to 1990. He is registered with the DEA as a practitioner authorized to handle controlled substances in Schedule II through V.

The DEA's allegations concern the Respondent's treatment of one patient, ''Patient A'', from March 1986 through October 1988. During this time period, Patient A had a number of significant physical conditions which caused pain, including pressure on the nerves from cervical degenerative joint disease; degenerative osteoarthritis of the lumbar vertebrae above a previous area where fusion surgery had been performed; spinal stenosis which occurs when the spinal canal narrows, at times putting pressure on a nerve with pain and muscle spasms; severe temporal mandibular joint degenerative disease; compression fracture of the patient's spine at L–1 and L–2; and trochanteric bursitis of the hip. Also during this time period, Patient A had a series of accidents which caused her acute pain: An automobile accident in which she was a passenger, resulting in a whiplash injury to her neck; an accident resulting in a knee injury; a fall down a spiral staircase, resulting in back strain; and a fall on a marble floor, resulting in a compression fracture of her spine. The record contains no evidence that drug intoxication caused any of these accidents.

During the time period of March 1986 through October 1988, the Government contended that the Respondent prescribed controlled substances to Patient A for other than a legitimate medical purpose and not in the usual course of his professional practice. Beginning March 20, 1986, the Respondent prescribed Demerol to Patient A. Demerol is a brand name for a medication containing meperidine hydrochloride, a Schedule II controlled substance. During the remainder of 1986, the Respondent prescribed Demerol and Percodan or Percocet, and occasionally he prescribed other Schedule II substances, such as Dilaudid, Doriden, and Tuinal. For example, from May 13 through December 26, 1986, the Respondent prescribed 1,604 tablets of Percodan or Percocet, and from March 20 through December 26, 1986, he prescribed approximately 30,000 milligrams of Demerol. This prescription practice continued into 1987 and 1988. However, also as a part of his prescription pattern, the Respondent tapered the amount of narcotics prescribed after the incidents of acute pain following the injuries suffered as a result of the various accidents. Dr. Smith, Dr. Ling, and Dr. Margoles testified that such tapering was within the usual course of professional practice.

Also throughout this time period, the Respondent used various non-narcotic methods of treating Patient A's pain. Specifically, he ordered bed rest, traction, hot packs, ultrasound, steroids, biofeedback, massage, electrocane, a cervical collar, facet blocks, physical therapy, acupuncture, and non-narcotic drugs. The Respondent also referred Patient A to numerous specialists, including Dr. Dodge, a neurosurgeon, Dr. Horacek, an orthopedic surgeon, and Dr. Woods, a neurologist.

However, Dr. Skinner was the primary treating physician for Patient A, and his treatment records were included in the record of this case. The medical records recounted the Respondent's observations, examination results, and the prescriptions issued as a result of his house calls to Patient A. Further, the medical records also contain hospital test results, hospital admission, treatment and discharge records, and consultation reports. For example, the medical records show that Patient A was hospitalized during this time period. On July 26, 1988, following a CAT scan, Dr. Joyce issued a report, writing that Patient A had a mild compression fracture at L1, mild stenosis at L2–3, moderate stenosis at L3–4, and a post-posterior bony fusion from L4 to the sacrum. Patient A was discharged on August 18, 1988. Again on September 29, 1988, Patient A was admitted to the hospital by Dr. Skinner, and she was discharged on October 4, 1988, with a diagnosis of a compression fracture, osteoporosis, and congenital scoliosis. On October 17, 1988, Patient A was again admitted with a complaint of severe left leg pain, and on October 23, 1988, she was discharged with the diagnosis of acute back pain secondary compression fracture of L1, acute lumbosacral spinal sprain and strain secondary to severe osteoarthritis at L2–3 with neuroforaminal narrowing, sciatica (resolved) and osteoporosis with high risk of possible spontaneous hip fracture.

Further, as Judge Tenney noted, ''[t]here is a 'debate' or difference of opinion between those [physicians who] specialized in addiction medicine and those in pain management regarding the use of narcotics for the treatment of severe pain.'' He also noted that Dr. Smith and Dr. Ling, the Government expert witnesses, were primarily experts in addiction medicine, and Dr. Margoles and Dr. Brechner, the Respondent's expert witnesses, were primarily experts in pain management. Dr. Smith and Dr. Margoles agreed that there exists a difference of opinion within the medical community as to the appropriate level of prescribing of controlled substances for the treatment of chronic pain patients. Also significant is the fact that the opinions of Dr. Brechner, Dr. Dodge, Dr. Horacek, and Dr. Woods were supported by either their personal examination, treatment, or both, of Patient A during the relevant time period, whereas the opinions of Dr. Smith and Dr. Ling were based upon their review of Patient A's treatment records and prescription documentation.

Initially, the Government presented evidence from expert witnesses who had concluded that Patient A was addicted to controlled substances, and that the Respondent had prescribed medications to Patient A to maintain her addiction. On March 3, 1990, Dr. Smith wrote in a report for the District Attorney: ''[the] spectrum of medications [prescribed to Patient A] was not justified by the medical pathology and, in fact, the medications caused the patient far more harm than benefit. The dosage of medication was clearly excessive and the duration over the several month period as outlined in the medical records was both excessive and not justified by the medical pathology.'' He concluded that ''[a]s a result of this analysis it is my opinion then, that Dr. Skinner and his colleagues were not prescribing a narcotic medication primarily for the management of pain but, in fact, were maintaining her addiction.'' During the hearing before Judge Tenney, Dr. Smith, after reviewing the quantities of controlled substances prescribed on selected dates, testified that those quantities were excessive in light of the standard therapeutic dosage. He then restated the conclusion he had reached in his 1990 letter to the District Attorney.

Based upon his review of Patient A's treatment record and relevant pharmacy records, Dr. Ling, a medical expert in the areas of neurology, psychiatry, addiction, and pain medicine, opined that the Respondent's prescribing practices did not meet the standard of care of the average practitioner with experience in the field of chemical dependency. 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 controlled substances. He testified: ''You'd be treating the tolerance. You'd be treating addiction, you're no longer treating the [diagnosed medical condition].''

Both Dr. Smith and Dr. Ling concluded that Patient A was an addict who was opiate dependent and