issued prescriptions while dining with her in a local restaurant.

In December 2001, Dr. Castle was named as a defendant in a $2,500,000 civil lawsuit filed in Sevier County Circuit Court by a former employee of Dr. Castle's medical practice. The suit alleged in part that Dr. Castle provided pain medications to his former employee when she was sixteen years old, prescribed pain medications while she was pregnant, and contributed to her addiction until the time she left Dr. Castle's employ at the age of twenty-one. The suit further alleges that Dr. Castle's actions contributed to the December 6, 2000, overdose on pain medications by the employee, which eventually led her to seek detoxification the following week. That matter is also pending resolution.

On January 10, 2002, DEA investigators conducted surveys of three pharmacies where several of Dr. Castle's patients had prescriptions filled: the pharmacies were Jabo's Pharmacy located in Newport, Tennessee; Murphy's Sav-Mor Pharmacy located in Jefferson City, Tennessee; and Mugford's Pharmacy located in Knoxville, Tennessee. The surveys revealed, that following the issuance to Dr. Castle of the Notice of Charges, as well as the execution of a search warrant at Dr. Castle's office, Dr. Castle continued to issue numerous Schedule II through IV controlled substance prescriptions for ''DE'' and ''JE.'' As noted above in paragraph six, the Department of Health alleged Dr. Castle's improper prescribing with respect to patients ''DE'' and his spouse ''JE.'' DEA's investigation revealed that between October 15, 2001 to January 12, 2002, these individuals had their prescriptions filled at different pharmacies including each of the above pharmacies.

DEA's review of prescriptions authorized by Dr. Castle, and obtained from Murphy's Sav-Mor Pharmacy revealed a Dandridge, Tennessee home address for ''DE'' and ''JE.'' Yet, a review of written prescriptions filled by ''DE'' and ''JE'' at Mugford's Pharmacy revealed a Knoxville, Tennessee home address for the couple. These addresses were not included on the prescriptions that were issued by Dr. Castle, and were added to the prescriptions by someone other than Dr. Castle. A subsequent investigation by DEA revealed that Dr. Castle failed to list addresses on prescriptions issued to ''DE'' and ''JE,'' as well as numerous prescriptions issued to other patients, as required by 21 CFR 1306.05(a).

On February 11, 2002, Special Agents from HHS, TBI and the Tennessee Office of Inspector General interviewed an individual herein referred to as ''JS.'' ''JS'' informed law enforcement officials that he had a long-term history of narcotic abuse and had purchased OxyContin from ''RS'' (referenced in paragraphs two through four above). ''JS'' further informed that Dr. Castle wrote prescriptions for OxyContin and Adderall for him in the name of the wife of ''JS.'' ''JS'' further informed law enforcement personnel that his wife had never been to Dr. Castle's office, and was not aware that Dr. Castle issued prescriptions in her name for ''JS.'' ''JS'' also informed that Dr. Castle created fictitious patient information in the name of his wife. Law enforcement personnel from the above agencies later conducted an interview of the wife of ''JS'' and she confirmed that she had never received any controlled substance prescriptions from Dr. Castle, nor had she ever visited Dr. Castle's office.

The investigation of Dr. Castle's practice also revealed that on or around September 6, 2001, ''JS'' requested that Dr. Castle send to him a prescription for OxyContin in his wife's name. Several days later, ''JS'' found the requested prescription in his mail box in his wife's name, which had been mailed from Dr. Castle's office and signed by Dr. Castle. DEA's investigation further revealed that between November and December 2001, Dr. Castle issued several Schedule II controlled substance prescriptions for ''JS'' in his wife's name.

On February 21, 2002, the Sevier County Street Crimes Unit executed a search warrant at Dr. Castle's medical practice. During the execution of the warrant, law enforcement officers recovered from Dr. Castle's person several syringes, including some that had been used. The syringes contained Adderall.

In November 2001, Dr. Castle was indicted in the United States District Court, Eastern District of Tennessee, on one count of possession of child pornography. However, after posting a $50,000 bond, Dr. Castle was granted pretrial release on November 7, 2001. As a condition of Dr. Castle's release, Dr. Castle was ordered not to download child pornography from Dr. Castle's personal computer, carry a firearm, or engage in the personal use of drugs. Nevertheless, an investigation by the Tennessee Office of Inspector General revealed that Dr. Castle continued to download child pornography in violation of a condition set by Dr. Castle's pretrial release. As a result, on February 26, 2002, the court ordered the revocation of Dr. Castle's bond, and further ordered Dr. Castle detained until Dr. Castle's May 7, 2002, trial on a charge of possession of child pornography.

In view of the foregoing, and pursuant to 21 U.S.C. 824(d), I find that Christopher E. Castle, M.D. has been responsible for the diversion of large quantities of controlled substances into other than legitimate medical channels. It is my conclusion that Dr. Castle has committed such acts as would render his continued registration inconsistent with the public interest. 21 U.S.C. 824(a)(4). Accordingly, the Deputy Administrator of the Drug Enforcement Administration, pursuant to the authority vested in him by 21 U.S.C. 823 and 824 and 28 CFR 0.100(b) and 0.104, hereby orders that DEA Certificate of Registration BC1157076, issued to Christopher E. Castle, M.D. be, and it hereby is, revoked. The Deputy Administrator further orders that any pending applications for renewal or modifications of such registration be, and they hereby are, denied. This order is effective December 30, 2002.

Dated: November 12, 2002.

John B. Brown, III,

Deputy Administrator.

[FR Doc. 02–30255 Filed 11–27–02; 8:45 am]

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DEPARTMENT OF JUSTICE

Drug Enforcement Administration

Joseph H. Talley, M.D.; Revocation of Registration

On January 28, 2002, the Administrator of the Drug Enforcement Administration (DEA), issued an Order to Show Cause and Notice of Immediate suspension of Registration to Joseph H. Talley, M.D. (Respondent) of Grover, North Carolina. The Respondent was notified of an opportunity to show cause as to why DEA should not revoke his DEA Certificate of Registration AT2853706, as a practitioner, and deny any pending applications for renewal of such registration pursuant to 21 U.S.C. 823(f) and 824(a) for reason that his continued registration would be inconsistent with the public interest. The order further notified the Respondent that his DEA registration was immediately suspended as an imminent danger to the public health and safety pursuant to 21 U.S.C. 824(d).

The order to Show Cause and Notice of Immediate Suspension alleged the following:

1. (The Respondent) is registered with DEA as a practitioner under DEA Registration No. AT2853706 for Schedules II, II–N, III, III–N, IV and V. The DEA registration was last renewed

on November 13, 2000. The registered location is PO Box 45, 318 Laurel Avenue, Grover, NC 28073.

2. (The Respondent) regularly engaged in the practice of prescribing excessive amounts of controlled substances, including combinations of Schedule II and III controlled substances such as OxyContin (II), Methodone (II) and Hydrocodone (III), along with a benzodiazepine such as Alprazolam (IV), to patients for no legitimate medical reason. (The Respondent's) patients have been associated with drug trafficking and drug abuse, and numerous patients have died due to drug overdose. The North Carolina Medical Board has filed charges alleging, in part, that (the Respondent's) practice of dispensing controlled substances falls below acceptable standards of care. Finally, (the Respondent has) circumvented DEA regulations by, in effect, post-dating Schedule II controlled substance prescriptions and maintaining at (his) registered location controlled substances that allegedly were returned to (the Respondent) by (his) patients.

3. During an interview with North Carolina investigators on March 13, 2001, (the Respondent) stated that (his) normal prescribing practice is to use at least two (2) opiates along with antidepressants, and that (he uses) Xanax and Klonopin because Xanax is short acting and Klonopin lasts longer. (The Respondent) also said that modern pain management calls for maintaining a level of drugs in the patient's system all the time, and at least 50 percent pain-related patients also suffer from anxiety and depression.

4. (The Respondent's) patients routinely received minimal or no medical examinations prior to receiving controlled substance prescriptions. Some of these patients were out-of-state patients who were treated after telephone consultations. (The Respondent has) numerous patients who are out-of-state patients from states including Tennessee, South Carolina, Georgia, Oklahoma, California, Wisconsin, Missouri, Rhode Island, New Jersey, New York, Louisiana, Florida and Alabama. Most of these patients were interviewed over the telephone rather than seen in person. The patients describe their symptoms during a telephone call every three months and receive prescriptions for controlled substances.

5. DEA obtained the prescription profiles of mail order customers of Medi Fare Drug Center, 100 Laurel Avenue, PO Box 309, Grover, NC 28073. The profiles revealed that approximately 60 customers were (the Respondent's) patients who lived in north central South Carolina, an hour or so distance from Grover, NC. Many of these patients received excessive amounts, in combination, of the following controlled substances: Morphine Sulfate (Schedule II), Methadone (Schedule II), Oxycodone (Schedule II), Hydromorphone (Schedule II), Hydrocodone (Schedule (III), Hydromorphone (Schedule II), Hydrocodone (Schedule III), Alprazolam (Schedule IV), Diazepam (Schedule IV), and/or Ambien (Schedule IV).

6. For instance, the prescription profiles of the following mail order customers revealed that:

A. Patient Sally B. received prescriptions for, among other things:

Date and Medication

3/13/00
#248 Hydrocodone/APAP 10–650
#93 Alprazolam 2 mg
#90 Methylphenidate 20 mg [Ritalin]
3/28/00
#250 OxyContin 80 mg
#360 Percocet 10/650
4/14/00
#248 Hydrocodone/APAP 10–500
#93 Alprazolam 2 mg
4/26/00
#248 OxyContin 80 mg
#93 Alprazolam 2 mg
5/24/00
#279 OxyContin 80 mg
#93 Alprazolam 2 mg
#90 Methylphenidate 20 mg
6/20/00
#279 OxyContin 80 mg
#93 Alprazolam 2 mg
#360 Percocet 10–650
#93 Lipitor 40 mg
7/19/00
#279 OxyContin 80 mg
#93 Alprazolam 2 mg
7/21/00
#90 Prozac 20 mg
#31 Furosemide 40 mg

B. Patient Debra M. received prescriptions for, among other things:

Date and Medication

5/1/00
#155 OxyContin 80 mg
#100 Oxycodone 5–500
#93 Alprazolam 2 mg
#30 Diazepam 10 mg
6/1/00
#155 OxyContin 80 mg
#100 Ocycodone 5–500
#93 Alprazolam 2 mg
#30 Diazepam 10 mg

C. Patient George N. received prescriptions for, among other things:

Date and Medication

5/10/00
#186 Hydrocodone/APAP 10–500
#136 Alprazolam 2 mg
#120 carisoprodol 350 mg
#62 Prozac 20 mg
6/5/00
#186 Hydrocodone/APAP 10–500
#136 Alprazolam 2 mg
#120 carisoprodol 350 mg
#62 Prozac 20 mg
#47 Remeron 30 mg
7/5/00
#186 Hydrocodone/APAP 10–500
#136 Alprazolam 2 mg
#120 carisoprodol 350 mg

D. Patient James W. received prescriptions for, among other things:

Date and Medication

4/18/00
#186 OxyContin 80 mg
#124 Hydromorphone 4 mg
#60 Promethazine 50 mg
5/17/00
#186 OxyContin 80 mg
#124 Hydromorphone 4 mg
#60 Promethazine 50 mg

E. Patient Debra C. received prescriptions for, among other things:

Date and Medication

6/7/00
#124 Hydrocodone/APAP 10–500
#124 Alprazolam 2 mg
#31 Trazodone 100 mg
#124 Carisoprodol 350 mg
6/8/00
#36 Dilaudid 3 mg
#124 MS CP 60 mg
7/7/00
#124 Hydrocodone/APAP 10–500
#124 Alprazolam 2 mg
#31 Trazodone 100 mg
#124 Carisoprodol 350 mg
#36 Dilaudid 3 mg
#124 MS S.R. CP 60 mg

F. Patient Charles K. received prescriptions for, among other things:

Date and Medication

4/3/00
#248 Hydrocodone/APAP 10–500
#93 Methadose 40 mg
#62 Alprazolam 2 mg
5/3/00
#248 Hydrocodone/APAP 10–500
#93 Metadose 40 mg
#62 Alprazolam 2 mg
6/2/00
#248 Hydrocodone/APAP 10–500
#93 Methadone 40 mg
#62 Alprazolam 2 mg
6/30/00
#248 Hydrocodone/APAP 10–500
#93 Methadone 40 mg
#62 Alprazolam 2 mg (RX 313579)
#62 Alprazolam 2 mg (RX 313574)

7. (The Respondent's) patients have been observed in (his) office discussing what prescriptions they would obtain from (him) and what they planned to do with the medication after obtaining it.

Patients also have been observed selling controlled substances in the parking lot outside of (the Respondent's) medical office.

8. (The Respondent's) patients have been implicated in drug dealing activities. For instance, (the Respondent) prescribed OxyContin for (his) patient, Debra M, who was known to trade her OxyContin for Methadone tablets. She also sold OxyContin for the following prices:

OxyContin 160 mg—$40/tab OxyContin 40 mg—$10/tab
OxyContin 80 mg—$20/tab OxyContin 20 mg—$5/tab

9. (The Respondent has) two patients who are husband and wife, Jerry C. and Carol C., both of whom are engaged in the abuse of Methadone. (The Respondent) continued to prescribe Methadone to them even though (he) knew or had reason to know that Jerry C. and Carol C. were abusing Methadone. When she rolled up her sleeves, Carol C.'s arms were covered with sores and her veins displayed huge knots consistent with drug abuse. Despite being informed that Jerry C. and Carol C. both admitted to drug abuse, (The Respondent) continued to write controlled substance prescriptions for them.

10. (The Respondent has) written controlled substance prescriptions for pregnant women and told them that taking narcotics would not harm their newborn babies. The newborn baby of one of (the Respondent's) former patients, Alice P., was born addicted to Methadone.

11. On May 14, 1999, (the Respondent) contacted the Spartanburg County, SC, Coroner's Office and spoke to (a representative from that office) regarding the death of Darrell S. During that conversation, (the Respondent) stated that the Spartanburg Co. Coroner's Office would be seeing (the Respondent's) name and the name of (his) clinic more often because doctors in Spartanburg would not give ''these people'' the medications that they needed, and sometimes (the Respondent) lose(s) some.

12. At least 23 of (the Respondent's) former patients have died, in part, due to drug overdoses.

13. On June 6, 2001, patient Teresa B., died of a drug overdose. (The Respondent) saw her as a patient on or about the day of her death and (he) issued her a prescription for controlled substances, including but not limited to Methadone. Teresa B. was known to receive a prescription for more than 100 Methadone tablets per month. During the evening hours of the date in which Teresa B. died, another one of (the Respondent's) patients, Debra M., visited the residence of Teresa B., for the purpose of exchanging Debra M.'s OxyContin for Teresa B.'s Methadone.

14. Debra M. traded her OxyContin that she received, based upon (the Respondent's) prescriptions, with Teresa B. as well as other drug abusers. Debra M. would exchange one (1) OxyContin 80 mg tablets for two (2) Methadone 40 mg tablets and had, over a period of time, exchanged hundreds of OxyContin tablets with Teresa B. Debra M. also engaged in sales of large quantities of OxyContin tablets.

15. On March 17, 2001, Kimberly (P.), age 24, died. She and her husband were (Respondent's) patients and both were drug abusers. A prescription profile from Fallston Pharmacy, Fallston, NC, indicated that Kimberly (P.) received prescriptions from the Respondent for the following:

Date and Medication

11/28/00
#124 Alprazolam 2 mg
#50 OxycodoneAPAP 5–325
12/27/00
#124 Alprazolam 2 mg
1/19/01
#3 Stadol 10 mg/ml
1/25/01
#124 Alprazolam 2 mg
2/26/01
#124 Alprazolam 2 mg

16. During the months of February and March 2001, Kimberly (P.'s) husband, Timothy (P.) received prescriptions from (the Respondent) that were filled at Fallston Pharmacy for the following medications:

Date and Medication

2/14/01
#75 Alprazolam 2 mg
#93 Hydrocodone 10–600
3/14/01
#120 Hydrocone 10–600
#140 Methadone 10 mg
#31 Clonazepam 2 mg

17. A prescription profile for Kimberly (P.) for the same time period from Medi Fare Drug Center, Grove, NC, indicated that she received prescriptions from (the Respondent) for the following:

Date and Medication

2/26/01
#120 Roxicet TA, 5–325
#20 Dilaudid 3 mg
#30 Prozac 20 mg
3/14/01
#14 Prozac 20 mg
#30 Prozac 20 mg

18. During the months of February and March 2001, Kimberly (P.'s) husband, Timothy (P.), received prescriptions from (the Respondent) that were filled at Medi Fare Drug Center, Grover, NC, for the following:

Date and Medication

1/12/01
#90 Hydrocodone 10–650
#75 Alprazolam 2 mg
#124 Oramorph 15 mg
2/9/01
#9 Hydrocodone 10–650
#4 Clonazepam 1 mg
3/14/01
#78 Alprazolam 2 mg

19. On or about April 12, 2001, Roger H., 50 years old, died at his home. Numerous pills were found on and around his body. The decedent was (the Respondent's) former patient and had completed rehabilitation for opiate abuse during December 2000. (The Respondent's) office was advised in January 2001 that Roger H. had recently undergone drug rehabilitation treatment. The cause of death was overdose of Oxycodone. The blood level of Oxycodone was .55 mg/L, which was well above the therapeutic level of .05 mg/L, and even above the potentially lethal level of .4 mg/L. The Respondent prescribed to the decendent #120 OxyContin, #63 Percocet and an unknown quantity of Roxicodone per month.

20. On March 26, 2001, DEA became aware of five (5) recent deaths of individuals residing in Union County, SC. Each of these individuals were former patients of (the Respondent). These individuals included: Terry J., Marshall S., George N., Debra G., and Tracey C. The cause of death for each of the patients, with the exception of Tracey C., was drug overdose. Although Tracey C's death was ruled to be due to cardiac arrhythmia, he had a history of drug abuse and his blood contained metabolites of controlled substances. Tracey C. and Terry J. were known to have obtained OxyContin from Debra M., and Debra M. was one of (the Respondent's) patients.

a. Terry J. died of respiratory insufficiency secondary to synergistic drug overdose.

b. Marshall S. died of respiratory arrest secondary to drug overdose.

c. George N died of respiratory insufficiency secondary to synergistic drug overdose.

d. Debra G. died of respiratory arrest from cardiomyopathy, but multiple drug ingestion was a contributing factor.

21. On December 4, 2001, DEA received from the North Carolina Office of the Chief Medical Examiner, among other things, copies of six (6) autopsy reports of former patients of (the

Respondent) who died of causes related to Oxycodone ingestion. The decedents lived in Gaston, Cleveland and Rutherford Counties in North Carolina and included the above mentioned Roger H., as well as the following individuals (approximate date of death listed after the name):

a. David M., 3/27/01.
b. Pamela Jean B., 1/5/00.
c. Clifford Ray G., 4.13/00.
d. David B., 8/16/00.
e. Adenna S., 12/3/00.

22. On October 10, 2001, the North Carolina Medical Board (Medical Board) issued a Notice of Charges and Allegations against (the Respondent). The complaint alleged that (the Respondent) self-prescribed, diverted and stockpiled the weight-loss drug Pondimin (Fenfluramine) for personal consumption without conferring with or receiving a prescription from (his) personal physician. In addition, the Medical Board alleged that (the Respondent) deviated from acceptable standards of medical care in a manner directly related to (his) dispensation and prescription of controlled substances. Specifically, the Medical Board alleged, with regard to (his) treatment of patients, (the Respondent):

a. Failed to perform adequate physical or objective examinations in order to properly evaluate or diagnose the etiology of patients' complaints;

b. Failed to perform follow-up physician examinations of patients including appropriate laboratory studies to rule out or confirm the causes of pain prior to instituting opioid therapy;

c. Failed to inquire during each patient visit as to whether patients received medications from other physicians or sources even though (the Respondent) knew or had reason to believe that many patients had a history of inappropriately obtaining drugs or engaging in substance abuse;

d. Failed to monitor patient compliance with (the Respondent's) prescribed therapeutic regime through appropriate laboratory studies and fluid screens even though (he) knew or had reason to believe that many patients had a history of inappropriately obtaining drugs or engaging in substance abuse.

e. Failed to insist that all prescriptions for each patient be filled at a single pharmacy in order to adequately monitor patient care even though (the Respondent) knew or had reason to know that many patients had a history of inappropriately obtaining drugs or engaging in substance abuse;

f. Failed to measure the degree and variations of pain symptoms in order to properly evaluate the effectiveness of therapy; and

g. Failed to vary treatment or attempt non-opioid therapy, even though (the Respondent) knew or had reason to believe that many patients had a history of inappropriately obtaining drugs or engaging in substance abuse.

22. On or about June 11, 2001, (the Respondent was) informed by DEA investigative personnel that (he was) not permitted to possess controlled substances that had been dispensed to (his) patients by virtue of prescriptions written by (the Respondent). (The Respondent) told DEA investigative personnel that (he) had been collecting and storing patients' controlled substances. These patients reportedly could no longer take their medications, sometimes due to allergic reactions. (The Respondent) said that (he) would write the patient a new prescription for a different medication and take possession of the old, discontinued controlled substance. DEA personnel informed (the Respondent) that the patients' controlled substances belonged to them and that (the Respondent) could not possess them.

23. On October 3, 2001, DEA and state investigative personnel conducted an audit of the controlled substances at (the Respondent's) registered location. In a closet, they located a cabinet full of controlled substances that (the Respondent) took from (his) patients when (he) changed their medications. Investigators told (the Respondent), as they had on June 11, 2001, that once the controlled substance has been dispensed to the patient, (the Respondent) could not possess it. DEA completed its audit of (the Respondent's) registered premises on October 4, 2001, and then destroyed hundreds of dosage units of controlled substances, including, but not limited to Methadone, OxyContin, Oramorph, Methylphenidate and Hydromorphone.

24. (The Respondent) circumvented DEA regulations by issuing multiple prescriptions for a 30-day supply of controlled substances, including those in Schedule II, to patients including but not limited to patient Teresa B. The prescriptions included the phrase ''do not fill until (insert date, either 30 or 60 days from the date on the prescription).'' The patients would then return to the Medi Fare Drug Center on a monthly basis, either 30 or 60 days after their visit to (the Respondent's) office, to fill their prescription(s). This had the effect of circumventing DEA regulations by, in effect, permitting (the Respondent's) patients to obtain refills of Schedule II prescriptions. Under DEA regulations, prescriptions are to be dated as of the date of issue. *See* 21 CFR 1306.05(a)(''All prescriptions for controlled substances shall be dated as of, and signed on, the day when issued * * *'') Prescriptions for Schedule II controlled substances are not refillable. *See* 21 CFR 1306.12 (''The refilling of a prescription for a Schedule II controlled substances listed in Schedule II is prohibited'').

By letter dated February 26, 2002, the Respondent requested a hearing in this matter. After the parties filed respective prehearing submissions, on June 26, 2002, the Government filed a Request for Stay of Proceedings and Motion for Summary Disposition. In support of its motion, the Government asserted that on June 20, 2002, the Medical Board issued Findings of Fact, Conclusions of Law and Order of Discipline in a disciplinary proceeding against the Respondent. The Medical Board's action resulted in the indefinite suspension of the Respondent's medical license, effective April 18, 2002.

On March 28, 2002, Administrative Law Judge Gail A. Randall (Judge Randall) issued her opinion, Order, and Recommended Ruling of the Administrative Law Judge (Opinion and Recommended Ruling). In her Opinion and Recommended Ruling, Judge Randall granted the Government's motion for summary disposition, and found that the Respondent lacks authorization to handle controlled substances in the State of North Carolina, and that the Respondent's medical license is unlikely to be reinstated in the near future.

In granting the Government's motion, Judge Randall also recommended that the Respondent's DEA registration be revoked and any pending applications for modification or renewal be denied. Neither party filed exceptions to her Opinion and Recommended Ruling, and on August 21, 2002, Judge Randall transmitted the record of these proceedings to the Office of the Deputy Administrator.

The Deputy Administrator has considered the record in its entirety, and pursuant to 21 CFR 1316.67, hereby issues his final order based upon findings of fact and conclusions of law as hereinafter set forth. The Deputy Administrator adopts, in full, the Opinion and Recommended Ruling of the Administrative Law Judge.

The Deputy Administrator finds that in its June 20, 2002 Order, the Medical Board reached findings that were alleged in its October 10, 2001 Notice of Charges. Those findings included *inter alia,* that the Respondent routinely failed to inquire as to whether a patient received medications from other physicians or sources when he knew or had reason to believe the patient was

abusing drugs. The Medical Board also found that the Respondent diverted and stockpiled the weight-loss drug Pondimin (Fenfluramine) (a Schedule IV controlled substance) for his personal use by asking the patients to return their supplies of the drug to him. Consistent with its findings and conclusions, the Medical Board ordered the indefinite suspension of the Respondent's North Carolina medical license. In addition, the Medical Board ordered that the Respondent may petition for reinstatement of his medical license ''no sooner than April 18, 2003.''

There is no evidence before the Deputy Administrator to rebut findings that effective April 18, 2002, the Respondent's license to practice medicine in the State of North Carolina was indefinitely suspended and that he is not eligible to petition for reinstatement of that license until April 18, 2003. Therefore, the Deputy Administrator finds that since the Respondent is not currently authorized to practice medicine in North Carolina, it is reasonable to infer that he is not authorized to handle controlled substances in that state.

DEA does not have statutory authority under the Controlled Substances Act to issue or maintain a registration if the applicant or registrant is without state authority to handled controlled substances in the state in which he conducts business. See 21 U.S.C. 802(21), 823(f) and 824(a)(3). This prerequisite has been consistently upheld. See Joseph Thomas Allevi, M.D., 67 FR 35581 (2002); Dominick A. Ricci, M.D., 58 FR 51104 (1993); Bobby Watts, M.D., 53 FR 11919 (1988).

The parties do not dispute the fact that Respondent is currently without authorization to handle controlled substances in North Carolina. Therefore, it is well settled that when no question of material fact is involved, a plenary, adversary administrative proceeding involving evidence and cross-examination of witnesses is not obligatory. See Gilbert Ross, M.D., FR 8664 (1996); Philip E. Kirk, M.D., 48 FR 32,887 (1983), aff'd sub nom Kirk v. Mullen, 749 F.2d 297 (6th Cir. 1984); NLRB v. International Association of Bridge, Structural and Ornamental Ironworkers, AFL–CIO, 549 F.2d 634 (9th Cir. 1977). This standard also applies in matters involving the immediate suspension of a DEA Certificate of Registration under 21 U.S.C. 824(d). Chemical Dependence Associates of Houston, 58 FR 3705 (July 12, 1993).

Here, it is clear that the Respondent is not licensed to handle controlled substances in North Carolina. Since Respondent lacks such authority, he is not entitled to a DEA registration in that state. In light of the above, Judge Randall properly granted the Government's Motion for Summary Disposition.

Because the Respondent is not entitled to a DEA registration in North Carolina Due to his lack of state authorization to handle controlled substances, the Deputy Administrator concludes that it is unnecessary to address whether the Respondent's registration should be revoked based upon the other grounds asserted in the Order to Show Cause and Notice of Immediate Suspension of Registration. *See* Nathaniel-Aikens-Afful, M.D., 62 FR 16871 (1997).

Accordingly, the Deputy Administrator of the Drug Enforcement Administration, pursuant to the authority vested in him by 21 U.S.C. 823 and 824 and 28 CFR 0.100(b) and 0.104, hereby orders that DEA Certificate of Registration, AT2853706, issued to Joseph H. Talley, M.D., be, and it hereby is, revoked. The Deputy Administrator further orders that any pending applications for renewal of such registration be, and they hereby are, denied. This order is effective December 20, 2002.

Dated: November 20, 2002.

John B. Brown, III,

Deputy Administrator.

[FR Doc. 02–30256 Filed 11–27–02; 8:45 am]

BILLING CODE 4410–09–M

DEPARTMENT OF JUSTICE

Drug Enforcement Administration

Clark G. Triftshauser, M.D., Revocation of Registration

On May 13, 2002, the Deputy Assistant Administrator, Office of Diversion Control, Drug Enforcement Administration (DEA), issued an Order to Show Cause to Clark G. Triftshauser, M.D. (Dr. Triftshauser) of Albion, New York, notifying him of an opportunity to show cause as to why DEA should not revoke his DEA Certificate of Registration, BT5294866, under 21 U.S.C. 824(a), and deny any pending applications for renewal or modification of that registration. As a basis for revocation, the Order to Show Cause alleged that Dr. Triftshauser is not currently authorized to handle controlled substances in New York, the state in which he practices. The OTSC also alleged that Dr. Triftshauser had been convicted of a felony related to controlled substances and had otherwise committed acts that would render his registration inconsistent with the public interest. The order notified Dr. Triftshauser that should no request for a hearing be filed within 30 days, his hearing right would be deemed waived.

The Order to Show Cause was sent by certified mail to Dr. Triftshauser at his registered location in Albion, New York and to the new York State Groveland Correctional Facility in Sonyea, New York, where Dr. Triftshauser is presently incarcerated. DEA received a signed receipt indicating that the Order to Show Cause was received on Dr. Triftshauser's behalf at the correctional facility on May 20, 2002. DEA has not received a request for hearing or any other reply from Dr. Triftshauser or anyone purporting to represent him in this matter. Therefore, the Deputy Administrator, finding that (1) 30 days have passed since the receipt of the Order to Show Cause, and (2) no request for a hearing having been received, concludes that Dr. Triftshauser is deemed to have waived his hearing right. After considering material from the investigative file in this matter, the Deputy Administrator now enters his final order without a hearing pursuant to 21 CFR 1301.43(d) and (e) and 1301.46.

The Deputy Administrator finds that on October 28, 1987, Dr. Triftshauser was issued DEA Certificate of Registration, AT6847240, in Schedules II through V. In 1987, Dr. Triftshauser's medical license was suspended after it was discovered that he had obtained Dexedrine, a Schedule II controlled substance, for his personal use. On March 21, 1991, Dr. Triftshauser surrendered his New York state medical license after it was discovered that over a thirty-two month period, he had obtained hydrocodone syrup (a Schedule III controlled substance) for his personal use. As a result, on December 14, 1991, Dr. Triftshauser surrendered DEA Certificate of Registration, AT6847240.

On June 30, 1994, Dr. Triftshauser's medical license was restored and he was placed on a five-year period of probation. As part of his probation, he agreed to refrain from the personal use of controlled substances and submit to random urinalysis for detection of any misuse of drugs. These urine screens were to be administered by the Committee for Physicians' Health of the State of New York Medical Society (''CPH'').

In May 1995, Dr. Triftshauser submitted a new application for DEA Certificate of Registration. He materially falsified that application by failing to disclose the 1987 suspension of his New York medical license, as well as his