No. 20-6296

IN THE SUPREME COURT OF THE UNITED STATES

DAVID LAGUE, PETITIONER

v.

UNITED STATES OF AMERICA

ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

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QUESTION PRESENTED

Whether the district court erred in admitting under Federal Rule of Evidence 404(b) practice-wide data of prescriptions issued for controlled substances in enormous quantities and in dangerous combinations as evidence of petitioner's intent to prescribe controlled substances outside the usual course of professional practice.

ADDITIONAL RELATED PROCEEDINGS

United States District Court (N.D. Cal.):

United States v. Lague, No. 4:17-cr-150 (Dec. 17, 2018)

United States Court of Appeals (9th Cir.):

United States v. Lague, No. 18-10500 (Aug. 20, 2020)

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-19a) is reported at 971 F.3d 1032. A separate opinion of the court of appeals is not published in the Federal Reporter but is reprinted at 817 Fed. Appx. 496. The oral decision of the district court (Pet. App. 27a-30a) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on August 20, 2020. The petition for a writ of certiorari was filed on November 5, 2020. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

Following a jury trial in the United States District Court for the Northern District of California, petitioner was convicted on 39 counts of unlawfully distributing controlled substances, in violation of 21 U.S.C. 841(a)(1), (b)(1)(C), and (b)(2). Judgment 1. The district court sentenced petitioner to 120 months of imprisonment, to be followed by three years of supervised release. Judgment 2-3. The court of appeals affirmed. Pet. App. 1a-19a.

1. Petitioner, a former physician's assistant licensed to prescribe controlled substances (including opioids), began working in a chronic pain-management medical practice in 2007. Pet. App. 4a. In 2014 or 2015, SL -- a drug addict and pill dealer who had twice been expelled from pain-management practices for abusing street drugs and selling prescribed medications -- became a patient of petitioner's practice after learning of its permissive approach to opioid prescriptions. Gov't C.A. Br. 7. In late 2016, in cooperation with the federal Drug Enforcement Administration (DEA), SL recorded his visits with petitioner. Id. at 8.

In the recordings, SL asked petitioner to double his current prescriptions for oxycodone and oxycontin so that he could sell the extra pills. C.A. E.R. 475-478; see Gov't C.A. Br. 8; see also C.A. E.R. 938-939. Petitioner agreed, instructed the patient how to avoid scrutiny while filling the prescriptions, and then falsified the patient's medical records to mask the reason for doubling the patient's prescription. Pet. App. 4a; C.A. E.R. 478.

Petitioner also falsified SL's records so that they would show he had monitored and confirmed SL's compliance with established opioid treatment protocols. Pet. App. 4a. In fact, medical evidence revealed that SL was not taking any of the opioid prescriptions himself. Ibid.

The DEA subsequently searched the clinic and seized over 100 patient files. Pet. App. 5a. The files, along with SL's recordings, provided the basis for a federal grand jury in the Northern District of California to indict petitioner on 39 counts of unlawfully distributing Schedule II and Schedule IV controlled substances to five former patients -- SL (the cooperator), DL, JF, KO, and MCM -- in violation of 21 U.S.C. 841(a)(1), (b)(1)(C), and (b)(2). Second Superseding Indictment 1-7; Pet. App. 5a. Petitioner was also charged with conspiring to commit health care fraud, in violation of 18 U.S.C. 1349, and with committing six substantive counts of health care fraud, in violation of 18 U.S.C. 1347. Second Superseding Indictment 7-10.

2. Before trial, the government moved in limine to admit evidence of petitioner's practice-wide prescription data under Federal Rule of Evidence 404(b). See C.A. E.R. 45-47 (describing the data). Rule 404(b) provides that while "[e]vidence of any other crime, wrong, or act is not admissible to prove a person's character in order to show that on a particular occasion the person acted in accordance with the character," such evidence may be admissible "for another purpose, such as proving motive, opportunity, intent,

preparation, plan, knowledge, identity, absence of mistake, or lack of accident." Fed. R. Evid. 404(b)(1)-(1).

The government explained that petitioner's data was sufficiently aberrational that it revealed a "deliberate practice of giving patients enormous quantities of powerful drugs" far "outside the normal [course of] medical practice." Id. at 48. The government further explained that the evidence tended to refute the notion that petitioner had no plan or intent to unlawfully distribute opioids, and instead simply "made a few bad judgments" or was "deceived by manipulative patients." Ibid. In response, petitioner acknowledged that the data may have been "aberrational, statistically speaking," but argued that the data were irrelevant to show intent absent any evidence that he intended to issue those prescriptions outside the usual course of professional conduct. Id. at 95.

In an oral ruling, the district court admitted the evidence as probative of petitioner's knowledge and intent. Pet. App. 27a-30a.

3. At trial, the government introduced the evidence gathered from the undercover investigation, along with additional details from patient files, pain-management standards issued by public health organizations, petitioner's own statements, patient testimony, and the practice-wide prescription data.

The government introduced evidence that, in 2009, the American Pain Society Guidelines recommended a ceiling of 200

milligrams of morphine equivalent (MME)[1] per day because no clinical data had been collected for doses above that threshold and such doses would be considered clinically unsound. C.A. E.R. 329-330, 634. And in 2016, the Centers for Disease Control and Prevention (CDC) recommended a ceiling of 90 MME. Id. at 634-639.

The government introduced records demonstrating that petitioner nevertheless had been prescribing patient DL 14 times the recommended ceiling for opioids, and continued to prescribe DL opioids after DL twice tested positive for cocaine. C.A. E.R. 650-655, 664-665. Records indicated that petitioner prescribed a different patient (JF) 90 oxycodone pills a day -- more than 50 times the CDC ceiling. Id. at 720. And he prescribed yet another patient (MCM) the daily equivalent of ten shots of fentanyl -- a drug that is FDA-approved only for patients with metastatic cancer, which MCM did not have. Id. at 686-689, 691-693, 1640-1641. MCM's fentanyl prescription was in combination with methadone, hydromorphone, and morphine sulfate, in an amount over 50 times the CDC ceiling. Id. at 694-695.

Medical standards introduced at trial also warned against prescribing or using certain controlled substances in combination.

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[1] The medical profession refers to "milligrams of morphine equivalent," or "MME," as a common measure by which to judge the strengths of prescriptions of different opioids. Pet. App. 5a; C.A. E.R. 46 n.1. Each opioid is assigned a conversion factor based on its potency relative to morphine. See ibid. Morphine's conversion factor is 1, and oxycodone's is 1.5, meaning that a single oxycodone 30 mg pill is equivalent to 45 mg of morphine. C.A. E.R. 46 n.1.

The government's expert testified that benzodiazepines are "almost never" necessary in pain practice, and that the risk of death and overdoses increases four-fold when they are combined with opioids. C.A. E.R. 793; see id. at 637-638; C.A. Supp. E.R. 92. He further explained that combining opioids, benzodiazepines, and muscle relaxants (a combination known as the "holy trinity") rarely, if ever, serves a legitimate medical purpose. C.A. E.R. 656, 686; see Pet. App. 5a-6a; see also C.A. E.R. 258. Meanwhile, petitioner acknowledged at trial that he prescribed a combination of opioids and benzodiazepine to DL, C.A. E.R. 1236-1238, and other records showed that he prescribed KO the "holy trinity" in amounts between four and seven times the CDC's recommended opioid ceiling, id. at 685-686, 829-831.

Petitioner's earlier statements, also introduced at trial, provided additional context for those practices. When interviewed by DEA agents, for example, petitioner had said he did not want to be a "policeman" with his patients and acknowledged that it was possible that he had falsified his patients' records. C.A. E.R. 1314; see id. at 1314-1315; see also Pet. App. 6a. And while testifying before the grand jury, petitioner had acknowledged that since about 2015 his office had been prescribing inappropriate levels of opioids and that it had become "obvious" to him that "drug-seeking" patients were targeting his practice. C.A. E.R. 942-943; see Pet. App. 6a.

Finally, the government introduced two years of petitioner's practice-wide prescription data, comparing petitioner's aggregate prescription levels with those of other opioid prescribers in California. Pet. App. 6a. The data, which covered more than 450 patients whose prescriptions were not included in the charged conduct, showed that petitioner's opioid prescriptions were among the highest of any California pain-management prescriber. Id. at 7a. One government expert, Robert Gibbons, identified petitioner as an "outlier," C.A. E.R. 418, among various pain-management specialists for (1) issuing more opioids, as measured by MME, than any other Medicare prescriber in California, id. at 406; (2) prescribing many more opioids than the top-prescribing pain-management specialists, anesthesiologists, and oncologists, id. at 410-412; and (3) prescribing an average MME to any given patient more than three times higher than that of the other top prescribers, id. at 415. Another expert, Paul Short, testified that petitioner had prescribed 1.4 million Schedule II pills in a single year, prescribed methadone and oxycodone in excess of the maximum recommended dosages by a wide margin, prescribed a combination of opioids and benzodiazepines to 32 percent of his patients, and prescribed the "holy trinity" to nine percent of his patients. C.A. E.R. 1085, 1088-1092; see Pet. App. 7a-8a. Short further explained that petitioner's prescriptions greatly exceeded the prescriptions of petitioner's own testifying expert on both an aggregate and per-patient basis. C.A. E.R. 1714-1718.

The jury found petitioner guilty on each of the unlawful distribution counts, but acquitted him on the conspiracy and health care fraud counts. Judgment 1. The district court sentenced petitioner to 120 months of imprisonment, to be followed by three years of supervised release. Judgment 2-3.

4. The court of appeals affirmed, rejecting petitioner's contention that the district court had erred in admitting petitioner's practice-wide prescription data. Pet. App. 1a-19a.

As most relevant here, the court of appeals reasoned that a district court may admit such other-act evidence under Federal Rule of Evidence 404(b) if (1) the evidence tends to prove a material fact other than the person's character; (2) the other acts are not "too remote in time"; (3) the evidence supports a finding that the defendant committed the other acts; and (4) "in certain cases," the acts are "similar to the offense charged." Id. at 10a. The court of appeals rejected petitioner's argument that the government in this case had failed to meet the first prong -- i.e., had failed to demonstrate that the practice-wide data were relevant to whether, in the charged prescriptions, petitioner intended to prescribe controlled substances without a legitimate medical purpose. Id. at 10a-11a.

The court of appeals observed that Rule 404(b) "is a rule of inclusion -- not exclusion." Pet. App. 14a (citation omitted). The court explained that, provided the government identifies an appropriate non-character basis for introducing other acts, "the

government need only lay a factual foundation from which a 'jury could reasonably conclude that [the defendant] committed the allegedly-similar bad acts,' and that he possessed the requisite intent in committing those bad acts." Ibid. (citation omitted; brackets in original). And the court found that, here, the "uncharged prescriptions of controlled substances in enormous quantities, and in dangerous combinations, support[ed] a reasonable inference that the underlying prescriptions were issued outside the usual course of professional practice and without a legitimate medical purpose." Id. at 15a.

The court of appeals observed that the Eleventh Circuit had similarly held in United States v. Merrill, 513 F.3d 1293 (2008), that a jury could "consider prescription data sets outside those specifically charged in the indictment to determine whether a physician has exceeded the 'legitimate bounds of medical practice.'" Pet. App. 12a (quoting Merrill, 513 F.3d at 1303). And while the court acknowledged that the Eighth Circuit in United States v. Jones, 570 F.2d 765 (1978), had concluded that the "quantity" of the physician defendant's other prescriptions "was not probative of whether the physician had 'acted unprofessionally'" "without specific evidence of the treatment of the patients underlying" uncharged prescriptions, Pet. App. 12a-13a (quoting Jones, 570 F.2d at 766), the court found the reasoning of the Eleventh Circuit more consistent with "the text and purpose of Rule 404(b)," id. at 14a. Accordingly, the court determined

that the district court had properly admitted the aggregate prescription data in this case under Rule 404(b). Id. at 15a.

The court of appeals then turned to Federal Rule of Evidence 403, under which a trial court may exclude evidence "if its probative value is substantially outweighed by a danger of," inter alia, "unfair prejudice," Fed. R. Evid. 403. See Pet. App. 15a-19a. The court of appeals reasoned that, even assuming that the district court abused its discretion under that Rule by "failing to preview the underlying prescription data before admitting it into evidence," any error was harmless in light of "the overwhelming evidence of guilt against" petitioner separate and apart from the practice-wide prescription data. Pet. App. 15a-16a. The court of appeals observed that, although the aggregate prescription data were highlighted in the government's opening statement and closing argument, "the focus of the nearly two-week trial was on the charged prescriptions," including through patient files, testimony by one patient's father, a patient's former surgeon, and investigators. Id. at 16a. The court accordingly found the evidence before the jury of petitioner's "unlawful intent to distribute controlled substances without a legitimate medical purpose" to each of the charged patients to be "compelling," "even without the uncharged prescription data." Id. at 16a-17a & n.11. And the court "reject[ed] [petitioner's] characterization of the trial as one based on the credibility of two competing expert witnesses." Id. at 19a. Instead, because the "patient-specific

evidence overwhelmingly pointed to [petitioner's] guilt," the court determined that "any Rule 403 error in admitting the prescription data did not materially affect the jury's verdict." Ibid.

ARGUMENT

Petitioner renews his contention (Pet. 11-26) that the district court erred in admitting, under Federal Rule of Evidence 404(b), uncharged prescription data as evidence of his unlawful intent to prescribe controlled substances outside the usual course of professional practice, in violation of 21 U.S.C. 841. The court of appeals correctly declined to disturb the district court's evidentiary ruling, and its decision does not conflict with any decision of this Court or of another court of appeals. In any event, this case would be a poor vehicle for addressing the question presented, because deciding that question in petitioner's favor would not change the outcome here, in light of the court of appeals' unchallenged harmlessness analysis under Rule 403.

1. Under Rule 404(b), "[e]vidence of any other crime, wrong, or act is not admissible to prove a person's character in order to show that on a particular occasion the person acted in accordance with the character." Fed. R. Evid. 404(b)(1). Such evidence may be admissible, however, "for another purpose, such as proving motive, opportunity, intent, preparation, plan, knowledge, identity, absence of mistake, or lack of accident." Fed. R. Evid. 404(b)(2). And this Court has recognized that such evidence in

fact "may be critical to the establishment of the truth as to a disputed issue, especially when that issue involves the actor's state of mind and the only means of ascertaining that mental state is by drawing inferences from conduct." Huddleston v. United States, 485 U.S. 681, 685 (1988). Accordingly, such evidence may be admitted if it is relevant to a proper, non-propensity purpose, Fed. R. Evid. 401-402; its probative value is not "substantially outweighed" by the potential for undue prejudice, Fed. R. Evid. 403; and, upon request, the district court instructs the jury that it may consider it only for the non-propensity purposes for which it was admitted. See Huddleston, 485 U.S. at 691-692.

The court of appeals correctly applied those principles to the district court's determination to admit petitioner's aggregate prescription data as evidence of petitioner's unlawful intent for the charged prescriptions. To establish a violation of 21 U.S.C. 841 under the court of appeals' precedents, the government had to prove that: (1) petitioner knowingly distributed a controlled substance by writing a prescription for it (2) outside the usual course of professional practice without a legitimate medical purpose and (3) with the intent to issue the prescription outside the usual course of professional practice. See United States v. Feingold, 454 F.3d 1001, 1008 (9th Cir.), cert. denied, 549 U.S. 1067 (2006). The aggregate data concerning petitioner's practice-wide prescriptions showed that petitioner prescribed enormous quantities of highly addictive and dangerous opioids, C.A. E.R.

406-415, far in excess of all recommended dosage ceilings and other similarly-situated specialists, id. at 1085-1091, and in dangerous combinations that multiplied his patients' risk of overdose death, id. at 1091. That data reinforced the inference that petitioner regularly wrote prescriptions with the intent to distribute drugs to addicts and diverters, and not for any legitimate medical purpose, undercutting the theory that any improper prescriptions reflected "a few bad judgments" or "manipulative patients." Id. at 48; see 1 John Henry Wigmore, A Treatise on the System of Evidence in Trials at Common Law § 302, at 390 (1904) ("[T]he doctrine of chances" describes the "logical process which eliminates the element of innocent intent by multiplying instances of the same result until it is perceived that this element cannot explain them all."). Rule 404(b) provides no barrier to the government's introduction of such evidence for that non-propensity purpose.

Contrary to petitioner's contention (Pet. 22-25), the court of appeals' decision does not conflict with this Court's decision in Huddleston. In that case, the Court reasoned that "similar act evidence is relevant only if the jury can reasonably conclude that the act occurred and that the defendant was the actor." Huddleston, 485 U.S. at 689. On that basis, petitioner argues (Pet. 23) that the aggregate prescription data were relevant here only if the government introduced sufficient evidence to permit the jury to find that the uncharged prescriptions were issued with

an unlawful intent. And he asserts (Pet. 23-25) that the government failed to make that showing.

The court of appeals, however, agreed that the aggregate data were relevant only if government established "factual foundation from which a 'jury could reasonably conclude that [petitioner] committed the allegedly-similar bad acts,' and that he possessed the requisite intent in committing those bad acts." Pet. App. 14a (citing Huddleston, 485 U.S. at 685). And it found that the evidence introduced at trial did "support a reasonable inference that the underlying prescriptions were issued outside the usual course of professional practice and without a legitimate medical purpose." Id. at 15a. Petitioner disputes (Pet. 23-25) that finding. But this Court ordinarily does not grant review of such factbound determinations of the lower courts. See Sup. Ct. R. 10 ("A petition for a writ of certiorari is rarely granted when the asserted error consists of erroneous factual findings or the misapplication of a properly stated rule of law."); United States v. Johnston, 268 U.S. 220, 227 (1925) ("We do not grant a certiorari to review evidence and discuss specific facts.").

In any event, the court of appeals correctly assessed the reasonable inferences available to the jury from this record. As the Court explained in Huddleston, in "assessing the sufficiency of the evidence" for establishing relevance of other-acts evidence, "the trial court must consider all evidence presented to the jury." 485 U.S. at 690-691. Thus, contrary to petitioner's

contention (Pet. 23-25), the court of appeals' consideration was not limited to petitioner's status as a "top prescriber" or merely "data disparities and trends." Rather, the universe of evidence relevant to the inquiry included pain-management standards establishing MME ceilings that should rarely, if ever, be exceeded, but which the aggregate data showed petitioner routinely exceeding. It also included medical standards restricting the type of opioids that should be prescribed in combination, which the aggregate data demonstrated petitioner routinely prescribing. And it included petitioner's own grand-jury testimony admitting that the level of opioids prescribed by his office beginning in 2015 was not appropriate. C.A. E.R. 942-943.

It was against that backdrop, and not merely petitioner's raw prescription numbers, from which the court below determined petitioner's uncharged prescriptions were issued "in enormous quantities, and in dangerous combinations," such that a jury could reasonably infer they were issued "outside the usual course of professional practice and without a legitimate medical purpose." Pet. App. 15a. That determination was consistent with Huddleston and the correct one on this record.

2. Petitioner also errs in contending that the court of appeals' decision conflicts with decisions of the Eighth and Tenth Circuits. See Pet. 11-18 (citing United States v. Jones, 570 F.2d 765 (8th Cir. 1978), and United States v. MacKay, 715 F.3d 807 (10th Cir. 2013), cert. denied, 571 U.S. 1196 (2014)). Neither

decision suggests that either of those courts would have resolved this case differently than the court below.[2]

In Jones, the Eighth Circuit considered whether evidence that the defendant physician's prescriptions for Schedule II drugs accounted for nearly 50 percent of a pharmacy chain's total volume of Schedule II prescriptions in a roughly two-year period, and that some of the patients were otherwise known to local police as drug addicts, was admissible under Rule 404(b) to prove the defendant's intent to act outside the bounds of professional practice in issuing the two prescriptions charged in that case. 570 F.2d at 766-768. The court concluded that the evidence was not admissible, where the government had not presented evidence from which a jury could reasonably infer that the uncharged prescriptions had been issued for an improper purpose. Id. at 768. The court explained that, in that case, the government "did not introduce any evidence concerning the doctor-patient relationship existing with respect to these prescriptions" or any "other proof that the prescriptions had not been issued for a proper medical purpose." Ibid. (emphasis added). Without such contextual evidence, the court held that the uncharged prescription data, standing alone, were not relevant to show unlawful intent for the charged prescriptions. Ibid.

[2] Nor does the dissent from the Sixth Circuit's unpublished decision in a tax-fraud case suggest that this case would have come out any differently in that circuit. Cf. Pet. 18-20 (citing United States v. Charles, 702 Fed. Appx. 288 (6th Cir. 2017)).

As explained above, the same cannot be said of the record here. Independent of the aggregate prescription data, the government introduced pain-management standards identifying maximum recommended doses for prescription opioids, C.A. E.R. 330-333, 634-639, and restrictions on the types of opioids that can be prescribed in combination, C.A. Supp. E.R. 92. In light of that evidence, petitioner's practice-wide prescription data revealed, among other things, that petitioner's methadone and oxycodone prescriptions generally exceeded the relevant maximum dosages by a wide margin, C.A. E.R. 1088-1091; a dangerous combination of opioids and benzodiazepines were prescribed to 32 percent of patients, id. at 1091; and the even more dangerous "holy trinity" was prescribed to nine percent of patients, id. at 1091-1092.

That additional evidence added meaningful context to the uncharged prescription data and makes this case more analogous to the Eighth Circuit's subsequent decision in United States v. Katz, 445 F.3d 1023, cert. denied, 549 U.S. 945 (2006). There, as in Jones and as here, the government introduced evidence of numerous uncharged prescriptions under Rule 404(b) as evidence of the defendant's intent to prescribe controlled substances outside of the normal course of professional practice and without a legitimate medical purpose. Id. at 1029. But in Katz, as here -- but not in Jones -- the government offered additional evidence that, considered together, permitted the jury to make a reasonable inference that the uncharged prescriptions were similarly made

with unlawful intent. See id. at 1027, 1029-1030 (describing testimony by one of the recipients of the uncharged prescriptions suggesting that the defendant "did not have a legitimate medical purpose in writing them"). Unlike in Jones, the Eighth Circuit affirmed the district court's evidentiary ruling in Katz. Id. at 1029. Thus, although the Ninth Circuit identified no difference between this case and Jones, see Pet. App. 13a-14a, the Eighth Circuit's decision in Katz -- if not Jones itself -- suggests that the Eighth Circuit could. There is no reason to conclude that the Eighth Circuit would necessarily find an abuse of discretion on the record here.

Petitioner's reliance (Pet. 15-16) on the Tenth Circuit's decision in MacKay is also misplaced. In MacKay, the Tenth Circuit affirmed the district court's admission of evidence showing that the defendant was for many years among his State's "top ten issuers of hydrocodone and oxycodone prescriptions" as relevant to whether the defendant intentionally issued certain charged prescriptions during that period outside the usual course of medical practice or without a legitimate medical purpose. 715 F.3d at 814; see id. at 838-840. The court explained that the government "had to prove [that the defendant] stepped outside his role as a doctor and became a criminal drug pusher" and that the "charts certainly painted a picture of [his] practice as a pain management physician." Id. at 839.

The Tenth Circuit analyzed the relevance of the aggregate prescription data in MacKay only for the purpose of engaging in Rule 403 balancing, because the defendant "did not object based on Rule 404(b)" in the district court "and likewise did not raise the issue on appeal." 715 F.3d at 841. And the Tenth Circuit's conclusion that the district court did not abuse its discretion under Rule 403 -- which itself includes a consideration of probativeness -- provides no sound basis for supposing that the Tenth Circuit would have found the evidence here irrelevant. Moreover, while the Tenth Circuit agreed, in dicta, with the Eighth Circuit's Rule 403 balancing of that relevance against any unfair prejudice in Jones, see id. at 841, no Rule 403 balancing question is before this Court. The court of appeals below did not directly pass on the district court's Rule 403 balancing, see Pet. App. 15a-16a & n.9, and petitioner has presented only a Rule 404(b) question in this Court, see Pet. i.

3. Finally, even if a shallow circuit conflict existed, the court of appeals' harmlessness analysis demonstrates that this case would be a poor vehicle in which to address it. After rejecting petitioner's Rule 404(b) argument, the court below determined that, even assuming that the district court abused its discretion under Rule 403 by failing to preview the underlying prescriptions before admitting the aggregate data, any error in admitting the aggregate data was harmless. Pet. App. 19a.

The court of appeals found that the "patient-specific evidence overwhelmingly pointed to [petitioner's] guilt." Pet. App. 19a (emphasis added). As the court explained, the jury "had access to the patients' medical charts" underlying the charged prescriptions, "showing continued 'red flags.'" Id. at 17a. It heard testimony from "one patient's father, a patient's former surgeon, and investigators." Id. at 16a. "[M]ost importantly," the jury had before it "the prescriptions for the charged patients that showed copious prescribed controlled substances." Id. at 17a.

The court of appeals thus correctly determined that "any Rule 403 error in admitting the [aggregate] prescription data did not materially affect the jury's verdict." Pet. App. 19a. While the aggregate prescription data were presented to the jury and "highlighted" in the government's opening and closing statement, "the focus of the nearly two-week trial was on the charged prescriptions." Id. at 16a. And in a separate, unpublished decision concerning the case, the court properly noted that, even considering additional purported evidentiary errors cumulatively, those errors were harmless because of the "overwhelming patient-specific evidence of [petitioner's] guilt." 817 Fed. Appx. at 496, 497 (emphasis added). For the same reasons, even if this Court were to adopt petitioner's application of Rule 404(b) to the record in this case, any error would be harmless and provide no basis to disturb the court of appeals' judgment affirming petitioner's conviction.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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