

DEPARTMENT OF JUSTICE

Drug Enforcement Administration

[Docket No. 06-62]

Jeri Hassman, M.D.; Denial of Application

On June 1, 2006, the Deputy Assistant Administrator, Office of Diversion Control, Drug Enforcement Administration issued an Order to Show Cause to Jeri Hassman, M.D. (Respondent), of Tucson, Arizona. The Show Cause Order proposed the denial of Respondent's application for a new DEA Certificate of Registration as a practitioner, authorizing her to dispense controlled substances in schedules II through V, on the grounds that the Respondent had "been convicted of a felony under the Controlled Substances Act, [had] materially falsified [her] application, and ha[d] committed such other acts as would render [her] registration under 21 U.S.C. 823 inconsistent with the public interest." ALJ Ex. 1, at 1 (citing 21 U.S.C. 824(a)(1)(2) and (4), 824(a) and 823).

More specifically, the Show Cause Order alleged that on November 1, 2002, DEA had immediately suspended Respondent's DEA registration on the ground that she "regularly engaged in the practice of prescribing excessive amounts of controlled substances * * * to patients for no legitimate medical purpose." *Id.* at 1-2. The Show Cause Order next alleged that patients to whom she had prescribed controlled substances had died of overdoses. *Id.* at 2-3.

Next, the Show Cause Order alleged that Respondent "prescribed excessive quantities of controlled substances to patients, including frequent early refills" to a number of other patients. *Id.* at 3. The Show Cause Order alleged that Respondent:

generally failed to adequately evaluate patients, failed to conduct complete physical examinations, failed to obtain adequate histories, failed to include pain ratings, failed to determine the exact location or character of the pain, failed to obtain information concerning previous treatment from other physicians or medication used.

Id. In addition, the Show Cause Order stated that "[d]espite these inadequate evaluations, [Respondent] immediately prescribed controlled substances to these patients." *Id.*

The Order to Show Cause also alleged that Respondent was "made aware of possible diversion incidents but continued to prescribe controlled substances for patients who were engaged in diversion." *Id.* at 4. The Show Cause Order related five known

incidents involving (1) F.L. and his son B.L., both patients of Respondent; (2) & (3) J.O. and her husband W.O., both patients of Respondent; (4) M.H., P.H., and A.B., a mother and two "daughters", all patients of Respondent; and (5) S.R., a patient of Respondent. *Id.* at 4-6.

The Show Cause Order further alleged that on January 29, 2004, Respondent pled guilty to "four felony violations of 18 U.S.C. 3 involving controlled substances: Accessory After the Fact to Possession of Controlled Substances by Misrepresentation, Fraud, Forgery, Deception or Subterfuge, 21 U.S.C. 843(a)(3)." *Id.* at 6.

Next, the Show Cause Order alleged that on March 10, 2004, Respondent "entered into a Consent Agreement with the Arizona Medical Board (the Board), in which the Board found that [Respondent] failed in many ways to properly care for [her] patients, including the prescribing of excessive amounts of controlled substances." *Id.* According to the Show Cause Order:

The Board also found that [Respondent] failed to conduct physical examinations, failed to obtain adequate patient histories and failed to obtain prior medical records. The Board also found that [her] patient notes often did not provide sufficient information to support the diagnoses, justify the treatments, accurately document the results, or indicate advice and cautionary warnings provided to the patients.

* * * Under the Consent Agreement the Board found [Respondent] guilty of unprofessional conduct and placed [Respondent's] Arizona medical license on probation for two years from the effective date of the Consent Agreement.

Id.

Finally, the Show Cause Order alleged that Respondent materially falsified her application, when, on January 28, 2005, Respondent applied for her DEA registration, she marked "no" to question 4(d), which "asked, in pertinent part, whether [Respondent] had ever had a State professional license revoked, suspended or placed upon probation." *Id.*

Respondent timely requested a hearing on the allegations, ALJ Ex. 2, and the matter was placed on the docket of the Agency's Administrative Law Judges (ALJ). Following pre-hearing procedures, a hearing was held on January 22-26, 2007 and February 27 to March 2, 2007, in Tucson, Arizona. Moreover, on March 13, 2007, the ALJ conducted a transcribed telephone conference at which Respondent gave her closing argument. Thereafter, both parties filed post-hearing briefs.

On October 9, 2008 the ALJ issued her Opinion and Recommended Decision (ALJ). With respect to factor one (the

recommendation of the State licensing board), the ALJ noted that, while Respondent has twice been placed on probation and either censured or reprimanded, she currently holds an active, unrestricted medical license, and that this factor weighs in favor of her continued registration. ALJ at 147-48.

With respect to factor two (Respondent's experience in dispensing controlled substances) and factor four (Respondent's compliance with applicable laws relating to controlled substances), the ALJ concluded that the Government had established that Respondent issued prescriptions to two persons (H.T. and R.T.) which lacked a legitimate medical purpose. ALJ at 150. The ALJ reasoned, however, that these were "only two patients out of more than 900 whom Respondent was treating at that time," and thus the Government had not shown that "Respondent's overall medical practices [were] consistently lacking in legitimate purpose." *Id.* at 150.

The ALJ specifically rejected the evidence of the Government's Expert with respect to twenty-three other patients, noting that various physicians who testified on behalf of Respondent had disagreed with the conclusions of the Government's Expert. *Id.* at 151. According to the ALJ, this was "not to minimize the seriousness of the Respondent's cavalier attitude toward handling controlled substances during 2001 and 2002, but rather to demonstrate that it is not clear that her general treatment practices were lacking in medical purpose." *Id.*

In support of her conclusion, the ALJ cited various areas in which she maintained "that there was no clear consensus in the medical community regarding which practices were required to meet the standard of care during 2001 and 2002." *Id.* According to the ALJ, these areas included the role of physical examinations in treating chronic pain patients, the use of laboratory tests, the need to refer patients to other doctors as part of the course of treatment, appropriate dosage levels of controlled substances for treating chronic pain, and the propriety of prescribing both long and short-acting opioids simultaneously. *Id.*

The ALJ also rejected the Government's contention that Respondent's falsification of H.T.'s medical record (who performed multiple undercover visits and wore a recording device) justified the denial of her application. *Id.* at 153-55. While acknowledging that "[i]t is indeed disturbing that the Respondent apparently altered H.T.'s medical chart to include a physical examination that

was not reflected in the recorded interaction between the Respondent and H.T.," *id.* at 153, the ALJ concluded "that a single instance does not rise to the level of [a] pervasive pattern of falsification." *Id.* at 155. In this regard, the ALJ also noted that Respondent was working with another physician to improve her recordkeeping practices.¹ *Id.* at 155–56. The ALJ did not, however, expressly find whether the evidence under factors two and four satisfied the Government's *prima facie* burden.

The ALJ further found that Respondent had been convicted of four counts of the felony offense of "Accessory After the Fact to Possession of Controlled Substances by Misrepresentation, Fraud, Forgery Deception or Subterfuge," and that the convictions could be considered as either an offense "under Federal * * * laws relating to the * * * dispensing of controlled substances," 21 U.S.C. 823(f)(4), or as "[s]uch other conduct which may threaten the public health and safety." *Id.* § 823(f)(5); *see also id.* at 158. While the ALJ found that Respondent's convictions "could * * * weigh in favor of denial of the * * * application," *id.* at 158, she also did not address whether this factor established the Government's *prima facie* case.

The ALJ further found that Respondent had "engaged in extensive remedial training," that she has "improved skills now available to her, including the use of risk assessment tools and [the] collection of extensive addiction histories on each patient," and

¹ The ALJ also noted that a 2002 DEA Audit of controlled substances which Respondent physically dispensed had found that Respondent was unable to account for 150 dosage units out of a total of 7,560 dosage units which were on hand. *Id.* at 153. DEA Investigators also found that Respondent had failed to keep receiving records for samples of controlled substances which her office received, that the records did not contain all of the information required by regulations, and that some records may have been missing because Respondent was not aware that she was required to keep them for two years. *Id.* I agree with the ALJ that these deficiencies are not sufficient by themselves to justify denying her application.

Finally, the ALJ rejected the Government's contention that Respondent had materially falsified her application because she answered "no" to the question whether her State license had ever been sanctioned. *Id.* at 160. The ALJ found that Respondent had attached to her application a letter from the Arizona Medical Board which indicated that she would "continue to be monitored every six months until the end of her probation in March 2007." *Id.* (quoting GX 3, at 4). According to Respondent, based on the wording of the letter she believed that she—and not her medical license—had been placed on probation by the Board. *Id.* In light of Respondent's having provided the letter with her application, as well as her having truthfully answered the other questions on the application, I agree with the ALJ that she "lacked the intent to deceive the" Agency. *Id.* at 161.

that she would continue to consult with another pain management expert. *Id.* at 161–62. The ALJ also found it significant that the State Board would conduct regular reviews of her medical charts and quarterly compliance reports. *Id.* at 162. Finally, the ALJ found that "Respondent's willingness to admit her past mistakes, accept responsibility for her actions, and remedy her professional deficiencies should weigh heavily in favor of granting her application." *Id.* at 162. The ALJ thus recommended that I grant Respondent a new registration subject to the conditions that she continue her mentoring arrangement with a pain management specialist for a period of three years and also submit the quarterly reports required by the State Board to the Agency. *Id.* at 163.

On November 3, 2008, the Government filed its exceptions to the ALJ's decision; and on November 28, 2008, Respondent submitted her response to the Government's exceptions. On December 22, 2008, the ALJ forwarded the record to me for final agency action.

Having considered the entire record in this matter, including the ALJ's decision and the parties' briefs, I adopt the ALJ's conclusion of law with respect to the allegations of material falsification. I also agree with the ALJ that Respondent's prescriptions for H.T. lacked a legitimate medical purpose. I reject, however, the ALJ's conclusions with respect to factors two and four.

The ALJ's failure to acknowledge that the Government established a *prima facie* case for denying the application was largely based on her conclusion that the Government had only proved that Respondent issued unlawful prescriptions to two patients and that it had not shown that her "other medical practices [were] consistently lacking in legitimate purpose." The ALJ's reasoning is erroneous for several reasons.

First, it is inconsistent with Agency precedent, which holds that proof of as few as two acts of diversion satisfies the Government's *prima facie* burden under the public interest standard and supports the revocation of a practitioner's registration when she fails to accept responsibility for her misconduct. *See Alan H. Olefsky*, 57 FR 928, 928–29 (1992); *see also Sokoloff v. Saxbe*, 501 F.2d 571, 576 (2d Cir. 1974). The record here, however, supports the conclusion that Respondent knowingly issued multiple prescriptions to H.T. which lacked a legitimate medical purpose and violated Federal law. Moreover, while the ALJ stated that she had made extensive findings to place

Respondent's treatment of various patients in context, ALJ at 151 n.34, she nonetheless frequently ignored relevant evidence establishing numerous other instances in which Respondent issued prescriptions which clearly violated the prescription requirement of Federal law. 21 CFR 1306.04(a).

Second, the ALJ's reasoning ignores longstanding precedent that the Agency's authority to revoke a registration or deny an application is not limited to those instances in which a practitioner intentionally diverts. Rather, a practitioner who ignores the warning signs that her patients are either personally abusing or diverting to others, commits acts inconsistent with the public interest even if her conduct is merely reckless or negligent. *See Paul J. Caragine, Jr.*, 63 FR 51592 (1998). My review of the patient records establishes numerous instances in which Respondent ignored obvious warning signs that her patients were either personally abusing or diverting. Relatedly, the ALJ did not make detailed findings regarding the frequency of Respondent's issuance of new prescriptions even though this was one of the significant issues in this matter. Moreover, I reject the ALJ's conclusion that Respondent only falsified H.T.'s patient record once and conclude that substantial evidence supports the finding that on six different occasions she falsified his patient record to indicate that she had performed a physical exam when she had not.

While I acknowledge that Respondent has undertaken some measures to improve her practice, I am compelled to reject the ALJ's findings that she has willingly "admit[ted] her past mistakes," and "accepted responsibility for her actions." ALJ at 162. As explained more fully below, with respect to the prescriptions she issued to H.T., Respondent continues to deny that she did anything wrong. Moreover, in her testimony, Respondent maintained that there is nothing wrong with persons using a controlled substance that has not been prescribed to them but to family members and that she did not know what the term "early refill" meant even though this was one of the central issues in this case. Accordingly, I conclude that Respondent has not rebutted the Government's *prima facie* showing that granting her a registration would be "inconsistent with the public interest." 21 U.S.C. 823(f). Respondent's application will therefore be denied. As ultimate factfinder, I make the following findings.

Findings²

Respondent graduated from New York University Medical School in 1981. Tr. 1346. She has been board-certified in physical medicine and rehabilitation since 1988, and she has practiced medicine in the State of Arizona since 1986. *Id.* Respondent practices as a physiatrist, a physician who specializes in physical medicine and rehabilitation. *Id.*

Respondent formerly held DEA registration BH1192359. ALJ Ex. 1, at 1. In August 2001, the Arizona Medical Board initiated an investigation of Respondent in response to two complaints from health care plans and one complaint from a pharmacy concerning Respondent's prescribing of controlled substances. GX 73, at 4. In July 2001, in response to complaints received from Tucson area pharmacists about Respondent's prescribing of controlled substances, DEA also initiated an investigation. GX 70, at 3. On May 16, 2002, DEA, along with law enforcement officers from other agencies, executed a search warrant at Respondent's registered location, Calmwood Medical in Tucson, Arizona. *Id.* at 20–21. On November 1, 2002, my predecessor immediately suspended Respondent's DEA registration. ALJ Ex. 1, at 1.

On March 26, 2003, a Federal grand jury indicted Respondent, charging her with numerous violations of Federal law. *See* GX 5. Thereafter, Respondent and the Government agreed to a plea bargain; and on January 29, 2004, Respondent pled guilty to four counts of Accessory After the Fact to Possession of Controlled Substances by Misrepresentation, Fraud, Forgery, Deception, or Subterfuge. GX 6, at 1.

The Consent Agreement With the Arizona Medical Board

On March 10, 2004, following the entry of the plea agreement on January 29, 2004, Respondent entered into a Consent Agreement For Decree of Censure And Probation with the Arizona Medical Board ("the Board").

² In this document I take official notice of several material facts because the record is unclear. Under the Administrative Procedure Act (APA), an agency "may take official notice of facts at any stage in a proceeding—even in the final decision." U.S. Dept. of Justice, *Attorney General's Manual on the Administrative Procedure Act* 80 (1947) (Wm. W. Gaunt & Sons, Inc., Reprint 1979). In accordance with the APA and DEA's regulations, Respondent is "entitled on timely request to an opportunity to show to the contrary." 5 U.S.C. 556(e); *see also* 21 CFR 1316.59(e). To allow Respondent the opportunity to refute the facts of which I take official notice, Respondent may file a motion for reconsideration within fifteen days of service of this order which shall commence with the mailing of the order.

See GX 73. In the consent agreement, the Board noted that its staff had reviewed twenty-three patient charts and that the Board's outside consultants had reviewed these charts and were critical of Respondent's practices in prescribing opioids. *Id.* at 4. The Board specifically found that: (1) Respondent "often failed to obtain adequate medical histories or perform adequate physical examinations" before prescribing controlled substances to the patients, (2) that much of her "medical histories came from information provided by the patients themselves," (3) that in some cases she "failed to further substantiate actual diagnoses and physical findings with prior medical records," and (4) that sometimes she "failed to obtain histories of previous drug abuse or monitor for signs of current drug abuse." *Id.* at 4.

The Board also found that in prescribing controlled substance medications, "Respondent [often] failed to maintain adequate records on the patients." *Id.* More specifically, the Board found that Respondent's "written notes often did not provide sufficient information to support the diagnoses, justify the treatments, accurately document the results and indicate advice and cautionary warnings provided to the patients." *Id.* The Board also found that Respondent "may have inappropriately prescribed higher than indicated doses of long- and short-acting opioid medication." *Id.* The Board further concluded that Respondent had engaged in "unprofessional conduct" under Arizona law for various reasons including, *inter alia*, that she had failed or refused to maintain adequate medical records and had engaged in conduct or practices "that is or might be harmful or dangerous to the health of the patient or the public." *Id.* at 6. Respondent was censured and placed on probation for two years with her office management and record-keeping practices under monitoring. *Id.* The Consent Agreement also provided for another two years of probation at the time that "her DEA Certificate is restored." *Id.* at 7. Respondent completed her initial probation on March 10, 2006. RX 30.

Respondent submitted a letter from the Arizona Medical Board, dated December 23, 2004, indicating that she was in compliance with the terms of the order and that Respondent "has the Board's support to pursue her DEA reinstatement." RX 53. The letter, however, also stated that "at no time [had Respondent] attempted to divert medications for non-medical purposes."

*Id.*³ She also submitted a letter from the Board dated January 8, 2007, which indicated that her probation terminated on March 10, 2006, but that new two-year probation would commence "when her DEA certificate is restored." RX 30. The letter indicated that Respondent's "license is currently active without restriction and she is off probation." *Id.*

The Consent Agreement also had required Respondent to complete ten hours of Continuing Medical Education (CME) in "the principles and practices of pain management or addiction medicine" before applying for a new DEA registration. GX 73, at 7. Respondent completed twelve hours of the required CME by April 2004. RX 53. "Since January 2004, she has also acquired 51.25 hours in a wide range of topics relating to pain management." *Id.*⁴

Respondent applied for her DEA Certificate of Registration on January 28, 2005. ALJ Ex. 1, at 6.

Respondent's Prescribing Practices

The Expert Testimony

Both parties put on extensive testimony relevant to the issue of whether Respondent's prescriptions were issued in the usual course of professional practice and were for a legitimate medical purpose.⁵ The Government's expert was Dr. Bradford D. Hare⁶; Respondent's experts were Dr.

³ As explained below, the record in this matter establishes instances in which Respondent did divert for non-medical purposes.

⁴ In June 2006, the Arizona Medical Board also reprimanded Respondent and placed her on probation for two years for performing "excessive joint and soft tissue injections without adequate indications and for inadequate documentation of the quantities of pharmaceuticals injected." GX 7, at 12.

⁵ While much of the testimony of both parties' experts was couched as to what practices were required to meet the standard of care, numerous courts have recognized that such testimony is relevant in determining whether a physician acted in the usual course of professional practice and for a legitimate medical purpose in prescribing a controlled substance. *See United States v. Feingold*, 454 F.3d 1001, 1012 n.3 (9th Cir. 2006) (in criminal case, jury can appropriately "consider the practitioner's behavior against the benchmark of acceptable and accepted medical practice"); *see also United States v. Alerre*, 430 F.3d 681, 691 (4th Cir. 2005) (in criminal case, "evidence that a physician's performance has consistently departed from accepted professional standards supports the proposition that the physician was not practicing medicine, but was instead cloaking drug deals under the guise of a professional medical practice").

⁶ Dr. Hare is an associate professor of anesthesiology and pharmacology at the University of Utah School of Medicine, where he is also the director of the pain management fellowship and the vice president of the Department of Pain Management Services. Tr. 144–45; GX 47. He is fellowship-trained and board-certified in pain management. Tr. 145. He has an M.D., special certifications from the Board of Anesthesiology and

Jennifer Schneider,⁷ who testified as an expert in pain management, and Marylee O'Connor, a Doctor of Pharmacy, who testified as both a fact witness and expert witness on pharmacy although she was not formally qualified as such. See Tr. 1137.⁸

In her decision, the ALJ concluded “that there was no clear consensus in the medical community regarding what practices were required to meet the standard of care during 2001 and 2002.” ALJ at 151. The ALJ’s finding paints with too broad a brush. While it is true that there were some issues on which the parties’ experts disagreed (e.g., the scope of an appropriate physical examination, the need to order diagnostic testing, appropriate dosing levels), there was substantial agreement as to what practices are necessary to meet the standard of care.⁹

Pain Management, and a Ph.D. in pharmacology. *Id.*; see also GX 47. He has performed research in pain management and is currently engaged in the practice of pain management. Tr. 147–48; see also GX 47.

⁷Dr. Schneider is board-certified in internal medicine, is certified by the American Society of Addiction Medicine, and is a diplomate of the American Academy of Pain Management. Tr. 807; see also RX K–1, at 1; RX 43, at 1. Respondent hired Dr. Schneider several months after the DEA executed its search warrant to mentor Respondent in record-keeping and in pain management. Tr. 808.

⁸Respondent also introduced a written report from Dr. Sharon Weinstein, an Associate Professor of Anesthesiology, Neurology and Oncology at the University of Utah and the Director of Pain Medicine and Palliative Care at the University of Utah’s Huntsman Cancer Institute. RX 32, at 1. Dr. Weinstein did not, however, testify at the hearing.

In her report, Dr. Weinstein criticized “Dr. Hare’s judgment of [Respondent’s] pain management practices [as] appear[ing] to be based at least in part upon * * * assumptions that are erroneous as stated,” and then listed what she attributed as being his assumptions. *Id.* at 2. It is unclear, however, the extent to which Dr. Weinstein has accurately characterized Dr. Hare’s assumptions, and in any event, many of her criticisms rely on snippets taken from his opinions and ignore extensive other evidence in the patient files that he relied upon.

Dr. Weinstein also opined “that the prescriptions by [Respondent] were written in the usual course of professional practice and for legitimate medical purposes.” *Id.* at 1. Because Dr. Weinstein did not testify and was thus not subject to cross-examination, her opinion lacks probative force.

⁹Respondent disputed the validity of Dr. Hare, who practiced in Utah, opining on the standard of care applicable to an Arizona practitioner. Tr. 1420–21. Even if the standard of care varies from one State to another (rather than simply between competing schools of thought within a medical practice specialty), Dr. Hare and Dr. Schneider (who practices in Arizona) had significant areas of agreement.

Respondent also disputed whether her prescribing practices should be evaluated under the standard of care applicable to a pain management specialist rather than the standard applicable to a physiatrist. Resp. Br. at 195. In her brief, Respondent apparently contends that the standard of care applicable to a physiatrist did not require her to obtain other provider’s medical records or to obtain addiction histories on her patients prior to

Initial Visit

Dr. Hare testified that at the initial visit, he asks the patient to characterize the pain and rate it on a scale of 1 to 10. Tr. 155. Dr. Hare also obtains the patient’s medical history and “drug history”; as part of the latter, Dr. Hare gathers information on the patient’s history of substance abuse including the use of both prescription and illicit drugs. *Id.* at 158. As Dr. Hare testified, he would “be more cautious” in handling a patient with a “significant drug abuse history.” *Id.* at 158. Dr. Hare also explained that he tries to get records from other physicians who have treated the patient, as well as the results of diagnostic studies. *Id.* at 156–57.

Dr. Hare then performs a physical examination focusing on the area of the body where the pain is occurring, but which also involves a more general examination. Tr. 152–53. The examination includes “a neurologic examination, an examination for strength, an examination for reflexes, an examination for tenderness, changes in sensitivity of the skin, tenderness in muscles, a whole range of different things, again depending on the nature of what the pain complaint is.” *Id.* at 153. Moreover, his examination would include “the vital signs, in other words[,] blood pressure, respiratory rate, heart rate, comments about just general appearance of the patient.” *Id.* Also, as part of his physical examination, Dr. Hare checks a patient’s heart, chest and abdomen.¹⁰ *Id.* at 154.

Dr. Schneider (Respondent’s expert) testified that in her practice, she will not treat a patient absent “old records.” Tr. 854. Dr. Schneider explained that the day before the initial visit, her office calls “to remind” patients that if they do not bring records with them, their physician will be called at the visit and asked to fax the records. Tr. 854–55. However, she noted that Respondent, as

prescribing controlled substances. See *id.* The short answer to this contention is that the Arizona Medical Board specifically found that “Respondent failed to further substantiate actual diagnoses and physical findings with prior medical records,” and “failed to obtain adequate histories of previous drug abuse.” GX 73, at 4. The Board further cited these findings as evidence that Respondent had engaged in unprofessional conduct under Arizona law. *Id.* at 6. Respondent’s contention is therefore meritless.

¹⁰Dr. Hare proceeded to distinguish different types of pain and the treatments appropriate to them. For instance, myofascial pain, characterized by “tender spots in the muscles” and which is usually the result of “an injury of some sort,” does not respond well to opioid medication although opioid medication may take the “edge off a bit.” *Id.* at 159. Dr. Hare also discussed neuropathic pain, “pain that’s due to nerve injury,” and stated that it “is a type of pain again that is first treated not with opioids but * * * with drugs like tricyclic antidepressants or the anticonvulsives agents.” *Id.* at 160.

a physiatrist, would often have the first visit after an injury so that there would not be prior records of treatment of a particular injury and so “it’s less essential to start out on day one with old records.” Tr. 855.

Dr. Schneider likewise testified as to the importance of obtaining a patient’s substance abuse history. According to Dr. Schneider, a patient who has a history of substance abuse can still be prescribed opioids for chronic pain, but the history is a “relative contraindication” for such treatment. Tr. 881. A physician thus needs to “get a careful history and * * * have much more stringent monitoring,” but, depending on “the nature of the previous substance abuse, on how long it’s been since the person last abused the substance and what kind of treatment they had for it,” a physician could still safely prescribe controlled substances. Tr. 881–82.

Dr. Schneider testified that her initial appointment usually takes 45 minutes. Tr. 863–64. In that time, she goes through “the four As.” Tr. 864. The first “A” is *analgesia*, and Dr. Schneider asks for a pain rating on a scale of 1–10. *Id.* The second “A” is *activities of daily living*, about how the patient is functioning, as “treating chronic pain is a lot about function, at least as much as about pain relief.” *Id.* The third “A” is *adverse effects*, such as side effects. *Id.* The fourth and final “A” is *aberrant drug related behaviors*, which is “anything that’s out of the ordinary, like if they say I need an early refill.” Tr. 865.

Dr. Schneider also testified that it is medically appropriate for a physician to prescribe based on a “focused physical exam.” Tr. 870. According to Dr. Schneider, when a physician sees “somebody for a particular problem, and this is not just in pain, but this is in any field, you limit your exam to that part.” *Id.* The exam is “called a focused physical exam because it is limited to the part of the body that the person is having trouble with.” *Id.*¹¹ While the parties thus disagree as to the proper scope of a physical exam, I assume without deciding that a focused physical exam is adequate to diagnose a patient.¹²

¹¹Dr. Schneider also testified that there is no lethal blood opioid level for non-opioid-naïve patients, and that insurance companies are often the reason why prescriptions may be written for high volume with low dosing. Tr. 904, 909–11.

¹²As one of the grounds for her finding that “there was no clear consensus” regarding what was required to meet the standard of care, the ALJ noted that “Dr. Hare concluded that the Respondent’s failure to always perform physical examinations or order tests to verify symptoms constituted

Continued

At the first visit, the physician should create a treatment plan. *Id.* at 170. According to Dr. Hare, he “[t]ypically” does not prescribe opioids on the first visit because he lacks other physicians’ records, test results, and the opportunity to consult with other members in his practice group. *Id.* at 164. However, it appears this may be also because Dr. Hare and the other physicians in his practice “oftentimes see the patient as a group,” and after evaluating the patient, discuss among themselves whether they “have something to offer that patient.” *Id.* Accordingly, to the extent Dr. Hare’s testimony suggests that is outside of the course of professional practice to prescribe a controlled substance at a patient’s first visit, it is not conclusive.

It was undisputed, however, that “the appropriateness of prescribing [controlled substance] medications * * * depends on the level of medical documentation.” *Id.* at 228. According to Dr. Hare, “[w]ithout the appropriate documentation it’s inappropriate to prescribe the controlled substances.” *Id.* at 229.

Titration of Dosing and Follow-up Visits

Both Dr. Hare and Dr. Schneider testified that when any medication has been prescribed, there will be follow-up visits at which the physician questions the patient about whether there has been improvement in his pain level and functionality, whether there have been side effects, and the continuing benefits of taking the medication. *Id.* at 172 & 181 (testimony of Dr. Hare); *id.* at 864 & 949 (Dr. Schneider’s testimony that she reviews the four “A”s with her patients at every visit). At follow-up visits, the physician should question the patient as to whether he is using the medication appropriately.¹³ *Id.* The

inadequate treatment of the patient for whom she prescribed controlled substances. Yet, Dr. Weinstein found that Dr. Hare’s conclusion rested on the erroneous assumption that all painful conditions would be objectively verifiable by a physical exam or test results.” ALJ at 52.

It is unclear, however, whether the ALJ was referring to Dr. Hare’s testimony regarding the need for the initial exam or for follow-up exams when patients report new symptoms. If the ALJ’s comment was referring to whether a patient should be physically examined at the initial visit, even Dr. Schneider indicated that the exam is part of the standard of medical practice. To the extent the ALJ was referring to the need for a physician to perform a physical exam on a subsequent visit when a patient reports new symptoms, obviously the necessity of performing a further physical exam depends upon the patient’s symptoms and complaint. Accordingly, whether an exam was required to meet the accepted standard of medical practice cannot be evaluated outside of the context of a specific patient.

¹³ Dr. Hare also testified that he asks his patients about their mood and sleep as chronic pain patients “almost uniformly * * * have problems with anxiety and depression.” Tr. 172. He indicated that

physician should document the patient’s response to medication, functionality, and adverse effects in the patient chart. *Id.* at 173; *id.* at 865 & 951.

Moreover, both parties’ expert were in agreement that when a patient is currently not on opioids they should be started at a low dose and titrated up slowly to achieve pain relief while minimizing the side effects such as nausea and sedation. Tr. 971–72; *see also id.* at 177 (testimony of Dr. Hare that “you don’t want to increase too quickly for fear of overshooting and getting the patient in trouble” by causing “dangerous side effects”).

Dr. Hare noted that in the event that the medication is increased, the usual increase is in the amount of 50 percent of the prior dosage. *Id.* at 176. However, according to Dr. O’Connor, it is acceptable to titrate at a rate of “no more than 50% to 100% every 5 or more days” so long as the increase in the dose does not cause adverse effects. RX 8, at 2. Moreover, because people respond differently to opioids, there can be great variability as to the dose necessary to alleviate a patient’s pain. Tr. 972. In treating unrelieved pain, “there is no dose which is too high unless the patient has toxicity or side effects.” RX 9, at 2.¹⁴

Managing Patients Who Are Receiving Controlled Substances

Both Drs. Hare and Schneider testified as to the importance of setting boundaries with patients who are receiving controlled substances through the use of written agreements. Tr. 161. As Dr. Schneider testified: “I have all my patients sign an agreement [which] lays down the rules and it says that they’re [the patients] not to make any changes in their medications without first consulting me.”¹⁵ *Id.* at 876. Dr. Schneider further explained that if she gives a patient permission to increase

the failure to monitor sleep and mood could cause a physician to “miss the boat” in medicating with opioids. *Id.* at 182.

¹⁴ According to Dr. Hare, if a patient states that the medications are not working well, “then we’d have to decide whether we’ve just undershot the prescribing or we’re dealing with a pain problem that isn’t going to respond to pain medicine.” *Id.* at 174. In the latter case, he would “make plans to back off on these opioids and look at other ways to manage the pain.” *Id.* While this testimony suggests the existence of a dispute over the maximum dosage levels, it is not necessary to resolve this dispute.

¹⁵ Dr. Schneider further explained that there is a “loss of control thing that is part of addiction [and] an addict who wants more medication is not going to be willing to call me in the office and leave a message and have me call him back four hours later to tell him that yes, you can take another pill because you’re having more pain.” *Id.* at 876.

his dose, she documents it. *Id.* at 877.¹⁶ If a patient comes in reporting that he took more medication than prescribed, Dr. Schneider asks why and if the response is not reasonable, her “reaction is * * * to build more structure around them.” *Id.* Sometimes this involves having a family member administer the medication, *id.* at 878; it may also involve writing very small prescriptions and having more frequent visits. *Id.* at 879. Similarly, Dr. Hare noted that “if a patient has overused medication,” a physician needs to find out why, and if the patient does not offer a “good reason, the physician should counsel the patient to use his medication as prescribed and “hold them to it.”¹⁷ *Id.* at 163.

¹⁶ Subsequently, Dr. Schneider testified that “three” to “five years” ago, a lot of people were not aware of pain agreements and were not using them. Tr. 1012–13. Dr. Hare, however, testified that the agreements had been in use for as “as long as” he could remember and in excess of fifteen years. *Id.* at 187–88. I further note that the record contains a pain management agreement signed by a patient of Respondent in July 2001. *See* RX 72, at 3–4. Whether or not the usual course of professional practice requires that the physician enter into a written agreement setting forth her expectations and what rules her patient must follow while being treated, it is undisputed that a physician must carefully monitor her patients’ use of controlled substances.

¹⁷ The record contains a copy of a pain management agreement Respondent used in treating R.T. GX 72, at 3–4. The agreement reads in relevant part:

I understand that if I break this Agreement, my doctor will stop prescribing these pain-control medicines.

In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

I will communicate fully with my doctor about the character and intensity of my pain, the effect of pain on my daily life, and how well the medicine is helping to relieve the pain.

I will not use any illegal controlled substances, including marijuana, cocaine, etc.

I will not share, sell or trade my medication with anyone.

I will not attempt to obtain any controlled substances, including opioid pain medicines, controlled stimulants, or anti-anxiety medications from any other doctor.

I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will only be replaced at the doctor’s discretion.

* * *

I agree to use _____ Pharmacy, located at _____, Telephone number _____, for filling prescriptions for all my pain medicine.

* * *

I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medicine.

I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

I will bring all unused medicine to every office visit.

GX 72, at 3a–3b.

Both Drs. Hare and Schneider testified that they require their patients to agree to obtain their medications only from themselves and not from other physicians.¹⁸ *Id.* at 161; *id.* at 963. Dr. Schneider testified that if she found out that a patient was obtaining drugs from another source, she would question the patient and determine the circumstances. *Id.* at 962. Moreover, if the patient was obtaining the drugs from another physician, she would call the physician and remind him that “the patient has a contract with” her, which the other physician knows about because she sends reports to him, and that she tells the other physician that he “cannot be prescribing for the patient.” *Id.* at 963. Dr. Schneider added that if the patient does it again, she “may discharge them.” *Id.* at 964.

Dr. Schneider further testified that if a patient is giving drugs to a family member, she counsels them that this is a felony offense and she is “certainly not going to replace a pill that [a patient] ha[s] one less of because [she] gave it to a family member.” *Id.* at 1007. Moreover, she documents the incident in the patient record. *Id.* at 1008. Dr. Schneider also noted that it is especially “egregious” when a patient is buying drugs on the street. *Id.* at 1006.

With respect to requests for early refills, Dr. Hare testified that “we try to come up with a plan that’s going to meet the patient’s needs until the time of the next visit,” including “a reasonable type of medicine,” and “a reasonable amount of medication.” *Id.* at 163. Dr. Hare further explained that “[w]e do our refills on a 30-day basis,” and we set “the dates that the refill is supposed to occur * * * so we have all of that information in our records” and that this allows for the physician “to quickly access * * * and determine when a refill is appropriate” and “when it’s not.” *Id.* at 164.

To similar effect, Dr. Schneider testified that when a patient ask for early refills, she discusses with the patient why the refill is needed and documents this in the patient record. *Id.* at 949. Moreover, Dr. Schneider may decline to refill the prescription. She

¹⁸ Dr. Hare further explained that his agreement provides the patients with instructions for obtaining refills and also establishes rules for dealing with a patient’s claim that his medication was lost or stolen. *Id.* at 161. According to Dr. Hare, the agreement “makes it clear that we may or may not choose to refill the medications under those circumstances.” *Id.* Continuing, he explained that his practice is “usually pretty flexible” the first time a patient reports that his medication has been lost or stolen and will issue a new prescription while counseling the patient. *Id.* at 162. If, however, it happens again, it raises a concern that the patient is “overusing their medicine” and “perhaps diverting them.” *Id.*

also noted that she has a page in her charts in which every prescription and the date of its issuance is recorded so that a refill request can be properly evaluated to determine whether it is too early.¹⁹ *Id.*

Dr. Schneider testified that when an anonymous phone call is received which indicates that a patient is either selling or abusing a drug, “[y]ou have to look into it * * * You have to pursue all these angles.” *Id.* at 830. According to Dr. Schneider, “there are some times when the information has a lot of validity and you have to follow it, and when the doctor doesn’t that’s a bad scene.” *Id.* As to a patient using “somebody’s prescription that happened to be around the house because they had a bad headache or whatever,” Schneider testified that “counseling them, and advising them, and warning them and so forth may be enough.” *Id.* at 836. However, if in truth it is a situation of “an active addiction problem,” the physician needs to inform the patient that the addiction will interfere with the prescribing and “that they need to get some help with their addiction problem.” *Id.*

Dr. Schneider further testified that there are “many sets of tools on the Internet to help pain specialists assess their patients for a history of addiction and for addiction issues and on how to monitor them and how to follow them.” *Id.* at 824. In addition, a physician should use such measures as pill counts (*i.e.*, requiring patients to bring in their prescriptions to determine whether they are taking them as prescribed) and random drug screening through either blood or urine tests to determine whether the patient is taking the prescribed medication and/or taking illicit drugs. *See* GX 72, at 4 (requiring that Respondent’s patients agree to “submit to a blood or urine test * * * to determine my compliance with my program of pain control medicine” and that they “bring all unused pain medicine to every office visit”).²⁰

¹⁹ Dr. Schneider also testified that many doctors “simply write down the prescription they wrote that day in the body of the records, meaning that the next time the patient comes, they’ve got to be rifling back through to see what was the last one.” Tr. 1001.

²⁰ In her testimony, Dr. Schneider vaguely suggested that in 2001–2002, the use of urine drug screens was not generally accepted as required by the standard of care. Tr. 1013. In August 1998, however, Dr. Schneider published an article in which she noted that required her patients to “obtain urine drug screens when asked. This feature of the contract prevents any refusals from the patient and lets me request a urine screen at any suspicion of drug addiction problems.” Jennifer P. Schneider, *Management of Chronic Non-Cancer Pain: A Guide To Appropriate Use Of Opioids*, 4 J. Care Mgmt. 10, 18 (Aug. 1998). Therein, Dr.

Dr. Schneider testified that it is important for a doctor to communicate with other doctors. Tr. 853. Dr. Schneider sends a copy of her notes on “every visit” to the primary care physician. *Id.* If she knows of a patient’s “ongoing relationship with some other specialist related to their pain problem,” she also sends a copy of the notes from every visit. *Id.* After making a referral to a specialist, she also requests “a copy of that report and of imaging studies.” *Id.*

Alleged General Practices

At the request of the DEA Investigators, Dr. Hare reviewed the medical records of Respondent’s patients.²¹ GX 46. In his first report (January 15, 2003), Dr. Hare indicated that he had reviewed the records of eight patients and found that Respondent’s care exhibited the following “general problems”:

- Respondent “failed to adequately evaluate” patients by not obtaining an adequate “pain history” and by not “obtain[ing] information from previous treatment such as records of treating physicians and the previous medications used.” GX 46, at 1. These would “have allowed [Respondent] to determine if there had been problems with medications or patient compliance.” *Id.*

- Despite the fact that “[t]he information in [Respondent’s] records was insufficient to make a proper diagnosis,” Respondent “prescribed Controlled Substances.” *Id.*

- Respondent “did not properly track the use of medications.” *Id.* at 2. She did

Schneider also noted the role of asking a patient “to bring in partly-used medication containers for a pill count” in assessing whether the patient has lost control over his/her drug use. *Id.* at 13. In accordance with 5 U.S.C. 556(e), I take official note of Dr. Schneider’s article and reject her suggestion that urine drug screens were not required to meet the standard of care in prescribing controlled substances by a pain specialist. Moreover, the Arizona Board found that Respondent had failed to monitor her patients for signs of current drug abuse. GX 73, at 4.

Dr. Schneider also contended that in 2001–2002, urine drug screens were difficult to interpret, in part because of the difference between opioids (which are semi-synthetic or synthetic) and opiates (which are derivatives of morphine), and that the opioids would not show up on a standard urine drug screen and that the physician had to specifically request that the lab test for them. Tr. 892. Putting aside whether a competent physician should have known the difference between opioids and opiates and how to properly screen for them, in her article she also noted that urine drug screens were useful in determining whether a patient is abusing illicit drugs. Were it the case that Respondent required her patients to undergo urine drug screens and mistakenly failed to request the correct test, it would be a relevant consideration. However, Respondent rarely required her patients to undergo urine drug screens.

²¹ In a subsequent report, Dr. Hare reviewed the medical records for an additional seven patients. *See* GX 46A.

not “comment on the lack of patient compliance” when patients used controlled substances “in excess of the prescribed amounts.” *Id.* Rather, she “usually increased the amount of the prescription to meet the patient’s use of medication, rather than exercising any control over the patient’s consumption.” *Id.*

- Respondent switched from one controlled substance to another, “based on patient request, not on what was reasonable therapeutically.” *Id.*

On cross-examination, Respondent admitted that she failed to take addiction histories. Tr. 2344. However, when asked whether she routinely failed to obtain prior medical records, she stated that “there is no obligation or rule that you have to get medical records.” *Id.*; but see GX 73, at 4 (State Board’s finding that “Respondent failed to further substantiate actual diagnoses and physical findings with prior medical records.”). She stated that in many cases she did get parts of medical records. *Id.* at 2345. She admitted that others might not always be able to “glean” her rationale for increasing opioid dosages from her records. *Id.* at 2346. When asked whether she often issued early refills on controlled substance prescriptions without documenting the reason in her medical records, Respondent said that she did not know what the term “early refill” meant. *Id.* at 2345–46. She indicated that she did not find doing frequent MRIs useful, that with chronic pain that was just a waste of medical resources. *Id.* at 1381.

Respondent testified that she always did an evaluation on new injury cases, that there was always a physical examination, and that it was always documented. *Id.* at 2347–48. She testified that she did not ignore that some patients had histories of addiction and that she did not ignore warning signs of addiction or abuse. *Id.* at 2348–49. She admitted that she was not in contact with primary care physicians in all cases, but she also justified that in the case of J.N., noting that her primary care physician wasn’t practicing due to a licensing issue. *Id.* at 2349. Respondent admitted that on occasion she failed to document the reason for increasing an opioid dose. *Id.* at 2351.

Respondent also stated that she did not believe in reprimanding patients when she found out that they were giving their controlled substances to another person. *Id.* at 2393–94. She compared the situation to one where a diabetic patient is not following his diabetic diet. *Id.*

Evidence Regarding Specific Patients

J.N.

On September 11, 2000, J.N., who was then forty-three years old and who undergone a cervical fusion in 1994, started treating with Respondent. GX 9, at 1. She “had been sexually assaulted and suffered [a] cervical fracture and needed emergency surgery.” *Id.* Her pain had recently worsened, and Respondent noted in her medical record that she “need[ed] another cervical fusion.” *Id.* J.N. had been on disability since 1994. *Id.*

There is no indication in J.N.’s patient record that Respondent inquired about any history of substance abuse at the initial visit. *Id.* at 1–2. At the first visit, Respondent performed a physical exam and diagnosed J.N. as having “[s]evere neck pain,” “left upper extremity pain,” and “signs of left cervical radiculopathy.” *Id.* at 2. Respondent gave J.N. a free trial of 21 tablets of OxyContin 40 mg q8h²² (one tablet every eight hours), 50 tablets of Oxycodone IR “1–2 q4h PRN for breakthrough pain,” and a prescription for 60 tablets of Xanax 0.5 mg twice a day, with one refill, although nothing in the patient record documented that J.N. experienced anxiety. *Id.* at 2. Respondent was to “[r]echeck in 1 week.” *Id.*

On September 15, Respondent noted that J.N. “is better on the OxyContin and Oxycodone. She feels less pain,” yet Respondent increased the OxyContin prescription to 60 (160 mg.) tablets, with one tablet to be taken every eight hours, (a twenty-day supply), which was a four-fold increase in the dosage over the initial prescription. *Id.* Respondent also issued prescriptions for 50 milliliters of Oxyfast 20 mg/ml, “1–2 ml q4h PRN breakthrough pain,” 360 tablets of MS Contin 100 mg., (4 tabs q8h), as well as 100 milliliters of morphine elixir “20 mg/ml 5 ml q6h PRN breakthrough pain.” *Id.* at 2–3. Respondent noted that the latter two prescriptions were being issued in “[i]n case Pima insurance doesn’t cover” the other medications. *Id.*

²² The record establishes that “q” means every, and that “h” means hour(s), and “hs” at bedtime. See Tr. 1122 & RX L, at 6; Tr. 1151 & GX 9, at 8; Tr. 1165 & GX 13, at 6; Tr. 1175. Thus, “q4h” means every four hours, “q6h” means every six hours, “q8h” means every eight hours, and “q12h” means every twelve hours. See Tr. 1122 & RX L, at 6; Tr. 1175; *id.* at 1151 & GX 9, at 8. In addition, the abbreviation “BID” means “twice a day,” Tr. 355 & RX 13, at 1; “TID” means “three times a day,” Tr. 403 & RX 13, at 1; and “QID” means “four times a day.” *Id.* at 358 & GX 22, at 18. The abbreviation “PRN” means “as needed.” *Id.* at 1174. It is also undisputed that prescribing in excess of 4 grams or 4000 mg. per day of drugs containing acetaminophen risks liver toxicity. See *id.* at 403–04.

Respondent also increased the dosage of Xanax four-fold to 2 mg. twice a day, again without any finding regarding anxiety. *Id.*

J.N. returned on October 5 and reported that she was “much better than she has been because of the MS Contin,” and Respondent wrote prescriptions for MS Contin at the same dosing and also MSIR (morphine sulfate immediate release) “30 mg 6qh PRN breakthrough pain #120,” to “recheck in one month.” *Id.* at 3. Respondent also added a prescription for ten tablets of Dilaudid 4 mg., 1–2 four times a day. *Id.* On October 25, J.N. reported that the medications helped with her pain and with sleep and that she would like more Dilaudid. *Id.* She also reported having had an EMG/NCV with a Dr. L. on September 14, but did not know the results. *Id.* at 4. Respondent wrote prescriptions for Dilaudid, MS Contin, MSIR, as well as Fioricet for “headache.”²³ *Id.* at 4. J.N. continued on Dilaudid, MS Contin, Xanax and Fioricet through June 14, 2001. *Id.* at 4–9.

J.N.’s patient record includes a Discharge Summary from University Medical Center in Tucson, Arizona, which was faxed to Respondent on January 16, 2001. Notably, the first page states that J.N. had a “history of IV heroin abuse.” *Id.* at 13. Continuing, the Summary stated that “she quit several years ago, but started using again one week ago because of increasing abdominal pain.” *Id.* at 13–14. The Summary also noted that a urine toxicology screen was “positive for opiates, barbiturates, benzodiazepines, and marijuana.” *Id.* at 15.

The Discharge Summary listed five medical problems J.N. had including “Chronic pain/narcotic addiction.” *Id.* at 15–16. The Summary specifically noted that J.N. was “preoccupied with her pain medications, requesting p.r.n. medications frequently” and was “resistant to weaning attempts.” *Id.* Moreover, while the hospital offered J.N. “drug abuse placement,” she “refused,” stating that “she was not an addict, and was only unable to get off Morphine due to her medical condition.” *Id.* at 16. The Summary also noted that on discharge, J.N. was given MS Contin, Dilaudid and Xanax in the doses that she had been receiving from Respondent and in quantities that would last until she could see her pain specialist. *Id.*

While the patient record indicates that Respondent was notified on

²³ The patient record also indicated that Respondent issued her a prescription for Amoxicillin, a non-controlled drug.

December 4, 2000 that J.N. had been hospitalized, GX 9, at 5, she did not obtain the Discharge Summary for another month. Moreover, J.N.'s medical record contains a note dated January 24, 2001, that Respondent "received records from UMC and discharge diagnosis was sludge in gallbladder"; the note contains no mention of either the results of the drug screen done by the hospital or of J.N.'s statement to the hospital staff that she had recently started using heroin again. *Id.* at 6.

J.N.'s record contains no indication that Respondent attempted to monitor her use of controlled substances through drug screens and pill counts. *See generally id.* Moreover, the medical record contains no indication that Respondent questioned J.N. about her use of marijuana, heroin, or the barbiturate (which Respondent had not prescribed to her).

On subsequent visits, Respondent primarily prescribed 120 tablets of Dilaudid 4 mg. (QID—one tablet four times a day), 180 tablets of MS Contin 200 mg. (two tablets every eight hours), Xanax 2 mg. (BID—one tablet twice a day), and Restoril (temazepam) (two tablets at bed time).²⁴ *Id.* at 5–9. After J.N.'s hospitalization, all of the MS Contin prescriptions and all but two of the Dilaudid prescriptions were for a quantity equaling 30 days of dosing. *See id.* Approximately half of the Dilaudid and MS Contin prescriptions were refilled at least five days early, with some being refilled as early as eight or nine days before the previous prescription would have run out. *See id.* (Rxs for: 180 MS Contin on 12/18, 1/11, 2/1, 2/26, 3/20, 4/19, and 5/14; for 120 Dilaudid on 1/11, 2/1, 2/26, 3/20, 4/19, and 5/14).

J.N. died of an overdose on June 18, 2001. According to a police report, "several syringes were found at the scene," as well as various drugs including hydromorphone and morphine sulfate.²⁵ GX 8, at 18. The police also found a white powder in the living room and were told by J.N.'s boyfriend that the two of them would mix "her prescription medication with water and inject it using the used syringes." GX 8, at 19. Moreover, in an interview with investigators, J.N.'s boyfriend stated that she would crush up the Dilaudid (hydromorphone) she

obtained from Respondent and inject it. GX 43, at 11. J.N.'s boyfriend also related that "[s]he didn't have veins" and that it was very hard to get blood from her. *Id.* at 22. Yet there is no indication in J.N.'s medical record that Respondent ever noticed this. *See generally* GX 9.

The Medical Examiner determined that the cause of J.N.'s death was "acute intoxication due to the combined effects of opiates, cyclobenzaprine, and amitriptyline." GX 8, at 2. Respondent disputed the Medical Examiner's conclusion. One of her experts (Dr. Schneider) maintained that it was not "black and white that a morphine overdose was her cause of death," and indicated (in response to Respondent's question whether her opinion would change if J.N. had been on the same dose of extended release morphine for the previous ten months), that unless J.N. had "suddenly taken a lot more" of the drug, she would question whether J.N.'s death was caused by a morphine overdose. Tr. 921–22. Dr. Schneider was not asked, however, whether her opinion would be different if J.N. had taken the drug intravenously.

Relatedly, another of Respondent's experts (Dr. O'Connor) testified that J.N.'s taking of the cyclobenzaprine and amitriptyline (neither of which was prescribed by Respondent) would have "certainly" caused her to have a heart attack. *Id.* at 1154. Yet the Medical Examiner did not note any evidence of a heart attack. *See generally* GX 8. Moreover, when Respondent asked her whether there are "any interactions between opiates, such as morphine, and * * * amitriptyline or cyclobenzaprine," the witness answered:

Certainly in [an] opioid-naïve patient, if they took * * * Tylenol with codeine, and then they took some cyclobenzaprine or flexeril on top of that * * * they might get more sleepy. The same goes for amitriptyline or tricyclics. In an opioid-tolerant patient, no. Tr. 1157. The expert's testimony does not make clear whether her answer as to the effect that would occur in an opioid-tolerant patient applies to a patient taking opiates other than Tylenol with codeine, a drug which is far less potent than either MS Contin 200 mg. or Dilaudid. Furthermore, the Medical Examiner did not conclude that J.N.'s death was caused solely by her use of morphine, but rather, the combined effects of opiates and the other two drugs.²⁶ GX 8, at 2.

In any event, it is not necessary to resolve the factual dispute. Even if J.N.'s intravenous use of either Dilaudid or MS Contin did not contribute to her death—it just being a coincidence that syringes and crushed medication were found in the vicinity of her body—the evidence nonetheless clearly established that she was abusing drugs, that Respondent had reason to know that she was abusing drugs, and that Respondent failed to properly supervise her use of controlled substances.

With respect to the discharge summary, which clearly indicated that J.N. was abusing drugs, Respondent testified that she failed to read the entire hospital discharge summary because it "was a lot of pages." Tr. 2367. According to Respondent, she "looked at the beginning" and "looked at the end" of the document but that the reference to J.N.'s heroin abuse was "buried in" the report. *Id.* at 1850 & 2367–68.²⁷

The discharge summary was, however, only five pages in length (and the fifth page did not contain any medical information). *See* GX 9, at 13–17. Moreover, the reference to J.N.'s "history of IV heroin abuse" was on the bottom of the first page. *See id.* at 1.

In her testimony, Respondent also maintained that that she was unaware that J.N. had crushed and injected her medication until she inferred it from a question DI Llenas asked her the day of the search warrant in May 2002. Tr. 2377. Yet other evidence indicated that J.N. had no veins and that it was difficult to draw blood from her, something which Respondent apparently never noticed.

With respect to J.N.'s initial visit, Dr. Hare concluded that Respondent "failed to obtain [an] adequate history * * * and [that] she did not obtain records from * * * the neurologist, by whom the patient had been evaluated," that she conducted a "minimal and inadequate physical examination," and that "the evaluation was inadequate to allow proper diagnosis and therefore the prescribing of controlled substances." GX 46, at 4. As to J.N.'s second visit, Dr. Hare's review of her patient record noted that her "already large dose of

level of 2837 ng/ml, a level which was higher than that found in JN (2374 ng/ml) following her death, was capable of functioning. *Compare* RX 39, at 4 with GX 8, at 10. Respondent did not, however, offer any evidence that she conducted blood tests of J.N. while she was alive to show what level she was functional act.

²⁷ Respondent testified that, despite being aware of the addiction history, the attending physician had continued the medications that she prescribed for JN—MS Contin 400 mg., Dilaudid 2 mg., and immediate release morphine 30 mg. Tr. 2368; GX 9, at 13. The Respondent was also listed as J.N.'s pain specialist in the discharge report. GX 9, at 13.

²⁴ Both Xanax (alprazolam) and Restoril (temazepam) are benzodiazepines and schedule IV depressants. *See* 21 CFR 1308.14(c).

²⁵ According to the police report, twenty syringes were found, several of which had been opened. GX 8, at 18–19. In addition to hydromorphone and morphine sulfate, the police found Duramorph, methocarbamol, Pancrease, Zyprexa, Naproxen, and Cimetidine. *Id.* at 18.

²⁶ Respondent also introduced into evidence an article discussing a survey of blood levels of opiates in opioid-tolerant patients. *See* RX 39. More specifically, Respondent pointed to a table which indicated that a patient with a Morphine SR blood

OxyContin" was "dramatically increased" "six-fold"²⁸ on September 15, 2000, "despite the patient's improvement." *Id.* He also noted that the strength of the alternative prescription that was written for MS Contin 100 mg. would "translate to about 8 times the original OxyContin [sic] dose."²⁹ *Id.* at 5.

Dr. Hare further noted that on January 11, 2001, the patient record "indicate[d] that the patient's [niece] died and that the patient was quite distressed." *Id.* He also remarked that "[t]his was the very first mention in the records of anxiety and depression, even though the patient had been treated with Xanax for a considerable period of time prior to this." *Id.* Dr. Hare also noted that on several occasions Respondent prescribed medications for J.N. that other doctors, in other specialties, had previously prescribed for J.N., without attempting to coordinate care with those physicians. *Id.*

Dr. Hare also observed that Respondent did not notice signs of abuse, did not acknowledge the Discharge Summary's information about J.N.'s current abuse and history of substance abuse, and failed to treat J.N. for depression or give a psychiatric referral.³⁰ *Id.* at 6. Dr. Hare thus concluded that Respondent's care of J.N. was "substandard" and "probably negligent." *Id.* at 6.

With respect to J.N. (as well as three other patients N.F., W.F., and C.O.), Dr. Schneider observed in her report that:

All had evidence of "aberrant drug-related behaviors" which should have been pursued but weren't, and all received early refills without adequate documentation. These charts certainly showed problems which indicated that [Respondent] needed additional education about obtaining an addiction history, careful monitoring, and review of the "big picture."

RX K-1, at 6.

W.F.

W.F. first visited Respondent in September 2001. At that time he was a disabled 44-year-old veteran. GX 13, at 1. W.F. had been in a severe jeep accident in 1973 while in the Marine Corps, fracturing his pelvis, femur, right wrist and left mandible. *Id.*; Tr. 1958. He walked with crutches. GX 13, at 1.

²⁸ Dr. Hare noted that the OxyContin 160 mg. was to be taken every four hours, but the patient chart indicated only every eight hours. I find that the dose increase was four-fold, not six-fold.

²⁹ In a patient narrative that Respondent wrote on C.O., which was included in C.O.'s medical record, Respondent wrote of her prescribings that "[t]he dose was increased by approximately 50%–100% at a time, when necessary, as is the appropriate way to titrate opioids." GX 36, at 35.

³⁰ Respondent testified that she made efforts to refer J.N. to a psychiatrist but did not record that in the patient file. Tr. 2356.

At the first visit, W.F. brought in an impairment rating from the Veteran's Administration (VA) establishing that he was disabled. *Id.* Respondent did not, however, contact the VA to obtain copies of his treatment records. *Id.* Nor is there any indication in the patient record that Respondent inquired about W.F.'s substance abuse history at the initial visit, nor is there any indication that she asked for pain ratings. *See id.* Respondent's physical exam involved observing W.F. walk with his crutches, noting that he had "severe pain with lumbar range of motion," "tenderness over bilateral lumbar paraspinals," and "tenderness over [his] right wrist and pain with right wrist range of motion." *Id.*

W.F.'s patient file includes several letters which advised Respondent that he had a history of substance abuse. The first letter, which was dated January 8, 2002, was written by Dr. H.G., a psychiatrist with Cope Behavioral Health. GX 13, at 13. Therein, Dr. H.G. explained that W.F. was "currently under court ordered treatment by the Psychiatric Security Review Board which mandates that all [of] his medications are to be prescribed by either psychiatrists at Cope * * * or by the VA." *Id.* The letter further states that W.F.'s "case manager * * * has recently learned that [he] was receiving narcotics & psychotropics from your office; unfortunately, this history has repeated itself to poor outcomes in the past for [W.F.] (addiction issues)." *Id.*

On January 24, 2002, Dr. H.G. sent another letter to Respondent. *Id.* at 15. Therein, he indicated that it was permissible for Respondent to prescribe for W.F. because he could not get an appointment at the VA until April. Dr. H.G. noted, however, that "[a]lthough he currently denies symptoms of abuse, please be aware he has had narcotics addiction problems in the past." *Id.* at 15.

Finally, on January 28, 2002, J.G., a case manager at Cope Behavioral Health, indicated that Cope had "received a phone call this afternoon from a family member of [W.F.], who is concerned that [W.F.] might be abusing his pain meds." *Id.* at 17.

The patient record contains some indication that on January 29, 2002, Respondent discussed addiction issues with W.F., as Respondent wrote: "[p]atient insists that the medications help with the pain, and he cannot function without the medications." *Id.* at 5. Respondent wrote prescriptions for 100 Methadone 10 mg. 1–2 QID (one to two tablets four times a day) and 100 Roxycodone 30 mg. q4h PRN (one tablet every four hours as needed for pain). *Id.*

at 6. Respondent issued the same prescriptions on February 11, 2002. Respondent had also previously written prescriptions for temazepam with multiple refills on October 29, 2001, and December 17, 2001. *Id.* at 3, 5.

On February 24, 2002, W.F. was found dead. The Medical Examiner's report concluded that W.F. "died of undetermined cause. Possibilities include seizure related and drug intoxication." GX 11, at 2. A toxicology report found that W.F. had a temazepam level of 1148 ng/ml; *id.* at 14, however, the Medical Examiner subsequently indicated in a letter to Respondent that this level of the drug "would not be expected to cause death." RX 52. The Medical Examiner also found that "[o]ther drugs identified in his body were in too low a concentration to allow me to come to the conclusion that death was likely the result of the combination of drugs, including Temazepam." *Id.* Relatedly, the toxicology tests found only a small amount of oxycodone and no presence of methadone in W.F. GX 11, at 9–15.

Dr. Hare observed that at the initial visit, Respondent did not obtain an adequate medical history and did not inquire about substance abuse issues. GX 46, at 3. Also, "the physical examination was minimal and inadequate to characterize various pain complaints." *Id.* Dr. Hare also faulted Respondent, who then knew of the history of substance abuse, for not limiting W.F.'s medication and not "requesting toxicology screens * * * to determine if he was using medications other than those she prescribed, or actually using the medication she was prescribing." *Id.* at 4. Dr. Hare further noted that the toxicology report done as part of the autopsy "was negative for opioids which he had been prescribed in sizable amounts" and that "[t]he lack of opioids would suggest that the patient was diverting significant portions or the entire prescriptions." *Id.*³¹ He concluded that Respondent's care was "substandard and inappropriate regarding the controlled substance prescriptions." *Id.*

³¹ The ALJ's findings contrast this with an excerpt from Dr. Weinstein's report in which she wrote: "Dr. Hare states, 'considering the huge amounts of medications and lack of side effects, the patient was likely diverting,' an inference that cannot be made from therapeutic information alone." ALJ at 82. I note that this comment was made in response to the patient file of a patient other than W.F. Given that the toxicology screen found no evidence of methadone, a drug with a very long half life, it is reasonable to infer that W.F. was not been taking the medication prescribed but rather was diverting it. Moreover, W.F. was identified by Dr. Schneider as a patient who had likely engaged in aberrant drug-related behavior. RX K-1, at 6.

On cross-examination, Respondent testified that she had heeded the psychiatrist's warning about the past heroin addiction and also his "judgment" that pain medications were appropriate.³² Tr. 2382. She admitted that she never did an addiction history. *Id.* In her testimony, Respondent did not, however, respond to Dr. Hare's contention that her physical exam was minimal and inadequate.

The ALJ credited Respondent's testimony that oxycodone is a short-acting medication and that half of it is gone after two hours. ALJ at 82 (citing Tr. 2165). The ALJ also credited Respondent's testimony that it was "quite possible that a patient could take a level of less than five," and that this "doesn't mean that a person is not taking his or her oxycodone." *Id.* Respondent did not, however, address why there was no methadone, a medication with a much longer half-life than oxycodone, in W.F. at the time of his death.

W.F. was one of those patients about whom Dr. Schneider concluded that there was "evidence of 'aberrant drug-related behaviors', which should have been pursued but weren't." RX K-1, at 6. Dr. Schneider further noted W.F. had "received early refills without adequate documentation and explanations," and that Respondent's charts indicated that Respondent "needed additional education about obtaining an addiction history, careful monitoring and review of the big picture." *Id.*

M.D. and S.R.

M.D. and S.R., who were both patients of Respondent, were unmarried but lived together. M.D. first visited Respondent on May 21, 2001, when he complained of having "fallen off a bicycle" and of a "back and leg injury." GX 17, at 1. M.D. further related that another physician had prescribed to him OxyContin 80 mg. (at a dosing of one tablet every twelve hours), Oxyfast, and methadone, but that the physician had

left the office and that he had been off the drugs for several months. *Id.* Respondent did not, however, attempt to contact the other physician's office to verify the statement and/or to obtain treatment records.

Respondent's physical exam noted that M.D. was a "lethargic male in no acute distress with antalgic limp, favoring left lower extremity," "pain with range of motion of the left ankle," "tenderness over bilateral thoracic and lumbar paraspinals," and "decreased lumbar range of motion associated with pain." *Id.* Respondent did not, however, otherwise indicate how severe M.D.'s pain was. *Id.* Respondent also had M.D. sign a pain contract and issued him prescriptions for 60 OxyContin 80 mg. q12h, 30 milliliters of Oxyfast, and 30 tablets of Oxycodone 5 mg. PRN. *Id.*

Later the same day, Respondent documented having received a phone call (apparently from a pharmacy) reporting that M.D. was "known to forge prescriptions and was arrested." *Id.* at 2. Respondent notified the pharmacy where M.D. had indicated on the pain contract that he would fill his prescriptions not to fill them. *Id.* M.D., however, filled the OxyContin prescription at a Walgreen's pharmacy. *Id.*

On June 8, 2001, M.D. returned to Respondent seeking a new OxyContin prescription. *Id.* M.D. reported that he was taking double the dose of the OxyContin. *Id.* He also did not remember what had happened at the pharmacy which had reported him to Respondent. *Id.* Respondent refused to issue the prescription. *Id.*

There are no further visits recorded in M.D.'s patient record. *Id.* The record indicates, however, that on October 8, 2001, the patient pharmacy manager at Tucson Medical Center reported that M.D. had been admitted to the hospital in a coma seven days earlier and had in his possession methadone 40 mg. tablets which were contained in a prescription bottle; the label indicated that the prescription was for Dilaudid 4 mg. and had been issued by Respondent to S.R.³³ *Id.*

S.R. first saw Respondent on August 3, 2001, complaining of abdominal and pelvic pain. GX 15, at 1. S.R. reported that she had a history of interstitial cystitis and active hepatitis C, but apparently she did not bring records about either condition with her. *See id.* S.R. indicated that she was taking Xanax and Vicodin, which she obtained from

another doctor. *Id.* She also stated that she was taking her deceased husband's OxyContin and Dilaudid.³⁴ *Id.*

Respondent's physical exam indicated that S.R. was "in moderate distress," that she had "pain with ambulation and limp," and had "tenderness over [her] abdomen." *Id.* Respondent diagnosed S.R. as having "interstitial cystitis and chronic pain," as well as Hepatitis C. *Id.* Respondent discussed the risks and benefits of long-acting opioids, including addiction and side effects, and prescribed Dilaudid 2 mg. "QID #30," OxyContin 10 mg. "q12h #30," and Xanax 0.5 mg. "TID PRN #90." *Id.* There is no indication that Respondent contacted the physician who had prescribed Vicodin and Xanax to her. *See id.* Moreover, there is no indication as to why she prescribed Xanax, an anti-anxiety drug. Nor did she counsel S.R. about the use of her deceased husband's medications. Tr. 2353.

S.R. returned seventeen days later, reported that she was out of Dilaudid and OxyContin, and asked for stronger medication. GX 15, at 1-2. Respondent found that S.R. had "pain with ambulation and limp" and "tenderness over [her] abdomen." *Id.* at 2. Respondent increased both the strength and quantity of the Dilaudid to 4 mg. "QID #60," and the strength of the OxyContin to 20 mg., with the same dosing and number of tablets ("q12h #30"). She also issued a new prescription for Xanax, 0.5 mg., TID PRN #90. *Id.* at 2.

On September 4, 2001, S.R. again saw Respondent. Respondent noted that S.R.'s urologist had "diagnosed interstitial cystitis," and that she needed to "obtain records from Dr. [M]." *Id.* Respondent also noted that while S.R. "gets abdominal pain," "she is more comfortable." *Id.* Respondent again wrote prescriptions for Dilaudid and OxyContin, doubling the strength of the latter to 40 mg. with the same dosing instruction of "q12h." *Id.*

On September 18, S.R. complained of "continued pain" and wanted a higher dose of OxyContin even though she was "more comfortable." *Id.* Respondent doubled the strength of the OxyContin to 80 mg. "q12h #30" and also wrote a prescription for 60 Dilaudid 4 mg. *Id.* at 3. Respondent noted that she "sent another request for records from Dr. [M]." *Id.*

On October 2, Respondent discontinued OxyContin in favor of MS Contin, 100 mg. "q8h #100," which was "less expensive," and also wrote a

³² Relatedly, the ALJ quoted Dr. Weinstein's report that Respondent "had received communication from a treating psychiatrist, agreeing that the medications she was prescribing for their mutual patient were appropriate." ALJ at 80 (FOF 289; quoting RX 32, at 3). Dr. Weinstein also wrote, "In this instance, [Respondent] had a concurring opinion from a psychiatrist for her management plan." RX 32, at 3.

This is a fundamental mischaracterization of the evidence as there is no indication in W.F.'s file that Respondent had a plan to manage his use of controlled substances. Moreover, Dr. H.G.'s letter merely stated that because W.F. could not see the VA for another three months, he was "in agreement that he should see you until his appointment." GX 13, at 15. Moreover, Dr. H.G. and his staff repeatedly cautioned Respondent about W.F.'s narcotics abuse history. *See id.* at 13-15. This is hardly a concurrence in whatever prescriptions Respondent would write.

³³ On January 6, 2002, M.D. was found dead at his residence. GX 18, at 3. The Medical Examiner found that M.D.'s death was caused by "opiate, cocaine and methadone intoxication." *Id.* at 2. Respondent had not seen M.D. in seven months.

³⁴ This incident of diversion furnished the basis of one of the counts of Accessory After the Fact in Respondent's plea agreement. *See* GX 6, at 7.

prescription for Dilaudid. *Id.* She also issued S.R. a prescription for 100 Xanax (1 mg.), with two refills, which was double the strength of the previous prescription, after S.R. had claimed that “the pills got wet and they dissolved.” *Id.* Respondent also noted that S.R. “has severe anxiety and needs the Xanax” and was complaining of abdominal pain. *Id.* The next day Respondent gave S.R. a prescription for 200 Methadone 10 mg. “3 tabs QID” for pain when S.R. returned, having not filled the MS Contin prescription due to its cost. *Id.*

On October 8, Respondent received the phone call described above reporting that M.D. had been admitted in a coma seven days earlier. *Id.* at 4. At S.R.’s next visit, which was on October 12, Respondent “explained to [her] that she must be very careful with her medications.” *Id.* According to the patient record, S.R. “denie[d] that [M.D.] could have ever gotten his [sic] medications.” *Id.* Respondent reported that S.R. was still complaining of abdominal pain and issued her a new prescription for 60 Dilaudid 4 mg. *Id.* Moreover, a week later, Respondent issued S.R. a new prescription for 200 Methadone 10 mg. Respondent did not institute any kind of monitoring on S.R.’s use of her medication. *Id.*

On November 2, S.R. returned “complaining of abdominal pain.” *Id.* Respondent referred her to another physician “for interstitial cystitis treatment and work-up.” *Id.* Respondent also wrote S.R. prescriptions for 60 Dilaudid 4 mg. and 200 Methadone 10 mg. *Id.*

On November 19, S.R. returned to obtain more “prescriptions, and [was] very irate that they weren’t ready.” *Id.* Respondent explained she would not write prescriptions for more opioids without further documentation of S.R.’s condition. *Id.* at 5. Respondent also noted that S.R. had indicated that she had not seen the physician who was to evaluate her for cystitis because her primary care doctor had not authorized the visit. *Id.*

On December 4, the patient record indicates that S.R. “HA[d] CALLED FOR THE PAST 3 DAYS REQUESTING RX—EVERYONE HAS EXPLAINED TO HER THAT UNTIL MEDICAL RECORDS ARE RECEIVED TO CONFIRM HER CONDITION RX WILL NOT BE WRITTEN PER [Respondent].” *Id.* S.R. offered money for the prescriptions and said that she would go back to Detroit to pick up her medical records “BUT NEED[ED] MEDS TO GO.” *Id.* Respondent told her to go to her primary care physician to get the prescriptions. *Id.* The final entry, December 14, indicates that S.R.’s

medical records were printed out for her to pick up. *Id.*

Dr. Hare did not review M.D.’s patient file, but he did review S.R.’s. Dr. Hare found that Respondent performed only a “minimal” physical examination and did not insist on getting documentation of the diagnosed interstitial cystitis and hepatitis until she had treated S.R. for several months. GX 46A, at 13. He indicated that Respondent’s “evaluation of the patient was insufficient to justify the prescribing of controlled substances.” *Id.* at 14. Dr. Hare further found that Respondent “escalated opioid doses by patient request, not because of favorable responses.” *Id.* While he found that it was “unlikely” that Respondent’s prescribing contributed to S.R.’s death, he suggested that Respondent’s prescribing “perpetuated an ongoing drug abuse problem.” *Id.*

J.R.

J.R. (GX 24) had been convicted of distributing marijuana. Tr. 1995. Respondent maintained, however, that he had turned his life around and was proud of that. *Id.* J.R. first visited Respondent at her Calmwood Medical clinic in August 1999, but she had treated him at another clinic previously and had not transferred those medical records into his chart. *See* GX 24, at 1.

Respondent maintained that J.R. needed to take “a very high dose of OxyContin” in order to work, and that without the medication, the migraine headaches were so bad he could not function. Tr. 1996–97. Respondent testified that she thought J.R. was a legitimate patient. *Id.* at 1997.

The ALJ also credited the testimony of Dr. O’Connor that she saw J.R. “when he picked up his prescribed medications at Wilmot Pharmacy” and he “was functional, his words were never slurred, and he appeared ‘fine.’” ALJ at 106. There is, however, no evidence in the record that Dr. O’Connor ever worked at Wilmot Pharmacy, *see* Tr. 1107–08, where J.R. picked up nearly all of his prescriptions. GX 23; *see also* RX 8 (affidavit of Dr. O’Connor indicating places of employment which do not include Wilmot Pharmacy). Moreover, Dr. O’Connor testified that she “remember[ed] how I talked to him on the phone several times.” Tr. 1129. At no point did Dr. O’Connor testify that she had actually seen J.R. when he picked up his prescriptions.³⁵ *Id.* at

³⁵ Dr. O’Connor also testified that she was aware of J.R.’s diagnosis and his work situation. Tr. 1129–30. With respect to the latter, she maintained that it was “just general patient knowledge. You ask them what they do, how their life is, to assess any addiction factors or anything else like that.” *Id.* at 1130. Again, there is no evidence that Dr. O’Connor

1129–30. I therefore reject the ALJ’s finding.

At J.R.’s first visit recorded in the patient file, August 25, 1999, Respondent noted that he suffered “chronic severe migraine headaches,” and that he “has been on opioids with good relief.”³⁶ GX 24, at 1. She also noted that he was on “methadone because it is inexpensive.” *Id.* That day she prescribed Oxycodone IR “2 tabs q8h 180” (a thirty-day supply), Percodan #200 (with no dosing instruction), OxyContin 40 mg. “4 tabs q8h #360 (a thirty-day supply), and methadone 5 mg. “QID #60 (a fifteen-day supply).” *Id.* On September 15, twenty-one days later, Respondent again prescribed to J.R. Oxycodone IR “2 tabs q8h #180 (a thirty-day supply), Percodan #200, OxyContin 40 mg. “4 tabs q8h #360” (a thirty-day supply), and methadone 5 mg. “QID #60” (a fifteen-day supply). *Id.* J.R.’s record also indicated that on September 22 (a week later), she issued “replacement prescriptions,” but gave no reason for doing so. *Id.*

On October 20, J.R. again visited Respondent. Respondent wrote prescriptions for Oxycodone IR “2 tabs q8h #180” (a thirty-day supply), Percodan #200, OxyContin 40 mg. “4 tabs q8h #360” (a thirty-day supply), and Methadone 10 mg. “QID #60.” *Id.* No reason was cited for increasing the Methadone. *See id.* On November 11 (twenty-two days later), J.R. returned and reported that he had taken “extra medicine this week because of low back pain,” which “started a few days ago.” *Id.* at 2. Respondent wrote him prescriptions for Methadone 10 mg. “QID #60,” Oxycodone IR “2 tabs q8h #180” (a thirty-day supply), OxyContin 40 mg. “4 tabs q8h #360” (a thirty-day supply), and “OxyContin #100.” *Id.* at 2. The patient chart indicates that the prescriptions for Oxycodone and the 360 OxyContin 40 mg. were for the Patient Assistance Program (PAP), with the 100 extra OxyContin “to fill now until medications arrive in the mail.” *Id.* On November 18, Respondent wrote another prescription for OxyContin 40 mg. “4 tabs q8h #360” (a thirty-day supply). *Id.*

On December 13, Respondent wrote the same prescriptions for 360 OxyContin 40 mg., 60 Methadone 10 mg., 180 Oxycodone IR, and 200 Percodan. *Id.* The record indicates that the Oxycodone prescription was for PAP, and Respondent additionally wrote a prescription for Valium 10 mg.

worked at the pharmacy where J.R. filled his prescriptions. Her testimony is not credible.

³⁶ It is unclear, however, whether Respondent had previously treated J.R. for migraines.

“TID #60 with three refills” (an eighty-day supply), and for Fioricet.³⁷ *Id.* The patient record gives no indication as to what medical purpose supported the prescribing of the Valium. *Id.*

On January 4, 2000, Respondent wrote that J.R. “continues on Oxycodone IR and OxyContin around the clock for excellent control of migraine headaches.” *Id.* She wrote the usual prescriptions for 360 OxyContin 40 mg. (thirty-day supply), 60 Methadone 10 mg., 200 Percodan and 180 Oxycodone IR (thirty-day supply), the latter “for PAP.” *Id.* at 3.

On January 21 (seventeen days later), J.R. returned and received two prescriptions for 360 OxyContin 40 mg. (two thirty-day supplies; “[o]ne prescription to be mailed to PAP, and other one to be filled locally”), and prescriptions for Methadone, Percodan and Oxycodone IR (again a thirty-day supply of the latter for PAP). *Id.* On February 7 (again after only seventeen days), Respondent again wrote two prescriptions for 360 tablets of OxyContin 40 mg., with one to be filled locally and one to be sent to PAP. *Id.* At the same visit, Respondent also wrote prescriptions for 180 Oxycodone IR (for PAP), 60 Methadone, and 200 Percodan. *Id.* at 4.

After just another fifteen days, on February 22, 2000, J.R. reported “a severe headache on Sunday, February 20.” *Id.* Respondent planned to “[c]ontinue same dose of medications,” but “[i]f he has another severe headache within the next 3 months,” she planned to “increase his dose by probably about 60–80 mg per day.” *Id.* She again wrote two prescriptions for 360 OxyContin 40 mg. (each a thirty-day supply), one “to be mailed to PAP, and other one to be filled locally.” *Id.* She also prescribed 100 Methadone 10 mg., 200 Percodan, and 180 Oxycodone IR (the latter for PAP, a thirty-day supply).

Twenty days later, on March 13, J.R. returned with another report of a “severe headache,” having taken “extra of the OxyContin and Oxycodone IR, and also methadone.” *Id.* Respondent decided to increase both the OxyContin and Oxycodone IR and wrote two prescriptions for both drugs with one to be sent to the PAP: OxyContin 40 mg. “5 tabs q8h #450” (a thirty-day supply), and Oxycodone IR “4 tabs q8h #360” (a thirty-day supply). *Id.* at 5. She also wrote prescriptions for an increased dosage of Methadone 10 mg. (“3 tabs TID #100”) and for Percodan (“2 tabs q4h #200”). *Id.* The next day, for no reported reason, Respondent wrote two new prescriptions for OxyContin and

Oxycodone IR, backdating them to March 5. *Id.* No mention was made of whether J.R. returned the prescriptions which she wrote the day before. *See generally id.*

Eight days later, on March 22, J.R. returned and reported that he would be going to “a rally in California,” and that he needed “extra medications for control of migraine headaches.” *Id.* Respondent prescribed Methadone 10 mg. “3 tabs TID #30” (3–4 days supply) and OxyContin 40 mg. “5 tabs q8h #30” (two-day supply). *Id.*

On April 12 (twenty-one days later), J.R. again reported a severe headache and that he was taking “extra medications.” *Id.* Respondent again wrote two prescriptions each for a thirty-day supply of 450 OxyContin 40 mg. and 360 Oxycodone IR, as well as Methadone 10 mg. “TID #100” and 200 Percodan. *Id.* at 6.

On May 2 (twenty days later), the patient record states that J.R. “needs to increase his OxyContin because he had a severe headache for 3 days.” *Id.* Respondent wrote a prescription for OxyContin 80 mg. “q8h #270” (a thirty-day supply) and noted that the next day, she would write prescriptions for OxyContin and Oxycodone IR for the PAP. *Id.*

On May 8 (six days later), Respondent wrote two prescriptions for OxyContin: one for 270 tablets of 80 mg. strength for PAP (a thirty-day supply based on her dosing instruction of 3 tabs q8h) and one for 450 tablets of 40 mg. strength (also a thirty-day supply). Moreover, Respondent wrote prescriptions for 360 Oxycodone IR (2 tabs q8h, a sixty-day supply) for PAP, as well as a 180 Oxycodone IR (2 tabs q8h, a thirty-day supply). *Id.* at 7.

On May 15, (a week later), Respondent wrote additional prescriptions which were to be filled by PAP: 270 tablets of OxyContin 80 mg. and 360 tablets of Oxycodone IR “to remain.” *Id.* Two days later, Respondent gave J.R. prescriptions for a one-week supply of both OxyContin 40 mg. (126 tablets) and Oxycodone IR (84 tablets), the latter being a “free 1 week trial.” *Id.*

On May 31, Respondent wrote prescriptions for Percodan “q4h PRN #200,” Methadone 10 mg. “QID #120” (a thirty-day supply), OxyContin 40 mg. “5 tabs q8h #540 (a thirty-six day supply) and Oxycodone IR “4 tabs q8h #360” (a thirty-day supply). *Id.*

On June 9, when J.R. complained “of worse headaches,” Respondent concluded that “we need to increase the OxyContin dose again” because he “doesn’t tolerate any lower dose of OxyContin.” *Id.* at 8. She again wrote for OxyContin 80 mg. “3 tabs q8h #270”

(thirty-day supply). Six days later, on June 15, Respondent wrote prescriptions for OxyContin 80 mg. “3 tabs q8h #360” (thirty-day supply), Methadone 10 mg. “QID #120” (a thirty-day supply), OxyContin 40 mg. “5 tabs q8h #540” (a thirty-six day supply, with no explanation of why J.R. needed both 40 and 80 mg. OxyContin), and Oxycodone IR “4 tabs q8h #360” (thirty-day supply). *Id.* The final sentence in the record for that date is “For PAP program,” but it does not indicate whether that is just the Oxycodone or all the prescriptions. *Id.*

This pattern of early prescribing and not explaining seemingly duplicative dosages continues in the treatment of this patient through its conclusion in April 2002. Notwithstanding the large quantities of drugs she was prescribing to J.R., there is no indication in the medical record that Respondent ever required him to undergo blood or urine tests to determine whether he was actually taking the drugs. Nor did she require him to bring in his medications for pill counts.

Subsequent to Respondent’s treatment of J.R., his next doctor (Dr. H.) wanted to reduce the amount of controlled substances that he was prescribed, as Dr. H. suspected diversion. GX 70, at 35–36. Dr. H. also told a DI that a third doctor who later treated J.R. was surprised that, when J.R. reported running out of medication, he was not experiencing withdrawal symptoms. *Id.* at 36. That doctor reportedly referred J.R. for detoxification treatment. *Id.*

Respondent asserted that Dr. H. had given contradictory statements by saying that he was “positive [J.R.] is diverting and selling all of those medications, and not taking them, and yet he is exhibiting signs of withdrawal.” Tr. 1994. The record indicates, however, that Dr. H. had been told by the third physician that J.R. was not “exhibiting any signs of withdrawal.” GX 70, at 36. According to Respondent, J.R. ultimately self-declared as a heroin addict in order to get methadone. Tr. 2001.

Regarding J.R., Dr. Hare observed that while Respondent had previously treated him at another clinic, there were no records from the clinic “indicating evaluation to confirm the diagnosis of migraine headache or to further characterize his headaches,” and that there were no “records from other physicians or record of treatment with” non-opioid medications even though migraines “typically respond to a number of non-controlled substance medications” which should have been tried first. GX 46, at 13.

³⁷ Fioricet is not a controlled substance.

Relatedly, Dr. Schneider testified that in treating a migraine headache of a recurring nature, a CAT scan should be ordered even though it will probably be “completely normal.” Tr. 872. There is, however, no evidence in the patient record that Respondent ordered a CAT scan for J.R.

Dr. Hare further noted that Respondent was giving J. R. “duplicate prescriptions for OxyContin, one to fill immediately and one to send to the Patient Assistance Program, and yet Respondent did not seem aware that she was giving him twice the amount of medication.”³⁸ GX 46, at 14. He further noted that, while in March 2000, J.R. was only periodically having worse headaches, Respondent increased the dosing of both the OxyContin (long-acting) and Oxy IR (short-acting), when “an increase in short-acting medications would have been a more appropriate step, if any change was indicated.” *Id.* Finally, Dr. Hare concluded that there was “no treatment plan,” and that “[a]ny time this patient wanted to increase medications, he did, and [Respondent] accommodated him by increasing the prescriptions.” GX 46, at 14–15.

N.F.

N.F. had previously been identified by two faxnets issued to Tucson area pharmacies by the Arizona State Board of Pharmacy as having allegedly engaged in doctor shopping and calling in fraudulent prescriptions for Lortab (hydrocodone). GX 35; Tr. 287–89. The faxnets were dated May 8, 2000, and April 13, 2001. GX 35, at 1–2.

In February 2003, a DEA Investigator interviewed N.F., who admitted to being addicted and to having gone initially to Respondent to “feed her addiction.” GX 70, at 38. N.F. told the Investigator that a pharmacist had called Respondent in N.F.’s presence and told Respondent that he did not want to fill a prescription Respondent had written because he believed N.F. had a drug problem. *Id.* According to the DI’s declaration, Respondent continued to prescribe for N.F. for another sixteen months after receiving the phone call and “never questioned [N.F.] about her medical history.” *Id.* at 39.

N.F.’s first visit with Respondent was on November 13, 2000, after the first faxnet, which alleged that N.F. was engaged in doctor shopping. *See* GX 34, at 1; GX 35, at 1–2. N.F. told Respondent that her vehicle had been rear ended in March 2000 and that she

was experiencing neck, shoulder, and back pain. GX 34, at 1. There is no indication in N.F.’s record that Respondent inquired about her substance abuse history. *See generally id.* at 1–2. N.F. complained of numbness in her left mid-thigh, muscle spasms and headaches. *Id.* at 1. Respondent performed a physical exam, which the Government’s Expert concluded was adequate, and diagnosed her as having a “post acute cervical sprain and acute lumbar sprain. Postpartum.” *Id.* at 2; GX 46, at 10. Respondent issued N.F. a prescription for thirty tablets of Vicodin ES with two refills, gave her samples of Skelaxin, recommended a program of physical therapy, and indicated that she would take Vioxx, which apparently had been prescribed after a knee surgery a year earlier. GX 34, at 2.

According to N.F.’s patient file, later that day, “Rachel from Albertson’s * * * called regarding multiple doctors prescribing Vicodin ES for” her. *Id.* According to the note, Albertson’s “will cancel the refills.” *Id.*³⁹ Notwithstanding this phone call, four days later Respondent gave N.F. a prescription for 30 tablets of Lortab 7.5/500 mg. (1–2 q4h to take as needed but maximum of eight tablets per day), another combination drug which (like Vicodin) contains hydrocodone and acetaminophen, with two refills. *Id.* at 3. Respondent also wrote additional prescriptions for Lortab with two refills on November 28. *Id.* On December 1, however, Albertson’s again called and told Respondent that N.F. wanted an early refill, which Respondent approved. *Id.*

On December 8, Respondent increased the Lortab prescription to forty tablets with two refills. *Id.* at 4. On December 22, Respondent re-issued the Lortab prescription with two refills. *Id.* at 5.

³⁹ The ALJ gave N.F.’s interview with the DI “little weight” because “[n]either N.F. nor the pharmacist testified at the hearing,” and N.F. had a “history of questionable truthfulness, honesty, and completeness” and had “fail[ed] to tell the Respondent of her addiction.” ALJ at 78 n.17. The ALJ also noted that “there is no evidence that the Respondent was made aware of N.F.’s addiction issues during the course of treatment.” *Id.*

I credit N.F.’s interview because the patient file corroborates her story regarding the pharmacist who called Respondent and reported that she was obtaining Vicodin prescriptions from multiple doctors. GX 34, at 2. I also expressly reject the ALJ’s finding that there is no evidence that Respondent was aware of N.F.’s addiction during the course of treating her as it is clear that Respondent had reason to know of N.F.’s potential addiction on the same day as the initial visit when the pharmacist told her that she was a doctor shopper. As for the ALJ’s reasoning that N.F.’s statement is not credible because she “fail[ed] to tell Respondent of her addiction,” one would hardly expect a person who seeks drugs to abuse them to tell a doctor the real reason she wanted the drugs.

Thereafter, N.F. began a pattern of seeking early refills. On January 2, Respondent issued N.F. a prescription for forty Lortab with three refills (with the same dosing). *Id.* While the prescription and refills should have lasted until January 22, on January 16, N.F. complained that she still had severe neck pain and Respondent issued another prescription for forty Lortab 7.5/500 with three refills. *Id.* at 6. However, on January 25, nine days later, Respondent issued a new prescription (again for 40 tablets with three refills) but which increased the strength of the Lortab to 10/500.⁴⁰ *Id.*

From early on in Respondent’s treatment of her, N.F. displayed a pattern of requesting early refills, which Respondent did not appear to notice as she always wrote the prescriptions as requested. For instance, on January 16, 2001, Respondent wrote a prescription for “Lortab 7.5/500 1–2 q6h PRN #40 with 3 refills,” which should have lasted at least twenty days. *Id.* However, on January 25, just nine days later, when N.F. complained that the medication wasn’t “strong enough,” Respondent increased the dose to “Lortab 10/500 #40 with 3 refills,” which should again have lasted twenty days, assuming that the dosing remained the same. *Id.*

However, N.F. returned on February 7, complaining of recent headaches and pain in both her neck and back. Respondent again issued her a prescription for “Lortab 10/500 #40 with 3 refills.” *Id.* On February 16, Respondent issued N.F. another prescription for 40 tablets of Lortab 10/500 with three refills. *Id.* at 7.

On April 25, Respondent switched N.F. from Lortab to Percocet (a drug combining oxycodone and acetaminophen), and approximately two weeks later added Percodan, a drug combining oxycodone with aspirin. *Id.* at 9–10. Four days later, Respondent changed from Percodan to oxycodone 5 mg. and continued to prescribe Percocet. Respondent prescribed both drugs on several occasions. *Id.* at 11–12.

On June 11, N.F. visited Respondent. According to N.F.’s file, she had “suffered [a] burn” in her “right thoracic area,” but did not “remember burning herself.” *Id.* at 12. Respondent continued to prescribe oxycodone and Percocet throughout the summer months. *Id.* at 12–14. Respondent, however, stopped prescribing the Percocet in late July when N.F. complained that it made her sick. *Id.* at 15. By September 11, N.F. was taking 30

⁴⁰ Due to the toxicity of acetaminophen, 4000 mg. is the maximum recommend daily dose. Tr. 403–04.

³⁸ Dr. Hare also noted that J.R. was being prescribed methadone because “it is inexpensive, and yet the methadone was only a small part of the patient’s total opioid intake, particularly as compared to OxyContin.” GX 46, at 13–14.

oxycodone tablets per day, and Respondent switched her prescription to 100 tablets of Roxicodone 30 mg. (q4h PRN). *Id.* at 17.

An entry in N.F.'s patient record for September 19, 2001, indicates that she was to move to Illinois at the end of the week and that she could not fill the Roxicodone prescription because of its cost. *Id.* at 18. On this date, Respondent wrote a prescription for 100 tablets of oxycodone 5 mg. (3–4 q4h PRN). *Id.*

Two days later, N.F. returned. N.F. told Respondent that she was not “moving until next Friday,” and “would like to get Roxicodone.” *Id.* Respondent issued a prescription for another 100 tablets of oxycodone 5 mg. *Id.* On September 27, however, Respondent gave N.F. a prescription for 100 tablets of Roxicodone 30 mg (1–2 q4h PRN). *Id.*

On October 2, N.F. was “back here to pick up her truck.” *Id.* Respondent gave her another prescription for 100 Roxicodone 30 mg. q4h. *Id.*

A note dated October 5 indicates that “[p]atient’s brother to pick up prescription for Roxicodone 30 mg q4h PRN 100.” *Id.* at 18–19. Moreover, a note dated October 9 indicates that N.F.’s cousin was to pick up a similar prescription for another 30 tablets of Roxicodone 30 mg. *Id.* at 19. Another note dated October 12, again indicated that N.F.’s cousin had picked up the prescription. *Id.*

On October 15, N.F. was back in town “to testify for the state” and reported that “[s]he ha[d] moved to Joliet.” *Id.* N.F. reported that she had continued pain but that she wanted to decrease her Oxycodone intake. *Id.* Respondent issued her a prescription for 200 tablets of Roxicodone 5 mg. (2–3 tabs q4h PRN) and indicated that N.F. “will see another doctor in Illinois.” *Id.*

On October 17, N.F. was back to see Respondent and underwent therapy. *Id.* Notwithstanding that just two days earlier N.F. had stated that she wanted to reduce her oxycodone intake, Respondent gave her a prescription for 100 tablets of Roxicodone 15 mg., 2–3 tab q4h PRN. *Id.* The dosing instruction was thus even greater than the dosing instructions of several of the previous prescriptions Respondent had written. *Id.* Notwithstanding N.F.’s claims of having moved to Joliet, she continued to appear at Respondent’s office multiple times each month through May 10, 2002, to obtain prescriptions. *See id.* at 19–33. At no point is there documentation that Respondent questioned N.F. about why she was still coming in for prescriptions if she had moved. *See id.* Instead, she authorized early refills. *See id.* at 18–19.

According to DI Llenas’ Declaration, N.F. told her that “for approximately one month” she had told Respondent “that she was moving to Illinois.” GX 70, at 39. During that time, individuals “pos[ing] as family members” would go to Respondent’s office to obtain refill prescriptions for N.F. *Id.* N.F. did this in order “to obtain early refills, under the guise that the ‘family members’ needed time to mail the prescriptions to Ms. [F.] in Illinois.” *Id.*

On October 17, 2001, in addition to the Roxicodone 15 mg. that N.F. was already taking (“2–3 tabs q4h PRN #100”), Respondent prescribed 30 Vicodin for “dental pain.”⁴¹ GX 34, at 19. There is, however, no evidence that Respondent referred N.F. to a dentist, who could properly diagnose the cause of her condition. Nor, given the Roxicodone that Respondent was prescribing, is it clear why N.F. would need to take Vicodin as well.

On October 19 (two days later), Respondent issued N.F. a prescription for 200 tablets of Roxicodone 15 mg. (1–2 q4h). *Id.* Moreover, on October 24 (five days later), Respondent issued N.F. a prescription for 200 tablets of Roxicodone 5 mg (3–4 tablets q4h). *Id.* On October 26 (two days later), N.F. was back again, complaining of additional symptoms including tingling and numbness, and that her right hand was turning purple. *Id.* Respondent did not conduct a neurologic or vascular exam and instead gave her another prescription for Roxicodone; the prescription was for 50 tablets 30 mg.-strength ½ tab q4h PRN. *Id.* at 20; *see also* GX 46, at 11.

On October 29 (three days later), Respondent gave N.F. another prescription for 100 tablets of Roxicodone 30 mg. q4h. GX 34, at 20. While the prescription should have lasted sixteen days, on November 1, Respondent gave N.F. another prescription (to be filled the next day), for 100 tablets of Roxicodone 30 mg. q4h. *Id.* On November 5, Respondent gave N.F. a prescription for 200 tablets of Roxicodone 5 mg. (3–4 q4h), and indicated in the patient record that N.F. could not fill the prescription because the pharmacy did not have the drug. *Id.* Yet there is no indication that Respondent checked with the pharmacy or asked N.F. to return the prescription. *Id.*

While this prescription should have lasted eight days, on November 7 (two days later) Respondent issued N.F. another prescription for 100 tablets of Roxicodone 30 mg. 1–2 q4h PRN. *Id.* at

⁴¹ Respondent also prescribed penicillin for a dental infection.

21. Five days later (on November 12), Respondent gave N.F. another prescription for 100 Roxicodone. *Id.*

On November 14, N.F., who apparently had not moved to Illinois after all—although at no point does it appear that Respondent questioned her about this—returned to Respondent and reported that she “had a motor vehicle accident at 6:30 this morning” with “increased neck pain.” *Id.* Respondent noted that N.F. “has increased muscle spasm and difficulty sleeping secondary to the motor vehicle accident,” which had occurred earlier that day. *Id.* Respondent gave N.F. a new prescription for 100 Roxicodone 30 mg., to be filled on November 19. *Id.*

On November 19, N.F. reported that she had lost her prescription. *Id.* Respondent noted that she had called TMC pharmacy and that the prescription had not been filled. *Id.* She also indicated that N.F.’s insurance would not cover another prescription if the prescription had already been filled. *Id.* Respondent wrote another prescription for 100 Roxicodone 30 mg. *Id.*⁴²

On November 21 (two days later), N.F. needed more “medications before * * * the weekend.” *Id.* Respondent noted that N.F. had “increased tenderness and muscle spasm” and gave her a prescription for 200 Roxicodone 5 mg. (5–6 tabs q4h PRN). *Id.* at 22. On November 26, N.F. told Respondent that she had “been beaten up by her neighbors over the Thanksgiving weekend” and that “[t]hey stole her medications and her money.” *Id.* Respondent further noted that N.F. “has a police report.” *Id.* It is unclear, however, whether N.F. showed the report to Respondent.

Dr. Hare noted further incidents of suspicious behavior on the part of N.F. For example, on January 24, 2002, N.F. reported that she had taken her children roller skating and had “increased soreness ever since.” *Id.* at 24. Respondent gave N.F. a new prescription for 100 tablets of Roxicodone and increased the dosing from 1–2 tablets every four hours to 3–4 tablets every four hours. *Id.*

Dr. Hare again found that Respondent “inadequately evaluated” the patient and that N.F.’s “condition did not warrant [c]ontrolled [s]ubstance prescriptions.” GX 46, at 12. In addition, Dr. Hare opined that N.F. “was placed on excessive medication and took more than prescribed and [with] no clear

⁴² As Dr. Hare noted, “this does not exclude the possibility that [N.F.] was paying for the prescriptions herself.” GX 46, at 11. Moreover, N.F. could have filled the prescription at another pharmacy.

benefit”; that “[c]hanges were made and new medications added with no explanations”; that N.F. “escalated her use of medication with no clear benefit, and prescriptions were increased to accommodate her”; and that with the “medication amounts and uses patterns such as [N.F.’s], abuse and diversion of these medications ha[ve] to be suspected.” *Id.* Dr. Hare further observed that “[n]o drug screen was done to see if the patient was using these medications, or other medications not prescribed by” Respondent. *Id.*

Respondent’s expert, Dr. Schneider, included N.F. as one of the patients for which there was “evidence of ‘aberrant drug-related behaviors’ which should have been pursued but weren’t.” RX K–1, at 6. As explained above, N.F.’s chart was among those that “showed problems which indicated that [Respondent] needed additional education about obtaining addiction history, careful monitoring, and review of the ‘big picture.’” *Id.*

Indeed, the patient record indicates that Respondent made absolutely no attempt to monitor N.F. even though she received information as early as the day of N.F.’s first visit that she was a doctor shopper. *See* GX 34. In addition, Respondent ignored other evidence of suspicious behavior on N.F.’s part such as her continued visits even when she she had supposedly moved to Illinois, her suffering a second-degree burn but not remembering why, and her claim that her neighbors had beaten her and stolen her medications and money.⁴³

C.O.

C.O. first treated with Respondent on March 5, 1999, complaining of neck and lower back pain from an industrial injury. GX 36, at 1. He was 28 years old. *Id.* His last visit with Respondent was on June 29, 2001. *Id.* at 34.

According to C.O.’s medical record, several weeks before he started treating with Respondent, C.O. had been in an industrial accident during which the brakes on a man-lift failed and the lift hit the ground hard. *Id.* at 1. C.O. went to the emergency room, where x-rays were taken of his lumbar and cervical spines, as well as his right knee; the x-rays were, however, negative. *Id.* The

emergency room gave him a prescription for Vicodin. *Id.*

At the first visit, C.O. complained of severe pain in both his back and neck, with a pins-and-needles sensation in his right leg, including his foot, and a dull aching in his back. *Id.* He also complained of headaches and that his fingers were stiff and numb. *Id.* at 1–2. With respect to the initial visit, the Government’s expert concluded that Respondent’s physical exam was adequate but noted that she had not taken a history of his medication use and possible substance abuse. GX 46, at 12. Respondent prescribed 40 Lortab 7.5/500 with two refills and physical therapy. GX 36, at 2.

On March 10, Respondent noted that C.O. was “complaining of severe neck pain and low back pain”; the next day, she noted that he was “taking 1 ½ of the Lortab 7.5.” *Id.* at 3. Respondent then gave C.O. a prescription for 40 tablets of Lortab 10/500 with two refills. *Id.*

On March 17, C.O. returned to Respondent’s practice and was seen by a Family Nurse Practitioner (F.N.P.). *Id.* According to the progress note, C.O. reported that he was out of medications, needed more, and had gone through 40 Lortab in six days. *Id.* The F.N.P. further recorded that “Patient requesting pain medication refill—he has two refills left. He swears he does not. Asking him to bring in bottle.” *Id.*

On March 19, C.O. returned and saw Respondent. *Id.* C.O. said that he had refilled the Lortab 7.5 two times and that he had no refills on the Lortab 10 even though the progress note for March 11 indicated that Respondent had authorized two refills. *Id.* He also said that he was taking up to 12 Lortab per day. *Id.* At this level, C.O. was exceeding by 2000 mg. the recommended maximum limit of 4000 mg. of acetaminophen per day.

On March 22, C.O. returned and complained of continued pain between his shoulder blades. *Id.* C.O. reported that he had only three Lortab 7.5 mg. remaining. *Id.* The progress note also indicates that C.O. had no refills on the Lortab 10. *Id.* Respondent performed a physical exam and found that C.O. “ha[d] no obvious pain with ambulation.” *Id.* at 4. She also found that he had “generalized tenderness over [his] mid thoracic area and complains of mid back pain with range of motion of the shoulders.” *Id.* Respondent prescribed thirty tablets of OxyContin 20 mg. q8h (1 tablet every eight hours).

C.O. returned on March 26 (five days later), saw the F.N.P., and reported that his back pain was worse. *Id.* The F.N.P. observed that C.O.’s “speech is slightly slurred.” *Id.* She also noted that C.O.

had “just [aken] two OxyContin 20 at 4 p.m. today,” which was twice the dose prescribed by Respondent. *Id.* The F.N.P. physically examined Respondent and did not find anything abnormal. *Id.* The F.N.P. further noted that she would “not refill OxyContin,” but would “speak with” Respondent. *Id.* The same day, Respondent gave C.O. a new prescription for 60 tablets of OxyContin 20 mg. (2q8h). *Id.* at 5. On April 2, Respondent gave C.O. an additional prescription for 60 OxyContin 20 mg. (2q8h). *Id.*

On April 9, C.O. saw the F.N.P. and complained that the “pain medication is not working anymore,” that his neck, shoulder, and the base of his spine were stiff, and that his back felt tight. *Id.* He also reported that he started taking three tablets, three times a day, which was again in excess of the prescribed dose. *Id.* With the exception of the F.N.P.’s finding that C.O.’s mid-back muscles were tense and that he complained of low back pain on forward flexion, the physical exam was normal. *Id.* The F.N.P. further noted that C.O. had “used 390 pain pills in 35 days”; she further recommended that C.O. “decrease pain medication use.” *Id.* at 6. Finally, the F.N.P. noted that she discussed C.O.’s treatment with Respondent and that C.O. should undergo an MRI of his cervical spine. *Id.* There is no indication in C.O.’s file that he went for this MRI. *See generally id.*

On April 12, C.O. saw Respondent and complained of continued pain in his neck and back. *Id.* He also denied “any side effects from the OxyContin” and maintained that it “allow[ed] him to work.” *Id.* Respondent wrote him a new prescription for OxyContin 20 mg., increasing the number of tablets to 100 and the dosing to three tablets every eight hours. C.O. saw Respondent approximately every nine to ten days and complained of stiffness and pain; Respondent continued to issue him the same prescription until his visit of June 16. *Id.* at 7–8. At this visit, Respondent decided to lower the dosing of the OxyContin to 2qam, 3qpm, and 2qhs because three months had passed since he was injured and “he should be able to tolerate a lower dose.” *Id.* at 9. At C.O.’s next visit (June 28), Respondent wrote the same prescription. *Id.*

On July 12, Respondent gave C.O. another prescription for OxyContin 20 mg. *Id.* However, she reduced the quantity to 84 tablets and the dosing to two tablets every eight hours. *Id.* Moreover, on both July 14 and July 19, C.O. reported that he had increased pain since Respondent had lowered the dose; Respondent did not, however, change the dose. *Id.* at 9–10. In the July 19 note,

⁴³ In her findings for NF, the ALJ also relied on Dr. Weinstein’s criticism in her letter that Dr. Hare “describe[d] titration of opioid medications as dosages being ‘dramatically increased,’ ‘aggressive,’ and given in ‘huge amounts,’ without noting subsequent stabilization of dosages.” ALJ at 78. However, Dr. Weinstein’s criticism was not directed specifically at Dr. Hare’s findings on N.F. While Dr. Hare did at one point write that N.F. herself increased “her use of hydrocodone (Lortab by this time) to excessive amounts,” Dr. Hare did not so characterize Respondent’s prescribing. GX 46, at 11.

Respondent also indicated that C.O. had undergone MRIs of both his thoracic and lumbar spines, and that each exam was negative. *Id.* at 10.

On July 26, however, C.O. complained of severe pain. Respondent gave him a new prescription for 130 tablets of OxyContin and increased the dosing to three tablets, three times a day. *Id.* at 11, 13. At the next visit (August 9), Respondent gave C.O. a new prescription for 130 tablets of OxyContin 20mg. (3 q8h). *Id.* at 14. Respondent also gave him a prescription for 30 Percocet, but did not document why. *Id.* Moreover, on August 16, C.O. reported that he was taking four tablets every eight hours. *Id.* Respondent then issued a prescription for 100 tablets and increased the dosing to four tablets every eight hours. *Id.* Respondent also wrote another prescription for 30 Percocet. *Id.* The progress note contains no indication, however, as to whether she asked C.O. about how he was using the Percocet.

On August 23, Respondent gave C.O. a new prescription which increased the strength of the OxyContin to 40 mg., but which reduced the dosing to two tablets every eight hours. *Id.* At C.O.'s next visit (September 1), he again reported that he had increased his dosing from two tablets to three tablets every eight hours; C.O. claimed that three tablets relieved his pain but that two tablets did not. *Id.* Respondent performed a physical exam and noted that C.O. had chronic neck and mid back pain, that he had less lower back pain, and a continued muscle spasm. *Id.* Respondent gave C.O. a prescription for 70 tablets of OxyContin and increased the dosing to three tablets every eight hours; she also gave him a prescription for 60 Percocet. *Id.*

Respondent continued to prescribe OxyContin 40 mg. (3 q8h) until October 22, when she decided to discontinue the drug and instead prescribed 200 tablets of MS Contin 60 mg. (3 q8h). *Id.* at 17. No explanation for the change was given. *See id.* At C.O.'s next visit (which was on October 29), Respondent was back to prescribing OxyContin 40 mg., and gave him a prescription for 200 tablets (3 q8h). *Id.* The October 29 entry does not indicate why Respondent changed back to OxyContin. *Id.*

On November 19, C.O. saw Respondent and reported that the MS Contin did not help with the pain, that he was taking nine tablets a day, and that the pain was "getting worse." *Id.* Respondent performed a physical exam and concluded that C.O. still had neck and back pain secondary to the February accident. *Id.* at 18. Respondent gave him prescriptions for 225 tablets of

OxyContin 40, with a dosing of ten tablets per day (3 qam, 4 qpm, 3 qhs).

On December 10, C.O. again saw Respondent and complained of various pains. In the note, Respondent indicated that C.O. "would like to increase the OxyContin to 4 tabs q8h." *Id.* Respondent performed a physical exam which "show[ed] no obvious pain with ambulation, but he complains of pain." Respondent also found that CO "has tenderness over bilateral cervical paraspinals, bilateral thoracic muscles and bilateral lumbar paraspinals" and "has hypertonicity of spinal muscles." *Id.* Respondent concluded that C.O. had chronic neck, mid-back and lower-back pain" and gave him a new prescription for 252 tablets of OxyContin 40 mg. and increased the dosing to four tablets every eight hours. *Id.* at 19. She also gave him a prescription for 50 tablets of Lortab 10/500 (q6h PRN) for breakthrough pain with two refills. *Id.*

On December 27, C.O. again saw Respondent. While the note for the visit indicated that C.O. "ha[d] been sick with the flu," it did not document that C.O. complained of any pain. *Id.* at 19. Moreover, Respondent performed a physical exam which found that he had "generalized tenderness over bilateral thoracic and lumbar paraspinals." *Id.* C.O., however, "ha[d] no pain with ambulation" and had a "full range of motion of both upper and lower extremities." *Id.* Respondent again concluded that C.O. had "chronic neck pain, mid back pain and low pack pain," and gave him prescriptions for 252 tablets of OxyContin 40 mg. (4 q8h), 50 Lortab 10/500 (q6h PRN) with two refills, and 50 Percocet 10/650. *Id.*

On January 21, Respondent again saw C.O. and stated that "this dose of 160 mg." every eight hours worked and that while he had some stiffness, he was able to "handle the pain as long as he takes the OxyContin." *Id.* He also "denie[d] any mental changes or ever feeling euphoria from the medications." *Id.* Following a physical exam in which she noted that he had general tenderness over his cervical, thoracic and lumbar paraspinals, normal ambulation without pain, and pain with both the cervical and lumbar range of motion, Respondent reissued the three previous prescriptions for 252 OxyContin 40 mg., 50 Percocet 10/650, and 50 Lortab 10/500 with two refills. *Id.*

Three days later, Respondent noted that C.O.'s insurance had "denied coverage for any medications" and that he had undergone "an independent medical examination by [another physician] in early December." *Id.* at 21. Respondent indicated that C.O. had been unable to fill the OxyContin

prescription "because of the cost" and wrote him a new prescription for 50 tablets. *Id.* The note does not indicate, however, what happened to the original prescription or whether C.O. had partially filled it. *Id.*

Respondent continued to treat C.O. through June 29, 2001, and generally prescribed the same drugs (OxyContin 40 mg., Lortab 10/500,⁴⁴ Percocet 5/325⁴⁵) with the same dosing as before. *See generally* GX 36. According to the record, at the September 8, 2000 visit, C.O. reported that he had obtained a job on a cruise ship. *Id.* at 28.

At C.O.'s next visit (October 10), he reported having injured his back and neck on the ship. *Id.* at 28. Respondent's physical exam "show[ed] no obvious pain with ambulation" and found "minimal tenderness over lower cervical paraspinal and over lumbar paraspinals." *Id.* at 29. Respondent also did a neurological exam of his upper and lower extremities; the exams were normal. *Id.* Respondent then issued four prescriptions for OxyContin 40 mg. (each dosing at four tablets every eight hours); the quantities were for 168 on two of the scripts, with 84 and 80 on the remaining two. *Id.* She also gave C.O. a prescription for 350 Lortab 10/500 (q4h PRN) with no refills. *Id.*

On October 31, C.O. returned to Respondent and told her that he would be going on a ship "in a few days and be gone for almost 13 weeks." *Id.* C.O. also told Respondent that he had not filled the two prescriptions for 168 OxyContin. *Id.* She performed a physical exam which found that C.O. had slight stiffness with ambulation and with lumbar range of motion. *Id.* She also found tenderness over his cervical, thoracic and lumbar paraspinals. *Id.* Respondent gave him a prescription for 60 OxyContin 40mg (4 q8h), and 360 Lortab 10/500 (q4h PRN) with three refills. *Id.* Moreover, on November 3, Respondent gave C.O. a prescription for another 60 OxyContin 40 mg. *Id.* at 30.

Five days later (on November 8), C.O. had still not gone on the ship. *Id.* C.O. told Respondent that he still had neck and back pain and that he would "be on the ship until January 22, 2000." *Id.* Respondent performed a physical exam in which she found "minimal tenderness over [his] cervical, thoracic and lumbar spine." *Id.* Respondent issued him four prescriptions for OxyContin 40 mg (4 q8h); the quantities

⁴⁴ Respondent also prescribed Percocet along with Lortab.

⁴⁵ Respondent last prescribed Percocet on June 19, 2000. GX 36, at 26. On several occasions (including January 21, February 9, March 3, March 29, and May 1, 2000), Respondent prescribed both Lortab with three refills, and Percocet. *Id.* at 20–26.

were 372, 280, 144 and 92 tablets. *Id.* Respondent also gave him a prescription for 350 Lortab 10/500 with no refills. *Id.*

On December 22, C.O. returned to Respondent seeking another prescription for OxyContin. *Id.* According to the note, C.O. "ran out of medications this Sunday" and claimed "that he tore up the prescriptions." *Id.* Respondent noted that C.O. "show[ed] very slurred speech," and concluded that "he probably took excess Soma." *Id.* She referred him to the "emergency room or for drug testing." *Id.*

Notwithstanding that C.O. had previously told Respondent that he would be working on a cruise ship until late January, there is no indication that Respondent questioned him as to why he was back so soon. *Id.* Indeed, according to a pharmacy profile which listed prescriptions C.O. had filled at Tucson area pharmacies, he had filled prescriptions for controlled substances on November 21, 22, and 27, as well as December 6, 21, and 22, 2000. GX 37, at 2.

On December 27, C.O. returned to Respondent seeking more OxyContin. GX 36, at 30. Respondent decided to taper C.O. down on the OxyContin to three tablets every twelve hours (for a total of 240 mg. of oxycodone) and wrote him prescriptions for sixteen and eight tablets.⁴⁶ *Id.* at 31. Respondent issued additional prescriptions for OxyContin 40 mg. in smaller quantities with the same dosing instruction on January 3, 8, 15 and 22; at the January 15 visit, Respondent also gave him a prescription for 100 Lortab 10/500 with two refills. *Id.*

On February 5, 2001, C.O. complained that he could not afford OxyContin and would like more Lortab and Soma. *Id.* Respondent told C.O. that there was a daily maximum dose of acetaminophen, which is used in Lortab. *Id.* Instead, Respondent prescribed 200 tablets of Roxycodone 5 mg. (5–6 q3h PRN). *Id.* Based on this prescription, C.O. would have taken a maximum of 240 mg. of oxycodone per day.

On February 14, Respondent gave him a prescription for 100 tablets of Roxycodone 30 mg., but the dosing instructions were not, however, recorded in C.O.'s record. *Id.* Respondent also gave C.O. a prescription for 100 Lortab 10/500 with five refills; this prescription thus authorized the dispensing of 600 tablets. *Id.* Based on the maximum daily recommended safe dose of

acetaminophen of 4000 mgs., the Lortab should have lasted seventy-five days.

By February 20, however, Respondent was prescribing two tablets of Roxycodone 30 mg. every 3 hours, for a total dosage of 480 mg. of oxycodone a day; this was the same daily amount of oxycodone as Respondent had been dosing on December 22.⁴⁷ *Id.* There is no indication in the February 20 note that C.O. had complained of worse pain or that Respondent had examined him. *Id.*

Respondent issued additional prescriptions for Roxycodone 30 mg. on March 9 (50 tablets) and 13 (three 50-tablet prescriptions), although she reduced the dosing to one to two tablets every four hours for a maximum daily dose of 360 mg. of oxycodone. *Id.* On March 27, Respondent gave C.O. not only a prescription for 50 Roxycodone 30 mg., but also for 100 Lortab 10/500 with five refills, even though the previous Lortab prescription (Feb. 14) with refills should have lasted seventy-five days or until late April. *Id.* There is no indication in the March 27 note that Respondent even recognized this.

Respondent issued additional Roxycodone prescriptions and by April 17, was back to prescribing 480 mg. of oxycodone a day. *Id.* On April 27, C.O. was again out of Lortab even though the March 27 prescription with refills should have lasted well into June. *Id.* at 33. Respondent noted that she told him that he could not take more than eight Lortab a day and that there would be "no more acetaminophen containing medications at least for now." *Id.* Respondent, however, gave C.O. a new prescription for 100 tablets of Roxycodone 30 mg., 1–2 tablets every three hours. *Id.*

Respondent continued to prescribe Roxycodone to C.O. and noted on May 11, that he was taking "approximately 16 Roxycodone per day." *Id.* Between May 11 and June 29, Respondent issued eight prescriptions for 100 Roxycodone 30 mg. *Id.* at 33–34. Moreover, on June 8, Respondent indicated that she was "discontinu[ing] Lortab and start[ing] Norco10/325 1–2 q4h PRN # 100 with five refills, maximum twelve per day." *Id.* at 34. This was an even greater dose of hydrocodone than before, and yet the note for June 8 contains no medical reason for issuing the prescription. *Id.*

Respondent issued additional prescriptions for 100 tablets of Roxycodone on June 18, 25 and 29. *Id.* On July 3, C.O. entered drug rehab. *Id.*

Following this entry Respondent wrote a two-page plus narrative of how

she had treated C.O. *Id.* at 35–37. Therein, she maintained that she had closely "watch[ed] his intake of Lortab" because of "the danger" associated with taking too much acetaminophen.⁴⁸ *Id.* at 36. Respondent also wrote:

If [C.O.] did in fact become "addicted" to either Roxycodone or Soma, it was not because I neglected to try to avoid that. He had a true injury, he was truly in pain and he truly required the medication to function. In rare instances, patients become "addicted" to medications that were prescribed appropriately. I do not know if this is the case with [C.O.], since I have had not follow up information on him since June 2001.

[C.O.] suffered no harm or injury as a result of the medications.⁴⁹

Id. at 37.

With respect to C.O., Dr. Hare concluded that Respondent's evaluation was inadequate "to justify prescribing [c]ontrolled [s]ubstances," and that while Respondent had developed "an acceptable treatment plan in 07/99 * * * to wean the patient from medications, * * * the medications were continued and increased." GX 46, at 13. Dr. Hare further noted that Respondent "exerted little control over the prescriptions," that "[t]he patient self-escalated drug doses, and then [Respondent] increased the prescription to match his use." *Id.* Moreover, "[t]here were no consequences for excessive medication over-use, and dangerous amounts were prescribed in general, and toxic doses of acetaminophen were prescribed on several occasions." *Id.* Finally, Dr. Hare opined that "[t]here seemed to be no plan; he was changed from medication to medication, strength to strength, dose to dose with no pattern or explanations." *Id.*

In her report, Dr. Schneider likewise concluded that C.O.'s chart "had evidence of aberrant drug-related behaviors which should have been pursued but weren't." RX K–1, at 6 (int. quotations omitted). Dr. Schneider further noted that C.O. had "received early refills without adequate documentation and explanation," and

⁴⁸ Respondent observed that she "would not allow his daily dose of acetaminophen to go above 4000 mg." GX 36, at 36. *Id.*

⁴⁹ In describing her treatment of C.O., Respondent maintained that it was C.O.'s overuse of Soma which caused him "to have slurred speech on 2 occasions." GX 36, at 36. The first of these incidents was on March 26, 1999, when C.O. told the F.N.P. that he had taken double the dose of OxyContin that was prescribed. *Id.* at 4. Moreover, in the progress notes for this visit, there is no indication that C.O. was either asked about his Soma use or stated that how many tablets he had taken. *Id.* at 4–5. Moreover, while Respondent indicated in the note the second incident of slurred speech that "he probably took excess Soma," Respondent did not follow through as to whether C.O. had undergone drug testing. *Id.* at 30.

⁴⁶ There is no indication as to whether Respondent followed up to determine whether C.O. went to the emergency room or for the drug test.

⁴⁷ On February 20, Respondent gave CO three 50-tablet prescriptions for Roxycodone 30 mg. GX 36, at 32.

that his chart "indicated that [Respondent] needed additional education about obtaining an addiction history, careful monitoring, and review of the big picture." *Id.* (int. quotations omitted).

N.S.

On February 20, 2001, N.S., an eighteen-year-old college student, first presented at Respondent's practice. GX 57, at 1. N.S. complained of lower back pain, "especially since going to [the] University of Arizona," and rated his pain level as "4" on a scale of 0 to 10. GX 57, at 1 & 5. N.S. denied that the "pain radiat[ed] to both lower extremities," "denie[d] numbness and tingling or weakness of both lower extremities," and denied "bowel and bladder problems." *Id.* at 1. N.S. "complain[ed] of problems with getting comfortable" and of pain with sitting. *Id.*

Respondent performed a physical exam. She found that N.S. "has normal ambulation without pain," that he was "able to walk on heels and on toes without pain and hop on either foot without pain." *Id.* Moreover, the "straight leg raising test was negative bilaterally," and N.S. had "no pain with bringing heel to buttocks bilaterally." *Id.* N.S. did, however, have "minimal low back pain with lumbar flexion." *Id.* Finally, Respondent performed a neurological exam of N.S.'s lower extremities and found that he had "normal motor strength, sensation and deep tendon reflexes." *Id.*

Respondent diagnosed that N.S. had a "history of episodes of low back pain," with a "[r]ecent increase in low back pain secondary to poor mattress and poor positioning." *Id.* She recommended a treatment plan of joint mobilization and physiotherapy; she also prescribed 30 tablets of OxyContin 20 mg., one tablet to be taken every twelve hours. *Id.* at 2.

Two days later, N.S. complained that the OxyContin was not working. *Id.* He also told Respondent that he had "doubl[ed] up on [the] dose, but [that] didn't work either." *Id.* Respondent then told him to try three tablets at a time. *Id.*

Four days later, N.S. complained that he still had low back pain and now claimed that his pain level was a six. *Id.* at 2 & 5. He also stated that the "OxyContin helps if he takes 60 mg. and [that] he would like something for breakthrough pain." *Id.* at 2. Respondent then gave him a prescription for 180 tablets of OxyContin 20 mg., with three tablets to be taken every twelve hours, as well as a prescription for 50 tablets of oxycodone 5 mg., one tablet to be taken every four hours as needed. *Id.*

On March 6, N.S. reported that the OxyContin⁵⁰ and physical therapy (including joint mobilization) were helping his pain and that his pain level was a four. *Id.* at 3 & 5. Respondent performed a physical exam which found that "[h]e has slight stiffness with lumbar range of motion." *Id.* at 3. She also found that "[h]e has tenderness and hypertonicity over bilateral lumbar paraspinals, but improvement in lumbar range of motion." *Id.* As her impression, Respondent again indicated: "history of episodes of low back pain. Recent increase in low back pain secondary to poor mattress and poor positioning." *Id.* For N.S.'s treatment plan, Respondent recommended that he continue the physiotherapy and joint mobilization. *Id.* She also recommended that he continue taking the OxyContin (the previous prescription was for a thirty-day supply). *Id.* She also gave him a prescription for 50 tablets of Roxicodone. *Id.* However, she increased the strength of the Roxicodone from five to fifteen mg., and the dosing from one tablet every four hours to one tablet every three hours. *Id.*

The last entry in N.S.'s medical record is dated March 19, 2001, and reports that N.S.'s father called and said that NS "was too sedated at home and obviously took too many." *Id.* at 3. The father also reported that N.S. "has history of depression." *Id.*

In an interview with a DEA Investigator, N.S. admitted that he had gone to Respondent "in order to obtain OxyContin prescriptions." GX 70, at 39. N.S. also told the Investigator that "[h]is primary purpose was drug seeking," and that "his back pain was only secondary." *Id.*

N.S.'s father confirmed to the DI that he had called Respondent and expressed his concern about his son's being overly medicated and having "nod[ded] out in a conversation." *Id.* at 39. According to N.S.'s father, Respondent stated that because his son "was of legal age, he could make his own decisions [and] that she had every right to prescribe whatever medications she deemed necessary." *Id.* at 39-40. Thereafter, N.S.'s father persuaded him to stop seeing Respondent. *Id.* at 40.

Dr. Hare concluded that Respondent had "reasonably evaluated" N.S. GX 46, at 15. He also concluded the plan of care was reasonable "with the exception of the medication [she] prescribed." *Id.* According to Dr. Hare, "[b]ased on [her] findings, there seemed to be no indication for opioids, and certainly not

* * * in the aggressive doses she prescribed." *Id.*

Dr. Hare also noted that while N.S. "had denied taking previous medications[,] he "rapidly self-escalated the medications to a large amount." *Id.* Dr. Hare further explained that "[i]n a patient not tolerant to opioid, this dose of OxyContin, coupled with the minimal findings for a pain problem, would not be well tolerated and could have fatal consequences. The fact that the patient tolerated these large doses * * * indicated that he was not opioid-naïve, or he was not taking the medication." *Id.*

Finally, Dr. Hare observed that N.S.'s "minimal response to a rather large initial dose would raise serious questions about opioid responsiveness of the pain problem." *Id.* Continuing, Dr. Hare explained that N.S.'s "insistence on escalating the dose would indicate an effect sought for mood or a medication-abuse situation." *Id.*

In her testimony, Respondent acknowledged that N.S.'s father had called her and expressed his concern that his son was taking excessive medication. Tr. 2173. Respondent did not respond to any of Dr. Hare's observations regarding the medical appropriateness of her prescribing OxyContin to N.S. *Id.* at 2172-73.

F.L. and B.L.

F.L. and B.L. were father and son. The records in evidence document Respondent's treatment of F.L. between August 16, 1999 and March 30, 2001, shortly before his death on April 17 due to complications from diabetes. See GX 49. The record does not, however, reflect when F.L. began seeing Respondent. See *id.* at 1.

In addition to having diabetes, F.L. was a recovering alcoholic. Tr. 2123. He had chronic pancreatitis and a lumbar spine condition; his diabetes had led to a below-the-knee amputation of one of his legs. *Id.* Respondent treated F.L. with a variety of drugs including large doses of OxyContin and Oxy IR. For example, on August 16, 1999, Respondent gave F.L. prescriptions for: (1) 1200 tablets of OxyContin 40 mg., twenty tablets to be taken every twelve hours; (2) 4080 tablets of Oxy IR, with seventeen tablets to be taken every three hours; (3) 140 Percocet; and (4) 200 Percodan. GX 49, at 1. On both February 21 and March 30, 2001, Respondent gave F.L. prescriptions for: (1) 1320 tablets of OxyContin 40 mg., with 22 tablets to be taken every twelve hours; (2) 4800 tablets of Oxycodone IR, with twenty tablets to be taken every three hours; (3) 280 Percocet, and (4) 400 Percodan. *Id.* at 15. The note for March

⁵⁰On March 2, N.S. complained that the OxyContin was causing "slight nausea." GX 57, at 2.

30 indicated that the script for 4800 tablets of Oxycodone IR was to be filled through the "PAP program";⁵¹ the note also indicates that Respondent gave F.L. an additional prescription for 500 tablets of this drug "to fill locally" and an additional prescription for 280 Percocet.⁵² *Id.* The prescriptions Respondent issued to F.L. totaled approximately 7,000 dosage units a month.⁵³

In October 2000, Respondent also commenced to treat B.L. (F.L.'s son) in October 2000 for Attention Deficit Disorder and an eating disorder. GX 50, at 1–2. Respondent prescribed several controlled substances including Ritalin and Dexedrine (both stimulants) to him. *Id.* at 1–2.

On April 23, 2001 (six days after F.L.'s death), B.L. visited Respondent. *Id.* at 4. During the visit, Respondent gave B.L. a prescription for 200 tablets of Dexedrine 10 mg. *Id.* at 4–5. In her testimony, Respondent maintained that she had questioned B.L. as to what had happened to the last shipment of OxyContin from the PAP to his father. Tr. 2126. (In her testimony, Respondent did not address whether she questioned B.L. regarding the other PAP prescription—for 4800 tablets of Oxycodone IR). According to Respondent's testimony, B.L. "didn't really answer [her], and [she] didn't know." Tr. 2126. Continuing, she added that "I never got an answer from him what [as to] what happened," and in any case, "I didn't know when that last shipment came," and did not "know how to contact" the company (Purdue Frederick).⁵⁴ *Id.* Several months later, B.L. was hospitalized for drug addiction or dependence. GX 50, at 5.

In her plea agreement, Respondent admitted that during B.L.'s April 23 office visit, she had prescribed to him 200 tablets of Dexedrine 10 mg. and that

after B.L. "informed [her] that he had accepted delivery of a prescription for his recently deceased father, FL, another patient of [hers,] in order to possess the prescribed controlled substance * * * OxyContin 40 mg." GX 6A, at 7. Moreover, in the agreement, Respondent admitted that she "upon learning this information from * * * B.L., [she] did knowingly * * * fail to rescind the prescriptions for Dexedrine for B.L."⁵⁵

Respondent did not document her discussion with B.L. regarding his father's OxyContin in his medical record. GX 50, at 4–5; Tr. 2360. While Respondent admitted that this was a shortcoming, she claimed she did not document the "diversion" because she lacked information to conclude that a diversion had taken place. Tr. 2359–60. I find, however, that Respondent's admission as part of the plea agreement precludes the relitigation of the issue of whether she knew that B.L. had obtained the OxyContin tablets dispensed pursuant to his father's prescription.⁵⁶

W.O. and J.O.

W.O. and J.O. were husband and wife. Respondent began treating W.O. in September 2000 for neck and low back pain from two motor vehicle accidents, one in June 2000 and the second in August 2000. GX 53, at 1. She began treating J.O. in October 2000 for neck and low back pain from a motor vehicle accident of September 2000. GX 51, at 1. At the initial visit of each, Respondent prescribed Percocet. GX 51, at 2; GX 53, at 2. Respondent also prescribed OxyContin and Soma to both J.O. and W.O. at numerous visits.⁵⁷

On November 13, 2000, J.O. saw Respondent and reported that their house had been burgled and that all of her and W.O.'s medications had been

stolen. GX 51, at 4. J.O., however, brought a police report with her. *Id.* Respondent wrote a replacement prescription for 60 tablets of OxyContin 40 mg., with one tablet to be taken every eight hours.⁵⁸ *Id.* While this prescription should have lasted twenty days, only four days later, Respondent gave J.O. another prescription for 21 tablets of OxyContin 40 mg, as well as 60 tablets of Oxycodone IR (1–2 tablets every four hours for breakthrough pain). *Id.* Moreover, on November 21, after only four more days, Respondent gave J.O. a prescription for another 100 tablets of OxyContin 40 mg., with the same dosing of one tablet every eight hours. This was followed by additional prescriptions for OxyContin 40 mg. December 20 (100 tablets); December 29 (50 tablets), January 12 (100 tablets of OxyContin 80 mg.). *Id.* at 5. Throughout the next four months, Respondent prescribed to J.O. OxyContin and either Oxycodone IR, Percocet, or Oxycodone.⁵⁹

On November 13, 2000, Respondent also saw W.O., performed a physical exam on him, and gave him a prescription for 100 tablets of Percocet. GX 53, at 5. Later that day, she wrote a replacement prescription for 100 Percocet in W.O.'s name, (which she apparently gave to J.O.) based on J.O.'s report that their medications had been stolen. *Id.* There is no indication, however, that Respondent asked J.O. about what time the robbery had

⁵⁸ Respondent also issued to W.O. prescriptions for Percocet, oxycodone 5 mg. and Oxyfast 20 mg./ml., and Roxicodone 30 mg. at various visits. After being on Roxicodone for several months, W.O. complained that it was expensive, and Respondent started prescribing methadone. GX 53, at 17. On September 21, W.O. also complained about the cost of Dilaudid; Respondent discontinued prescribing the drug and increased the methadone. *Id.* at 19. However, on November 1 and 14, she again prescribed Dilaudid, only to stop prescribing the drug at the November 26 visit. *Id.* at 20. However, while Respondent had increased the dosing of methadone when she initially discontinued the Dilaudid, *id.* at 19; she did not decrease the methadone dosing when she resumed prescribing the Dilaudid. *Id.* at 20.

As for Percocet, on October 3, Respondent issued W.O. a prescription for 300 Percocet "to fill October 20." *Id.* Yet on October 19, she issued W.O. another prescription for 300 Percocet. *Id.* at 19–20. The file contains no explanation as to why the latter prescription was needed.

⁵⁹ Here again there were frequent instances in which Respondent issued new prescriptions when J.O. should have had ample medication remaining from previous prescriptions. For example, on March 9, 2001, Respondent gave J.O. a prescription for 200 tablets of Roxicodone 30 mg., with one tablet to be taken every three hours. GX 51, at 14. While this prescription should have lasted twenty-five days, on March 21 (only twelve days later), Respondent gave J.O. a prescription for another 100 tablets with the same dosing. *Id.* at 15. And while these two prescriptions should have lasted until approximately April 15, Respondent gave her another prescription for 100 tablets on April 3. *Id.* at 16.

⁵¹ While the note for F.L.'s last visit does not indicate that prescription for 1320 tablets of OxyContin was to be filled through the PAP program, an earlier note indicated that F.L. was "on [the] PAP program for the OxyContin and Oxycodone IR." GX 49, at 3. I therefore find that the oxycodone prescription was also to be filled by PAP.

⁵² The Government's Expert did not discuss Respondent's prescribing to F.L. in either of his reports, see GX 46 & 46A. Nor did he testify regarding Respondent's prescribing to him. See generally Tr. 144–229.

⁵³ F.L.'s patient record is devoid of any evidence that Respondent subjected him to pill counts or drug screens, even though on several occasions he stated that he had lost medications or prescriptions. See generally GX 49.

⁵⁴ Several months earlier, however, Respondent had contacted the same PAP (Purdue Frederick) with respect to another patient J.R., after his application was denied. See GX 24, at 22–24. As the record indicates, Respondent knew the phone numbers.

⁵⁵ In the plea agreement, Respondent agreed that these "facts accurately describe my conduct in connection with the offenses to which I am pleading guilty." GX 6A, at 6.

The incident involving B.L. was the second of the four counts of Accessory After the Fact to Possession of Controlled Substances by Misrepresentation, Fraud, Forgery, Deception or Subterfuge" to which Respondent pled guilty. See GX 6A (Plea Agreement; citing 18 U.S.C. 3 & 21 U.S.C. 843(a)(3)).

⁵⁶ The medical record does show, however, that Respondent did not prescribe any more controlled substances to B.L. after the April 23 visit.

⁵⁷ Respondent prescribed OxyContin 20 mg. to J.O. at her initial visit, GX 51, at 2; she started prescribing OxyContin 40 mg. to both J.O. and W.O. a week after their first visits. GX 51, at 1–2; GX 53, at 1–3. In early November, Respondent increased the dosing of the OxyContin from one tablet every twelve hours to one tablet every eight hours for both J.O. and W.O. without providing any explanation in their medical records as to why doing so was medically necessary. See GX 51, at 2 & 4; GX 53, at 4–5.

occurred and whether W.O. had even had time to fill the first prescription she wrote on that day.

Thereafter, on November 17, Respondent gave W.O. a prescription for 21 tablets of OxyContin 40 mg (q8h—a week's supply), and 60 tablets of oxycodone (1–2 q4h). *Id.* Respondent wrote W.O. additional prescriptions for 100 tablets of OxyContin 40 (q8h—a thirty-three day supply) on November 20, as well as on December 8 and December 15. *Id.* at 7. On January 8, 2001, she doubled the dosing and gave him a prescription for 100 tablets of OxyContin 80 (q8h). *Id.* at 9. On January 18, she issued another prescription for 100 tablets of OxyContin 40 and doubled the dose to two tablets every eight hours; yet, on January 31, the dosing of the prescription was back to one table of OxyContin 40 every eight hours. *Id.* at 11. Moreover, on February 12, while W.O.'s low back pain was then a "zero," she gave him another prescription for 100 tablets of OxyContin 40 and increased the dosing back to two tablets every eight hours. *Id.* at 13.

On May 14, 2001, Respondent switched W.O. from OxyContin to Dilaudid because of the former's cost, GX 53, at 17; on May 18, 2001, she did the same for J.O. GX 51, at 17. At their respective visits, Respondent wrote W.O. prescriptions for Dilaudid 8 mg. "2 tabs QID # 100" and 300 Percocet; she wrote J.O. prescriptions for Dilaudid 4 mg. "4 tabs QID #200," as well as for 100 Roxicodone (1–2 q3h) and 200 Percocet. GX 53, at 17; GX 51, at 17. Moreover, on June 25 and 26, Respondent started prescribing methadone 10 mg, with four tablets to be taken four times a day, to both J.O. and W.O.⁶⁰ GX 51, at 18; GX 53, at 17.

On November 9, Respondent wrote J.O. a prescription for 200 Percocet q4h PRN, which was to be filled on November 14 (along with prescriptions for Dilaudid and Methadone). GX 51, at 20. However, on November 15, 2001, W.O. (J.O.'s husband) came to Respondent's office to pick up a replacement prescription for the November 9 prescription, which had been altered. *Id.* W.O. "insist[ed] that the] prescription was ripped in his pocket even though the other 2 prescriptions were unripped." *Id.* Respondent had the pharmacy mail the prescription to her and found that the "fill date of November 14 was obviously

torn out." *Id.* Respondent did not write a replacement prescription. *Id.*

On November 21, J.O. went back to Respondent and asked for a replacement prescription for the Percocet. *Id.* Respondent "explained "the modification of prescription and that it was illegal." *Id.* J.O. claimed that she knew nothing about the modification of the prescription and that it was W.O. who had picked it up and dropped it off at the pharmacy. *Id.*

The notation for this visit also states that Respondent had "received anonymous call that [J.O.] selling Percocet." *Id.* Respondent told J.O. that she "would not and could not" write controlled substance prescriptions for her anymore. *Id.* at 21. Respondent placed J.O. on a tapering schedule for methadone and did not prescribe other controlled substances thereafter. *Id.* However, at J.O.'s very next visit, December 3, 2001, J.O. "had more pain on the Methadone only." *Id.* Respondent then abandoned the plan to taper J.O. off the methadone and increased her dose. *Id.*

On March 4, 2002, J.O. brought to Respondent a consent agreement she had entered into with the State Nursing Board. *Id.* at 22. Apparently, the Nursing Board had initiated a disciplinary proceeding against J.O. because she had abused medications and taken some from a nursing home at which she worked. *Id.* Under the Consent Agreement, J.O. needed to have Respondent "notify the nursing board about what medications she is on." *Id.* At the visit Respondent gave J.O. a prescription for 600 methadone 10 mg. *Id.* at 22.

On March 12, J.O. appeared "need[ing] half of [the] methadone prescription because she gave [W.O.] half of them."⁶¹ *Id.* Respondent obliged and issued her a prescription for 300 tablets of methadone. *Id.* Respondent further noted that that she and J.O. had "discussed problems with [W.O.], but [Respondent] didn't tell her what he did." *Id.* According to W.O.'s patient file, on February 27, 2002, Respondent had received a phone call from G.A. stating that W.O. had stolen approximately 100 OxyContin tablets from him. GX 53, at 21.

On April 16, Respondent wrote a letter to the Arizona State Board of Nursing, listing J.O.'s medications. GX 51, at 24. Notwithstanding the report she had previously received that J.O. was selling her medication, the incident

with the torn prescription, and J.O.'s having admitted to giving half of a methadone prescription to W.O., Respondent wrote that she was "aware of [the] history of this nurse's diversion of drugs in the past, but there is no evidence of continuation of this behavior." *Id.*⁶²

With respect to her prescribing to W.O. and J.O., Respondent testified that after receiving the phone call which reported that J.O. was selling Percocet, she stopped prescribing the drug to her and prescribed methadone to her, which she maintained has a low risk of abuse and diversion, Tr. 2162, notwithstanding its inclusion on schedule II, which indicates that it "has a high potential for abuse." 21 U.S.C. 812(b)(2)(A). She also maintained that she had stopped treating W.O. after she received the phone call from G.A. Tr. 2162. While Respondent testified that J.O. had told her she was going to get a divorce, *id.*, J.O.'s file indicates that she had given half of her methadone to W.O. after she told Respondent that she had left him. GX 51, at 22. Moreover, Respondent did not explain why she subsequently wrote the Nursing Board that there was no evidence that J.O. was continuing to divert drugs. *See* Tr. 2160–63.

There is likewise no evidence that Respondent attempted to monitor J.O. through such measures as pill counts and drug screens after receiving the report that she was selling her controlled substances. Moreover, the medical record contains no documentation that Respondent counseled J.O. as to the illegality of her giving her methadone to W.O.

M.H., P.H., and A.B.

P.H. started seeing Respondent in January 1999 for low back pain, which she had suffered for six years after her "dog knocked her off the couch while she was sleeping." GX 55, at 1. A.B., who lived with P.H., first saw Respondent on November 27, 2000, complaining of right leg pain. *See* GX 56, at 1; Tr. 2129. M.H., the mother of P.H., initially treated with Respondent in July 2001, suffering left thoracic pain at the time. GX 54, at 1; Tr. 2129. M.H. had undergone lumbar surgery in 1989. GX 54, at 1.

Respondent initially treated P.H. with Percocet and a non-controlled muscle relaxant (first Skelaxin, then Flexeril, and then Robaxin), as well as physical therapy. GX 55, at 2 & 5. On April 7, 1999, P.H. saw Respondent and told her

⁶⁰ On July 17, Respondent doubled J.O.'s dose of methadone to eight tablets, four times a day. GX 51, at 18. There is, however, no indication in J.O.'s patient file explaining the basis for doing so. *See id.*

⁶¹ On February 25, W.O. had picked up a prescription for 600 tablets of Methadone. GX 53, at 21. W.O. did not return to Respondent's office after that.

⁶² This was the fourth count of diversion in the plea agreement, which Respondent failed to report to law enforcement authorities. *See* GX 6A, at 8.

that “her Percocet was stolen approximately 2 weeks ago, and [that] she has only had Darvocet N100 to take for the past 2 weeks.” *Id.* at 4. While Respondent had not prescribed Darvocet (a schedule IV controlled substance, see 21 CFR 1308.14) to P.H., there is no indication that Respondent asked P.H. from whom she had obtained this drug. *Id.* at 7–8.

Throughout the first six months that Respondent treated P.H., she prescribed Percocet and muscle relaxants. See *id.* at 1–6. On September 1, 1999, Respondent noted that “[t]he OxyContin 10 # 60 made her nauseated.” *Id.* at 6. P.H.’s record contains no indication as to what date she prescribed OxyContin to her. *Id.* At this visit, Respondent wrote P.H. another OxyContin prescription as well as a prescription for 250 Percocet. *Id.* at 7.

On May 12, 2000, a pharmacist called Respondent and told her that two days earlier P.H. had filled a prescription for 42 Percocet which had been issued by Dr. K., her primary care physician. *Id.* at 11. While at P.H.’s next visit (June 12), Respondent questioned her about the incident,⁶³ on or about October 10, Respondent received another call from a pharmacy which reported that every two weeks, P.H. was obtaining 84 Vicodin tablets from Dr. K. *Id.* at 13.

Once again, there is no indication that Respondent contacted Dr. K. to coordinate their prescribing. Moreover, on October 10, Respondent changed the prescription from 250 tablets of Percocet to 90 tablets of OxyContin 20 mg., one tablet to be taken every eight hours.⁶⁴ *Id.* at 13.

P.H. returned nine days later and Respondent noted that she had “severe tenderness over [her] lumbar muscle area.” *Id.* at 13. While Respondent found that P.H. “has pain and stiffness with ambulation,” a finding which was essentially the same as at the previous visit (“pain with ambulation” and “stiffness and pain with lumbar range of motion”), she concluded that P.H. now had “severe low back pain” and increased the strength of the OxyContin four-fold to 80 mg. and prescribed 90

tablets, with the same dosing of one tablet every eight hours. *Id.*

On November 9, P.H. again saw Respondent. *Id.* at 14. Respondent noted that her physical exam showed less pain and stiffness with ambulation and that P.H. had less swelling over her lower lumbar area. *Id.* Respondent gave her another prescription for 90 tablets of OxyContin 80 mg. (q8h), along with Robaxin. *Id.* On November 14 (five days later), P.H. was back and complaining that the OxyContin was “causing severe drowsiness” and “increased swelling over [her] lumbar spine.” *Id.* Respondent now found that P.H. had “severe pain with ambulation,” “swelling over lower lumbar spine,” and “severe tenderness over [her] lumbar spine.” *Id.* Respondent concluded that P.H. had a “poor response to long acting opioids” and told her to discontinue the OxyContin. *Id.* She then gave P.H. prescriptions for 200 Percocet and 200 oxycodone 5 mg. (2–3 q4h) PRN. *Id.* at 14–15.

Respondent issued additional prescriptions for 200 Percocet on December 11, and January 9, and for 200 oxycodone 5 mg. (with the same dosing of 2–3q4h) on December 11, January 9, and January 22. *Id.* at 14–15. On February 6, Respondent noted that while P.H. was “still with low back pain,” she was “doing better in general” and that the “physical exam shows she is in less distress with less pain with ambulation.” *Id.* at 15. Respondent gave her a prescription for 200 Percocet as well as 100 Roxicodone. *Id.* The Roxicodone prescription was, however, for the 30 mg. strength and gave a dosing of one tablet every eight hours and thus increased the amount of the drug from a maximum of 90 mg. (18 5 mg. tablets) to 240 mg. (eight 30 mg. tablets) per day. *Id.*

On February 28, Respondent gave P.H. additional prescriptions for both 200 Percocet and 100 Roxicodone 30 mg., and on March 8, she gave P.H. an additional prescription for Roxicodone 30 mg. *Id.* at 16. On March 20, Respondent noted that P.H. “continues on medications with good pain relief,” that she had only “slight swelling” and had “slight pain with ambulation.” *Id.* Respondent gave P.H. new prescriptions for 200 Percocet and 100 Roxicodone 30 mg (q3h); she also added a prescription for 100 oxycodone 5 mg. (3–4 q3h). *Id.*

On March 27, P.H. was complaining of severe pain, that her hips were “locked up,” that it was “the third time in less than 2 weeks that she had bad pain,” and that “the Roxicodone isn’t working.” *Id.* Respondent performed a physical exam and noted that P.H. had “stiffness antalgic wide based ataxic gait,” “tenderness over [her] bilateral

lumbar paraspinals,” “swelling” over [her] “lumbar spines,” and “pain with lumbar range of motion, which is limited.” *Id.* Respondent diagnosed P.H. as having chronic low back pain and doubled the dosing of the Roxicodone 30 mg. to two tablets every three hours. *Id.* at 16–17. Three days later, Respondent noted that P.H. had blacked out and “has been having a lot of blackouts.” *Id.* at 17.

On April 2, Respondent gave P.H. another prescription for 100 Roxicodone 30 mg. with the same dosing. *Id.* At the next visit (April 11), P.H. also complained of right calf pain. *Id.* Respondent diagnosed P.H. as having a right calf muscle spasm (in addition to low back pain) and gave her prescriptions for 100 Roxicodone 30 mg., 200 Percocet, and 100 oxycodone 5 mg. *Id.* Respondent issued additional prescriptions for Roxicodone 30 mg. on April 30 and May 3, for oxycodone 5 mg. on April 24, and for Percocet on May 3. *Id.* at 17–18.

On May 15, P.H. again saw Respondent and indicated that she had an appointment to see a dermatologist, Dr. H., in two weeks for a condition (bulbous pemphigoid) which had been diagnosed by a physician at an emergency room. *Id.* at 18. Respondent’s physical exam indicated that P.H. had a “severely antalgic gait,” and “open sores over burning and both lower extremities and [a] severe sore over [her] right foot.” *Id.* Respondent diagnosed P.H. as having bulbous pemphigoid and chronic low back pain, and gave her a prescription for 500 tablets of Roxicodone 30 mg., with five tablets to be taken even four hours as needed. *Id.* Respondent thus increased the dosing of Roxicodone from approximately 480 mgs. to 900 mgs. of oxycodone per day. *Id.* There is no evidence that Respondent ever consulted with the dermatologist that P.H. saw for the condition. See *id.* at 18–19. According to the Government’s expert, these “superficial skin lesions * * * would not be justification for anything other than mild analgesics.” GX 46A, at 9.

Throughout June and July, Respondent continued to prescribe approximately 900 mgs. per day of Roxicodone. GX 55, at 18–19. She also gave P.H. prescriptions for 200 Percocet on June 4, June 18, July 2, and July 18. *Id.* As Dr. Hare noted with respect to the Percocet prescriptions, a review of P.H.’s “prior prescriptions would [have] indicate[d] that she was using 14 tablets/day which could result in acetaminophen toxicity, [and] the Percocet would be totally unnecessary with the amount of Roxicodone the patient was receiving.” GX 46A, at 9.

⁶³ According to the note, P.H. told Respondent that she had obtained the prescription from Dr. K. because she was not going to see Respondent “for a few more days.” GX 55, at 11. P.H. also told Respondent that she did not fill the latter’s prescription until May 15. *Id.* There is, however, no indication that Respondent contacted Dr. K. to determine the extent to which P.H. was obtaining other prescriptions or to coordinate their prescriptions. *Id.*

⁶⁴ None of the progress notes preceding this date indicate what the dosing of the Percocet was. The first note indicating the dosing is not dated until April 11, 2001. GX 55, at 1–17.

Respondent initially treated A.B. for right leg pain with oxycodone (dosage strength not indicated) and Percocet, as well as Zanaflex, a non-controlled drug. GX 56, at 1–2. Respondent's initial evaluation indicated that A.B. was already taking Percocet and Robaxin (a non-controlled drug), *id.* at 1, but Respondent "did not document the effects of the medications." GX 46A, at 10. Nor is there any indication that she contacted the physician who had presumably prescribed these drugs to A.B. to obtain records of prior treatment. GX 56, at 1–2. Moreover, while A.B. reported that an MRI of her lumbar spine had indicated that she had a herniated nucleus pulposus, A.B. did not know at what level the disk was, *id.* at 1, and there is no evidence that Respondent even attempted to obtain the MRI report. *Id.*; *see also* GX 46A, at 10.

On January 9, 2001, Respondent added OxyContin 10 mg. and prescribed 60 tablets, with one tablet to be taken every twelve hours (and which should have lasted 30 days). GX 56, at 2–3. She also gave A.B. prescriptions for 200 Oxycodone 5 mg. and 100 Percocet. *Id.* Respondent further noted that there would be a "recheck in one month." *Id.* Yet only thirteen days later, A.B. was back and complaining of a severe migraine, right leg pain, and a severe inverting of her foot. *Id.* at 3. Respondent gave her additional prescriptions for 200 oxycodone 5 mg. and 100 Percocet. *Id.* Respondent also gave her another prescription for 60 OxyContin and doubled the strength of the drug to 20 mg. *Id.* However, the dosing remained the same, and thus the OxyContin should have lasted thirty days.

On February 6, A.B. returned. *Id.* While the note for this visit indicated that A.B. had pain with right straight leg raising test, there is no other indication as to the extent of A.B.'s pain and there is no indication that she was still complaining of migraines. *Id.* at 3–4. Respondent gave A.B. a new prescription for 60 tablets of OxyContin 20 mg., and increased both the Percocet and Oxycodone prescriptions to 150 and 300 tablets respectively. *Id.* Again, there is no indication as to why A.B. already needed another OxyContin prescription.

On February 21, A.B. apparently called Respondent and reported that she had undergone a lumbar laminectomy a week earlier, that she was in severe pain, and had only been given 20 Percocet for post-operative pain. *Id.* Respondent gave her prescriptions for 60 tablets of OxyContin (doubling the strength to 40 mg.), with one tablet to be taken every twelve hours, and 200

tablets of oxycodone 5 mg. *Id.* As the Government's Expert noted, there was "no indication that the patient had already used all of the previous OxyContin prescription and this was not accounted for by" Respondent. GX 46A, at 11. Moreover, on February 28, Respondent gave A.B. another prescription for 150 tablets of Percocet. GX 56, at 4.

On March 9, Respondent gave A.B. additional prescriptions for 60 OxyContin 40 mg. and 200 oxycodone 5 mg. *Id.* at 4. Again, even though the previous OxyContin prescription should have lasted thirty days if taken as prescribed and only sixteen days had passed, there is no indication that Respondent questioned A.B. as to why she needed more of the drug. *Id.*

On March 20, A.B. returned. *Id.* At this visit, Respondent noted that A.B. had supination of her right lower extremity with ambulation and that muscle spasm had returned there; she also noted that A.B. had chronic low back pain. *Id.* Respondent then gave A.B. a prescription for 60 tablets of OxyContin and doubled the strength from 40 to 80 mgs. *Id.* at 5. She also gave A.B. prescriptions for 200 oxycodone 5 mg. and 150 Percocet. *Id.*

In April, Respondent received a note (apparently from the surgeon who performed the laminectomy) that A.B. was complaining that the symptoms she had before her back surgery had returned. *Id.* Moreover, her surgeon was going to repeat an MRI and "get an EMG/NCV of [her] right lower extremity to rule out neuropathy." *Id.* However, according to a June 4 note, the MRI of her brain was normal. *Id.* at 6. A.B. was to also get another MRI of her lumbar spine, but there is no indication in the record that she did so. *Id.*

At the June 4 visit, Respondent noted that A.B. "complains of problems with sleeping, and would like to take 2 OxyContin at night instead of 1." *Id.* Respondent issued her a prescription for 90 tablets of OxyContin 80 mg., with one to be taken in the morning and two to be taken at night (also a thirty-day supply if taken as prescribed). *Id.* On June 26, Respondent increased the dosing to two tablets every twelve hours of OxyContin (120 tablets or a thirty-day supply). *Id.* at 7. At both June visits, she also gave A.B. prescriptions for 100 tablets of Roxicodone 30 mg. and 150 Percocet. *Id.* at 6–7. On July 18, Respondent gave A.B. new prescriptions (in the same quantity and dosing) for each of these three drugs. *Id.*

At M.H.'s initial visit on July 23, 2001, Respondent diagnosed her as having shingles and gave her prescriptions for 60 tablets of both

OxyContin 20 mg. (q12h) and Percocet (1–2 q4h). GX 54, at 1. On July 27, M.H. returned to Respondent and reported that her "[i]nsurance wouldn't cover OxyContin or MS Contin." *Id.* at 2. There is no indication in the file that Respondent requested that M.H. return or destroy the OxyContin prescription. *Id.* Respondent did, however, give her a prescription for another 100 Percocet. *Id.*

On July 30, 2001, a local pharmacist called Respondent and told her that the day before A.B. had picked up an OxyContin prescription for M.H. and paid cash for the drugs. GX 56, at 7. The pharmacist observed A.B. walk past M.H.'s car to a silver sports car and place the unopened bag through the window of the sports car. *Id.* at 7–8.

The pharmacist further told Respondent that A.B. had come to the pharmacy the day after the incident to pick up a prescription. *Id.* at 8. The pharmacist asked A.B. "if she knew anyone who owned a silver sports car." *Id.* A.B. answered "no," but when the pharmacist recounted the incident of the day before, A.B. stated that "her mother said that that was her nephew, and that [A.B.] just forgot." *Id.* According to A.B.'s patient record, A.B. "told the pharmacist not to make a big deal about it." *Id.*⁶⁵

M.H. returned to Respondent's office on August 10. GX 54, at 2. According to the note for the visit, M.H. explained that it was P.H. and not A.B. who had passed the OxyContin to the silver car and that the drugs had been for M.H.'s nephew, who she claimed had pain. *Id.* M.H. also told Respondent that she was "never going to buy the OxyContin, because it [was] too expensive," and that her nephew had "paid for it." *Id.* M.H. "promised this would never happen again, and she understood the severity of the situation." *Id.*

On August 3, P.H., who Respondent was treating for both knee and back pain with Percocet and Roxicodone, saw Respondent. GX 55, at 20. According to the progress note, P.H. "ha[d] given Percocet to her mother and sister and wants more Percocet." *Id.* While Respondent did not issue any prescriptions at this visit, there is no indication that she counseled P.H. regarding this. *See id.*

On August 5, both P.H. and A.B. were in an auto accident. GX 55, at 20; GX 56, at 8. On August 17, P.H. again saw Respondent, who again concluded that she had a knee injury and low back pain. GX 55, at 20. Respondent again prescribed Percocet (200 tablets, 1–2

⁶⁵This was the first count in the plea agreement. *See* GX 6, at 7.

q4h), and Roxicodone 15 mg. (1000 tabs 10 q4h). *Id.* Notably, while this was P.H.'s first visit since M.H. had told Respondent that P.H. had been the one who had obtained the OxyContin and delivered it to M.H.'s nephew, there is no indication in P.H.'s record that Respondent counseled her about the incident. *See id.*

On August 23, P.H.'s file contains a note indicating that Respondent had again spoken with the pharmacist who reported the July 29 diversion incident. *Id.* Once again, the pharmacist "insist[ed] that [P.H.] and [A.B.] are selling" their medications. *Id.*

On August 27, P.H. again saw Respondent and was accompanied by A.B. *Id.* at 21. Respondent wrote P.H. a prescription for the balance of the Roxicodone prescription that she had written on August 17, which P.H. had been unable to fill completely. *Id.* at 20–21. There is, however, no indication in P.H.'s file that Respondent questioned P.H. about whether she was selling her medications. *Id.* Moreover, while the pharmacist had insisted that A.B. was also selling medications, there is no indication in A.B.'s patient file that Respondent had counseled her not to do so.

Respondent testified that although she did not notate it in any file, A.B. and P.H. were present when she counseled M.H. about the diversion. Tr. 2355. The ALJ did not credit this testimony. Nor do I. As found above, Respondent counseled M.H. about the incident on August 10th. A.B., however, had been in a motor vehicle accident on August 5th, and according to the August 17 entry in her patient file, A.B. was then "at Healthsouth Rehabilitation [I]nstitute with 'brain swelling.'" GX 56, at 8. A.B. was not discharged until August 23rd. *Id.* A.B. thus could not have been present when Respondent counseled M.H. I further conclude that the lack of documentation in A.B. and P.H.'s files conclusively establishes that Respondent did not counsel either one of them regarding the July 30 incident or any other diversion incidents.

Following the incidents, Respondent continued to treat P.H. for injuries she incurred during the August 5 motor vehicle accident. On October 29, Respondent concluded that P.H. had reached maximum medical improvement with respect to the injuries she incurred in the accident and ceased treating her for them. GX 55, at 25. Respondent, however, continued to treat her for low back pain, phlebitis in her left calf (a condition which she diagnosed on Oct. 15), and bulbous pemphigoid. *Id.* For these conditions, Respondent prescribed 200 tablets of

Percocet and 500 tablets of Roxicodone 15 mg. (with 10 tablets to be taken every 4 hours). *Id.*

On December 21, Respondent noted in P.H.'s record: "faxed refill request from Bashas' [pharmacy] for Vicodin prescribed by Dr. H. [P.H.'s dermatologist] denied." *Id.* at 27; *see also id.* at 18. Here again, there was evidence that P.H. had either obtained or attempted to obtain controlled substance prescriptions from other physicians. *Id.* at 27. And once again, there is no documentation that Respondent questioned P.H. about other controlled substance prescriptions she had obtained or that Respondent had contacted the prescribing physician to coordinate their prescribing to P.H. *Id.*

Respondent also introduced two letters into evidence from a Dr. Kaplan, the primary care physician for A.B. and P.H., apparently to show that he approved of Respondent's prescribing to them. Tr. 2131; RX B & C. Respondent further indicated that Dr. Kaplan had to authorize her prescriptions for the insurance plan that the two were on. Tr. 2131.

Dr. Kaplan's letter regarding P.H. simply says that he "was aware that she was receiving chronic high dose narcotic analgesic therapy for chronic pain from" Respondent. RX C. The letter does not, however, say that Respondent's prescribing to P.H. was medically appropriate. *See id.*

In contrast to the letter he wrote about P.H., Dr. Kaplan stated that A.B. "has been receiving appropriate analgesic medications from [Respondent] during 2001 and 2002." RX B. While Dr. Kaplan stated that his chart notes confirmed that he had been aware that Respondent had been treating A.B. since early 2001, he did not claim that he had reviewed the entire course of Respondent's prescribing to A.B. *See id.*

In a letter dated October 22, 2002, Respondent's own expert, Dr. Schneider, who was mentoring Respondent, noted that P.H. "has an addiction history" and instructed Respondent to "[f]ind out to what was she addicted and how recent." RX D–6, at 2. Dr. Schneider also noted that P.H. "attends COPE," and instructed Respondent to find out "if they know about her opioid treatment." *Id.* P.H., however, died before Dr. Schneider sent the letter. *Id.*

Dr. Hare reviewed the patient files of P.H. and A.B. GX 46A, at 8–12. With respect to P.H., Dr. Hare observed that she was "a patient with multiple complain[t]s which were not adequately evaluated by [Respondent] and yet she continued to prescribe increasing amounts of controlled substances,

particularly opioids with no apparent improvement in the patient's condition." *Id.* at 10. Moreover, "[e]ven though there were numerous 'red flags' regarding the patient's misuse of medication, including use of the prescriptions in excess of the prescribed amounts, possible diversion of medication and the admitted sharing of medication with relatives, Respondent continued to prescribe unabated. Any reasonable physician would have noted these strong warning signs and investigated these problems while not prescribing further for this patient." *Id.*

With respect to A.B., Dr. Hare observed that she "presented as a patient with many problems which were not properly diagnos[ed] and evaluated by" Respondent. *Id.* at 12. Dr. Hare further noted that, while "there were a number of indications of overuse of medications" including "early prescriptions," as well as "clear reports of diversion," Respondent continued to prescribe to her.⁶⁶ *Id.*

H.T.

H.T. was the patient name for an FBI informant who started treating with Respondent at her prior clinic in May 1998. GX 71, at 16. Initially, H.T. was treated for continuing lower back pain with physiotherapy and other methods; Respondent did not, however, prescribe controlled substances to him. *See generally* GX 71. According to H.T.'s record, during this phase of Respondent's treatment of him, she did her last physical exam of him on March 8, 2000. *Id.* at 7.

After a lengthy absence, H.T. returned to Respondent's office in February 2002 and met with C.M., a chiropractor who worked with Respondent. GX 60. H.T. mentioned that he had been living in Montana and doing roofing work, and that "a couple of times when [he] was roofin[g], [he] had a little twinge" or "twitch back there." *Id.* at 4. H.T. added, however, that he was feeling good. *Id.* While Respondent saw H.T. at this visit, she did not prescribe any drugs to him. *Id.*

H.T. returned on March 4.⁶⁷ GX 61. During the visit, H.T. told Respondent

⁶⁶ In her findings, the ALJ writes, "Yet Dr. Weinstein credibly wrote that Dr. Hare's premise that 'medication abuse and diversion are related to the amount of medication prescribed to an individual patient' was false." ALJ at 87. However, Dr. Hare's finding of "red flags" was not related solely to the amount of medication prescribed but to the reported behavior of diversion.

⁶⁷ In her response to the Government's Exceptions, Respondent challenges the authenticity of the transcripts of the recordings of H.T.'s undercover visits. I reject her challenge noting that the underlying tapes had previously been provided to either her or her attorney in the course of the

that when he was working “in Montana I had a sore back sometimes. But I just think it was because I was working.” *Id.* at 12. H.T. subsequently told Respondent he had “been feeling really good” and denied that the pain went down his leg. *Id.* at 12–13. H.T. then told Respondent that one of his friends had a relative who was doctor and that the doctor had given him Percocet Tens (10 mg.). *Id.* at 15–16. H.T. then asked Respondent if she could give him Percocet Tens. *Id.* at 16–17. Respondent tried to persuade H.T. to take Percocet Fives (5 mg.). *Id.* at 17. H.T. insisted that he wanted the Percocet Tens. *Id.* at 21. After telling H.T. that because the Percocet Tens were new and half of the area pharmacies didn’t stock it, Respondent asked him whether he wanted to try forty or sixty tablets. *Id.* H.T. said sixty, *id.*, and Respondent gave him a prescription for sixty tablets of Percocet 10/325. *Id.* at 26. Respondent told H.T. to take only six tablets a day, because the Tylenol (acetaminophen) is “a bad thing.” *Id.* at 27. Continuing, Respondent stated that the “the other stuff is a fun thing” and that H.T. could also try pure oxycodone. *Id.*

The patient record indicates that a physical examination was performed, but there is no such indication in the transcript from that visit. Compare GX 71, at 7–8, with GX 61. According to the patient file, Respondent found that H.T. “ha[d] slight pain with lumbar range of motion and especially has pain with lumbar extension combined rotation,” and diagnosed him as have “chronic biomechanical low back pain.” GX 71, at 8. There is, however, no indication in the transcript of the visit that Respondent performed a physical exam on H.T. See GX 61.

On March 11, H.T. returned to Respondent. GX 62. During the visit, H.T. told Respondent that he had “just tested positive” for Hepatitis C and wanted to change to pure oxycodone from Percocet, which contains acetaminophen. GX 62, at 4. H.T. told Respondent that changing the prescription to pure oxycodone would make him “pretty happy.” *Id.* at 4. Respondent asked H.T. if he wanted sixty tablets; H.T. said he “would love” to get sixty. *Id.* at 6. Respondent wrote

criminal proceeding, that the transcripts were mailed to her on December 28, 2006, and the hearing did not convene until January 22, 2007. See Tr. 45. While Respondent maintained that she got the transcriptions “late,” she did not establish on what date she received them. *Id.* Accordingly, I conclude that Respondent had more than adequate time to compare the transcripts with the underlying tapes and to prepare a motion setting forth those instances (were there any) in which the transcripts did not accurately reflect the content of the tapes.

H.T. a prescription for sixty tablets of Roxicodone 5 mg. GX 71, at 8.

Three days later, on March 14, H.T. returned to Respondent. Respondent asked him to rate his back pain, and suggested “three, four, five, six?” GX 63, at 3. H.T. replied: “ya know, the Doc always sa-, helps me, He puts em down so he can get the insurance company payin[g].” *Id.* Respondent replied: “Okay, five,” and H.T. agreed stating: “Five, I’ve got worse.” *Id.*

H.T. asked Respondent for 120 oxycodone, stating that he was going to be gone all of the next week and maybe for a part of the week after that. *Id.* at 6. Respondent then asked H.T. whether he liked the oxycodone; H.T. replied that he “like[d] it, but I had to eat ‘em like M & M’s,” because they were “only fives.” *Id.* After explaining to Respondent that she had previously prescribed only 5 mg. tablets, H.T. added that he “was eatin[g] them codones like candy until I noticed they were just five milligramers.” *Id.* at 7.

Respondent then asked whether H.T. wanted to stick with the fives because they “are the cheapest.” *Id.* H.T. stated that he wanted “something that’s stronger.” *Id.* Respondent then asked whether he wanted fiftens; H.T. replied that he would “be much happier with fiftens.” *Id.* at 7–8. Respondent then explained that “the price breaks at a hundred” so that she would “write a hundred” because the pharmacist could just give him a box and not have to count out extra pills. *Id.* at 9. H.T. then added that oxycodone fives “didn’t make me feel as good as those ten Percocets * * * [u]ntil I ate a few more.” *Id.*

According to H.T.’s patient record, Respondent wrote a prescription for 100 tablets of Roxicodone 15 mg. GX 71, at 8. The patient record also indicates that Respondent performed a physical exam. *Id.* Again, however, the transcript of the visit does not reflect a physical examination. See generally GX 63.

On March 25, H.T. went back to see Respondent. GX 64. According to the transcript, Respondent asked H.T. why he needed to see her because it had not been two weeks since the last visit. *Id.* at 4. H.T. told Respondent that he was there to beg her to give him some OxyContin forties (40 mg.), that an acquaintance had told him that he had “gotta try and get her to give you some of them OxyContin,” and the acquaintance had told him that the OxyContin were “really good.” *Id.* at 4–5.

Respondent then asked H.T. if he wanted to try the ten milligram OxyContin; H.T. replied: “Ten? He had forties.” *Id.* at 5. After H.T. repeated that

his acquaintance had gotten forties, Respondent explained that the forties were “for him” and that “there’s ten, twenty, forty, and eighty,” which are four of the different strengths of the drug. *Id.* at 6. H.T. then suggested that “we split difference,” and Respondent said “twenty.” *Id.* Respondent next asked if H.T. could take “one of the fiftens and it’s fine?” *Id.* H.T. replied that he “probably ate six a day” and asked “is that too many?” Respondent then suggested that “it helped and it’s for your back.” *Id.* While H.T. initially said “well yeah Doc” and laughed, he shortly added that “my back feels great, but, I like these,” and then asked “is that a bad thing?” *Id.* at 7.

After discussing how H.T. was paying for his drugs, H.T. asked Respondent “How many you gonna give me?” *Id.* Respondent replied: “Well, a month would be sixty. You’re supposed to take one every twelve hours.” *Id.* at 8. H.T. replied “really,” and Respondent asked him whether he wanted sixty or thirty tablets. *Id.* H.T. answered that he was “hopin[g] you’d give me a hundred” but that “sixty sounds really good” and laughed. *Id.* Respondent then suggested that H.T. “go through your insurance” and asked him if he was still driving the truck. *Id.* H.T. replied that “if I drive, I’ll still do em.” *Id.* Respondent then stated: “Alright. Your back is still * * * bad, but the adjustments help.” *Id.* Respondent then wrote H.T. a prescription for 60 tablets of OxyContin 20 mg. (q12h), a thirty-day supply if taken as prescribed. GX 71, at 9.

According to the progress note prepared by Respondent for this visit, Respondent performed a physical exam which showed that H.T. “has pain with lumbar range of motion and stiffness with lumbar range of motion.” *Id.* Respondent also indicated that she discussed the “risks and benefits of long acting opioids” with H.T., “including risks of addiction and side effect,” and that a “pain contract was signed.” *Id.* But as the transcript makes clear, Respondent did not perform a physical exam on this date. Nor is there any indication in the transcript that Respondent discussed the addiction risks with H.T. Finally, the transcript does not include any evidence that suggests that Respondent had H.T. sign a pain contract at this visit. Indeed, the record establishes that Respondent did not have H.T. sign a pain agreement until April 23, and that she had him back-date the agreement to March 25. See GX 67, at 7–8.

On April 4 (ten days later), H.T. returned to Respondent’s office. GX 65. After making small talk about their respective ages, Respondent asked H.T.

if he “like[d] the Oxycoton [sic]?” *Id.* at 4. H.T. answered affirmatively, and Respondent asked him: “That’s what you want?” *Id.* H.T. answered: “Yes, please.” *Id.*

Respondent then noted that she had given H.T. a month’s supply at the previous visit and asked him if he was “takin[g] more of it then.” *Id.* H.T. answered affirmatively and subsequently stated that he had taken 50 tablets in seven days, or “about seven a day.” *Id.* at 5.

Respondent then asked H.T. if he “want[ed] [a] stronger pill” or if he wanted her “to write that you take more of em.” *Id.* H.T. asked: “Do they got ‘em stronger?” *Id.* Respondent answered that “[t]hey have a forty milligram.” *Id.* H.T. answered “Sure!” *Id.* Respondent stated: “Let’s try that. But if you’re taking seven, that’s ah, four. Okay, let’s try three a day.” *Id.* H.T. then told Respondent: “You are so good to me.” *Id.* H.T. then asked Respondent if she had to write something every time he visited, and Respondent said “I’ve always had to write somethin[g].” *Id.* at 6.

Respondent then asked H.T.: “what’s your number today?” *Id.* H.T. replied: “tell me, what do I look like. You know, you, you guys always help me with my insurance. That’s to keep the insurance pay, company payin[g].” *Id.* Respondent replied that she did not know, and H.T. asked her if he “look[ed] like a seven.” *Id.* When Respondent replied that he “look[e]d like a zero,” H.T. laughed and said: “That means on a pain level, right?” *Id.* H.T. then went to see the chiropractor.⁶⁸ At the visit, Respondent gave H.T. a prescription for 90 tablets of OxyContin 40 mg., with a dosing of one tablet every eight hours. GX 71, at 9. The prescription thus not only doubled the strength of the previous prescription but also increased the quantity by another 30 tablets. Based on the dosing instruction, the prescription would last for 30 days.

In the progress note for this visit, Respondent indicated that H.T. had “continued low back pain,” and that she had performed a physical exam, which “show[ed] that he has pain [and stiffness] with lumbar range of motion.” *Id.* She also noted that he was “doubling up on the OxyContin” and was “even taking more than double.” *Id.*

On April 11, one week later, H.T. again saw Respondent and requested a refill prescription, indicating that he would be going out of town for two

weeks. GX 66, at 5. As the previous prescriptions would last for 30 days and only one week had passed, H.T. did not need another prescription if he was only going to be gone two weeks. After some small talk, Respondent asked H.T. “do you want the OxyContin?”; H.T. answered: “Yeah.” *Id.* at 8–9.

Respondent then noted (incorrectly) that H.T. had “just got it March 25th”; before Respondent could complete her next sentence H.T. replied: “I know. I got a maybe about um, fifty left. But I’m gonna be gone for two weeks I think.” *Id.* at 9. Respondent and H.T. then discussed when the latter would be leaving, how many pills he had left, and whether his insurance would cover it because he was “so early.” *Id.*

Respondent eventually agreed, however, to write H.T. a prescription for twenty-milligram strength and asked him if he “want[ed] ninety?” *Id.* at 11. H.T. replied: “Oh, please. I probably been eatin[g] a few more of those than three a day, okay?”; he then added that he wanted “to be totally honest with” Respondent. *Id.* After an unintelligible comment by Respondent, H.T. reiterated that he only had “fifty left.” *Id.* Respondent then asked H.T. whether he would be out of town “for two weeks,” and H.T. stated that he was “pretty sure” that he would be gone “for two weeks.” *Id.* at 12. Respondent then gave H.T. a prescription for another 90 tablets of OxyContin 40 mg. (also q8h). *Id.*; see also GX 71, at 10. H.T. then told Respondent: “You’re okay, Doc,” and Respondent replied: “I know * * * You caught me at a soft moment.” GX 66, at 12.

On April 23, H.T. returned to Respondent and again sought more OxyContin. GX 67, at 6–7. After discussing with H.T. whether he was on the forty or eighty-milligram strength tablets, Respondent asked him if he had signed a pain management agreement at the last visit. *Id.* at 7. After H.T. replied that he did not think so, Respondent told him that he needed to do so and to date the agreement March 25, 2002. *Id.* at 8. Respondent then explained some of the requirements of the pain agreement. *Id.* at 8–12.

Respondent and H.T. then discussed how many tablets she had given him at some of the previous visits. *Id.* at 12–13. Respondent noted that she had given him 90 tablets and asked him if he was “takin[g] more than three a day?” *Id.* at 14. When H.T. answered “[y]eah,” Respondent asked him if he was “out of ‘em.” *Id.* H.T. then asked: “[i]s that a bad thing?” and added that he had “a few left.” *Id.*

Respondent then told H.T.: “They’re watchin’ me, Hal.” *Id.* at 15. H.T. asked:

“They’re what?” Respondent replied: “I gave you ninety of the forties. I gave you ninety, wait a sec. I gave you on ni-, on the fourth and the eleventh.” *Id.* H.T. then said: “I told you I got the * * * constitution of * * * a mammoth. And you have the heart of a mammoth.” *Id.* H.T. then added that “I’d never tell you none of them stories about losing ‘em or anything. I just tell ya the truth. I’d just like a few more of those okay?” *Id.*

Following a discussion of what to put in his medical record, (*Compare id. with* GX 71, at 10), Respondent asked him if he could “taper down a little?” because she had given him 90 tablets and a week after that, another prescription because he was “going out of town.” *Id.* at 16. H.T. asked “is that a bad thing?,” and Respondent explained: “Well, they’re watching me, so, I, I can’t do it again until this investigation’s over.” *Id.* After H.T. asked who was watching her, Respondent answered that the State medical board was. *Id.* H.T. then told Respondent that he did not want to get her in trouble, that if the Board came to him, he would “have nothing but nice things to say about” her, and that he would not be coming in with Morley Safer from Sixty Minutes. *Id.* at 17.

Later in the conversation, Respondent asked H.T. to make his drugs “last a little more” and added: “[u]ntil my investigation is over.” *Id.* at 18. H.T. initially agreed to, but added that “I hate like though when it says just take three” and that “there’s a part of me that want to take one more than or two more than.” *Id.* H.T. then suggested that if Respondent gave him the “bigger ones, they’d last longer.” *Id.* Respondent replied that “[f]orty is good enough.” *Id.*

Respondent then suggested that H.T. try Celebrex, an anti-inflammatory which is not a controlled substance. *Id.* at 19. H.T. replied that “[t]he only pain in my life is the ache in my heart when I’m around you visions of loveliness that work here.” *Id.* Apparently, Respondent then gave H.T. a prescription for Celebrex, see GX 71, at 19; and H.T. asked if she could give him “some more” OxyContin. GX 67, at 19.

When Respondent said that she couldn’t because she had recently given him 90 tablets, H.T. complained that “I only got a few of those left.” *Id.* at 20. Respondent then told H.T. she was giving him the Celebrex and that she had given him 90 OxyContin “on the eleventh,” which “was like eleven days ago,” and he was “taking nine a day” when he was “supposed to take three a day.” *Id.* After H.T. complained that he was going to “run out,” Respondent told him that he had to be good until next

⁶⁸ During his time with the chiropractor, the chiropractor said that H.T. was “doin[g] great,” and H.T. agreed that he was “feeling great.” GX 65, at 8.

week.⁶⁹ *Id.* at 20–21. H.T.’s record also reflects a physical examination, without corroboration from the transcript of the visit. *Compare* GX 71, at 10, with GX 67.

On April 29, H.T. again saw Respondent. GX 68. H.T. told Respondent he did not fill the Celebrex and asked: “What do I need an anti-inflammatory for?” *Id.* at 6. Respondent answered “It’s for pain,” and added that he “should try it.” *Id.* H.T. then replied: “Doc, you know between you and me my pain level is non-existent, but, I really like them Oxyco[ntin]. They make me feel good.” *Id.*

Respondent then asked H.T. “if you’re not using ‘em for pain what’re ya using ‘em for?” *Id.* H.T. replied: “Cause life is painful, ya know, just that, the heartache and the psoriasis and all that other stuff.” *Id.* Respondent then asked H.T. if he was “using it to just make you feel like, mellow?” *Id.* When H.T. replied (laughingly), “what should I say no?” Respondent answered: “I can’t prescribe ‘em for that reason.” *Id.* at 7. When H.T. told Respondent to “put down that I’m in a lot of pain then, okay?,” Respondent answered: “But you’re not in a lot.” *Id.* Respondent then noted that she had given him 90 tablets, and yet he was out of the drugs “by the end of the week” and that he was “getting addicted to ‘em.” *Id.* at 8–9. H.T. insisted, however, that he was not getting addicted because he had the “metabolism of an elephant” and had “quite a body mass.” *Id.* at 9–10.

While Respondent again maintained that she could not keep filling the prescriptions for the reasons H.T. wanted the drugs, she then told him that she could not do it because she was being “watched like a hawk now because * * * everybody thinks I’m writing too many prescriptions for people.” *Id.* at 10. H.T. then told Respondent that she did not “have to worry about” him. *Id.*

Respondent then suggested that she “could cut down the dose” and asked H.T.: “You want a small dose?” *Id.* Respondent also told H.T. that “Forties is a high dose.” *Id.* Respondent subsequently told H.T. that she had given him “a month’s supply on April eleventh” and that “[i]t’s not a month.” *Id.* at 11. H.T. insisted that it was “pretty dang near though?” *Id.* Respondent told him that he would have to wait until May 11th. *Id.*

H.T. then asked Respondent for a prescription to last until May 11. *Id.* Respondent asked H.T. what had happened to the 100 tablets of

oxycodone 15 mg. which she had given him in March. *Id.* at 12. H.T. told Respondent that they were “like aspirin” and that OxyContin “was better than them.” *Id.* Respondent then insisted that if H.T. read the news, he would know that “[e]verybody’s all afraid of” OxyContin, and that “we have to live with rules.” *Id.*

When H.T. reminded Respondent that she had told him that he would be able to get a new prescription “this week,” Respondent replied: “you * * * unfortunately told me why you were taking ‘em. Has nothing to do with your back pain and that’s the only reason you should be taking ‘em.” *Id.* at 13. Respondent then told H.T. to “[w]ait till May eleventh. Then at least you’ll have a month.” *Id.* Respondent then added that she was “gonna cut and give [him] twenties.” *Id.* H.T. replied: “Twenty. How can you do that?” and Respondent answered: “Hal, wait till my investigation’s over.” *Id.* at 14.

On May 15, H.T. again saw Respondent. GX 69. H.T. told Respondent that he “love[d] those pills” and added that while she had told him “to wait till the eleventh,” he had “been so good” and that it was then “past the eleventh.” *Id.* at 2. Respondent told H.T. that the pills were “supposed to be for back pain.” *Id.* H.T. replied he was “getting into that mode, doc,” asked if she had seen him “come in here kinda all kinked over and everything,” and added that his “modality [was] messed up” and that “homeostasis [wa]s unaligned.” *Id.* H.T. then facetiously added that he had “great internal and mental stress” because he had abandonment issues as a child and his wife had divorced him and run off with a bald guy (who was considerably older) more than fifteen years earlier. *Id.* at 2–3.

H.T. then offered to be a character witness for Respondent in the board investigation. *Id.* at 4. When Respondent said that the board would say that she had been giving him drugs and that he was a drug addict, H.T. interjected that he had not been getting drugs from her for that long. *Id.* at 5. Respondent then observed that she had first put him “on twenties then you like the forties.” *Id.* H.T. responded that he had the metabolism of a mammoth, and that he would not ask her “again until thirty-five days or whatever.” *Id.* Respondent then asked H.T. if he wanted to “take three a day?”; H.T. said “sure.” *Id.* at 5–6. Respondent then asked H.T. if he was taking the Celebrex; H.T. said that he had filled the prescription but that it did “not really” help. *Id.* at 6.

Following a discussion of whether H.T. was going to the pharmacy that he

said he would use in the pain agreement, H.T. suggested that he fill his prescriptions in Mexico. *Id.* at 7. Respondent said that she did not think that he would be able to fill the prescriptions in Mexico, “especially OxyContin.” *Id.* at 8. H.T. then told Respondent that if you went to the border towns such as Nogales, people would come up to him “trying to hustle you for everything,” and that one such individual had tried to sell him Viagra. *Id.* H.T. added that he asked this individual about buying OxyContin, and that the individual offered to sell him twenty-milligram tablets for “two dollars a milligram.” *Id.* H.T. also added that this individual “wanted to sell everything. Vicodin, ah, Viagra, ah, he was just like a walkin[g] PDR.” *Id.* at 9. Shortly thereafter, Respondent issued H.T. a prescription for 90 tablets of OxyContin 40 mg. GX 71, at 11. After he again offered to be a witness for Respondent in the Board’s investigation, H.T.’s visit with Respondent ended. GX 69, at 10.

The entry in H.T.’s patient record for this visit indicated that Respondent performed a physical exam and found that he had “pain” and “stiffness with lumbar range of motion.” GX 71, at 11. Respondent also indicated that she had performed a “neurological exam of both lower extremities [which] showed normal motor strength, sensation and deep tendon reflexes.” *Id.* Again, however, the transcript lacks any indication that Respondent performed the tests she documented as part of her physical exam.

In her Response to the Government’s Exceptions, Respondent also contended that H.T.’s loud laughter would have drowned out evidence of the physical examinations she claims to have performed. Response to Exceptions at 2. Respondent also maintained that “after four years of these physical exams, there are necessarily fewer specific directions to the patient,” and that H.T. knew the routine for her focused physical examination and did not have to be told what to do. *Id.*

Respondent’s arguments are not persuasive. As for her contention that he knew her routine after so many years of exams, the record establishes that on March 4, 2002 (the date she started prescribing controlled substances to him), she had not physically examined him since March 8, 2000, a period of nearly two years. See GX 71, at 7. Between these exams, H.T. had been physically examined by at least two other physicians (on May 31, 2000 and January 24, 2001) for the same condition. See *id.* at 23 & 27. It is therefore exceedingly unlikely that H.T.

⁶⁹ The patient record indicated that Respondent performed a physical exam at the April 23 visit. GX 71, at 10.

would have remembered Respondent's routine for performing a physical exam.

Moreover, the transcripts of H.T.'s various visits do not contain even a trace of the prompting that a physician would use in performing a physical exam. As for Respondent's further contention that H.T.'s laughter drowned out her directions when she performed an exam, the instances of laughter (and by whom) were noted in the transcripts and were quite limited. Finally, while Respondent maintains that "[t]he actual audio tape contains lots of loud laughing by H.T.," she did not identify specific examples of this in her briefs. I thus conclude that Respondent failed to physically examine H.T. on March 4, 14, and 25, April 4 and 23, and May 15, 2002. I further find that Respondent falsified H.T.'s medical record for these six visits by indicating that she had performed a physical exam when she did not.⁷⁰

The gist of Respondent's testimony with respect to H.T. was that she was duped. For example, Respondent testified that H.T. "was always a very loud, obnoxious patient," that he "was a three-time convicted felon who somehow made a deal with the FBI to become * * * [a] 'mole,'" and that he carried a "Tri-Care insurance card, which identified him as E-8, enlisted man 8, which is a pretty high rank for an enlisted person." Tr. 2068. According to the Respondent, "[d]octors being

⁷⁰Dr. Hare reviewed H.T.'s patient file. Dr. Hare remarked that when H.T. returned in March 2002, Respondent's physical examination was "minimal," and Respondent did not inquire as to the physician who had prescribed the Percocet to him. GX 46A, at 2. Dr. Hare further noted that Respondent started H.T. at "one of the stronger doses of Percocet," and Dr. Hare questioned why she did not begin with a lower dose. *Id.* On March 11, 2002, when Respondent switched H.T. from Percocet to oxycodone, she did not notate her reasoning in the file. *Id.* At that time H.T. was taking approximately nine tablets of Percocet a day, in excess of the prescribed amount. On March 14, when he returned, he was taking approximately 20 tablets/day, "2/3 oxycodone at a time," without any indication of improvement in his pain. *Id.* On April 4, when Respondent noted that H.T. was "doubling up on OxyContin, even taking more than double," Respondent wrote for OxyContin 40 mg., one each eight hours. *Id.* Dr. Hare noted that one week later, when H.T. indicated he would be going out of town for two weeks, Respondent again wrote for 90 OxyContin 40 mg. *Id.* He noted that the "same information and the same physical examination is stated in the chart" for both April 23 and the subsequent visit on May 15. *Id.*

Dr. Hare concluded that "the history and the physical were inadequate to allow prescribing of a control [sic] substance." *Id.* at 3. Respondent "rapidly escalated the dose" without any documentation that the pain responded to opioid medication, and the patient "consistently used the medication in excess of her prescriptions." *Id.* For Dr. Hare, "[t]his should have been an indication to [Respondent] that the patient was non-compliant and using medication in excess, raising the likelihood of abuse or diversion." *Id.*

human, we give some credibility to a person based on their credentials." Tr. 2068–69. *See also* Tr. 2316 ("In my mind [the prescriptions were] for a legitimate medical purpose, but obviously, when I'm confronted with the fact * * * that the person I thought I was prescribing to was lying to me and faking, then one can't but help but then conclude based on that retrospectively that that was not for a legitimate medical purpose.").

Continuing this theme, Respondent complained that H.T. presented "a true * * * a seemingly true insurance card" such that the insurance company would have received payments "[s]o there was no question, to us, that he was telling the truth * * * about who he was." Tr. 2071. She also testified that his visits followed September 11, 2001, and that there "was certainly a new-found respect for the military after 9/11" such that she "afforded him some deference." Tr. 2072.

Respondent further claimed that "we kept thinking that he was coming because he had back pain" and that "all of our documentation and our conversations with him were assuming that he was having back pain." *Id.* at 2073. Yet she also acknowledged that there were several times when she "wanted to" put him on "maintenance care" and have him come less frequently because his back was "much better." *Id.* at 2072. Respondent claimed that "it's really hard for a doctor to just get rid of patients" and "the fact that we didn't like him is not a reason to get rid of him." *Id.* at 2072–73.

Moreover, Respondent testified that at the visit when H.T. asked for Percocet, he did not present any "significant change" in his condition and that his "physical exam was never very significant." *Id.* at 2075. She claimed that she "trusted him" and that "when he asked [her] for Percocet * * * he needed it" even though he "was using words very unusually." Tr. 2075–76.

Respondent testified that "in retrospect" she "should have been suspicious because he's laughing" as they talked.⁷¹ *Id.* at 2074. Respondent maintained, however, that medical professionals are "not trained to be suspicious of people" or "to figure out inconsistencies in what people tell us." *Id.* at 2075. But she then acknowledged that H.T. never had neurological symptoms or that there was "any reason to suspect he had a herniated disc and needed to have surgery or any emergency procedure." *Id.* at 2075–76. Finally, while Respondent admitted on

cross-examination that the prescriptions she issued to H.T. lacked a legitimate medical purpose, this was because he "was not a true chronic pain patient" and "the fact that everything he was presenting to me was not correct." *Id.* at 2322.

The transcripts of H.T.'s visits make plain that Respondent's testimony is self-serving and disingenuous. For example, at the March 4, 2002 visit when H.T. returned and requested Percocet, he indicated that he had had "a sore back" only "sometimes," and that was when he was working. He also made clear that he had "been feeling really good" and denied that the pain went down his leg. Moreover, he asked for a specific drug—Percocet 10/325. Finally, when Respondent counseled him about the risk of taking too many tablets because of the drug's acetaminophen content, which she characterized as "a bad thing," she then added that "the other stuff [the oxycodone] is a fun thing." Moreover, Respondent did not physically examine him even though she had not seen him in nearly two years. In short, Respondent knew that H.T. was not seeking the Percocet to treat a legitimate pain complaint.

At subsequent visits, H.T. made additional comments which made clear that he was engaged in drug-seeking. For example, at the March 11 visit, H.T. told Respondent that changing his prescription to oxycodone would make him "pretty happy," and when Respondent asked if he wanted 60 tablets, H.T. told her that he "would love" to get 60. Moreover, H.T. told Respondent that he was eating the oxycodone 5 mg. tablets "like candy" and "M & Ms." Moreover, Respondent did not perform a physical exam even though she indicated that she had in H.T.'s record.

At the March 25 visit, H.T. told her that he was there to beg her to give him some OxyContin 40s. And when Respondent commented that it was o.k. that H.T. was taking six fifteen-milligram Roxicodone tablets a day because it was for his back, H.T. laughed and added that his back felt great but that he liked the drugs.

Throughout these visits, H.T. also presented a pattern of seeking additional drugs, as well as more powerful drugs, well before the previously issued prescriptions would have run out. Moreover, after she gave H.T. a prescription for another 90 tablets of OxyContin 40 mg. (merely a week after a previous prescription for the same strength and quantity, which should have lasted thirty days based on the dosing instruction), H.T. told her

⁷¹The transcripts reflect, however, that Respondent frequently found H.T. to be amusing.

"You're okay, Doc," to which Respondent replied: "I know * * * You caught me at a soft moment."

When H.T. sought more OxyContin at the next visit (April 23), H.T. did not claim that he was in pain and told her that he never made up any stories about losing the drugs and that he was telling the truth and just wanted to get "a few more." Moreover, Respondent told H.T. that she could not write another prescription so soon because the State Board was investigating her.

Furthermore, later in this visit H.T. told Respondent that he did not have pain ("the only pain in my life is the ache in my heart when I'm around you visions of loveliness that work here").

At the next visit, H.T. once again made clear that his "pain level is non-existent." When Respondent questioned H.T. further as to why he wanted the drugs, H.T. made plain that he was seeking the drugs to abuse them and not to treat pain. Respondent further told H.T. that she could not give him a new prescription until at least a month had passed from the previous prescription and that he should wait until the investigation was over.

Finally, at the last visit, H.T. once again made clear that he was seeking the drugs to abuse them and not to treat pain. Moreover, he also told Respondent that he had tried to buy OxyContin on the street in Mexico and even cited the price per milligram. Respondent nonetheless gave him another prescription for 90 tablets of OxyContin 40 mg.

It is thus clear that Respondent knew that H.T. was not seeking the drugs to treat a legitimate pain condition, but rather to abuse them. Respondent was in no sense duped by H.T. as to his reason for seeking the drugs; indeed, she clearly knew that he was seeking the drugs for an illicit purpose.

K.Q.

Respondent treated K.Q. as early as 1992, but her patient record in evidence starts in 1997.⁷² Tr. 2097; GX 58, at 2. On March 17, 1997, K.Q., who was then a 37-year-old female, visited Respondent. *Id.* K.Q. complained of "low back pain radiating to right lower extremity and numbness right lower extremity" after having fallen down in a grocery store some three to four days earlier. *Id.*

K.Q. was on disability and had been in two prior motor vehicle accidents. *Id.* K.Q. had been diagnosed two years earlier with "pseudotumor cerebri" and was still being treated for this condition

by another physician, Dr. S. *Id.* K.Q. had had "dozens of LPs⁷³ to drain CSF fluid." *Id.* She was also still treating with Dr. L., who was prescribing Percocet to her, apparently for either a bulging or herniated disk at L2-3. *Id.*

In her medical history, Respondent noted that K.Q. was taking Lorcet, a schedule III controlled substance which contains hydrocodone; Xanax, a schedule IV controlled substance; as well as two non-controlled drugs, Prozac and Mevacor. *Id.* There is, however, no indication in the progress note as to who was prescribing these other drugs. *Id.*

Respondent performed a physical examination and diagnosed K.Q. as having chronic low back pain and muscle spasm, with a temporary exacerbation of pain, cervical pain, and muscle tenderness. *Id.* at 2-3. As part of the treatment plan, Respondent gave K.Q. a prescription for 20 Percocet. *Id.* at 3. She also recommended that K.Q. get "cervical and lumbar x-rays," cervical and lumbar range of motion testing to accurately document ROM deficits and motion [K.Q.'s] progress through rehabilitation, and a "[c]omprehensive program of joint mobilization and physiotherapy." *Id.* There is no indication in the progress note, however, that Respondent contacted Dr. L., who reportedly was still treating her and prescribing Percocet, or Dr. S., to determine what drugs they were prescribing to K.Q. and to coordinate her prescribing.

K.Q. underwent physical therapy the same day, as well as on the next two days. *Id.* at 4. During her March 19 visit, K.Q. sought a prescription for 90 Percocet "because of a price break and because she got a check from the church made out for exact amount of 90 Percocet." *Id.* Respondent wrote a prescription for 90 Percocet. *Id.* After this, K.Q. did not appear for any more physical therapy sessions. *Id.* Moreover, there is no entry in the progress notes indicating that x-rays were done. *Id.* at 3-4.

On October 27, more than seven months after her last visit, K.Q. reappeared. *Id.* at 4. She complained of "severe low back pain, mid back pain and headaches," and reported that she was "on OxyContin and Duracet, as well as either Xanax or Valium." *Id.* K.Q. said she saw Dr. L. every two weeks but had missed her October 1 appointment and had missed getting her prescriptions and that Dr. L. was out of town until November 3. *Id.* K.Q. and Respondent apparently did not discuss why, if K.Q. was seeing Dr. L. every two weeks, she

had not seen him in the middle of October. Moreover, there is no indication that Respondent contacted Dr. L.'s office to verify whether he was away (or whether there was no one else in his practice who was covering for him).

After a physical examination, Respondent diagnosed K.Q. as having chronic low back pain and myofascial pain. Respondent then prescribed 60 OxyContin 20 mg. BID, 90 Xanax 1 mg. TID, and 30 Duracet 10 TID. *Id.* at 5. Respondent discussed the risks and benefits of long-acting opioids with K.Q., that any early renewals would be at her discretion, that "any doses changes need[ed] to be order[ed] by" her, that K.Q. should undergo a program of joint mobilization and physiotherapy two times per week with a recheck in three weeks. *Id.* Respondent also noted that K.Q. should "[c]ontinue care with Dr. [L]." *Id.* Notably, there is no explanation as to why Respondent prescribed Xanax other than that K.Q. told her that she was taking it.

Later that day, the pharmacy called to tell Respondent that "[t]here is no medication Duracet." *Id.* Moreover, there are no progress notes (as there were in March) indicating the dates, if any, on which K.Q. underwent physical therapy. *Compare id.* at 4 with *id.* at 5.

On November 17, K.Q. returned and again complained of "severe low back pain" and a "shooting pain" in her right leg. *Id.* K.Q. indicated that she had neck pain associated with migraine headaches. *Id.* She also told Respondent that she was currently taking OxyContin 40 mg. in the morning and OxyContin 20 mg. in the evening, as well as "a muscle relaxant called 'Durect.'" *Id.* Respondent gave K.Q. samples of Zanaflex 4 mg. and prescriptions for 90 tablets of OxyContin 20 mg. "2 q AM and 1 q PM" (a thirty-day supply), and 90 tablets of Xanax 1 mg. "TID" (also a thirty-day supply). *Id.* at 6. Again, notwithstanding that K.Q. had told Respondent that she was taking a drug that Respondent had not prescribed to her, there is no indication that Respondent contacted any of the others physicians whom K.Q. was seeing.

Twelve days later, on November 29, Respondent phoned in a prescription for thirty Vicodin when KQ reported that her "purse was stolen." *Id.* Respondent had not previously prescribed Vicodin (or any other medication containing hydrocodone) to K.Q. While this was another indication that K.Q. was obtaining drugs from multiple physicians or from the street, again there is no indication that Respondent even questioned K.Q. as to who the source of the Vicodin was. *Id.* Nor is

⁷² According to Respondent, the earlier records had been archived. Tr. 2097.

⁷³ Lumbar punctures.

there any indication that Respondent required K.Q. to present a police report.

On December 8, K.Q. returned and complained of severe low back pain, neck pain, and headaches. *Id.* She also complained of numbness and of a shooting pain in her right lower extremity. *Id.* Following a physical exam which was limited to palpating her right upper trapezius muscle and lumbar area, Respondent wrote her prescriptions for another 90 tablets of both OxyContin 20 mg. (2 qam and 1 qpm) and Xanax (1 tablet three times a day). *Id.* Notably, the prescriptions she issued on November 17 should have lasted another nine days (until December 17). Respondent also noted that she “need[ed] to discuss case with Dr. L.” *Id.* There is, however, no indication in the patient file that Respondent ever called Dr. L.

On December 23, K.Q. needed a three-month prescription for OxyContin and Xanax “to mail away for.” *Id.* Respondent obliged and wrote her prescriptions for 279 tablets of OxyContin and 270 tablets of Xanax. *Id.* at 7.

About one month later, on January 20, 1998, K.Q. returned, complained of severe low back pain, and indicated that she had “taken slightly more of OxyContin.” *Id.* K.Q. told Respondent that she had “never mailed away for the [three] month supply of the OxyContin” but apparently had for the Xanax, as she did not need another prescription for the latter. *Id.* Respondent did not perform a physical exam on K.Q. Nor did she question how she had managed to continue taking OxyContin and done so at an increased dose when the last prescription Respondent issued to her (prior to the one she claimed not to have filled) was on December 8, six weeks earlier. Nor did she ask K.Q. to return the OxyContin prescription she issued on December 23. *Id.*

On February 2, Respondent discontinued the OxyContin and placed K.Q. on Duragesic patches. *Id.* at 8. She also noted that K.Q. was “very depressed,” diagnosed her as having depression, and gave her a prescription for 90 Valium 10 mg.⁷⁴ *Id.* Respondent did not indicate in the record why she was switching K.Q. from Xanax, a drug which is in the same class as Valium. Moreover, given the size of the previous Xanax prescription (a three-month supply which was written in late

December), the Xanax should have lasted until late March.

On March 2, after a brief trial of the Duragesic patches, K.Q. complained that patches did not work well and “want[ed] back on the OxyContin.” *Id.* at 9. Respondent, who did not perform a physical exam, diagnosed K.Q. as having both chronic pain and fibromyalgia and gave her prescriptions for 60 OxyContin 40 mg. (BID) and 90 Valium 10 mg. (TID).⁷⁵ *Id.*

Sixteen days later, on March 18, K.Q. returned and “complain[ed] of severe pain for past 2 weeks” and reported that she had been “taking extra medications, including extra Valium and OxyContin.” *Id.* Respondent’s physical exam found that she had “multiple areas [of] pain and tenderness to palpation.” *Id.* Respondent doubled the dosing of the OxyContin 40mg. to two tablets every twelve hours; the progress note does not, however, indicate how many tablets she prescribed. *Id.* Respondent also gave her a prescription for 120 tablets of Valium (TID and HS). *Id.*

On March 27, K.Q. complained that she had not voided or had a bowel movement in three days. *Id.* Respondent found her bladder distended and referred her to an emergency room for a bladder catheterization and evaluation. *Id.* at 10. On March 31, K.Q. returned and told Respondent that she “believe[d] that the nurse took her OxyContin.” *Id.* Respondent gave her a new prescription for 180 OxyContin 40 mg. (q8h), as well as for 30 Halcion (triazolam), a schedule IV controlled substance. 21 CFR 1308.14(c).

On April 14, K.Q. wanted to try a medication other than OxyContin because she thought it caused nausea, vomiting and headaches. *Id.* at 10. According to Dr. Hare, “it would be unusual for [a] patient to suddenly start having side-effects after 6 months of treatment with the medication.” GX 46A, at 4. K.Q. also told Respondent that she was changing to an insurance plan that “would not pay for the OxyContin,” GX 58, at 11; and that she had previously taken methadone. *Id.* Respondent then wrote K.Q. a prescription for methadone 10 mg. “2 tabs QID” (eight tablets a day) but did not indicate in the patient record the quantity. *Id.* Respondent also gave her a prescription for another 120 tablets of Valium. *Id.* There is no indication, however, that Respondent questioned K.Q. regarding her prior use of methadone; whether it was prescribed to her, and if so, who treated her; why was she taking it (methadone is

prescribed both for pain and detoxification/maintenance treatment); and when she had previously taken it.

K.Q. next visited on May 1, and reported that she was taking up to 120 mg. methadone per day, one and one-half times the prescribed daily dose. *Id.* Although K.Q. reported that she was “doing better” on the methadone, and the physical exam found she had less distress, less pain with lumbar ranger of motion and ambulation, Respondent gave her a prescription for 300 tablets and doubled her dose to four tablets, four times a day. *Id.* She also wrote her a prescription for 120 Xanax 1 mg. “TID” (a forty-day supply if taken as directed) and noted that K.Q. would discontinue use of Valium. *Id.*

On May 20 (nineteen days later), Respondent again wrote K.Q. a prescription for 120 tablets of Valium 10 mg. “QID.” *Id.* at 12. Respondent did not indicate in the progress note why she was switching K.Q. back to Valium. *Id.* Respondent also wrote K.Q. another prescription for 300 methadone 10 mg. *Id.*

On June 5, K.Q. reported that while she was taking the recommended dosage of four tablets, four times a day, she had only ten Methadone tablets remaining. *Id.* K.Q. told Respondent that “she believe[d] some workmen may have ‘gotten into’ her medications.” *Id.* Once again, there is no indication that Respondent questioned K.Q. as to how this could have happened. *Id.* Respondent counseled K.Q. that “she needs to lock up her medications,” and K.Q. agreed to. *Id.* She then wrote K.Q. another prescription for 300 tablets of methadone 10 mg. “4 tabs QID.” *Id.*

On June 19 (two weeks later), K.Q., who had recently twisted her ankle, wanted to switch off of methadone. *Id.* at 16. Apparently, another doctor told K.Q. that because she had pseudotumor cerebri, methadone could cause a side effect. *Id.* K.Q. also told Respondent that she would like to switch to MS Contin, because she could not afford OxyContin. *Id.*

Respondent performed a physical exam and found that K.Q.’s right ankle had slight swelling and that she had “severe numbness of [her] right lateral thigh and lateral calf.” *Id.* Respondent noted her impression as “post mild right ankle sprain.” *Id.* Respondent also diagnosed K.Q. as having “chronic numbness right lower extremity secondary to right lumbar radiculopathy vs myofascial pain,” *id.*, but according to Dr. Hare, there was no evidence in the chart to support the diagnosis. GX 46A, at 5. Respondent wrote K.Q. a prescription for 180 tablets of MS

⁷⁴ At K.Q.’s March 17 visit, Respondent noted that she was taking Prozac, a non-controlled drug prescribed for depression. It does not appear that Respondent attempted to contact whoever had treated K.Q. with the Prozac.

⁷⁵ Respondent also gave her a prescription for Zanaflex.

Contin 60 mg. “2 tabs q8h,” a thirty-day supply. GX 58, at 16.

Three days later, K.Q. told Respondent that “they only filled 100 of the MS Contin.” *Id.* Respondent did not, however, document the reason for the partial filling. *Id.* K.Q. also told Respondent that she was taking 3–4 tablets every eight hours, one and one-half to twice the prescribed dose. *Id.* There is no indication in the record that Respondent counseled K.Q. regarding her self-escalating the dose of the medication or that she questioned her as to whether it was necessary to address her pain. *Id.* Respondent then gave K.Q. another prescription for MS Contin 100 mg. “2 tabs q8h #180,” a thirty-day supply. *Id.* at 16–17.

On July 10, K.Q. returned to Respondent and told her that her left knee had gone out thirteen days earlier. *Id.* at 17. K.Q. told Respondent that she had seen Dr. H.’s physician assistant, who told her to wear a knee brace and stay on bedrest for four weeks. *Id.* K.Q. also told Respondent that she would see Dr. H. on July 20. *Id.* Respondent performed a physical exam on K.Q.’s knee and found slight swelling and that she had severe pain with knee range of motion. *Id.* Respondent concluded that K.Q. had possibly re-injured her meniscus and injected her knee with a combination of Marcaine and Depomedrol. *Id.* She also gave her new prescriptions for 240 tablets of MS Contin 100 mg., which increased the dosing to two tablets every six hours (from every eight hours) and a prescription for 120 Valium (one tablet four times a day). *Id.*

Less than two weeks later, on July 23, K.Q. complained that she had had “a bad last few weeks and request[ed] increasing her MS Contin.” *Id.* Respondent gave her another prescription for 240 tablets of Ms Contin 100 mg. and increased the dosing to three tablets every six hours. *Id.* Yet even at this increased dosing, the prescription issued on July 10 should have lasted another week. *Id.*

The following day, K.Q. saw Respondent and complained of severe knee pain. *Id.* at 17–18. K.Q. told Respondent that she had been to the emergency room twice in the last three weeks because of the dislocation of her left patella (she had not mentioned an ER visit at her July 10 visit with Respondent). *Id.* at 17. K.Q. also told Respondent that Dr. L. had advised her that she was “not a candidate for [a] cartilage transplant.”⁷⁶ *Id.* at 18. Once

again, there is no indication that Respondent contacted the doctor who had evaluated K.Q. to determine what treatment he had recommended and whether he had prescribed any controlled substances for her knee pain.

On August 6, K.Q. called Respondent and complained of “severe headaches and pain” and requested an “increase in her MS Contin and [a] change to Xanax.” *Id.* at 17. She also “complain[ed] of symptoms of pseudotumor.” *Id.* Respondent wrote her a prescription for 120 tablets of MS Contin 100 and increased the dosing to six tablets every eight hours (a fifty percent increase); she also wrote K.Q. a prescription for 150 Xanax (1 mg. q6h and 2 mg. qhs). *Id.* at 19. Respondent wrote K.Q. additional prescriptions for 120 MS Contin 100 (with the same dosing) on August 14, 20, and 27.⁷⁷ *Id.*

On the latter date (Aug. 27), Respondent also wrote K.Q. a prescription for 120 Valium (TID and HS) with one refill. *Id.* Respondent did not, however, indicate in the record why K.Q. was being switched back to Valium. *Id.* On September 25, Respondent wrote K.Q. another prescription for 120 Valium (QID—a thirty day supply) even though the August 27 prescription had included a refill. *Id.* at 20. Respondent did not indicate in the record why K.Q. already needed more Valium.

On October 5, K.Q. indicated that she had “been taking extra MS Contin for her headaches.” *Id.* Respondent again increased her prescription to 336 tablets of MS Contin 100 mg., with a dosing of eight tablets every eight hours, a two-week supply. *Id.* at 20.

Nine days later, on October 14, K.Q. reported taking the MS Contin “every 6 hours instead of every 8” and that she had “only 4 tabs left.” *Id.* at 21. As Dr. Hare observed, K.Q.’s consumption of MS Contin indicated that she was taking 37 pills a day, and not the 24 tablets that Respondent had prescribed and was even in excess of what K.Q. had told her (32 per day). GX 46A, at 5.

Respondent’s response to this information was to give K.Q. a prescription for 600 tablets of MS Contin 100 mg. and to increase the dosing to ten tablets every eight hours. GX 58, at 21. Moreover, while the previous Valium prescription (which Respondent wrote on September 25),

pseudotumor” in addition to degenerative joint disease in her left knee. GX 58, at 18. Respondent sent her to the emergency room where she had a spinal tap. *Id.*

⁷⁷ Respondent wrote K.Q. additional prescriptions for 270 tablets of MS Contin 100 mg. on September 2 and 25 with the same dosing of six tablets every eight hours. GX 58, at 20.

should have lasted another eleven days, Respondent wrote K.Q. another prescription for 120 tablets (QID), increasing the dosing from four to six tablets per day. *Id.*

Two weeks later, K.Q. was back and complaining of “severe headaches,” “vomiting up the medications,” and severe knee pain because she had “hit her left knee against the dashboard.” *Id.* K.Q. also complained that she was taking generic MS Contin, and that it was “much weaker than the brand MS Contin” and that she had “to take much more of these to get any effect.” *Id.* Respondent issued her another prescription for 600 tablets of MS Contin 100 mg.; while the note states “12 tabs,” it does not indicate the frequency. *Id.* Respondent also gave her a prescription for 90 tablets of Xanax 1 mg. (TID). *Id.* Once again, there was no indication as to why Respondent was changing K.Q. back to Xanax. *Id.*

On November 5, K.Q. was back and told Respondent that she had received only 400 tablets of MS Contin. *Id.* at 22. Respondent further noted that K.Q. had brought “in the bottle of the MS Contin and she has at least 100 left.” *Id.* Respondent wrote her a prescription for 200 tablets of methadone 10 mg., with four tablets to be taken every six hours, to last “for approximately 11–12 days.” *Id.* Respondent also wrote a prescription for 120 tablets of Valium, with two tablets to be taken every eight hours, and with two refills. *Id.* Again, Respondent did not indicate why she was changing from MS Contin to methadone and from Xanax (which had been prescribed just a week earlier) back to Valium.

On November 18, K.Q. returned and complained that the methadone did not “help as much as the MS Contin” and made her more tired. *Id.* Respondent gave her two prescriptions for 300 tablets of MS Contin 100 mg., one of which was dated November 18, the other being dated November 25. *Id.* Respondent gave K.Q. additional MS Contin prescriptions until December 31, when she told Respondent that “she would like to try the OxyContin again because it helps with the headaches.” *Id.* at 24. Respondent had not prescribed OxyContin since March 31st (nine months earlier) and on April 14, had discontinued prescribing the drug when K.Q. complained that it was causing headaches. *See id.* at 10. Respondent wrote K.Q. prescriptions for 180 tablets of OxyContin 40 mg (three tablets every eight hours); 300 tablets of an extended-release morphine 100 mg. (twelve tablets every eight hours), and 100 Valium 10 mg., (two tablets TID) with two refills. *Id.* at 24. This represented a

⁷⁶ During a physical exam, Respondent found that K.Q. showed eversion of her left eye and Respondent diagnosed her with an “exacerbation of

fifty-percent increase in K.Q.'s intake of morphine alone (not to mention the oxycodone), and yet there is no indication in the progress note that K.Q. had complained that her pain was worse. *Id.*

On January 11, 1999, Respondent gave K.Q. two additional prescriptions for 300 tablets of extended release morphine 100 mg. (with the same dosing), as well as a trial 100 milligrams of morphine elixir for headaches. *Id.* Notwithstanding that only eleven days earlier she had given K.Q. a prescription for 100 Valium with two refills, she also wrote a prescription for 100 Xanax 1 mg. (two tablets, three times a day) with one refill. *Id.*

Respondent issued K.Q. additional prescriptions for extended release morphine on January 26 and February 3, and for 60 OxyContin on the latter date. *Id.* at 24–25. On February 11, Respondent wrote additional prescriptions (dated Feb. 11 and 18) for 300 tablets of MS Contin 100 mg. (twelve tablets every eight hours) and for 100 tablets of Xanax 1–2 tablets three times a day PRN with one refill. *Id.* at 25. On March 4, Respondent switched K.Q. back to Valium but did not indicate how many tablets she prescribed. *Id.* at 26. She also wrote two more prescriptions for 300 tablets MS Contin. *Id.*

On March 18, Respondent wrote K.Q. two more prescriptions for 300 MS Contin 100 mg., as well as 100 tablets of OxyContin 40 mg. (one tablet every twelve hours). *Id.* at 27. While Respondent indicated at this visit that K.Q. “had a bad headache,” the progress note does not state that this was medical justification for the new OxyContin prescription. *Id.* at 26–27. K.Q. was not, however, able to fill the prescription “because of insurance” and returned it to Respondent at her next visit (March 30). *Id.* at 27. On this date, Respondent wrote her two more prescriptions for 300 tablets of MS Contin 100 mg. (12 q8h, or 36 tablets per day), and a prescription for 50 milliliters of morphine elixir 20mg./5ml. *Id.* As Dr. Hare noted, by this point K.Q. was taking 50 tablets per day of MS Contin. GX 46A, at 6.

Respondent continued to prescribe both MS Contin and morphine elixir to K.Q. over the ensuing months, along with additional prescriptions for either Xanax or Valium. *See* GX 58, at 33–38.⁷⁸

⁷⁸On April 29, Respondent wrote K.Q. a prescription for 120 tablets of Xanax 1 mg., with two tablets to be taken twice a day (a thirty-day supply). GX 58, at 33. On May 12, Respondent was back to writing her a prescription for Valium 10 (2 tabs TID) with 2 refills, but did not indicate the quantity. *Id.* at 34.

On September 30, however, Respondent began prescribing methadone 10 mg. again (three to four tablets, four times a day) when K.Q. claimed that she could not find generic MS Contin because it was no longer being manufactured. *Id.* at 38.

On October 7, K.Q. reported that she was “[d]oing better” and “without side effects,” *id.* at 39, even though the methadone was prescribed at “a dose far less than that of MS Contin.” GX 46A, at 6. While K.Q. had reported that she was “[d]oing better,” Respondent increased the dosing to four to five tablets, four times a day. GX 58, at 39. However, on November 8, K.Q. complained that the methadone made “her too fatigued.” *Id.* Respondent went back to prescribing MS Contin 100 mg. (300 tablets, with twelve tablets to be taken every eight hours) and gave her prescriptions which were dated November 8 and 15. *Id.* at 40. According to the Government’s expert, the MS Contin dose “would have 6 times the analgesic effect as the methadone” K.Q. had been switched from. GX 46A, at 6.

Nine days later, K.Q. complained of severe headaches and Respondent gave

On August 19, Respondent wrote an additional Valium prescription for 100 tablets (two tablets, three times a day) with three refills. *Id.* at 38. Two weeks later (on September 3), she wrote another prescription for 100 tablets of Valium 10, with the same dosing, with three refills. *Id.* On September 13, Respondent went back to writing K.Q. a prescription for 120 tablets of Xanax 1mg. (two tablets, two times a day) with two refills. *Id.* Again, no reason was stated for changing from Valium to Xanax. *See id.* On September 29, a pharmacy called to clarify the dosing of the Xanax; Respondent told the pharmacist to change it back to two tablets, three times a day. *Id.* On October 25, Respondent was back to prescribing 100 Valium (two tablets, three times a day) with three refills. *Id.* at 39. Again, no reason was stated for the change. *Id.* While this prescription with refills should have lasted 66 days, on December 1, Respondent gave her a prescription for 100 Xanax 1 mg. (2 tablets TID) with two refills. *Id.* at 40, 138.

On December 21, Respondent wrote K.Q. a prescription for 180 tablets of Valium 10 mg. (2 tabs TID), with three refills. *Id.* While on January 7 K.Q. told Respondent that she had not filled the prescription and obtained a prescription for another 180 tablets (2 TID) with three refills, even if this was true, no explanation was given for why the prescription was issued given that she had issued a Xanax prescription three weeks earlier. *Id.* at 41, 138–39.

On February 16, notwithstanding that the January 7 prescription and refills should have lasted four months, Respondent gave K.Q. another prescription for 180 tablets of Valium at the same dosing with the three refills. *Id.* at 48. Moreover, on April 25, Respondent gave K.Q. another prescription for 180 tablets of Valium at the same dosing with three refills even though the February 16 prescription should have lasted until the middle of June. *Id.* at 50. This was followed by a May 12 prescription for 180 Valium (2 TID), *id.*, and a July 14 prescription for 100 tablets with a dosing of 1–2 tablets twice a day and three refills. *Id.* at 50–51. On September 18, Respondent wrote K.Q. another prescription with the same quantity, dosing and refills, as the July 14 prescription. *Id.* at 52.

her more prescriptions for 300 tablets of MS Contin 100 mg., as well as for 100 tablets of immediate-release morphine 30 mg., one tablet every two hours as needed for breakthrough pain. *Id.* at 137. Respondent wrote additional prescriptions for these drugs on December 1 and 21. *Id.* at 138. In addition, on December 21, Respondent wrote a prescription for 270 tablets of OxyContin 80 mg., with a dosing of three tablets every eight hours. *Id.*

In early February, K.Q. told Respondent that her insurance would not cover the MS Contin. *Id.* at 48. Respondent resumed prescribing methadone 10 mg., and wrote her a prescription for 300 tablets with a dosing of four tablets, four times a day. *Id.* This again was at a dose that was “much lower than [n] that of the MS Contin.” GX 46A, at 7. At the next visit (Feb. 16), K.Q. was nonetheless “OK on the [m]ethadone now.” GX 58, at 48. Respondent gave her another prescription for 300 methadone (as well as one to be filled on March 2) and additional prescriptions for 200 immediate-release morphine (1 q2h) and for 180 Valium (2 TID) with three refills. *Id.*

At her next visit (March 13), K.Q. reported that she was taking eight tablets, three times a day, which was a fifty-percent increase over the prescribed daily dosing. *Id.* Respondent increased the dosing of her prescription to the amount she was taking and gave her two prescriptions for a total of 600 tablets, as well as two prescriptions for a total of 200 tablets of immediate-release morphine. *Id.* at 49.

This basic pattern of prescribing methadone, Valium, and immediate-release morphine continued until June 19 when K.Q. told Respondent that “she is going to discontinue MS Contin and wants Percocet.” *Id.* at 50. K.Q. had not, however, received an MS Contin prescription from Respondent in four to five months. *Id.* at 48. Respondent did not further question K.Q. about whether she had continued to use MS Contin and wrote her a prescription for 100 Percocet. *Id.* at 50.

Over the next four months, Respondent continued to prescribe methadone, Percocet, and Valium to K.Q. *Id.* at 50–53. With respect to the Percocet, Respondent gave K.Q. prescriptions for 100 tablets on September 6, 11, 18, and 25, as well as on October 2, 9, 16, 23, and 30. *Id.* at 51–53. The size and frequency of the prescriptions suggest that K.Q. was taking 100 tablets every seven days and fourteen tablets a day, and consuming 4643 mgs. of acetaminophen a day, an amount well in excess of the

recommended daily maximum of 4000 mgs.

Moreover, on October 30, Respondent prescribed (in addition to the Percocet and methadone) 20 tablets of Demerol (meperidine), another schedule II opiate. See 21 CFR 1308.12(c)(18). GX 58, at 53. The progress note, however, contains no explanation as to why the Demerol prescription was medically necessary. *Id.*

Two days later on November 1, K.Q. was admitted to St. Mary's Hospital behavioral health unit "for [a] psychotic episode" and was "manic, rambling, labile, tearful and with auditory hallucinations." *Id.* According to the report documenting her admission, Catalina Behavioral Health had sent her to St. Mary's and upon her admission, K.Q. "said [that] she cannot stop crying," "present[ed] with pressed speech, flight of ideas," was "very difficult to interview," and needed a psychiatric evaluation. RX Z, at 1.

Relatedly, the discharge summary noted that K.Q. had been referred by Catalina because she "had been progressively becoming agitated, over talkative, confused, disorganize[d] [in] thought, rambling in her speech, and unable to sleep." *Id.* at 3. The report from Catalina was that K.Q. "has been self medicating and this is contributing to her mood transient problems." *Id.*

The discharge summary stated that K.Q. had "denie[d] previous psychiatric hospitalization except for one time that she was admitted at the Westchester when she had attempted to quit narcotics back in 1997." *Id.* While K.Q. apparently denied the use of alcohol and recreational drugs and maintained that her opiates had been prescribed by Respondent and another doctor, she also reported "being seen in pain clinics and didn't want to elaborate any further." *Id.* at 4.

The report further noted that while she was hospitalized, K.Q. engaged in "some medication seeking behavior." *Id.* at 5. In addition, the summary reported that "[t]he patient admits to being cognizant that her narcotics are a lot; she wants to try to get off of them, however not at the expense of being in pain." ⁷⁹ *Id.* at 4.

As to this incident, Respondent testified that "the staff believ[ing] [K.Q.] was overmedicated" was not mentioned in the phone call from the unit or in the hospital's record. Tr. 2106. Apparently,

⁷⁹ The psychiatrist diagnosed K.Q. as having "[u]nresolved issues related to the death of her child," "[n]oncompliance with treatment," "[u]ntreated depression," and "[d]ramatic mood swings, probably secondary to untreated depression and PTSD in addition to opioids on extreme high doses." RX Z, at 5.

the statement at the bottom of the first page of the discharge summary "that the patient has been self medicating and this is contributing to her mood transient problems" and the diagnosis that her dramatic mood swings were "probably secondary * * * to opioids on extreme high doses" did not express the staff's belief with sufficient clarity. RX Z, at 1 & 5.

Respondent also maintained that the hospital maintained K.Q. on her pain medications. Tr. 2106; *but see* RX Z, at 5 ("For the time being we will continue patient on similar narcotic medications," and suggesting a "pain medical consult for issues regarding her pain management"). Given the short amount of time K.Q. was hospitalized (approximately five days), it is not as if the hospital had the time to try to taper her intake of the drugs.

On November 13, K.Q. went back to see Respondent. GX 58, at 53. While the progress note contains a brief discussion of her stay in the hospital, there is no indication that Respondent asked her about "the cause of the hospitalization even though the symptoms [she] experienced could have been caused by excessive medication or withdrawal from medication." GX 46A, at 7. At the visit, Respondent prescribed Demerol (20 tablets), Percocet (100 tablets) and methadone 10 mg. (200 tablets) (when a prescription for 100 methadone 40mg. could not be filled). GX 58, at 53.

Respondent prescribed these three drugs on November 21 and 29, as well as on December 6; on December 12, she wrote for 100 Percocet and more Demerol. *Id.* at 53–54. The next day, Respondent wrote K.Q. a prescription for 100 oxycodone. *Id.* The note does not indicate the reason for the prescription, the strength, or the dosing. *Id.* at 54. Moreover, on December 19, Respondent wrote K.Q. additional prescriptions for 100 tablets of Percocet and OxyContin. *Id.* Again, the note did not indicate the reason for the OxyContin, the strength, or the dosing.

On January 15, Respondent noted that she had talked with K.Q.'s parents "regarding [her] overuse of medications and * * * sedation." *Id.* at 55. Respondent initially agreed to prescribe only two to four days of medication at a time. *Id.*

On January 18, Respondent prescribed 30 tablets of Dilaudid (QID), another schedule II drug, a seven-day supply based on the dosing. *Id.* at 56. Once again, Respondent did not indicate the reason for prescribing the drug. See also GX 46A, at 7. Moreover, on February 20, Respondent increased the dosing of the Dilaudid to four tablets, four times a day, a four-fold increase. *Id.* Again,

there was no explanation for the increase in the dosing. GX 58, at 55.

Respondent continued to prescribe methadone, Roxicodone, Dilaudid, Valium, and Xanax⁸⁰ throughout most of 2001. On October 3, K.Q. complained of increased neck pain and increased the dosing of the Roxicodone from four to six tablets to eight to ten tablets every four hours (and gave her two prescriptions for a total of 600 tablets) and added a prescription for 60 tablets of MSIR (morphine sulfate immediate release, one tablet every four hours PRN). *Id.* at 62.

On October 9, K.Q. returned and reported that four days earlier she had been in an automobile accident in which her car's "[a]irbags deployed." *Id.* at 62. K.Q. complained of bruising of her upper extremities and that her pain had increased; K.Q. was wearing a knee brace. *Id.* at 63. Respondent performed a physical exam which found K.Q. "awake and alert" and with "minimal stiffness with cervical range of motion." *Id.* Respondent did not, however, indicate that she observed any bruising on K.Q. See *id.* Respondent concluded that K.Q. had an "exacerbation of pain" and wrote her prescriptions for 200 methadone 10 mg. (eight tablets, three times a day) and for 120 tablets of MSIR 39 mg. (one tablet every four hours as needed for pain), as well as for ninety Xanax (q8h) with three refills. *Id.*

Three days later, Respondent gave K.Q. another prescription for 200 methadone 10 mg., with the same dosing, even though the previous prescription should have lasted until October 17.⁸¹ *Id.* On October 18, K.Q. again saw Respondent, whose only finding on physical examination was that she had "slight pain and stiffness with cervical range of motion." *Id.* Respondent gave K.Q. prescriptions for 400 tablets of methadone 10 mg. (with

⁸⁰ On August 9, Respondent gave K.Q. a prescription for 100 Valium 10mg. (q4h) with five refills. GX 58, at 61. On October 9, four days after K.Q. reported that she had been in what appears to have been a minor automobile accident (given the limited findings of Respondent's physical exam and the fact that she did not change the dosing of K.Q.'s pain medications), Respondent discontinued the Valium and gave her a prescription for 90 Xanax 1 mg. (q8h) with three refills. *Id.* at 62–63. Only nine days later, Respondent gave K.Q. another Xanax 1mg. prescription, which was for 60 tablets with two refills and which doubled the dosing to two tablets every eight hours PRN. *Id.* at 63. There is no indication, however, as to whether she contacted the pharmacy that dispensed the October 9 prescription to cancel the refills. *Id.* Moreover, while the October 18 prescription with its refills should have lasted thirty days, on November 6, Respondent wrote K.Q. another prescription for 180 tablets (at the same dosing) with three refills. *Id.* at 64.

⁸¹ Respondent also wrote K.Q. a prescription for 200 Roxicodone (8–10 q4h) at this visit. *Id.*

the same dosing of eight tablets, three times a day), 200 tablets of MSIR 30 mg. (with an increased dosing of one tablet every three hours), 400 tablets of Roxicodone, and another 60 tablets of Xanax (which doubled the dosing to 2 q8h) with two refills. *Id.* Respondent did not indicate why she was increasing the dosing of the Xanax and the MSIR. *Id.* Nor did she indicate why it was medically necessary to issue another MSIR prescription when the previous prescription should have lasted until October 29. *Id.*

On November 6 and 19, Respondent wrote K.Q. additional prescriptions for 200 and 100 tablets of MSIR 30 mg. (q3h), respectively. *Id.* at 64. As the October 18 prescription should have lasted at least until November 12, the November 6 prescription was six days early. And as the November 6 prescription should have lasted at least until December 1, the November 19 prescription was twelve days early.

On December 20, 2001, another of Respondent's patients, who performed security at the apartment complex where K.Q. lived, told Respondent that K.Q. "is selling her meds to people in her apartment complex." *Id.* at 65. This person further stated that "several people have told her that [K.Q.] has approached them with drugs to sell, and this is an ongoing problem." *Id.*

According to the patient record, "the complex [was] considering action." *Id.* Later that day, Respondent wrote K.Q. a letter terminating her as a patient. *Id.*

In summarizing his findings regarding Respondent's treatment of K.Q., Dr. Hare observed that K.Q.:

Was prescribed control[led] substances without adequate evaluation or followup. There were many indicators that she was consistently over-using her medication and yet [Respondent] took no steps to correct this. In fact she prescribed more medication. Despite warnings that the patient was over medicated, Respondent continued to prescribe[] unabated. Respondent never took steps to control K.Q.'s medication use or to even do blood or urine tests to establish that she was in fact taking the medication. Reports of diversion that [Respondent] received should have come as no surprise, yet [Respondent] seemed oblivious that [K.Q.] was misusing her medication. Clearly this is substandard care. [Respondent's] prescribing encouraged overuse and/or diversion of medication.

GX 46A, at 7–8.

Respondent's Efforts at Rehabilitation

Pursuant to the consent agreement she entered into with the Arizona Medical Board, Respondent took ten hours of Continuing Medical Education (CME) in the principle and practice of pain management or addiction medicine. RX

53, GX 73. Respondent also took an additional 51.25 hours of CME in a range of topics related to pain management. RX 53.

In 2002, in response to the State's Board investigation, Respondent also entered an arrangement under which Dr. Schneider mentored her. Tr. 808. More specifically, over a period of several months, Dr. Schneider met with Respondent on a weekly basis to review the medical records of those patients she had seen that week and to whom she had prescribed opioids. *Id.* Dr. Schneider advised her as to how to improve her documentation and management of these patients. RX K–1, at 2. Dr. Schneider testified that she now considered Respondent to be "one of the most knowledgeable people about addiction issues in the community." Tr. 812.

Respondent testified that in the event she was granted a new registration, she would limit her practice to musculoskeletal pain and would use opioid risk assessment tools and addiction histories to evaluate her patients. *Id.* at 2412. Respondent also testified that she "intended to use urine drug screening a lot more frequently" and that she would continue to consult with Dr. Schneider regarding her patients.⁸² *Id.*

At the hearing, Respondent also submitted a list of 29 patients she had fired. See RX 37. However, all but six of the patients were fired after the Medical Board began investigating her.⁸³ See *id.*

Moreover, substantial portions of Respondent's testimony undercut her claim that she has reformed. For example, while Respondent testified that she was not saying "that each and every prescriptions I ever write is 100 percent perfect," that "my medical records are perfect or fully comprehensive," and that "there wasn't room for improvement on my part," as noted above, she emphatically denied having done anything wrong with respect to any of the prescriptions she issued to H.T. Tr. 2305–06. Relatedly, she also denied that she falsified H.T.'s medical records.

⁸² Dr. Schneider testified that she had volunteered to mentor Respondent for three years in connection with a settlement offer that was made in the course of these proceedings and that she would be willing to mentor Respondent for three years as a condition of her receiving her DEA registration. Tr. 860–62.

⁸³ Moreover, most of the patients' records are not in the record and thus the circumstances prompting the firings (and whether Respondent ignored any earlier warning signs) are not established. Accordingly, to the extent Respondent offered this document as evidence that she is capable of properly monitoring her patients, it is of limited probative force.

Moreover, her testimony regarding several other issues raises serious questions as to what she has learned from this experience. With respect to patient S.R., who admitted to taking her deceased husband's controlled substance medications, Respondent testified that she "did not see that it would cause any potential harm to" her. *Id.* at 2353. Speaking generally of a person taking a controlled substance that had been prescribed not to them but to a spouse, she testified:

There's just continuing medical care, and to me, it seems no harm to the patient, I might add. I've never seen an example where bad came, any harmful outcome, but I see it time and time again, dozens of times.

Id. at 2395.

Later, Respondent added:

Our party line as a physician is don't take anyone else's prescriptions, period, whether it's controlled or not controlled. Of course, I know at issue here is only controlled, and then controlled has an extra layer on top of it, meaning it's a felony to do it. But really as a physician, from a medical standpoint, it refers to all prescriptions.

The party line is don't use anyone else's prescriptions, don't use expired medications, et cetera, et cetera, but the fact is people do use each other's prescription medications, and almost always there's no harm because people know * * * They know what they are taking. People develop, certainly develop, an area of knowledge about their medications.

Id. at 2400–01.

Moreover, when asked by the Government whether she had "often issued early refills on prescriptions without documenting the reason why?," Respondent answered:

The record speaks for itself there, and there are many reasons why a prescription is not filled on, for instance, the thirtieth day on a 30-day supply. The definition [of] early refill, if a persons says, well, if you go to the pharmacy on day 29, that's considered an early refill, so the definition of early refill is questionable and not clear and not well-agreed upon. So it would be difficult for me to answer that question unless you are defining for me terms such as that.

Id. at 2345.

Relatedly, when asked a follow-up question as to whether she had a definition of the term "early refill," Respondent answered:

No, not really. It was a DEA term, early refill. With physicians, there never was any lesson about early refills in medical school. That's not anything that was covered, so no, I have no definition.

Id. at 2346. Apparently, Respondent had not asked Dr. Schneider to explain what the term means, even though the latter had noted with respect to six of the patient files she reviewed that they "all received early refills without adequate

documentation and explanation.” RX K-1, at 6.

Respondent also disagreed that she had “ignored the fact that some of [her] patients had addiction histories.” *Id.* at 2348. Finally, she “absolutely disagreed” that she had “ignored warning signs that a patient might be” addicted to, or abusing drugs. *Id.* at 2348–49.

Discussion

Section 303(f) of the Controlled Substances Act (CSA) provides that “[t]he Attorney General may deny an application for [a practitioner’s] registration if he determines that the issuance of such registration would be inconsistent with the public interest.” 21 U.S.C. 823(f). In making the public interest determination, the Act requires the consideration of the following factors:

- (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.*

“[T]hese 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 an application for a registration should be denied. *Id.* Moreover, I am “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). The Government bears the burden of proving that the requirements for registration are not satisfied. 21 CFR 1301.44(d).

Having considered all of the factors, I conclude that the Government has made out a *prima facie* case that issuing Respondent a new registration would be inconsistent with the public interest. In particular, I conclude that the Government’s evidence with respect to Respondent’s experience in dispensing controlled substances (factor two) and record of compliance with applicable controlled substance laws (factor four), is far more extensive than the ALJ acknowledged it to be and establishes numerous instances in which Respondent improperly dispensed

controlled substances. While in some instances, Respondent may have been only gullible or naive, in other instances (H.T.) she engaged in intentional diversion as well as falsified medical records or acted with deliberate ignorance of a patient’s real purpose in seeking the prescriptions. While I have carefully considered all of Respondent’s various contentions, including her evidence that she has reformed her prescribing practices, I conclude that Respondent has not rebutted the Agency’s *prima facie* showing because she has refused to acknowledge her wrongdoing with respect to her most egregious acts.

Factor One—The Recommendation of the State Licensing Board

While Respondent has twice been sanctioned by the Arizona Medical Board for unprofessional conduct including the improper prescribing of controlled substances, it is undisputed that she currently holds an active State license. The Agency has long held, however, that a practitioner’s reinstatement by a State board “is not dispositive” because “DEA maintains a separate oversight responsibility with respect to the handling of controlled substances and has a statutory obligation to make its independent determination as to whether the granting of [a registration] would be in the public interest.” *Mortimer B. Levin*, 55 FR 8209, 8210 (1990); see also *Jayam Krishna-Iyer*, 74 FR 459, 461 (2009).

Respondent also relies on a letter from a Senior Compliance Officer with the Arizona Board which states that she “has the Board’s support to pursue her DEA reinstatement.” RX 53; see also Resp. Br. 157. Continuing, the letter stated that Respondent “at no time attempted to divert medications for non-medical purposes.” RX 53. Even assuming that the letter represents the official view of the Board (and not simply the view of one of its employees), the evidence presented in this proceeding establishes that Respondent engaged in far more egregious conduct than the evidence which apparently was presented to the Board. I thus conclude that, at most, this factor is entitled to nominal weight in the public interest analysis.

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 “[a]n 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 relating to controlled substances.” *Id.* As the Supreme Court recently 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)).

While many cases under the public interest standard involve practitioners who violated the prescription requirement and did so intentionally, the Agency’s authority to deny an application (or to revoke an existing registration) is not limited to those instances in which a practitioner intentionally diverts a controlled substance. See *Paul J. Caragine, Jr.*, 63 FR 51592, 51601 (1998). As my predecessor explained in *Caragine*: “Just because misconduct is unintentional, innocent or devoid of improper motivation, [it] does not preclude revocation or denial. Careless or negligent handling of controlled substances creates the opportunity for diversion and [can] justify” the revocation of an existing registration or the denial of an application for a registration. *Id.* at 51601. A practitioner’s failure to properly supervise her patients to prevent them from personally abusing controlled substances or selling them to others constitutes conduct “inconsistent with the public interest” and can support the denial of an application or the revocation of an existing registration. *Id.*; see also *Gonzales*, 546 U.S. at 274.

The ALJ concluded that the Government had proved that Respondent’s prescriptions to H.T. were “not issued for a legitimate medical purpose.” ALJ at 150. I agree and note that, at no time during any of his visits with Respondent occurring between February and April 2002, did H.T. complain that he was in pain. On six occasions, however, Respondent gave H.T. prescriptions for schedule II narcotics including Percocet 10, Roxycodone (oxycodone) in both five-

and fifteen-mg. strength, and OxyContin in both twenty- and forty-mg. strength.

Substantial evidence also supports the conclusion that Respondent knew that H.T. was not seeking the drugs to relieve pain but to abuse them. Respondent did not perform a physical exam of H.T. at any of the visits at which she issued the prescriptions, yet falsified H.T.'s medical records to indicate that she had done so. Moreover, in addition to his failure to ever complain of being in pain, H.T. made numerous statements which made clear that he was seeking the drugs to abuse them.

These included, *inter alia*: (1) H.T.'s statements that he liked oxycodone but was eating them "like M & Ms" or "candy"; (2) that he would be "happier with fifteens"; (3) that an acquaintance had told him that he had "gotta try and get her to give you some * * * OxyContin"; (4) that he was "hopin[g] you'd give me a hundred" tablets of OxyContin; (5) "My back feels great, but I like these" and asking "is that a bad thing?"; (6) "Doc, you know between you and me my pain level is non-existent, but I really like them Oxy[C]ontin. They make me feel good"; (7) "I'd never tell you none of them stories about losing 'em or anything. I just tell ya the truth. I'd just like a few more of those, okay?"; (8) H.T. relating that he had asked someone on the street in Nogales, Mexico about buying OxyContin and stating the price per milligram.

Finally, Respondent made numerous statements which show that she knew H.T. was seeking the prescriptions for non-medical reasons. These included, *inter alia*: (1) Respondent's statement that Tylenol "is a bad thing" but "the other stuff [in Percocet, oxycodone] is a fun thing"; (2) asking H.T. whether he "like[d] the Oxy[C]ontin?"; (3) asking H.T. "do you want the OxyContin?"; (4) after giving H.T. a prescription for ninety OxyContin 40 mg., responding to H.T.'s statement that "You'r[e] okay, Doc," with "You caught me at a soft moment"; (5) Respondent stating that the State Board was watching her and telling H.T. to wait "until my investigation is over"; (6) Respondent stating that she could not keep prescribing to H.T. for the reasons he wanted the drugs and again telling him to wait until her investigation was over, yet prescribing 90 tablets of OxyContin 40 mg. on a subsequent visit.

As the evidence makes plain, Respondent issued H.T. six prescriptions for schedule II controlled substances which were outside of the usual course of professional practice and lacked a legitimate medical purpose. 21 CFR 1306.04(a). Moreover,

Respondent clearly knew that H.T. was not seeking the drugs to treat pain, but rather to abuse them.

The ALJ concluded, however, that H.T. (and R.T.⁸⁴) were the only patients to whom Respondent issued unlawful prescriptions. As found above, however, the patient records establish numerous other instances in which Respondent violated the CSA's prescription requirement.

Respondent gave K.Q. numerous prescriptions for both schedule II narcotics as well as schedule IV benzodiazepines. Many of these prescriptions were issued well before previous prescriptions for either the same or similar drugs would have run out if K.Q. had taken them in accordance with Respondent's dosing instructions.

For example, on December 31, 1998, Respondent gave K.Q. a prescription for 100 Valium with two refills. Based on the dosing of two tablets, three times per day, the prescription should have lasted 50 days if taken as prescribed. Yet on January 11, 1999 (just eleven days later), Respondent issued K.Q. prescriptions for 100 Xanax with one refill.

Moreover, as discussed in footnote 79, on August 19, 1999, Respondent wrote K.Q. a prescription for 100 tablets of Valium with three refills and thus authorized the dispensing of 400 tablets. Based on the dosing of two tablets, three times a day, the prescription with refills should have lasted approximately 66 days. Yet on September 3 (only fifteen days later), Respondent wrote K.Q. another prescription for 100 tablets of Valium with three refills and the previous dosing. Ten days later, Respondent wrote K.Q. a prescription for 120 tablets of Xanax with two refills and a dosing of two tablets, two times a day. Respondent did not indicate why she was switching from Valium to Xanax. While Respondent changed the dosing of the Xanax to two tablets, three times a day after being contacted by a pharmacist, even at this increased dosing the prescriptions with refills should have lasted 60 days. Yet on October 25, Respondent was back to prescribing Valium and issued K.Q. a prescription for 100 tablets (dosing at two tablets, three times per day) with three refills.

Here again, the prescriptions should have lasted approximately 66 days if taken as prescribed. Yet on December 1 (thirty-six days later), Respondent was

back to prescribing 100 Xanax (two tablets, three times a day) with two refills. Not even three weeks later, however, Respondent returned to prescribing 180 tablets of Valium (two tablets, three times a day) with three refills. Again, Respondent provided no explanation for why she had changed drugs.

On January 7, Respondent gave K.Q. a prescription for another 180 tablets of Valium with the same dosing and three refills after the latter claimed that she had not filled the December 21 prescription. Respondent did not, however, inquire as to what had happened to the previous prescription. Moreover, even if K.Q. was not obtaining drugs pursuant to the December 21 prescription, the January 7 prescription should have lasted four months or until early May. Yet on February 16, Respondent gave K.Q. another prescription for 180 Valium at the same dosing with three refills (which should have lasted until the middle of June), and on April 25, Respondent gave K.Q. an additional prescription for 180 tablets with the same dosing and three refills (which ignoring all the previous prescriptions should have lasted until late August). This was followed by a May 12 prescription for 180 Valium at the same dosing, and a July 14 prescription for 100 tablets with a lowered dosing (of 1–2 tablets twice a day) but also with three refills.

Given Respondent's repeated issuance of these prescriptions, frequently months before the previous prescriptions would have run out, her prescribing cannot be attributed to negligence in failing to check K.Q.'s record. Rather, the frequency of the prescribings supports the conclusion that Respondent was deliberately ignorant as to why K.Q. was seeking the prescriptions and thus can be charged with knowledge that the prescriptions were not for a legitimate medical purpose. *See United States v. Katz*, 445 F.3d 1023, 1031 (8th Cir. 2006) (knowledge can be inferred when a practitioner is put "on notice that criminal activity was particularly likely and yet * * * failed to investigate those facts") (other citations and quotations omitted).

Furthermore, Respondent had other reasons to know that K.Q. was engaged in drug-seeking behavior. At the first visit, K.Q. reported that she was being treated by two other physicians, one of whom was prescribing Percocet to her, and that she was also taking Lorcet and Xanax. Respondent gave her a prescription for twenty Percocet and yet did nothing to contact these other

⁸⁴ The ALJ also found that Respondent had issued refills to R.T. which lacked a legitimate medical purpose. ALJ at 150. In light of the extensive and more egregious evidence of Respondent's prescribing to other patients, I conclude that it is not necessary to discuss R.T. further.

physicians to determine what they were prescribing and to coordinate their prescriptions. Moreover, two days later, Respondent gave K.Q. a prescription for 90 Percocet based on K.Q.'s representation that there was a price-break on the drug and that she had gotten a check from a church made out for the exact amount of 90 Percocet. Respondent did not indicate in K.Q.'s record, however, why the prescription was medically necessary, and I conclude that prescription lacked a legitimate medical purpose.

K.Q. engaged in other scams to obtain drugs, including claiming that she had missed an appointment with another physician (who was prescribing OxyContin to her and either Xanax or Valium) and that the physician was out-of-town. Respondent did not, however, even bother to pick up the phone and call the doctor to determine if this was true. Respondent then prescribed OxyContin, Xanax and "Duracet," the same drugs which K.Q. had told her she was currently taking only to be told by the pharmacy that there was no such drug as Duracet. Moreover, at the next visit, K.Q. told her that she was taking "a muscle relaxant called Durect" even though Respondent had not prescribed a muscle relaxant to her. Yet this did not prompt Respondent to investigate further.

This was followed not even two weeks later by a phone call from K.Q. reporting that her purse (which contained Vicodin) had been stolen. Respondent dutifully called in a prescription for 30 Vicodin even though Respondent had not prescribed this drug to K.Q. Nor did she question K.Q. as to who the source of the Vicodin was. Moreover, two months later, K.Q. claimed that she had not mailed away a prescription Respondent had issued to her at her last visit for a three-month's supply of OxyContin, even though the last prescription before the three-month one was for a thirty-day supply, had been issued six weeks earlier, and K.Q. had reported that she taking more than the recommended dosing.⁸⁵

Respondent thus had ample reason to know early on in her treatment of K.Q. that the latter was engaging in drug-seeking behavior. Moreover, on various occasions throughout her treatment,

⁸⁵ On another occasion, K.Q. reported that she had previously taken methadone, a drug which is used not only to treat pain but to treat addiction as well. Yet Respondent did not inquire as to who had prescribed it to her and why. On another occasion, K.Q. reported that "she believe[d] that some workmen may have gotten into her medications." While Respondent did counsel her to lock up her medications, the incident did not prompt Respondent to institute any type of monitoring of K.Q.

K.Q. reported that she had self-escalated the dosing of various narcotics. Typically, Respondent did not question K.Q. as to whether it was necessary to do so to address her pain. Notably, much of K.Q.'s problematic behavior had occurred prior to Respondent's issuance of the Xanax and Valium prescriptions discussed above.

During another period of her prescribing, Respondent gave K.Q. nine prescriptions at approximately weekly intervals for 100 tablets of Percocet, a drug which contains a minimum of 325 mg. of acetaminophen no matter what strength of oxycodone it contains. If K.Q. had consumed 100 tablets every week, she would have been taking approximately fourteen tablets and consuming 4643 mgs. of acetaminophen, an amount well in excess of the recommended daily maximum of 4000 mgs. because of its potential to cause liver toxicity. Respondent did not, however, direct that K.Q. undergo liver function tests.

Moreover, after K.Q. was hospitalized for a psychotic episode, Respondent received reports which indicated that she had seen not only Respondent and another doctor, but was also going to pain clinics and did not want to elaborate further. The discharge summary also stated that K.Q. was "self medicating" and was engaging in "some medication seeking behavior." Even after receiving this information, as well as a subsequent phone call from K.Q.'s parents reporting that she was overusing her medications, Respondent continued to prescribe to her and did nothing to monitor her use of the drugs. Respondent also gave her early refills on various drugs including methadone, MSIR, and Xanax (including a prescription which was issued for 60 tablets with two refills only nine days after giving her a prescription for 90 Xanax (q8h) with three refills). She also prescribed additional drugs (such as Dilaudid) and increased the dosing of various drugs (including increasing the dosing of Dilaudid four-fold at a single visit) without any medical justification. While Respondent eventually terminated K.Q. (more than a year after her hospitalization) after being told by another patient that she was selling her medications, it is clear that many of the controlled substance prescriptions which Respondent issued to K.Q. lacked a legitimate medical purpose and were issued outside of the usual course of professional practice. 21 CFR 1306.04(a); GX 46A, at 8.

Respondent also issued numerous prescriptions to J.R., who had previously been convicted for distributing marijuana, for schedule II

drugs including methadone, 360 tablets of OxyContin 40 mg., 180 tablets of Oxycodone IR, and 200 tablets of Percodan. The medical purpose for the prescriptions was initially to treat J.R.'s migraine headaches; subsequently J.R. also complained of lower back pain.

While at the first visit in the patient file (8/25/99), Respondent issued prescriptions for OxyContin and Oxycodone IR⁸⁶ which should have lasted thirty days based on the dosing instructions, only twenty-one days later, Respondent issued additional prescriptions for the same quantities and dosing of both OxyContin 40 mg. and Oxycodone IR, and for the same quantity of Percodan. A week later, Respondent gave J.R. replacement prescriptions but gave no reason for doing so.

On October 20, Respondent issued additional prescriptions for thirty-day supplies of OxyContin 40 mg. (360 tabs) and Oxycodone IR (180 tabs), which were re-issued eight days early on November 11. While the latter prescriptions were to be sent to a Patient Assistance Program (PAP), Respondent added a separate prescription for 100 OxyContin to be filled locally while J.R. waited for the PAP prescription to arrive. Respondent wrote additional prescriptions for 360 Oxycontin 40 mg. and 180 Oxycodone IR (and 200 Percodan) on December 13 and January 4 of the following year.

Only seventeen days after the latter prescription, on January 21, Respondent gave J.R. two more prescriptions, each of which was for 360 tablets of OxyContin 40, one to be filled locally and one to be filled by the PAP. On both February 7 (again after only seventeen days) and February 22 (after only fifteen days), Respondent issued J.R. two more prescriptions (one to be filled locally, the other by the PAP), each for 360 tablets of OxyContin 40 mg. Thus, during February alone, Respondent gave prescriptions which authorized the dispensing of 1440 tablets, which was four times the quantity required based on her dosing instruction. At the visits, Respondent also issued additional prescriptions for 180 Oxycodone and 200 Percodan, which were invariably early, typically by nearly two weeks.

On March 13, based on J.R.'s report of a severe headache, Respondent wrote two prescriptions for both 450 tablets of OxyContin 40 mg. and 360 Oxycodone IR and increased the dosing of both drugs (including doubling the dosing of the Oxycodone IR). Moreover, the next day, Respondent wrote J.R. further

⁸⁶ There was no dosing instruction listed for the Percodan.

prescriptions for 450 OxyContin 40 mg. and 360 Oxycodone IR, which she backdated to March 5 with no explanation. See 21 CFR 1306.05(a) (“All prescriptions for controlled substances shall be dated as of, and signed on, the day when issued * * *”). Thus, in the month of March, Respondent gave J.R. prescriptions which authorized the dispensing of three times the amount of both OxyContin and Oxycodone IR that her dosing instructions called for.

Respondent’s pattern of early and duplicative prescribing did not end there. On April 12, Respondent wrote J.R. two more prescriptions for 450 OxyContin 40 mg. and 360 Oxycodone IR. While these drugs should have lasted until the middle of June, on May 2 (twenty days later), Respondent gave J.R. a prescription for 270 OxyContin 80 mg. and noted that the next day, she would write additional prescriptions for OxyContin and Oxycodone IR.

Six days later, Respondent wrote J.R. two more prescriptions for OxyContin: one for 270 tablets of 80-mg. strength for the PAP and one for 450 tablets of 40-mg. strength presumably to be filled locally; both of the prescriptions were for a thirty-day supply. Moreover, Respondent wrote prescriptions for 360 Oxycodone IR for the PAP (a sixty-day supply) and 180 Oxycodone IR (a thirty-day supply). Yet on May 15, Respondent wrote two more prescriptions (purportedly to be re-mailed) which were to be filled by the PAP—one for 270 tablets of OxyContin 80 mg. and one for 360 tablets of Oxycodone IR. This was followed two days later by prescriptions for 126 tablets of OxyContin 40 mg. (a further one-week supply) and 84 tablets of Oxycodone IR. Finally, on May 31, Respondent wrote J.R. prescriptions for 540 tablets of OxyContin 40 mg. (a thirty-six day supply based on the dosing), and 360 tablets of Oxycodone IR (a thirty-day supply based on the dosing).

Accordingly, in this month alone, Respondent gave J.R. prescriptions authorizing the dispensing of 1080 tablets of OxyContin 80 mg. and approximately 1116 tablets of OxyContin 40 mg. While Respondent’s dosing instructions varied between a total of 600 and 720 milligrams a day, even using the larger figure, a single 270 tablet prescription of 80 mg. strength was enough to provide J.R. with a thirty-day supply. Yet Respondent gave J.R. prescriptions for 80-milligram tablets totaling four times this amount (120-days supply) and the prescriptions for 40-milligram tablets provided another sixty-two day supply.

Similarly, during this month, Respondent gave J.R. multiple prescriptions for Oxycodone IR which likely totaled 1700 dosage units.⁸⁷ Here again, even using the largest dosing she prescribed for this drug during the month (four tablets, every eight hours or twelve tablets a day), a single 360-tablet prescription was enough to provide J.R. with a thirty-day supply. Respondent’s prescriptions thus provided J.R. with more than 4.5 times the amount of drugs he was to take. Similar patterns of prescribing continued throughout the course of Respondent’s treatment of J.R.

In her brief, Respondent cites a written report from her pharmacy expert to contend that her prescribings to J.R. complied with the prescription requirement. Resp. Br. at 132 (quoting RX 33, at 6). More specifically, Respondent’s expert noted that “patient assistance programs are riddled with problems and delays, and it is common practice for physicians to write the patient extra medications to avoid the more significant problem of the patient going without medications.” RX 33, at 6. Continuing, the expert asserted that Respondent “did the medically responsible thing by writing enough to ensure that [J.R.] would not run out of medications, and she accounted for all of the medications she prescribed, and they were all part of his overall dose.” *Id.*

I reject these arguments for several reasons. First, J.R. repeatedly came in at intervals well short of thirty days and thus there was little risk that he would run out of medication. Second, even assuming that it is medically appropriate for a physician to initially issue two prescriptions to a patient, when, due to legitimate financial or insurance considerations, that patient must use a PAP, a physician who issues multiple prescriptions still has the duty to ensure that the issuance of the prescriptions in this manner does not create an undue risk of diversion and abuse by accounting for her previous prescriptions. Put another way, before she issues additional prescriptions, the physician must ensure that the new prescriptions are in fact then necessary to treat a legitimate medical condition.

Moreover, the evidence does not support her expert’s contention that she “accounted for all of the medications

⁸⁷ It is noted that Respondent did not document the prescriptions she indicated that she would write on May 3 for the PAP. However, during this period, the prescriptions Respondent gave J.R. for the PAP were typically for 360 tablets of Oxycodone IR, and for either 270 tablets of OxyContin 80 mg. or 450 tablets of OxyContin 40 mg. Given the total quantities of drugs she was dispensing, whether Respondent wrote the former or latter OxyContin prescription is not significant.

she prescribed, and they were all part of his overall dose.” *Id.* at 6. As explained above, the evidence shows that Respondent repeatedly issued J.R. prescriptions which authorized him to obtain drugs in quantities far in excess of what was necessary for a thirty-day supply based on her own dosing instructions. Nor is there evidence that Respondent even questioned J.R. regarding whether he had obtained his PAP prescriptions. For that matter, even the prescriptions Respondent issued J.R. for local filling were several times what was necessary for a thirty-day supply. Accordingly, even if the initial prescriptions Respondent gave to J.R. to treat his migraine headaches were issued for a legitimate medical purpose, many of the subsequent prescriptions were not. Here again, Respondent acted with deliberate ignorance of the likely purpose of the prescriptions.

With respect to other patients, even Respondent’s expert (Dr. Schneider) observed that they had engaged in “‘aberrant drug-related behaviors,’ ‘which should have been pursued but weren’t,’” including “‘early refills without adequate documentation and explanations.’” RX K–1, at 6. These patients included J.N., N.F., W.F., and C.O.

With respect to J.N., the evidence establishes that Respondent did not ask her about her substance abuse history even though both Drs. Hare and Schneider agreed that a physician needs to do “a careful history.” Tr. 881. Moreover, at the first visit, Respondent prescribed Xanax to J.N. even though she had not diagnosed her as having anxiety. At the next visit, which was only four days later, Respondent increased the dosing of the OxyContin four-fold even though J.N. had reported less pain. Moreover, this increase in dosing far exceeded what both Drs. Hare and O’Connor testified to as the acceptable titration rate (50 to 100 percent). At the same visit, Respondent also increased four-fold the dosing of J.N.’s Xanax even though she made no findings as to why the drug was medically necessary.

Two months later, J.N. was hospitalized. While in the hospital, J.N. admitted that she had a “history of IV heroin abuse” and that she had started using the drug a week earlier. Moreover, a urine toxicology screen found that J.N. was “positive for opiates, barbiturates, benzodiazepines, and marijuana,” and the discharge summary stated that she was pre-occupied with her pain medications. (In addition, J.N.’s boyfriend told investigators that she did not have veins, a classic sign of IV drug

abuse, and that it was very difficult to draw blood from her.)

The information regarding J.N.'s admission of IV heroin abuse and the positive urine screens for both illicit drugs (marijuana) and drugs Respondent had not prescribed to her (barbiturates) was contained in the discharge summary which Respondent eventually received. According to Respondent, she did not notice this information because the summary "was a lot of pages" to read (even though the medical information was limited to four pages), and the reference to J.N.'s IV heroin abuse was "buried in" the report (even though it was printed on the bottom of the first page). Relatedly, Respondent offered no credible explanation as to why she had not noticed the condition of J.N.'s veins.

Examined in isolation, Respondent's failure to read the discharge summary might be viewed as simply evidence of medical malpractice. However, after J.N.'s release from the hospital she sought numerous early refills of both Dilaudid and MS Contin, with some being sought and obtained as early as eight or nine days before previous prescriptions should have run out. Again, however, Respondent did not notice. The evidence taken as a whole (including the failure to take J.N.'s substance abuse history, the increase in OxyContin dosing at a rate far in excess of the acceptable titration rate, the increase in Xanax dosing without any indication as to why it was medically necessary, the failure to contact other physicians who were treating her to coordinate prescribing, and the early refills), supports the conclusion that many of Respondent's prescriptions for J.N. were issued outside of the "usual course of * * * professional practice" and lacked a "legitimate medical purpose." 21 CFR 1306.04(a).

In a written submission, Respondent's pharmacy expert opined that people refill prescriptions early for such legitimate reasons as "vacations," not "run[ning] out * * * over the weekend," "because it is much more convenient to pick it up then, and because they are undermedicated." RX 33, at 4. Respondent's expert also maintains that "just because a chronic pain patient is receiving their medication early does not necessarily mean that they have taken all of their medication." *Id.*

As for the last contention, while that may be true, even Dr. Schneider has written that "[f]requent requests for early refills" are a "sign[] of possible drug addiction." RX 36, at 3. Moreover, Respondent never requested that J.N. bring in her prescriptions for a pill count. Furthermore, with respect to J.N.'s early refills, one does not need to

refill a prescription eight days (or even five days) early to avoid running out on a weekend. Nor is there any indication that Respondent issued any of the early refills because J.N. was going on vacation. Finally, while it is acknowledged that a patient may run out of medications because the prescribed quantity and dosing are not adequate to address a patient's pain, Respondent made no such contention with respect to J.N., who, of course, was abusing drugs by injecting them.⁸⁸

As for N.F., on the date of her first visit, Respondent was told by a pharmacist that N.F. was a doctor shopper. While Respondent cancelled the refills she had authorized, four days later Respondent gave her another prescription for Vicodin with two refills. Thereafter, N.F. began seeking early refills, with many of them being sought more than a week early. Respondent repeatedly complied with N.F.'s requests for drugs, escalated the strength and dosing of the prescriptions, and ignored numerous warning signs that N.F. was addicted.

For example, at one visit, N.F. reported that she had burned herself but did not remember how she had done so. Later on, N.F. told Respondent that she was moving to Illinois. Yet even after telling Respondent this, N.F. continued to return multiple times each month for the next seven months. While N.F. initially told Respondent such stories as she was back to pick up her truck, or that she was in town to testify for the State but that she had moved, Respondent apparently never questioned N.F. as to why she was still coming in months later. During this period, Respondent also wrote N.F. prescriptions and allowed N.F.'s purported family members to pick up the prescriptions. In the month of October alone, Respondent wrote prescriptions on October 2 (100 Roxicodone 30 mg. q4h—a sixteen-day supply), October 5 (same Rx), October 9 (30 Roxicodone 30 mg.—another five-day supply), October 15 (200 Roxicodone 5 mg. 2–3 q4h—an eleven-day supply), October 17 (100 Roxicodone 15 mg. 2–3 q4h—a five-day supply), October 19 (200 Roxicodone 15 mg. 1–2 q4h—a sixteen-day supply), October 24 (200 Roxicodone 5 mg. 3–4 q4h—an eight-day supply), October 26 (50 Roxicodone 30 mg. 1/2 q4—a sixteen-day supply), October 29 (100

Roxicodone 30 mg. q4h—a sixteen-day supply).

This pattern continued in the ensuing months with N.F. engaging in additional scams, such as claiming that she had lost her prescription and that her neighbors had beaten her up and stolen her drugs. Moreover, during the October 17 visit, N.F. complained of dental pain and Respondent issued her an additional prescription for 30 tablets of Vicodin. Notably, she did not refer N.F. to a dentist who could properly diagnose and treat her condition. Nor did Respondent explain why a Vicodin prescription was necessary given the Roxicodone prescriptions.

While Dr. Schneider opined that N.F.'s chart showed that Respondent needed additional education about "careful monitoring" of patients and reviewing "the big picture," this ignores that Respondent knew from the date of N.F.'s first visit that she had engaged in drug-seeking behavior. Respondent therefore cannot credibly claim that she was duped by N.F. Moreover, even ignoring the early refills N.F. sought and obtained for the Vicodin prescriptions in the first months of her seeking drugs from Respondent, the size and frequency in relation to the dosing instructions of the subsequent Roxicodone prescriptions amply demonstrated that N.F. was engaged in drug-seeking behavior and that the prescriptions were not for a legitimate medical purpose and violated the CSA. 21 CFR 1306.04(a). Moreover, the size and frequency of the prescriptions support the further conclusion that Respondent was deliberately ignorant as to the likely purpose of the prescriptions.

W.F. was treated by Respondent for only approximately five months before his death. At the initial visit, W.F. brought in an impairment rating from the Veterans Administration, and yet Respondent did not contact the VA to obtain W.F.'s treatment records. She also did not inquire with W.F. regarding his past substance abuse before prescribing various narcotics to him including Percocet, OxyContin, and Dilaudid.

Respondent, however, was subsequently informed on two occasions by a psychiatrist who was treating W.F. that the latter had a history of narcotic addiction problems. Respondent was also notified by a case manager who worked at the psychiatrist's practice that the practice had received a phone call from a family member expressing concern that W.F. might be abusing his pain medicines. While Respondent indicated in his medical record that she had discussed

⁸⁸ As for the expert's claim that patients legitimately seek early refills for their own convenience, the physician is still obligated to properly supervise her patient's use of a controlled substance and can accommodate both interests by indicating a fill date on the prescription (e.g., "Do Not Fill Until [Date]").

W.F.'s addiction issues with him (who told her that the drugs helped with the pain), she continued to prescribe narcotics to him including both methadone and Roxicodone 30 mg. and yet his record contains no indication that Respondent planned to institute such measures as pill counts or toxicology screens to monitor his use of the drugs. Finally, the Government's Expert not only noted Respondent's failure to contact the VA to obtain other records and to take a substance abuse history, but also that her physical exam was minimal and was not adequate to diagnose his various pain complaints. Respondent admitted that she did not do a substance abuse history (testifying that at the time she did not know what questions to ask, Tr. 2382), and offered no testimony on the issue of the adequacy of her physical examination. While Respondent's conduct in prescribing to W.F. may not have been as egregious as it was with respect to the patients above, she still acted outside of the usual course of professional practice in prescribing controlled substances to him and thus violated the CSA's prescription requirement in doing so.

With respect to C.O., who was also identified by Respondent's Expert as a patient who had engaged in aberrant drug-related behavior, the Government's Expert acknowledged that Respondent's initial physical exam was adequate. However, Respondent again failed to inquire as to his past substance abuse.

C.O. rapidly escalated his use of drugs and engaged in drug-seeking behavior; once again, Respondent did nothing to control him. For example at the first visit, Respondent gave him a prescription for 40 Lortab 7.5/500 with two refills, a prescription which thus authorized the dispensing of 120 tablets and which, based on the maximum daily dose of acetaminophen of 4000 mg., should have lasted fifteen days. Five days later, Respondent, however, gave him another prescription for 40 Lortab 10/500 with two refills. A week later when C.O. saw a nurse practitioner, he reported that he was out of medication and needed more even though he had at least two refills left. C.O. swore, however, that he did not have any refills. Two days later, C.O. told Respondent that he was taking up to twelve Lortab per day.

Three days later, Respondent performed a physical exam finding no obvious pain with ambulation but noted generalized tenderness and that he complained of mid-back pain with range of motion of his shoulders. Respondent changed his prescription to 30 OxyContin 20 mg., with one tablet every eight hours. Four days later, C.O.

returned, saw the nurse practitioner and claimed his back pain was worse. His speech was slurred, and he indicated that he had recently taken twice the prescribed dose. Upon finding nothing abnormal in her physical exam, the Nurse Practitioner spoke with Respondent about refilling C.O.'s OxyContin prescription; Respondent then wrote C.O. a new prescription for 60 tablets and doubled the dosing and apparently did so without even seeing C.O. C.O. repeatedly escalated his use of OxyContin (although Respondent briefly reduced his dose, only to increase it again).

Subsequently, C.O. claimed that he had gotten a job on a cruise ship and that he would be going on the ship in a few days for thirteen weeks. While Respondent gave him prescriptions for 60 OxyContin 40 mg. and 360 Lortab 10/500 with three refills, he was back three days later (at which visit he obtained another prescription for 60 OxyContin 40 mg.) and again only five days later, at which visit he obtained four additional OxyContin prescriptions (for 372, 280, 144 and 92 tablets) and one prescription for 350 Lortab, with no refills.

After only six weeks (and six weeks before the thirteen-week period on the ship would have ended), C.O. returned, showed very slurred speech, and sought another prescription for OxyContin because he had run out. While Respondent referred him to get a drug test, there is no indication that he complied. Respondent also did not question C.O. as to why he was back so soon from the ship. C.O. had, however, filled prescriptions at Tucson pharmacies on multiple occasions during the period in which he claimed that he would be on the cruise ship.

While Respondent decided to taper down C.O.'s OxyContin, she continued to prescribe Lortab and eventually started prescribing Roxicodone to him. Notably, while Respondent briefly reduced the dosing of Roxicodone to 240 mg. per day, fifteen days later she was back to prescribing 480 mg. a day, which was the same dose as the OxyContin she had previously prescribed. Moreover, at one of these visits, Respondent had given him a prescription for 100 Lortab (10/500) with five refills, which thus authorized the dispensing of 600 tablets. While this prescription should have lasted at least 75 days, after only six weeks Respondent gave C.O. another Lortab prescription for the same quantity and refills. C.O. used up (whether by taking or selling is irrelevant) this prescription and the refills in a month's time. Although Respondent then temporarily

stopped prescribing Lortab to him (because of its acetaminophen content), she continued to prescribe Roxicodone to C.O. Approximately two months later, C.O. entered drug treatment.

Here again, early on in the course of C.O.'s seeing Respondent, there was evidence that he had rapidly self-escalated his use, had sought early refills, and engaged in other scams to obtain more drugs. When Respondent referred him for a drug test, there is no evidence that he complied or that she even sought to determine whether he had gone for the test. Moreover, after C.O. had represented that he was going to be away for thirteen weeks, Respondent did not question him as to why he was back to see her after only six weeks and continued prescribing to him. Later, she refilled his Lortab prescription approximately six weeks early, and, even though C.O. used up this prescription in a month's time, she continued to prescribe to him. As Dr. Hare noted, Respondent did little to supervise and control C.O.'s use of controlled substances. Accordingly, even if it was medically appropriate initially to prescribe controlled substances to C.O., it is clear that many of the prescriptions she wrote were not issued for a legitimate medical purpose and thus violated the CSA.

N.S. was an eighteen-year-old college student who complained of lower-back pain since enrolling at the University of Arizona. Even though N.S. rated his pain as only a four on a scale of one to ten, Respondent's physical exam found that he had a normal neurological exam and could perform a variety of movements without pain, with the exception of his incurring minimal low back pain with lumbar flexion, and Respondent had concluded that the cause of his back pain was a "poor mattress and poor positioning," at N.S.'s first visit, Respondent gave him a prescription for OxyContin 20 mg. (with one tablet to be taken every twelve hours). Moreover, two days later, N.S. returned and told Respondent that he had doubled up on the dose but that hadn't worked. Respondent then told him to take three tablets at a time. This was followed four days later by Respondent's issuance of a prescription for 180 tablets of OxyContin 20 mg., as well as 50 tablets of oxycodone 5 mg. (one tablet every four hours) after he asked for something for breakthrough pain.

Approximately a week later, Respondent gave N.S. an additional prescription for 50 tablets of Roxicodone which increased the strength from five to fifteen milligrams and the dosing to one tablet every three

hours, a four-fold increase in the daily amount of this drug. Moreover, she did so even though N.S. had reported a substantially lower pain level from the visit at which she had added the two previous prescriptions.

With respect to N.S., Dr. Hare observed that, while Respondent had reasonably evaluated N.S., her findings did not support prescribing opioids “and certainly not * * * in the aggressive doses she prescribed.” GX 46, at 15. Dr. Hare further observed that N.S. had rapidly self-escalated his dosing “to a large amount,” and the fact that he tolerated these doses suggested that he was either “not opioid-naïve, or [that] he was not taking the medication.” *Id.* I further note that Respondent increased N.S.’s dosing nearly four-fold (from 40 mg. to 150 mg. a day) in only four days, a rate which exceeded by several times the acceptable rate of titration as testified to by both parties’ experts. See RX 8, at 2 (testimony of Respondent’s expert that “no more than 50% to 100% every 5 or more days” is acceptable). Dr. Hare also noted that Respondent had further increased the amount of Roxicodone at the subsequent visit even though N.S. was reporting less pain. Finally, Respondent did not specifically address any of Dr. Hare’s findings with respect to N.S. Based on the above, I conclude that, even if Respondent was duped by N.S. and believed that he was in pain, she acted outside of the usual course of professional practice in prescribing controlled substances to him.

Respondent also prescribed to both M.D. and S.R., who lived together. At his first visit, M.D. complained that he had fallen off a bicycle and injured his back and leg. He also reported that another physician had previously prescribed to him OxyContin 80 mg., Oxyfast and methadone, but that he had been off these medications for several months because the prescribing physician had “left the office.” Respondent did not attempt to contact the office of M.D.’s previous physician to determine whether his statement was true and/or to obtain his treatment records. Nor did she obtain a pain rating and indeed, during the physical found that he was not in acute distress.

Following a physical exam, Respondent issued M.D. prescriptions for 60 OxyContin 80 mg. (q12h) (the second strongest formulation of the drug), 30 oxycodone 5 mg., and Oxyfast. Later that day, a pharmacist called and told Respondent that M.D. was known to forge prescriptions and had been arrested; Respondent told the pharmacist not to fill the prescriptions. M.D., however, had managed to get the

OxyContin filled at another pharmacy. At M.D.’s next visit, he again sought OxyContin. Respondent did, however, question Respondent about the incident at the pharmacy and as to why he had gone to a different pharmacy than the one he had put on his pain contract. Respondent then refused to give him a new prescription, and, after that, M.D. did not go back to her.

Subsequently, Respondent received a phone call reporting that a week earlier, M.D. had been admitted to a local hospital in a coma and, upon his admission, had in his possession a prescription vial which contained methadone 40 mg. tablets; the vial’s label indicated that it had originally contained Dilaudid which Respondent had prescribed to S.R.

Respondent had first treated S.R. approximately nine weeks earlier when she complained of abdominal and pelvic pain and reported that she had a history of cystitis and active hepatitis C. S.R. also indicated that another physician had prescribed Xanax and Vicodin for her and that she was taking her late husband’s leftover OxyContin and Dilaudid. Respondent’s physical exam was limited to noting that she had pain with ambulation, that she limped, and that she had tenderness over her abdomen. As the Government’s expert noted, Respondent’s physical exam was minimal, she did not obtain records from other physicians who had treated S.R. before prescribing, and her evaluation was inadequate to justify prescribing the controlled substances which she did (OxyContin, Dilaudid, and Xanax). Apparently, Respondent did not find troubling S.R.’s use of drugs which had not been prescribed to her (OxyContin and Dilaudid).

Two weeks later, Respondent gave S.R. new prescriptions for all three drugs even though the original Xanax prescription (90 tablets TID PRN) should have lasted thirty days and S.R. was to come in for a recheck in two weeks. Moreover, the Xanax prescriptions she issued on this date provided for 90 tablets with two refills (a total of 270 tablets—a ninety-day supply if taken as directed). Yet six weeks later, S.R. claimed that her Xanax had gotten wet and that the pills had dissolved and could not be taken. Even if the story was true, S.R. should still have had a refill for 90 tablets left. Respondent nonetheless gave her a new prescription for 100 tablets of Xanax with two refills.

Respondent subsequently counseled S.R. about the incident involving M.D., and S.R. denied that he could have gotten her medications. Moreover, after S.R. failed to go to another doctor on a

referral, Respondent refused to write any more prescriptions for her until she obtained more documentation of her condition.

While Respondent’s conduct in prescribing to M.D. and S.R. was not as egregious as her prescribing to the patients discussed above, I nonetheless conclude that the prescriptions were issued outside of the usual course of professional practice and lacked a legitimate medical purpose. While Dr. Hare did not offer an opinion specific to M.D., both parties’ experts were in agreement that when a patient is not currently on opioids, they should be started at a low dose and titrated up gradually to achieve pain relief while minimizing adverse side effects. At his first visit, M.D. admitted that he had not been on opioids for several months. Yet Respondent started him out with a daily dose of 160 mg. of OxyContin plus other drugs, which was the same dose that M.D.’s previous doctor had supposedly prescribed although whether this was in fact the case is unknown because Respondent never even attempted to contact this physician. While M.D. claimed to have back and leg injuries, Respondent did not even obtain pain ratings from him. While I note that Respondent told the pharmacy not to fill his prescriptions upon being informed that he was known to forge prescriptions, the prescriptions should never have been written in the first place.

As for S.R., Respondent did not find it troubling that she was taking two powerful and highly abused narcotics—Dilaudid and OxyContin—for which she did not have prescriptions. Not only was Respondent’s physical examination minimal, she did not obtain records from other treating physicians including the one who supposedly had prescribed Xanax and Vicodin to S.R. before she prescribed Dilaudid, Oxycontin, and Xanax for her. Indeed, it appears that her diagnosis was based largely on S.R.’s representation as to her condition. Respondent also gave S.R. early refills. While Respondent eventually refused to write more prescriptions for her, it should not have taken three months to conclude that S.R. was seeking drugs to abuse them.

Respondent also prescribed to W.O. and J.O., a married couple, each of whom claimed to have been injured in various (but different) motor vehicle accidents. As found above, Respondent issued both persons numerous prescriptions for schedule II drugs including OxyContin, Roxicodone and Percocet well before previously issued prescriptions would have run out, with some prescriptions being issued only

days after earlier prescriptions were issued and weeks early. Moreover, on various occasions, Respondent increased the dosing of both persons' medications without providing any explanation in their respective medical records. Indeed, at one visit, Respondent doubled the dosing of W.O.'s OxyContin prescription even though he had rated his lower back pain as "zero."

Moreover, W.O. and J.O. engaged in other problematic behavior including J.O.'s claiming that their house had been burglarized and that all of their medications had been stolen, W.O.'s attempt to alter a Percocet prescription issued to J.O. by tearing out the fill date, J.O.'s reported selling of Percocet, and J.O.'s giving 300 tablets of methadone to W.O. although she had previously told Respondent that she had left W.O. Finally, during the course of treating J.O., Respondent received information from the State Nursing Board that J.O. had been subjected to disciplinary proceedings because she had abused medications and taken some from a nursing home where she worked; Respondent received this information before J.O. gave W.O. half of her methadone prescription. Yet Respondent continued to prescribe to her for several months thereafter. Finally, notwithstanding the various reports she had received, Respondent falsely wrote the State Nursing Board that there was "no evidence" that J.O. was continuing to divert drugs.

Accordingly, even if Respondent's initial prescriptions to J.O. and W.O. were issued in the usual course of professional practice and for a legitimate medical purpose, it is clear that many of the subsequent prescriptions she issued to J.O. and W.O. did not comply with the prescription requirement. Moreover, whether Respondent's conduct in writing the letter to the State Board is considered under factor two (the experience factor) or under factor five (such other conduct which may threaten public health and safety), it does not reflect well on her candor.

Respondent also ignored evidence of problematic behavior engaged in by P.H., M.H. (P.H.'s mother) and A.B. (who lived with P.H.). For example, several months after Respondent started treating P.H., the latter reported that her Percocet had been stolen two weeks earlier and that she had only Darvocet N100 to take following the theft. Respondent had not, however, prescribed this drug to P.H., yet Respondent did not question her as to how she had obtained this drug. Several months later, P.H. complained that the

OxyContin she was taking made her nauseous. P.H.'s medical record contained no indication that Respondent had previously prescribed OxyContin to P.H. Yet Respondent did not question P.H. as to how she had gotten this drug.

Eight months after this incident, Respondent was called by a pharmacist and told that P.H. had filled a prescription for Percocet (which Respondent was then prescribing to her) which had been issued by another doctor. While Respondent questioned P.H. about the incident, she did not contact the other doctor to discuss the extent to which P.H. was obtaining other prescriptions and to coordinate their prescribing. Five months later, Respondent received another phone call from a pharmacist and was told that P.H. was obtaining 84 Vicodin tablets every two weeks from the same doctor who had prescribed Percocet to her. Again, however, there is no indication that Respondent contacted this doctor.

Subsequently, P.H. was diagnosed by an emergency room physician as having a skin condition and told Respondent that she had an appointment to see a dermatologist in two weeks. According to the Government's Expert, the condition did not justify "anything other than mild analgesics," yet Respondent nearly doubled the dosing of Roxicodone from 480 mg. to 900 mg. a day. Moreover, there is no evidence that Respondent ever contacted the dermatologist to coordinate any prescribing that might be necessary to treat the condition. Furthermore, during this period, Respondent issued Percocet prescriptions to P.H. in amounts and at a frequency that would be toxic if P.H. was actually taking the drug according to Respondent's own evidence regarding the maximum daily dose. P.H. was subsequently identified by her own mother (M.H.) as the person who had passed the OxyContin which had been prescribed to M.H. to the latter's nephew during the July 29, 2001 diversion incident.

At A.B.'s initial visit, she reported that she was taking Percocet and a non-controlled drug. Here again, Respondent did not contact the physician who had prescribed the drugs to her. Moreover, while A.B. reported that an MRI had shown that she had a herniated disk, there is no evidence that Respondent attempted to obtain the MRI report. Shortly thereafter, A.B. began to seek early refills which Respondent typically approved without any documentation of her questioning A.B. as to why she needed the refills, which in some

instances were as many as seventeen days (on a thirty-day Rx) early.⁸⁹

At M.H.'s first visit, Respondent diagnosed her with shingles and gave her a prescription for 60 tablets of OxyContin 20 mg. While four days later M.H. returned and told Respondent that her insurance wouldn't cover the drug, Respondent did not ask her to return or destroy the prescription. Two days later, either P.H. or A.B. picked up the prescription and passed it to M.H.'s nephew who was in another car. While Respondent counseled M.H. about the incident at a subsequent visit (which was a criminal act), there is no credible evidence that she ever discussed the incident with P.H. and A.B. Moreover, while three weeks later the same pharmacist who reported the July 29 incident again told Respondent that he believed P.H. and A.B. were selling their drugs, once again there is no indication that Respondent questioned either P.H. or A.B. after receiving this additional report. Respondent, however, continued to prescribe to them and instituted no measures such as pill counts and drug screens to monitor them.

Following the incident, Respondent continued to prescribe Percocet and Roxicodone to P.H. Several months later, Respondent again received information suggesting that P.H. had either obtained or was attempting to obtain Vicodin from another physician (P.H.'s dermatologist). Yet the same day she received this information, Respondent again prescribed 200 tablets of Percocet and 500 tablets of Roxicodone and did not question P.H. about whether she was obtaining additional controlled substance prescriptions from other doctors. Nor did she contact the other physician. Subsequently, Respondent added Dilaudid and continued to prescribe the other drugs to her as well. Respondent did not have P.H. sign a pain contract

⁸⁹In one instance, A.B. sought a refill of OxyContin and oxycodone a week after having undergone back surgery. A.B. complained that she had only been given 20 Percocet and was in severe pain, and Respondent wrote prescriptions for 60 Oxycontin 40 mg. and 200 oxycodone 5 mg. Here, again, she did not coordinate her prescribing with A.B.'s surgeon.

It is acknowledged that a patient may seek an early refill because a previous prescription does not adequately address legitimate pain. But as Respondent's own records indicate (and as Dr. Schneider testified), it is the physician—and not the patient—who is responsible for deciding whether a change in the dose is medically necessary. See GX 56, at 3 (Respondent writing in A.B.'s chart: "Any dose changes need to be ordered by me."). Notwithstanding the above statement (which appeared in numerous other charts), Respondent rarely exercised control over her patients and repeatedly acceded to the self-escalation they engaged in.

until May 2002, at which time she was aware that she was being investigated.

Here again, even assuming that these three patients initially presented with legitimate medical conditions which required treatment with controlled substances and that Respondent had a legitimate medical purpose in prescribing to them, Respondent nonetheless violated the prescription requirement because she failed to properly supervise her patients in their use of controlled substances. *See Gonzales*, 546 U.S. at 274 (“the prescription requirement * * * ensures patients use controlled substances under the supervision of a doctor so as to prevent addiction and recreational abuse”). She repeatedly ignored that these patients were obtaining drugs from other doctors or the street; she prescribed drugs for conditions that were putatively being treated by other physicians and yet did not contact the other physicians to coordinate their prescriptions; she issued new prescriptions well before previous prescriptions should have run out and did so without even questioning the patients as to why they already needed additional medication; she did not even counsel A.B. and P.H. after receiving reports that they had engaged in criminal acts and were selling their medications; she prescribed Percocet to P.H. in quantities that would have been toxic if she was actually taking the drug (as opposed to selling it); and she did nothing to monitor P.H., A.B. and M.H.’s use of their medications. Thus, even if these patients initially presented to Respondent legitimate medical complaints, Respondent repeatedly acted outside of the usual course of professional practice in the course of prescribing to them.

As the forgoing demonstrates, in numerous instances beyond those identified by the ALJ, Respondent issued prescriptions which violated the CSA’s prescription requirement. With respect to several of the patients, Respondent did so either knowing or having reason to know that the prescriptions were not being sought for a legitimate medical purpose.

This conduct was more than enough to establish the Government’s *prima facie* case to deny Respondent’s application. Indeed, DEA has revoked a practitioner’s registration for as few as two incidents of diversion and has done so where the conduct was far less egregious than that in which Respondent engaged. *See, e.g., Alan H. Olefsky*, 57 FR 928 (1992) (revoking registration of practitioner who presented two fraudulent prescriptions); *see also Sokoloff v. Saxbe*, 501 F.2d 571,

574 (2d. Cir. 1974) (upholding revocation based on three acts of unlawful distribution).

The ALJ’s reasoning that the Government had only shown that Respondent’s prescribing to “two patients out of more than 900” lacked a legitimate medical purpose, and that her “overall medical practices are not consistently lacking in legitimate purpose,” ALJ at 150, is thus erroneous. More disturbingly, this reasoning has been previously—and expressly—rejected by the Agency. *See, e.g., 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.’”); *Caragine*, 63 FR at 51600 (“[E]ven though the patients at issue are only a small portion of Respondent’s patient population, his prescribing of controlled substances to these individuals raises serious concerns regarding [his] ability to responsibly handle controlled substances in the future.”).

I therefore conclude that the evidence relevant to Respondent’s experience in dispensing controlled substances and her record of compliance with applicable laws related to controlled substances establishes *prima facie* that granting Respondent’s application would be “inconsistent with the public interest.” 21 U.S.C. 823(f).

Factor Five—Such Other Conduct Which May Threaten Public Health or Safety

Respondent also prescribed controlled substances to F.L. and B.L., who were father and son. As found above, F.L., who suffered from chronic pancreatitis, lower back pain and diabetes (which led to the amputation of one of his lower legs) was receiving approximately 7000 dosage units a month of schedule II drugs including OxyContin 40 mg., OxyIR, Percocet and Percodan, and was obtaining some of the drugs through the Purdue Frederick (who manufactured both OxyContin and Oxy IR) Patient Assistance Program. At the last visit before his death, Respondent issued him prescriptions for 1320 tablets of OxyContin 40 mg. and 4800 Oxycodone IR, which were to be filled through the PAP program.⁹⁰

Six days after F.L.’s death, B.L., who was obtaining Dexedrine—a schedule II amphetamine and stimulant,

⁹⁰ To make clear, while F.L.’s prescriptions were very large, there is no evidence establishing that the prescriptions were issued in violation of 21 CFR 1306.04.

presumably for fatigue and to prevent weight gain,⁹¹ saw Respondent and obtained another prescription for Dexedrine. Moreover, as found above, during this visit, B.L. admitted to Respondent that he had accepted the delivery of the 1320 OxyContin 40 mg. tablets dispensed pursuant to his father’s prescription. Respondent admitted to this fact in her plea agreement and that she had also failed to rescind the Dexedrine prescription she issued to B.L. Based in part on this conduct, Respondent ultimately pled guilty to violating 18 U.S.C. 3.

In this proceeding, Respondent vigorously contested whether she committed any crime in failing to report B.L.’s diverting of the prescription to law enforcement authorities. In this regard, Respondent put forward evidence that there is no requirement that a physician report a patient’s act of diversion to the authorities. *See RX O.*⁹² Whether her conduct constituted a crime was an issue that should have and could have been litigated in the criminal proceeding (and with respect to B.L., it was not just her failure to report but also her failure to rescind the prescription which was the basis for conviction).⁹³ In any event, in light of the extensive and egregious evidence found under factors two and four, Respondent’s conviction with respect to this incident adds very little to the Government’s case.

Sanction

Under longstanding 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 [she] can be entrusted with the responsibility carried by such a registration.” *Medicine Shoppe*, 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),

⁹¹ While the progress notes indicate that Respondent was treating B.L. for weight gain and an eating disorder, there is no indication in any of the progress notes as to his height and weight.

⁹² As support for this proposition, Respondent also cited a document entitled: *Prescription Pain Medicines: Frequently Asked Questions and Answers for HealthCare Professionals, and Law Enforcement Personnel*. RX T. DEA never published the document in the **Federal Register**, because it “was not an official statement of the agency,” and “withdrew the document because it contained misstatements.” 69 FR 67170 (2004).

⁹³ This is not a close case and therefore I need not consider whether a practitioner’s failure to report an act of diversion by a patient is grounds for denying an application.

[DEA] has repeatedly held that where a registrant has committed acts inconsistent with the public interest, the registrant must accept responsibility for [her] actions and demonstrate that [she] 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).

Relatedly, a respondent’s lack of candor is an important and typically dispositive consideration in determining whether she has accepted responsibility for her misconduct. *See id.* (“Candor during DEA investigations, regardless of the severity of the violations alleged, is considered by the DEA to be an important factor when assessing whether a physician’s registration is consistent with the public interest” and noting that physician’s “lack of candor and failure to take responsibility for his past legal troubles * * * provide substantial evidence that that his registration is inconsistent with the public interest.”). *See, e.g., Prince George Daniels*, 60 FR at 62887.

Finally, to rebut the Government’s *prima facie* case, an applicant/registrant is required not only to accept responsibility for her misconduct, but also to demonstrate what corrective measures she has undertaken to prevent the re-occurrence of similar acts. *Jayam Krishna-Iyer*, 74 FR 459, 464 & n.8 (2009). Both conditions are essential requirements for rebutting the Government’s *prima facie* showing that granting an application or continuing an existing registration would be “consistent with the public interest.” 21 U.S.C. 823(f).

In her recommended decision, the ALJ asserted that Respondent “took full responsibility for her actions and the consequences that followed those actions.” ALJ at 155. Not so. Indeed, with respect to her most egregious misconduct as established on this record—her six prescribings of various schedule II narcotics to H.T., knowing that he was not seeking the drugs to treat a legitimate medical condition but rather to abuse them—Respondent denied any failing on her part and maintained that she was duped. Relatedly, Respondent also denied that she had falsified H.T.’s medical records (which she did on six occasions) to indicate that she had done a physical exam when she had not.

With respect to her falsification of H.T.’s patient record, the ALJ explained

that although this “does not reflect well upon Respondent’s propensity for truthfulness, * * * a single instance does not rise to the level of the pervasive pattern of falsification that was present in” another DEA proceeding, *see* ALJ at 155 (citing *Jayam Krishna-Iyer*, 71 FR 52148, 52155–56 (2006)), “particularly in light of the Respondent’s substantial rehabilitation since then.” *Id.*

The ALJ’s reasoning ignores that Respondent falsified H.T.’s record six different times in order to provide a justification for prescribing controlled substances. Thus, Respondent’s acts of falsification were, in fact, even more extensive than that engaged in by Krishna-Iyer, who was shown to have falsified patient records on three separate occasions. Whether a practitioner’s falsifications involve a single patient multiple times or multiple patients a single time is irrelevant.

Moreover, throughout this proceeding, Respondent has continued to deny that she falsified H.T.’s records. In her brief, she contends that she performed physical exams but that the transcripts do not reflect them because H.T. “was quite familiar with the routine of bending over to touch his toes, allowing me to palpate his lumbar muscles, sitting on the exam table and lifting his legs, having me test his ankle strength and allowing me to lift his leg in a straight leg raising test” and that after all of the exams she had performed on him (when she had not examined him in nearly two years), “there are necessarily fewer specific directions to the patient” (in fact, there were no directions to H.T. related to any of the above parts of the exam). Respondent’s Resp. to Gov.’s Exc. at 2. As found above, Respondent’s contention is patently absurd and disingenuous. Given the scope of the falsifications, it buttresses the conclusion that Respondent has failed to accept responsibility for her misconduct.⁹⁴

Nor is this the only evidence that supports the conclusion that Respondent has failed to accept responsibility. With respect to patient J.N., whose admission of IV heroin abuse and positive-drug-test results for various illicit drugs were contained in a discharge summary, Respondent offered nothing but excuses for failing to read

⁹⁴ On the issue of Respondent’s propensity for truthfulness, I further note Respondent’s letter to the Arizona Nursing Board in which she falsely stated that there was “no evidence” that J.O. was continuing to divert drugs. Respondent made this statement notwithstanding that J.O. had previously admitted to giving 300 tablets of methadone to her husband, that Respondent had received reports that J.O. was selling Percocet, and the incident in which her prescription had been altered.

the report. *See* Tr. 2367–68 (contending that four-page report “was a lot of pages” and that the reference to J.N.’s heroin abuse was “buried in” the report when it was at the bottom of the first page).

In other instances, Respondent did not even address the propriety of her prescribings to other patients even though the prescribings were clearly at issue. For example, on the first day she prescribed to N.F., a patient who engaged in a variety of obvious scams including claiming that she had moved to Illinois, Respondent was told by a pharmacist that N.F. was a doctor shopper. Yet in her testimony, Respondent did not even address why she prescribed to her.

While one of Respondent’s generic arguments is that she was duped by her patients, *see* Resp. Proposed Findings at 192 (“Being duped by professional comment does not indicate that I am a threat to the public interest”), she cannot credibly contend that she was duped by N.F. when she was told by a pharmacist on day one that N.F. was a doctor shopper and yet continued to prescribe to her. Nor can Respondent credibly claim to have been duped in the case of K.Q., who repeatedly sought and obtained prescriptions for Xanax and Valium not merely days, but months early.

As the forgoing demonstrates, Respondent has failed to accept responsibility for many of her most egregious acts of misconduct. As I recently explained, even where the Government’s proof establishes that a practitioner has committed only a few acts of diversion—and in this case the record demonstrates that Respondent committed numerous acts inconsistent with the public interest—an applicant/registrant is not entitled to be registered absent a substantial showing that she has accepted responsibility. *See Krishna-Iyer*, 74 FR at 464.⁹⁵

⁹⁵ Respondent also contends that her practices between the service of a search warrant in May 2002 and November 2002, when she lost her registration, “are very significant and highly relevant in determining whether my having a registration is in the public interest.” Resp. Proposed Findings at 200. As I have previously explained, evidence of one’s compliance with Federal law may “be entitled to some weight in assessing whether a registrant/applicant has demonstrated that she can be entrusted with a new registration where the Government’s proof is limited to relatively few acts and a registrant puts forward credible evidence that she has accepted responsibility for her misconduct.” *Krishna-Iyer*, 74 FR at 464.

Here, however, the record establishes that Respondent committed not merely a few, but rather numerous acts that were inconsistent with the public interest and that she has not accepted responsibility for her misconduct. Of further note, while Respondent was clearly aware that the State Board was investigating her, she nonetheless prescribed more Oxycontin to H.T. and falsified his

Finally, while Respondent maintains that she has undergone extensive remedial training including CME and working with a mentor to improve her record-keeping and management of patients, her testimony suggests that she has learned little from the experience. For example, even though Respondent's mentor had specifically identified various patients as having "received early refills without adequate documentation and explanation," RX K-1, at 6, Respondent testified that she could not answer the question as to whether she had issued early refills without documenting the reason why, because the definition of the term is "not clear and not well agreed upon." Tr. 2345. Even more disturbing is her testimony that it is not harmful for a patient to use a controlled substance (in the case of this patient, no less than OxyContin) which had not been prescribed to them but to a family member. Amplifying her views, Respondent claimed that this is "just continuing medical care" and causes "no harm to the patient" because people "develop an area of knowledge about their medications." *Id.* at 2395 & 2401. In her view, the notion that a person should not take a controlled substance that has not been prescribed to her is simply "our party line as a physician," and that there is "almost always * * * no harm because people know * * * what they are taking." *Id.* at 2400-01.

As I have noted in other cases,⁹⁶ the diversion of controlled substances has

records. Respondent's willingness to violate Federal law, even at a time when she knew she was under investigation, and falsify records to provide a medical reason to justify a drug deal, provides ample reason to give no weight to this evidence.

⁹⁶ See, e.g., *Krishna-Iyer*, 74 FR at 464; *Southwood Pharmaceuticals, Inc.*, 72 FR 36487, 36504 (2007).

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." National Center on Addiction and Substance Abuse, *Under the Counter: The Diversion and Abuse of Controlled Prescription Drugs in the U.S.* 3 (2005). Moreover, "[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.* Relatedly, "[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.* at 4.

Moreover, according to the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2007 National Survey on Drug Use and Health, more than half (56.5%) of "individuals aged 12 or older who used prescription opioid pain relievers nonmedically in the past year * * * acquired these drugs from a friend or relative for free." U.S. Dept. of Justice, *National Prescription Drug Threat Assessment 2009* 6 (April 2009).⁹⁷ Furthermore, "data from a 2006 study

⁹⁷ I also take official notice of the findings of the SAMSHA Survey.

released in the June 2008 edition of the *American Journal of Public Health* indicated that 22.9 percent of 700 participants in the study 'loaned' their medications to someone else, and 26.9 percent 'borrowed' someone else's prescriptions medication." *Id.* at 15-16. Finally, "[n]early 22 percent of" the participants in this study "reported sharing prescription pain medications." *Id.* at 16.

Intra-family diversion is thus an important contributor to the diversion and abuse of controlled substances. It is manifest that notwithstanding her remedial efforts, Respondent still does not comprehend the seriousness of this problem. Because Respondent has utterly failed to demonstrate that she can be entrusted with a new registration, I am compelled to reject the ALJ's conclusion that granting her application would be consistent with the public interest. Respondent's application will therefore be denied.

Order

Pursuant to the authority vested in me by 21 U.S.C. 823(f), as well as 28 CFR 0.100(b) & 0.104, I order that the application of Jeri B. Hassman, M.D., for a DEA Certificate of Registration as a practitioner be, and it hereby is, denied. This order is effective March 25, 2010.

Dated: February 2, 2010.

Michele M. Leonhart,
Deputy Administrator.

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