DEPARTMENT OF JUSTICE

Drug Enforcement Administration

[Docket No. 16–17]

Lon F. Alexander, M.D.; Decision and Order

On February 4, 2016, the Deputy Assistant Administrator, of the then Office of Diversion Control, issued an Order to Show Cause to Lon F. Alexander, M.D. (hereinafter, Respondent), of Hattiesburg, Mississippi. ALJ Ex. 1, at 1. The Show Cause Order proposed the denial of Respondent's application for a DEA Certificate of Registration as a practitioner, on the ground that his ''registration is inconsistent with the public interest.'' *Id.* (citing 21 U.S.C. 823(f)).

As for the Agency's jurisdiction, the Show Cause Order alleged that Respondent had previously held a registration which he surrendered for cause on January 16, 2014. *Id.* The Order further alleged that on January 9, 2015, Respondent applied for a new registration as a practitioner in schedules II through V, at the proposed registered address of 36 Bridgefield Turn, Hattiesburg, Mississippi. *Id.*

As for the substantive grounds for the proceeding, the Show Cause Order raised multiple allegations to the effect that, on numerous occasions in 2011 through 2013, Respondent violated federal and state law by issuing controlled substance prescriptions to his wife ''that were nontherapeutic, were for other than a legitimate medical purpose, and were issued outside of the usual course of [his] professional practice.'' *Id.* at 1–3. The Show Cause Order alleged that Respondent ''repeatedly issued'' prescriptions for schedule IV controlled substances which included zolpidem tartrate, alprazolam, and diazepam, ''when she was concurrently being issued prescriptions for the same or similar class of drugs by her own psychiatrist, which [he] did without [the] psychiatrist's knowledge or permission.'' *Id.* The Order further alleged that Respondent's ''actions dramatically increased the chances of [his] wife's dependency, overdose, or diversion of those controlled substances, while also potentially complicating her psychiatric condition.'' *Id.* (citing 21 CFR 1306.04; Miss. Admin. Code Part 2640, Ch. 1, r. 1.7, 1.10, and 1.16; Miss. Code Ann. Sec. 73–25–29(3) & (13)).[1]

The Show Cause Order also alleged that on various occasions from 2011 through 2013, Respondent violated federal and state law by issuing his wife prescriptions for hydrocodone, then a schedule III narcotic, as well as other controlled substances, which were also nontherapeutic, for other than a legitimate medical purpose, and were outside the usual course of professional practice. *Id.* at 2–3. Specifically, the Show Cause Order alleged that ''[o]n at least one occasion in 2011,'' Respondent issued prescriptions for hydrocodone and diazepam ''to [his] wife concurrently with another prescription [for clonazepam] issued by her . . . psychiatrist,'' and that he did so ''without her psychiatrist's knowledge or permission.'' *Id.* at 2. The Order again alleged that Respondent's ''actions dramatically increased the chances of [his] wife's dependency, overdose, or diversion of . . . controlled substance[s], while also potentially complicating her psychiatric condition.'' *Id.* (citing same authorities as above).

Next, the Show Cause Order alleged additional instances of non-therapeutic prescribing by Respondent to his wife in that, ''[o]n at least four different occasions in 2013,'' he ''repeatedly issued . . . prescriptions for hydrocodone . . . zolpidem tartrate . . . and alprazolam . . . when she was concurrently being issued other controlled substances prescriptions for the same or similar drugs, as well as amphetamines, by her . . . psychiatrist, which [he] did without his knowledge or permission.'' *Id.* at 2–3. As with the previous allegations, the Order alleged that Respondent's ''actions dramatically increased the chances of her dependency, overdose, or diversion of those controlled substances, while also potentially complicating her psychiatric condition.'' *Id.* at 3 (citing same authorities as above).

The Show Cause Order also alleged that ''[o]n at least fifteen different occasions between 2011 and 2013, [Respondent] violated state and federal law by issuing'' to his wife prescriptions for hydrocodone, and/or zolpidem, and/or alprazolam, ''without conducting any examination of [his] wife (or documenting such in her file) or noting the . . . prescriptions in her patient chart.'' *Id.* (citing same authorities as above). The Show Cause Order then alleged that ''[o]n at least nine occasions between 2011 and 2013, [Respondent] violated state and federal law by issuing'' to his wife prescriptions for these drugs, ''without conducting sufficient examinations of [her] (or documenting such in her file).'' *Id.* (citing same authorities as above).

Finally, the Show Cause Order alleged that Respondent ''engaged in conduct which may threaten public health and safety . . . by attempting to mislead DEA investigators.'' *Id.* (citing 21 U.S.C. 823(f)(5)). Specifically, the Government alleged that, ''on February 2, 2016, [Respondent] turned over to DEA in response to an administrative subpoena a record purporting to be the patient file'' of his wife. *Id.* The Order alleged that the file ''contained false entries'' in that it contained ''repeated reference to conversations with and attempts to contact [his wife's] treating psychiatrist'' and that ''DEA's investigation . . . indicate[s] that these statements and others presented as part of the purported patient file are false.'' *Id.*

Following service of the Show Cause Order, Respondent, through his counsel, requested a hearing on the allegations. ALJ Ex. 2. The matter was placed on the docket of the Office of Administrative Law Judges and assigned to ALJ Charles Wm. Dorman. Following pre-hearing procedures, the ALJ conducted an evidentiary hearing in Jackson, Mississippi on June 29–30, 2016, at which both parties elicited testimony from witnesses and submitted various documents for the record. Following the hearing, both parties submitted briefs of their proposed findings of fact, conclusions of law, and argument.

On September 20, 2016, the ALJ issued his Recommended Decision. Therein, with respect to Factors Two (Respondent's experience in dispensing controlled substances) and Four (compliance with applicable laws related to controlled substances), the ALJ found that the Government had proved that Respondent violated 21 CFR 1306.04, Mississippi Code Sec. 73–25–29(3) and 73–25–29(13), as well as Mississippi Administrative Rules 1.7, 1.10, and 1.16 when he issued numerous controlled substance prescriptions to his wife.

Specifically, the ALJ found that during 2011, Respondent issued nine zolpidem, two alprazolam, seven hydrocodone, and one diazepam prescription(s) in violation of these provisions. R.D. at 39–40. The ALJ also found that during 2012, Respondent issued five alprazolam prescriptions, and that during 2013, he issued 11 alprazolam prescriptions in violation of these provisions. *Id.* at 41–43. The ALJ further found that in 2013, Respondent issued five hydrocodone prescriptions and one zolpidem prescription in violation of these provisions. *Id.* at 44.

In addition to the above, the ALJ found that between 2011 and 2013,

[1] *See also* ALJ Ex. 1, at ¶¶ 5–6.

Respondent prescribed hydrocodone 11 times, zolpidem 12 times, and alprazolam five times without documenting the prescriptions or a prior examination in his wife's patient file in violation of various provisions of Mississippi law and administrative rules. *Id.* at 46. He also found that on nine occasions when Respondent did document a prescription in his wife's file, he failed to include information required by state rules such as a medical history, examination results, or a diagnosis. *Id.* at 47–48 (citing Miss. Admin. Rule 1.4). The ALJ further concluded that ''nothing in . . . Respondent's file for his wife necessarily indicates that [he] ever conducted any type of physical or mental status examination of his wife prior to prescribing controlled substances to her.'' *Id.* at 48. He thus found proved the ''allegation that the Respondent failed to conduct examinations and/or lacked adequate documentation of examinations of his wife'' in violation of various provisions of Mississippi law and administrative rules. *Id.* at 49.

Turning to Factor Five (such other conduct which may threaten public health or safety), the ALJ rejected the allegation that Respondent attempted to mislead DEA investigators by providing to them the patient file containing false entries to the effect that he had made his wife's psychiatrist aware of the prescriptions. *Id.* at 49–52. The ALJ reasoned that it appeared that Respondent created the file ''as he was treating his wife,'' that he ''did nothing more than turn over his file when ordered to do so by the . . . subpoena,'' and that there was ''[n]o evidence . . . that, after the DEA subpoenaed the file, [he] created false entries or altered the file he already maintained.'' *Id.* at 51.

The ALJ nonetheless concluded that ''Factors Two and Four weigh substantially in favor of denying . . . Respondent's application because he prescribed controlled substances to his wife for illegitimate and nontherapeutic purposes, outside the scope of professional practice, and because he did not appropriately document examinations of, any prescriptions to, his wife.'' *Id.* at 52. The ALJ thus found ''that the Government has made a *prima facie* case . . . that the Respondent's registration would be inconsistent with the public interest.'' *Id.*

The ALJ acknowledged that ''[t]o rebut the Government's *prima facie* case, the Respondent must both accept responsibility for his actions and demonstrate that he will not engage in future misconduct.'' *Id.* (citation omitted). The ALJ explained that a ''[a] respondent *must* express remorse for all acts of documented misconduct, and *may* be required to acknowledge the scope of his misconduct.'' R.D. 52 (citations omitted); *see also id.* at 54. The ALJ also explained that ''[a]cceptance of responsibility and remedial measures are assessed in the context of the egregiousness of the violations and the [DEA's] interest in deterring similar misconduct by [the] Respondent in the future as well as on the part of others.'' *Id.* at 52 (internal quotations and citations omitted).

The ALJ concluded that ''Respondent's misconduct was egregious'' in that he ''repeatedly and wrongfully prescribed addictive, dangerous, and potentially harmful controlled substances to his wife for approximately three years,'' which ''interfered with his wife's treatment and could have caused her to overdose, lose consciousness, or die.'' *Id.* at 53. The ALJ nonetheless concluded that Respondent had accepted responsibility for his misconduct in prescribing outside the usual course of practice because, by ''[s]imply acknowledging that he failed to properly document his treatment of his wife, [he] admitted to practicing outside the usual scope of professional practice.'' *Id.* at 54.

The ALJ also acknowledged Respondent's testimony ''that he did not think that his actions increased his wife's chances of dependency, overdose, or diversion,'' and that ''[t]he Government's argument that that Respondent did not accept responsibility for putting his wife at risk is also understandable.'' *Id.* The ALJ reasoned, however, that ''a respondent is not required to admit to every single component of an allegation in order to accept responsibility.'' *Id.* The ALJ then noted that in a proceeding before the Mississippi Board, ''Respondent acknowledged that his prescriptions were probably hurting his wife and keeping her from getting appropriate treatment.'' *Id.*

As for the Government's contention that Respondent did not specifically acknowledge his misconduct in ''failing to conduct examinations and/or conduct insufficient examinations prior to issuing'' the prescriptions, the ALJ noted that this ''is technically correct.'' *Id.* at 54–55. The ALJ, however, rejected the Government's contention, reasoning that ''the Government overlooks the central concern of this case, which is that the Respondent wrote prescriptions for his wife when he should not have.'' *Id.* at 55. The ALJ then explained that ''[i]n his view, the Respondent's acceptance of responsibility for failing to examine his wife before writing her a prescription is subsumed in his general acceptance of responsibility.'' *Id.*

While the ALJ acknowledged that Respondent declined ''to admit that he violated federal laws because he did not want to speculate on what statutes he might have violated'' and ''testif[ied] that he did not know whether the prescriptions were outside the scope of his professional practice as the DEA defines those terms,'' the ALJ reasoned that Respondent was not required to ''identify the specific federal code provisions he violated, or interpret federal laws and apply them to his circumstances.'' *Id.* at 56. The ALJ further explained that he found Respondent's remorse to be ''sincere and that his commitment to adhere to all regulations governing controlled substances is genuine.'' *Id.* at 56–57.

The ALJ further found that Respondent had undertaken ''reasonable and appropriate'' remedial measures. *Id.* at 59. As for the Agency's interest in specific deterrence, the ALJ suggested that it ''might be negligible,'' reasoning that Respondent ''thoroughly understands that if he engages in any further misconduct he will face immediate sanctions from the'' Physicians Health Program and the State Board ''that will end his medical career.'' *Id.* at 59. And while the ALJ noted that ''Respondent's conduct was egregious,'' he reasoned that the circumstances were unique because ''every allegation of misconduct . . . involved . . . Respondent prescribing to only his wife.'' *Id.* at 60. The ALJ then explained that Respondent's testimony in a State Board proceeding to the effect that his prescribing ''was not a matter of judgment but a matter of the heart[] merits some consideration.'' *Id.* The ALJ thus recommended that Respondent's application be granted subject to various conditions. *Id.* at 61–62.

The Government filed Exceptions to the Recommended Decision. In its Exceptions, the Government contended that the ALJ committed error in concluding that Respondent has sufficiently accepted responsibility for his misconduct. Exceptions, at 3–15. The Government also contended that the ALJ committed error in concluding that Respondent is entitled to a new registration notwithstanding the egregiousness of his misconduct. *Id.* at 16–20. The Government thus argues that I should deny Respondent's application. *Id.* at 20. Respondent did not file a response to the Government's Exceptions.

Thereafter, the ALJ forwarded the record to me for final agency action. Having considered the record in its

entirety including the Recommended Decision, the parties post-hearing briefs and the Government's Exceptions, I adopt the ALJ's findings of fact (while making several additional findings as to prescriptions) and legal conclusions with respect to paragraphs two through ten of the Show Cause Order. I conclude, however, that the Government's Exception to the ALJ's legal conclusion that Respondent has sufficiently accepted responsibility for his misconduct is well taken. Accordingly, I deny his application. I make the following factual findings.

Findings of Fact

Respondent's Registration and Licensure Status

Respondent is a neurosurgeon licensed by the Mississippi State Board of Medical Licensure. R.D. 3 (citing Stipulation of Fact No. 4); Tr. 481–82. Respondent also previously held a DEA Certificate of Registration, pursuant to which he was authorized to dispense schedule II through V controlled substances as a practitioner. GX 1, at 1. However, on January 17, 2014, Respondent surrendered this registration for cause. *Id.* According to Respondent, he agreed to surrender his registration at the time of the State Board hearing that suspended his medical license. Tr. 485. On January 9, 2015, Respondent applied for a new practitioner's registration seeking authority to dispense controlled substances in schedules II through V, at a registered address in Hattiesburg, Mississippi. R.D. 3 (citing Stipulation of Fact No. 1).

In 2008, Respondent referred himself to the Betty Ford Center, ''when [he] realized [he] had a problem with prescription medicines'' and spent 90 days in treatment. Tr. 487. According to Respondent, ''[o]nce [he] went to the Betty Ford Center, [he] disclosed to the MPHP [Mississippi Physician's Health Program] and ultimately the [B]oard of [M]edicine that [he] was now a participant.'' *Id.* at 488.

In May 2008, Respondent entered into a Recovery Contract Agreement (hereinafter, recovery contract, contract, or RCA) with the MPHP. GE 14, at 13. The RCA's terms included that he completely abstain from mood-altering addictive substances, that he not treat himself or his family, that he undergo random drug screens, and that he be honest. *Id.; see also* R.D. at 4.[2]

In March 30, 2012, Respondent tested positive for Tramadol. He then returned to the Betty Ford Center for one month, after which he was discharged with a diagnosis of opioid dependence. GE 14, at 14–16. The MPHP did not, however, withdraw its advocacy on his behalf, and on June 11, 2012, Respondent entered into a new RCA which contained the same terms as the previous RCA, including the prohibition on prescribing to family members. *Id.* at 16–17.

On September 10, 2012, Respondent met with the Mississippi Professionals Health Committee due to its concerns that he had ''missed callings for random drugs screens,'' had failed to attend Caduceus meetings, failed to continued his aftercare therapy, failed to pay his bill for the drug screen testing, and had ''fail[ed] to turn in his support group attendance records.'' *Id.* at 19–20. According to Dr. Hambleton's testimony at the second State Board hearing, the committee ''warned [Respondent] very carefully that any future noncompliance would result in [the] potential loss of [the] MPHP['s] advocacy'' and ''that this was really his last chance to demonstrate that he could do what was necessary to prove that he's safe.'' *Id.*

While Respondent was compliant with the issues raised by the committee, the committee was unaware that Respondent had been violating his RCA by writing controlled substance prescriptions for his wife. *Id.* at 20–21. According to Dr. Hambleton, he did not know that Respondent had been calling in controlled substance prescriptions for his wife until the State Board informed him on October 7, 2013. *Id.* Dr. Hambleton also testified in the State Board proceeding that Respondent did not disclose this information to his ''treatment providers at Betty Ford, to our committee, or [to] our staff at MPHP.'' *Id.*

On October 15, 2013, the MPHP, having concluded that Respondent's ''continued practice of medicine represent[ed] a definite threat to the public health'' withdrew its advocacy on behalf of Respondent. GE 14, at 23. Eight days later, the Board issued Respondent an order of prohibition which barred him from practicing medicine until further notice. GE 13, at 5.

Thereafter, Respondent was charged with two counts of violating the State's Medical Practice Act, including violating an existing Board Order, Stipulation or Agreement, *see* Miss. Code Ann. Sec. 73–25–29(13), and engaging in unprofessional conduct, by engaging in dishonorable or unethical conduct. GE 14, at 5; *see also* Miss. Code Ann. Sec. 73–25–29(8)(d) (unprofessional conduct includes ''[b]eing guilty of any dishonorable or unethical conduct likely to deceive, defraud or harm the public'').

On January 16, 2014, the Board held a hearing on the allegations at which Respondent appeared. As the record of the hearing shows, the allegations were based on Respondent's violations of his RCA, particularly in his prescribing of controlled substances to his wife. Also at issue was his lack of honesty in failing to disclose his prescribing to his treatment providers as well as the MPHP committee and the MPHP's staff. GE 14, at 21.

Following the hearing, the Board found Respondent guilty on both counts and suspended his medical license for one year, after which he was entitled to petition the Board for reinstatement of his license. *Id.* at 91. The Board ordered that he ''successfully complete multidisciplinary treatment at a treatment facility approved in advance by the MPHP,'' as well ''establish a provisional contract [and] take those steps necessary to obtain affiliation and advocacy with the MPHP.'' GE 13, at 7–8.

On January 15, 2015, Respondent appeared before the Board seeking reinstatement. At the hearing, Dr. Hambleton (the MPHP Medical Director) testified in support of Respondent's petition, stating that he ''complied with all of our requirements and he's begun the treatment process at Acumen.'' *Id.* at 13. Dr. Hambleton further expressed his ''belief . . . that he will comply with his contract.'' *Id.* At the conclusion of the testimony, the Board reinstated Respondent's medical license. *Id.* at 15.

The DEA Investigation

At some point not clearly established on the record, a DEA Diversion Investigator (DI) assigned to the Jackson, Mississippi office opened an investigation into Respondent's

[2] The ALJ noted that these facts, which are based on the testimony of Dr. Hambleton, the Director of the MPHP, at Respondent's January 15, 2015 Board Hearing, are ''*not* necessarily proven by a preponderance of the evidence.'' R.D. 4. The Director was, however, placed under oath in the State Board proceeding. GE 14, at 11. He also testified in this proceeding and explained that with the exception of its duration, the terms of Respondent's current RCA (which ''is his fourth contract'') are the same as they were for his previous contracts. Tr. 452. Notably, his current contract requires that, ''[o]ther than cases of medical emergencies, I agree to abstain from the use of any mood-altering, addictive, or potentially addictive prescription medication, including amphetamine preparations, without written permission from MPHP.'' RX C, at 2. The RCA's terms also state that ''I agree not to prescribe, dispense or administer to family members or myself any drug having addiction-forming or addiction-sustaining liability.'' *Id.*

prescribing practices.[3] Tr. 31, 90. As the DI explained, Respondent's ''history with the Medical Board . . . gave us pause, so we began an investigation into . . . his prescribing habits.'' *Id.* The DI testified that he had access to the Board's investigation, Tr. 22 & 32, and obtained reports from the State's Prescription Monitoring Program showing Respondent's controlled substance prescribing. *Id.* at 22–23. Specifically, the DI obtained a ''Prescriber Activity Report'' showing Respondent's prescriptions from January 1, 2011 through December 31, 2013. Tr. 24; GX 10. The DI also obtained a PMP report using the various names of Respondent's wife for the same period. Tr. 29; GX 11. Of note, however, GX 10 contains a number of prescriptions which Respondent issued to his wife which are not listed on GX 11.[4]

In reviewing the PMP reports, the DI found it suspicious that Respondent was prescribing controlled substances to his wife as ''she was seeing a psychiatrist, Dr. Mark Webb, during that timeframe.'' Tr. 30. The DI ''noticed multiple prescriptions'' which Respondent authorized for drugs that his wife ''was receiving'' from Dr. Webb. *Id.* at 31. The DI further explained that he was ''aware that [Respondent] was married to . . . Ms. Alexander, so [I] knew there was a pretty good assumption that he was aware that she was receiving these medications, because she had seen Dr. Webb for such a long time.'' *Id.* at 32. According to the DI, during a phone conversation with Respondent's wife ''[s]he advised that she needed the medications'' and that Respondent had written ''her some prescriptions, but that she didn't feel like that was a problem.'' *Id.* at 33. Respondent's wife also told the DI that ''she didn't know if her husband had patient files . . . for her [but] that he did prescribe some prescriptions to her.'' [5] *Id.* at 34.

Thereafter, the DI visited Dr. Webb and ''asked him if he was aware'' that Respondent's wife was ''receiving these prescriptions from'' Respondent. *Id.* Dr. Webb ''said that he was not'' and asked the DI to ''look into it further.'' *Id.* Following the visit, the DI served a subpoena on Dr. Webb and obtained his patient file for Respondent's wife. *Id.* at 35; GX 3, at 1–2. Dr. Webb's file for Respondent's wife was entered into evidence as GX 5. Tr. 68–75.

The DI also obtained some of ''the hard copy prescriptions from several different pharmacies throughout'' the State.[6] Tr. 35–36. The DI presented the prescriptions to Dr. Webb and asked him: ''were these authorized? Did you know?'' *Id.* at 36. Dr. Webb ''again maintained that he did not'' know about the prescriptions. *Id.*

The DI also served a subpoena on Respondent for ''[a]ny and all charts, files and/or documents, written, typed or computerized, relating to'' his wife. GX 4, at 1. A ten-page exhibit of Respondent's Medical Progress Notes for his wife was entered into evidence as GX 6. Tr. 67.

Dr. Webb's Testimony

The Government called Dr. Mark Webb as a fact witness. Dr. Webb testified that he has practiced psychiatry in Mississippi since 1990 and that Respondent's wife has been his patient since November 2000. *Id.* at 102, 105. Dr. Webb acknowledged that he prescribes both controlled and non-controlled substances and that for most of the patients who are treated with controlled substances, he prescribes only ''two weeks' worth of medications'' so that ''it's a tighter leash.'' *Id.*

According to Dr. Webb, he has ''known [Respondent] for a long time'' and the two ''referred patients back and forth in the 90s and the early 2000[s].'' *Id.* at 110. Dr. Webb testified that he saw Respondent's wife at his request. *Id.* He also testified that during the 2011 through 2013 period, his medication regimen for Respondent's wife was to prescribe ''an anti-depressant,'' an Attention Deficit Disorder (ADD) medication such as Adderall XR, a sleeping medication such as Ambien or Restoril, and an anxiety medication such as Xanax or Clonazepam. *Id.* at 204.

Dr. Webb testified that while he and Respondent ''talked a lot in the 90s and the early 2000s,'' they have ''talked less and less over the last 10 years.'' *Id.* at 110. Dr. Webb testified that his records show that he had talked to Respondent ''about four times'' in the period from January 2011 to December 2013. *Id.* at 111; *see also* GX 7, at 1 (memo prepared by Dr. Webb memorializing meeting with DEA noting that he had talked with Respondent on Dec. 20, 2011, Feb. 20, 2012, Sept. 4, 2012, and Aug. 5, 2013).

According to Dr. Webb, Respondent ''would call me whenever he felt [his wife] was in a crisis . . . to give me that information and to . . . garner some help from me to her.'' Tr. 110. Dr. Webb testified that he never had a discussion with Respondent about the latter's prescribing controlled substances to his wife. *Id.; see also id.* at 138. When then asked if Respondent had contacted him and told him that he had prescribed because his wife had ''run out'' and ''need[ed] some'' medication on a temporary basis, Dr. Webb answered ''no'' and explained that ''that would not make a lot of sense,'' because he (Dr.Webb) ''would be the person authorized that needed to call that in.'' *Id.* at 111. While Dr. Webb testified that there was an instance during which he ''walked out to the car with [Respondent's wife] . . . and [Respondent] was in the car with their newborn son,'' and they ''chit-chatted [for] two seconds,'' there was no discussion of Respondent's prescribing of controlled substances to his wife. *Id.* at 111–12; *see also* R.D. 16 (ALJ Finding of Fact No. 28). Dr. Webb also testified that he did not have a conversation with Respondent's wife about Respondent's prescribing to her until either late in 2015 or 2016. Tr. 174–75.

Dr. Webb testified that DEA Investigators showed him the ten pages of notes Respondent created with respect to the prescriptions he issued for his wife and that he compared them with the patient file he maintained on Respondent's wife. *Id.* at 116. However, ''none of'' the dates in the records created by Respondent ''correspond[ed] to [Dr. Webb's] treatment records.'' *Id.* at 16 (quoting GX 9 (memo created by Dr. Webb re: Feb. 25, 2016 meeting with DEA)). In his testimony, Dr. Webb adhered to his statement in the memo that he ''did not speak to [Respondent] on these times in question and certainly would not have authorized him to call in medication for my patient.'' GX 9; Tr. 117. As he testified, ''[t]here's no reason for somebody else to call in the

[3] Earlier in his testimony, the DI stated that the investigation was prompted by Respondent's 2015 application. Tr. 31. Yet later in his testimony, the DI stated that the case was opened earlier, after the Board provided DEA ''with documentation regarding his history with them.'' Tr. 90. The DI explained that ''[w]hen we obtain information from the Medical Board, whether or not somebody's applied for a DEA license or not, we have to document that information . . . the different allegations that the Board has made[,] or evidence that they may have against a physician.'' *Id.* at 90–91.

[4] According to the DI, when calling in the prescriptions, Respondent used ''several different variations of'' his wife's name. Tr. 38.

[5] According to the DI, during this conversation, he told Respondent's wife (who holds a DEA registration as a Nurse Practitioner) that she appeared to be obtaining controlled substances ''from multiple doctors, including her husband'' and that he ''would potentially be asking her to surrender her DEA license because of that.'' Tr. 33–34. The DI testified that shortly after this conversation, he was contacted by Respondent's counsel, who advised that he was also representing Respondent's wife and was told ''not to contact her anymore unless there, you know.'' *Id.* at 34. The DI did not clarify what conditions Respondent's counsel asserted during this conversation. *Id.* The DI did not subsequently speak to Respondent's wife. *Id.*

[6] According to the DI, he provided the pharmacies with the prescription numbers, Respondent's wife's name, and her date of birth. Tr. 38.

prescriptions. That's my job.'' Tr. 117. Subsequently, Dr. Webb reiterated that he did not authorize Respondent to issue any prescriptions to his wife during the relevant time frame. *Id.* at 119.

Respondent's Prescriptions for His Wife

The evidence shows that between January 1, 2011 and October 14, 2013 (when his medical license was suspended), Respondent issued the following controlled substances prescriptions for his wife.[7]

1. January 9, 2011, eight tablets of alprazolam (Xanax) 1 mg, one tablet to be taken twice day, a four-day supply. GE 10, at 85; GE 11, at 14; GE 29, at 1–2. The record does not establish when Dr. Webb had last prescribed alprazolam to Respondent's wife.[8] Respondent did not document the prescription in the patient file he maintained for his wife. *See generally* GE 6. Nor did he inform Dr. Webb that he had issued the prescription.

2. January 31, 2011, 30 tablets of zolpidem tartrate (Ambien) 10 mg, a 15-day supply. GE 10, at 19; GE 11, at 14. Notably, on January 8, 2011, Respondent's wife had refilled a prescription issued by Dr. Webb on August 31, 2010 for 60 tablets, this being a 30-day supply. GE 11, at 14. Thus, if taken as directed, the refill of Dr. Webb's prescription should have last Respondent's wife until February 7, 2011. On February 3, 2011 (only three days later), Dr. Webb prescribed 60 units of zolpidem 10 to Respondent's wife. GE 11, at 13. GE 5, at 112. Respondent did not document the prescription in the patient file he maintained for his wife. GE 6. Nor did he inform Dr. Webb that he issued the prescription.

3. February 7, 2011, 20 tablets of hydrocodone/acetaminophen (Lorcet) 7.5–650, a three-day supply. GE 10, at 23; GE 11, at 13; *see generally* Tr. 373–74 (testifying that her husband prescribed hydrocodone for her once in 2011). Other than on one occasion in June/July 2013, which is discussed below, Dr. Webb did not prescribe hydrocodone to Respondent's wife. Moreover, the PMP report does not list any hydrocodone prescriptions that were issued by any other provider until November 30, 2011. GE 11, 11. Respondent did not document this prescription in the patient file he maintained on his wife. *See generally* GE 6. He also did not disclose the prescription to Dr. Webb.

4. March 30, 2011, 30 tablets of zolpidem tartrate (Ambien) 10 mg, with a dosing instruction of one tablet at bedtime but ''may repeat for early,'' a 15–30-day supply. GE 10, at 85; GE 11, at 13; GE 30, at 1–2. Notably, the zolpidem prescription which Dr. Webb issued on February 3, 2011 (RX #949559) provided for multiple refills, as it was refilled by Respondent's wife on April 9, 2011, May 23, 2011, and July 7, 2011. GE 11, at 13; Tr. 254–55. Respondent did not document the prescription in the patient file he maintained on his wife. GE 6. Nor did he inform Dr. Webb that he issued the prescription.

5. April 8, 2011, 15 tablets of hydrocodone/acetaminophen (Lorcet) 10–650, one tablet every six hours as needed, a three-day supply. GE 10, at 85; GE 11, at 13; GE 31, at 1–2. As explained above, other than in June/July 2013, Dr. Webb did not prescribe this drug to Respondent's wife, and no other physician prescribed hydrocodone to her until November 30, 2011. Respondent did not document the prescription in the patient file. GE 6. He also did not disclose the prescription to Dr. Webb.

6. May 6, 2011, 30 tablets of zolpidem tartrate (Ambien) 10 mg, one tablet at bedtime but ''may repeat,'' a 30-day supply. GE 10, at 85; GE 11, at 13; GE 32, at 1–2. As discussed above, Respondent's wife still had refills available for 60 dosage units based on the prescription issued by Dr. Webb on February 3, 2011, and eventually refilled the prescription on May 23, 2011. GE 11, at 13; Tr. 255. Respondent did not document the prescription in the patient file. *See generally* GE 6. Nor did he disclose the prescription to Dr. Webb.

7. May 14, 2011, 14 tablets of hydrocodone/acetaminophen (Lorcet) 10–650, a two-day supply. GE 10, at 19; GE 11, at 13. As explained above, other than in June/July 2013, Dr. Webb did not prescribe this drug to Respondent's wife, and no other physician prescribed hydrocodone to her until November 30, 2011. Respondent did not document the prescription in the patient file. GE 6. Nor did he disclose the prescription to Dr. Webb.

8. June 28, 2011, 30 tablets of zolpidem tartrate (Ambien) 10 mg, a 30-day supply. GE 10, at 84; GE 11, at 12. Respondent's wife still had a refill available for 60 dosage units based on the prescription issued by Dr. Webb on February 3, 2011, and eventually refilled the prescription on July 7, 2011. GE 11, at 12. Respondent did not document the prescription in the patient file. *See generally* GE 6. Nor did he disclose it to Dr. Webb.

9. July 15, 2011, prescription (assigned RX # 4002009 by the pharmacy) for 28 tablets of hydrocodone-acetaminophen (Lorcet) 10–650, a five-day supply. GE 10, at 64. This prescription also authorized a refill, which Respondent's wife obtained on July 29, 2011. *Id.* As explained above, other than in June/July 2013, Dr. Webb did not prescribe this drug to Respondent's wife, and no other physician prescribed hydrocodone to her until November 30, 2011. Respondent did not document the prescription in the patient file. GE 6. Nor did he disclose the prescription to Dr. Webb.

10. July 31, 2011, 12 tablets of zolpidem 10 mg, one tablet at bedtime, a 12-day supply, with one refill. GE 10, at 84; GE 11, at 12; GE 33, at 1–2. As found above, on July 7, 2011, Respondent's wife obtained a refill of a prescription for 60 zolpidem issued by Dr. Webb, which, if taken as directed, should have lasted her until August 6, 2011 (this being in addition to the 30 zolpidem prescription Respondent issued on June 28, 2011). GE 11, at 12; Tr. 251–53. Respondent did not document the prescription in the patient file. *See generally* GE 6. Nor did he disclose the prescription to Dr. Webb.

11. August 13, 2011, 20 tablets of alprazolam (Xanax) 1 mg, one-half to one tablet, to be taken twice a day, a 10–20-day supply. GE 22, at 1–2.[9] Notably, on August 4, 2011, Respondent's wife had refilled a prescription issued by Dr. Webb for 45 alprazolam 2 mg, a 15 day supply. GE 11, at 12. Thus, if taken as directed, this refill should have lasted Respondent's wife until August 19, 2011. Moreover, on August 16, 2011, Dr. Webb issued Respondent's wife a new prescription for 90 alprazolam 2mg, a 30-day supply. *Id.* Respondent did not document the prescription in his wife's patient file. *See generally* GE 6.[10] Nor

[7] The ''fill dates'' are used to identify these prescriptions because some of the prescriptions are not dated or bear illegible dates.

[8] The ALJ found that this prescription overlapped with a 30-day prescription for zolpidem tartrate (Ambien) from Dr. Webb, which was filled on January 8, 2011. R.D. 16. Given that Dr. Webb testified that he was prescribing both Xanax for anxiety and Ambien for sleep to Respondent's wife simultaneously, the record does not establish that these were overlapping prescriptions.

[9] Although this prescription was filled on August 13, 2011, *see* GE–22, at 2, it does not appear on Mrs. Alexander's PMP. *See* GE–11, at 12. However, a copy of the prescription and the fill sticker is in the record. GE 22.

[10] The Respondent's patient file for his wife mentions a prescription for 20 tablets of Xanax, 2 mg, dated July 13, 2011. *See* GE–6, at 1. The patient file says he prescribed Xanax because ''Jill out of Xanax—in Philadelphia—Has had twitching—[illegible] Dr. Webb has not called back.'' GE–6, at 1. Dr. Webb, however, had no notes in his file about any attempt by the Respondent to contact him on July 13, 2011. *See* Tr. 126. However, neither the

did he disclose the prescription to Dr. Webb.

12. August 28, 2011, 12 tablets of zolpidem tartrate (Ambien) 10 mg, a 12-day supply. GE 10, at 19. Notably, on August 16, 2011, Respondent's wife had obtained and filled a new prescription from Dr. Webb for 60 zolpidem, a 30-day supply. GX 11, at 12. If taken as directed, Dr. Webb's prescription should have lasted Respondent's wife until September 15, 2011. Moreover, as found above, Respondent had also provided a refill when he issued the July 31, 2011 prescription (RX# 443737), and this refill was still available to his wife on August 28, 2011. GE 11, at 12. Respondent did not document the prescription in the patient file. *See generally* GE 6. He also did not disclose the prescription to Dr. Webb.

13. September 6, 2011, 12 tablets of zolpidem tartrate (Ambien) 10 mg, a 12-day supply, this being a refill authorized by Respondent's July 31, 2011 prescription. GE 11, at 12. As discussed in the preceding paragraph, Dr. Webb's August 16, 2011 prescription should have lasted Respondent's wife until September 15, 2011. In addition, Respondent's August 28, 2011 prescriptions provided his wife with additional medication in excess of what Dr. Webb had prescribed. As found above, Respondent did not document the original prescription in the patient file nor disclose it to Dr. Webb. *See generally* GE 6.

14. September 28, 2011, 16 tablets of hydrocodone/apap 10/650, a four-day supply with one refill. *See* GE 10, at 64. As explained above, other than in June/July 2013, Dr. Webb did not prescribe this drug to Respondent's wife, and no other physician prescribed hydrocodone to her until November 30, 2011. Respondent did not document the prescription in the patient file. *See* GE 6. Nor did he disclose the prescription to Dr. Webb.

15. October 11, 2011, 20 tablets of zolpidem tartrate (Ambien) 10 mg, one tablet at bedtime, a 20-day supply. GE 10, at 84; GE 11, at 11; GE 34, at 1–2; Tr. 249. Of note, on September 19, 2011, Respondent's wife had refilled Dr. Webb's August 16, 2011 prescription and obtained 60 tablets, a 30-day supply. GE 11, at 12. If taken as directed, the September 19 refill should have lasted Respondent's wife until October 19. GE 11, at 12; Tr. 248–49. Respondent did not document the prescription in the patient file. *See generally* GE 6. Nor did he disclose it to Dr. Webb.

16. October 20, 2011, 16 tablets of hydrocodone-acetaminophen (Lorcet) 10–650, a four-day supply, this being a refill of the September 28, 2011 prescription. GE 10, at 64. As explained above, other than in June/July 2013, Dr. Webb did not prescribe this drug to Respondent's wife, and no other physician prescribed hydrocodone to her until November 30, 2011. As found above, Respondent did not document the prescription or the refill in the patient file. *See* GE 6. Nor did he disclose the prescription to Dr. Webb.

17. November 13, 2011, 18 tablets of clonazepam 2mg, a six-day supply. GE 10, at 19. Notably, on November 3, 2011, Respondent's wife had refilled a prescription issued by Dr. Webb on October 19, 2011 for 45 dosage units, a 15 day supply. GE 11, at 11. If taken as directed, the November 3 refill should have lasted Respondent's wife until November 18, 2011. Moreover, on November 15, 2011, only two days after filling the prescription she obtained from her husband, Respondent's wife obtained a further refill of Dr. Webb's prescription for 45 dosage units of clonazepam. GE 11, at 11. Respondent did not document the prescription in the patient file. *See generally* GE 6. Nor did he disclose it to Dr. Webb.

18. November 25, 2011, 10 tablets of clonazepam 2 mg, a three-day supply. GE 10, at 63. If taken as directed, by itself, the November 15, 2011 refill should have lasted Respondent's wife until November 30, 2011. Respondent did not document the prescription in the patient file. GE 6. Nor did he disclose it to Dr. Webb.

19. November 29, 2011, four tablets of hydrocodone/acetaminophen (Lorcet) 10–650 mg, one tablet to be taken four to six times a day, a one-day supply. GE 26. Respondent did not document the prescription in the patient file. GE 6. He also did not disclose the prescription to Dr. Webb.

20. Also on November 29, 2011, one Diastat Acudial, 5–7.5–10 mg kit. GE 10, at 92; GE 11, at 11; GE 28, at 1. Diastat Acudial is a rectal suppository of diazepam, which is also a benzodiazepine and a schedule IV controlled substance.[11] Tr. 260–61; 21 CFR 1308.14(c). Respondent did not document the prescription in the patient file. *See* GX 6. Nor did he disclose it to Dr. Webb.

21. December 5, 2011, 10 tablets of hydrocodone-acetaminophen (Lorcet) 10–650, a three-day supply. GE 10, at 63. Respondent did not document the prescription in the patient file. *See generally* GE 6. Nor did he disclose it to Dr. Webb.

22. December 27, 2011,[12] 30 tablets of zolpidem tartrate (Ambien) 10 mg, one tablet a day at bedtime, a 30-day supply. GE 10, at 80; GE 21, at 1–2. However, on December 16, 2011, Respondent's wife had obtained a refill of Dr. Webb's August 16, 2011 prescription for 60 dosage units, a 30-day supply. GE 11, at 11. Thus, if taken as directed, the December 16 refill should have lasted Respondent's wife until January 15, 2012. In Respondent's patient file for his wife, he documented: ''Jill not sleeping. Holiday schedule at Mississippi Neuropsychiatric—stress of house repossession and moving in with mother-in-law. Erratic. Bugs. Ambien 10 mg #30 [one to two orally at bedtime]. No response on-call dr.'' GE 6, at 1. Respondent did not disclose the prescription to Dr. Webb.

23. January 7, 2012, 28 tablets of zolpidem 10 mg, a 28-day supply. GE 10, at 63. As found above, on December 16, 2011, Respondent's wife had obtained a refill of Dr. Webb's prescription and obtained medication that should have lasted her until January 15, 2012. Moreover, on December 27, 2011, she filled the prescription Respondent wrote her for 30 more tablets. Respondent's patient file for his wife does not document the issuance of a zolpidem prescription on this date, but rather on January 10, 2012. *See generally* GE 6. That entry states: ''Jill Philadephia at M-I-L house,'' ''Pills discarded—tension—No vehicles (Bankruptcy).'' GE 6, at 2. The entry then lists a prescription for 30 Ambien 10 mg, with a dosing instruction of one tablet by mouth per day. *Id.* Moreover, Respondent did not disclose the prescription to Dr. Webb.

24. January 16, 2012, 30 tablets of alprazolam (Xanax) 2 mg, to be taken ''as directed.''[13] GE 23, at 1–2. However, on January 5, 2012, Respondent's wife had refilled a prescription (Rx# 976879) issued by Dr. Webb for 45 tablets, a 15-

PMP reports, nor the copies of the prescriptions, support a finding that Respondent issued an alprazolam prescription on or about this date.

[11] Dr. Chambers, the Government's Expert testified that this prescription ''is a bit puzzling because it's clear she's taking oral meds and usually that's reserved for people who can't take'' the oral form of the drug. Tr. 259.

[12] The Government established that this was a Tuesday. Tr. 190.

[13] While neither PMP report contains an entry for an alprazolam prescription issued by Respondent for his wife on this date, Government Exhibit 23 contains a copy of the prescription and the fill sticker showing that on January 16, 2012, Respondent issued, and his wife filled a prescription for 30 alprazolam 2 mg. Notwithstanding that the prescription appears to be dated ''1/16/11,'' the fill sticker states that the prescription was written on ''01/16/12.'' GX 23, at 1–2.

day supply, and that prescription had an additional refill remaining which Respondent's wife obtained on February 14, 2012. GE 11, at 10. In his wife's patient file, Respondent wrote: ''Dr. Webb wants Jill to come in. Difficult [with] transportation—Will Rx 10 day supply til 1/26/12—Webb aware—Xanax 2 mg #30 [two orally three times a day].'' GE 6, at 2. Dr. Webb testified, however, that neither Respondent nor Respondent's wife ever told him about any prescription issued by Respondent.[14] Tr. 115–17, 119, 138, 174–75; *see also* R.D. 16 (Finding of Fact No. 28).

25. February 26, 2012, 20 tablets of diazepam 5 mg, a six-day supply. GX 11, at 10. Of note, on February 23, 2012, Respondent's wife had obtained and filled a new prescription from Dr. Webb for 45 alprazolam 2 mg, a 15-day supply; this prescription (Rx# 982872) also authorized three refills. *Id.* at 10–11. Diazepam and alprazolam are both benzodiazepines and are used to treat anxiety. Tr. 259. Dr. Webb did not prescribe diazepam to Respondent's wife. *See generally* GE 11; Tr. 204; GX 5. Respondent did not document the prescriptions in his wife's patient file. *See* GE 6. Nor did he disclose the prescription to Dr. Webb.

26. March 4, 2012, 30 tablets of zolpidem10 mg, a 30-day supply. GE 10, at 13; GE 11, at 10. Of note, on February 23, 2012, Respondent's wife obtained and filled a prescription from Dr. Webb for 30 zolpidem, a 15-day supply. GE 11, at 10. If taken as directed, Dr. Webb's prescription should have lasted Respondent's wife until March 9, 2012. Moreover, Dr. Webb's Feb. 23 prescription provided for two refills, the first of which Respondent's wife obtained on March 19, 2012, respectively. GE 11, at 10. Respondent did not document the prescription in the patient file. *See generally* GE 6. Nor did he disclose the prescription to Dr. Webb.

27. March 12, 2012, 12 tablets of alprazolam (Xanax) 2 mg, one tablet to be taken three times a day, a four-day supply. GE 10, at 80; GE 20. As found above, on February 23, 2012, Dr. Webb issued a prescription for 45 tablets of alprazolam 2 mg, a 15-day supply, which authorized three refills. GE 11, at 9–10. In the patient file, Respondent wrote: ''Out of Xaax [sic] x 5 days—Jerky & twitching—feels like Extreme anxiety—digging at arms [-] delusional parasitosis? Will give 4 day supply—[illegible] talk to Dr. Webb—Xaax [sic] 2 mg #12,'' followed by the dosage instruction of one tablet by mouth, three times a day.'' GE 6, at 3. Respondent's wife had available a refill of Dr. Webb's February 23 prescription which she could have filled on this date (without being early) but which she did not fill until March 19, 2012. GE 11, at 10. Respondent did not disclose the prescription to Dr. Webb.

28. March 12, 2012, 30 tablets of zolpidem 10 mg, 30-day supply. GE 10, at 80. As found above, on March 4, 2012, Respondent prescribed 30 zolpidem (a 30-day supply) for his wife which she filled the same day. GE 11, at 10. If taken as directed, Respondent's March 4 prescription should have lasted until April 3, 2012. Also, Dr. Webb's Feb. 23, 2012 prescription (for 30 tablets) authorized multiple refills and Respondent's wife obtained a refill on March 19, 2012. *Id.* Respondent did not document the prescription in his wife's patient file. *See* GE 6. Nor did he disclose the prescription to Dr. Webb.

29. April 1, 2012, 24 tablets of zolpidem tartrate (Ambien) 10 mg, a 24-day supply. GE 10, at 13; GE 11, at 10. Putting aside that Respondent's March 4 prescription should have lasted through April 3, 2012, as found above, Respondent's wife obtained 30 tablets on March 12 when she filled his prescription and another 30 tablets on March 19, when she refilled Dr. Webb's Feb. 2, 2012 prescription. GE 11, at 10. Respondent did not document the prescription in his wife's patient file. *See* GE 6. Nor did he disclose the prescription to Dr. Webb.

30. April 2, 2012, 120 units of hydrocodone-homatropine syrup (Hycodan), one teaspoon every four to six hours as needed. GE 19, at 1–2.[15] Respondent did not document the prescription in his wife's patient file. *See* GE 6. Nor did he disclose the prescription to Dr. Webb.

31. June 18, 2012, 20 tablets of alprazolam (Xanax) 2 mg, one tablet to be taken twice a day, a 10-day supply. GE 10, at 75; GE 11, at 9; GE 15, at 1–2; Tr. 262. Respondent's wife still had a refill remaining on Dr. Webb's Feb. 23, 2012 prescription for 45 alprazolam, which she filled on July 5, 2012. GE 11, at 9. Respondent did not document the prescriptions in his wife's patient file. *See generally* GE 6. Nor did he disclose the prescription to Dr. Webb.

32. July 17, 2012, 20 tablets of alprazolam (Xanax) 2 mg, one tablet twice a day, a 10-day supply. GE 10, at 13; GE 11, at 9; *see* Tr. 262–63. As noted above, on July 5, 2012, Respondent's wife obtained 45 tablets (15 days) of alprazolam when she refilled Dr. Webb's prescription. GE 11, at 9. In a note (dated July 14, 2012) in his wife's patient file, Respondent wrote: ''she had done very well without medicine—even though extremely stressful living conditions. . . . 4 month no meds—depressed, crying, jittery—Has been in contact [with] Dr. Webb. . . . She feels self harm—but no SI. Xanax 2 mg #20 6 day supply.'' GE 6, at 4; Tr. 130. Respondent did not disclose the prescription to Dr. Webb, and Dr. Webb did not talk to the Respondent's wife on July 14, 2012. *See generally* GE 5; Tr. 131. Dr. Webb also testified that neither Respondent nor Respondent's wife ever told him about any prescription issued by Respondent. Tr. 115–17, 119, 138, 174–75; *see also* R.D. 16 (Finding of Fact No. 28).

33. August 13, 2012, 30 tablets of hydrocodone/acetaminophen, 10–650, one tablet every four hours, a five-day supply. GE 10, at 80; GE 11, at 9; GE 16, at 1. Respondent did not document the prescription in his wife's patient file. *See* GE 6. Nor does the PMP report show that any other doctor prescribed hydrocodone to Respondent's wife between December 22, 2011 and December 16, 2012. GE 11, at 8–10. Respondent did not disclose the prescription to Dr. Webb.

34. October 5, 2012, 12 tablets of alprazolam (Xanax) 2 mg, a four-day supply. GE 10, at 22; GE 11, at 9. On September 24, 2012, Dr. Webb prescribed and Respondent's wife filled a prescription for 45 alprazolam 2 mg, a 15-day supply, which also provided for two refills. GE 11, at 9. If taken as directed, Dr. Webb's prescription should have lasted until October 9, 2012. In his wife's patient file, Respondent wrote: ''Dr. Webb Rx Xanax—She is out 2 days early—Laceration/cutting—severe anxiety & depression—arms excoriated No return call from weekend MD—I have to leave to work out of town Xanax 2 mg #12 Walgreens 3–4 day supply through weekend.'' GE 6, at 5. While the note also appears to state ''aware -,'' Dr. Webb did not have any notes in his file regarding any calls from Respondent on October 5, 2012, Tr. 131, and I find that Respondent did not disclose the prescription to Dr. Webb. I also find that Respondent's wife did not disclose the prescription. Tr. 174–75.

35. December 22, 2012, 15 capsules of Dextroamphetamine-Amphetamine ER 20 mg, a five-day supply. GE 11, at 8. While Dr. Webb had prescribed this drug to Respondent's wife, *see id.,* Respondent did not disclose the prescription to Dr. Webb. Nor did

[14] January 16, 2012 was a Monday. Tr. 190.

[15] Although this prescription does not appear on either of the PMP reports, the Government produced both the prescription and the fill sticker showing that the drug was dispensed on April 2, 2012. *See* GE 19, at 2.

Respondent document the prescription in his wife's patient file. *See* GE 6.

36. January 11, 2013, 10 tablets of alprazolam (Xanax) 2 mg, a three-day supply. GE 10, at 21; GE 11, at 8. According to the PMP report, on January 10, 2013, Respondent's wife refilled a prescription issued by Dr. Webb [16] (Rx #996307) for 45 tablets of alprazolam 2 mg, a 15-day supply. *Id.* If taken as directed, the January 10 refill provided enough medication to last Respondent's wife until January 25. The PMP report also shows that on December 30, 2012, Respondent's wife had refilled a different prescription issued by Dr. Webb [17] (RX #2703928) for 45 tablets of alprazolam 2 mg, a 15-day supply. *Id.* If taken as directed, the December 30 refill provided enough medication to last Respondent's wife until January 14, 2013. Respondent did not document the prescription in his wife's patient file. *See generally* GE 6. Nor did he disclose the prescription to Dr. Webb.

37. January 11, 2013, six capsules of temazepam, a three-day supply. GE 11, at 8. According to the PMP report, on January 10, 2013, Respondent's wife refilled a prescription issued by Dr. Webb for 30 capsules of the drug, a 30-day supply. *Id.* If taken as directed, the January 10 refill provided enough medication to last Respondent's wife until February 9, 2013. Respondent did not document the prescription in his wife's patient file. *See* GE 6. Nor did he disclose the prescription to Respondent.

38. January 23, 2013, 15 tablets of alprazolam 2 mg, to be taken ''as directed.'' [18] GE 17; GE 10, at 79; GE 11, at 7. An entry in Respondent's file (dated January 20, 2013) states ''Jill has opened sore on nose,'' ''arms—del. parastosis [sic]—arms,'' ''cutting—Anxiety/depression,'' ''Out of her Xanax—inconsolable,'' ''weekend—No return from on-call,'' ''Xanax #15,'' ''will contact Dr. Webb in Am,'' ''No HI/SI,'' and a dosing instruction of ''TID prn.'' GE 6, at 5. Dr. Webb's patient file for his wife does not document a call from the Respondent on or near this date. *See* GE 5; Tr. 131–32. I therefore find that Respondent did not disclose the prescription to Dr. Webb.

39. January 23, 2013, 30 tablets of hydrocodone/apap 10–650, a five-day supply. GE 11, at 7. Respondent's wife had obtained prescriptions on December 16, 2012 for 20 tablets for hydrocodone/apap 7.5/500 (a two-day supply) and on December 18, 2012 for 20 tablets of hydrocodone/apap 10/500 (a five-day supply) from Dr. Pecunia. GE 11, at 8. However, she was not regularly being prescribed hydrocodone. *See generally* GE 11. Respondent did not document the prescription in his wife's patient file. *See* GE 6. Nor did he disclose the prescription to Dr. Webb.

40. February 5, 2013, eight tablets of alprazolam 2 mg, a two-day supply. GE 10, at 86; GE 11, at 7; GE 40, at 2. In his wife's patient file, Respondent wrote: ''Agitated—open sore on nose & hair line—Back from attempted trip—weathered out—returned with tons of anxiety—ran out of meds while OOT [19]—Minneapolis.'' GE 6, at 6. The note further states: ''Xanax #8 CVS Hattiesburg Zoloft #7'' and ''Filled Dr. Webb in on Travel—Jill did.'' GE 6, at 6. Respondent did not, however, disclose the prescriptions to Dr. Webb.

41. February 27, 2013, 10 tablets of alprazolam 2 mg, a three-day supply. GE 6, at 6; GE 10, at 86; GE 11, at 7. On February 19, 2013, Respondent's wife filled a prescription written by Dr. Webb for 45 alprazolam 2 mg, a 15-day supply. GE 5, at 70; GE 11, at 7. If taken as directed, Dr. Webb's prescription should have provided Respondent's wife with enough medication to last until March 6, 2013. In his wife's patient file, Respondent wrote: ''Anxious about marital situation—sores on nose/forehead will not heal—No HI/SI—out of her meds early—Out of Xanax,'' ''Xanax #10 [one orally three times a day] CVS Hardy St (enough for weekend) (Monday: Dr. Webb refilled for her).'' GE 6, at 6.

42. March 27, 2013, 14 tablets of alprazolam (Xanax) 2 mg, one tablet to be taken three times a day as needed, a five-day supply, which was filled the next day.[20] GE 36; GE 10, at 86; GE 11, at 7. On March 19, 2013, Respondent's wife had refilled a prescription issued by Dr. Webb for 45 alprazolam 2 mg, a 15-day supply. GE 11, at 7. If taken as directed, the refill of Dr. Webb's prescription should have provided Respondent's wife with enough medication to last until April 3, 2013. A note dated ''3/28/13'' in his wife's patient file, states: ''Marital/physical/mental stress. Sky high Marriage Workshop in Montana just accentuated—depilitating hairline—[illegible] meds needs plastic surg[ery] to fix—Out of Xanax early—rebound anxieties—self-harm—Xanax #14—CVS Hardy St.'' GE 6, at 7. The note also includes the following addendum: ''Dr. Webb aware—he called in Restoril/Zoloft & the Xanax (3/30/13).'' *Id.* Dr. Webb, however, was not aware of this prescription. Tr. 132–33; 174–75. Further, Dr. Webb's file contains no documentation of any contact by Respondent around March 28 through 30. Tr. 133; *see generally* GE 5; GE 7–9. Notably, Respondent did not note what dose of Xanax he prescribed or the dosing instructions. *See* GE 6, at 7; *see* Tr. 266, 287–88.

43. May 10, 2013, 14 tablets of alprazolam (Xanax) 2 mg, one tablet to be taken three times a day as needed, a four-day supply. GE 10, at 86; GE 11, at 7; GE 37, at 1–2. On April 30, 2013, Respondent's wife obtained a refill of a prescription issued by Dr. Webb for 45 alprazolam 2 mg, a 15-day supply. GE 11, at 7; Tr. 267. If taken as directed, the refill of Dr. Webb's prescription should have provided Respondent's wife with enough medication to last until May 15, 2013. Respondent did not document the prescription in his wife's patient file. GE 6. Nor did he disclose the prescription to Dr. Webb.

44. May 13, 2013, 12 tablets of alprazolam (Xanax) 2 mg, one tablet to be taken three times a day, a four-day supply. GE 10, at 21; GE 11, at 7; GE 41, at 1–2. Respondent wrote in his wife's patient file: ''Out of Xanax 2 days early—she says repeated [illegible] calls—no answer—No healing on face/arm—repeated re-openings. I am scheduled OOT next 4 days—Xanax #12 [once orally three times a day].'' GE 6, at 8. Respondent had already prescribed a four-day supply of Xanax to his wife on May 10; additionally, Respondent's wife still should have had two days' worth of Xanax left from Dr. Webb's April 30 refill. GE 11, at 7; Tr. 267. Respondent did not disclose the prescription to Dr. Webb. While the note also states that Respondent prescribed ''Ambien 10 for sleep,'' GE 6, at 8, the record does not contain a zolpidem prescription with this date.

45. May 20, 2013, 20 tablets of zolpidem 10 mg, one tablet at bedtime, a 20-day supply. GE 10, at 85; GE 11, at 7; GE 38, at 1–2. Respondent's patient file contains no note for a prescription issued on this date. GE 6, at 8. On May 23, 2013, Dr. Webb prescribed 30 du of another sleep medication, Restoril 30 mg (temazepam), with five refills, to Respondent's wife. GE 5, at 102; GE 11, at 6; Tr. 133–34. Moreover, the PMP report shows that Dr. Webb had been prescribing temazepam with refills to Respondent's wife beginning on July 26,

[16] The prescription was originally issued on July 26, 2012 and provided five refills. GE 11, at 8.

[17] The prescription was originally issued on November 6, 2012. GE 11, at 8.

[18] Both the prescription label and the PMP report list this as being a 30-day supply. *See* GE 17; GE 10, at 79. However, according to Respondent's note in the file, the dosing instruction was take the drug three times a day as needed.

[19] The ALJ presumed, with reason, that ''OOT'' is an abbreviation for ''out of town.'' R.D. 22 n.32.

[20] Although the PMP entry (as well as Respondent's note) are dated March 28, 2013, the prescription was written on March 27. *See* GE 36, at 1.

2012 and had not issued a zolpidem prescription to her since February 23, 2012, which she last refilled more than a year earlier on April 12, 2012. GE 11, at 7–10. Respondent did not discuss the prescription with Dr. Webb. Tr. 133. In an entry dated ''5/23,'' Respondent wrote: ''Dr Webb—started Zoloft & Buspar—And [R]estoril[.] Ambien discarded—only Restoril.'' GE 6, at 8. As also found above, Respondent had previously prescribed temazepam for his wife on January 11, 2013. GE 11, at 8.

46. July 1, 2013, 20 tablets of hydrocodone/acetaminophen (Lorcet), 10–650, a five-day supply.[21] GE 10, at 93; GE 11, at 6; GE 27, at 1. In his wife's patient file, Respondent wrote: ''Her mother in hospital in Jackson—dying—in ICU/hospice—she had *seizure*—injured shoulder/rib finger. Fractured teeth. Would not go to ER—Lorcet 10/650 #20,'' which was followed by illegible handwriting. GE 6, at 9; Tr. 134. Respondent did not discuss those injuries with Dr. Webb at any point; further, Respondent's wife had an appointment with Dr. Webb on July 1. Tr. 134. While Dr. Webb did not prescribe any medications to Respondent's wife at this visit, she did fill a prescription for 90 capsules of Adderall XR 20 (amphetamine), which Dr. Webb issued on June 28, 2013. GE 11, at 6; Tr. 273. Also, on June 28, 2013, she had obtained from Dr. Webb and filled new prescriptions for 45 alprazolam 2 mg, a 15-day supply, and 30 temazepam 30 mg, a 30-day supply. GE 11, at 6.

47. July 7, 2013, 12 tablets of alprazolam (Xanax) 2 mg, one tablet to be taken twice a day, a six-day supply. GE 35, at 1–4; *see* GE 10, at 41; GE 11, at 6; Tr. 268–69. However, if taken as directed, the June 28 alprazolam prescription from Dr. Webb should have provided enough medication to last Respondent's wife until July 13, 2013. In his wife's patient file, Respondent wrote: ''She is out of her Xanax early. Dr. Webb is aware of the tremendous stress of her mother's illness. No return call on-call MS Neuro [illegible] Xanax #12/Lorcet #12 Walgreens.'' GE 6, at 9; Tr. 135. Dr. Webb's file for Respondent's wife does not document a call from Respondent on this date. *See generally* GE 5; GE 7–9; Tr. 135.

48. July 7, 2013, 12 tablets of hydrocodone/apap 10–650 mg, one tablet to be taken four to six times a day, a two-day supply. Respondent's note in his wife's patient file does not discuss his reason for prescribing hydrocodone. *See* GE 6, at 9. Respondent did not disclose the prescription to Dr. Webb.

49. July 25, 2013, 12 tablets of hydrocodone/apap, 10–650, one tablet every six hours as needed, a three-day supply. GE 10, at 21; GE 11, at 5; GE 42, at 1–2. Respondent did not document this prescription in his wife's patient file. *See generally* GE 6. He also did not disclose the prescription to Dr. Webb.

50. July 29, 2013, eight tablets of alprazolam 2 mg, one tablet to be taken three times a day as needed, a two-day supply. GE 10, at 85; GE 11, at 5; GE 39, at 1–2. The PMP shows that on July 19, 2013, Respondent's wife had obtained a refill of a prescription issued by Dr. Webb for 45 alprazolam 2 mg, a 15-day supply. GE 11, at 6. If taken as directed, the refill should have provided Respondent's wife with enough medication to last until August 3, 2017. In his wife's patient file, Respondent wrote: ''Out of Xanax—buried her mother—funeral—Dr. Webb back Thursday. Xanax #8 [once orally three times a day].'' GE 6, at 9; Tr. 136. Dr. Webb testified that he did not receive any message or have any contact with Respondent on this day, Tr. 136, and there is nothing in Dr. Webb's file for Respondent's wife that indicates that he was contacted by Respondent around July 29, 2013. *See* GE 5; GE 7–9. I find that Respondent did not disclose the prescription to Dr. Webb.

51. August 15, 2013, 14 tablets of hydrocodone/apap 10–650, one tablet every four to six hours as needed, a two-day supply. GE 10, at 21; GE 11, at 5; GE 43, at 1–2. Respondent did not document the prescription in his wife's patient file. *See generally* GE 6. Nor did he disclose the prescription to Dr. Webb.

52. August 22, 2013, 15 tablets of alprazolam (Xanax), 2 mg, one tablet to be taken three times a day, a five-day supply. GE 10, at 67; GE 11, at 5; GE 24, at 1–2. According to the PMP report, Dr. Webb issued his last alprazolam prescription to Respondent's wife on July 31, 2013 for 45 tablets, a 15-day supply, and the PMP report contains no entry for any refill of this prescription. GE 11, at 1–5. The PMP report further shows that on August 5, 2013, Dr. Webb had re-commenced prescribing clonazepam, a different benzodiazepine. GE 11, at 5; *see also* GE 5, at 71. In an entry in his wife's patient file dated ''8/24/13,'' Respondent wrote: ''Following [her mother's] death, she has been very labile. Dr. Webb has tried multiple medications. Jill is very morose, often cannot stop crying. Denies SI/HI—No self-harm this month.'' GE 6, at 10. Continuing, the note states: ''Multiple Rx & calls to Dr. Webb. Could not reach this weekend—Rx: Xanax #12 [once orally three times a day]'' and ''[w]ill update Dr. Webb.'' GE 6, at 10; Tr. 136–37. However, there is nothing in Dr. Webb's file for Respondent's wife that indicates that he was contacted by the Respondent around August 22, 2013 and Dr. Webb testified that Respondent never disclosed any of the prescriptions. *See* GE 5; Tr. 137. I find that Respondent did not disclose the prescription to Dr. Webb.

53. September 5, 2013, 24 tablets of alprazolam (Xanax), 2 mg, an eight-day supply. GE 10, at 21; GE 11, at 5. The Respondent recorded in his wife's patient file: ''Will not leave room—depressed—needs to get back with Dr. Webb—anorexic—very anxious/depressed—Xanax #20 [once orally three times a day].'' GE 6, at 10. Respondent did not disclose the prescription to Dr. Webb.

Dr. Webb's Testimony Regarding Respondent's Prescriptions

Asked if there were ''any risks'' in Respondent's wife ''receiving prescriptions from someone other'' than himself, Dr. Webb testified that ''this particular patient . . . has some severe problems[,] and takes a high dose of medication. . . . my concern is that I'm keeping a close tab on it, but if there's somebody out there writing that I don't know about, that's dangerous.'' *Id.* at 120. Dr. Webb explained that Respondent's prescribing was dangerous because ''you're going above the maximum dose that should be prescribed and more medicines can lead to sedation, more sedation, difficulty, death, loss of balance, falls, poor judgment, things like that.'' *Id.* at 121.

Dr. Webb also explained that the prescriptions ''interfered with [my] treatment for her, because I wasn't seeing the real patient, because there's a ghost writer out there that I don't know about.'' *Id.* Dr. Webb testified that ''I have certain timed prescriptions and if that timed prescription is getting gapped . . . by another prescription, it's distracting me from my decisionmaking.'' *Id.* He also testified that this would ''[m]ost definitely'' interfere with his decisionmaking, in that ''[if] she was out of . . . my medicines, then I would hear a distressed phone call . . . and I would need to reorient my treatment for her [by] put[ting] her in the hospital.'' *Id.* at 122.

In a July 13, 2011 entry in Respondent's wife patient file, which documents a prescription for 20 Xanax 2mg, but for which there is no corresponding prescription in either the PMP reports or the other exhibits,

[21] *See* GE–14, at 59 (admitting to calling in a prescription for Lorcet in July).

Respondent wrote: ''Dr. Webb has not called back.'' GX 6, at 1. Regarding this entry, Dr. Webb testified that there are ''five other [ ]'' practitioners that work at his clinic and the phones are covered 24 hours a day, seven days a week. Tr. 124. Moreover, his clinic has an answering service for after office hours and weekends. *Id.* at 125. Dr. Webb testified that Respondent's note did not state what time the call to him had been placed and he maintained that he ''always called patients back.'' *Id.* at 126.

Dr. Webb further testified that the file did not contain a note ''from the answering service or the secretary that on [this date] a message was left.'' *Id.* Dr. Webb then testified that his ''file contains every telephone message notation that is given to our office'' and that ''the actual notes written by the office staff are kept,'' and that there are no notes for this date.[22] *Id.* The closest phone message by date are two messages on July 21, 2011 from Respondent's wife; the earlier message states ''please call asap'' and the later message states ''urgent out of med.'' GE 5, at 137. Notably, the PMP shows that on the same day, Dr. Webb issued to Respondent's wife a new prescription for 45 alprazolam 2 mg. GE 11, at 12.

The Government also asked Dr. Webb about Respondent's note dated ''1/16/12'' (prescription No. 24). The note appears as follows:

Dr. Webb wants Jill to come in
Difficult s transportation
Will Rx 10 day supply til
1/26/12—Webb aware—
Xanax 2 mg # 30
[ ] po TID prn

GX 6, at 2, Tr. 126. Dr. Webb testified that he was not sure if the prescription referenced in the note was ''attached to the January 16 or January 26th note.'' Tr. 127. He then testified that he had no contact with Respondent's wife on January 16, 2012,[23] but that on January 26, 2012, he called in a prescription for 45 Xanax 2 mg, three tablets a day. *Id.* at 127–28; *see also* GX 5, at 69. He also had no contact with Respondent on January 26, 2012.[24] Tr. 128.

The Government also asked Dr. Webb about an entry Respondent made on July 7, 2013, which states in part: ''She's out of her Xanax early. Dr. Webb is aware of the tremendous stress of her mother's illness. No return on call.'' GX 6, at 9; *see also* Tr. 135. As found above, on this date, Respondent prescribed to his wife 12 Xanax and 12 Lorcet. GX 6, at 9; GX 11, at 6. Notably, the PMP report shows that Respondent's wife had refilled a prescription issued by Dr. Webb on May 23, 2013 for 45 Xanax (15 day supply) on June 21, 2013, and had obtained and filled a new prescription for 45 Xanax (15 day supply) on June 28, 2013.[25] GX 11, at 6. After again noting that there was no record of any call to the clinic or its answering service by Respondent on this date, Dr. Webb testified that the fact that Respondent's wife was out of her Xanax early would concern him ''[b]ecause it lets me know that she's using more than prescribed and would . . . ha[ve] me wondering whether we need to put her in the hospital, to monitor her, or [if] there [are] other issues going on.'' Tr. 135–36.

An entry in Respondent's file dated July 29, 2013 states: ''Out of Xanax—buried her mother—funeral—Dr Webb back Thursday Xanax #8'' and includes dosing instructions of ''po TID.'' GX 6, at 9. As found above, the PMP report shows that Respondent issued his wife a prescription for eight Xanax 2 mg. GX 11, at 5. The PMP report also shows, however, that Respondent's wife refilled prescriptions for 45 Xanax (15 day supply) issued by Dr. Webb on both July 10 and 19, 2013. GX 11, at 6. *Id.* Dr. Webb testified that he spoke with Respondent's wife on July 30, 2013, and prescribed more Xanax to her and referred her to a psychologist. Tr. 136. According to the PMP report, Dr. Webb issued Respondent's wife a prescription for 45 Xanax on July 31, 2013. GX 11, at 5.

Dr. Webb testified that in his view ''gap filling . . . means that there's a prescription that is used to get [the patient] to the next authorized refill.'' Tr. 138. Dr. Webb then cited stolen medication as an example of when a gap fill would be appropriate. *Id.* Dr. Webb also testified that if a doctor sets up a regimen of refills, the patient ''needs to follow that timeline. And so, if they're short on set refills, that's a problem.'' *Id.* at 139.

On cross-examination, Respondent's counsel asked Dr. Webb about a statement he wrote in a memo he prepared following a January 11, 2016 meeting with DEA personnel in which he noted that Respondent's ''prescriptions consisted of large quantities of controlled medications such as Xanax, [h]ydrocodone, [and] Ambien.'' Tr. 151; *see also* GX 8. Asked how he concluded that the prescriptions were for large quantities, Dr. Webb explained that ''[t]hey appeared to be more than just a day or so'' and that while ''some were less than 10 . . . my recollection was that more, most of them were more than 10'' tablets. Tr. 151.

Dr. Webb subsequently explained that he had Respondent's wife ''up to max doses of all prescriptions . . . that I had her on'' and that ''[a]nything over was a potentially large impact.'' *Id.* at 152. He added that ''[m]aybe the number isn't large, but the potential impact is large.'' *Id.* Asked by Respondent's counsel if he ''agree[d] that compared to [his] prescribing, the number of controlled substances prescribed by [Respondent] was relatively small,'' Dr. Webb answered ''correct,'' but then added that it was ''[m]ore than I prescribe and moving into . . . above my max and serious harm.'' [26] *Id.* at 152–53.

[22] On cross-examination, Dr. Webb acknowledged that the clinic's answering service would not necessarily page the on-call doctor just for a patient ''who needs a normal refill.'' Tr. 156. However, Dr. Webb maintained that if a patient was out of medicine early and in distress, the answering service would pass this message on to the doctor. *Id.* at 157, 182. He also testified that ''[i]t's our policy to call everybody back.'' *Id.* at 183.

Dr. Webb further testified that to the best of his recollection, all of the phone call messages ''should be'' in the patient file for Respondent's wife. *Id.* at 159. Dr. Webb testified that he did not ''find it odd'' that there was ''only [in the words of Respondent's counsel] a handful of . . . call notes in her file.'' *Id.* at 160. Putting aside that there are 48 such notes in the patient file, Dr. Webb explained that Respondent's wife ''typically kept pretty good contact. Knowing that I'd be in the daytime, she's in the medical field, she knows night time phone calls . . . aren't very productive . . . [b]ecause you're unlikely to have your doctor on call.'' *Id.* He also testified that Respondent's wife had not expressed any dissatisfaction with her being able to reach him other than when he was not on call during a weekend. *Id.* at 184.

Dr. Webb further testified that his practice has not received complaints about the clinic's ''on call service'' and ''the inability to connect with a doctor'' or to ''get a request fulfilled by a doctor.'' *Id.* at 161. The ALJ specifically found that Dr. Webb's testimony was credible. R.D. 8.

[23] With respect to Respondent's wife, Dr. Webb testified that early in his treatment of her, she lost a bottle of Xanax which prompted him ''to shorten the leash and give smaller amounts.'' *Id.* at 162.

[24] Dr. Webb also identified other instances in which Respondent made notes in his wife's file documenting phone calls but Dr. Webb's file contained no record that the call was made to his office. *See* Tr. 129–33,137. These include notations for Feb. 18, 2012 (''called answering service for Dr. Webb No response—weekend Dr''); Oct. 5, 2012 (''No return call from weekend doctor''); Jan. 20, 2013 (''No return from on call'' and ''Will contact Dr. Webb in AM''); Mar. 28, 2013 (''Dr. Webb aware.''); Aug. 24, 2013 (''Will update Dr. Webb''). The record, however, does not establish whether these notations were intended to document that Respondent or his wife had placed the call and/or notified, or intended to notify Dr. Webb.

[25] Respondent's wife also obtained a refill of the June 28, 2013 prescription for 45 Xanax on July 10, 2013, and a refill of the May 23, 2011 prescription (which also was for 45 Xanax) on July 19, 2013. GX 11, at 6; Tr. 144.

[26] As found above, the evidence shows that Respondent issued a number of prescriptions, especially for zolpidem, that provided quantities that were for periods considerably longer than two to three days. Specifically, Respondent authorized prescriptions on May 20, 2013, for 20 dosage units (du) of zolpidem (a 20 day supply); on April 1,

Continued

Dr. Webb testified that he had been ''very careful in regimenting'' the prescriptions he issued for Respondent's wife based on his ''years of working with her'' and her visit in either 2002 or 2009 (or both years) when ''she went to Sierra Tucson'' to be evaluated for Xanax abuse. Tr. 146–47. According to Dr. Webb, Sierra Tucson did not diagnose her as being addicted or abusing controlled substances. *Id.* at 164. While he ''was not aware'' that she was ''overtly abusing,'' Dr. Webb testified that she ''[s]he had been early . . . sometimes on her prescriptions.'' *Id.* at 185. Dr. Webb also cited ''the severity of her illness'' as a reason for why he generally limited the prescriptions to 15 days.[27] *Id.*

Dr. Webb subsequently testified that ''[s]ince I did not know about the other prescriptions out there, it did not appear to be as big of an issue. She was early a day or two here and there. But, yes, substance dependence was on the radar.'' *Id.* at 194. On still further questioning by the Government, Dr. Webb testified that if he had known about Respondent's prescriptions to his wife during the 2011–2013 period, this ''would have'' changed his opinion as to whether she was abusing controlled substances. *Id.* at 196–97. On questioning by the ALJ, Dr. Webb testified that ''[k]nowing what [he] know[s] today . . . I would have suggested'' that she undergo ''in-patient'' treatment to address both ''her primary . . . and secondary problem[s].'' *Id.* at 197.

Asked about the notes he maintained for his phone conversations with Respondent's wife, which typically were no more than one or two lines, Dr. Webb maintained that he and Respondent's wife ''always had in-depth conversations'' and that ''[t]hey were usually fairly long, like 20, 30, 45 minute phone conversations.'' *Id.* at 169. He also testified that his notes met the standard for documentation. Dr. Webb acknowledged, however, that he is ''not perfect'' and that there may have been some phone calls that he had with Respondent's wife ''that were not noted.'' *Id.* at 203.

Dr. Webb acknowledged that psychiatrists do not typically prescribe opioids such as hydrocodone; he testified that he had ''written maybe less than five [prescriptions] in my last 20 years.'' *Id.* at 170–71. Asked why he issued the June 28, 2013 prescription for 10 tablets of hydrocodone/acetaminophen 10/650 mg, *see* GX 11, at 6, Dr. Webb testified that the prescription was filled ''at Beemon, so potentially she had come up from Hattiesburg.'' Tr. 171. Continuing, Dr. Webb testified: ''[t]hat was right around her mother's death, mother's sickness, and maybe she told me she was out of her medicine potentially. I'd want to see my note if I put it in there.'' *Id.* Subsequently, Dr. Webb added that Respondent's wife had undergone a procedure by a different doctor and received hydrocodone about nine or ten days earlier, but he could not otherwise recall the circumstances. *Id.* at 172. Dr. Webb then admitted that this prescription ''certainly could'' interfere with the treatment being provided by the other doctor. *Id.* However, he explained that Respondent's wife ''was out of town from her treating . . . physician, and out of her opiate for pain relief.'' *Id.* at 186. Moreover, this was the only instance in which he prescribed hydrocodone or any other opioid to her. *Id.* at 200–01.

Dr. Webb testified that he did not have a conversation with Respondent's wife about Respondent's prescribing controlled substances to her until either late 2015 or 2016, after he was contacted by the Diversion Investigator. *Id.* at 175. Dr. Webb testified that he ''believe[d] at times'' that Respondent was trying to help his wife and that ''[t]hey have had lots of difficulty.'' *Id.* at 177. Based on the four phone calls he had with Respondent during the 2011 through 2013 period and because Respondent would ''[t]ypically call if there would be a crisis,'' Dr. Webb acknowledged that Respondent's wife was often in crisis. *Id.* at 178.

On subsequent questioning, Respondent's counsel suggested that just as the other doctors in his practice can appropriately prescribe gap fills to his patients because they can access the patient's file and see ''abuse issues in the patient file . . . someone living with the patient can assess that person.'' *Id.* at 196. Dr. Webb took issue with this suggestion, explaining that ''the difficulty with living with someone is that you're not potentially an expert.'' *Id.*

Dr. Webb testified that Respondent's notes did not contain a patient history and specific diagnosis. *Id.* at 188. As for whether the notes contained evidence of an examination, Dr. Webb explained that, ''other than the subjective notes that are listed, no.'' *Id.*

The Testimony of the Government's Expert

The Government called R. Andrew Chambers, M.D., to testify as an expert in psychiatry, the proper prescribing of controlled substances and their effects on patients, and on addiction; the ALJ accepted Dr. Chambers as an expert in these areas. Tr. 246. Dr. Chambers obtained his B.S. degree in Chemical Physics from Centre College, Danville, Kentucky in 1991 and his M.D. degree from the Duke University School of Medicine in 1996. GX 12, at 1. Thereafter, he completed a residency in psychiatry at the Yale University School of Medicine in 2002 and a fellowship in addiction psychiatry at the Indiana University (IU) School of Medicine in 2012. *Id.* From 2002 through 2003, he served as an Assistant Professor of Psychiatry, Division of Substance Abuse at Yale; from 2003 through 2009, he served as an Assistant Professor of Psychiatry at the Indiana University School of Medicine; and since 2010, he has been an Associate Professor of Psychiatry with Tenure at the IU School of Medicine. *Id.* Also since 2012, Dr. Chambers has been the Director of the Fellowship Training Program in Addiction Psychiatry at the IU School of Medicine. *Id.*

Dr. Chambers has had appointments in the Department of Psychiatry at various hospitals including the West Haven (Connecticut) VA Hospital, Yale New-Haven Hospital, Connecticut Mental Health Center, and Indiana University Health Hospitals. GX 12, at 2. He is board certified in general adult psychiatry and addiction psychiatry. Tr. 227–28. He has also been published in the areas of psychiatry and addiction ''on the order of 50 times'' in peer-reviewed journals, published in multiple textbooks, and made a number of presentations to professional conferences. *Id.* at 229–30; GX 12, at 3–7, 11–18.

Dr. Chambers testified that treating patients with mental illness and addiction is his ''bread and butter work.'' Tr. 231. He testified that he is ''familiar with and utilize[s] a broad range of pharmacotherapies for both mental illness and addiction, as well as psychotherapies for both mental illness and addiction'' and that ''the vast majority of [his] patients have both mental illness and addiction.'' *Id.* at 231–32. He testified that he is familiar with the prescribing of controlled

2012, for 24 du of zolpidem (24 days); on March 4, 2012, for 30 zolpidem (30 days); on October 11, 2011, for 20 du of zolpidem (20 days); on July 31, 2011, for 12 du (12 days) plus a refill; on June 28, 2011, for 30 du (30 days); on May 6, 2011, for 30 du (30 days); on March 30, 2011, for 30 du (15 days), and on January 31, 2011, also for 30 du (15 days). GX 11, at 7, 10–14. He also authorized prescriptions on July 7, 2013, for 12 du of alprazolam (6 day supply); on March 28, 2013, for 14 du of alprazolam (5 days); and on both July 17, 2012 and June 18, 2012, for 20 du of alprazolam (10 days). GX 11, at 6–7, 11.

[27] Dr. Webb testified that he ''feel[s] that . . . she's primarily a psychiatric disorder first, and then medication difficulty second, rather than the other way around.'' *Id.* at 165; *id.* at 194–95.

substances to psychiatric patients, the risks of controlled substances, and the typical practices undertaken by psychiatrists to mitigate the risks or dangers of the diversion of controlled substances. *Id.* He further testified that he is familiar with the standards for prescribing controlled substances in Mississippi, as well the circumstances under which a doctor may fail to conduct himself in a manner that comports with a legitimate medical purpose or is within the course of proper professional practice. *Id.* at 233.

While Dr. Chambers had never previously testified in a proceeding based on the Mississippi law and the State Board's rules, *id.* at 240, he testified that he had reviewed the State's laws and rules. *Id.* at 236. He further testified that the Mississippi provisions on prescribing controlled substances are ''fairly universal.'' *Id.* at 237. Dr. Chambers explained ''that the codes around the country are informed by the medical profession . . . and there are universal, fairly universal ethical standards, evidence-based standards that are scientific that then inform the code.'' *Id.* at 240. Dr. Chambers subsequently cited the Patient Record provisions of the State Board's Rule 1.4 as one such standard that is accepted across the medical profession. *Id.* at 244.

Turning to Respondent's October 11, 2011 prescription for 20 zolpidem (No. 15 above), Dr. Chambers noted that the refill obtained by Respondent's wife on September 19 was for 30 days and should have lasted until October 19. *Id.* at 249. Dr. Chambers testified that Respondent's October 11 prescription was ''a problem.'' *Id.* As to why, Dr. Chambers explained: ''[t]his is a prescription for a controlled substance that is coming from a separate source that's occurring on top of a prescription from the primary psychiatrist, and the combination of these kinds of controlled substances could have serious consequences.'' *Id.* Dr. Chambers further explained that ''Ambien and other benzoate medications have central nervous system effects that can cause oversedation, memory disturbances, and, if taken in combination with other drugs, especially opioids, death.'' *Id.* at 250. While Dr. Chambers testified that 10 milligrams (the dose prescribed by Respondent) ''is not the maximum dose of Ambien that can be prescribed,'' a patient obtaining the drug from another source ''would be of concern.'' *Id.* Dr. Chambers explained that the concern would be driven by the ''the size of the dose, the nature of the drug,'' as well as ''the fact the primary physician who is prescribing the drug . . . would not . . . necessarily [be] aware'' that the patient was obtaining the drug ''from a separate source.'' *Id.*

According to Dr. Chambers, when a patient is obtaining a drug from other sources, ''it can create a great deal of confusion on the part of the primary prescriber about the effects or side effects of the drug and the mental status of the patient.'' *Id.* at 250–51. Continuing, Dr. Chambers testified that ''there are also synergistic overdose risks of being on both doses at the same time. . . . It's obviously not the dose that the primary prescriber wants because they would have prescribed that dose if that's what they wanted.'' *Id.* at 251. Dr. Chambers then explained that ''the same concerns'' were raised by the zolpidem prescription Respondent wrote on July 31, 2011 because the refill his wife obtained on July 7, 2011 of Dr. Webb's prescription for 30 days of zolpidem should have lasted for another week. *Id.* at 252.

Dr. Chambers identified several instances in which Dr. Webb's prescriptions ''overlapped'' with those of Respondent.[28] These included the zolpidem prescription (for 30 tablets/30 days) which Respondent issued on May 6, 2011 and the refills obtained on both April 9, 2011 and May 23, 2011 by Respondent's wife of Dr. Webb's Feb. 3, 2011 prescription for 60 tablets (a 30-day supply). Tr. 255. Dr. Chambers testified that while ''[t]he one before is a relatively minor overlap[,] about one or two days, which is fairly insignificant, . . . the secondary overlap is more significant.'' *Id.* The prescriptions presented the same concerns of danger to the patient and confusion for the doctor. *Id.*

Dr. Chambers subsequently testified that it does not matter whether Dr. Webb's prescriptions were new prescriptions or refills because the prescription ''is essentially an instruction both to the pharmacist and the patient for the daily dosing and the number of days that the patient should follow that dosing.'' *Id.* at 257. Dr. Chambers then testified that ''[r]efills is [sic] just a way to communicate to the patient and the pharmacist . . . that you're allotting the schedule out in monthly, usually monthly allotments, and then it starts over.'' *Id.* Continuing, Dr. Chambers explained that ''the bottom line is that when the doctor writes the prescription and the pharmacist records it . . . there's a complete understanding of what's expected. There should be no haziness on the part of the doctor or the pharmacist or the patient . . . about the expected rate of consumption . . . from the start to finish, whether it be a 30-day supply or a 30-day supply with two refills.'' *Id.* at 257–58.

Next, the Government questioned Dr. Chambers about the combination of prescriptions/refills that Respondent's wife filled on November 28–29, 2011. *Id.* at 258–59. Specifically, on November 28, 2011, she refilled a prescription issued by Dr. Webb for 45 clonazepam (15 days) as well as filled a new prescription issued by Webb for 90 capsules of Adderall. GX 11, at 11. The next day, she filled prescriptions for a one-day supply of Diastat Acudial (a rectal suppository of diazepam) and a one-day supply (four tablets) of hydrocodone/apap 10/650. *Id.*

Dr. Chambers noted that the Diastat prescription ''is a bit puzzling because it's clear [Respondent's wife] is taking oral meds and usually [Diastat] [is] reserved for people who can't take [drugs] oral[ly].'' *Id.* He then testified that ''it's a very high risk and potentially lethal combination one day after receiving a 15-day supply of'' clonazepam and ''also a stimulant'' from Dr. Webb. *Id.* Dr. Chambers then testified that ''[t]he combination of an opioid and a benzodiazepine is causing an unprecedented epidemic of death in the United States . . . because when the two drugs are together they synergistically suppress consciousness and breathing and the central nervous system.'' *Id.*

Addressing the prescriptions which Respondent issued on both June 18 and July 17, 2012, for 20 du of alprazolam 2 mg (both being for a 10-day supply),[29] each of which was filled on the date of issuance, as well as the refill she obtained on July 5, 2012 of Dr. Webb's prescription for 45 du (15 days), Dr. Chambers testified that the prescriptions had different dosing instructions and overlapped. *Id.* at 262–63. Dr. Chambers then testified that ''we don't know what she was actually taking, but if she was actually taking the dose per both doctor's directions, she would be taking 10 milligrams of [alprazolam] a day . . . which would render me unconscious.'' *Id.* at 263. As another example of Respondent's issuance of an alprazolam

[28] This particular overlap involved Respondent's zolpidem prescription of March 30, 2011 for 30 tablets (a 15-day supply) (Rx No. 4 above) and an April 9 dispensing of a zolpidem prescription. Tr. 254–55. Dr. Chambers testified that ''on April 9, 2011, Dr. Webb issue[d] the same med for a 30-day supply. So now you have an example of Webb unknowingly overlapping a controlled substance with Dr. Alexander that happened on 3–30.'' *Id.* at 255. The PMP report shows, however, that the latter event did not involve the issuance of a new prescriptions but a refill of Dr. Webb's February 3, 2011 prescription. *See* GE 11, at 13. Nonetheless, Respondent's prescription still created an overlap.

[29] *See* prescription Nos.31 and 32 above.

prescription which resulted in ''nearly a week of overlap of the same dose by two different doctors'' and raised ''the same concern,'' Dr. Chambers identified Respondent's March 28, 2013 prescription for 14 dosage units (three tablets a day), which overlapped with a refill his wife obtained on March 19, 2013 for 45 tablets (also three tablets a day).[30] *Id.* at 266.

Addressing Respondent's July 7, 2013 prescriptions (Nos. 46 and 47) for 12 du of hydrocodone/apap 10/650 (two-day supply) and 12 alprazolam 2 mg (six-day supply), Dr. Chambers characterized the latter prescription as ''remarkable,'' explaining that ''it's prescribed at the same time [Respondent] also prescribed hydrocodone, an opioid medication, also on the same day, again introducing the risk of a potentially lethal overdose.'' *Id.* at 268–69. Dr. Chambers noted that Respondent's prescribing was ''also occurring in the context of'' an amphetamine (Adderall XR) prescription for 30 days issued by Dr. Webb ''six days'' earlier. *Id.* at 269. Dr. Chambers then testified that if Respondent's wife was ''taking as prescribed, she's doing what street people call a speedball, which is essentially an amphetamine/opioid combination with a . . . benzodiazepine garnish.'' *Id.* Dr. Chambers also noted that on July 1, 2013, the same day that Respondent's wife filled the Adderall[31] prescription, Respondent had also issued her a prescription for 20 hydrocodone/apap 10/650, which she filled that day. *Id.* at 269–70. Dr. Chambers noted that this hydrocodone prescription was ''a higher dose than what Dr. Webb did.'' *Id.* at 273. He explained that ''there's a combination of multiple overlaps of multiple classes of addictive substances that can produce overdose and severe psychiatric disturbances from two different physicians who are apparently in no communication.'' *Id.* Continuing, he explained that ''in [his] experience, when you see all three of those [classes of] drugs represented and you have multiple physicians contributing to it . . . that indicates a patient who is in serious trouble iatrogenically . . . meaning harmed being caused through medical practice.'' *Id.* at 274.

Asked if he had ''reach[ed] a conclusion'' as to whether Respondent's prescriptions were issued ''within the usual course of professional conduct,'' Dr. Chambers testified:

> I did. It is not [the] usual course of clinical conduct for someone with mental illness or someone without mental illness to be prescribed these combinations of drugs and to have these combinations being prescribed by different individuals who—one of who—where there's not communication or awareness that it's happening. So it's not only not usual clinical practice, but the reason it's not usual is because it's dangerous for patients and harmful. So it's actually not only is it not usual, it's essentially malpractice.

Id. at 275. On further questioning, Dr. Chambers testified that the Respondent's prescribing was not ''legitimate medical practice'' and the prescriptions were ''non-therapeutic.'' *Id.* Dr. Chambers further testified that ''[b]ased on the entirety of the evidence [he] reviewed,'' Respondent's prescribing did not comply with either the Controlled Substances Act or the standards of the Mississippi Administrative Code, including the State's requirements for patient records. *Id.* at 276, 278.

Addressing the patient file Respondent maintained on his wife, Dr. Chambers testified that ''there is a paucity of data to support the diagnosis or the prescription . . . that the note is built around. There's a lack of physical or mental status exam that normally would be in a note like this to justify and direct the use of controlled substances.'' *Id.* at 277. Dr. Chambers further observed that in comparing the patient file with the PMP data, ''about 40 percent of the prescriptions'' had ''no corresponding note at all. There's no data. There's no diagnosis, no detailing of what was prescribed.'' *Id.* He also observed that ''there are instances where the dosing or type of the drug is left out of the record.'' *Id.* at 278.

Dr. Chambers identified Respondent's entry dated January 16, 2012 (Prescription No. 24) as one such example. Tr. 278. As found above, on this date, Respondent prescribed 30 alprazolam 2 mg ''to be taken as directed'' and wrote in the note: ''Dr. Webb wants Jill to come in. Difficult [with] transportation—will Rx 10 day supply till 1/26/12—Webb aware—Xanax 2 mg'' with a dosing instruction of ''po TID.'' GE 6, at 2.

Dr. Chambers testified that ''this note does not have a diagnosis. It doesn't have an examination to justify . . . why that prescription happened at that dose . . . was he aware of what the prescription was from another doctor? Was he continuing? Was there any plan to taper it?'' Tr. 279. Dr. Chambers added that ''he's kind of writing as if the reason he's doing it is because the patient can't get to Dr. Webb, and he's documenting that Webb is aware . . . but in review of Webb's chart, there no indication that Webb was ever aware that this kind of stuff was going on.'' *Id.* When then asked if a 10-day supply is ''unusual for . . . a gap fill,'' Dr. Chambers answered:

> . . . I think it's unusual for one doctor to be gap filling another regardless of what the duration is, especially when there's no knowledge that that's happening. So any duration is odd, I think. I guess the longer the number of days the more concerning it is because you're dispensing bigger doses. I mean, she's got 30 tabs. That's quite a bit.

Id. at 280.

Addressing Respondent's note of February 18, 2012, Dr. Chambers acknowledged that it contained ''a little bit more of what you could call a clinical assessment'' in that Respondent described his wife's symptoms. *Id.* at 281. Dr. Chambers observed, however, that the note did not indicate ''how many he prescribe[d].'' *Id.* As for Respondent's statement that his wife was ''[o]ut of her Xanax for . . . 10 days'' and ''[o]ut of her Ambien for a week,'' GE 6, at 3, Dr. Chambers testified:

> It's not clear exactly what that means, but I take it to mean that he is prescribing because she's been out. And so, first of all, why is she out? Is it because she's using it too rapidly? It's just not clear. But he is filling the gap with an unclear amount and then suggesting by my read . . . [that] he's documenting he's contacting Dr. Webb,

[30] Other examples of overlapping prescriptions involved Respondent's May 10 and May 13, 2013 prescriptions (Nos. 43 and 44 above) for 14 and 12 dosage units of alprazolam 2 mg, which overlapped with the refill his wife obtained on April 30, 2013 of Dr. Webb's prescriptions for 45 du (15 days) of alprazolam 2 mg. Tr. 267. According to Dr. Chambers, even Respondent's May 10 and May 13 prescriptions overlapped, and that on May 13, ''what you actually have here is a triple compounding of the dosing based on the disposition dates and the way the drugs were instructed to be taken.'' *Id.* Dr. Chambers then explained that ''that is a very dangerous dose that would normally never be prescribed outside an intensive care unit.'' *Id.* at 267–68.

Another such example is Respondent's July 29, 2013 alprazolam prescription which provided eight tablets (TID). Dr. Chambers testified that Respondent's prescription provided a dosing instruction of eight milligrams a day, Tr. 271, which is supported by the PMP report which lists the prescription as providing a two-day supply. GE 11, at 5. However, the dosing instruction on the actual prescription was TID, or one tablet, three times a day. GX 39, at 1–2. Nonetheless, the prescription overlapped with the refill Respondent's wife obtained on July 19, 2013 for Dr. Webb's prescription for 45 tablets (15 days), and on July 31, 2013, she obtained a new prescription from Dr. Webb for 45 tablets (15 days). GE 11, at 5. However, even if Respondent's prescription only had a dosing instruction of 3 tablets a day, if she took the medications as prescribed by both Dr. Webb and Respondent for the period in which the prescriptions overlapped, she would have taken six tablets a day or 12 milligrams. Tr. 272.

[31] Dr. Chambers explained that while Adderall is ''used for a number of clinical indications, including attention deficit disorder [and] narcolepsy . . . [i]t also has significant street value'' and is ''basically a cousin of methamphetamine.'' Tr. 270.

informing them of this gap fill, the best I could tell.

But what's beginning to emerge here in this note and does come in later is that he is becoming—Dr. Alexander is becoming aware that she's running out and I assume prematurely because when you look at the PDMP data from Dr. Webb, Dr. Webb is not creating gaps. . . . He is not leaving her hanging with no medication a whole lot of times.

Id. at 281–82.

Continuing on to the next note (March 12, 2012), Dr. Chambers testified that this was ''the first time I've seen a diagnosis in the chart.'' *Id* at 282. He then explained that ''delusional parasitosis is a non-specific psychotic symptom,'' and that while it can be caused by ''a primary delusional illness . . . more commonly [it] is a sign of severe drug withdrawal'' including ''benzodiazepine . . . or even opiate withdrawal.'' *Id.* at 282–83. Dr. Chambers testified that the behavior documented in the chart (jerking, twitching, and delusional parasitosis) ''suggests extreme discomfort'' and ''could suggest vital sign changes [and] impending catastrophic withdrawal.'' [32] *Id.* at 283. Dr. Chambers observed, however, that Respondent did not obtain his wife's blood pressure and pulse or perform a mental status exam. *Id.* at 284.

Respondent's note of July 14, 2012 documents a prescription for 20 alprazolam 2 mg, a ''6 day supply,'' and states, among other things, that his wife had been off medications for four months and had been staying with her mother-in-law. GE 6, at 4. Regarding the note, Dr. Chambers testified that ''I don't know that she's even around when this prescription happens. It's just not clear where . . . she [is]. There's no evidence that she's even in front of him on July 14, and that's also a concern.'' Tr. 285.

Dr. Chambers observed that, in the October 5, 2012 note (''[s]he is out 2 days early''), Respondent documented that his wife was ''actually overusing the prescription that Dr. Webb ha[d] provided her. So he's documenting evidence that she's demonstrating abuse of these drugs and then he . . . say[s], '[s]he's lacerating and cutting herself, severe anxiety and depression, arms excoriated. No return call from a weekend doctor. I have to leave to work out of town.''' *Id.* After criticizing Respondent for ''abandoning the patient,'' who was self-mutilating and in a ''potentially life threatening withdrawal,'' Dr. Chambers testified that Respondent's ''leaving for the weekend and leaving her with more medication unsupervised'' is ''of grave concern.'' *Id.*

Dr. Chambers offered similar testimony regarding Respondent's May 13, 2012 note. *See id.* 288 (''So again he's now creating a track record in his . . . notation that the patient is essentially out of control and abusing Xanax and injuring herself. His response is to attempt to prescribe a combo of Xanax and Ambien . . . .).

Respondent's February 27, 2013 note states that his wife was ''[a]nxious about marital situation.'' As to the note, Dr. Chambers testified that ''it's not considered a normal medical practice'' to treat family members and ''that when it comes to controlled substances it's a whole different ball game'' when the prescription is ''for a family member.'' [33] *Id.* at 286–87.

Dr. Chambers offered similar testimony with respect to Respondent's March 28, 2012 note, which states: ''Marital/physical/mental stress sky high—Marriage workshop in Montana just accentuated'' and ''Out of Xanax early—rebound anxiety—self harm.'' GE 6, at 7. Dr. Chambers testified that he found that entry was ''interesting because the marital, physical and mental stress . . . involves him, and he's prescribing this medication to somebody who is in acute distress that's ultimately related to the medication.'' Tr. 287. Dr. Chambers also testified that Respondent's notation of a prescription for ''Xanax # 14'' ''is incomplete'' because it does not state ''the dose'' or the patient's instructions. *Id.*

Subsequently, the Government asked Dr. Chambers to address ''the situation where'' a primary care doctor is prescribing to a patient who is also being treated by a psychiatrist. *Id.* at 291. Dr. Chambers testified that in his ''own practice,'' if a new patient is receiving psychoactive medication from another physician, he ''will call them to stop that because you can't have two chefs in the kitchen.'' *Id.* Dr. Chambers then explained:

> If you have two chefs in the kitchen, this is the kind of stuff that can happen as you get chaos and harm and polypharmacy and no one understanding what is the illness versus what is [sic] the side effects of the medications, and it can lead to escalation of mental illness, addiction, and even death.

Id.

Finally, on direct examination, Dr. Chambers testified that ''[a] competent psychiatrist would document [in the patient's chart] if they knew that another doctor was prescribing controlled substances that were overlapping or representing a threat.'' *Id.* at 298. A competent psychiatrist would also ''take action to stop it or to stop their practice.'' *Id.*

On cross-examination, Dr. Chambers agreed that ''[i]n many cases,'' Respondent prescribed the same drugs to his wife as were prescribed by Dr. Webb. *Id.* at 307. Dr. Chambers also acknowledged that he had not examined Respondent's wife and that ''someone who sees her in person'' is in a better position to evaluate her than a person who only reads her chart. *Id.* at 310. After accusing Dr. Chambers of making a ''serious allegation []'' when he testified that Respondent's ''wife was going through withdrawal'' and which ''could be interpreted as she was abusing controlled substances,'' Respondent's counsel asked Dr. Chambers whether he or Dr. Webb was in a better position to make that determination. *Id.* Dr. Chambers answered that Dr. Webb was, but noted that he ''was looking at data from'' Respondent and ''had the ability to look at two charts.'' *Id.* at 310–11; *see also id.* at 319 (Q. You don't know if she was exhibiting physical characteristics that correspond to drug addiction. A. I can only go on what I've read.'').

Asked by Respondent's counsel if ''providing gap fills necessarily mean[s] there's a drug abuse issue,'' Dr. Chambers answered that ''[i]t can mean.'' *Id.* at 311. After Respondent's counsel asserted that ''[i]t can . . . it's not definitive,'' Dr. Chambers answered: ''I don't see gap filling happen[ing] in this case. There is no gap filling going on. There's overlaying.'' *Id.* After Respondent's counsel asserted that Dr. Webb ''ha[d] categorized the same

[32] Dr. Chambers further criticized Respondent because ''the standard of care for the treatment of acute withdrawal'' requires as part of ''the basic response to get a blood pressure or a pulse,'' and ''[i]f these measures aren't taken, people die routinely.'' *Id.* at 284.

[33] Dr. Chambers also testified that there is a prohibition against a psychiatrist treating a spouse for two reasons. Tr. 293. According to Dr. Chambers, the first reason is that the practice of psychiatry requires ''getting inside the mind of the patient'' and ''is a very invasive process'' and that ''romantic and sexual . . . motives will contaminate the clarity of the practitioner. . . . A psychiatrist who is falling in love with his patient will begin to take actions that benefit . . . him or her rather than the patient.'' *Id.* at 293–94. The second reason is that ''there is an implicit power differential'' between ''a psychiatrist and a patient'' and that ''to exploit that power differential on a patient who's vulnerable with mental illness through romantic or erotic counter-transference is regarded fairly much as a cardinal sin in psychiatry.'' *Id.* at 294. Continuing, Dr. Chambers testified that in ''many cases, these are patients who have already suffered physical and sexual abuse previously'' and are ''susceptible'' to more abuse ''later on.'' Thus, if a ''psychiatrist engages in a sexual relationship with a patient . . . the very real danger is [that] there could . . . be a revictimization . . . of the patient.'' *Id.* at 295.

Dr. Chambers also testified, however, that ''[t]his standard is actually not true for other branches of medicine'' such as family practice. *Id.* at 294.

evidence . . . as gap filling,'' Dr. Chambers testified: ''[i]t would surprise me if he's seen the same evidence . . . It would surprise me because that's not what I see in the data.'' [34] *Id.*

Assuming facts not in evidence, Respondent's counsel then asked Dr. Chambers if ''somebody who sees [the patient] regularly five or six times a week as a patient [35] or someone who's paid to review her patient file'' is ''in a better position'' to diagnose a patient as a substance abuser. *Id.* While Dr. Chambers agreed that a psychiatrist who saw the patient is in a better position to evaluate a patient, in response to the question of whether ''it would not surprise [him] that Dr. Webb concluded that [Respondent's wife] didn't have a substance abuse issue,'' Dr. Chambers explained that ''[i]t wouldn't'' because Dr. Webb is ''not an addiction psychiatrist.'' *Id.* at 312–13. When subsequently asked by Respondent's counsel if he ''disagree[d] . . . with the doctor that's seen her for 15 years five to six times a week with his diagnosis,'' Dr. Chambers answered that he did.[36] *Id. See also id.* at 319 (Q. ''So it's better to leave it to the psychiatrist who sees her five to six times a week over a 15-year period to make that decision.'' A. ''Well, not always. Not always, right.'').

Dr. Chambers acknowledged that Respondent's and Dr. Webb's dosing of alprazolam were ''often in the same ballpark.'' *Id.* at 317. However, Dr. Chambers explained that, while ''taken separately both of the [doctors'] dose ranges might be acceptable, . . . if they're . . . overlapping, that's when you get into the danger.'' *Id.* Dr. Chambers acknowledged, however, that ''[n]o one'' knows how much of the drug Respondent's wife was taking. *Id.* at 318.

Respondent's counsel then asked Dr. Chambers if ''you're saying that she was addicted or . . . was abusing controlled substances . . . wouldn't . . . the individual who prescribed her over 1500 doses of controlled substance in one year . . . be more responsible for that versus the individual who prescribed 200 doses of controlled substances a year?'' *Id.* at 320. Dr. Chambers answered: ''but what we're seeing here, that's not what happened. We're seeing two people prescribing [to] one person.'' *Id.* Continuing, Dr. Chambers explained that ''it could be a totally different picture if . . . only Dr. Webb'' was prescribing but he had ''no idea what that whole trajectory would look like'' and whether ''[s]he might be more stable.'' *Id.* Dr. Chambers held to his earlier testimony that having two physicians prescribe to Respondent's wife was ''creating chaos that could actually cause the treatment to get even worse'' and ''to evolve in the wrong direction.'' *Id.* at 321.

After Dr. Chambers acknowledged that ''Dr. Webb prescribed a significant amount of controlled substances, Respondent's counsel asked him if he ''was aware that in 2011 [Respondent] only prescribed 128 dosage units to her?'' [37] *Id.* at 321. After answering ''yes,'' Dr, Chambers added that ''Dr. Alexander prescribed about 20 percent of the controlled prescriptions and Dr. Webb about 70 percent on average over three years. *Id.*

Following questions about the relative amounts of controlled substances prescribed by Dr. Webb and Respondent, Respondent's counsel asked Dr. Chambers if Respondent's wife had ''a substance abuse issue, . . . isn't it logical that Dr. Webb would have as much, if not more, responsibility for that?'' *Id.* at 322. Dr. Chambers disagreed, explaining: ''not necessarily because Dr. Webb is not aware that . . . two doctors [were] putting drugs into one person.'' *Id.* While Dr. Chambers acknowledged that there is evidence in Dr. Webb's chart ''that he had discussions'' with Respondent about his wife, he found ''no evidence at all . . . that [Dr. Webb] knew that [Respondent] was also prescribing controlled substances.'' *Id.*

Dr. Chambers testified that he did not see any notation in Dr. Webb's patient file that he was aware that Respondent's wife ''was running out early and that [Dr. Webb] was filling earlier.'' *Id.* at 328. Asked if he would be surprised that Dr. Webb testified that he was aware that Respondent's wife was getting early refills, Dr. Chambers answered that he ''would be'' and explained that PMP ''data doesn't really reflect [that] there was a great deal of early refill activity going on from Webb by himself,'' and while ''[t]here may be a few instances of it, [it was] not very frequent.'' *Id.* at 329. Dr. Chambers explained that Dr. Webb's ''prescribing shows a relative lack of overlap of his . . . prescriptions for controlled substances. And when I say 'relative lack,' I mean maybe a day or two,'' which is ''not really significant because people have got to go to the pharmacy.'' *Id.*

Respondent's counsel then questioned Dr. Chambers about the alprazolam prescriptions which were issued by Dr. Webb and filled by Respondent's wife on May 14, June 10, July 4, July 21, August 4, and August 16, 2011, and whether the overlap between the prescriptions concerned him. *Id.* at 331. Dr. Chambers acknowledged that the June 10, 2011 filling created an overlap of three/four days and was ''on the margin'' as did the August 16, 2011 filling. *Id.* at 331–32. Dr. Chambers also acknowledged that the July 21 prescription ''would concern me.'' *Id.* at 332. Dr. Chambers offered similar testimony with respect to several alprazolam prescriptions that Respondent's wife filled on February 14 and 23, 2012, finding that the latter fill was ''five days early'' and ''[t]hat's when the red flag begins to go up.'' *Id.* at 332–33. Of note, however, several of these fills were actually refills of prescriptions written much earlier, *see* Tr. 333, and in any event, to the extent that Dr. Webb should have been aware that a previous prescription he issued had provided sufficient refills such that there was no reason to issue a new prescription on a particular date, Dr. Webb is not the respondent in this proceeding.[38] Likewise, while Respondent's counsel raised a series of questions as to whether the pharmacies that filled the prescriptions should not have dispensed various early refills, *id.* at 334–336, the

[34] As found above, while Dr. Webb testified that gap filling ''means a prescription that is used to get you to the next authorized refill'' and gave various examples, including ''something that would speak to a need for more medication,'' his testimony was clear that with the exception of a prescription issued by ''one of my on call doctors,'' a gap fill by another provider was not appropriate. Tr. 138–39, 192, 195–96.

[35] Dr. Webb's patient file contains progress notes for 10 visits by Respondent's wife during the years 2011 through 2013. GX 5, at 42–53. Thus, contrary to the premise of the question, there is no evidence that Dr. Webb saw Respondent's wife ''five or six times a week as a patient.'' Tr. 311.

[36] While the ALJ admitted only Dr. Webb's chart for Respondent's wife during the years 2011 through 2013, Tr. 74, here again, there is no evidence in the entire record that Dr. Webb saw Respondent's wife five to six times a week.

[37] This, too, is a misstatement of the evidence. Rather, the evidence shows that during 2011, Respondent issued prescriptions for 206 dosage units of zolpidem, 151 dosage units of hydrocodone, 28 dosage units of clonazepam, 28 dosage units of alprazolam, and one kit of Diastat acudial.

Respondent's counsel also misstated the evidence when he asked Dr. Chambers if he was ''aware [that] in 2012 Dr. Webb prescribed approximately 1720 dosage units of controlled substances versus the 132 that [Respondent] prescribed] to'' is wife. Tr. 321. Rather, the evidence shows that Respondent prescribed 112 du of zolpidem, 94 du of alprazolam, 20 du of diazepam, 30 du of hydrocodone, 15 du of Adderall, as well as Hycodan cough syrup.

[38] Specifically, Dr. Webb's February 3, 2011 alprazolam prescription, which was for a 30-day supply, see GE 5, at 111, authorized five refills, and Respondent's wife obtained refills which were authorized by this prescription on June 10 and July 4, 2011. *See* GE 11, at 12. However, on May 2, 2011, Dr. Webb issued Respondent's wife an additional prescription for 30 days of alprazolam. GE 11, at 13; GE 5, at 111.

ALJ properly ruled that the conduct of the pharmacies is irrelevant. *Id.* at 336.

Respondent's counsel subsequently asked Dr. Chambers if the hydrocodone prescription which Dr. Webb issued on June 28, 2013 concerned him. *Id.* at 338. Dr. Chambers testified that he did ''have a concern in that [Dr. Webb] is concurrently prescribing two other benzodiazepines at the same time,'' these being temazepam and alprazolam. *Id.* at 338–39. Dr. Chambers also acknowledged that the Adderall prescription issued by Dr. Webb on this date created ''a speedball.'' *Id.* at 339. Continuing, Dr. Chambers testified:

> So that is a concern. When you step back from the record and you look at where—the opiate is the main threat actually, and when you look at the predominance of opiate prescribing over three years, the majority of it came from Dr. Alexander. So the number of opiates that were prescribed were quite rare. The incidents you're putting in there—you're pointing out is a concern, but . . . the relative frequency of which Webb did that was much, much, much lower than when Dr. Alexander [did] it, and that's interesting because, as you pointed out, Dr. Webb is prescribing . . . three or four times more number of prescriptions. So it's a matter of degree as well.

Id. at 340.

Asked if it is within the usual course of professional practice for a psychiatrist to prescribe an opiate, Dr. Chambers testified that a psychiatrist ''may treat pain on occasion.'' *Id.* at 341. While Dr. Chambers then testified that he was surprised that Dr. Webb had testified that that he had written the June 28, 2013 hydrocodone prescription knowing that another physician was prescribing the drug to Respondent's wife and did so without consulting that physician, when Respondent's counsel asked Dr. Chambers if this called into question Dr. Webb's treatment of her, the ALJ properly sustained the Government's objection. *Id.* at 341–42.

Addressing the prescription for Diastat Acudial, a rectal suppository form of diazepam, Dr. Chambers testified that while Dr. Webb's file shows that Respondent's wife suffers from seizures, he did not see how administering Diastat would ''be consistent with treating someone who was having a seizure.'' *Id.* at 345. While Dr. Chambers testified that Valium (diazepam) and benzodiazepines ''can be used to treat seizure disorder[s],'' he added that these drugs ''can also cause seizure disorders.'' *Id.* at 346. Dr. Chambers subsequently testified that a rectal suppository might be used ''to treat a seizure disorder if someone can't take [the drug] orally, meaning [the patient] would be in status epilepticus, like actively seizing and not conscious.'' *Id.*

Respondent's Testimony at the State Board Hearing Regarding His Reasons for Issuing the Prescriptions

At the January 2014 Board hearing which resulted in the suspension of his medical license, Respondent was asked to explain why he issued the prescriptions. GE 14, at 56. Respondent explained that his wife has a ''fragile'' psychiatric condition, which ''became even more fragile'' in ''about November or December of last year.'' *Id.* He testified that while ''[t]here were times [that his wife] would run out of medicine and not decompensate . . . there was never a decompensation where she had her medicines.'' *Id.* at 57. Respondent testified that ''[w]ith [his] history, there was no way to call anyone else'' and ask them to prescribe Xanax to his wife because anyone he knows would ''be immediately suspicious that it was for me.'' *Id.* at 58. According to Respondent, ''as regards my wife herself, I would phone in usually a two- or three-day stop gap supply of medicines. And if you'll look at the numbers dispensed, it's usually 12, which would be a three-day supply for'' her. *Id.*

Continuing, Respondent testified that ''[w]e tried to . . . contact [Dr.] Webb, but . . . you can't get him at night, on weekends, and I don't blame him. And as he always tells [my wife], this is a matter that she shouldn't be running out prematurely.'' *Id.* Respondent maintained that ''[t]his happened . . . in December, in January, in February. I don't think it happened in April or May.'' *Id.* He further asserted that ''[i]t was sporadic'' and ''was always for a confined number of pills, a small amount, that bridged her gap between obviously when she was in crisis and didn't have any medicine.'' *Id.* Respondent also testified that ''we've got a baby here,'' ''I may be working out of town,'' and ''I've got to do something to calm this situation down.'' *Id.* Respondent added that he ''felt as if [he] was in an emergency situation.'' *Id.*

Apparently referring to the prescriptions he issued for hydrocodone, Respondent testified that ''[w]hen that changes—there were two occasions in general'' when he ''called in.'' *Id.* Respondent then related that a plastic surgeon had drained an abscess in his wife's thigh and testified that he ''noticed that there was one prescription for Lorcet then for a few, and it happened again in July of last year'' when his wife's mother died and his wife ''had a seizure [and] fell,'' suffering various injuries. *Id.* While Respondent testified that ''there was pain medicines [sic] then,'' he added that ''in general, the majority of the medicine were Xanax, two milligrams, three days' supply were common.'' *Id.* at 59–60. Respondent then maintained that his wife ''would get in with Dr. Webb the following Monday morning, and he will refill everything.'' *Id.* He further testified that ''I think the record reflects that I filled in in times where I just didn't think I had no other choice. I didn't know what to do.'' *Id.*

Continuing, Respondent testified that ''I have never denied that I called things in for Jill . . . I always thought that if called to task for it, the context would not speak for itself but would be evidenced by number, etcetera.'' *Id.* at 61. Respondent then testified that he was monitored by the Board and that ''[t]here's not been any diversion. There has not been any suggestion of that and, fortunately, got a lot of urine tests that were negative. I only ever did what I did when I perceived I had no other options having exhausted anything else that I knew to do.'' *Id.*

Asked about the December 2012 Adderall prescription, Respondent stated that he did not ''recall ever writing'' the prescription and that his wife ''was in the hospital in Hattiesburg at the time.'' *Id.* at 62. Continuing, Respondent stated that ''that one prescription doesn't seem to fit for me. I don't think that's mine, but I would be glad if somebody had a copy of it to look at it.'' *Id.* at 62–63. The prescription is, however, in the record of this proceeding. GE 18, at 102. It shows Respondent as the prescriber and Respondent offered no testimony in this proceeding disputing that he issued it. *Id.*

Respondent also told the Board that his prescribing was ''not a matter of judgment'' but ''a matter of heart.'' GE 14, at 63. He further told the Board that:

> I never did anything that I didn't think at the moment . . . was necessary, and I think if you look at the record you can see that. There can be no more. There can be no more. You know, if I have to call 911 every time, then I am Jill's husband. I am not—I was never her doctor. I stopped gapped, but I can't even do that anymore. I mean, I know that is a matter of fact going forward.

Id. at 63–64.

During cross-examination at the Board proceeding, Respondent admitted that he did not disclose that he had been issuing the prescriptions until he was asked by the Board. *Id.* at 64–65. He further asserted that he did not ''come up with [his wife's] regimen,'' that he ''didn't change her regime,'' and that he only ''mirrored what her treating psychiatrist had done.'' *Id.* at 65.

However, after a Board member identified multiple hydrocodone and Xanax prescriptions that he issued in July 2013 and asked if he thought ''that's wise,'' Respondent stated that ''I have to alter what I said. She also has a treating neurologist'' (Dr. Bell) who ''also does musculoskeletal medicine'' and that when his wife ''had a seizure'' she saw the neurologist. *Id.* at 66. Respondent then explained that ''[w]hen I say psychiatrist, that's what Dr. Bell had given her for pain, and she ran out, and she was sitting constantly in the . . . [h]ospital.'' *Id.* Respondent asserted that ''that was an isolated incident there.'' *Id.*

During the Board proceeding, Respondent acknowledged that he had violated his RCA and an agreement with the Board. *Id.* at 68. He further asserted that he never issued the prescriptions ''out of defiance[,] . . . self will, power, or arrogance'' and that ''[i]t was always done in a short stop gap times [sic] when I believed again . . . that there were no other options.'' *Id.* at 69.

Before the Board, Respondent further asserted that he did not notify Dr. Webb about the prescriptions because his wife ''assured [him] that [Webb] was apprised of every situation.'' *Id.* at 78. However, when a Board member noted that ''[c]ommon sense would dictate as a physician [that] the next morning you pick up the phone and call this psychiatri[st] that's taken care of [her] for 18 years and knows her probably better than any healthcare professional'' and tell him ''this is what happened last night, and this is what I did,'' Respondent answered: ''Not with every time.'' *Id.* at 79. Asked more specifically why he did not talk to Dr. Webb, Respondent maintained that his wife told him that ''[w]ith your Betty Ford attitude, he's going to take me off my Xanax'' and ''I don't want you to talk to him.'' *Id.* at 80. While Respondent testified that he should ''have overridden her concerns and intruded . . . upon her doctor/patient relationship,'' he then added that ''[i]n retrospect, I should have done that, more than the few times that I did do it. I certainly did it sometimes. I didn't do it with every issuance herein.'' *Id.*

The same Board member noted that ''there's an insinuation that [Dr. Webb] knew something had happened and that weekend or something had happened and that emergency medicine had been called in'' and asked ''is that correct?'' *Id.* Respondent answered: ''I certainly know that certain times he did. I don't know that at every time he did.'' *Id.* Respondent added that he was ''certain that the answering service's message was, '[c]all Dr. Alexander.' '' *Id.* at 80–81. Respondent subsequently testified that ''no, I didn't do it every time. I have had the discussion with him.'' *Id.* at 81.

Respondent testified that when he would call Dr. Webb's answering service, he would ''ask [ ] for a call back from Dr. Webb or the doctor on call.'' *Id.* at 84. When asked if he ''communicate[d] to the answering service the gravity of the situation,'' he admitted that he did not. *Id.* at 85. He then explained that ''I think I communicated that it was a medicine shortfall and that we needed someone to remedy that.'' *Id.*

Respondent's Case

Respondent's first witness was his wife. Tr. 357–401. Of consequence, the ALJ found ''that her testimony was not helpful in resolving the issues in this case.'' R.D. 9. Specifically, the ALJ found that ''her testimony was confusing, lacked specificity, and, at times, was internally inconsistent'' and that ''she could not remember many details of the underlying events about which she was testifying.'' *Id.* (citing Tr. 373–74, 376–77, 382, 384, 391). The ALJ also ''found her responses to some questions to be evasive, and her demeanor to be somewhat combative.'' *Id.* The ALJ also provided extensive reasons for why he gave ''little credence to her testimony, and where it [was] contradicted by other evidence,'' he did not find her testimony as credible.

These included:

She could not recall the number of times she had called Dr. Webb's answering service and had not received a return phone call. Tr. 360–62. She could not provide an adequate explanation of why she continued to be Dr. Webb's patient even though she was dissatisfied with his failure to return her phone calls. Tr. 361–62, 382, 391. In explaining her difficulty in recalling details from 2011 to 2013, she said she could not recall because that was ''seven years ago.'' Tr. 372. She testified that she did not have appointments with Dr. Webb between 2011 and 2013, yet Dr. Webb's treatment notes document several appointments during that period. *Compare* GE 5, at 42–46, 49–53, *with* Tr. 386. She testified that she told Dr. Webb that she would only get her prescriptions from him, and that that had been her practice for the past three years, but later testified that she had this discussion with Dr. Webb in 2016. Tr. 363, 368, 398–99. She testified that she only used one pharmacy, but her PMP report shows she filled prescriptions at numerous pharmacies. GE 11; Tr. 369. She did not give a direct answer to the question of whether she had told Dr. Webb that the Respondent had provided her with prescriptions, and when she provided an example of when she had passed that information to Dr. Webb, the example was outside of the time range of the Respondent's alleged violations. Tr. 360–63, 398–99.

R.D. 9.

Respondent's wife testified that she is known by various names including Mona Jill Graham Alexander, Mona Jill Graham, Mona Jill G. Alexander, and Jill Alexander. Tr. 357–58. She testified that she has been a patient of Dr. Webb for 16 years and she would usually see Dr. Webb three times a year and speak on the phone two to three times a month for 30 minutes to one hour. *Id.* at 359.

Respondent's wife testified that during the 2011 through 2013 time period, she ''would tell'' Dr. Webb that Respondent was prescribing controlled substances for her, ''especially if I got out of medication.'' *Id.* at 360. I do not find this credible. Nor apparently did the ALJ. R.D. 16 (FoF #28: ''Dr. Webb did not know that the Respondent was simultaneously prescribing controlled substances to Mrs. Alexander.'') (citations omitted). While Respondent's wife also testified that when she called after hours, ''[n]o one would ever . . . call me back,'' that this ''was very frustrating'' to her, and that she expressed her frustration to Dr. Webb, Tr. 360–61, the ALJ did not find this testimony credible. R.D. 15 n.21. Indeed, the ALJ specifically found credible Dr. Webb's testimony that Respondent's wife ''never told [him] that she was dissatisfied with her ability to contact him or his office.'' R.D. 15 (FOF #23.). I agree with these findings.

Respondent's wife testified that ''[t]he only conversation we [she and Dr. Webb] ever had about [her husband's prescribing] was to let me be the only one that prescribes you this medicine.'' Tr. 363. She initially testified that this conversation ''probably [occurred] towards the end'' of 2013, *id.* at 391, only to testify that the conversation occurred ''after [she] got discharged from the hospital'' in March 2016. *Id.* at 398–99. She also testified that during the 2011 through 2013 time period, she was hurting herself and that to the best of her recollection, she shared this with Dr. Webb. *Id.* at 364.

Regarding the Diastat prescription, Respondent's wife testified that she uses the drug because she has seizures and because ''I've had seizures, I just always try to travel with it and keep some on me.'' *Id.* at 366. Asked by the ALJ if she was using this medication in the 2011–2013 time period, Respondent's wife answered: ''I always keep it with me. It's something that I'll try not to ever run out.'' *Id.* She also subsequently testified that the Diastat was not prescribed by Dr. Webb but by her ''neurologist.'' *Id* at 393.

Respondent's wife testified that she believed her husband prescribed the controlled substances because he was trying to help her. *Id.* at 367. She further

testified that her husband ''never prescribed medicines that weren't prescribed for [sic] Dr. Webb when I got—until we could get in touch with him.'' *Id. See also id.* at 383 (''[B]ut he never prescribed anything that I hadn't already been prescribed by Dr. Webb.'').

She also testified that when her husband wrote a prescription for her, she was in crisis, and that her husband had never provided her with a controlled substance prescription when she was not in crisis. *Id.* at 367–68, 376. She further maintained that she ''would try to get in touch with Dr. Webb, and in the interim of a two- or three-day fill-in, I did get medicine from'' my husband. *Id.* at 371. When later asked why her husband would have to prescribe to her when she was in crisis, she maintained that ''[t]here would be occasional times I might run out a day early on a weekend . . . and he would see me very upset, crying, very emotional, and I feel like his intent was never to harm me. He was just trying to help me.'' *Id.* at 379. *See also id.* at 381 (''I don't know if I told him I need more or if he just knew that I just needed just two, three, four to get back to Dr. Webb because no one would call us back.''). However, when asked if Respondent had ever given her a prescription for a longer time period than two to four days, she answered: ''Not to my knowledge. I do not remember.'' *Id.* at 384.

On cross-examination, she also admitted that Respondent had written a hydrocodone prescription for her but maintained that he did so when her mother ''was dying in the hospital'' and she developed back pain because she sat at her ''mother's bedside waiting for her to die.'' *Id.* at 374. Respondent's wife then maintained that she did not recall her husband as having written ''[m]ore than one'' hydrocodone prescription. *Id.*

However, as found above, Respondent issued numerous hydrocodone prescriptions to her well before Dr. Webb issued the single hydrocodone prescription on June 28, 2013. Also, a substantial number of the prescriptions (especially those for zolpidem) were for quantities that far exceeded the amount necessary to provide medication until she was able to get a new prescription from Dr. Webb. Moreover, in a number of instances, Respondent issued the prescription notwithstanding that his wife had either recently refilled a prescription for the same drug or had refills outstanding which were authorized by an existing prescription issued by Dr. Webb.

On questioning by the ALJ, Respondent's wife maintained that during the period of 2011 and 2013, she ''usually [did] not'' get a call back from Respondent's office when she would leave a message. Tr. 387. Not only did the ALJ not find her testimony credible, her medical file contains evidence of only two phone calls she made during this period in which Dr. Webb did not document that he called back or Dr. Webb did not issue a prescription either the same day or the following day.[39]

Respondent called as a witness Peter Graham, Ph.D. Dr. Graham is a psychologist who works with Acumen Assessments, which provides clinical evaluations of physicians who are referred to it by physician health programs and state boards, and the Acumen Institute, which provides treatment, education and coaching to ''licensed professionals who are in the process of being rehabilitated for one or another professional reason.'' Tr. 403–04. Dr. Graham testified that the main focus of Acumen's evaluations is not whether a physician is competent to practice medicine, but whether the physician's ''mental status, personality variables, [and] character traits . . . may impact on decision-making, ethical judgment, self-regulation, ability to remain responsible and maintain the duties of licensure.'' *Id.* at 416–17.

Dr. Graham testified that Respondent was referred to him ''for evaluation of his fitness secondary to having engaged in conduct that was contrary to his [recovery] contract,'' that being writing the prescriptions for his wife. *Id.* at 417. According to Dr. Graham, the evaluation determined ''that there was an interaction between certain personality factors that affected his judgment and the way he was deciding to comply or not with his contract, as well as anxiety and situational stress related to'' his home life that ''affect[ed] his mental status.'' *Id.* at 419. The evaluation recommended to the MPHP that Respondent ''undergo treatment designed for professionals who have made ethical misjudgments or engaged in some kind of misconduct . . . with a focus on examining his ethical decision-making'' and how his ''personality traits'' affected his behavior. *Id.* at 420.

Respondent subsequently underwent treatment, which included both a three-week inpatient and one-week follow-up visits at three and six months, individual psychotherapy in his home community, and a three-day wrap up visit at the one-year mark. *Id.* at 421–22. According to Dr. Graham, Respondent's treatment team has determined that he can ''return to supervised and monitored practice.'' *Id.* at 425.

Respondent also called as a witness, Scott Hambleton, M.D., the medical director of the MPHP. *Id.* at 435–37. Dr. Hambleton testified that ''the heart of [Respondent's recovery] contract concerns abstinence from any mood-altering or addictive substances, which would increase the risk of a relapse to substance use and active addition.'' *Id.* at 443. He further testified that Respondent is subject to random testing approximately 30 times a year for both drug and alcohol use, that he is subject to a workplace monitor, and in the event he needs to take controlled substances, he ''is required to use a medication monitor'' and all such prescriptions must be approved by the MPHP ''in advance.'' *Id.* at 443–44. Dr. Hambleton also testified that Respondent is required to attend 12-step and Caduceus meetings for physicians in recovery. *Id.* at 445. In addition, according to Dr. Hambleton, a Board investigator visits Respondent on a random basis at least once a quarter to witness a drug screen and evaluate his appearance. *Id.* at 446–47. Dr. Hambleton further stated that Respondent's contract will last for as long as he has an active medical license. *Id.* at 447.

As for how the MPHP monitors the provision in Respondent's contract that prohibits prescribing to family members and himself, Dr. Hambleton testified that this is done by the Board's investigators. *Id.* at 448. Dr. Hambleton testified that if the MPHP found out that Respondent had prescribed controlled substances to himself or a family member it ''would withdraw advocacy immediately.'' *Id.* at 449. Dr. Hambleton further testified that he had no reservations about Respondent returning to the unrestricted practice of medicine. *Id.* at 450. The record does not establish, however, what ''the unrestricted practice of medicine'' entails in light of Respondent's recovery contract.

On cross-examination, Dr. Hambleton acknowledged that Respondent had violated his first two recovery contracts.[40] *Id.* at 452. He also

[39] The first of these was on August 25, 2011. GX 5, at 140. Notably, Respondent's wife had an office visit with Dr. Webb on August 16, 2011, during which he wrote her prescriptions for 30-day quantities of Adderall 20 mg, zolpidem 10 mg, and 90 alprazolam 2 mg. *Id.* at 49; GX 11, at 12. While the phone messages states ''Having problems,'' GX 5, at 140, Respondent did not issue a prescription until August 28, 2011, when he authorized 12 zolpidem.

The second of these occurred on July 10, 2013. GX 5, 133. However, the same day, Respondent's wife refilled a prescription for 45 alprazolam 2 mg (15 days). GX 11, at 6.

[40] Dr. Hambleton explained that Respondent had been subject to a ''provisional contract'' during the period of his license suspension ''to establish a

Continued

acknowledged that at some point when Respondent had a job opportunity in Tennessee, the MPHP had written to that State's Board recommending against granting a license to Respondent. *Id.* at 475.

Dr. Hambleton testified that he supported Respondent's return to the unrestricted practice of medicine because the Board's suspension of his license was ''a profound experience, especially for a neurosurgeon, with that amount of training,'' and ''[t]hat type of intervention has a powerful effect on the recovery process.'' *Id.* at 470. He also testified that ''Acumen has more expertise in dealing with personality issues'' and ''[s]o that treatment in itself . . . represents a profound event that makes it possible to provide advocacy.'' *Id.* at 470–71.

Dr. Hambleton further testified that Respondent's ''treatment has been effective'' and that ''[h]e's gaining insight, sensitivity, demonstration of more regard for others, responsibility, authenticity, the markers of recovery.'' *Id.* at 471.

However, on questioning by the ALJ, Dr. Hambleton testified that his ''frequency of contact'' with Respondent ''is not what allows me to make that assessment of him.'' *Id.* at 472. Rather, Dr. Hambleton explained that his assessment was based on reports he received from other participants in Respondent's Caduceus group, ''from another facilitator of the group,'' his cases manager's reports, and ''watching him interact with other physicians during'' the MPHP's ''annual Caduceus retreat.'' *Id.* at 472. Dr. Hambleton then acknowledged that when he ''provides advocacy, [his] interaction with participants is very limited'' and that he ''provide[s] advocacy based on the constellation of collateral sources of information [and] their drug testing'' results. *Id.* at 473.

Dr. Hambleton testified that ''[i]n the event that there is evidence of substance abuse, we will withdraw advocacy immediately, and it [will] be the end of his medical career.'' *Id.* at 477. He also testified that ''[i]n the event that he prescribes inappropriately . . . our medical board investigators will monitor it closely'' and the Board would ''issue an immediate prohibition on practice.'' *Id.* Dr. Hambleton was ''not sure'' as to how the Board found out about Respondent's prescribing to his wife, but based on ''conversations'' he has ''had with investigators,'' he asserted that ''now it is part of their policy to do regular PMP checks'' on the MPHP's participants.'' *Id.* at 477–78. The MPHP does not, however, have that authority. *Id.* at 478.

Respondent also testified on his own behalf. *Id.* at 481. After discussing his background, training and current employment, *id.* at 481–82, Respondent testified that he ''[a]bsolutely'' prescribed controlled substances to his wife and did so when she was under the care of another physician. *Id.* at 484.

Asked if his prescribing of controlled substances to his wife ''violated his obligations as a licensed doctor in . . . Mississippi,'' Respondent answered: ''I know it violated my contract with the professionals healthcare program.'' *Id.* Asked if he believed that his prescribing ''in the manner that'' he did ''violated [his] obligations as a DEA registrant,'' Respondent testified: ''I don't know the specific legalities of DEA registration, but I'm here to tell you what I did was wrong, period, without any equivocation.'' *Id.*

Respondent testified that when he testified before the State Board, he accepted responsibility for prescribing to his wife. *Id.* at 486. He then testified that he is under a lifetime monitoring contract, and that he is monitored by both the MPHP and the Board. *Id.*

Asked why the Agency should entrust him with a DEA registration, Respondent testified:

> even . . . if I don't know the letter or spirt of any law that I transgressed, I do know that becoming involved in a loved one's care is foolish. There is no subjectivity there. I can be Jill's husband, but that's all I can be to her, period. There can't be any clinical judgment, or any family member for that matter.
>
> As I testified in my [2014] board hearing . . . , regardless of what it had come from, I thought I'd hit a brick wall. And there are no other options for me. If I can't practice medicine, conforming to every jot, tittle, to the letter of the law, I can't practice medicine. There are no more get-out-of-jail cards for me. There aren't.

Id. at 489–90. Continuing, Respondent testified:

> I have tried to—perhaps I made enough missteps, I can provide a beacon of some sort to younger physicians that might think it's okay to prescribe outside the bounds of normal patients. I don't know what else I possibly could do at this point to convince Your Honor what more I could do to be—that I am worthy to be entrusted with a DEA registration. I will do it. If someone suggests something to me, I will gladly do it, but —.

Id. at 491.

On cross-examination, the Government asked Respondent if he understood that ''DEA is alleging something slightly different than prescribing outside the contract.'' *Id.* at 494. After the ALJ overruled the objection of Respondent's counsel that the question was outside the scope of direct examination, Respondent testified that he was ''not certain that [he] understand[s] that fully.'' *Id.* at 495. The Government then asked Respondent if he understood that ''DEA is asserting that with respect to the prescriptions you issued for your wife that you violated Mississippi and federal law.'' *Id.* Respondent answered: ''I understand that you just asserted that, but my understanding would only stop there.'' *Id.*

The Government followed-up by asking: ''so . . . you are not admitting that you violated either federal or state law with respect to the prescriptions you issued to your wife?'' *Id.* Respondent testified: ''I think my answer is I'm uncertain as to every component, specifically of the federal, to be able to answer that as honestly as I want to.'' *Id.*

The Government asked Respondent if he understood that what he had been charged with in the DEA proceeding ''had nothing to do with'' his recovery contract. *Id.* at 497. Respondent testified: ''I understand that you just represented half of what I understand'' and added that ''I was found guilty of two things one, violation of a previous order . . . Number two, the unethical behavior, which in my interpretation is subsumed by the number of things that you have cited as far as Mississippi conduct, et cetera.'' *Id.*

After noting that Respondent was only ''admitting responsibility to what the Board found'' and that was not what DEA had charged him with, the Government explained that it was ''trying to get a clarification as to what you're accepting responsibility for?'' *Id.* at 497–98. Respondent testified:

> . . . as I've said already . . . I wrote prescriptions. I shouldn't have written prescriptions. It violated my contract. It violated my duty to my wife. It violated—in this one instance, in all my years of practice, that's the only time I've ever been called into question, but it violated as a layperson everything I think I should have done, regardless of why I thought at the time it might—erroneously thought it could be proper.
>
> As far as me as a physician testifying to what statutes I may or may not have transgressed, I can't. That would be speculative at least on some level for me.

Id.

After the ALJ sustained Respondent's objection to the Government's attempt to question him about both his testimony before the State Board and the patient file he maintained on his wife, the Government asked Respondent if he

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period of compliance and recovery.'' Tr. 452. Respondent did not violate this contract, which ended when he entered his current (fourth) contract. *Id.* at 453.

''accept[ed] that the prescriptions that you issued to your wife were outside the course of professional practice as defined by the DEA?'' *Id.* at 501. Respondent answered:

> I think I've answered that already. I don't know precisely how the DEA defines it, and to be scrupulously honest, I can't. I will once again accept the responsibility that what I did was wrong and I should not have done it. And I have done everything in my power to remediate that. But I do not know again . . . the specifics of the—of what I'm being charged with by DEA now, three years after I have assiduously striven to do everything I can to clean up and do everything right, and then you come along and ask me about new things.
>
> What hope is there for any other physician that follows me for redemption if we do everything we can. . . . What more, I mean, that's—I'm sorry. I'm getting emotional.

Id. at 501. Then asked if he had been treated unfairly by DEA, Respondent testified that ''I'm not certain I have a well-founded opinion of that. I know that I have done everything I humanly can and will continue to do so and provide the DEA and every other regulatory body with anything I can to ensure that I am safe for the public.'' *Id.* at 502.

The Government then attempted to ask Respondent if he accepted responsibility for failing maintain patient files in compliance with Mississippi law. *Id.* at 502–03. The ALJ disallowed the question, explaining that Respondent's ''counsel has decided not to ask him if he wants to accept responsibility for that.'' *Id.*

After both the Government and Respondent's counsel stated they had ''[n]othing further,'' the ALJ observed that he was ''was just a little bit puzzled as to [Respondent's] answer about acceptance of responsibility.'' *Id.* at 503. While the ALJ stated that he found Respondent ''generally very credible,'' he then explained that ''[w]hat puzzles me is how you could come to this hearing without knowing what the charges against you by DEA are?'' *Id.* Respondent answered that he ''presumed . . . that they would parallel that which the state charged me with. I mean, I knew we were having a hearing.'' *Id.* Respondent then testified that when he ''first applied for re-registration,'' he was told by a DI that ''it was all about my past history with addiction'' but that when he ''had the temerity to get an attorney, it morphed into something else,'' so he ''wasn't sure if'' he was to talk about his ''recovery or other things.'' *Id.* at 503–04.

After the ALJ asked if he had read the Show Cause Order and pointed out that it ''didn't say anything about [his] failure in recovery,'' Respondent acknowledged that ''[i]t didn't'' and asserted ''that's why [he] was confused.'' *Id.* at 504. Noting that the allegations involved his prescribing to his wife and his failure to make adequate notes in his wife's record, the ALJ again expressed his puzzlement as to what Respondent was ''accepting responsibility for.'' *Id.* at 504–05. Respondent replied that he knew ''exactly what the State . . . said I did'' and ''I think I believe that the DEA mimicked that . . . [or] paralleled that.'' *Id.* at 505. Continuing, Respondent stated: ''And if those two specifications or charges are the same, then, yes, I do accept responsibility for what DEA says.'' *Id.*

The ALJ then explained that he was not sure what Respondent meant; Respondent stated that it went to his ''understanding of what I was charged and found guilty with by the State,'' which included violating his Recovery Contract and ''basically unethical behavior.'' *Id.* Respondent added that he ''assumed that that was also what DEA was doing here . . . [and] that I was being called to task for the same things.'' *Id.* at 506.

Thereafter, the ALJ stated to Respondent's counsel that if he was ''getting into an area that you don't want me to ask about, don't hesitate to object because I know I'm going beyond what your direct examination was.'' *Id.* The ALJ further stated that he ''want[ed] to respect the relationship between you and your client and your client's rights in this hearing,'' and that if he asked a question that Respondent's counsel ''vigorously object[ed] to,'' he expected Respondent's counsel ''to say so.'' *Id.* Respondent's counsel then stated that ''[t]here are lines that I'm concerned about here and based on the history here of whether or not a full-throated, yes, I violated this statute was going to result in, you know additional action against'' Respondent. *Id.* The ALJ then offered Respondent's counsel the opportunity to further question his client. *Id.* at 507.

Respondent's counsel resumed questioning Respondent and asked him to ''clarify . . . what specific actions [he was] accepting responsibility for?'' *Id.* Respondent testified: ''Violating the previous order, right? Writing prescriptions for my wife when I wasn't a treating physician, which I think is not proper document, not fully proper documentation of those things.'' *Id.* Respondent's counsel then asked if ''it matter[ed] . . . what provisions that the violations fall under?'' *Id.* at 508. Respondent answered:

> . . . I have found me guilty, and so if someone shows me—and perhaps . . . what I was saying that I'm ignorant of the specifics of a DEA charge. But if I meet the criteria and I accept I did it, then I did it. From my hearing in January of 2014, I never said I didn't. I sat there and said, yes, this is what happened. There are some prescriptions errors in that record, but in general, yes, this is what happened.

Id. Respondent further testified on re-direct that he was, in the words of his counsel, ''accepting responsibility for inappropriate prescribing practices related to [his] wife.'' *Id.*

On re-cross, the Government asked Respondent ''[w]hat portion of the prescribing to [his] wife [was] inappropriate?'' *Id.* Respondent answered:

> Through my education with Dr. Webb—well, first of all, prescribing for family members is a bad idea in general. I think the contract specifies it because commonly that means there's diversion going on, and I'm prescribing for someone, and they're kicking it back to me, but that's not a question, and I think my urine tests show that didn't happen.
>
> I think that in general the objectivity required even in exigent circumstances must be called into question when it's a loved one.

Id. at 508–09.

Subsequently asked by the Government if ''there [was] anything else wrong with your prescriptions to your wife, aside from the fact that she's a family member,'' Respondent answered:

> Let me think on that a minute. I'm a little almost frightened to answer because at no time do I want anyone in this courtroom thinking, exigent or not, that I'm saying it was right or that you'd have done it too if you were there. There's not a complete patient file. I mean, is that what you're asking me?

Id. at 510. After the Government again asked Respondent what he thought he ''did wrong with respect to the prescriptions,'' Respondent answered: ''again, I shouldn't have written. I violated the contract. Prompt me . . . I'm not trying to minimize anything. I'm blanking, frankly.'' *Id.*

The Government then asked Respondent if he ''admit[ted] that the prescriptions you issued to your wife were outside the usual course of professional practice?'' *Id.* at 511. Respondent answered:

> As I understand that term of art . . . if the documentation is substandard, that that renders it outside the course of professional practice, then I would accept that, if I'm—any hesitancy previously has been based on that. I mean, you know, as a physician, I don't understand that term. When you say outside the course of medical practice, it makes me think that someone just gave rat poison or something absurd like that. But when you lay the predicate about proper documentation, for instance, then, yes, I would have to accept that.

Id. at 511–12. The Government subsequently asked Respondent if he ''believe[d] that [his] actions increased the chances of [his] wife's dependency, overdose, or diversion of controlled substances?'' *Id.* at 512. Respondent answered ''[n]o.'' *Id.*

On still a further round of re-direct, Respondent acknowledged that he is ''not a psychiatrist'' and that ''[t]hese medicines are . . . chiefly used in psychiatric conditions. *Id.* at 513. Respondent's counsel further asked him if he understood that the DEA had alleged that he ''prescrib[ed] controlled substances to someone who was under the care of another physician for those same ailments.'' *Id.* Respondent testified that he understood that and ''accept[ed] that'' it was wrong for him to do that. *Id.* at 513–14.

Respondent's counsel then asked if could ''be trusted to not engage in such prescribing in the future?'' *Id.* at 514. Respondent testified:

> I will first say strongly, absolutely. I have spent the last three years trying to redeem this situation, to show everyone exactly how driven I am. And, Your Honor, I'm not trying to avoid anything. If someone shows me I've done something wrong, I will admit it. I'm not even bringing up the subtext. I did wrong. I throw myself upon the mercy of the process. I have done everything that I know to do to try to remedy this situation and I can do no more than give my sworn oath that this will not happen again.

Id.

Respondent's counsel concluded his examination by asking Respondent if his acceptance of responsibility included his ''prescribing to [his wife] while she was under the care of another doctor, perhaps providing medications too soon in terms of early refills, providing gap fills, [and] not having an adequate medical file?'' *Id.* at 515. Respondent answered ''[y]es.'' *Id.*

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 the Attorney General determines that the issuance of such registration . . . would be inconsistent with the public interest.'' 21 U.S.C. 823(f). With respect to a practitioner, the Act requires the consideration of the following factors in making the public interest determination:

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

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

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

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

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

Id.

''[T]hese factors are . . . considered in the disjunctive.'' *Robert A. Leslie, M.D.,* 68 FR 15227, 15230 (2003). It is well settled that ''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 registration [should be] denied.'' *Paul H. Volkman,* 73 FR 30630, 30641 (2008) (citing *id.*), *pet. for rev. denied, Volkman* v. *DEA,* 567 F.3d 215, 222 (6th Cir. 2009); *see also MacKay* v. *DEA,* 664 F.3d 808, 816 (10th Cir. 2011); *Hoxie* v. *DEA,* 419 F.3d 477, 482 (6th Cir. 2005). Moreover, while I am required to consider each of the factors, I ''need not make explicit findings as to each one.'' *MacKay,* 664 F.3d at 816 (quoting *Volkman,* 567 F.3d at 222 (quoting *Hoxie,* 419 F.3d at 482)).[41]

The Government has the burden of proving, by a preponderance of the evidence, that the requirements for denial of an application pursuant to 21 U.S.C. 823(f) are met. 21 CFR 1301.44(d). However, once the Government has made a *prima facie* showing that issuing a new registration to the applicant would be inconsistent with the public interest, an applicant must then present sufficient mitigating evidence to show why he can be entrusted with a new registration. *Medicine Shoppe-Jonesborough,* 73 FR 364, 387 (2008) (citing cases)); *see also MacKay,* 664 F.3d at 817.

Having considered all of the factors, I find that the Government's evidence with respect to Factors Two and Four satisfies its *prima facie* burden of showing that granting Respondent's application would be inconsistent with the public interest.[42] I further find that Respondent has failed to produce sufficient evidence to rebut the Government's *prima facie* case.

[41] In short, this is not a contest in which score is kept; the Agency is not required to mechanically count up the factors and determine how many favor the Government and how many favor the registrant. Rather, it is an inquiry which focuses on protecting the public interest; what matters is the seriousness of the registrant's misconduct. *Jayam Krishna-Iyer,* 74 FR 459, 462 (2009). Accordingly, as the Tenth Circuit has recognized, findings under a single factor can support the revocation of a registration or the denial of an application. *MacKay,* 664 F.3d at 821.

[42] As to factor one, while the Mississippi Board has taken disciplinary action against Respondent based on his issuance of the prescriptions, the Board has not made a recommendation to the Agency with respect to whether his application should be granted. To be sure, as a result of the Board's subsequent restoration of his medical license without restriction of his controlled substance prescribing authority under Mississippi law, Respondent satisfies the CSA's prerequisite for obtaining a new practitioner's registration. *See* 21 U.S.C. 823(f)(1); *see also id.* 802(21). (defining ''the term 'practitioner' [to] mean[ ] a . . . physician . . . or other person licensed, registered or otherwise permitted, by . . . the jurisdiction in which he practices . . . to distribute, dispense, [or] administer . . . a controlled substance in the course of professional practice''). However, the restoration of Respondent's state authority is not dispositive of the public interest inquiry. *See Mortimer Levin,* 57 FR 8680, 8681 (1992) (''[T]he Controlled Substances Act requires that the Administrator . . . make an independent determination [from that made by state officials] as to whether the granting of controlled substance privileges would be in the public interest.'').

To be sure, the Agency's case law contains some older decisions which can be read as giving more than nominal weight in the public interest determination to a State Board's decision (not involving a recommendation to DEA) either restoring or maintaining a practitioner's state authority to dispense controlled substances. *See, e.g., Gregory D. Owens,* 67 FR 50461, 50463 (2002) (expressing agreement with ALJ's conclusion that the board's placing dentist on probation instead of suspending or limiting his controlled substance authority ''reflects favorably upon [his] retaining his . . . [r]egistration, and upon DEA's granting of [his] pending renewal application''); *Vincent J. Scolaro,* 67 FR 42060, 42065 (2002) (concurring with ALJ's ''conclusion that'' state board's reinstatement of medical license ''with restrictions'' established that ''[b]oard implicitly agrees that the [r]espondent is ready to maintain a DEA registration upon the terms set forth in'' its order).

Of note, these cases cannot be squared with the Agency's longstanding holding that ''[t]he Controlled Substances Act requires that the Administrator . . . make an independent determination [from that made by state officials] as to whether the granting of controlled substance privileges would be in the public interest.'' *Levin,* 57 FR at 8681. Indeed, neither of these cases even acknowledged the existence of *Levin,* let alone attempted to reconcile the weight it gave the state board's action with *Levin.* While in other cases, the Agency has given some weight to a Board's action in allowing a practitioner to retain his state authority even in the absence of an express recommendation, *see Tyson Quy,* 78 FR 47412, 47417 (2013), the Agency has repeatedly held that a practitioner's retention of his/her state authority is not dispositive of the public interest inquiry. *See, e.g., Paul Weir Battershell,* 76 FR 44359, 44366 (2011) (citing *Edmund Chein,* 72 FR 6580, 6590 (2007), *pet. for rev. denied, Chein* v. *DEA,* 533 F.3d 828 (D.C. Cir. 2008)).

As to factor three, I acknowledge that there is no evidence that Respondent has been convicted of an offense under either federal or Mississippi law ''relating to the manufacture, distribution or dispensing of controlled substances.'' 21 U.S.C. 823(f)(3). However, there are a number of reasons why even a person who has engaged in criminal misconduct may never have been convicted of an offense under this factor, let alone prosecuted for one. *Dewey C. MacKay,* 75 FR 49956, 49973 (2010), *pet. for rev. denied, MacKay* v. *DEA,* 664 F.3d at 822. The Agency has therefore held that ''the absence of such a conviction is of considerably less consequence in the public interest inquiry'' and is therefore not dispositive. *Id.*

As for factor five, because the Government did not file exceptions to the ALJ's legal conclusions with respect to this factor, I deem it unnecessary to make any findings.

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). *See also* Miss. Code Ann. Sec. 41–29–137 (''a 'valid prescription' means a prescription that is issued for a legitimate medical purpose in the usual course of professional practice'').

Under the CSA, it is fundamental that a practitioner must establish a bonafide doctor-patient relationship in order to act ''in the usual course of . . . professional practice'' and to issue a prescription for a ''legitimate medical purpose.'' *See United States* v. *Moore,* 423 U.S. 122, 142–43 (1975); *United States* v. *Lovern,* 590 F.3d 1095, 1100–01 (10th Cir. 2009); *United States* v. *Smith,* 573 F.3d 639, 657 (8th Cir. 2009); *see also* 21 CFR 1306.04(a) (''an order purporting to be a prescription issued not in the usual course of professional treatment . . . is not a prescription within the meaning and intent of [21 U.S.C. 829] and . . . the person issuing it, shall be subject to the penalties provided for violations of the provisions of law related to controlled substances''). As the Supreme Court has explained, ''the prescription requirement . . . ensures patients use controlled substances under the supervision of a doctor so as to prevent addiction and recreational abuse. As a corollary, [it] also bars doctors from peddling to patients who crave the drugs for those prohibited uses.'' *Gonzales* v. *Oregon,* 546 U.S. 243, 274 (2006) (citing *Moore,* 423 U.S. 122, 135, 143 (1975)).

Both this Agency and the federal courts have held that ''establishing a violation of the prescription requirement 'requires proof that the practitioner's conduct went ''beyond the bounds of any legitimate medical practice, including that which would constitute civil negligence.'' ' '' *Laurence T. McKinney,* 73 FR 43260, 43266 (2008) (quoting *United States* v. *McIver,* 470 F.3d 550, 559 (4th Cir. 2006)). *See also United States* v. *Feingold,* 454 F.3d 1001, 1010 (9th Cir. 2006) (''[T]he *Moore* Court based its decision not merely on the fact that the doctor had committed malpractice, or even intentional malpractice, but rather on the fact that his actions completely betrayed any semblance of legitimate medical treatment.''); *Jack A. Danton,* 76 FR 60900, 60904 (2011) (finding violations of 21 CFR 1306.04(a), in the absence of expert testimony, ''where a physician has utterly failed to comply with multiple requirements of state law for evaluating her patients and determining whether controlled substances are medically indicated and thus has 'completely betrayed any semblance of legitimate medical treatment' '') (quoting *McKinney,* 73 FR at 43266 (quoting *Feingold,* 454 F.3d at 1010)).[43]

Under the Mississippi Board's Rule 1.4:

> Patient Record. A physician who prescribes, dispenses, or administers a controlled substance shall maintain a complete record of his or her examination, evaluation and treatment of the patient which must include documentation of the diagnosis and reasons for prescribing, dispensing or administering of any controlled substance; the name, dose, strength, quantity of the controlled substance and the date that the controlled substance was prescribed, dispensed or administered. The record required by this rule shall be maintained in the patient's medical records, provided that such medical records are maintained at the office of the physician . . . .
>
> No physician shall prescribe, administer or dispense any controlled substance or other drug having addiction-forming or addiction-sustaining liability without a good faith prior examination and medical indication therefore.

Miss. Admin. Code part 2640, Ch.1 r. 1.4. Continuing, Rule 1.4 explains that:

> A determination as to whether a ''good faith prior examination and medical indication therefore'' exists depends upon the facts and circumstances in each case. One of the primary roles of a physician is to elicit detailed information about the signs and symptoms which a patient presents in order that he or she may recommend a course of treatment to relieve the symptoms and cure the patient of his or her ailment or maintain him or her in an apparent state of good health. In order for a physician to achieve a proper diagnosis and treatment plan, a history and physical examination consistent with the nature and complaint are necessary. . . . The paramount importance of a complete medical history in establishing a correct diagnosis is well established. Standards of proper medical practice require that, upon any encounter with a patient, in order to establish proper diagnosis and regimen of treatment, a physician must take three steps: (a) take and record an appropriate medical history, (b) carry out an appropriate physical examination, and (c) record the results. The observance of these principles as a function of the ''course of legitimate professional practice'' is particularly of importance in cases in which controlled substances are to play a part in the course of treatment. It is the responsibility of the physician to dispense, prescribe or administer such drugs with proper regard for the actual and potential dangers.

Id.

Rule 1.4 further notes that ''[a] determination of proper 'medical indication'[ ] also requires a careful examination of the nature of the drug and all circumstances surrounding dispensation.'' *Id.* The Rule also specifically notes that ''repeated refills over relatively short periods of time or the issuance of prescriptions at a time when the patient should not have finished taking the same medication from a prior prescription had the prescription directions been properly followed or the correct dosage taken'' is a factor indicating a lack of good faith on the part of a physician. *Id.* Also, the Board's Rule 1.16 specifically provides that ''[t]he prescribing, administering or dispensing of any controlled substance in violation of the above rules shall constitute the administering, dispensing or prescribing of any narcotic drug or other drug having addiction-forming or addiction-sustaining liability otherwise than in the course of legitimate professional practice, in violation of Mississippi Code [ ] Section 73–25–29(3). '' Miss. Admin. Code part 2640, Ch. 1, r. 1.16).

Here, the ALJ found that that Respondent acted outside of the usual course of professional practice and lacked a legitimate medical purpose when he issued numerous prescriptions for controlled substances included alprazolam, diazepam, hydrocodone, zolpidem, and Adderall (amphetamine). R.D. 39–44. I agree with the ALJ that Respondent violated 21 CFR 1306.04(a) in issuing the prescriptions. I further find that in issuing each of the prescriptions enumerated above (Nos. 1 through 53), Respondent acted outside of the usual course of professional practice and lacked a legitimate medical purpose in doing so.

Dr. Chambers provided unrefuted testimony that it is not within the usual

[43] However, as the Agency has held in multiple cases, ''the Agency's authority to deny an application [and] to revoke an existing registration . . . is not limited to those instances in which a practitioner intentionally diverts a controlled substance.'' *Bienvenido Tan,* 76 FR 17673, 17689 (2011) (citing *Paul J. Caragine, Jr.,* 63 FR 51592, 51601 (1998)); *see also Dewey C. MacKay,* 75 FR at 49974. As *Caragine* explained: ''[j]ust because misconduct is unintentional, innocent, or devoid of improper motive, [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. 63 FR at 51601.

''Accordingly, under the public interest standard, DEA has authority to consider those prescribing practices of a physician, which, while not rising to the level of intentional or knowing misconduct, nonetheless create a substantial risk of diversion.'' *MacKay,* 75 FR at 49974; *see also Patrick K. Chau,* 77 FR 36003, 36007 (2012).

course of professional practice to prescribe a controlled substance to a patient with mental illness when the patient is being treated by a primary prescriber and the second physician does not communicate to the primary physician that he has issued the prescription. Tr. 275. Dr. Chambers testified as to the serious risks created by such prescribing, including oversedation, memory disturbance, overdose and potentially death, especially if the patient is also taking opioids. *Id.* at 250; *see also id.* at 268–69. Dr. Chambers also explained that when a patient is obtaining drugs from other sources and the primary prescriber is unaware, this ''can create a great deal of confusion on the part of the primary prescriber about the effects or side effects of the drug and the mental status of the patient.'' *Id.* at 251; *see also id.* at 291 (''If you have two chefs in the kitchen, this is the kind of stuff that can happen as you get chaos and harm and polypharmacy and no one understanding what is the illness versus what is [sic] the side effects of the medications, and it can lead to escalation of mental illness, addiction, and even death.'').

Dr. Chambers also offered unrefuted testimony that Respondent's prescribing resulted in ''a combination of multiple overlaps of multiple classes of addictive substances that can produce overdose and severe psychiatric disturbances.'' *Id.* at 273. And while Respondent is not a psychiatrist, Dr. Chambers offered unrefuted testimony that within the practice of psychiatry, there is a prohibition against treating a spouse. *Id.* at 293. Dr. Chambers further offered unrefuted testimony that Respondent's prescribing was not for legitimate medical practice and was non-therapeutic. I thus find that Respondent violated 21 CFR 1306.04(a) with respect to each of the prescriptions set forth above.

Respondent's failure to maintain adequate records to support the prescriptions provides additional support for this conclusion, as well as the conclusion that Respondent violated Mississippi Board Rule 1.4's provisions with respect to patient records.[44] As found above, there was no documentation at all to support 36 of the prescriptions. Moreover, even with respect to the entries Respondent did make, Dr. Chambers found that ''there is a paucity of data to support the diagnosis or the prescriptions . . . that the note is built around. There's a lack of physical or mental status exam that normally would be in a note like this to justify and direct the use of controlled substances.'' Tr. 277. Dr. Chambers also observed that ''there are instances where the dosing or type of the drug is left out of the record.'' *Id.* at 278. *See also* GE 6, at 6 (entry for 2/5/13); *id.* at 7 (entry for 3/28/13); *id.* at 8 (5/13/13 no dosing for Ambien); *id.* at 9 (entries for 7/1/13 no dosing for Lorcet and 7/7/13 no dosing for Lorcet and Xanax); *id.* at 10 (no drug strength for Xanax prescriptions of 8/24/13 and 9/5/13).

Before the State Board, Respondent testified that his prescribing ''was sporadic'' and ''was always for a confined number of pills, a small amount, that bridged her gap between obviously when she was in crisis and didn't have any medicine.'' GE 14, at 58. He maintained that ''the majority of the medicine were Xanax, two milligrams, [and that a] three day supply were [sic] common.'' *Id.* at 59–60. Also before the State Board, he maintained that ''I think the record reflects that I filled in in times where I just didn't think I had no other choice.'' *Id.* He further asserted that his writing of the prescriptions ''was always done in a short stop gap times [sic] when I believed again . . . that there were no other options.'' *Id.* at 69.

Although the Government introduced into evidence the transcript of the January 2014 state board proceeding, it did not submit the Board's order prohibiting him from practice and/or the charging document, any of the exhibits submitted in the Board proceeding which may have shown what prescriptions were at issue in the proceeding, or even the Board's order suspending his license after the January 2014 proceeding. However, while it may have been the case that Respondent's explanation as to his reasons for prescribing during the 2014 board proceeding was consistent with the evidence presented at that proceeding, it is not consistent with much of the evidence submitted in this proceeding.

As found above, the record contains numerous prescriptions which are not fairly characterized as two to three-day gap fills. With respect to Respondent's prescribing of zolpidem, they include fourteen prescriptions which clearly were not short-term gap fills. These prescriptions include numbers 2, 4, 6, 8, 22, 26, 28 (each for 30 du [45]), 23 (28 du), 29 (24 du), 15, 45 (each for 20 du), and 10, 12, 13 (each for 12 du).

With respect to Respondent's prescribing of alprazolam, they include prescription numbers 11 (20 du, a 10 to 20-day supply), 34 (30 du, a 10-day supply [46]), 53 (24 du, an eight-day supply), 31, 32 (each for 20 du, each for a 10-day supply), 38, 52 (15 du, a five-day supply) 42, 43 (14 du, a 4–5 day supply), and 44, 47 (12 du, one a four-day supply, the other a six-day supply). Respondent also issued a prescription for 18 tablets of clonazepam (a six-day supply), 15 capsules of Dextroamphetamine-Amphetamine 5 mg (a five-day supply), and 20 tablets of diazepam (a six-day supply). With respect to the diazepam prescription, Dr. Webb did not even prescribe this drug to Respondent's wife. Of note, before the State Board, Respondent testified that he did not change his wife's treatment regimen and only ''mirrored what [Dr. Webb] had done.'' GE 14, at 65.

Likewise before the State Board, Respondent initially offered testimony regarding his prescribing of hydrocodone which addressed only the prescriptions he wrote after a plastic surgeon had drained an abscess in his wife's thigh and when his wife had a seizure and fell. Moreover, when on cross-examination a Board member identified the multiple hydrocodone prescriptions Respondent issued in July 2013, Respondent testified that ''that was an isolated incident there.'' *Id.* at 66. The evidence in this proceeding shows, however, that during 2011, Respondent issued seven hydrocodone prescriptions (Nos. 3, 5, 7, 9, 14, 16, 19) for his wife prior to any other doctor prescribing the drug to her. *See* GE 11, at 11 (hydrocodone Rx written on Nov. 30, 2011 by Dr. Bell, who Respondent identified as his wife's neurologist). Respondent has offered no explanation in either proceeding as to why he issued these seven prescriptions, as well as the hydrocodone prescriptions he issued on December 5, 2011 (No. 21), Aug. 13, 2012 (No. 33) and Jan. 23, 2013 (No. 39).[47]

Also, in a number of instances, Respondent issued prescriptions even though his wife had refills available under prescriptions that were previously issued by Dr. Webb. For example, on March 30, 2011, Respondent issued a prescription for 30 zolpidem. (Rx No. 4). However, Dr. Webb's February 3, 2011 zolpidem

[44] *See supra* findings for RXs No. 1–21, 25, 26, 28–31, 33, 35–37, 39, 43, 45, 49, and 51.

[45] While some of Respondent's prescriptions for 30 du of zolpidem had a dosing instruction of two tablets, the dosing instructions generally provided for one tablet.

[46] This is based on Respondent's note for the prescription.

[47] While Dr. Bell (his wife's neurologist) issued hydrocodone prescriptions to Respondent's wife on November 30, 2011 and June 19, 2013, Respondent's testimony before the Board addressed only his July 2013 prescriptions. GE 14, at 86.

provided for multiple refills, which Respondent's wife filled on April 9, 2011, May 23, 2011, and July 7, 2011. Moreover, Respondent issued new prescriptions for 30 zolpidem to his wife on May 6, 2011 and June 28, 2011 (Rx No. 6 & 8). Respondent's prescriptions of March 30, May 6, and June 28 were clearly not ''gap fills.''

Moreover, when Respondent issued the July 31, 2011 prescription for 12 zolpidem, he also authorized a refill, which was available to his wife on August 28, 2011 (which she did not fill until September 6, 2011), when Respondent issued her a new prescription for 12 zolpidem. *See* Rx No. 10 & 12. (Dr. Webb had also issued a 60 du zolpidem prescription on August 16, 2011 which provided multiple refills.). Even ignoring the prescription she obtained from Dr. Webb, Respondent's August 28, 2011 prescription was not a gap fill given that she had a refill available on Respondent's July 31, 2011 prescription.

So too, Respondent's October 11, 2011 prescription for 20 zolpidem, a 20-day supply, (Rx No. 16) was issued notwithstanding that Dr. Webb's August 16, 2011 zolpidem prescription provided for five refills, one of which his wife filled on October 19, 2011. *See* GE 11, at 10–12. Even if Respondent's wife had run out of medication early because she failed to follow Dr. Webb's dosing instruction, she did not need this quantity of drugs to last her to the day on which she could refill Dr. Webb's prescription.

Another such example involves Respondent's December 27, 2011 prescription for 30 zolpidem and his January 7, 2012 prescription for 28 zolpidem. (Nos. 22 & 23). Respondent's wife had obtained a refill of Dr. Webb's August 16, 2011 prescription for 60 du on December 16, 2011, only 11 days earlier (Dec. 16). Thus, there was no gap to fill. Nor was there a gap to fill on January 7, 2012, when he issued the prescription for an additional 28 dosage units given the quantity of drugs his wife had recently obtained.

Still more examples are provided by the zolpidem prescriptions Respondent issued on March 4 and 12 (both for a 30-day supply), as well April 1, 2012 (for a 24-day supply). During this period, Respondent's wife obtained a prescription for 30 du (a 15-day supply) on February 23, 2012, which provided for two refills, the first of which she obtained on March 19, 2012. Here again, the only potential gap was likely created by the failure of Respondent's wife to follow Dr. Webb's dosing instructions on the February 23rd prescription. Moreover, the March 12, 2012 prescription was not a gap fill given that Respondent issued the March 4, 2012 prescription, which provided a 30-day supply. Nor was the April 1, 2012 prescription a gap fill given Respondent's issuance of the March 12 prescription and the refill she obtained on March 19, 2012 pursuant to Dr. Webb's Feb. 23 prescription.

Similarly, the evidence shows that on January 11, 2013, Respondent issued a prescription for 10 du of alprazolam (*see* No. 36). While this prescription provided only a three-day supply, the evidence shows that Respondent's wife had refilled a prescription issued by Dr. Webb for 45 du of alprazolam the day before. GE 11, at 8. Thus, this was not a gap fill. Nor was Respondent's January 11, 2013 temazepam prescription (No. 37) a gap fill as the evidence shows that his wife had also refilled a prescription for a 30-day supply of this drug the day before. GE 11, at 8.

As one further example, on May 20, 2013, Respondent issued a prescription for 20 tablets of zolpidem (No. 45). The evidence shows, however, that Dr. Webb had not issued a zolpidem prescription since February 23, 2012, which his wife last refilled in April 2012. Here again, this was not a gap fill.

Had Respondent's prescribing been limited to a few instances of small (two to three day) gap fills, his conduct would be considerably less egregious given the circumstances of his wife's illness. The evidence shows, however, that his illicit prescribing went on for nearly three years. Even more disturbing is that the evidence shows that many of the prescriptions were not for gap fills at all, let alone for gap fills for two to three day periods as he testified before the State Board.

Notably, in this proceeding, Respondent has personally offered no explanation as to why he issued the prescriptions. Moreover, the only evidence he offered was the discredited testimony of his wife that there occasionally were times when she ''might run out a day early on a weekend'' and only needed a short term supply until Dr. Webb got back to her and that Respondent had never given her a prescription for a time period longer than two to four days. Tr. 379, 381, 384.

I thus conclude that the Government's evidence with respect to Factors Two and Four makes out a *prima facie* case to deny Respondent's application as ''inconsistent with the public interest.'' 21 U.S.C. 823(f). I further find that Respondent's misconduct was egregious.

Sanction

Where, as here, the Government has met its *prima facie* burden of showing that issuing a new registration to the applicant would be inconsistent with the public interest, a respondent must come forward with ''sufficient mitigating evidence'' to show why he can be entrusted with a new registration. *Medicine Shoppe-Jonesborough,* 73 FR 364, 387 (2008) (quoting *Samuel S. Jackson,* 72 FR 23848, 23853 (2007) (quoting *Leo R. Miller,* 53 FR 21931, 21932 (1988))). ''Moreover, because 'past performance is the best predictor of future performance,' *ALRA Labs, Inc.* v. *DEA,* 54 F.3d 450, 452 (7th Cir.1995), [DEA] has repeatedly held that where a registrant has committed acts inconsistent with the public interest, the registrant must accept responsibility for [his] actions and demonstrate that [he] will not engage in future misconduct.'' *Medicine Shoppe,* 73 FR at 387; *see also Jackson,* 72 FR at 23853; *John H. Kennedy,* 71 FR 35705, 35709 (2006); *Prince George Daniels,* 60 FR 62884, 62887 (1995). *See also MacKay* v. *DEA,* 664 F.3d at 820; *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).

Moreover, the egregiousness and extent of a registrant's misconduct are significant factors in determining the appropriate sanction. *See Jacobo Dreszer,* 76 FR 19386, 19387–88 (2011) (explaining that a respondent can ''argue that even though the Government has made out a *prima facie* case, his conduct was not so egregious as to warrant revocation''); *Paul H. Volkman,* 73 FR 30630, 30644 (2008); *see also Paul Weir Battershell,* 76 FR 44359, 44369 (2011) (imposing six-month suspension, noting that the evidence was not limited to security and recordkeeping violations found at first inspection and ''manifested a disturbing pattern of indifference on the part of [r]espondent to his obligations as a registrant''); *Gregory D. Owens,* 74 FR 36751, 36757 n.22 (2009).

Finally, the Agency has also held that '' '[n]either *Jackson,* nor any other agency decision, holds . . . that the Agency cannot consider the deterrent value of a sanction in deciding whether a registration should be [suspended or] revoked' '' or an application should be denied. *Wesley Pope,* 82 FR 14944, 14985 (2017) (quoting *Joseph Gaudio,* 74 FR 10083, 10094 (2009) (quoting *Southwood Pharmaceuticals, Inc.,* 72 FR 36487, 36504 (2007))). *See also Robert Raymond Reppy,* 76 FR 61154, 61158

(2011); *Michael S. Moore,* 76 FR 45867, 45868 (2011). This is so, both with respect to the respondent in a particular case and the community of registrants. *See Pope,* 82 FR at 14985 (quoting *Gaudio,* 74 FR at 10095 (quoting *Southwood,* 71 FR at 36503)). *Cf. McCarthy* v. *SEC,* 406 F.3d 179, 188–89 (2d Cir. 2005) (upholding SEC's express adoptions of ''deterrence, both specific and general, as a component in analyzing the remedial efficacy of sanctions'').

The ALJ acknowledged that ''to rebut the Government's *prima facie* case, the Respondent must both accept responsibility for his actions and demonstrate that he will not engage in future misconduct.'' R.D. at 52 (citing *Patrick W. Stodola,* 74 FR 20727, 20734–35 (2009)). The ALJ then explained that ''[t]he Respondent may accept responsibility by providing evidence of his remorse, his efforts at rehabilitation, and his recognition of the severity of his misconduct.'' [48] *Id.* (citing *Robert A. Leslie,* 68 FR 15227, 15228 (2003)). He also explained that ''[t]o accept responsibility, a respondent must show 'true remorse' for wrongful conduct,'' which includes an ''acknowledgment of wrongdoing.'' *Id.* (citing *Michael S. Moore,* 76 FR 45867, 45877 (2011) and *Wesley G. Harline,* 65 FR 5665, 5671 (2000)).

However, there are also numerous cases, that were not discussed in the Recommended Decision, which hold that where the Government has proved that a respondent committed knowing or intentional misconduct, he must unequivocally acknowledge his misconduct. *See Daniel A. Glick,* 80 FR 74800, 74800–01 (2015) (rejecting exception to ''CALJ's conclusion that [r]espondent has not unequivocally acknowledged his misconduct'' and holding that ''[a] registrant's acceptance of responsibility must be unequivocal''); *Annicol Marrocco,* 80 FR 28695, 28706 (2015) (denying application, holding that respondent's ''equivocal testimony provided substantial evidence to support a finding that she does not accept responsibility for her misconduct''); *Arthur H. Bell,* 80 FR 50035, 50041 (2015) (denying application finding that physician's ''acceptance of responsibility is equivocal at best'' and ''his failure to accept responsibility for [intentional] misconduct is reason alone to conclude that he cannot be entrusted with a new registration''); *Michael A. White,* 79 FR 62957, 62598, 62967–68 (2014) (revoking registration adopting ALJ's finding that physician did not accept responsibility when his ''acceptance of responsibility was tenuous at best,'' ''not once during the hearing did [he] unequivocally admit fault for his improper . . . prescriptions,'' and he ''minimized the severity of his misconduct''); *The Medicine Shoppe,* 79 FR 59504, 59510 (2014) (revoking registration where respondent ''offered generalized acceptance of responsibility'' but then denied filling any unlawful prescriptions); *Ronald Lynch,* 75 FR 78745, 78754 (2010) (revoking registration agreeing with ALJ's finding that respondent did not accept responsibility noting that he ''repeatedly attempted to minimize his [egregious] misconduct).[49]

I disagree with the ALJ's conclusion that Respondent is entitled to a finding that he has accepted responsibility for his misconduct. To the contrary, I find that his testimony was equivocal and that he repeatedly attempted to minimize his misconduct. Indeed, even after the ALJ granted Respondent a second chance to explain what he was accepting responsibility for, he still did not unequivocally acknowledge his misconduct.

In this matter, Respondent was specifically charged with violating 21 CFR 1306.04(a), the CSA's prescription regulation which requires that a controlled substance prescription ''be issued for a legitimate medical purpose by [a] practitioner acting in the usual course of professional practice.'' ALJ Ex. 1, at 1–3 (¶¶ 3–9). Indeed, the Government specifically alleged that the prescriptions ''were nontherapeutic, were for other than a legitimate medical purpose, and were outside the course of professional practice.'' *Id.* The Government also alleged that the prescriptions violated the counterpart provision of State law. *See id.* (citing Board Rule 1.16 and Miss. Code Sec. 73–25–29–(3)). The Government further alleged that Respondent violated provisions of State regulations prohibiting the prescribing of controlled substances ''without conducting any examination of [his] wife (or documenting such in her file) or noting the . . . prescriptions in her patient chart,'' as well as ''without conducting sufficient examinations of [his] wife (or documenting such in her file).'' *Id.* at 3 (citing, *inter alia,* Board Rules 1.4 and 1.16, Miss. Code Ann. Sec. 73–25–29(3)).

Notwithstanding that the Show Cause Order clearly set forth these violations, and that Dr. Chambers offered unrefuted testimony that Respondent's prescribing was outside of the ''usual course of clinical conduct,'' ''was dangerous and harmful,'' ''non-therapeutic,'' not for a ''legitimate medical practice,'' that there was ''a paucity of data to support the diagnosis or the prescriptions'' and there was ''a lack of physical or mental status exam'' documented in the noted to justify the prescriptions, Respondent repeatedly refused to acknowledge that he violated 21 CFR 1306.04(a).

While Respondent testified that he violated his contract with the State PHP (which was not a charge in this proceeding), when asked by his counsel if he violated his obligations as a DEA registrant, he asserted that he did not ''know the specific legalities of DEA registration'' but was willing ''to tell you what I did was wrong, . . . without any equivocation.'' Tr. 484–85. While he

[48] To the extent the ALJ's statement suggests that a respondent can satisfy his burden of production on the issue of acceptance of responsibility by only producing evidence of efforts at rehabilitation, this is not the Agency's rule. Indeed, *Leslie* makes it clear that it was describing the total showing that is required to refute the Government's *prima facie* case. *See Leslie,* 68 FR at 15228 (discussing previous agency decision involving respondent and stating that ''[t]he agency also found that although he was free to offer evidence that he would never again engage in the sort of conduct that resulted in his conviction, [r]espondent did not avail himself of that opportunity and offered no evidence of remorse for his misconduct, efforts at rehabilitation, or recognition of the severity of his conduct'').

The Agency has explained that where the Government has proved that a respondent has committed knowing or intentional misconduct, a respondent must fully acknowledge the misconduct that has been proved on the record to be deemed to have accepted responsibility, and absent such a showing, his evidence of remedial measures is irrelevant. *See Hatem M. Ataya,* 81 FR 8221, 8242–43 (2016) (''the Agency has held that proof of remedial measures is rendered irrelevant where a respondent fails to accept responsibility for his knowing or intentional misconduct'').

[49] More recently, in *Roberto Zayas,* 82 FR 21410, 21429 (2017), I rejected the reasoning of *Jeffrey Martin Ford,* 68 FR 10750 (2003), which granted a new registration to a respondent who had a history of substance abuse and had been convicted of several drug felonies. In *Zayas,* I noted that the *Ford* ''decision apparently excused the respondent's failure to unequivocally accept responsibility based on his having attended drug rehabilitation and remained sober for more than 10 years, as well [as] having satisfied the conditions for reinstatement of his state license.'' 82 FR 21429. I also noted that ''the decision [did] not even address whether [the respondent] accepted responsibility for his criminal conduct.'' *Id.* I further explained that I found ''the reasoning of this case unpersuasive, [and] were a case with similarly egregious misconduct presented to me, I would not grant a registration absent a clear and unequivocal acceptance of responsibility for all of the misconduct that was proven on the record.'' *Id. See also Jones Total Health Care,* 81 FR 79188, 79200–01 (2016) (''[W]here the Government has proved that a registrant has engaged in intentional or knowing misconduct, revocation is warranted in the absence of the registrant's unequivocal acceptance of responsibility for its misconduct.''); *Joe W. Morgan,* 78 FR 61961, 61963 (2013) (''Given [r]espondent's multiple statements in which he blamed others for his troubles, that he never once acknowledged that he prescribed in violation of the CSA and Florida law, and that he attempted unpersuasively to minimize his culpability, the overwhelming weight of the evidence fully supports the ALJ's conclusion that [r]espondent is sorry only because he was caught.'').

also acknowledged that ''becoming involved in a loved one's care is foolish,'' he then stated that he did not ''know the letter or spirit of any law that I transgressed.'' *Id.* at 489. And when asked why the Agency should entrust him with a new registration, he testified that ''[i]f I can't practice medicine, conforming to every jot, tittle, to the letter of the law, I can't practice medicine,'' but he offered no explanation as to how he would conform ''to the letter of the law'' given his acknowledgment that he does not ''know the letter of or spirit of any law that [he] transgressed.'' *Id.* at 489–90.

Indeed, throughout his testimony, Respondent asserted that he thought the charges in this proceeding simply involved the same charges that he was found guilty of in the State Board proceeding. He doggedly denied that he violated the CSA's prescription requirement, asserting that that it ''would be speculative . . . on some level'' for him to testify as ''to what statutes I may or may not have transgressed.'' *Id.* at 498. And when asked if he accepted that the prescriptions he issued to his wife ''were outside the course of professional practice,'' he asserted that he did not know how DEA defined the term ''outside the course of professional practice'' and maintained that I ''do not know again . . . the specifics of . . . of what I'm being charged with by DEA now.'' [50] *Id.* at 501.

Given that the Show Cause Order provided fair notice to Respondent that he was charged with violating 21 CFR 1306.04(a) and that he heard the evidence against him and put up no defense, he was not required to speculate as to ''what statutes [he] may or may not have transgressed.'' Moreover, the CSA's requirement that ''a prescription for a controlled substance . . . must be issued for a legitimate medical purposes by [a] practitioner acting in the usual course of professional practice'' is hardly a ''jot'' or a ''tittle'' of the Act.[51] To the contrary, the rule is one of the Act's fundamental features, as one of its purposes is to ''ensure [] patients use controlled substances under the supervision of a doctor so as to prevent addiction and recreational abuse.'' *Gonzales,* 546 U.S. at 274.

Notably, even after the ALJ repeatedly expressed his puzzlement as to what Respondent was accepting responsibility for, Respondent testified that he was accepting responsibility for what the State said he did and again asserted that he thought the charges in the DEA proceeding were the same as the charges which he was found guilty of by the State Board. Tr. 503–05. While the ALJ subsequently gave Respondent several chances to answer this question, his testimony continued to manifest equivocation, minimization and an unwillingness to acknowledge that he violated the CSA's prescription requirement.

For example, when asked to ''clarify . . . what specific actions [he was] accepting responsibility for,'' Respondent answered: ''[v]iolating the previous order, right? Writing prescriptions for my wife when I wasn't a treating physician, which I think is not proper document, not fully proper documentation of those things.'' Tr. 507. He subsequently testified that ''if someone shows me . . . what I was saying that I'm ignorant of the specifics of a DEA charge. *But if I meet the criteria and I accept I did it, then I did it.*'' *Id.* at 508 (emphasis added). *See also id.* at 514 (''If someone shows me I've done something wrong, I will admit it.'')

However, as found above, the unrefuted evidence, including the testimony of Dr. Chambers, establishes that Respondent's prescribing did ''meet the criteria'' for a violation of 21 CFR 1306.04(a). Yet even when confronted with this evidence, Respondent still was unwilling to accept that he ''did it.'' *Id.*

On further cross-examination, Respondent was again asked what he thought was ''wrong with respect to the prescriptions.'' *Id.* at 510. While he answered that ''I shouldn't have written'' and ''I violated the contract,'' he then stated: ''[p]rompt me. I'm not trying to minimizing anything.'' *Id.*

Minimizing is, however, exactly what Respondent was engaged in. And when the Government again asked Respondent if he was admitting that the prescriptions were issued outside the usual course of professional practice, Respondent maintained that ''as a physician, I don't understand that term'' and he was only willing to admit to acting outside of the usual course to the extent that his documentation was ''substandard.'' *Id.* at 511. He then denied that his prescribing had increased the chances of his wife's becoming dependent, overdosing or diverting controlled substances.

While it is true that on a still further round of re-direct examination, Respondent testified that it was wrong for him to ''prescribe controlled substances to someone who was under the care of another physician for those same ailments,'' this is not a full acknowledgment of his illegal behavior. Indeed, the mere fact that a physician prescribes controlled substances to someone who is under care of another physician for the same ailments would not necessarily give rise to liability under 1306.04(a). Such prescribing would be entirely lawful under the CSA in bona fide emergency situations provided the prescriptions were limited to what was medically necessary to treat a patient before the primary physician could resume care.

Here, however, Respondent has admitted to acting outside of the usual course of professional practice only to the extent he maintained ''substandard records.'' Notwithstanding Dr. Chambers' testimony, Respondent has failed to acknowledge that his prescribing increased the risks of his wife become dependent, overdosing, or diverting controlled substances, his failure to conduct appropriate examinations, as well as his failure to notify Dr. Webb that he had prescribed the drugs.

Moreover, before the State Board, Respondent maintained that his prescribing ''was sporadic,'' ''was always for a confined number of pills,'' that they were simply short gap fills which ''mirrored what [Dr. Webb] had done.'' However, as found above, many of the prescriptions provided substantially more medication than was necessary for a two to three-day period. These include 14 zolpidem prescriptions, each of which provided at least a 12-day supply (with 11 of the prescriptions providing 20 to 30 dosage units, most of which for a 20 to 30-day supply) and five of the alprazolam prescriptions, four of which were for a ten-day supply, the other being for an eight-day supply. There were also the seven hydrocodone prescriptions and a diazepam prescription, which although they were for small amounts, did not ''mirror what [Dr. Webb or any other doctor] had done,'' and are unsupported by the findings of an examination and a diagnosis.

Respondent personally offered no explanation in this proceeding (or before the State Board) as to why he issued these prescriptions, which clearly provided more drugs than were medically necessary to address a two- to three-day period.[52] Indeed, while

[50] Yet in his Pre-hearing Statement, Respondent stated that he ''will acknowledge the allegations raised by DEA in the Order to Show Cause.'' ALJ Ex. 5, at 3.

[51] *See Webster's Third New International Dictionary,* at 1221 (1976) (defining ''jot'' as ''the least bit: IOTA''); *see also id.* at 2401(defining ''tittle,'' in part, as ''a very small part'').

[52] In his Pre-hearing Statement, Respondent also stated ''he will discuss the circumstances in which

Continued

Respondent maintained that he could ''absolutely'' be trusted to not engage in such prescribing in the future, that he was ''not trying to avoid anything'' and that ''I have done everything that I know to do to try to remedy this situation,'' he has not been forthcoming in this matter. Thus, I disagree with the ALJ that Respondent has ''express[ed] remorse to the full extent of [his] wrongful conduct.'' R.D. at 56.

The ALJ also gave weight to Respondent's testimony during the second State Board hearing that he was ''committed to 'absolute and complete adherence' to applicable rules and regulations,'' *id.* at 55 (citing GE 13, at 9–10), and further asserted ''that his commitment to adhere to all regulations governing controlled substances is genuine.'' *Id.* at 56–57. The ALJ did not explain how Respondent would accomplish this given his repeated assertions in this proceeding that he did not ''know the specific legalities of DEA registration,'' did not ''know the letter or spirit of any law that [he] transgressed,'' that he does not ''know precisely how the DEA defines'' the term ''outside the course of professional practice,'' and ''as a physician, [he does not] understand [the] term.'' Tr. 511.

The ALJ also rejected as only ''technically correct'' the Government's argument that Respondent did not accept responsibility for failing to conduct examinations and/or conducting insufficient examinations prior to issuing the prescriptions. R.D. 54–55. While the ALJ found that Respondent did not ''specifically acknowledge that it was wrong of him to issue a prescription without first conducting an examination,'' the ALJ faulted the Government for not asking this question of Respondent. *Id.* at 55. The ALJ further reasoned that the Government ''overlook[ed] the central concern of this case, which is that the Respondent wrote prescriptions for his wife when he should not have.'' *Id.* In the ALJ's ''view, the Respondent's acceptance of responsibility for failing to examine his wife before writing her a prescription is subsumed in his general acceptance of responsibility.'' *Id.* (citing Tr. 515).

I cannot agree with this reasoning. As for the ALJ's faulting of the Government for not asking Respondent if he accepted responsibility for his failure to conduct examinations or conducting inadequate examinations, Respondent, and not the Government, had the burden of production on this issue. As for the ALJ's assertion that ''the central concern of this case . . . is that the Respondent wrote prescriptions for his wife when he should not have,'' the central concern of this case is what the Government alleged in the Show Cause Order and proved at the hearing.[53] The proof fully supported the allegations, which included that he issued controlled substance prescriptions that ''were nontherapeutic, were for other than a legitimate medical purpose, and were outside the usual course of professional practice,'' that he issued the prescriptions when his wife was ''being issued prescriptions for the same or similar class of drugs by her . . . psychiatrist, which [he] did without her psychiatrist's knowledge or permission,'' and that his ''actions dramatically increased the chances of [his] wife's dependency, overdose or diversion.'' ALJ Ex. 1, at 1–3 (¶¶ 3–7). Moreover, the Government's allegations that Respondent violated state and federal law by issuing controlled substance prescriptions ''without conducting any examination,'' *Id.* at 3 (¶ 8), or ''without conducting sufficient examinations,'' *id.* (¶ 9), were not simply additional factual allegations to support the charges in paragraphs three to seven of the Show Cause Order but were stand-alone charges.

With respect to the proven misconduct, Respondent admitted that he acted outside of the usual course of professional practice only to the extent that he failed to maintain proper records. As for the ALJ's further assertion that his acceptance of responsibility for failing to conduct examinations was ''subsumed in his general acceptance of responsibility,'' the cited testimony does not support this, as the question, which was asked by his counsel, made no reference to his failing to conduct examinations. Tr. 515.

The ALJ acknowledged that ''[i]t is true . . . that Respondent did not plainly and expressly accept responsibility for violating specific federal regulations.'' R.D. 56. Indeed, at no point did Respondent admit that he violated 21 CFR 1306.04(a) with respect to any of the prescriptions, including those which clearly were not two to three day ''gap fills.'' Nor did he ever admit that any of the prescriptions were non-therapeutic or lacked a legitimate medical purpose. And he denied that his prescribing increased the risks of his wife become dependent, overdosing, or diverting controlled substances. Respondent has therefore failed to ''express remorse to the full extent of [his] wrongful conduct.'' [54] R.D. 56.

The ALJ further explained that he found Respondent's remorse to be sincere and that his acceptance of responsibility was ''credible.'' R.D. 56–57. This case, however, is less about Respondent's credibility (although there is ample reason to question it given his testimony regarding what he thought he had been charged with in this proceeding) [55] and more about the weight to be given to his testimony. Moreover, the ALJ failed to apply the Agency's extensive case law which requires that an acceptance of responsibility be unequivocal, as well as that which requires a full acknowledgment of the proven misconduct.

While I appreciate that the ALJ closely examined Respondent's testimony both at this hearing and before the state board (as have I), I find it particularly disturbing that Respondent has never offered an explanation in any proceeding [56] for the

he prescribed controlled substances to his wife.'' ALJ Ex. 5, at 3. Respondent, however, offered no such testimony.

[53] Based on the Board's order and his recovery contract, Respondent ''should not have'' written the prescriptions. Yet, as the ALJ recognized when he expressed his puzzlement (multiple times) at to what Respondent was accepting responsibility for, the Government did not allege that Respondent violated his recovery contract or a Board Order; it alleged specific violations of federal and state laws and regulations.

[54] Earlier in his Recommended Decision, the ALJ asserted that my decision in *Arvinder Singh,* 81 FR 8247 (2016), ''states only that a registrant *may* be required to acknowledge the scope of his misconduct,'' thus suggesting that a respondent's acknowledgment of the scope of his misconduct is optional and that he is not required to ''accept responsibility for the consequences of his acts.'' R.D. 54 (citing 81 FR at 8250–51). This is mistaken, as the case clearly stated that the respondent ''was required to acknowledge . . . the full scope of his criminal behavior and the risk of diversion it created.'' 81 FR at 8250. The risk of diversion was, of course, a consequence of the respondent's acts, which involved pre-signing prescriptions for controlled substances which were subsequently issued by nurses who were not lawfully authorized to prescribe controlled substances and the respondent did not see the patients. *Id.* at 8248–49.

The ALJ also gave weight to Respondent's having ''expressed remorse and accepted responsibility for writing those prescriptions during the first three weeks of his treatment at Acumen'' as well as his testimony during the second Board hearing. R.D. 55. However, whether Respondent accepted responsibility for writing the prescriptions during his treatment at Acumen is wholly irrelevant. Likewise, because the Agency was not a party in the State Board's proceedings, the weight to be given to Respondent's testimony before the Board is substantially diminished. What matters is whether he accepted responsibility for the misconduct alleged and proved in this proceeding.

[55] While Respondent professed that he did not understand what he was charged with in this proceeding, the Show Cause Order was clear on its face. Respondent was also represented and if he truly did not understand the allegations, he should have asked his counsel.

[56] While I have noted Respondent's testimony in the State Board proceeding as to why he issued the prescriptions, so that there is no lack of clarity for future matters, a respondent is required to present his evidence in the Agency's proceeding.

many prescriptions he issued which clearly were not for short-term gap fills, an issue which is not even discussed in the Recommended Decision. Thus, I conclude that Respondent does not recognize the full extent of his misconduct. *See MacKay* v. *DEA,* 664 F.3d 808, 820 (10th Cir. 2011); *see also Samuel Jackson,* 72 FR 23848, 23852 (2007) (noting a respondent's burden to produce sufficient evidence to assure the Administrator that he/she can be entrusted with the responsibility carried by such a registration'').

I therefore find that Respondent has failed to produce sufficient evidence to support a finding that he accepts responsibility for his misconduct. While there are cases in which the Agency has imposed a sanction less than denial or revocation where a respondent has failed to meet his burden on acceptance of responsibility, those cases have involved considerably less egregious misconduct than the knowing and intentional diversion of controlled substances which occurred here. Because Respondent engaged in egregious misconduct which he has failed to fully acknowledge, his evidence of remedial measures cannot rebut the Government's *prima facie* showing that his registration ''would be inconsistent with the public interest.'' 21 U.S.C. 823(f). Accordingly, I will deny his application.

Order

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

Dated: October 17, 2017.

Robert W. Patterson,

Acting Administrator.

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