withdrawal syndrome, and never did she evidence, while under my care at home or in the hospitals, any evidence of street-like drug seeking behavior."

The Respondent also testified before Judge Tenney, stating that Patient A was "opiate dependent" or "opiate reliant," but not addicted. "I don't feel she was addicted to the medication from the point of view that she needed the medication every so many hours as an addict would for maintenance of the use of the drug. But she relied on the medication to take away her pain. In that sense, I'm saying she was reliant on the medication. But she could go days without having medication, even weeks, when her pain wasn't bad. Then the pain would get bad and she was reliant, again, on the medication to take away the pain." He concluded by stating that, although he was not the primary treating physician during 1988, he issued prescriptions in good faith and as part of the regimen established by her primary treatment physicians. Further, he affirmed that he did not issue any prescriptions for the purpose of enabling Patient A to reach a state of

As to his prescribing practices during 1991 through 1993, the Respondent testified that Patient A complained that her pain was causing her insomnia. He first referred Patient A to the sleep clinic at Cedars Sinai Hospital, but she did not follow up on that referral. Next, the Respondent consulted with the director of that clinic and used the treatment regimen he suggested to try to provide Patient A relief from both her insomnia and her pain. The recommended regimen involved trying to rotate insomnia medications to determine what medication would provide Patient A relief. He prescribed benzodiazepines, to include Restoril, Prosom, Chloral Hydrate, and Dalmane. The Respondent testified that he would give Patient A three prescriptions at one time for small dosages of different substances, stating "the reason that we gave her the three medications at one time was to give her the alternative to try one and if one didn't work to try a second." The Respondent testified that he cautioned Patient A about the addictive nature of these substances, and Patient A affirmed that she was just trying to get some sleep so she could work. The Respondent affirmed that it was never his intention that Patient A would take all three prescribed medications at the same time, and that "[Patient A] knew absolutely that that wasn't the indication." Finally, the Respondent testified that he was prescribing these substances in good faith to assist Patient A in trying to

obtain some sleep, not to obtain a state of euphoria.

Dr. Margoles agreed with the Respondent, testifying that Patient A needed the medications prescribed during this time period to control her pain and to help her sleep, given the pain she was experiencing. Dr. Smith, however, testified generally about sedative-hypnotic dependence, and, after reviewing the prescriptions issued during 1992 through 1993, he concluded that the Respondent's prescriptions to Patient A were beyond therapeutic use and were issued for the purpose of sustaining her addiction. However, undisputed in the record was the Respondent's testimony that Patient A's medical records reflecting his treatment of her during this time period had been stolen from the Respondent's office. Acknowledging the lack of medical records, Dr. Smith admitted that if he had been able to review the medical records "[he] could have a better understanding of what was going on in the physician's mind and whether it was appropriate prescribing.

However, the Respondent submitted letters written between September 1990 and February 1993, reflecting his referral of Patient A to other physicians for consultation. Dr. Ling, after reviewing the consulting physician's opinions, conceded that the letters supported the Respondent's opinion that Patient A suffered intractable pain during this time period. Dr. Ling also testified that he did not see any overall strategy for the treatment of Patient A. but he conceded that, lacking the medical treatment record, he could not render an opinion as to whether the Respondent's medical practices were consistent with the skill and knowledge

of the average practitioner.

Also in dispute was the adequacy of the medical treatment records for Patient A during the 1988 time period. The Respondent testified that, since he shared a practice with Dr. Gottlieb, he had not kept a separate medical record, but rather he had followed the treatment regimen of Dr. Gottlieb and Dr. Skinner. Dr. Smith testified that Dr. Gottlieb's treatment records did not meet the usual medical standard of practice regarding prescription of controlled substances. Yet Dr. Brechner also reviewed Patient A's treatment records provided by Dr. Skinner and Dr. Gottlieb, as well as the hospital records, and he testified that the acute and chronic medical conditions were well documented in the medical records. Also, Dr. Margoles testified that the records sufficiently supported the Respondent's prescribing practices, for Dr. Gottlieb's records included diagnoses and a treatment plan for Patient A. Finally, there was no expert witness testimony to establish that the Respondent's recordkeeping practices, under the circumstances, failed to meet the usual medical standard.

As to Patient B, the Government's attorney stated on the record that "the government will really not submit any argument to the issue of . . . whether Patient B had legitimate medical conditions that were being treated," but noted that the Respondent's recordkeeping practices as to Patient B were deficient. Patient B's medical chart was of record, and in it the Respondent had listed several diagnoses, including "migraine v. cluster" headaches and insomnia. The Respondent also testified that a cluster headache could incapacitate someone and could cause insomnia. Three times in June, twice in July, and once in September 1992, the Respondent prescribed Fiorinal, a barbiturate containing butalbital, a Schedule III controlled substance, for Patient B's headaches. For Patient B's insomnia condition, the Respondent prescribed Prosom, a triazolobensodiazepine derivative, which is a Schedule IV controlled substance. The Respondent also testified that Patient B's medical problems were documented in his medical record, and that given the small amount of medication prescribed for Patient B, he felt it was not relevant to go into a long, lengthy work-up for this patient.

Dr. Margoles testified that Fiorinal was a medication that was used to control cluster headaches, and that the Respondent prescribed this medication to Patient B in appropriate dosages. He also testified that the Prosom was prescribed to Patient B in appropriate dosages to help him sleep, and that there was no evidence in the medical records that Patient B sought either of these medications for the purpose of euphoria. Therefore, he concluded that the medications were prescribed for a legitimate medical purpose and in the appropriate course of normal medical

practice.

Pursuant to 21 U.S.C. 823(f) and 824(a)(4), the Deputy Administrator may revoke a DEA Certificate of Registration if he determines that the continued registration would be inconsistent with the public interest. Section 823(f) requires that the following factors be considered in determining the public interest:

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

(2) The applicant's experience in dispensing, or conducting research with respect to controlled substances.