treatment. All such requests should be directed to the Secretary to the Commission and must include a full statement of the reasons why the Commission should grant such treatment. *See* 19 CFR 201.6. Documents for which confidential treatment by the Commission is properly sought will be treated accordingly. All nonconfidential written submissions will be available for public inspection at the Office of the Secretary and on EDIS.[5]

This action is taken under the authority of section 337 of the Tariff Act of 1930, as amended (19 U.S.C. 1337), and of sections 201.10 and 210.8(c) of the Commission's Rules of Practice and Procedure (19 CFR 201.10, 210.8(c)).

By order of the Commission.

Issued: October 16, 2014.

Lisa R. Barton,

Secretary to the Commission.

[FR Doc. 2014–24972 Filed 10–20–14; 8:45 am]

BILLING CODE 7020–02–P

DEPARTMENT OF JUSTICE

Drug Enforcement Administration

[Docket No. 13–16]

Michael A. White, M.D.; Decision and Order

On April 16, 2014, Administrative Law Judge (ALJ) Gail A. Randall issued the attached Recommended Decision (R.D.).[1] Respondent filed Exceptions to the Recommended Decision. Having reviewed the entire record including Respondent's Exceptions, I have decided to adopt the ALJ's findings of fact, conclusions of law, and recommended sanction except as explained below.[2] A discussion of Respondent's Exceptions follows.

Respondent's Exceptions

In his Exceptions, Respondent raises five different contentions. Notably, however, Respondent does not challenge any of the ALJ's factual findings (including her findings that were based on the testimony of the Government's Expert) regarding his prescribing of phentermine to the sixteen patients at issue in this proceeding. *See generally* Exceptions, at 1–4. Nor does he challenge the ALJ's legal conclusion ''that Respondent failed to establish a bona-fide doctor-patient relationship before prescribing [p]hentermine to the sixteen patients at issue here, thus violating 21 CFR 1306.04(a).'' R.D. at 33; *see also* Exceptions, at 1–4.

The ALJ also made extensive findings based on the results of a January 19, 2012 hearing conducted by the Mississippi State Board of Medical Licensure regarding Respondent's prescribing of phentermine to five other persons. GX 5. Following the hearing, at which Respondent was represented by counsel, the Board found him guilty of violating various provisions of both state law and the Board's rules.

More specifically, with respect to each of the five persons, the Board found that Respondent failed to obtain a thorough history or complete a thorough physical examination prior to initiating treatment utilizing a Schedule IV controlled substance.[3] *Id.* at 49 (citing Miss. Code Ann. § 73–25–29(13); 25 Miss. Code R. § 501(2)). The Board further found that Respondent had violated its rule prohibiting the continued prescribing of controlled substances classified as amphetamine like anorectics and/or central nervous system stimulants to a patient who had failed to lose weight after taking the controlled substances over a period of thirty days. *Id.* (citing Miss. Code Ann. § 73–25–29(13)).

Most significantly, with respect to each of the five patients at issue in the proceeding, the Board found Respondent ''guilty of dispensing drugs having addiction-forming or addiction-sustaining liability otherwise than in the course of legitimate professional practice.'' *Id.* at 16 (citing Miss. Code Ann. § 73–25–29(3)). This finding is equivalent to a finding that Respondent violated 21 CFR 1306.04(a), which requires that a controlled-substance prescription ''be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice.''

Here again, Respondent did not challenge the ALJ's findings of fact and conclusions of law which were based on the Board's findings. Indeed, nowhere in his Exceptions does he dispute the ALJ's legal conclusions that he violated the Controlled Substance Act's prescription requirement with respect to some twenty-one patients.

Instead, he argues that the denial of his application is unwarranted because there is no evidence that any person he prescribed to has been injured or died as a result of his unlawful prescribing of controlled substances. Exceptions, at 1–2. The short answer to Respondent's contention is that proving injury is not an element of an allegation that a physician violated 21 CFR 1306.04(a). Rather, proof of such a violation is established by showing that in issuing the prescription, the physician acted outside of the usual course of professional practice and lacked a legitimate medical purpose, and such proof establishes that a physician knowingly or intentionally diverted a controlled substance.

Respondent also argues that the ALJ's findings and recommendation are erroneous because he was found not guilty in a criminal proceeding ''after the exact evidence was presented and the same witness testimony[ ] that was presented'' at the DEA hearing. Exceptions, at 2. Putting aside whether the exact same evidence was presented at both his criminal trial and the DEA proceeding (the latter appearing to include evidence of his misconduct in prescribing to far more patients than were at issue in the former), Respondent ignores that the State Board also found him guilty of dispensing controlled substances other than in the course of legitimate professional practice (*i.e.,* without a legitimate medical purpose). *See* GX 5, at 50.

As for his related argument that ''[t]he irony is overwhelming that the public who he could potentially harm did not buy the DEA's assertions while sitting in the jury box,'' Exceptions, at 2–3; Respondent ignores that because of the greater consequences that attach upon a criminal conviction, a higher standard of proof applies in a criminal trial than in an administrative proceeding. Indeed, given that Respondent does not challenge any of the ALJ's findings with respect to whether he violated the CSA's prescription requirement and diverted controlled substances, there is more than ample evidence to support the conclusion that he poses a potential danger to the public. *See Gonzales* v. *Oregon,* 546 U.S. 243, 274 (2006) (''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

[5] Electronic Document Information System (EDIS): *http://edis.usitc.gov.*

[1] All citations to the Recommended Decision are to the slip opinion as issued by the ALJ.

[2] I decline to publish the ALJ's discussion of the substantial evidence standard. It suffices to say that in reviewing the factual findings of a recommended decision, this Agency adheres to the principles set forth in *Universal Camera Corp.* v. *NLRB,* 340 U.S. 474, 496 (1951).

[3] The Board also found that he had ''initiated treatment utilizing a Schedule IV controlled substance without having performed a review of the patient's prior medical and weight-loss program records to determine that the patient had made a substantial good-faith effort to lose weight in a treatment program utilizing a regimen of weight reduction based on caloric restriction, nutritional counseling, behavior modification and exercise, without the utilization of controlled substances, and that said treatment had been ineffective, all in violation of Miss. Code Ann. § 73–25–29(13).'' GX 5, at 49 (citing 25 Miss. Code R. § 501(1)).

crave the drugs for those prohibited uses'') (citing *United States* v. *Moore,* 423 U.S. 122, 135, 143 (1975)).

As further support for his contention that he ''poses no threat or risk'' to the public, Respondent points to the fact that the State Board has allowed him to continue to practice medicine.[4] Exceptions, at 3. Contrary to Respondent's understanding, the denial of his application for a DEA registration does not prevent him from practicing medicine. It only prevents him from dispensing controlled substances, a remedy which is more than warranted considering the extensiveness of his misconduct and his failure to accept responsibility for it. *See* R.D. at 37 (noting that Respondent's ''acceptance of responsibility was tenuous at best,'' that ''not once during the hearing did Respondent unequivocally admit fault for his improper [p]hentermine prescriptions,'' and that his ''purported admission of guilt was also undermined by his tendency to blame others and make excuses for his misconduct'').

As the Tenth Circuit has recognized:

> The DEA may properly consider whether a physician admits fault in determining if the physician's registration should be revoked. When faced with evidence that a doctor has a history of distributing controlled substances unlawfully, it is reasonable for the [Agency] to consider whether that doctor will change his or her behavior in the future. And that consideration is vital to whether continued registration is in the public interest.

MacKay v. *DEA,* 664 F.3d 808, 820 (10th Cir. 2011) (citing *Hoxie* v. *DEA,* 419 F.3d 477, 483 (6th Cir. 2005)); *see also Jayam Krishna-Iyer,* 74 FR 459, 462 (2009) (holding that even where the evidence shows that an applicant or registrant has committed only a few acts of intentional diversion, ''this Agency will not grant or continue the practitioner's registration unless he accepts responsibility for his misconduct'').

As for his contention that this proceeding ''is nothing more than a vindictive act by'' the Agency because he was acquitted in his criminal case, Exceptions at 3, here again, Respondent ignores that two separate bodies have found that he knowingly diverted controlled substances, and the ALJ's findings, which he does not challenge, establish that he diverted controlled substances to more than twenty patients. Because his misconduct is egregious and Respondent has failed to accept responsibility for it, I reject his exceptions and will adopt the ALJ's recommended order that I deny his application.[5]

Order

Pursuant to the authority vested in me by 21 U.S.C. 823(f), as well as 28 CFR 0.100(b) and 0.104, I order that the application of Michael A. White, M.D., for a DEA Certificate of Registration as a practitioner be, and it hereby is, denied. This Order is effective immediately.

Dated: October 10, 2014.

Thomas M. Harrigan,

Deputy Administrator.

Michelle F. Gillice, Esq., and Frank W. Mann, Esq., *for the Government*

Rodney A. Ray, Esq., *for the Respondent*

RECOMMENDED RULINGS, FINDINGS OF FACT, CONCLUSIONS OF LAW, AND DECISION OF THE ADMINISTRATIVE LAW JUDGE

Gail A. Randal, Administrative Law Judge.

I. *INTRODUCTION*

This proceeding is an adjudication pursuant to the Administrative Procedure Act, 5 U.S.C. § 551 *et seq.,* to determine whether the Drug Enforcement Administration (''DEA'' or ''Government'') should deny a physician's application for a DEA Certificate of Registration pursuant to 21 U.S.C. § 823(f) (2006). Without his registration, the physician, Michael A. White, M.D. (''Respondent'' or ''Dr. White''), would be unable to lawfully prescribe, dispense or otherwise handle controlled substances in the course of his medical practice.

II. *PROCEDURAL HISTORY*

The Deputy Assistant Administrator, Drug Enforcement Administration (''DEA'' or ''Government''), issued an Order to Show Cause (''OTSC'') dated July 2, 2013, proposing to deny the Respondent's application for a DEA Certificate of Registration, as a practitioner, pursuant to 21 U.S.C. §§ 824(a)(4) and 823(f) because the Respondent's registration would be inconsistent with the public interest, as that term is defined in 21 U.S.C. § 823(f). [Administrative Law Judge Exhibit (''ALJ Exh.'') 1 at 1].

Specifically, the OTSC stated that according to a January 19, 2012 order (''Board Order'' or ''Order'') from the Mississippi State Board of Medical Licensure (''Board''), Respondent violated several state laws relating to controlled substances. [*Id.* at 2]. First, the OTSC alleged that, according to the Board Order, Respondent violated title 73, chapter 25, section 29(3) of the Mississippi Code by dispensing drugs having addiction-forming or addiction-sustaining liability outside of the course of legitimate professional practice. [*Id.*]. Second, the OTSC alleged that, according to the Board Order, Respondent violated Chapter 25, Section 501 of the Board's Rules and Regulations by prescribing a Schedule IV controlled substance without first reviewing the patient's records to determine if the patient had made a good-faith effort to lose weight using caloric restriction, nutritional counseling, behavior modification, and exercise. [*Id.*]. Third, the OTSC alleged that, according to the Board Order, Respondent violated Chapter 25, Section 501(2) of the Board's Rules and Regulations by prescribing a Schedule IV controlled substance without first obtaining a thorough history or completing a thorough physical examination of the patient. [*Id.*]. Fourth, the OTSC alleged that, according to the Board Order, Respondent violated Chapter 25, Section 501(5)(a) of the Board's Rules and Regulations by continuing to prescribe a Schedule IV controlled substance to patients who failed to lose weight over a thirty day period. [*Id.*]. Finally, the OTSC alleged that, according to the Board Order, Respondent's improper prescribing of a Schedule IV controlled substance constituted unprofessional conduct under Mississippi Code Ann. 73–24–83(a). Additionally, the Order alleged that Respondent failed to obey the Board Order's requirement that Respondent submit proof that he completed 40 hours of continuing medical education (''CME''). [*Id.* at 2–3]. The OTSC alleged that as a result of these violations, the Board suspended Respondent's medical license for six months and permanently prohibited Respondent from treating patients for

[4] While in exercising its sovereign power to regulate the medical profession within the State, the Mississippi Board may have chosen to allow Respondent to continue to practice medicine, this ''Agency has long held that 'the Controlled Substances Act requires that the Administrator . . . make an independent determination [from that made by state officials] as to whether the granting of controlled substance privileges would be in the public interest.' '' *David A. Ruben,* 78 FR 38363, 38379 n.35 (2013) (quoting *Mortimer Levin,* 57 FR 8680, 8681 (1992)).

[5] I have also considered his final contention, which takes issue with the ALJ's finding that Respondent took a ''hostile tone'' during the hearing and argues that this finding establishes that the ALJ was not impartial. R.D. at 38; Exceptions, at 3–4. He cites no authority for the contention that a trier of fact cannot consider a witness's tone in assessing his credibility, and because the ALJ was in the best position to observe Respondent's demeanor during the hearing, I reject the contention.

weight loss with controlled substances. [*Id.*at 2].

The OTSC further alleged that Respondent's issuing of prescriptions for Schedule IV controlled substances without a legitimate medical purpose and outside the usual course of business violated 21 C.F.R. § 1306.04(a). [*Id.*].

On July 31, 2013, the Respondent, through counsel, timely filed a request for a hearing. [ALJ Exh. 2].

The hearing in this case took place on January 29, 2014 in Oxford, Mississippi. [ALJ Exh. 7; Transcript (''Tr.'') 1]. Respondent and the Government were each represented by counsel. At the hearing, the Government introduced documentary evidence and called three witnesses and Respondent called one witness, himself. [Tr. 3].

After the hearing, the Government and the Respondent submitted proposed findings of fact, conclusions of law, and argument.

III. *ISSUE*

The issue in this proceeding is whether or not the record as a whole establishes by a preponderance of the evidence that the Drug Enforcement Administration should deny the application for a DEA Certificate of Registration (''COR'') of Dr. Michael A. White, as a practitioner, pursuant to 21 U.S.C. § 823(f), because to grant his application would be inconsistent with the public interest, as that term is defined in 21 U.S.C. § 823(f). [Tr. 6; ALJ Exh. 4 at 1].

IV. *FINDINGS OF FACT*

A. Stipulated Facts

The parties have stipulated to the following facts:

1. Respondent applied for a DEA COR as a practitioner in Schedules II–V at the Pain Clinic LLC, 3499 Bluecutt Road, Suite 1, Columbus, Mississippi, 39701 on March 21, 2012.

2. Respondent was previously registered with DEA as a practitioner in Schedules II–V under DEA COR number BW3923009 at 3499 Bluecutt Road, Suite 1, P.O. Box 7757, Columbus, Mississippi, 39705.

3. On September 22, 2011, DEA issued an Order to Show Cause to Respondent seeking revocation of his DEA COR BW3923009.

4. Phentermine is a Schedule IV controlled substance pursuant to 21 C.F.R. § 1308.14(e)(9).

5. Respondent voluntarily surrendered his COR BW3923009 on March 16, 2012.

6. On June 21, 2011, DEA and other law enforcement officials executed a search warrant at Respondent's medical practice which was also his registered address and seized among other items, Respondent's patient files.

7. Government Exhibit #12 is a true and accurate copy of the Respondent's patient file of patient [C.H.][6] seized during the execution of a search warrant at Respondent's registered address on June 21, 2011.

8. Government Exhibit #13 is a true and accurate copy of the Respondent's patient file of patient [R.G.] seized during the execution of a search warrant at Respondent's registered address on June 21, 2011.

9. Government Exhibit #14 is a true and accurate copy of the Respondent's patient file of patient [C.B.] seized during the execution of a search warrant at Respondent's registered address on June 21, 2011.

10. Government Exhibit #15 is a true and accurate copy of the Respondent's patient file of patient [A.G.] seized during the execution of a search warrant at Respondent's registered address on June 21, 2011.

11. Government Exhibit #16 is a true and accurate copy of the Respondent's patient file of patient [J.H.] seized during the execution of a search warrant at Respondent's registered address on June 21, 2011.

12. Government Exhibit #17 is a true and accurate copy of the Respondent's patient file of patient [T.H.] seized during the execution of a search warrant at Respondent's registered address on June 21, 2011.

13. Government Exhibit #18 is a true and accurate copy of the Respondent's patient file of patient [K.H.] seized during the execution of a search warrant at Respondent's registered address on June 21, 2011.

[ALJ Exh. 4 at 1–2; ALJ Exh. 5].

B. Respondent's Background

Respondent earned his undergraduate degree in Chemistry and Biology from the University of California, Irvine. [Tr. 186]. Thereafter, he earned his medical degree from the California College of Medicine at Irvine in 1981 and later completed his residency in anesthesiology at Emory University in Atlanta, Georgia. [Tr. 186–87]. He obtained DEA COR BW3923009 on March 4, 1994. [Gov't Exh. 1 at 1]. On March 20, 2012, the Respondent surrendered this registration for cause. [*Id.*].

Respondent practiced anesthesiology in Mississippi until 2008 when, due to his hearing beginning to deteriorate, he felt he could not properly perform his job function and might pose a danger in the surgery room. [Tr. 187]. Drawing on his experience in pain management as an anesthesiologist, Respondent then opened a pain management clinic in Columbus, Mississippi. [Tr. 188]. Respondent started the practice ''from scratch,'' and most of his patients sought relief from neck or back pain and were referred by another physician. [Tr. 188–89].

In the Fall of 2008, Respondent agreed to treat the patients of a weight loss physician, ''Dr. Burtman,'' who, in Respondent's words, ''was shut down by . . . the DEA and the Medical Board.'' [Tr. 189]. Respondent testified that he did not intend his weight loss practice to be permanent, but that he maintained the weight loss patients because it was a financial buoy for his developing pain management practice. [Tr. 190].

C. Law Enforcement's Investigation of Respondent

The DEA investigation into Respondents' weight loss practice began when the Lowndes County Narcotics Task Force notified DEA that Respondent and another doctor may be ''running pill mills'' and that ''there were some concerns about some overdose deaths.''[7] [Tr. 15–16]. DEA investigators worked together with the Lowndes County Narcotics Task Force, Mississippi Bureau of Narcotics, and the Mississippi State Board of Medical Licensure to conduct the investigation of Respondent's practice. [Tr. 15].

During the course of the investigation, law enforcement officers interviewed Respondent's patients and sent undercover informants to book appointments with Respondent's practice. [Gov't Exh. 5 at 36; Tr. 17]. The informants first attempted to book appointments with Respondent for pain management, but were turned away.[8]

[6] Before the hearing, I issued a Protective Order which protects the identities of third parties in these proceedings. [ALJ Exh. 3]. Thus, in this recommended decision, I will refer to all parties protected by the Protective Order by their initials.

[7] On cross examination, Diversion Investigator Sean Baudier admitted that although the investigation began because of ''initial complaints'' about overdose deaths, no such overdoses were ever substantiated during the investigation. [Tr. 26–27]. In fact, DI Baudier testified that DEA did not even seriously investigate the reported drug overdose deaths because ''a lot of times in overdose deaths, there are—there are poly drugs or alcohol involved.'' [Tr. 26]. Moreover, the president of the Board testified that he is not aware of any injuries or deaths resulting from Respondent's practice. [Tr. 70]. Therefore, because the Government did not establish that any deaths occurred due to misconduct by Respondent, my recommendation to the Administrator does not take into account DI Baudier's mention of deaths by overdose.

[8] There is some dispute as to why Respondent turned away the informants on the pain management side of his practice. On direct

Continued

[Tr. 16–17; 41–42]. When the informants were able to get appointments with Respondent for weight loss, DEA centered its investigation on the weight loss side of Respondent's practice. [Tr. 17, 48]. Diversion Investigator Sean Baudier testified that the informants obtained Phentermine from Respondent ''[e]very time'' they visited Respondent's practice. [Tr. 17]. Phentermine, also called Adipex, is a Schedule IV controlled substance. [Tr. 52; ALJ Exh. 4 at 2]; 21 C.F.R. § 1308.14(e)(9).

DEA executed a warrant to search and seize evidence from Respondent's practice on June 21, 2011 and obtained all patient files kept by Respondent. [Tr. 17–18, 191; ALJ Exh. 5 at 1; Gov't Exhs. 12–27]. Respondent credibly testified, and the Government did not refute, that he ceased treating weight loss patients on the day the warrant was executed. [Tr. 192].

D. The Board Hearings and Board Order

The investigation of Respondent resulted in the Board issuing a Summons and Affidavit in November of 2011, formally charging Respondent with twenty three counts of misconduct. [Gov't Exh. 5 at 1–33]. Respondent, represented by counsel, attended a hearing before the Board on January 19, 2012. [Gov't Exh. 5 at 35; Gov't Exh. 6 at 1–2; Tr. 51, 58–59]. Respondent did not testify at that hearing because criminal charges related to the same facts were pending. [Tr. 66–67]. The Board issued its decision orally and in writing on the day of the hearing. [Gov't Exh. 5 at 35–52; Gov't Exh. 6 at 215–218].

The Board considered Respondent's misconduct with respect to five patients, J.B., A.S., T.S., C.R., and T.S., three of whom were confidential informants employed by law enforcement. [Gov't Exh. 5 at 36–48]. Regarding those patients, the Board made the following factual and legal findings, which are binding on this Court under the principles of collateral estoppel. *See David A. Ruben,* 78 Fed. Reg. 38,363, 38,365 (DEA 2013); *Robert L. Dougherty, M.D.,* 76 Fed. Reg. 16,823, 16,830 (DEA 2011).

1. J.B.

J.B., referred to in the Board Order as ''Patient #1,'' was one of Respondent's patients who was interviewed by law enforcement during the course of its investigation. [Gov't Exh. 5 at 36–37]. At the time she first came to see Respondent for weight loss on February 2, 2009, J.B. was 5′7″ tall and weighed 148 pounds, ''which the Board determine[d] is not obese.'' [Gov't Exh. 5 at 37]. On the initial visit, Respondent issued a prescription for 30 doses of Phentermine and subsequently issued eight more prescriptions for 30 doses of Phentermine between March 9, 2009 and September 27, 2010. [Gov't Exh. 5 at 37]. Additionally, Respondent prescribed to J.B. 90 doses of Sibutramine, a Schedule IV controlled substance. [Gov't Exh. 5 at 37].

Respondent issued these prescriptions without performing a physical examination, properly documenting J.B.'s medical history, recording adiposity measurements such as BMI or waist circumference, conducting an EKG, conducting any laboratory testing, or verifying that J.B. had made good-faith efforts to lose weight without the aid of controlled substances. [Gov't Exh. 5 at 37–38]. Furthermore, Respondent continued to prescribe controlled substances to J.B. despite the patient's failure to lose weight after six months of treatment. [Gov't Exh. 5 at 39]. In fact, after the nineteen month-long treatment, J.B. actually gained twenty pounds. [Gov't Exh. 5 at 39].

2. A.S.

A.S., referred to in the Board Order as ''Patient #2,'' was also one of Respondent's patients who cooperated with the law enforcement investigation. [Gov't Exh. 5 at 39]. A.S. was 5′6″ tall and weighed 180 pounds when she first saw Respondent for weight loss. [Gov't Exh. 5 at 39]. She told Respondent that she had previously received ''diet medication'' from another doctor, Dr. Burtman, but Respondent did not include Dr. Burtman's charts in A.S.'s file. [Gov't Exh. 5 at 40].

Respondent prescribed controlled substances to A.S. without performing an adequate physical examination, properly documenting her medical history, recording adiposity measurements such as BMI or waist circumference, conducting any laboratory testing, or verifying that J.B. had made good-faith efforts to lose weight without the aid of controlled substances. [Gov't Exh. 5 at 39–41]. In total, Respondent prescribed 150 doses of Phentermine to A.S. [Gov't Exh. 5 at 39].

3. T.S.

T.S., referred to in the Board Order as ''Patient #3,'' was a confidential informant employed by law enforcement to gather information about Respondent's practice. [Gov't Exh. 5 at 41]. She was thirty four years old, 5′4″ tall, and weighed 225 pounds at the time of her initial visit to Respondent's practice. [Gov't Exh. 5 at 41–42]. Law enforcement chose her to participate in the investigation because she is not only obese, but has a number of other medical conditions as well. [Gov't Exh. 5 at 41].

As with the other patients, Respondent prescribed controlled substances to T.S. without performing an adequate physical examination, properly documenting her medical history, recording adiposity measurements such as BMI or waist circumference, conducting any laboratory testing, or verifying that T.S had made good faith efforts to lose weight without the aid of controlled substances. [Gov't Exh. 5 at 42–43]. In total, Respondent prescribed 150 doses of Phentermine to T.S. [Gov't Exh. 5 at 41].

4. C.R.

C.R., referred to in the Board Order as ''Patient #4,'' was another confidential law enforcement informant. [Gov't Exh. 5 at 43]. At the time of her initial visit with Respondent, she was twenty two years old, 5′3″ tall, and weighed 139 pounds. [Gov't Exh. 5 at 43–44]. The Board found that although she was not obese, Respondent noted in C.R.'s chart that she was ''overweight.'' [Gov't Exh. 5 at 44].

As with the other patients, Respondent prescribed controlled substances to C.R. without performing an adequate physical examination, properly documenting her medical history, recording adiposity measurements such as BMI or waist circumference, conducting any laboratory testing, or verifying that C.R. had made good faith efforts to lose weight without the aid of controlled substances. [Gov't Exh. 5 at 43–45]. Additionally, Respondent did not document an individualized treatment plan for C.R. Rather, under ''Plan of Care'' in the chart, Respondent merely

examination, DI Baudier testified that the informants were turned away on the pain management side because Respondent was ''not taking any patients.'' [Tr. 16–17]. He clarified this testimony on cross examination, testifying that Respondent turned the informants away because he ''[w]asn't accepting new patients.'' [Tr. 41]. Respondent's counsel suggested while cross examining DI Baudier that the informants were turned away because Respondent only accepted new patients with referrals, not because Respondent was not taking new patients. [Tr. 41–42]. DI Baudier responded that because he did not personally make the phone calls to book the appointments, he could not dispute Respondent's explanation. [Tr. 41, 42]. Respondent himself testified that all of his pain management patients were referred by physicians and that ''[y]ou couldn't walk off the street into my clinic.'' [Tr. 188–89]. To the extent that it is relevant, I find that the Government has failed to establish that Respondent turned the informants away because he was not accepting new pain patients.

wrote ''Weight Loss Program Month #1,'' which apparently included prescriptions for Phentermine and a ''Low carb Diet.'' [Gov't Exh. 5 at 45]. Respondent prescribed C.R. a total of 120 doses of Phentermine. [Gov't Exh. 5 at 43].

5. T.S.1

T.S.1, referred to in the Board Order as ''Patient #5,'' was another confidential informant who visited Respondent for weight loss. [Gov't Exh. 5 at 46]. At the time of her initial visit, she was twenty nine years old, 5′8″ tall, and weighed 125 pounds. [Gov't Exh. 5 at 46]. The Board found that she was not obese. [Gov't Exh. 5 at 46].

As with the other patients, Respondent prescribed controlled substances to T.S.1 without performing an adequate physical examination, properly documenting her medical history, recording adiposity measurements such as BMI or waist circumference, conducting any laboratory testing, or verifying that T.S.1 had made good faith efforts to lose weight without the aid of controlled substances. [Gov't Exh. 5 at 46–47]. Additionally, Respondent continued to prescribe Phentermine to T.S.1 even though she actually gained nine pounds while being on the weight loss program. [Gov't Exh. 5 at 48]. In total, Respondent prescribed 120 doses of Phentermine to T.S.1. [Gov't Exh 5 at 46].

6. The Board's Conclusions of Law

Based on these factual findings, the Board concluded that Respondent violated a number of rules and regulations. First, it found that Respondent's failure to verify that these five patients made a good-faith effort to lose weight without the aid of controlled substances violated Chapter 25, Section 501(1) of the Rules and Regulations of the Board, as well as title 73, Chapter 25, section 29(13) of the Mississippi Code. [Gov't Exh. 5 at 49].

Second, the Board found that Respondent's failure to obtain full medical histories and perform adequate physical examinations of the five patients violated Chapter 25, Section 501(2) of the Rules and Regulations of the Board, as well as title 73, Chapter 25, section 29(13) of the Mississippi Code. [Gov't Exh. 5 at 49].

Third, the Board found that Respondent's continued prescribing of controlled substances to patients who failed to lose weight after thirty days of taking the controlled substances violated Chapter 25, Section 501(5)(a) of the Rules and Regulations of the Board, as well as title 73, Chapter 25, section 29(13) of the Mississippi Code. [Gov't Exh. 5 at 49].

Fourth, the Board found that Respondent dispensed ''drugs having addition-forming or addition-sustaining liability otherwise than in the course of legitimate professional practice, all in violation of Miss. Code Ann. 73–25–29(3).'' [Gov't Exh. 5 at 50].

Finally, the Board found that Respondent's actions constituted ''dishonorable or unethical conduct likely to deceive, defraud, or harm the public in violation of Miss. Code Ann. 73–25–29(8)(d) and 73–24–83(a).'' [Gov't Exh. 5 at 50].

Having made these findings, the Board suspended Respondent's medical license for six months, but stayed the suspension contingent on certain conditions. [Gov't Exh. 5 at 50–51]. Namely, the Board ordered Respondent to complete certain continuing medical education courses within six months of the Board Order and to report such completion to the Board. [Gov't Exh. 5 at 50–51]. The Board also permanently prohibited Respondent from treating patients for weight loss and ordered Respondent to reimburse the Board for its costs in adjudicating the matter. [Gov't Exh. 5 at 51]. Additionally, the Board stated that it would monitor Respondent's compliance with the Board Order by periodically reviewing Respondent's patient charts. [Gov't Exh. 5 at 51].

7. The Second Board Hearing

In November of 2013, the Board held another hearing to determine why Respondent had not complied with the Board Order. [Tr. 60; Gov't Exh. 32]. At that hearing, Respondent testified that he had not taken the CME courses because he could not afford them.[9] [Tr. 60]. The Board found that Respondent ''failed to comply with the . . . conditions as set forth in the January 19, 2012 Determination Order. Specifically, [Respondent] failed to submit proof of successful completion of Continuing Medical Education (CME) hours; failed to communicate with the Board as to the status of same; and failed to reimburse the Board for all costs. . . .'' [Gov't Exh. 32 at 5].

Thereafter, the Board allowed Respondent more time to complete the CME courses and reimburse the Board for its expenses. Specifically, the Board ordered Respondent to complete the courses and pay the Board within six months of this DEA hearing. [Gov't Exh. 32 at 5]. The Board also ordered Respondent to notify the Board ''when the DEA hearing is scheduled and conducted.'' [Gov't Exh. 32 at 5].

At the hearing in these proceedings, the Board's executive director, Dr. Harris Van Craig, testified that Respondent, to date, had not notified the Board of the scheduled date for the DEA hearing. [Tr. 63]. He also testified regarding Respondent's ''demeanor'' in the second Board hearing. [Tr. 60–61]. Specifically, Dr. Van Craig testified that Respondent appeared ''angry with the Board for . . . disciplining him'' and that Respondent thought he had received ''rather harsh treatment from the Board because of what he was doing.'' [Tr. 60, 61; *see also* Tr. 66]. Dr. Van Craig also testified that Respondent felt he was being ''singled out'' by law enforcement because ''other practitioners in his area were doing the same thing as he was.'' [Tr. 60; *see also* Tr. 61].

E. Respondent's Criminal Charges

A month or two[10] after the Board handed down its Order, federal criminal charges were brought against Respondent for ''knowingly and intentionally dispensing and distributing phentermine, which is a Schedule IV controlled substance[,] without a legitimate medical purpose and outside the usual course of medical practice.'' [Gov't Exh. 10 at 6; *see also* Tr. 21, 192]. A jury trial was conducted on October 22 and October 23, 2012, resulting in Respondent being acquitted of all charges. [Gov't Exh. 10 at 1; Gov't Exh. 11 at 1, 224; Tr. 33]. Respondent credibly testified, and the Government did not refute, that he stopped practicing medicine altogether on the day he was indicted. [Tr. 192].

F. The Standard of Care for Prescribing Phentermine

At the hearing in these proceedings, the Government offered, and I certified, Dr. Stephen Sudderth as an expert in weight loss medicine and the medical use of Phentermine for weight loss. [Tr. 77–78]. Dr. Sudderth is a general surgeon, a bariatric surgeon, and a bariatric physician, licensed to practice in Mississippi. [Tr. 72, 73]. His bariatric specialty means he ''specializes in the field of metabolic and obesity disease.'' [*See* Tr. 72–73]. He has been practicing weight-loss medicine for twelve years.

[9] The transcripts for the second Board hearing were not entered into the record, but Dr. Van Craig testified that Respondent told the Board at the hearing that he could not afford the CME courses. [Tr. 60]. This testimony is corroborated by Respondent's own testimony in these proceedings. [Tr. 205–06].

[10] The record is not clear as to exactly when Respondent was indicted. Respondent testified that he was indicted four to six weeks after the Board issued its Order on January 19, 2012, [Tr. 192], but the indictment itself is not in evidence.

[Tr. 73]. He attended medical school at Louisiana State University Medical School, completed his internship at Yale University-affiliated hospitals in New Haven, Connecticut, and completed his general surgery residency at the University of Nevada, Las Vegas. [Tr. 74–75; Gov't Exh. 28]. He is board-certified in bariatric medicine and general surgery. [Tr. 75]. He is a fellow of the American College of Surgeons and a diplomat to the American Board of Bariatric Medicine, which is an honor denoting ''that you are at the top of your field.'' [Tr. 75]. Dr. Sudderth testified that he has treated ''[t]housands'' of patients for weight loss in his career and regularly prescribes Phentermine. [Tr. 76]. In fact, he helped draft the recent changes to the regulations regarding the prescription of Phentermine for weight loss. [Tr. 76]. As such, he is familiar with the regulations and standards both as they are now and as they were when Respondent's misconduct occurred. [Tr. 76–77].

Dr. Sudderth credibly testified regarding the standard of care when prescribing Phentermine. He testified that physicians should document the patient's history of diet, weight, exercise, and controlled substance use ''to determine if they had gone through other programs or used drugs for the purpose of weight loss by a prescription.'' [Tr. 83, 84]. Dr. Sudderth also testified that the patient's medical history should be noted in the chart, including allergies and other medical conditions the patient may have. [Tr. 85]. The physician should also note any medications the patient is taking, the patient's primary care physician, the patient's gynecological history, and the patient's family medical history. [Tr. 85]. This information should all be noted in the patient's chart. [Tr. 84]. According to Dr. Sudderth, documenting this information is necessary for a physician to meet the standard of care when prescribing Phentermine. [Tr. 87].

Dr. Sudderth testified that a physical examination is also necessary to meet the standard of care. [Tr. 87, 103]. This means that before prescribing Phentermine, the physician should measure and document the patient's vital signs, including temperature, pulse, blood pressure, height, and weight. [Tr. 87]. In addition, the physician should measure the patient's body mass index (''BMI''), waist circumferences, or body fat percentage, each of which give ''some indication of the patient's fat content.'' [Tr. 87, 93].

BMI, which is a ''common standard used in most states and certainly in Mississippi'' to measure adiposity, is calculated by dividing the patient's weight by the patient's height squared. [Tr. 88–90]. A BMI of 18 to 24 is considered ''normal weight,'' 25 to 29.9 is considered ''overweight,'' 30 to 39 is considered ''obese,'' 40 to 49 is considered ''morbidly obese,'' and anything over 50 is considered ''super morbid obese.'' [Tr. 90]. To be prescribed Phentermine for weight loss, a patient must have a BMI of 27 or greater and have at least one ''comorbid medical problem,'' which Dr. Sudderth testified is ''[a]nother medical problem that's related directly to the weight.'' [Tr. 91]. Common comorbid conditions include high blood pressure, diabetes, sleep apnea, arthritis, lower back pain, heartburn, urinary incontinence, breast cancer, and prostate cancer. [Tr. 91]. A patient without a comorbid condition must have a BMI of at least 30 to be prescribed Phentermine for weight loss. [Tr. 91]. Dr. Sudderth also testified that although these are the customary standards, a physician has some ''latitude'' to prescribe Phentermine to a patient with a slightly lower BMI if the physician believes the patient's weight is significantly aggravating a medical condition. [Tr. 92–93].

Measuring vital signs and adiposity, however, is not the only important part of the physical exam. Dr. Sudderth testified that various observations made during a routine physical exam might indicate the patient has medical conditions that are contributing to the patient's weight or would make controlled substances unsafe to prescribe. [Tr. 94–98].

Dr. Sudderth also testified that lab work is ''essential'' in determining whether to prescribe Phentermine because it uncovers things that a physical examination typically does not. [Tr. 99]. Specifically, lab work can identify conditions that may hinder weight loss or make prescribing certain controlled substances improper, such as anemia, liver disease, hypothyroidism, and high cholesterol. [Tr. 99–101]. Dr. Sudderth testified that in Mississippi, the standard of care is to perform blood work and to document the results before or at the visit when prescribing Phentermine for weight loss occurs.[11] [Tr. 101–02].

[11] On cross examination, counsel for Respondent suggested that cost sometimes prohibits lab work. [Tr. 170–71]. However, Respondent offered no evidence, expert or otherwise, to contradict Dr. Sudderth's credible testimony that lab work is essential before prescribing Phentermine. Therefore, I find that lab work is required before prescribing Phentermine under the standard of care in Mississippi, regardless of the cost.

G. The Sixteen Additional Patient Files

Dr. Sudderth also testified that he reviewed the patient files of sixteen of Respondent's patients not included in the Board Order and concluded that Respondent did not meet the standard of care when he prescribed Phentermine to all sixteen patients. [Tr. 80; Gov't Exhs. 12–27; Tr. 79–80, 106, 117, 123, 127, 128, 133, 138, 140–41, 145, 146, 150, 151, 152, 153]. The Government questioned Dr. Sudderth on only six of the sixteen patients whose files were entered into evidence: C.H., R.G., A.G., J.G., K.C., and P.H.

1. C.H.

C.H.'s height and weight at the initial visit were recorded in the chart as 5′6″, 150 pounds. [Gov't Exh. 12 at 13; Tr. 107–08]. No BMI was recorded, however, and Dr. Sudderth testified that he calculated C.H.'s BMI to be 24.2 using the patient's recorded height and weight. [Tr. 109, 111; Gov't Exh. 31]. Based on this BMI calculation, Dr. Sudderth testified that C.H. did not qualify for Phentermine prescriptions. [Tr. 111]. Dr. Sudderth further testified that Respondent's ''impression'' that C.H. is ''overweight,'' recorded in the chart, is an incorrect diagnosis, and that there are no co-morbid conditions recorded in C.H.'s chart that would justify prescribing Phentermine. [Tr. 115]. As such, Dr. Sudderth testified that, in his opinion, Respondent did not ''take a thorough history of [C.H.] as contemplated by the State regulations.'' [Tr. 115].

Dr. Sudderth further testified that while Respondent recorded C.H.'s blood pressure and heart rate in the chart, he failed to record C.H.'s weight, diet, and gynecological history. [Tr. 111–12]. Additionally, on the chart, Respondent had drawn ''squiggly lines'' through all of the spaces designed to notate that the various organs were ''normal.'' [Tr. 112–13; Gov't Exh. 12 at 14]. The chart also had no indication that any lab work was conducted on C.H. [Tr. 114]. Thus, Dr. Sudderth testified that Respondent did not conduct a ''thorough physical examination as contemplated under the regulations.'' [Tr. 115–16].

Dr. Sudderth concluded that Respondent did not meet the standard of care when he prescribed C.H. Phentermine on her initial visit. [Tr. 117]. He noted that the chart does not reflect any legitimate medical justification for prescribing Phentermine to C.H. [Tr. 123–24].

Additionally, Dr. Sudderth testified that Respondent failed to meet the standard of care for prescribing Phentermine at each of C.H.'s follow-up

visits. [Tr. at 123]. He reached this conclusion partly because in each of the seven follow-up visits notated in the chart, neither Respondent nor C.H. had any questions or concerns about the weight loss plan. [Tr. 120–23; Gov't Exh. 12 at 11]. Dr. Sudderth testified that this is ''very significant because I haven't seen that in my 12-year career of doing weight loss, that there are no problems at any follow-up visit ever.'' [Tr. 122].

2. R.G.

R.G.'s initial height and weight were recorded in the chart as 5′4″, 141 pounds. [Tr. 125; Gov't Exh. 13 at 13]. R.G.'s body fat and BMI were not measured, however, but Dr. Sudderth calculated R.G.'s BMI to be approximately 24, which is ''normal.'' [Tr. 125; Gov't Exh. 31]. Thus, Dr. Sudderth testified that R.G. did not qualify for weight loss treatment with Phentermine. [Tr. 125].

Dr. Sudderth testified that R.G.'s weight, diet, exercise, and gynecological history were not recorded in the chart, except to note that R.G. is not pregnant.[12] [Tr. 125; Gov't Exh. 13 at 13–14]. Like in C.H.'s chart, the ''Physical Examination'' section of R.G.'s chart contained ''squiggly lines'' through all of the spaces designed to notate that the various organs were ''normal.'' [Tr. 126; Gov't Exh. 13 at 14]. Because the chart contained a line through the part marked ''Laboratory Findings,'' Dr. Sudderth testified that he assumed no labs were conducted. [Tr. 126; Gov't Exh. 13 at 14].

Dr. Sudderth testified that because R.G. has no co-morbid conditions and a BMI of 24, it was not appropriate to prescribe Phentermine to the patient. [Tr. 126, 127]. Also, similar to C.H.'s chart, Dr. Sudderth noted that the follow-up visits uncovered no questions or concerns about the weight loss program. [Tr. 127–28; Gov't Exh 13 at 11]. Thus, Dr. Sudderth concluded that Respondent did not meet the standard of care in prescribing R.G. Phentermine during the seven follow-up visits. [Tr. 128; Gov't Exh. 13 at 4–10]. In sum, Dr. Sudderth testified that ''[t]here is no justification'' for prescribing Phentermine to R.G. [Tr. 128].

3. A.G.

A.G.'s height and weight at the initial visit were 5′1″, 141 pounds. [Tr. 129, Gov't Exh. 15 at 8]. A.G.'s BMI was not in the chart, but Dr. Sudderth calculated it to be 26.6. [Tr. 129; Gov't Exh 31]. Respondent recorded his ''impression'' of A.G. as ''obesity.'' [Tr. 129; Gov't Exh 15 at 9]. Dr. Sudderth testified, however, that A.G. was not ''obese,'' but ''overweight'' according to the standard in Mississippi. [Tr. 129–30].

Dr. Sudderth further testified that A.G.'s diet, weight, exercise, and gynecological history were not noted in the file except that A.G. is not pregnant and that ''she is on a Depo shot for birth control.'' [Tr. 130; Gov't Exh. 15 at 8]. In physical examination section of the chart, there were lines through all of the spaces designed to notate that the various organs were ''normal.'' [Tr. 130–31; Gov't Exh. 15 at 9]. The only organ with a notation other than the line was the abdomen, which had ''obese'' written in the ''normal'' column.[13] [Tr. 130–31; Gov't Exh. 15 at 9]. No lab work or co-morbid conditions were indicated on the chart. [Tr. 131; Gov't Exh. 15 at 9]. Thus, Dr. Sudderth ultimately concluded that Respondent did not meet the standard of care when he prescribed A.G. Phentermine. [Tr. 133; Gov't Exh. 15 at 4–5, 7].

4. J.G.

According to the chart, J.G. weighed 282 pounds and was 5′4″ tall when she first visited Respondent for weight loss. [Tr. 134; Gov't Exh 20 at 12]. Her BMI was not included in the chart, but Dr. Sudderth calculated it to be approximately 48, which is high enough to qualify for a Phentermine prescription. [Tr. 134; Gov't Exh. 31].

Respondent recorded three co-morbid conditions for J.G.: High blood pressure, high cholesterol, and diabetes. [Tr. 134–35; Gov't Exh. 20 at 12]. Dr. Sudderth testified that he would have ''done a thorough history and physical'' and ''gotten labs on this patient and an EKG'' before prescribing Phentermine, which can aggravate the co-morbid conditions reported by J.G. [Tr. 135]. J.G.'s chart had no lab findings recorded. [Tr. 136–37; Gov't Exh. 20 at 13].

No weight, diet, exercise, or gynecological history was recorded on the chart except that J.G. is not pregnant. [Tr. 135–36; Gov't Exh. 20 at 12]. J.G.'s chart included heart rate and blood pressure measurements, but the section for organ examinations, like in the other charts, had a ''squiggly line'' through the ''normal'' boxes. [Tr. 136; Gov't Exh. 20 at 13]. Respondent recorded his ''impression'' of J.G. as ''overweight,'' which Dr. Sudderth testified is an inappropriate diagnosis—Respondent should have diagnosed J.G. as ''morbidly obese.'' [Tr. 137; Gov't Exh. 20 at 13].

Dr. Sudderth testified that Respondent did not meet the standard of care when he prescribed Phentermine to J.G. on her first visit because Respondent did not conduct and record an adequately thorough physical examination and history. [Tr. 138].

Respondent prescribed J.G. Phentermine in each of six follow-up visits. [Tr. 139, 140; Gov't Exh 20 at 4–9, 11]. Dr. Sudderth testified that a visit on August 9, 2010 was particularly troubling, since J.G.'s blood pressure was especially high that day, apparently because J.G. had not taken her blood pressure medication. [Tr. 138–39; Gov't Exh. 20 at 10]. Dr. Sudderth testified that, given J.G.'s unregulated blood pressure, prescribing J.G. Phentermine on that visit fell below the standard of care. [Tr. 139]. Similarly, J.G.'s blood pressure was even higher on her next visit, and Respondent once again prescribed Phentermine. [Tr. 139–40]. Dr. Sudderth thus concluded that Respondent fell below the standard of care by prescribing Phentermine to J.G. at each follow-up visit because he failed to perform adequate histories and physicals, he ignored contraindications such as high blood pressure, and ''he has no follow-up visit that is of any substance, whatsoever.'' [Tr. 141].

5. K.C.

K.C. was sixteen years old, weighed 142 pounds, and was 5′4″ tall when she first visited Respondent for weight loss. [Tr. 141–42; Gov't Exh 21 at 9]. Her BMI was not recorded in her file, but Dr. Sudderth calculated it to be approximately 24, which classifies her weight as ''normal.''[14] [Tr. 142, 144; Gov't Exh. 31]. The patient chart included no weight, diet, or gynecological history recorded except that K.C. is not pregnant. [Tr. 143–44; Gov't Exh. 21 at 9]. Notably, K.C.'s chart did not include any physical examination; in fact, the patient file did not even include the form Respondent normally used to record physical examinations. [Tr. 144; Gov't Exh. 21].

Dr. Sudderth testified that Respondent fell below the standard of care by prescribing Phentermine on the

[12] Dr. Sudderth testified that simply noting the pregnancy status of a female patient does not constitute an adequate gynecological history report. [Tr. 136].

[13] Dr. Sudderth noted that describing an abdomen as ''obese'' is inaccurate. ''You may characterize it as protuberant, large. It may be described in many different ways, but you wouldn't describe an abdomen as obese. You may describe a person as obese but not an abdomen.'' [Tr. 131].

[14] Dr. Sudderth explained that there is a slightly different standard for determining whether Phentermine is appropriate to prescribe to pediatric patients such as K.C. Specifically, children must be ''in the 99th percentile or greater'' in relation to ''other kids their age'' to qualify for a Phentermine prescription. [Tr. 144]. He testified that K.C. is a ''normal 16-year-old girl who falls in the normal percentile of girls.'' [Tr. 143–44].

initial visit. [Tr. 144–45; Gov't Exh. 21 at 8]. He also testified that Respondent fell below the standard of care by prescribing Phentermine to K.C. during three follow-up visits, where no problems or concerns were reported or discussed. [Tr. 145–46]. Dr. Sudderth testified that nowhere in the file was a legitimate medical reason or justification for prescribing K.C. Phentermine recorded. [Tr. 146; Gov't Exh. 21].

6. P.H

P.H. weighed 162 pounds and was 5′5″ tall on her initial visit to Respondent. [Gov't Exh. 27 at 22]. No body fat or BMI were recorded, but Dr. Sudderth calculated it to be 26.9, which is classified as ''overweight.'' [Tr. 147; Gov't Exh. 31]. No weight, diet, or gynecological history were recorded except that P.H. is not pregnant. [Tr. 147–48; Gov't Exh. 27 at 22]. P.H.'s heart rate and blood pressure were recorded in the chart, and Dr. Sudderth testified that P.H. had high blood pressure. [Tr. 148; Gov't Exh. 27 at 23]. Dr. Sudderth also testified that P.H.'s high blood pressure is probably ''controlled'' because ''it's high, but it's not excessively high.'' [Tr. 149]. No lab work was recorded in the file. [Tr. 148]. Respondent recorded his ''impression'' of P.H. as ''desires weight loss,'' which Dr. Sudderth testified was an inappropriate diagnosis. [Tr. 149].

Dr. Sudderth noted that P.H.'s BMI, combined with her co-morbid condition of high blood pressure, qualified her for Phentermine. [Tr. 150]. Dr. Sudderth concluded, however, that the physical examination and history of P.H. fell below the standard of care for prescribing Phentermine on the initial visit. [Tr. 150].

Respondent treated P.H. for about three years, prescribing Phentermine at each of fifteen follow-up visits. [Tr. 150–51, 152; Gov't Exh. 27 at 4–23]. As with the other patients, Respondent noted no problems at any of the follow-up visits. [Tr. 151; Gov't Exh 27 at 19–20]. Dr. Sudderth testified that P.H.'s blood pressure was high at every follow-up visit, and ''was worsening by the time she finished with Dr. White.'' [Tr. 151; Gov't Exh. 27 at 19–20]. Notably, Respondent did not diagnose or record P.H's blood pressure as being high at any time during her treatment. [Tr. 151; Gov't Exh. 27]. Dr. Sudderth concluded that Respondent fell below the standard of care each time he prescribed P.H. Phentermine at a follow-up visit. [Tr. 152].

7. The Sixteen Patient Files Generally

Outside the six patient files about which he specifically testified, Dr. Sudderth also testified generally that he reviewed all of the sixteen patient files the Government entered into evidence and that none of them included adequate histories, physicals, or lab work. [Tr. 106–07, 120, 152]. He thus concluded that Respondent fell below the standard of care in prescribing Phentermine to ''[a]ll sixteen'' of those patients'' both in their initial visits, and in all follow-up visits. [Tr. 153]. He additionally testified that seven of the sixteen patients did not qualify for Phentermine based on their BMIs, which Dr. Sudderth calculated himself since they were not documented in the charts. [Tr. 110–11; Gov't Exh. 31]. Dr. Sudderth also testified that in the sixteen patient files he reviewed, ''there was no follow-up visit to speak of, of any substance that would qualify these patients to receive more Phentermine.'' [Tr. 106–07].

H. Letters from Respondent's Patients

At the hearing, the Government offered into evidence hundreds of letters written by Respondent's patients, vouching for the quality of care Respondent provided them. [Gov't Exh. 30; Tr. 54]. To the extent that Respondent relies on these letters to prove that denying his registration would impose a burden on his patients, I find the letters irrelevant. The Agency has consistently held that so-called ''community impact evidence'' is not relevant in these proceedings. *See Linda Sue Cheek, M.D.*, 76 Fed. Reg. 66,972, 66,973 (DEA 2011); *Steven M. Abbadessa, D.O.*, 74 Fed. Reg. 10,077, 10,078 (DEA 2009); *Mark De La Lama, P.A.*, 76 Fed. Reg. 20,011, 20,020 n.20 (DEA 2011); *Bienvenido Tan, M.D.*, 76 Fed. Reg. 17,673, 17,694 n.58 (DEA 2011); *Gregory D. Owens, D.D.S*, 74 Fed. Reg. 36,751, 36,757 & n.22 (DEA 2009); *Kwan Bo Jin, M.D.*, 77 Fed. Reg. 35,021, 35,021 (DEA 2012).

V. *STATEMENT OF LAW AND DISCUSSION*

A. Positions of the Parties

1. Government's Position

The Government timely filed Government's Proposed Findings of Fact and Conclusions of Law (''Government's Brief'') with this Court on April 2, 2014. The bulk of the Government's argument is that Respondent deviated from the standard of care by performing ''woefully inadequate'' physical examinations, failing to obtain patient's medical histories, and failing to measure patients' BMI before prescribing Phentermine to the sixteen patients at issue in these proceedings and to the five patients at issue in the Board Order. [Gov't Br. at 36–39]. In addition, the Government argues that Respondent violated the Board's order to complete certain CME courses within six months of the Order. [Gov't Br. at 39]. According to the Government, these facts, which are largely undisputed, prove that Respondent's registration would be inconsistent with the public interest. [Gov't Br. at 39–40].

The Government also argues that Respondent failed to prove that he has taken responsibility for his actions and therefore failed to rebut the Government's prima facie case. [Gov't Br. at 42]. The Government points out various portions of Respondents' testimony where Respondent attempted to minimize his misconduct and criticized the laws, standards, rules, and regulations concerning the prescription of Phentermine. [Gov't Br. at 42–45]. This testimony, the Government argues, shows that Respondent has failed to take responsibility for his actions. [Gov't Br. at 44]. Moreover, the Government argues that Respondent failed to take responsibility for his actions in the criminal trial, where he testified that he had done nothing improper. [Gov't Br. at 44]. Accordingly, the Government argues that Respondent has failed to rebut the Government's prima facie case because any acceptance of responsibility—which is minimal—is not credible. [Gov't Br. at 44–45].

2. Respondent's Position

Respondent timely filed Respondent's Proposed Findings of Fact and Conclusions of Law (''Respondent's Brief'') on April 2, 2014. Therein, Respondent makes three arguments. First, Respondent argues that his registration would be consistent with the public interest because he has never harmed any of his patients and has never been the subject of any medical malpractice complaint. [Resp't Br. at 7]. In Respondent's view, the fact that law enforcement investigated Respondent for months before taking any action supports the conclusion that Respondent's misconduct was not seriously harmful or egregious. [Resp't Br. at 8–9].

Second, Respondent argues that he has taken responsibility for his actions, as evidenced by his voluntary relinquishment of his DEA registration and his agreement to forego treating patients for weight loss. [Resp't Br. at 7].

Lastly, Respondent argues that his registration is consistent with the public interest because, after a criminal trial

and two hearings before the Board, the Board still saw fit to permit Respondent to practice medicine. [Resp't Br. at 9–10].

B. Statement of Law and Analysis

Pursuant to 21 U.S.C. § 823(f), the Deputy Administrator may deny an application for a DEA COR if he determines that such registration would be inconsistent with the public interest.[15] In determining the public interest, the following factors are considered:

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

(2) The applicant's experience in dispensing, or conducting research with respect to 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. 21 U.S.C. § 823(f).

These factors are to be considered in the disjunctive; the Deputy Administrator may rely on any one or a combination of factors and may give each factor the weight he deems appropriate in determining whether a registration should be revoked or an application for registration be denied. *See Robert A. Leslie, M.D.*, 68 Fed. Reg. 15,227, 15,230 (DEA 2003) (citing *Henry J. Schwartz, Jr. M.D.*, 54 Fed. Reg. 16,422, 16,424 (DEA 1989)). Moreover, the Deputy Administrator is ''not required to make findings as to all of the factors.'' *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). Thus, ''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'' each party. *Jayam Krishna-Iyer, M.D.*, 74 Fed. Reg. 459, 462 (DEA 2009). ''Rather, it is an inquiry which focuses on protecting the public interest. . . .'' *Id.*

The Government bears the ultimate burden of proving that the requirements for registration are not satisfied. 21 C.F.R. § 1301.44(d) (2014). Specifically, the Government must show that Respondent has committed acts that are inconsistent with the public interest. 21 U.S.C. § 823(f); *Jeri Hassman, M.D.*, 75 Fed. Reg. 8,194, 8,227 (DEA 2010). However, where the Government has made out a *prima facie* case that Respondent's application would be ''inconsistent with the public interest,'' the burden of production shifts to the applicant to ''present[ ] sufficient mitigating evidence'' to show why he can be trusted with a new registration. *See Medicine Shoppe—Jonesborough*, 73 Fed. Reg. 364, 387 (DEA 2008). To this point, the Agency has repeatedly held that the ''registrant must accept responsibility for [his] actions and demonstrate that [he] will not engage in future misconduct.'' *Id.; see also Samuel S. Jackson, D.D.S.*, 72 Fed. Reg. 23,848, 23,853 (DEA 2007). The Respondent must produce sufficient evidence that he can be trusted with the authority that a registration provides by demonstrating that he accepts responsibility for his misconduct and that the misconduct will not reoccur. *See id.; see also Samuel S. Jackson, D.D.S.*, 72 Fed. Reg. at 23,853. The DEA has consistently held the view that ''past performance is the best predictor of future performance.'' *Alra Laboratories*, 59 Fed. Reg. 50,620 (DEA 1994), *aff'd, Alra Laboratories, Inc. v. DEA*, 54 F.3d 450, 451 (7th Cir 1995).

Factor One: Recommendation of Appropriate State Licensing Board

Recommendations of state licensing boards are relevant, but not dispositive, in determining whether a respondent should be permitted to maintain a registration. *See Gregory D. Owens, D.D.S.*, 74 Fed. Reg. 36,751, 36,755 (DEA 2009); *see also Martha Hernandez, M.D.*, 62 Fed. Reg. 61,145, 61,147 (DEA 1997). According to clear agency precedent, a ''state license is a necessary, but not a sufficient condition for registration.'' *Robert A. Leslie, M.D.*, 68 Fed. Reg. at 15,230; *John H. Kennedy, M.D.*, 71 Fed. Reg. 35,705, 35,708 (DEA 2006).

DEA possesses ''a separate oversight responsibility with respect to the handling of controlled substances,'' which requires the Agency to make an ''independent determination as to whether the granting of [a registration] would be in the public interest.'' *Mortimer B. Levin D.O.*, 55 Fed. Reg. 8,209, 8,210 (DEA 1990); *see also Jayam Krishna-Iyer*, 74 Fed. Reg. at 461. Even the reinstatement of a state medical license does not affect this Agency's independent responsibility to determine whether a DEA registration is in the public interest. *Levin*, 55 Fed. Reg. at 8,210. The ultimate responsibility to determine whether a registration is consistent with the public interest has been delegated exclusively to the DEA, not to entities within state government. *Edmund Chein, M.D.*, 72 Fed. Reg. 6,580, 6,590 (DEA 2007), *aff'd Chein v. DEA*, 533 F.3d 828 (D.C. Cir. 2008). Thus, Agency precedent holds that even where a respondent is licensed to practice medicine by a state licensing agency, factor one weighs neither for nor against registration unless the state licensing agency makes a direct recommendation regarding the respondent's DEA registration. *Mark G. Medinnus, D.D.S.*, 78 Fed. Reg. 62,683, 62,692–93 (DEA 2013); *George R. Smith, M.D.*, 78 Fed. Reg. 44,972, 44,979 (DEA 2013); *Robert M. Brodkin, D.P.M.*, 77 Fed. Reg. 73,678, 73,681 n.5 (DEA 2012); *Jeffrey J. Becker, D.D.S.*, 77 Fed. Reg. 72,387, 72,403 (DEA 2012); *Scott D. Fedosky, M.D.*, 76 Fed. Reg. 71,375, 71,377 (DEA 2011); *Paul W. Battershell*, 76 Fed. Reg. 44,359, 44,365 (DEA 2011); *Robert L. Dougherty*, 76 Fed. Reg. 16,823, 16,833 n.13 (DEA 2011); *Gilbert Eugene Johnson*, 75 Fed. Reg. 65,663, 65,666 n.3 (DEA 2010).

Although it is undisputed in this case that Respondent's state license is valid, [ALJ Exh. 4 at 4], the Board has not given a recommendation on whether Respondent's application for a DEA registration should be granted. Therefore, factor one weighs neither for nor against Respondent's registration.[16]

[15] The Deputy Administrator has the authority to make such a determination pursuant to 28 C.F.R. §§ 0.100(b), 0.104 (2013).

[16] The Government argues that because Mississippi law prohibits physicians who have been the subject of a disciplinary action for improper prescribing practices from operating pain management clinics, the Board's prohibition against Respondent operating a weight loss clinic ''is the equivalent to a Board recommendation against Respondent handling controlled substances for pain management.'' [Gov't Br. at 31]. This argument, however, does not square with the Board Order, which allowed Respondent to practice medicine with full knowledge that Respondent owned a pain management clinic. Had the Board wished to restrict Respondent's ability to practice pain management, it could have done so. Moreover, Agency precedent strongly suggests that anything less than a specific, direct recommendation from a state board to DEA regarding respondent's suitability for DEA registration does not constitute a ''recommendation'' under factor one of the public interest analysis. *See Mark G. Medinnus, D.D.S.*, 78 Fed. Reg. 62,683, 62,692–93 (DEA 2013) (holding that factor one weighed neither for nor against granting a registration because the state board ''has not made a specific recommendation concerning the granting of a DEA registration to the Respondent''); *George R. Smith, M.D.*, 78 Fed. Reg. 44,972, 44,979 (DEA 2013) (holding that factor one weighed neither for nor against granting a registration because the state board ''did not directly recommend that the Respondent's DEA application for registration should be granted''). I therefore decline to construe the Board's findings as a recommendation by the Board that Respondent's registration should be denied.

Factors Two and Four: Applicant's Experience with Controlled Substances and Applicant's Compliance with Applicable State, Federal, or Local Laws Relating to Controlled Substances

Respondent's experiences with handling controlled substances, as well as his compliance with laws related to controlled substances, are relevant considerations under the public interest analysis. Pursuant to the Controlled Substances Act, ''[p]ersons registered by the Attorney General under this subchapter to . . . dispense controlled substances . . . are authorized to possess . . . or dispense such substances . . . to the extent authorized by their registration and in conformity with the other provisions of this subchapter.'' 21 U.S.C. § 822(b); *Leonard E. Reaves, III, M.D.,* 63 Fed. Reg. 44,471, 44,473 (DEA 1998); *see also* 21 C.F.R. § 1301.13(a) (providing that ''[n]o person required to be registered shall engage in any activity for which registration is required until the application for registration is granted and a Certificate of Registration is issued by the Administrator to such person.''). As such, the DEA properly considers practitioners' past compliance with CSA requirements and DEA regulations in determining whether registering such a practitioner would be in the public interest.

The first regulation applicable here is DEA's long-standing requirement that a prescription be issued for ''a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice.'' 21 C.F.R. § 1306.04(a). DEA precedent establishes that ''a practitioner must establish and maintain a bona-fide doctor-patient relationship in order to be acting 'in the usual course of . . . professional practice' and to issue a prescription for a 'legitimate medical purpose.' '' *Paul H. Volkman,* 73 Fed. Reg. 30,630, 30,642 (DEA 2008). Whether a valid doctor-patient relationship was established is determined by looking to state law. *Id.*

Here, Dr. Sudderth credibly testified regarding the steps physicians must take to create a doctor-patient relationship before legitimately prescribing Phentermine. Specifically, he testified that in Mississippi, before prescribing Phentermine, a physician must (1) document the patient's history of diet, weight, exercise, and use of controlled substances for weight loss [Tr. 83–84]; (2) document the patient's medical and family history [Tr. 85]; (3) perform and document a physical examination of the patient, including vital signs and some form or adiposity measurement (BMI, waist circumference, or body fat) [Tr. 87–98]; and (4) perform lab work such as blood tests and an EKG [Tr. 99–102]. Dr. Sudderth further testified that to be prescribed Phentermine for weight loss, a patient must either (1) have a BMI of at least 30; or (2) have a BMI of at least 27 and have at least one comorbid condition. [Tr. 91, 105]. Some of these standards, including the requirement to perform physicals, document histories, and investigate prior weight loss efforts, are found in Chapter 25, Section 501(1) and (2) of the Rules and Regulations of the Board.[17] [Gov't Exh. 29].

Dr. Sudderth testified that Respondent fell below this standard of care for each of the sixteen patient files he reviewed. [Tr. 80, 106]. Specifically, Dr. Sudderth testified that Respondent failed to document the patients' histories, conduct or document adequate physical exams, measure patients' BMI, or do any lab work on the patients. [Tr. 114, 115–16, 120, 125, 126, 129, 130, 131, 137, 138, 142, 147, 148]. Additionally, Dr. Sudderth testified that seven of the sixteen patients had BMIs too low to justify prescribing Phentermine. [Tr. 110–11; *see also* Gov't Exh. 31]. Further, Dr. Sudderth testified that Respondent failed to conduct any follow-up visit ''of substance'' that would justify the continued prescription of Phentermine to the patients. [Tr. 106–07].

I find Dr. Sudderth's testimony credible because his credentials are impeccable, his testimony was internally and externally consistent, and the testimony itself was largely unrebutted by Respondent. Indeed, when asked at the hearing if he disputes Dr. Sudderth's testimony, Respondent replied, ''Why would I dispute his testimony? He's an expert.'' [Tr. 219]. Accordingly, I find that Respondent failed to establish a bona-fide doctor-patient relationship before prescribing Phentermine to the sixteen patients at issue here, thus violating 21 C.F.R. § 1306.04(a).[18]

I also find that Respondent's improper prescriptions of Phentermine to the sixteen patients at issue in these proceedings violated Chapter 25, Section 501(1) and (2) of the Rules and Regulations of the Board, which requires documentation of a thorough physical examination, medical history, and a good-faith effort by the patient to lose weight without controlled substances before prescribing anorectics. [Gov't Exh. 29 at 1–2].

Moreover, as noted *supra,* the Board found that Respondent violated multiple rules, regulations, and statutes by improperly prescribing Phentermine to five additional patients. Specifically, the Board found that Respondent violated Chapter 25, Section 501 of the Rules and Regulations of the Board by (1) failing to verify that the five patients made a good-faith effort to lose weight without the aid of controlled substances; (2) failing to obtain full medical histories and perform adequate physical examinations of the five patients; and (3) continuing to prescribe controlled substances to patients who failed to lose weight after thirty days of taking the controlled substances. [Gov't Exh. 5 at 49–50]. Additionally, the Board found that Respondent violated title 73, chapter 25, section 29(3) of the Mississippi Code by dispensing ''drugs having addiction-forming or addiction-sustaining liability otherwise than in the course of legitimate professional practice.'' [Gov't Exh. 5 at 50]. Finally, the Board found that Respondent's actions constituted ''dishonorable or unethical conduct likely to deceive, defraud, or harm the public, in violation of *Miss. Code Ann.* 73–25–29(8)(d) and 73–24–83(a).'' [Gov't Exh. 5 at 50]. These findings of fact and law are binding on the Agency. *David A. Ruben, M.D.,* 78 Fed. Reg. at 38,365–66; *Dougherty,* 76 Fed. Reg. at16,830–31.

Respondent also failed to attend the CME courses required by the Board Order. Although Respondent offered an explanation for this failure—that he could not afford the courses[19]—such explanations do not alter the fact that failing to attend the courses within six month of the Board Order constituted a violation of the Order.

Therefore, because Respondent violated multiple rules, regulations, and statutes by prescribing Phentermine to twenty-one patients without a legitimate medical purpose and outside the usual course of professional practice, and because Respondent violated the Board Order by failing to attend the required CME courses, I find that factors two and four clearly weigh against Respondent's registration.

[17] The standards set forth in the Rules and Regulations of the Board for prescribing anorectics were revised in 2012. [Tr. 76]. The Government entered into evidence the version of the regulations that was in place during the time in question. [Tr. 81–82; Gov't Exh. 29].

[18] 21 C.F.R. § 1306.04(a) provides, in relevant part, ''A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice.''

[19] I find this reason incredible, since the Respondent also testified that he has a monthly income of $15,000. [Tr. 207].

Factor Three: Applicant's Conviction Record Relating to Controlled Substances

Pursuant to 21 U.S.C. § 823(f)(3), the Deputy Administrator may deny a pending application for a certificate of registration upon a finding that the applicant has been convicted [20] of a felony related to controlled substances under state or federal law. *See Thomas G. Easter II, M.D.,* 69 Fed. Reg. 5,579, 5,580 (DEA 2004); *Barry H. Brooks, M.D.,* 66 Fed. Reg. 18,305, 18,307 (DEA 2001); *John S. Noell, M.D.,* 56 Fed. Reg. 12,038, 12,039 (DEA 1991).

Here, it is undisputed that Respondent has not been convicted of any crimes relating to controlled substances. However, DEA precedent clearly holds that because there are ''a number of reasons why a person may never be convicted of an offense falling under this factor, let alone be prosecuted for one, the absence of such a conviction is of considerably less consequence in the public interest inquiry.'' *Ruben,* 78 Fed. Reg. at 38,379 n.35 (quoting *Dewey C. MacKay, M.D.,* 75 Fed. Reg. 49,956, 49,973 (DEA 2010), *pet. for rev. denied, MacKay v. DEA,* 664 F.3d 808 (10th Cir. 2011)). I therefore find that factor three weighs neither for nor against Respondent's registration.

Factor Five: Such Other Conduct Which May Threaten the Public Health and Safety

Under the fifth public interest factor, the Agency considers ''[s]uch other conduct which may threaten the public health and safety.'' 21 U.S.C. § 823(f)(5). Because the facts of this case do not implicate this factor,[21] I find that factor five weighs neither for nor against Respondent's registration.

Therefore, because the Government proved by a preponderance of the evidence that Respondent violated multiple statutes, rules, and regulations relating to dispensing controlled substances, I find that the Government met its burden to prove its prima facie case that Respondent's registration would be inconsistent with the public interest.

Sanction

Where the Government has made out a *prima facie* case that Respondent's registration would be inconsistent with the public interest, the burden of production shifts to the applicant to ''present[] sufficient mitigating evidence'' to show why he can be trusted with a new registration. *See Medicine Shoppe—Jonesborough,* 73 Fed. Reg. at 387. To this point, the Agency has repeatedly held that the registrant must ''accept responsibility for [his] actions and demonstrate that [he] will not engage in future misconduct. *Id.; see also Samuel S. Jackson, D.D.S.,* 72 Fed. Reg. 23,848, 23,853 (DEA 2007). Specifically, to rebut the Government's prima facie case, the respondent is required ''to accept responsibility for [the established] misconduct, [and] also to demonstrate what corrective measures [have been] undertaken to prevent the re-occurrence of similar acts.'' *Jeri Hassman, M.D.,* 75 Fed. Reg. 8,194, 8,236 (DEA 2010) (citing *Jayam Krishna-Iyer, M.D.,* 74 Fed. Reg. 459, 464 n.8 (DEA 2009)).

In determining whether a respondent has accepted responsibility and whether misconduct will reoccur, the Agency has historically looked to a number of considerations, including genuine remorse and admission of wrongdoing, *Lawrence C. Hill, M.D.,* 64 Fed. Reg. 30,060, 30,062 (DEA 1999), lapse of time since the wrongdoing, *Norman Alpert, M.D.,* 58 Fed. Reg. 67,420, 67,421 (DEA 1993), candor with the court and DEA investigators, *Jeri Hassman, M.D.,* 75 Fed. Reg. 8,194, 8,236 (DEA 2010), and attempts to minimize misconduct, *Ronald Lynch, M.D.,* 75 Fed. Reg. 78,745, 78,754 (DEA 2010).

The Agency has placed special emphasis on the need to deter intentional diversion of controlled substances, which includes issuing prescriptions ''outside of the usual course of professional practice and [without] a legitimate medical purpose.'' *David A. Ruben, M.D.,* 78 Fed. Reg. at 38,386–87; *see also Joseph Gaudio, M.D.,* 74 Fed. Reg. 10,083, 10,094–95 (DEA 2009). ''Indeed, this Agency has revoked a practitioner's registration upon proof of as few as two acts of intentional diversion and has further explained that proof of a single act of intentional diversion is sufficient to support the revocation of a registration.'' *David A. Ruben, M.D.,* 78 Fed. Reg. at 38,386 (citing *Dewey C. MacKay, M.D.,* 75 Fed. Reg. 49,956, 49,977 (DEA 2010)).

Here, Respondent's improper prescribing methods clearly constituted intentional diversion. *See David A. Ruben, M.D.,* 78 Fed. Reg. at 38,386–87 (defining intentional diversion as prescribing controlled substances ''outside of the usual course of professional practice and [without] a legitimate medical purpose''). The Agency thus has an interest in deterring Respondent and others from engaging in similar egregious behavior. That no one was injured as a result of Respondent's misconduct is irrelevant; Agency precedent is clear that in light of the prescription drug abuse epidemic, even a single act of intentional diversion justifies revocation. *David A. Ruben, M.D.,* 78 Fed. Reg. at 38,386.

Moreover, Respondent's purported acceptance of responsibility was tenuous at best. When asked on direct examination whether his weight loss prescribing practices were improper, he responded equivocally: ''When I got busted, I realized it, yeah. I didn't know—I had no idea that there was a strict rule on BMI.'' [Tr. 193]. When asked on cross-examination whether he admits to prescribing controlled substances without medical justification, Respondent responded that he had ''never given anything to somebody without a medical justification, in my opinion.'' [Tr. 214]. But when pressed on the same question, Respondent quickly changed his tune and answered, ''According to the rules, I guess, yes.'' [Tr. 214]. Similarly, when asked whether his weight-loss practice was ''improperly run,'' Respondent replied, ''I said I broke some rules and regulations. I didn't say it was anything improper.'' [Tr. 221–22]. Indeed, not once during the hearing did Respondent unequivocally admit fault for his improper Phentermine prescriptions.

Respondent's purported admission of guilt was also undermined by his tendency to blame others and make excuses for his misconduct. For example, he testified several times that in his weight loss practice he was ''just doing the same practice that I know other physicians do.'' [Tr. 217; *see also* Tr. 190 (''. . . there were a lot of doctors doing it in town, and I followed what they did.'')]. Indeed, when Respondent was asked on cross examination whether he believed he was ''picked on by the DEA,'' he responded, ''I don't believe it. I know it.'' [Tr. 222]. In addition, Respondent admitted that his practices were ''less than desirable,'' and then, practically in the same breath, blamed the undesirable practices on his staff: ''I didn't know that [my histories and physicals] were that less than desirable because they were all done by

[20] The Administrator interprets the term ''conviction'' by affording it the ''broadest possible meaning.'' *Donald Patsy Rocco, D.D.S.,* 50 Fed. Reg. 34,210, 34,211 (DEA 1985). Thus, evidence of a guilty plea is probative under the third factor of the public interest analysis. *See, e.g., Farmacia Ortiz,* 61 Fed. Reg. 726, 728 (DEA 1996); *Roger Pharmacy,* 61 Fed. Reg. 65,079, 65,080 (DEA 1996).

[21] Under the heading of factor five, the Government's Brief makes a host of arguments about Respondent's credibility and his failure to accept responsibility. [Gov't Br. at 40–45]. These arguments, however, are more properly asserted in the context of Respondent's rebuttal case. *See, e.g., Jeri Hassman, M.D.,* 75 Fed. Reg. 8,194, 8,235–36 (DEA 2010). I therefore address these arguments *infra* in the ''Sanction'' discussion.

my nurse practitioners.'' [22] [Tr. 197]. In short, Respondent blamed other physicians, the DEA, and his own staff for his current predicament rather than take the responsibility himself.

Respondent also minimized the severity of his misconduct by suggesting that he thinks the requirements for prescribing Phentermine are too strict. For example, Respondent testified in these proceedings and at his criminal trial, ''I mean, you can get a tummy tuck, a facelift, whatever you want, but you can't get a—you can't get a diet pill. Come on.'' [Tr. 193; *see also* Tr. 198–99; Gov't Exh. 11 at 115]. In his criminal trial, Respondent testified, ''You can get phentermine over the internet from Canada. Nurses can write for it. It's a Schedule IV drug like cough syrup. I mean, it's so safe. The addiction potential is so low.'' [Gov't Exh. 11 at 119]. Additionally, Respondent testified in his criminal trial that BMI measurements are ''worthless.'' [Tr. 216; Gov't Exh. 11 at 117]. In other words, rather than acknowledging his faults, Respondent opted to criticize the standards put in place by the medical community, the Board, and the DEA.

I also find it significant that Dr. Van Craig, the executive director of the Board, remembered Respondent as being ''angry with the Board for disciplining him'' and felt that Respondent believed he had received ''rather harsh treatment from the Board because of what he was doing.'' [Tr. 60, 61; *see also* Tr. 66]. Indeed, Respondent's demeanor described by Dr. Van Craig is consistent with the hostile tone Respondent took during the hearings in these proceedings.[23]

The above-noted examples do not reflect someone who feels remorse for his misconduct or understands the gravity of his mistakes. Rather, they illustrate that Respondent takes no responsibility for his actions, blames others for his improper prescribing methods, and disagrees with the rules regarding the dispensing of Phentermine. Additionally, other than a promise to comply with the Board's order to refrain from treating weight loss patients, Respondent has offered no evidence of remedial measures he has taken to ensure that future violations will not occur. As such, I find that Respondent has not taken responsibility for his misconduct and therefore has failed to rebut the Government's prima facie case.

VI. *CONCLUSION AND RECOMMENDATION*

Because the Government met its burden to prove that Respondent's registration would be inconsistent with the public interest, and because Respondent failed to rebut the Government's case, I recommend that the Deputy Administrator deny Respondent's application.

Dated: April 16, 2014

s/Gail A. Randall,
Administrative Law Judge

CERTIFICATE OF SERVICE

This is to certify that the undersigned, on _____, 2013, caused a copy of the foregoing to be faxed and placed in the interoffice mail addressed to DEA Headquarters, Attn: Office of Chief Counsel/Michelle Gillice, Esq., 8701 Morrissette Drive, Springfield, VA 22152, Fax: (202) 307–4946, and a copy to be faxed and mailed to Respondent's Counsel, Rodney A. Ray, Esq., P. O. Box 1018, Columbus, MS 39703, Fax: (662) 329–3522.

Carlene R. Thomas,
Secretary to The Honorable Gail A. Randall

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[22] I note that immediately following this remark, Respondent purported to take responsibility by saying, ''Although, I'm responsible, so I take the cold blame for them myself.'' [Tr. 197]. In context, however, I find this acceptance of responsibility to be disingenuous; he made this statement only after clearly placing blame on someone else.

[23] Respondent's counsel, at the hearing, suggested that Respondent's ''loud and obnoxious'' tone is a result of his hearing impairment rather than his lack of remorse or hostility toward the Board or the DEA. [Tr. 66]. During the hearing in these proceedings, I certainly noticed that Respondent's hearing disability affected him. [*E.g.,* Tr. 225, 226]. But Respondent's hearing did not appear to be what motivated his tone or his statements, discussed *supra,* which gave cause for concern regarding his remorse and acceptance of responsibility.

DEPARTMENT OF JUSTICE

Federal Bureau of Investigation

Meeting of the CJIS Advisory Policy Board

AGENCY: Federal Bureau of Investigation (FBI), DOJ.

ACTION: Meeting notice.

SUMMARY: The purpose of this notice is to announce the meeting of the Federal Bureau of Investigation's Criminal Justice Information Services (CJIS) Advisory Policy Board (APB). The FBI CJIS APB is a federal advisory committee established pursuant to the Federal Advisory Committee Act (FACA). This meeting announcement is being published as required by Section 10 of the FACA.

The FBI CJIS APB is responsible for reviewing policy issues and appropriate technical and operational issues related to the programs administered by the FBI's CJIS Division, and thereafter, making appropriate recommendations to the FBI Director. The programs administered by the CJIS Division are the Next Generation Identification, Interstate Identification Index, Law Enforcement Enterprise Portal, National Crime Information Center, National Instant Criminal Background Check System, National Incident-Based Reporting System, National Data Exchange, and Uniform Crime Reporting.

This meeting is open to the public. All attendees will be required to check-in at the meeting registration desk. Registrations will be accepted on a space available basis. Interested persons whose registrations have been accepted may be permitted to participate in the discussions at the discretion of the meeting chairman and with approval of the Designated Federal Officer (DFO). Any member of the public may file a written statement with the Board. Written comments shall be focused on the APB's current issues under discussion and may not be repetitive of previously submitted written statements. Written comments should be provided to Mr. R. Scott Trent, DFO, at least seven (7) days in advance of the meeting so that the comments may be made available to the APB for their consideration prior to the meeting.

Anyone requiring special accommodations should notify Mr. Trent at least seven (7) days in advance of the meeting.

DATES AND TIMES: The APB will meet in open session from 8:30 a.m. until 5 p.m., on December 3–4, 2014.

ADDRESSES: The meeting will take place at Hyatt Regency Jacksonville, 225 E. Coastline Drive, Jacksonville, Florida, 32202, telephone (904) 588–1234.

FOR FURTHER INFORMATION CONTACT: Inquiries may be addressed to Ms. Skeeter J. Murray; Management and Program Analyst; CJIS Training and Advisory Process Unit, Resources Management Section; FBI CJIS Division, Module C2, 1000 Custer Hollow Road, Clarksburg, West Virginia 26306–0149; telephone (304) 625–3518, facsimile (304) 625–5090.

Dated: October 14, 2014.

R. Scott Trent,

CJIS Designated Federal Officer, Criminal Justice Information Services Division, Federal Bureau of Investigation.

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