Tenth Circuit No. 19-8054

IN THE UNITED STATES COURT OF APPEALS

FOR THE TENTH CIRCUIT

UNITED STATES OF AMERICA, Plaintiff/Appellee, v. **SHAKEEL KAHN,** Defendant/Appellant.	

APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF WYOMING

The Honorable Alan B. Johnson
United States District Court Judge

District Court No. 17-CR-29-J

SUPPLEMENTAL BRIEF OF APPELLEE

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INTRODUCTION

In *Ruan v. United States*, 142 S. Ct. 2370 (2022), the Supreme Court held that a medical practitioner may be convicted under the Controlled Substances Act (CSA) only if he "knowingly or intentionally" prescribes a controlled substance for a non-legitimate medical purpose outside the usual course of his professional practice. The jury instructions in this case do not exactly correspond to *Ruan*'s holding. But to the extent they fall short, any such error was harmless given the overwhelming evidence at trial—including the Defendant's own records, statements, and admissions—documenting his knowledge of the accepted medical standards governing the prescription of controlled-substance medications and his serial violation of them. This court should accordingly affirm his convictions.

STATEMENT OF THE CASE

Following a jury trial, the Defendant was convicted of multiple violations of the federal controlled substances, firearms, and money laundering statutes. *United States v. Kahn*, 8989 F.3d 806, 813 (10th Cir. 2021). These charges arose out of the Defendant's practice of regularly prescribing powerful controlled substances, including oxycodone, alprazolam, and carisoprodol, to his patients outside the usual course of professional medical practice and without any legitimate medical purpose.

On appeal, the Defendant focused on the district court's "good faith" instruction, which he claimed allowed the jury to convict him for issuing improper prescriptions in a negligent or reckless fashion, rather than for knowingly or intentionally issuing them outside the scope of professional practice or for other than legitimate medical purposes. Instruction 39 provided that a physician's "good faith" in issuing prescriptions was a

complete defense to the "unlawful dispensing" charges under 21 U.S.C. §841 in the indictment, because such "good faith" would be inconsistent with a physician's knowingly and intentionally issuing prescriptions outside the usual course of professional practice or for no legitimate medical purpose. *Kahn,* 989 F.3d at 823. The instruction explained that "good faith connotes an attempt to act in accordance with what a reasonable physician should believe to be proper medical practice." (*Id*).

The instruction went on to note that it was the jury's job to determine whether the Defendant in fact made an honest effort to prescribe for his patients' medical conditions in accordance with generally recognized and accepted standards of practice (*Id*). And it emphasized that the Defendant had no burden with respect to this issue: "It is the Government's burden to prove to you, beyond a reasonable doubt, *that a defendant knowingly and intentionally acted unlawfully"* (*Id*.) (*emphasis supplied).*

This court rejected the Defendant's challenge to Instruction 39. *Kahn*, 989 F.3d at 826. In doing so, it noted the jury could not have convicted him of simply failing to apply the standard of care required of his profession; rather, "it could only convict Dr. Kahn if it found, beyond a reasonable doubt, that Dr. Kahn failed to even attempt or make some honest effort to apply the appropriate standard of care." *Id.*, at 826 (citing, *inter alia, United Sates v. Wexler*, 522 F.3d 194, 206 (2nd Cir. 2008) (noting a comparable good faith instruction shielded a defendant from criminal liability for any mistake, however gross).

In the Supreme Court, the government argued that a similar, but not identical, good faith instruction – under which a defendant could not be convicted if he made "*an objectively reasonable attempt* to ascertain and act within the bounds of professional

practice" – would suffice for purposes of satisfying § 841's "knowing and intentional "*mens rea"* requirement (emphasis supplied).[1] The Court rejected that concept, both because "good faith" nowhere appears in the text of §841, and because it would turn a defendant's criminal liability on "the mental state of a 'hypothetical reasonable doctor', and not on the mental state of the defendant himself or herself." *Ruan,* 142 S. Ct. at 2381.

That said, the court went on to recognize that the government can prove a defendant's knowledge of his lack of authorization through circumstantial evidence. *Id*, at 2382. Moreover, the court noted that

> …the regulation defining the scope of a doctor's prescribing authority does so by reference to objective criteria such as "legitimate medical purpose" and "usual course" of "professional practice." (citations omitted). As we have said before, "the more unreasonable" a defendant's "asserted beliefs or misunderstandings are," especially as measured against objective criteria, "the more likely the jury … will find that the Government has carried its burden of proving knowledge." (citation omitted).

Id., at 2382.

The Court declined to resolve whether the instructions actually given in this case were sufficient. Nor did it address whether any shortcomings in these instructions could be deemed harmless. Those issues it left for this court to address on remand. *Id.*, at 2382.

[1] The government's proposed test before the Supreme Court differs from the instruction at issue here. Instruction 39 asks whether the Defendant made *any* effort to satisfy the prescribing standards of his profession. Under that instruction, any genuine effort – objectively reasonable or not – would have required an acquittal. *See Kahn*, 989 F.3d at 826.

INSTRUCTIONAL ERROR

The first question before the court on remand is whether the instructions actually given to the jury are in compliance with the Supreme Court's opinion. The short answer is no – at least not entirely. The instructions actually given in this case for sure repeatedly instructed the jury that it could convict the Defendant only if it found beyond a reasonable doubt that he issued prescriptions *knowingly and intentionally* outside the usual course of medical practice or without a legitimate medical purpose (*See* generally Defendant's App. at 214 [Instruction 20]; at 215 [Instruction 21]; at 224-25 [Instruction 27]; at 237 [Instruction 37]; at 239-40 [Instruction 39]; and at 290 [Instruction 74]).

That said, the instructions did not advise the jury that to convict, it had to find that the Defendant's knowledge and intent went beyond the simple act of issuing the prescriptions, but in addition required it to find that, when he issued them, he knew or intended that they were outside the usual course of professional practice or not for a legitimate medical purpose, *i.e.*, that he "knowingly or intentionally acted in an unauthorized manner". *Ruan,* 142 S. Ct. at 2382.

Thus, the question before this court now is whether, to the extent the instructions actually given fell short of what *Ruan* requires, any such deficiencies could, on this record, be considered harmless beyond a reasonable doubt. *See United States v. Little,* 829 F.3d 1177, 1183 (10th Cir. 2016)*; see also Neder v. United States*, 527 U.S. 1, 8-9 (1999). The burden to establish harmlessness is on the government. *United States v. Holly,* 488 F.3d 1298, 1307-08 (10th Cir. 2007). That burden can be carried when the evidence establishing

the Defendant's knowledge and intent was overwhelming, such that the instructional error could not have affected the jury's verdict. *Little*, 829 F.3d at 1185.

Before addressing "harmlessness", however, two points concerning the Defendant's supplemental brief must be made. First, the Defendant repeatedly argues that the instructions generally, and Instruction 39 specifically, invited the jury to convict him simply on a finding that his prescribing practices were negligent, rather than on a finding that he knowingly or intentionally prescribed in an unauthorized manner. That isn't so. As noted above, the instructions repeatedly advised the jury that it was the government's burden to show he acted knowingly and intentionally, and not merely negligently, carelessly, etc. (*See* Instructions 20, 21, 27, 33, 39, and 74). Moreover, this court previously recognized that the instructions did not permit the jury to convict him for "merely failing to apply the appropriate standard of care; *it could only convict Dr. Kahn if it found, beyond a reasonable doubt, that Dr. Kahn failed to even attempt or make some honest effort to apply the appropriate standard of care." Kahn*, 989 F.3d at 826 (*emphasis supplied*). Nothing in the Court's opinion in *Ruan* undermines this conclusion. That determination thus constitutes law of the case and therefore governs these proceedings on remand. *See United States v. Monsisvais*, 946 F.2d 114, 115 (10th Cir. 1991) ("The law of the case doctrine posits that when a court decides upon a rule of law, that decision should continue to govern the same issues in subsequent stages in the same case.") (internal quotation marks and citation omitted).

To be sure, proof that the Defendant "failed even to try" to conform his prescribing practices to the standards of his profession is not perfectly equivalent to proof that he

"knowingly or intentionally" acted outside his authorization as a licensed physician. But neither is it far off. Indeed, the jury's implicit finding that he made no such effort would go far to show, circumstantially at least, that he actually knew he was acting outside the standards of his profession.

Second, the Defendant takes issue (Supp. Br. 5-6) with the notion that the jury should consult accepted medical standards when assessing his mental state at the time of the prescriptions, rather than focusing only on his subjective, idiosyncratic notion of what these standards should be. In this, he turns a blind eye to *Ruan*, where the Supreme Court affirmed that "the scope of a doctor's prescribing authority" remains tethered to "objective criteria such as 'legitimate medical purpose' and 'usual course' of 'professional practice.'" *Id*. at 2382. A physician's serial disregard of accepted medical norms constitutes relevant evidence of his mental state.

As the Supreme Court explained, "the more unreasonable a defendant's asserted beliefs or misunderstandings are, *especially as measured against objective criteria*, the more likely the jury will find that the Government has carried its burden of proving knowledge." *Id*. (emphasis added; internal quotation marks, alterations, and citation omitted). Moreover, what constitutes legitimate medical purposes and the usual course of professional practice are, contrary to the Defendant's understanding (*See* Defendant's Supp. Brief, at 6-7), questions for the jury to sort out "the old-fashioned way: through witnesses and documentary proof at trial focused on the contemporary norms of the medical profession." *United States v. Lovern*, 590 F.3d 1095, 1100 (10th Cir. 2009). Nothing in *Ruan* contradicts this holding.

In sum, the government concedes that the instructions did not require the jury specifically to decide whether the Defendant, in issuing the controlled substance prescriptions at issue here, knowingly or intentionally contravened the standards of his profession. But, as this court noted in *Kahn*, the jury necessarily *did* find beyond a reasonable doubt that he made no genuine effort whatsoever to satisfy those standards. *Kahn*, 989 F.3d at 826. Thus, the "harmless error" question must be whether, given what the jury necessarily did find based on the instructions it was actually given, and given all the evidence at trial bearing on the issue of intent, there is any reasonable possibility that a *Ruan*-compliant instruction on *mens rea* might have produced an acquittal. As we show below, the evidence with respect to the Defendant's knowledge concerning the objective standards of his profession was overwhelming and essentially uncontested. Given that, and given the jury's well supported finding that he made no effort to satisfy those standards, there can be no reasonable doubt but that a *Ruan*-compliant instruction on *mens rea* could not have affected the outcome of this case.

HARMLESS ERROR

As we note above, the government's burden is to show that any error in the instructions given in this case was harmless beyond a reasonable doubt. *See, United States v. Little* 829 F.3d at 1183. The record in this case does so in spades. It contains "overwhelming evidence support[ing] a finding of [the Defendant's] actual knowledge" of the accepted medical standards governing controlled-substance prescriptions. *Little*, 829 F.3d at 1185. Because the Defendant knew those standards, and because he repeatedly prescribed controlled substances in violation of them, the record overwhelmingly

establishes his guilt under Section 841(a)(1). The court should accordingly affirm his convictions, notwithstanding the *Ruan* instructional error.

a. The trial record overwhelmingly establishes the Defendant's actual knowledge of the accepted medical standards governing opioid prescriptions.

As the Supreme Court and this court have acknowledged, the medical profession has accepted and well-understood standards governing a practitioner's decision to prescribe controlled substances to a patient. Among them:

- Obtaining a patient's medical history and performing a diagnostic exam before prescribing a controlled-substance medication;
- Recording accurate information on patient medical records;
- Notifying patients of dangers inherent to controlled substances and obtaining informed consent;
- Issuing prescriptions based on patient need, rather than allowing patients to select drugs;
- Addressing signs of patient drug abuse and drug diversion;
- Charging fees based on professional services rendered, rather than on the quantity or dosage of drugs prescribed to patients; and
- Collecting ordinary compensation in exchange for professional services.

See, e.g., *United States v. Moore*, 423 U.S. 122, 142-143 (1975); *MacKay v. Drug Enf't Admin.*, 664 F.3d 808, 818-19 (10th Cir. 2011); *United States v. Lovern*, 590 F.3d 1095, 1101 (10th Cir. 2009).

The government's expert in this case (Dr. Shay) identified these same medical standards when reviewing the Defendant's prescribing conduct:

- The physician must select an appropriate dose of opioid drugs and avoid unjustified dose escalation without adequate attention to the risks (TT. Vol. IV at 20-23, 79-80, 103, 174-75, 205-09 and Vol. VII 179-184);

- The physician must avoid prescribing drugs that present a risk of fatal complications for the patient and provide patient education and informed consent about the drugs prescribed (TT. Vol. IV at 21, 111-216);

- The physician must maintain accurate and complete records of evaluations, treatment plans, and patients' informed consent (TT. Vol. IV at 71-80, Vol. VII at 179-84, 205-09);

- The physician should not rely excessively on high dose opioids in pain management (TT. Vol. IV at 21);

- The physician must examine the patient before issuing the prescription (TT. Vol. IV at 11, 40, 51);

- The physician cannot charge fees based on the quantity and dosage of the drug prescribed to the patient (TT. Vol. IV at 92-97, 218); and

- The physician cannot falsify records documenting patient visits that never occurred (TT. Vol. IV at 80, 126-27, 218-20 and Vol. VII at 179-181).

The Defendant did not assert a lack of knowledge or understanding of these accepted standards of patient care, each of which would seem obvious to anyone who has ever visited a doctor for a prescription. *See Lovern*, 590 F.3d at 1101 (observing that jurors could rely on "their common experiences" in "determin[ing] that issuing prescriptions for controlled substances based solely on online questionnaires fell outside the usual course of medical conduct"). To the contrary, the trial record overwhelmingly establishes the Defendant's knowledge (and utter disregard) of these standards at the times he prescribed the controlled substances in this case.

First, the Defendant was aware that a practitioner should conduct certain tests and consider alternative therapies *before* issuing a controlled-substance prescription. His

records "g[ave] an illusion of practicing medicine" by noting his supposed consideration of non-opioid treatments like anti-inflammatory medications or physical therapy and his supposed ordering of diagnostic tests like X-rays, MRIs, and neurological evaluations. Yet, he in fact did none of those things, but he continued to prescribe "oxy" anyway (TT. IV at 219-20).

Second, the Defendant knew the importance and hazards of opioid dosing. During his 2007 residency, he received counseling against quick dosage escalation (TT. Vol XVI at 29-30). In 2010, the Arizona Medical Board issued a letter of reprimand addressing the Defendant's deviations from the standard of care in dosing opioids—further alerting him to these dangers (TT. Vol IX at 27-28, TT Vol. XVI at 32-33, Exhibit 7027). And in 2012, and after receiving complaints about his opioid prescriptions, the Arizona Medical Board directed the Defendant to attend an "intense, in-person opioid prescribing course" (TT. IX at 28-29 and Exhibit 7037 at 4), which the Defendant admitted to completing (TT. XVI at 52). Finally in 2015, the Defendant acknowledged—in response to further complaints—that a clinician should make "specific and well-documented dosage adjustments in response to feedback from patients," and that dosing "[s]hould be tailored to the individual patient" (Exhibit 7011 at 5 and 8) (TT. Vol VIII at 308).

Third, the Defendant appreciated his obligation to keep proper medical records. In April 2013, the Arizona Medical Board issued an advisory letter to the Defendant due to the inadequate documentation in his medical records confirming discussions with patients on the use, side effects, and safety of controlled substances (TT. Vol. IX at 28-29, TT. Vol XVI at 48-54, Exhibit 7028).

Fourth, the Defendant knew about and claimed that he followed published medical standards when issuing prescriptions. In 2015, during an Arizona Medical Board inquiry, he stated that he "follow[ed] the guidelines set out by the American Academy of Pain Management (AAPM) (TT. VIII at 303-306 Exhibit 7011 at 2-3) (Exhibit 7030 Management of Opioid Therapy for Chronic Pain). The following year, upon opening his practice in Wyoming, the Defendant stated that "[his] practice conforms to the guidelines set forth by the Wyoming Board of Medicine in all respects including employing the Chronic Opioid Toolkit" (Exhibit 7024).[2]

Fifth, while on the witness stand at trial, the Defendant conceded his knowledge of multiple standards that the government's expert discussed:

- The practice of going "low and slow" with dosing and escalation of opioid prescriptions (TT. Vol. XV at 46 and XVI at 29, 31, 40-46, 206);
- The importance of treating patients as individuals, serving their needs and health first (TT. Vol. XV at 153 and Vol. XVI at 17, 5, 28);
- The physician should conduct a "history, physical examination and appropriate diagnostic testing" before prescribing opioid drugs (TT. Vol. XVI at 42);
- The physician should counsel patients on the use of opioids (TT. Vol. XV at 145, 156);
- The physician should pay special attention to those patients at risk for medication misuse, abuse or diversion (*Id*. at 84);
- A physician should not charge patients for prescriptions (*Id*. at 75); and

[2] The Wyoming Board of Medicine's guidance and the Chronic Opioid Toolkit incorporate the Federation of State Medical Boards Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain. The AAPM and other recognized compilations detail the objective medical standards for treating chronic pain. Dr. Shay's evaluation of the Defendant's prescriptions compared the Defendant's behavior to these policies (TT. Vol. IV at 5-27, 100-104).

- A physician should not prescribe controlled substances if he obtained information that the patient was diverting them (TT. Vol. XVI at 223).

The Defendant may, as he stated at trial, personally disagree with several of these standards or precautions (TT. Vol. XV at 45-50). But the Supreme Court long ago rejected the contention that a physician is immune from prosecution under Section 841(a)(1) so long as he prescribes controlled substances based on where *he thinks* the boundaries should be placed. *See Moore*, 423 U.S. at 143-145 (rejecting physician's defense that he was experimenting with a new "blockade" theory of detoxification).[3]

The Supreme Court's decision in *Ruan* simply demands proof that the physician *knew* the accepted standards and procedures required of medical practitioners who prescribe controlled substances, and knowingly or intentionally disregarded those standards. The Defendant's own records, correspondence, and testimony unequivocally illustrate his knowledge of those standards here.

b. The Defendant serially disregarded those accepted medical standards when he prescribed controlled substances to his patients.

The evidence at trial also overwhelmingly documented the Defendant's serial and knowing violation of the medical standards cataloged above.

[3] Even so, it is unlikely a reasonable jury would have believed the Defendant's assertions, as his credibility was totally eviscerated at trial. For example, the jurors learned he was kicked out of the University of Toronto medical school for lying during the admission process (TT. Vol. XVI at 15-16, 69). And he admitted, at trial, to committing insurance fraud in 2015 because it was easier to go with the lie (TT. Vol. III at 222, Vol. XV at 37-40, Vol. XVI at 163-168). Additionally, the Defendant admitted in 2015-2016, he wrote oxycodone 30-milligram prescriptions, on multiple occasions, for his brother in the name of his stepdaughter to avoid scrutiny from pharmacists (TT. Vol. III at 221; Vol. XV at 40; Vol. XVI at 5-7).

i. Failing to obtain patient history or conduct medical exams.

Though the Defendant's files were full of the standard forms used in legitimate pain practice, his patients' office visits with him were "perfunctory" at best, he did not counsel patients on the dangers of addiction and side effects or the health risks of mixing or abusing these prescritions, and the forms served only to cover the Defendant's "behind" (TT. Vol. VI at 35-45 [Beland], 188-208, 213 [Cabana]); TT. Vol. VII at 79-95, 131-32 [Muehlhausen], 214-22, 233 [Thacker]; TT. Vol. VIII at 69-72, 75, 169, 177-80 [D. and S. Drndarski]; TT. Vol. IX at 88-90, 97, 113-14 [R. Moody]; TT. Vol. XI at 117-120 [D. Antelope]; TT. Vol. XII at 205-08 [A. Vargas]; TT. Vol. XIII at 38-40 [A. Vargas]; TT. Vol. XVI at 75, 91-96, 132-35 [Defendant]).

ii. Recording false information on patient records.

The Defendant admitted at trial that he added falsified notes in his patient charts indicating he had provided treatment, completed assessments, made referrals, collected urine samples, and personally saw patients in the office, when in fact he had done none of those things (TT. Vol. XVI at 65-77). He also conceded that his progress notes were often only "copy and paste" versions of prior visits his patients had with him and did not reflect reality. Sometimes the "copy and paste" notes went unchanged for months or even years (Vol. XV at 146-53; Vol. XVI at 74-77). In addition to his own admissions, L. Kahn testified she assisted the Defendant in falsifying medical files submitted to the AMB to make it falsely appear that he was following the usual course of professional practice (TT. Vol. XII at 26-74); (Exhibits 3019, 3020, 3026, 3028, 3031, 3036, 3037, 3038 and 10045).

iii. Prescribing dangerously high drug dosages or combinations without identifying a justification.

Experts opined that the Defendant's patient files revealed that prescriptions were outside the usual course of medical practice and not for legitimate medical reasons for a variety of reasons including that:

- He relied excessively on opioids at high doses, using 20 and 30 milligram extensively. Often times prescribing 180 or more tablets of oxycodone 30 milligram tablets and 20 milligram tablets for every patient.

(TT. Vol. IV at 103, 174-220 generally).

- He prescribed dangerous combinations of drugs without proper monitoring, or counseling.

(TT. Vol. II at 104-05, 109, 129-31; Vol. IV at 208-09).

- He failed to follow CDC and recognized guidance when determining when to initiate and continue opioids, selection of opioid dosage, duration, discontinuation, and assessing risk and harm of opioid use.

(*Id.* at 104-05).

- His charts demonstrated that he failed to complete a thorough evaluation of patients, did not consider opioid treatment alternatives, and did not use screening tools.

(TT. Vol. IV at 105).

- His medical records did not establish a legitimate medical reason for which to prescribe pain medication or controlled substances. Worse, he prescribed those substances when the patients were not present for a visit but documented that they were.

(TT. Vol. IV at 218).

In addition, two Wyoming patients testified that the Defendant agreed to prescribe for patients they referred to him a regimen of 120 of oxycodone 30 milligram tablets and

120 oxycodone 15 or 20 milligram tablets, as well as Xanax and Soma, and all of that "sight unseen" with respect to the actual patients. The government's exhibits corroborated that arrangement (TT. Vol. V at 203; TT. Vol. VI at 167-69; TT. Vol. XI at 39-50, 52-54; TT. Vol. XIII at 196-209; Vol. XVI at 179-82; Exhibits 4104-H and 4104-I); (*See also* Trial Exhibit 1040-A [recorded call between the Defendant and Beland]).

iv. Disregarding evidence of drug abuse or diversion.

The evidence showed that the Defendant knew patients were selling their pills, and that he wanted his "cut" (TT. Vol. VIII at 61, 185-89); (TT. Vol. VII at 46-47, 238); (TT. Vol. V at 218-20; TT. Vol. VII at 46-47; TT. Vol. XI at 36-37; TT. Vol. XII at 220-22, 249-51; TT. Vol. XIII at 40). And after one patient died, the Defendant commented "[s]he was probably selling her prescriptions for illegal drugs" (TT. Vol. VIII at 181).

The Defendant and his brother were armed with a shotgun and a pistol while at the office, ostensibly as a protection against robbery (TT. Vol. V at 12-16, TT. Vol. XII at 216-18 and Vol. XVI at 193-94). The Defendant also accepted firearms and personal property in trade for prescriptions (TT. Vol. V at 16-18, TT. Vol. VIII at 43, 49-51, 90, 173-75 and Vol. XVI at 193-94). Thus, it was reasonable for the jury to infer that the Defendant was aware that his clientele consisted of addicts and drug dealers who paid exorbitant fees to acquire the Defendant's product.

v. Requiring payments based on the quantity or dosage of the drug prescribed.

The Defendant's fee schedule was exclusively keyed to the kinds and quantities of drug he prescribed, rather than on the medical services he provided. *See Kahn,* 989 F.3d at

812-13. Prescriptions were escalated very quickly in dosage and pill amounts. And as the pill count increased, so did the prices (TT. Vol. V at 12-19, 81-82, 113-15, 139-41, 167-71; VII at 31-34, 103, 213-17, 221-22 (Muehlhausen and Thacker); TT. Vol. VIII at 42-43 (D. Drndarski); TT. Vol. IX at 86-89 (R. Moody); TT. Vol. XI at 32-35, 49-55 (D. Antelope); TT. Vol. XII at 211-16, 220-23, 241-42, 249-50 (A. Vargas); TT. Vol. XIII at 115-36; Trial Exhibits 2000-2022-A). And if a patient could not pay the going rate, the Defendant withheld their prescription or decreased the amount of pills prescribed commensurate with what was paid (TT. Vol. V at 210-14 (Beland); TT. Vol. VI at 89-91 (Beland); TT. Vol. XI at 143; TT. Vol. XII at 95-96). Intercepted calls between L. Kahn, the Defendant and customers verified this arrangement (TT. Vol. III at 169-77; TT. Vol. XI at 77-80) (Exhibits 1011-C, 1016-C, 1020-B, 1021-B, 1022-B, 1054-B).

Similarly, patients were encouraged to refer to him other customers with medical records that would support their need for pain pills. In return, the Defendant agreed to prescribe an oxycodone regimen to their referrals on a sliding fee schedule and to provide a discount to the referring patient as well (TT. Vol. V at 203; TT. Vol. VI at 167-69; TT. Vol. XI at 15-22, 28-31, 38-47; TT. Vol. VII at 199, 211; TT. Vol. V at 203; TT. Vol. VI at 167-69; TT. Vol. XI at 42-46, 54-64; TT. Vol. XIII at 196-205). The Defendant and his brother were overheard discussing patients re-selling pills and the street value of the drugs the Defendant prescribed (TT. Vol. VIII at 61, 181, and 185-89). Patients testified the Defendant confronted them about selling pills and would increase the cost of their prescription based on the street value of the pills (TT. Vol. V at 218-20; TT. Vol. VII at 46-47; TT. Vol. XI at 36-37; TT. Vol. XII at 220-22, 249-51; TT. Vol. XIII at 40). Some

patients also testified that the Defendant's rates seemed commensurate with the street value of the medication (TT. Vol. VIII at 61, 185-89; TT.Vol. XIII at 40, 249-51). Though the Defendant asserted his fees were for visits, he admitted he assessed a fee for each prescription written even if he did not personally see the patient. (TT. Vol. XVI at 75)

Moreover, despite the Defendant's insistance that his fees were for medical services, he admitted at trial that he required patients to fill out medical forms and to pay his fees for prescriptions to his brother or employees, even if he did not see them for a visit. The Defendant sometimes directed patients to meet his family members in parking lots or at a vape shop to receive their prescriptions (TT. Vol. V at 174-176; TT Vol. XV at 180-85, TT. Vol. XVI at 90-96, 132-35). And he also admitted that, on these occasions, his notes in his patient charts falsely indicated that he actually saw a patient in person, even when he didn't (TT. Vol. XVI at 75, 91-96, 132-35).

The Defendant's treatment of patients Jessica Burch and her boyfriend, Anthony Vargas, from 2013 through 2016 is illustrative of these practices. Regarding Burch, Dr. Shay opined that the Defendant engaged in the same pattern of prescribing high dose narcotics with minimal evaluation and inadequate monitoring with her, as with the rest of his patients. At one point, the Defendant moved both patients from monthly to bi-weekly appointments (thus doubling their medication dosages) without justification (TT. Vol. IV at 208-216 and Exhibit 7006). Then, he prescribed opioids, twice a month for five months, to Anthony Vargas, while he was incarcerated. During that time, the Defendant filled out fake medical forms and added a photocopy of Vargas' signature to pad Vargas' patient chart - creating the false illusion Vargas was seen in the office on every occasion. Likewise,

twice a month, the Defendant charged Jessica Burch $750 for her prescriptions and $750 for Vargas' prescriptions (again, while Vargas was incarcerated), clearly ignoring signs that Burch was abusing or diverting Vargas' medication (TT. Vol. XVI at 131-134). Incredulously, at trial, the Defendant maintained he was charging for office visits, not prescriptions (*Id*. at 133).

Additionally, the Defendant's medical files falsely indicated that he examined Burch at each office visit, including a visit that allegedly occurred while she was hospitalized following a cesarian section delivery (TT. Vol. IV at 209-210). For an entire year preceding her delivery, the Defendant's files indicated he performed a physical exam, including palpating her abdomen. Yet his patient files never indicated she was pregnant (*Id.* at 210-212). And the Defendant continued to prescribe her Xanax and opioids during her pregnancy (I*d*.), indicating either he did not examine her at all or he prescribed medication contraindicated during pregnancy. Both scenarios fall outside the usual course of medical practice. And the Defendant systematically raised the price of Burch and Vargas' prescriptions, in proportion with the number of drugs prescribed, from $750 to $1250 each, until Burch overdosed and died from the Defendant's prescriptions in 2015 (TT. Vol. XVI at 137). And yet he continued to raise Vargas' fee to $1650 and raised the amount of oxycodone Vargas received from 180, 30 milligram tablets to 240 tablets (twice monthly) (*Id.* at 138).

The Defendant's novel insistence that patients sign his "drug addiction statement" - which proclaimed that he was not a "drug dealer," that the patient was not an "addict[]," and that the patient would be liable to the Defendant for $100,000 in liquidated damages

in the event that a civil or criminal action was brought – likewise illustrates beyond any reasonable doubt that he *knew* he was a drug dealer and that his patients were addicted and/or diverting the controlled substances he prescribed (TT. Vol. XV at 127-28; TT. Vol. XVI at 198). *See also*, L. Kahn testimony (TT. Vol. XII at 108-10; TT. Vol. XIII at 18).

Also noteworthy is that, in August of 2016, the Defendant sold medication originally prescribed for his Arizona patients (the Drndarskis) to Paul Beland, a patient living in Massachusetts. On that occasion, L. Kahn (his wife/co-conspirator) paid to fill the Drndarskis' opioid prescriptions in Wyoming. Because the Drndarskis could not afford these pills, the Defendant decided to sell the pills. He thus called Paul Beland and offered to sell Beland the Drndarksis' oxycodone pills for $1200, to which Beland agreed (TT. Vol. XII at 83-89 and Vol. VI at 45-48). The Defendant accordingly tore the labels from the prescription bottles and packaged them for mailing. He thereafter had them mailed to Beland, who subsequently sold them (TT. Vol. VI at 46, Vol. XII at 83-89 and Exhibit 10047).

In sum, the evidence overwhelmingly demonstrated that the Defendant knowingly acted as a drug dealer, not as a medical professional, dispensing addictive drugs that endangered his patients simply to line his own pockets and not for any legitimate medical purpose. Thus, even if the district court had instructed the jury in conformance with what *Ruan* requires, there is no reasonable doubt but that it would still have found him guilty. That is especially so given that, in reaching its verdict at trial, the jury necessarily found that the Defendant made no effort whatsoever to conform his prescribing practices to the standards of his profession. *See, e.g.*, *United States* v. *Lane*, 474 U.S. 438, 450 (1986) ("In

the face of overwhelming evidence of guilt shown here, we are satisfied that the claimed error was harmless.").

CONCLUSION

Because the instructional error in the case was harmless beyond any reasonable doubt, this court should affirm the Defendant's convictions.

DATED this 25th day of October, 2022.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

As required by the Order (Doc. 010110718635) filed on August 1, 2022, I certify that this supplemental brief is proportionally spaced in Times New Roman font size 13 and is 20 pages. I relied on my word processor and Microsoft Word 2016 software to obtain the count.

I certify that the information on this form is true and correct to the best of my knowledge and belief formed after a reasonable inquiry.

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CERTIFICATE OF SERVICE

I hereby certify that on October 25, 2022, I electronically filed the foregoing **Supplemental Brief of Appellee** using the court's CM/ECF system, which will send notification of such filing to Defense Counsel, Beau Brindley.

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