a registration should be revoked." *Id.; see also Volkman* v. *DEA,* 567 F.3d 215, 222 (6th Cir. 2009). While I must consider each factor, I am "not required to make findings as to all of the factors." *Volkman,* 567 F.3d at 222; *see also Hoxie* v. *DEA,* 419 F.3d 477, 482 (6th Cir. 2005); *see also Morall* v. *DEA,* 412 F.3d 165, 173–74 (D.C. Cir. 2005).[33]

The Government has the burden of proof. *See* 21 CFR 1301.44. However, once the Government's establishes its *prima facie* case that the registrant has committed acts which render his registration inconsistent with the public interest, the burden shifts to the Respondent to show why the continuation of his registration is consistent with the public interest. *See Medicine Shoppe-Jonesborough,* 73 FR 364, 387 (2008) (citing cases).

Having considered all of the factors, I acknowledge that Respondent holds a valid medical license from the State of Utah and that there is no "recommendation" one way or the other from the State Board as to whether Respondent should retain his registration (factor one). Moreover, it is also undisputed that Respondent had not been convicted of an offense related to controlled substances under either Federal or State law (factor three).

In enacting the CSA, Congress vested this Agency with "a separate oversight responsibility [apart from that which exists in State authorities] with respect to the handling of controlled substances." *Mortimer B. Levin,* 55 FR 8209, 8210 (1990). DEA has therefore long recognized that it has "a statutory obligation to make its independent determination as to whether the granting of [a registration] would be in the public interest." *Id.* Accordingly, "DEA has long held * * * that a State's failure to take action against a registrant's medical license is not dispositive in determining whether the continuation of a registration is in the public interest." *Jayam Krishna-Iyer,* 74 FR 459, 461 (2009); *see also Levin,* 55 FR at 8210 (holding that practitioner's reinstatement by State board "is not dispositive" in public interest inquiry). Thus, that the Utah Department of Professional Licensing has taken no action with respect to Respondent's medical license is of no consequence in determining whether his continued registration is consistent with the public interest.

Likewise, while a history of criminal convictions for offenses involving the distribution or dispensing of controlled substances is a highly relevant consideration, there are any number of reasons why a registrant may not have been convicted of such an offense, and thus, the absence of such a conviction is of considerably less consequence in the public interest inquiry. *Krishna-Iyer,* 74 FR at 461; *Edmund Chein,* 72 FR 6580, 6593 n.22 (2007). Accordingly, that Respondent has not been convicted of an offense related to the distribution or dispensing of controlled substances is not dispositive of whether the continuation of his registration is consistent with the public interest.

The primary focus of this proceeding is—as the Government alleged—his unlawful controlled substance prescribing practices under both Federal and State law, *see* 21 CFR 1306.04(a), and whether he engaged in various practices which "encouraged the abuse of controlled substances and allowed their misuse." Show Cause Order at 2. This conduct is clearly relevant in assessing Respondent's experience in dispensing controlled substances (factor two), his compliance with applicable laws related to controlled substances (factor four), and whether he engaged in "other conduct which may threaten public health and safety" (factor five). 21 U.S.C. 823(f). Accordingly, I turn to whether the evidence relevant under these factors establishes that Respondent has committed acts which render his "registration inconsistent with the public interest." 21 U.S.C. 824(a)(4).

Factors Two and Four—Respondent's Experience in Dispensing Controlled Substances and Record of Compliance With Applicable Controlled Substance Laws

Under a longstanding DEA regulation, a prescription for a controlled substance is not "effective" unless it is "issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice." 21 CFR 1306.04(a). This regulation further provides that "an order purporting to be a prescription issued not in the usual course of professional treatment * * * is not a prescription within the meaning and intent of [21 U.S.C. 829] and * * * the person issuing it, shall be subject to the penalties provided for violations of the provisions of law related to controlled substances." *Id. See also* 21 U.S.C. 802(10) (defining the term "dispense" as meaning "to deliver a controlled substance to an ultimate user by, or pursuant to *the lawful order of, a practitioner,* including the prescribing and administering of a controlled substance") (emphasis added).

As the Supreme Court has explained, "the prescription requirement * * * ensures patients use controlled substances under the supervision of a doctor so as to prevent addiction and recreational abuse. As a corollary, [it] also bars doctors from peddling to patients who crave the drugs for those prohibited uses." *Gonzales* v. *Oregon,* 546 U.S. 243, 274 (2006) (citing *United States* v. *Moore,* 423 U.S. 122, 135, 143 (1975)).

Under the CSA, it is fundamental that a practitioner must establish and maintain a bonafide doctor-patient relationship in order to act "in the usual course of * * * professional practice" and to issue a prescription for a "legitimate medical purpose." *Laurence T. McKinney,* 73 FR 43260, 43265 n.22 (2008); *see also Moore,* 423 U.S. at 142–43 (noting that evidence established that physician "exceeded the bounds of 'professional practice,' " when "he gave inadequate physical examinations or none at all," "ignored the results of the tests he did make," and "took no precautions against * * * misuse and diversion"). Consistent with the CSA's recognition of the State's primary role in regulating the practice of medicine, the Act generally looks to State law and standards of medical practice to determine whether a doctor and patient have established (and are maintaining) a bonafide doctor-patient relationship. *See Kamir Garces-Mejias,* 72 FR 54931, 54935 (2007); *United Prescription Services, Inc.,* 72 FR 50397, 50407

[33] As I recently explained, "this is not a contest in which score is kept; the Agency is not required to mechanically count up the factors and determine how many favor the Government and how many favor the registrant. Rather, it is an inquiry which focuses on protecting the public interest," and thus, "what matters is the seriousness of the registrant's misconduct," *Jayam Krishna-Iyer,* 74 FR 459, 462 (2009); and whether he has demonstrated that the continuation of his registration is consistent with the public interest.

(2007); *see also Volkman,* 567 F.3d at 223. *But see* 21 U.S.C. 829(e) (requiring in-person examination by physician in order for pharmacy to lawfully dispense controlled substances through the Internet).

Except for in circumstances not relevant here, under Utah law it is "unprofessional conduct" for a licensed physician to issue "an order or prescription for a drug * * * without first obtaining information in the usual course of professional practice, that is sufficient to establish a diagnosis, to identify conditions, and to identify contraindications to the proposed treatments[.]" Utah Code Ann. § 58–1–501(2)(m). Under Utah law, it is also "unprofessional conduct" for a licensed physician to "sexually abus[e] or exploit[] any person through conduct connected with the licensee's practice under this title or otherwise facilitated by the licensee's license." *Id.* § 58–1–501(2)(k).

The rules promulgated under the Utah Controlled Substances Act further define "[u]nprofessional conduct" to include:

> (2) Violating any Federal or State law relating to controlled substances;
> * * *
> (4) failing to maintain controls over controlled substances which would be considered by a prudent practitioner to be effective against diversion, theft, or shortage of controlled substances;
> * * *
> (6) knowingly prescribing, selling, giving away, or administering, directly or indirectly, or offering to prescribe, sell, furnish, give away, or administer any controlled substance to a drug dependent person, as defined in Subsection 58–37–2(s), except for legitimate medical purposes as permitted by law[.] [34]

Utah Admin. Code r.156–37–502. *See also id.* r.156–67–502 (Utah Medical Practice Act Rule) ("'Unprofessional conduct' includes * * * knowingly prescribing * * * any controlled substance as defined in Title 58, Chapter 37 to a drug dependent person, * * * unless permitted by law and when it its prescribed, dispensed or administered according to a proper medical diagnosis and for a condition indicating the use of that controlled substance is appropriate.").

In addition, the Utah Controlled Substance Rules require that "[p]rescribing practitioners shall keep accurate records reflecting the examination, evaluation and treatment of all patients. Patient medical records shall accurately reflect the prescription or administration of controlled substances in the treatment of the patient, the purpose for which the controlled substance is utilized and information upon which the diagnosis is based." *Id.* r.156–37–602(1). The rule also requires that "[a] practitioner shall not prescribe or administer a controlled substance without taking into account the drug's potential for abuse, the possibility the drug may lead to dependence, the possibility the patient will obtain the drug for a nontherapeutic use or to distribute to others, and the possibility of an illicit market for the drug." *Id.* r.156–37–603(2).

Finally, under the "General Rule" of the Utah DOPL, "'[u]nprofessional conduct'" also includes "failing, as a prescribing practitioner, to follow the 'Model Policy for the Use of Controlled Substances for the Treatment of Pain', 2004, established by the Federation of State Medical Boards, which is hereby adopted and incorporated by reference." *Id.* r.156–1–502(6). As noted above, with respect to the evaluation of a patient, the *Model Policy* provides that:

> A medical history and physical examination must be obtained, evaluated, and documented in the medical record. The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of pain on physical and psychological function, and history of substance abuse. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.

GX 9, at 3.

With respect to the physician's treatment plan, the *Model Policy* provides that:

> The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain and the extent to which the pain is associated with physical and psychosocial impairment.

Id. at 4.

With respect to the physician's monitoring and supervision of his patient, the *Model Policy* states that "[t]he physician should periodically review the course of pain treatment and any new information about the etiology of the pain or the patient's state of health." *Id.* Continuing, the policy provides that "[o]bjective evidence of improved or diminished function should be monitored * * * If the patient's progress is unsatisfactory, the physician should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities." *Id.*

Finally, the *Model Policy* states that "[t]he physician should keep accurate and complete records to include[:] 1. the medical history and physical examination, 2. diagnostic, therapeutic and laboratory results, 3. evaluations and consultations, 4. treatment objectives, 5. discussion of risks and benefits, 6. informed consent, 7. treatments, 8. medications (including date, type, dosage and quantity prescribed), 9. instructions and agreements and 10. periodic reviews." *Id.*

Applying these standards, the record clearly establishes numerous violations of both the CSA's prescription requirement and State law. More specifically, while the evidentiary standard applicable in this proceeding is the preponderance standard, *Steadman* v. *SEC,* 450 U.S. 91, 100–01 (1981), there is clear and convincing evidence that Respondent engaged in the knowing or intentional diversion of controlled substances.[35]

[34] Under Utah law, the term "[d]rug dependent person means any individual who unlawfully or habitually uses any controlled substance to endanger the public morals, health, safety, or welfare, or who is so dependent upon the use of controlled substances as to have lost the power of self-control with reference to the individual's dependency." Utah Code Ann. § 58–37–2(s).

[35] As numerous courts have noted with respect to whether a violation of the prescription requirement constitutes an act of intentional diversion, there must be "proof that the practitioner's conduct went 'beyond the bounds of any legitimate medical practice, including that which would constitute civil negligence.'" *United States* v. *McIver,* 470 F.3d 550, 559 (4th Cir. 2006) (quoted in *Laurence T. McKinney,* 73 FR 43260, 43266 (2008)). As the Fourth Circuit further explained, "the scope of unlawful conduct under § 841(a)(1) [requires proof that a physician] used 'his authority to prescribe controlled substances * * * not for treatment of a patient, but for the purpose of assisting another in the maintenance of a drug habit' or some other illegitimate purposes, such as his own 'personal profit.'" *Id.* (quoted at 73 FR at 43266). *See also United States* v. *Feingold,* 454 F.3d 1001, 1010 (9th Cir. 2006) ("[T]he *Moore* Court based its decision not merely on the fact that the doctor had committed malpractice, or even intentional malpractice, but rather on the fact that his actions betrayed any semblance of legitimate medical treatment.").

To make clear, this is not a criminal trial, but rather, a proceeding brought under sections 303 and 304 of CSA to protect the public interest. While proof of intentional or knowing diversion is highly consequential in these proceedings, the Agency's authority to act is not limited to those instances in which a practitioner is shown to have engaged in such acts. *See Paul J. Caragine, Jr.,* 63 FR 51592, 51601 (1998) ("Just because misconduct is unintentional, innocent or devoid of improper motivation, does not preclude revocation or denial [of a registration]. Careless or negligent handling of controlled substances creates the opportunity for diversion and could justify revocation or denial.").

Among the patients to whom he intentionally diverted controlled substances are M.R. and K.D. M.R. testified that her complaints of wrist and back pain were false and were done so in order to obtain controlled substance prescriptions. While a physician is entitled to believe a patient's complaint, he still must comply with the fundamental requirements necessary to establish a legitimate doctor-patient relationship and properly diagnose his patient.

As the medical records show and as Dr. Hare testified, at the initial visit, Respondent did not obtain a history "even in regards to the occurrence of the wrist pain and its characterization," his physical exam was limited to finding that M.R. was neurologically intact and grabbing her wrist, and no further tests were ordered. Thus, from the outset, Respondent did not comply with the *Model Policy's* and Utah's requirement for obtaining, evaluating and documenting M.R.'s medical history and physical examination, which mandates that the medical record "document the nature and intensity of the pain, current and past treatment for pain, underlying or coexisting disease or conditions, the effect of pain on physical and psychological function" and substance abuse history. While it is true that he did not prescribe Lortab to her until the second visit (which occurred a month later), the only additional finding related to her wrist pain made at the second visit was that she had "diffuse tenderness over the dorsum of the wrist."

When M.R. also complained of back-pain, which too was a feigned complaint, Respondent's physical exam lasted all of ten seconds and was limited to having her stand up, bend over, and then stand up straight again. Respondent nonetheless prescribed Lortab to her. As Dr. Hare observed, Respondent's evaluation of M.R.'s pain complaints "was inadequate to justify the prescribing of controlled substances for her conditions." It is thus clear that Respondent did not comply with Utah's standards for prescribing controlled substances for pain and that he lacked a legitimate medical purpose and acted outside of the usual course of professional practice and violated the CSA's prescription requirement. 21 CFR 1306.04(a).

There is ample evidence to infer that Respondent knew full well that M.R. was not a legitimate pain patient. More specifically, she testified that she "never really" had to mention anything to get a refill, and that she "didn't really need to complain" about being in pain "because he didn't ask if you were in pain." She further testified that at 95% of her appointments, he just issued her a prescription whether for Lortab or either Valium or Xanax without discussing her medical condition. Moreover, Respondent issued her numerous prescriptions for Valium and Xanax which are unsupported by any documentation of a medical purpose. In addition, M.R.'s patient file contains a DOPL report which indicated that M.R. was obtaining controlled substances from another physician at the same time she was actively seeing him.

Then there is the evidence pertaining to M.R.'s undercover visits. For example, while at the first of these visits Respondent refused to prescribe to an undercover Agent whom M.R. introduced to him, he nonetheless gave M.R. a refill for 90 tablets of Lortab 10 without doing something as basic as asking her about her pain level. The transcript further shows that Respondent did not perform even a perfunctory physical exam, and yet he fabricated M.R.'s patient record to indicate that he had conducted a physical examination in which he found that she "has diffuse tenderness L4–S1" and was "neurologically intact."

At the second undercover visit, his inquiry was limited to asking M.R., "how are you today?" Again, Respondent made no inquiry regarding her pain level and once again fabricated the patient record to indicate that he had performed a physical exam when he had not. Moreover, during the visit M.R. told him that she had shared some of her drugs with the Agent who had accompanied her at the previous visit and asked him if this was "okay." While Respondent initially told M.R. that this was "against the law," he then stated, "Just * * * don't tell me about it." Thus, Respondent was clearly aware that M.R. was diverting drugs, and yet he gave her another prescription for 90 Lortab. He also made clear that his reason for declining to see the undercover Agent was because she had stated that she had previously gone to another physician who had been jailed for drug dealing and that he was "staying away from" persons who had gone to that physician.

It is thus clear that Respondent knew that M.R. was not a legitimate pain patient and that she was seeking the controlled substances for illicit purposes (whether to self-abuse or sell to others is irrelevant). Yet he continued to prescribe to her. And even following these two visits, when it cannot be disputed that he knew that she was not a legitimate pain patient, he wrote her additional prescriptions at both her third and fourth undercover visits for 90 Lortab, each of which also authorized a refill.

With respect to M.R., Dr. Fine (Respondent's expert) offered only the disingenuous testimony that he could not opine on the validity of Respondent's prescribings during the undercover visits without "a full audiovisual recording of these visits" and that, without knowing the context of the physician-patient relationship, he couldn't "make sense out of" the transcripts. Contrary to Dr. Fine's testimony, it is possible to make sense out of the transcripts. What they manifest is that Respondent's prescribings to M.R. "betrayed any semblance of legitimate medical treatment," *Feingold,* 454 F.3d at 1010, were well outside of the usual course of professional practice, and lacked a legitimate medical purpose. In short, Respondent knowingly and intentionally dealt drugs to M.R. and violated Federal law in doing so. 21 U.S.C. 841(a)(1).

As for K.D., while she testified that she had a legitimate pain condition, she also acknowledged that a "huge percentage" of the prescriptions she obtained from Respondent were "for recreational use." Moreover, even if is true that she was still suffering pain at the time of her initial visit, Dr. Hare noted that "there is an inadequate history and physical evaluation to justify prescribing chronic controlled substance prescriptions and particularly in escalating amounts." Indeed, as K.D. testified, Respondent's physical exam was limited to looking at her neck; he did not order diagnostic tests such as x-rays and did not even ask her about the severity of her pain. Moreover, as Dr. Hare noted, when Respondent changed his diagnosis from cervical spine pain to low back pain, "there was no significant additional evaluation done to try to delineate the problem or other means for treatment suggested."

Beyond this, throughout the course of his prescribing to her, Respondent escalated the prescriptions from Lortab 7.5 mg, a schedule III controlled substance, to OxyContin 40 mg., a schedule II controlled substance; he also frequently prescribed either more Lortab or Percocet simultaneously with these prescriptions. Yet, as Dr. Hare explained, there was no "documentation or indication of patient improvement even with [the] dramatic increase in the medications, such as OxyContin and Oxycodone."

Accordingly, under the public interest standard, DEA has authority to consider those prescribing practices of a physician, which, while not rising to the level of intentional or knowing misconduct, nonetheless create a substantial risk of diversion.

Moreover, as Dr. Hare observed, Respondent escalated his prescribing notwithstanding that there were "many signs and outright indications" of overuse and abuse. These include K.D.'s claims that her medications were stolen (which occurred as early as her third visit); a police report for a domestic disturbance in May 2005, which indicated that she had a problem with substance abuse; a December 2007 letter in which Respondent recounted that he would no longer see her because she had claimed that her insurance would not pay to fill an OxyContin prescription and needed a prescription for another drug, but then filled the OxyContin prescription; a report from a local narcotics task force, which included a DOPL report, showing that she was getting controlled substances from five different prescribers; K.D.'s seeking early refills (which he provided) even after he received the DOPL report; and K.D.'s continuing to see him even after she had reported that she was moving out of state. Notwithstanding each of these incidents, Respondent continued to prescribe to K.D.

To make clear, this is not a case of doctor who was merely indifferent to the warning signs that his patient was abusing or selling drugs. Rather, the record demonstrates that Respondent continued to prescribe to K.D. even after he was aware of some of these incidents, because he was using his prescribing authority to receive sexual favors from her.

As the evidence shows, on multiple occasions beginning in September 2006 and lasting through March 2008, Respondent engaged in sexual activities with K.D., which included giving her topless massages and digitally penetrating her, in exchange for controlled substance prescriptions. As even Dr. Fine acknowledged, Respondent's conduct "would not be viewed as within the Code of Ethical Conduct," and it would not be within the usual course of professional practice for a physician, who had engaged in such conduct, to issue controlled substance prescriptions to that person. Tr. 763–64. Indeed, the conduct is so far outside the bounds of professional practice as to constitute evidence of intentional diversion.

K.D. also made several undercover visits. While at the first of these visits (Nov. 2008), Respondent asked her if she was getting pills from other doctors, he was then already aware that he was under investigation, complained that DEA had "actually sent people in with wires," and also asked her if she was "a plant from the police or the DEA." Given the context of the conversation (as well as all the other evidence regarding his relationship with her), it is reasonable to conclude that Respondent's reason for asking K.D. whether she was getting pills from other doctors was not because he was concerned that she was a drug abuser or drug dealer, but rather, that he would be caught.

While K.D. stated at this visit that she had "been in a lot of pain," his response was limited to stating, "I'll bet you have," with no further inquiry as to her pain level and how it was affecting her ability to function, the efficacy of what Respondent had previously prescribed, and any side effects. In addition, Respondent fabricated K.D.'s medical record to indicate that he had performed a physical exam when he did not. Respondent nonetheless gave her prescriptions for 90 tablets of OxyContin 40 mg., 120 tablets of oxycodone IR 30 mg., and 30 tablets of Ambien.

At the next undercover visit, Respondent again asked K.D. if she was "working with the DEA, or wearing a wire?" This, of course, is not the type of conversation one would expect to occur in the usual course of an office visit involving a legitimate patient and doctor. While at this visit, Respondent stated that he could not refill one of her previous prescriptions (likely the OxyContin 40) because it was "less than four weeks," he then gave her a prescription for 60 tablets of oxycodone IR 30 mg. (also a schedule II drug, which is nearly as potent as OxyContin 40 mg.) to supply her until the following week. At this visit, Respondent did not ask her a single question about her purported medical condition and K.D. made no statements about being in pain. Moreover, once again Respondent falsified her medical record to indicate that he had performed a physical exam when he had not done so.

At the next undercover visit, Respondent asked K.D. what she needed and she replied with a shopping list of drugs including "My OxyContin, my Roxicet, my Fioricet, my Ambien, and I have been so stressed out, so I was going to see if I could get some Xanax too." While K.D. complained that she was going though some "sh-t," Respondent asked how many Xanax she wanted, a question not typically asked of a patient by a physician in the usual course of professional practice but one which is consistent with drug dealing. While there was no discussion of how the previously prescribed drugs affected her pain level, functional capacities, and whether she had experienced any side effects, Respondent gave her new prescriptions for 90 OxyContin 40 mg., 120 Oxycodone 30 mg., and 30 Xanax. And again, K.D.'s record indicates that at this visit Respondent performed a physical exam although the transcript contains no evidence that he did so.

As for K.D.'s final undercover visit which likely occurred on December 18 (only 17 days after the previous visit), the recording contains no indication that Respondent performed a physical exam on her although he indicated in her record that he had done so. There is also no indication in the recording that K.D. and Respondent discussed how the prescriptions were affecting her pain level and functionality although he indicated in her medical record that the prescriptions controlled her pain well. Once again, Respondent asked K.D. what she needed, and K.D. requested several controlled substances. Respondent then gave her prescriptions for 90 OxyContin 40 mg. (so much for the law which he had previously stated required four weeks between prescriptions) as well as 120 oxycodone 30 mg. and 30 Xanax.[36]

As Dr. Hare opined, in the usual course of professional practice, a physician engaged in pain management would have adequately evaluated his patient "to set the base," which Respondent did not do. Moreover, when, as in K.D.'s case, there are "multiple indications" that a patient is abusing controlled substances, a physician must "closely monitor the patient[]," and discharge a patient who did not comply with the plan.

Of course, Respondent did none of these things in the course of his prescribing to K.D. I thus agree with Dr. Hare's conclusion that Respondent issued to K.D. numerous prescriptions which were not "within the usual course of professional practice and for a legitimate medical purpose." 21 CFR 1306.04(a). And I further conclude that the totality of the evidence with respect to K.D. not only establishes that Respondent violated the CSA's prescription requirement, but also that he did so knowingly and intentionally. 21 U.S.C. 841(a)(1).

[36] In his exceptions, Respondent argues that K.D. testified that "she was in fact in real pain during the final undercover visit, [and] she felt the prescription was legitimate because she had legitimate pain." Resp. Exc. at 27. Even if K.D. was in pain, this does not make the prescriptions Respondent issued at this visit lawful because he did not ask K.D. a single question about the nature and intensity of her pain and thus had no clinical basis for concluding that the prescriptions, *which were for multiple drugs,* were medically necessary to treat her pain. In addition, at this visit, Respondent also gave K.D. a prescription for Xanax. Yet K.D. did not testify that she had anxiety, the medical condition which Xanax is typically prescribed for. In sum, at this visit, K.D. presented a shopping list of drugs and in issuing the prescriptions, Respondent abdicated his role as a physician. I thus reject Respondent's contention.

Consistent with DEA precedent, my findings that Respondent intentionally diverted to M.R. and K.D. and did so on multiple occasions are sufficient to hold that the Government has made a *prima facie* showing that Respondent has committed acts which render his registration inconsistent with the public interest. As I have previously noted, the Agency has revoked other practitioner's registration for committing as few as two acts of diversion, *see Krishna-Iyer,* 74 FR at 463 (citing *Alan H. OIefsky,* 57 FR 928, 928–29 (1992)), and the Agency can revoke based on a single act of intentional diversion. Accordingly, there is no need to make findings regarding the other patients.

In his post-hearing brief, Respondent argues that he presented the testimony of three physicians (as well as the affidavits of sixteen others) to the effect that he should be allowed to keep his registration because of the benefit he provides to his local community. Resp. Summation Br. at 26. Respondent also cites an unpublished decision of the Eleventh Circuit, which vacated my Decision and Order in *Jayam Krishna-Iyer, M.D.,* 71 FR 52148 (2006), on the ground that I "did not consider any of Petitioner's positive experience in dispensing controlled substances." *Id.* (quoting *Krishna-Iyer* v. *DEA,* 249 Fed. Appx. 159, 160 (11th Cir. 2007)). According to Respondent, "[a] better assessment of [his] medical practice and habits can be ascertained from [his] numerous positive experiences in prescribing controlled substances, some of which were recounted by the patients themselves * * * at the hearing." *Id.* at 3.

However, as I noted in my Decision on remand in *Krishna-Iyer,* the Eleventh Circuit "did not cite to any decision of either this Agency or another court defining the term 'positive experience.' Nor did the Court offer any guidance as to the meaning of this term, which is not to be found in the" CSA. 74 FR at 460. Accordingly, in *Krishna-Iyer,* I assumed that the physician's controlled-substance prescribings to every other patient in the course of her medical career "constitute[d] 'positive experience,'" whatever that means. *Id.* at 461. However, as I noted therein, "[h]er prescribings to thousands of other patients [did] not * * * render her prescribings to the undercover officers any less unlawful, or any less acts which 'are inconsistent with the public interest.'" *Id.* at 463. *See also Medicine Shoppe-Jonesborough,* 73 FR 364, 386 & n.56 (2008) (noting that pharmacy "had 17,000 patients," but that "[n]o amount of legitimate dispensings can render * * * flagrant violations [acts which are] 'consistent with the public interest.'"), *aff'd, Medicine Shoppe-Jonesborough* v. *DEA,* 300 Fed. Appx. 409 (6th Cir. 2008).

This is so because under the CSA, "registration is limited to those who have authority to dispense controlled substances in the course of professional practice." *Krishna-Iyer,* 74 FR at 463. Because "patients with legitimate medical conditions routinely seek treatment from licensed medical professionals, every registrant can undoubtedly point to an extensive body of legitimate prescribing over the course of [his] professional career." *Id.*

In *Krishna-Iyer,* I further explained that "evidence that a practitioner has treated thousands of patients [without violating the CSA] does not negate a *prima facie* showing that a practitioner has committed acts inconsistent with the public interest. While such evidence may be of some weight in assessing whether a practitioner has credibly shown that she has reformed her practices, where a practitioner commits intentional acts of diversion and insists she did nothing wrong, such evidence is entitled to no weight." *Id.*

Accordingly, even assuming, without deciding, that Respondent's prescribing practices to all of his other patients (including those whose medical records were reviewed by the Government's expert) fully complied with the CSA and Utah law, these prescribings do not refute the evidence showing that he intentionally diverted to M.R. and K.D. in violation of both the CSA and Utah law.[37] I thus reject Respondent's arguments and conclude that the Government has established a *prima facie* case that his continued registration is "inconsistent with the public interest."[38] 21 U.S.C. 823(f).

Sanction

Under Agency precedent, where, as here, "the Government has proved that a registrant has committed acts inconsistent with the public interest, a registrant must 'present[] sufficient mitigating evidence to assure the Administrator that [he] can be entrusted with the responsibility carried by such a registration.'" *Medicine Shoppe-Jonesborough,* 73 FR at 387 (quoting *Samuel S. Jackson,* 72 FR 23848, 23853 (2007) (quoting *Leo R. Miller,* 53 FR 21931, 21932 (1988)). Moreover, because "past performance is the best predictor of future performance, *ALRA Labs, Inc.* v. *DEA,* 54 F.3d 450, 452 (7th Cir. 1995), [DEA] has repeatedly held that where a registrant has committed acts inconsistent with the public interest, the registrant must accept responsibility for [his] actions and demonstrate that [he] will not engage in future misconduct." *Medicine Shoppe,* 73 FR at 387; *see also Jackson,* 72 FR at 23853; *John H. Kennedy,* 71 FR 35705, 35709 (2006); *Prince George Daniels,* 60 FR 62884, 62887 (1995). *See also Hoxie* v. *DEA,* 419 F.3d at 483 ("admitting fault" is "properly consider[ed]" by DEA to be an "important factor[]" in the public interest determination).

As noted above, Respondent did not testify in this proceeding. It has long been settled, however, that the Fifth Amendment privilege does not preclude the Agency from drawing an adverse inference based on a registrant's failure to testify in a proceeding under sections 303 and 304 of the Act. *Cf. Baxter* v. *Palmigiano,* 425 U.S. 308, 318–20 (1976); *see also The Lawsons, Inc.,* 72 FR 74334, 74339 (2007); *United Prescription Services, Inc.,* 72 FR 50397, 50409 n.31 (2007). Based on Respondent's failure to testify, I further conclude that Respondent does not accept responsibility for his misconduct, and therefore, he has not rebutted the Government's *prima facie* showing that his continued registration is inconsistent with the public interest. *See Krishna-Iyer,* 74 FR at 464.

Respondent nonetheless argues that the revocation of his "registration is an extreme penalty and a limited restriction of his DEA registration is likely more appropriate." Resp. Summation Br. Findings at 31. As support for his contention, Respondent cites several agency decisions which granted a restricted registration to a practitioner. *See id.* at 31–32. None of these cases support Respondent.

In *Larry L. Kompus,* 55 FR 30990, 30991–92 (1990), the physician's misconduct, which involved trading controlled substances for sexual favors, had occurred "more than ten years" earlier. Moreover, in contrast to Respondent, the physician "acknowledged the wrongfulness of his actions and ha[d] shown remorse for them." *Id.*

Likewise, in *William P. Jerome,* 61 FR 11867, 11867–68 (1996), there was extensive evidence of the physician's misconduct which also involved trading controlled substances (both samples and prescriptions) for sexual favors and trading controlled substances for other controlled substances and/or cash. *Id.*

[37] As for the evidence provided by Respondent's fellow practitioners, none of them have personal knowledge of his prescribing practices with respect to M.R. and K.D. The evidence is thus not probative of whether he violated the CSA and Utah law in prescribing controlled substances to them.

[38] In light of my findings under factors two and four, I conclude that it is not necessary to make findings under factor five.

However, the physician had committed the acts at least six years earlier. *Id.* Most importantly, in addition to presenting evidence of his rehabilitation, the physician admitted that he had violated Federal law and "testified as to his remorse for his past misconduct and his determination that he [would] not engage in such conduct in the future." *Id.* at 11870. The case thus provides no comfort to Respondent.

In another portion of his brief, Respondent cites three additional cases in which the Agency granted a restricted registration to a practitioner. *See* Resp. Summation Br. at 26–27 (citing *Karen A. Kruger,* 69 FR 7016 (2004); *Wesley G. Harline,* 65 FR 5665 (2000); *Paul J. Caragine, Jr.,* 63 FR 51592 (1998)). However, none of these cases support granting Respondent a restricted registration.

In *Caragine,* unlike here, there was no evidence of intentional diversion and the physician testified that he had undergone training to help him better identify and manage drug-seeking patients.[39] *See* 63 FR at 51601. Likewise, in *Harline,* there was no evidence of intentional diversion. Indeed, the Agency specifically held that the prescriptions in dispute were issued for a legitimate medical purpose and thus did not violate the CSA. *See* 65 FR at 5671. Furthermore, the practitioner admitted that he had violated State law and gave assurance that he would not do so in the future. *Id.* Finally, *Kruger* involved a practitioner who wrote fraudulent prescriptions to obtain drugs for self-abuse and not to divert to others. The practitioner, however, readily admitted her misconduct and provided evidence that she had undergone treatment.

In contrast to these cases, Respondent does not remotely meet the Agency's standards for obtaining a restricted registration. His failure to testify precludes a finding that he has accepted responsibility for his misconduct. His misconduct is egregious; that he continued to provide unlawful prescriptions even when he knew he was under investigation renders it especially so. Thus, even if Respondent provided treatment to some legitimate patients and those patients benefitted from his treatment of them, the evidence with respect to M.R. and K.D. establishes that he is still a drug dealer.

In short, Respondent has not rebutted the Government's *prima facie* case that he has committed acts which "render his registration * * * inconsistent with the public interest." 21 U.S.C. 824(a)(4). Accordingly, I conclude that the public interest requires that his registration be revoked and his pending application be denied. And because of the egregiousness of his misconduct, I conclude that the public interest requires that his Order be effective immediately. *See* 21 CFR 1316.67.

Order

Pursuant to the authority vested in me by 21 U.S.C. 823(f) & 824(a), as well as by 28 CFR 0.100(b) & 0.104, I order that DEA Certificate of Registration, AM9742380, issued to Dewey C. MacKay, M.D., be, and it hereby is, revoked. I further order that any pending application to renew or modify the registration be, and it hereby is, denied. This Order is effective immediately.

Dated: August 3, 2010.

Michele M. Leonhart,

Deputy Administrator.

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[39] In *Krishna-Iyer,* I made clear that while there may be a few isolated decisions that suggest that a practitioner who has committed only a few acts of diversion may regain his registration "without having to accept responsibility for his misconduct, the great weight of the Agency's decisions is to the contrary." 74 FR at 464 (citation omitted). I explained that "[b]ecause of the grave and increasing harm to public health and safety caused by the diversion of prescription controlled substances, even where the Agency's proof establishes that a practitioner has committed only a few acts of diversion, this Agency will not grant or continue the practitioner's registration unless he accepts responsibility for his misconduct." *Id.* I further held that to the extent any decision of this Agency suggests otherwise, it is overruled. *Id.* at n.9. Thus, were a case to present facts similar to those of *Caragine,* I would likely deny the practitioner's application.

As I also noted in *Krishna-Iyer:* "The diversion of controlled substances has become an increasingly grave threat to this nation's public health and safety. According to The National Center on Addiction and Substance Abuse (CASA), '[t]he number of people who admit abusing controlled prescription drugs increased from 7.8 million in 1992 to 15.1 million in 2003.'" 74 FR at 463 (quoting National Center on Addiction and Substance Abuse, *Under the Counter: The Diversion and Abuse of Controlled Prescription Drugs in the U.S.* 3 (2005) [hereinafter, *Under the Counter*]). CASA also found that "[a]pproximately six percent of the U.S. population (15.1 million people) admitted abusing controlled prescription drugs in 2003, 23 percent more than the combined number abusing cocaine (5.9 million), hallucinogens (4.0 million), inhalants (2.1 million) and heroin (328,000)." *Id.* (quoting *Under the Counter* at 3). Finally, CASA found that "[b]etween 1992 and 2003, there has been a * * * 140.5 percent increase in the self-reported abuse of prescription opioids," and in the same period, the "abuse of controlled prescription drugs has been growing at a rate twice that of marijuana abuse, five times greater than cocaine abuse and 60 times greater than heroin abuse." *Id.* (quoting *Under the Counter* at 4).

DEPARTMENT OF JUSTICE

Drug Enforcement Administration

Nicholas J. Jerrard, M.D.; Revocation of Registration

On September 30, 2009, the Deputy Assistant Administrator, Office of Diversion Control, Drug Enforcement Administration (DEA), issued an Order to Show Cause to Nicholas J. Jerrard, M.D. (Respondent), of San Diego, California. The Show Cause Order proposed the revocation of Respondent's DEA Certificate of Registration, BJ6361036, which authorizes him to dispense controlled substances as a practitioner, on the ground that he does not "have authority to practice medicine or handle controlled substances in the state of California." Show Cause Order at 1. The Order also proposed the denial of "any pending applications for renewal or modification of" Respondent's registration. *Id.*

Specifically, the Order alleged that the Medical Board of California (MBC) had "revoked [Respondent's] State medical license" and that he is "currently without authority to handle controlled substances in the State of California." *Id.* The Order also alleged that the Board based its revocation of his license "on a report from the Oregon Board of Medical Examiners" which indicated that he "failed a pre-employment drug screen by testing positive for two Schedule IV controlled substances and failed to provide proof of valid prescriptions for the medications." *Id.* at 2. Finally, the Order alleged that in an interview with an MBC investigator in June 2008, Respondent "admitted that [he] had used methamphetamine approximately every two months since 2005." *Id.* Finally, the Order notified Respondent of his right to request a hearing on the allegations, the procedure for doing so, and the consequences for failing to do so. *Id.*

On December 10, 2009, a DEA Diversion Investigator (DI) served Respondent by leaving a copy of the Show Cause Order at Respondent's registered address. Moreover, on December 22, 2009, the DI left a copy of Show Cause Order at an address in San Diego for Respondent which he had obtained from the MBC.[1]

[1] In addition, the DI had previously gone to Respondent's registered address and met its "current occupant," who stated that he was in contact with Respondent but that the latter "had been out of the country for a few years." The DI gave this person his contact information and asked that he have Respondent contact him; however, Respondent did not contact the DI. The DI also