during 1988 did not meet the standard of care of the average practitioner. He stated, "If this was the only records there [were], then I don't think it meets the standard of care." He also testified that, in 1988, the standard of care was not to prescribe a large amount of narcotics, for such practice could result in the patient's developing a tolerance to a controlled substance: "You'd be treating the tolerance. You'd be treating addiction, you're no longer treating the [diagnosed medical condition]. Further, Dr. Ling recommended that a physician treating a patient with a potential drug dependency problem should consult with a specialist in drug addiction. Both Dr. Smith and Dr. Ling concluded that Patient A was an addict who was opiate dependent and benzodiazipine dependent.

The Respondent presented evidence from consulting physicians, who had concluded that Patient A was not an addict, but that she was dependent upon controlled substances to treat her chronic and sometimes acute pain. Specifically, after having reviewed Patient A's medical history and having interviewed her twice, Dr. Margoles, a medical expert in pain management, testified, that throughout the years 1986 to 1988, Patient A had experienced intractable pain as a result of numerous medical problems and degenerative changes. He concluded that Patient A was a chronic pain patient, as opposed to an opioid abuser, and that she sought and was given medications to control her pain, not for euphoria. He found that, although Patient A received an increase in amounts of opioids prescribed for her use, such an increase resulted from the severity of her pain, not addiction. "It was obvious that the medication was being used to keep her going in her professional career." Also, he noted that there was no evidence in the patient's records that she sought drugs in order to obtain euphoria, no evidence of abstinent syndrome, nor clinical or laboratory evidence of toxicity. Dr. Margoles testified that the lack of toxicity evidence meant that the "patient obviously tolerated the medication that she had, that was used in her case, and evidently benefitted her and [that] she had no toxic side effects * * * no slurred speech, inability to have cognitive speech, straight speaking.

As to the Respondent's specific involvement in 1988, Dr. Mangoles also opined that the 13 prescriptions Dr. Roth wrote during a seven month period were needed to control the patient's pain problems. He also noted that the Respondent appeared "to be tapering her down all the time," and that such

tapering was within the usual course of professional practice. Dr. Smith agreed with Dr. Margoles concerning the propriety of tapering Patient A, under the circumstances. Further, Dr. Margoles testified that the Respondent "acted in good faith and prescribed medication that was adequate for a given diagnosis and following good faith examination."

and following good faith examination." Finally, Dr. Margoles noted that in the 1980's, guidelines were established in prescribing controlled substances for chronic conditions. These guidelines were endorsed by various medical and legal groups, to include the California Board of Medical Quality Assurance and the California Bureau of Narcotic Enforcement. Dr. Margoles testified that the Respondent's prescribing to Patient A met these standards. Thus, he concluded that the Respondent prescribed controlled substance in the appropriate course of his professional conduct, and not for the purpose of maintaining Patient A's condition as an addict.

Also, the Respondent produced an affidavit from Dr. Dodge, a consulting neurosurgeon involved with the treatment of Patient A from 1986 through 1988, who wrote:

In my opinion, although the amounts of drugs were large compared to the average patient, they were necessary in order to treat the patient's pain. Although the patient clearly had a drug dependence problem, I do not believe the pain was controllable by other means besides narcotics. The amounts of narcotics tended to increase at the time of the acute events . . . Dr. Skinner and the other physicians responsible for her care always attempted to minimize the amounts of drugs that she took and sought to detoxify her from those drugs when the acute phase of pain and muscle spasm from the injuries passed.

In my opinion, Dr. Skinner and the other physicians responsible for her care did not violate the standard of practice in prescribing narcotic analgesics to this patient.

Further, in an affidavit, Dr. Woods, a neurologist who treated Patient A from January 1987 to January 1988, made similar observations as Dr. Dodge, and concluded: "In my opinion, Dr. Skinner and the other physicians responsible for her care did not violate the standard of practice in prescribing narcotic analgesics to this patient, in that the drugs were prescribed to control the patient's pain not to maintain her addiction."

As to the legitimacy of the quantities of the controlled substances prescribed, Dr. Brechner, a medical expert in the field of pain management and anesthesiology, testified that in 1988 he was consulted concerning an aspect of Patient A's treatment, for he had performed a facet block procedure to aid in the diagnosis of the source of Patient

A's back pain. In the course of performing that procedure, he administered narcotic analgesics, observing that Patient A had "an extraordinary tolerance to narcotics, even when potentiated with the tranquilizers." Dr. Brechner also noted that Patient A suffered from severe chronic pain and from periods of acute, intractable pain. Dr. Brechner concluded that Patient A had received narcotics prescribed in amounts that were "extraordinary compared to the average patient," because of her extreme tolerance for narcotics, and that she needed the narcotics in the amounts prescribed in order to control her pain. He testified that prescribing the narcotics in lower doses was not effective, and thus, she was not "overdosed.'

Also, Dr. Brechner testified that alternative means of treatment were tried to control Patient A's pain, but that he did not believe such treatment was effective alone in treating the pain resulting from her acute pain-inducing incidents, such as the automobile accident or the fall down the stairway. Finally, Dr. Brechner testified that the doctors treating Patient A prescribed narcotics for a legitimate medical purpose, to treat her pain, and not to maintain her condition as an addict.

Further, Dr. Skinner, the Medical Director of St. John's Chemical Dependency Center from 1981 to 1990, and a medical expert in chemical dependency, testified that he had begun treating Patient A at the Respondent's request in 1983. Dr. Skinner testified extensively about the acute pain incidents experienced by Patient A through 1988, the consulting physicians' diagnoses resulting from these incidents, and the various narcotic and non-narcotic treatment regimen implemented to control her pain. He also stated that there was no evidence that drug intoxication caused any of Patient A's acute events, and that he had made an extra effort to insure her lack of toxicity throughout his treatment of her. Further, Dr. Skinner testified that all narcotics were either administered in the hospital or under the supervision of a private duty nurse selected by him from the nursing staff of the Chemical Dependency Center at Saint John's Hospital, and that the nurses were familiar with Patient A's case, her tolerances, and with treating patients who had Patient A's type of problems. As a result of his treatment of Patient A, Dr. Skinner concluded that she was not an addict: "She did not demonstrate typical findings of addiction behavior. * never did she evidence toxicity,

* * never did she evidence toxicity, never did she evidence any abstinence