

BEFORE THE DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING  
OF THE DEPARTMENT OF COMMERCE  
OF THE STATE OF UTAH

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IN THE MATTER OF THE LICENSES OF	:	FINDINGS OF FACT
LAYFE ROBERT ANTHONY, MD	:	CONCLUSIONS OF LAW
TO PRACTICE AS A PHYSICIAN/SURGEON	:	AND RECOMMENDED ORDER
AND TO ADMINISTER AND PRESCRIBE	:	
CONTROLLED SUBSTANCES	:	Case No.
IN THE STATE OF UTAH	:	DOPL-OSC-2001-70
	:	

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**Appearances :**

Judith A. Jensen for the Division of Occupational and  
Professional Licensing  
Carrie L. Towner for Respondent

**BY THE PANEL:**

Pursuant to a November 17, 2008 notice, a November 24-25, 2008 hearing was conducted in the above-entitled proceeding before J. Steven Eklund, Administrative Law Judge for the Department of Commerce, and a three member Panel (Kathy Berg, Kevin Olsen and Keith Woodwell). The November 17, 2008 notice recites that Ms. Berg, Mr. Olsen and Mr. Woodwell were designated by F. David Stanley (Director of the Division of Occupational and Professional Licensing) to act as a substitute presiding officer for the Physicians Licensing Board in this proceeding.

The Panel was thus designated as the fact finder in this proceeding and to discharge the duties which would have been otherwise performed by the Physicians Licensing Board. A

substitute presiding officer was designated because a quorum of the Physicians Licensing Board would not be available for the extended hearing in this proceeding. The November 24-25, 2008 hearing was thus conducted, whereby evidence was taken and argument presented as to whether Respondent's licenses should be subject to disciplinary action.

At the conclusion of the November 24-25, 2008 hearing, the Panel took the case under advisement and thereafter conducted its deliberations. The Panel now enters its Findings of Fact, Conclusions of Law and submits the following Recommended Order for review and action by the Division:

**FINDINGS OF FACT**

1. Respondent is, and at all time relevant to this proceeding has been, licensed to practice as a physician and surgeon and to administer and prescribe controlled substances in this state. Respondent was initially so licensed on September 13, 1994.

2. Pursuant to an April 3, 2001 Emergency Order, Respondent's license to administer and prescribe controlled substances in this state was suspended. Pursuant to that same Order, Respondent's license to practice as a physician and surgeon in this state was restricted. That license was then suspended pursuant to an August 31, 2001 Emergency Order.

3. Pursuant to an August 26, 2003 Order, the suspension of Respondent's license to practice as a physician and surgeon in

this state was terminated and that license was placed on probation for five (5) years, subject to various terms and conditions. Pursuant to that Order, the suspension of Respondent's license to administer and prescribe controlled substances in this state was partially terminated and that license was placed on probation for five (5) years, also subject to various terms and conditions.

4. The August 26, 2003 Order was based on a stipulation between the Division and Respondent. Respondent thus acknowledged he performed medical procedures and/or provided patient care for five (5) patients between July 1997 and August 2001 in a manner evidencing a lack of professional competence such that professional re-education is required.

5. Sparring extended detail, Respondent pled no contest to Negligent Homicide, a Class A misdemeanor, on or about February 4, 2002 with regard to treatment which he provided a patient on or about November 1999. Respondent also acknowledged he performed three (3) incomplete procedures on patients on or about 1997 or 1998 and he had thus failed to report his knowledge of that fact to those patients.

6. Respondent further acknowledged he provided medical treatment to one (1) patient on or about July 2001 beyond the terms of the April 3, 2001 Emergency Order. Respondent acknowledged all of the just-stated conduct constitutes

unprofessional conduct and provides a basis to enter a disciplinary sanction as to his licenses.

7. The August 26, 2003 Order sets forth various restrictions governing Respondent's medical practice and his issuance of controlled substance prescriptions. That Order specifically provides Respondent was to issue all controlled substance prescriptions in sequentially-numbered triplicate form and submit a copy of those prescriptions to the Division every thirty (30) days for its verification and review. Moreover, the Order provides Respondent was to refrain from engaging in further acts of unprofessional and/or unlawful conduct.

8. Respondent submitted a June 3, 2003 request to the Nevada State Board of Medical Examiners to renew his license to practice medicine in that state. The renewal application included an inquiry whether Respondent ever had "a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country, or U.S. territory". Respondent replied "no" to that inquiry. He thus failed to disclose the prior entry of the April 3, 2001 Emergency Order and the August 31, 2001 Emergency Order, whereby disciplinary action had been taken as to his Utah licenses.

9. Pursuant to a September 15, 2006 Consent Agreement (Case No. 05-11193-1), the Nevada State Board of Medical Examiners took disciplinary action as to Respondent's Nevada license to practice medicine. Specifically, the Nevada Board

suspended that license for twelve (12) months, a stay of the suspension was entered and Respondent's license was placed on probation.

10. The September 15, 2006 Consent Agreement was entered pursuant to a settlement. Respondent thus admitted the disciplinary action in that proceeding was based on his failure to have provided timely notice to the Nevada State Board of Medical Examiners in 2001 that: (1) his privileges to practice medicine in Utah were initially restricted on April 3, 2001; (2) those privileges were then suspended on August 31, 2001; and (3) his privilege to prescribe controlled substances had also been suspended.

11. The Nevada Board also noted Respondent's Utah licenses were placed on probation subject to various terms and conditions as of August 26, 2003. The Nevada Board acknowledged Respondent failed to disclose the various disciplinary actions taken against his Utah licenses when he applied for renewal of his Nevada license to practice medicine on June 3, 2003.

12. Commencing September 2005, Respondent was employed as the acting physician at the Hensley Family Medical Center in West Jordan, Utah. Based on the sufficient and credible evidence presented, Respondent informed investigators for the Drug Enforcement Administration on February 22, 2007 that he (Respondent) had recently changed the location of his medical office from the Hensley Family Medical Center to an office

located across the street from St. Mark's Hospital in Salt Lake City, Utah. Respondent issued various prescriptions subsequent to February 22, 2007. Those prescriptions were issued on forms which recited that Respondent's address was the Hensley Family Medical Center.

13. Respondent contacted a pharmacy by telephone on June 11, 2007 to authorize a refill on a prescription for a patient (referred to herein as L.J.). Respondent thus authorized the refill for testosterone, a Schedule III controlled substance. Respondent failed to submit a triplicate copy of the prescription for that controlled substance to the Division for verification and review of that prescriptive practice by the Division.

14. Based on the more substantial and credible evidence, and the reasonable inferences drawn therefrom, Respondent had his first contact with an individual (referred to herein as A.S.) through an online dating service in mid May 2006. Respondent and A.S. then met for dinner on May 30, 2006.

15. There is a lack of sufficient and credible evidence that Respondent and A.S. engaged in sexual intercourse at any time. Based on the substantial evidence and the reasonable inferences drawn therefrom, Respondent and A.S. engaged in some sexually oriented contact of an intimate nature on at least one occasion within ten (10) days from May 30, 2006.

16. Based on the more substantial and credible evidence, a romantic relationship developed between Respondent and A.S.

between late May 2006 and mid June 2006. However, Respondent and A.S. came to the understanding in mid June 2006 that they would have no ongoing romantic relationship. Respondent and A.S. maintained a dating relationship until early August 2006 and they remained very good friends through December 2006.

17. Respondent was a preceptee associated with Dr. Fred Civish in June 2006. Respondent was present in that capacity at Dr. Civish's office on June 5, 2006 during a clinical appointment between Dr. Civish and A.S. Based on Respondent's admission, he and A.S. were involved in a romantic and sexually oriented relationship on or about that time.

18. Respondent subsequently provided clinical services to A.S. on August 9, 2006, October 23, 2006, November 2, 2006, November 29, 2006 and January 3, 2007. Respondent provided a complete physical examination for A.S. on November 2, 2006. He also performed minor shoulder surgery on A.S. to treat her fibrosis. This record does not reflect the date of that surgical procedure.

19. Respondent issued prescriptions for A.S. on July 5, 2006, August 6, 2006, August 9, 2006, August 29, 2006, September 1, 2006, November 8, 2006 and November 29, 2006. Many of those prescriptions were for controlled substances previously prescribed for A.S. by a Dr. Dye.

20. Respondent issued a prescription for Omnicef to A.S. on August 29, 2006 for her son. This record does not reflect

whether that prescription was filled. Respondent treated A.S.'s son on 6-8 occasions. Respondent did not document his assessment, diagnosis or the medical services which he thus provided.

21. Based on the substantial and credible evidence, and the reasonable inferences drawn therefrom, Respondent treated A.S.'s son between August 2006 and December 2006. Respondent issued continuing refills on prescriptions to treat the child's asthmatic condition. Respondent issued a prescription to treat the child's ear infection and he also administered two (2) steroid injections to A.S.'s son.

22. A.S. contacted Respondent on one (1) occasion at night when her son was upset and unable to sleep. A.S. inquired of Respondent what she could do and the latter asked A.S. what she had available. A.S. informed Respondent that she had a prescription for Klonopin, which had been previously prescribed for her. A.S. also informed Respondent as to the dosage of that medication, which is a Schedule IV controlled substance.

23. Based on the child's weight, Respondent informed A.S. that she could administer a portion of that medication to her son. Respondent did not make or otherwise maintain any clinical records to document services which he provided for A.S.'s son on that occasion.

24. Based on the more credible and substantial evidence, and the reasons inferences drawn therefrom, Respondent, A.S. and

their respective children periodically socialized in group settings during the Fall and early Winter of 2006. A.S. and, at times, her son accompanied Respondent to his parent's house during the holiday season. Both Respondent and A.S. engaged in various social activities during December 2006.

25. A.S. sold her residence and Respondent assisted A.S. with her move from that residence in mid December 2006. Both A.S. and her son became sick sometime in mid December 2006. A.S. thus inquired of Respondent if she and her son could stay with him at his home for a few days.

26. When Respondent agreed, both A.S. and her son, who was 4 1/2 years old at the time, resided with Respondent for approximately six (6) days. There is a lack of sufficient and credible evidence to find Respondent and A.S. slept together or engaged in any intimate relationship or sexual contact during that time.

27. Respondent was involved in an automobile accident on August 4, 2006. Police officers who responded to the accident conducted a search of Respondent's vehicle and located various medications, which included several hundred loose pills, several vials of injectable controlled substances, medical supplies, syringes and 41 prescription pads which contained multiple blank prescriptions that had been presigned by other physicians.

28. The medications found in Respondent's vehicle included controlled substances, legend drugs and over-the-counter

medications. Versed and Provigil, both Schedule IV controlled substances, were found in Respondent's vehicle.

29. There were more than 1,000 pills and capsules of approximately fifty (50) brands and/or concentrations of legend drugs and over-the-counter medications found in Respondent's vehicle. Those medications had been removed from manufacturer packaging and stored loosely together in various plastic boxes and a cloth bag. The medications were not labeled as to identify the names of the medications, their lot numbers or expiration dates.

30. The medications found in Respondent's vehicle also included ointments and more than ten (10) vials of injectable medications. All of those vials contained medications which had passed their date of expiration. Various vials had been opened and were not labeled to document when those vials had been opened.

31. The medications in Respondent's vehicle also included Grepafloxacin. That legend drug had been voluntarily withdrawn from the market in October 1999 based on a manufacturer's recall due to reported associations of the drug with QTc prolongation and adverse cardiovascular events.

32. Based on Respondent's admission, the medications found in his vehicle were drug samples and he had dispensed some of those medications to patients in his medical practice. Based on Respondent's admission, he could identify and then select

medications from those stored in his vehicle, he would place the medication in a bottle and then prepare and affix a written label to the bottle which included the patient's name and the name and dosage of the medication.

33. Respondent obtained the medications which he stored in his vehicle as samples during the course of his medical practice. Based on Respondent's admission, he kept those medications in his vehicle because he believed that was a more secure place to store the medications than in his office. Based on Respondent's admission, he did not maintain an inventory of the sample medications. Respondent has never been licensed to practice pharmacy in Utah.

34. Respondent admits the prescription pads found in his vehicle had been presigned by four other physicians and given to him for use at the Hensley Family Medical Center where he had been previously affiliated. Respondent admits the office manager of that Center had instructed him to issue the presigned prescriptions only to patients of the physician who had signed the prescriptions.

#### **CONCLUSIONS OF LAW**

The Division contends Respondent engaged in unprofessional conduct when he stored controlled substances, legend drugs and blank presigned prescriptions in his personal vehicle, he failed to dispose or maintain appropriate control over expired

medications and he failed to properly return, dispose of and/or maintain appropriate control over recalled medication.

The Division also contends Respondent engaged in unprofessional conduct when he stored various medications and presigned prescription forms in his personal vehicle, yet failed to maintain appropriate control over those items as to protect against diversion and/or theft.

The Division asserts Respondent engaged in unprofessional conduct when he removed sample medications from their original manufacturer packaging and loosely stored those medications in his personal vehicle without labels or proper documentation to identify the medication, their lot number or expiration date. The Division also asserts Respondent engaged in unprofessional conduct when he stored multiple vials of injectable medications in his personal vehicle when those vials had been opened and not labeled to identify the date of opening.

The Division contends Respondent engaged in unprofessional conduct when he failed to protect the sterility and the temperature of the medications which he stored in his personal vehicle as to ensure the safety and potency of those medications. The Division also contends Respondent engaged in unprofessional conduct when he dispensed those medications stored in his personal vehicle to patients of his medical practice.

The Division asserts Respondent engaged in unlawful conduct when he dispensed the medications in question to his patients,

placed those medications in bottles and labeled the bottles to identify the patient name, the name and dosage of the medication. The Division urges Respondent thus engaged in the unlawful practice of pharmacy.

The Division next contends Respondent maintained a continuing physician/patient relationship with A.S. and her child at times that he also engaged in a dating and intimate relationship with A.S. and later permitted both her and her child to share his personal residence. The Division urges Respondent's conduct violated generally accepted professional and/or ethical standards and he was thus engaged in unprofessional conduct.

The Division also asserts Respondent engaged in unprofessional conduct when he advised A.S. to administer Klonopin to her son when that medication had been initially prescribed for A.S. Moreover, the Division urges Respondent engaged in unprofessional conduct when he failed to make and/or maintain clinical records to document the medical services which he provided to A.S.'s son.

The Division next contends Respondent engaged in unprofessional conduct when he issued prescriptions on forms which falsely reflected his address as that of the Hensley Family Medical Center. The Division also contends Respondent violated the August 26, 2003 Order and he was engaged in unprofessional conduct when he failed to submit a triplicate copy of the testosterone prescription which he had issued to L.J.

The Division next asserts Respondent engaged in unprofessional conduct when, based on his failure to have disclosed disciplinary actions taken in this state to Nevada licensing authorities, Respondent's license to practice medicine in Nevada was thus subject to disciplinary action. The Division also urges Respondent engaged in unprofessional conduct in various instances violative of the August 26, 2003 Order.

The Division generally contends Respondent has failed to practice medicine in a minimally competent manner in various respects and his misconduct reflects a repeated lack of good judgment. The Division asserts Respondent's licenses to practice medicine and to administer and prescribe controlled substances in this state should be subject to further disciplinary action as to adequately protect the health, safety and welfare of the public. The Division also contends Respondent should be fined for his various acts of unprofessional and unlawful conduct and the amount of those fines should be based on due consideration of the nature and seriousness of Respondent's misconduct.

Respondent acknowledges he did not maintain the sample medications in his vehicle in appropriate packaging and he should not have removed the sample medications from his office. Respondent also admits he improperly dispensed those medications when he repackaged and labeled containers for those medications with the patient's name, the medication in question and its

dosage. Respondent also acknowledges his use of the presigned prescriptions.

However, Respondent contends he did not know it was improper to remove the sample medications from their original packaging. Respondent suggests he did so to simply make it easier to dispense those medications to impoverished patients and he has not since used any sample medications.

Respondent also contends he was merely mistaken when he failed to disclose the disciplinary action taken as to his Utah licenses when he applied to renew his Nevada medical license. Respondent urges that nondisclosure was not made with any intent to mislead or intentionally deceive the Nevada licensing authorities.

Respondent also asserts there are no allegations that the medical care he provided to either A.S. or her son was not warranted. Respondent pointedly contends he did not engage in any sexual misconduct with A.S..

Respondent contends there was no actual harm due to any of his conduct. Respondent urges there is no basis to revoke or suspend either his Utah medical license or controlled substance license. Alternatively, Respondent urges that any action on those licenses in this proceeding should be rational and reasonable.

Utah Code Ann. §58-1-401(2) provides the Division may revoke, suspend, restrict, place on probation, issue a public or

private reprimand to, or otherwise act upon the license of any licensee in any of the following cases:

- (a) the . . . licensee has engaged in unprofessional conduct, as defined by statute or rule under this title . . .;
- (b) the . . . licensee has engaged in unlawful conduct as defined by statute under this title.

§58-1-501(2) generally defines unprofessional conduct to include:

- (a) violating . . . any statute, rule, or order regulating an occupation or profession under this title;
- (b) violating . . . any generally accepted professional or ethical standard applicable to an occupation or profession regulated under this title;
- (c) . . . . .
- (d) engaging in conduct that results in disciplinary action . . . by any other licensing or regulatory authority having jurisdiction over the licensee . . . if the conduct would, in this state, constitute grounds for . . . disciplinary proceedings under Section 58-1-401;
- (e) . . . . .
- (f) . . . . .
- (g) practicing . . . an occupation or profession regulated under this title through gross incompetence, gross negligence, or a pattern of incompetency or negligence.

Based on the substantial evidence and the reasonable inferences drawn therefrom, including the expert testimony presented during the hearing, the Panel readily finds and concludes Respondent violated a generally accepted professional standard and he was grossly negligent when he elected to maintain the various controlled substances, legend drugs and over-the-counter medications in his vehicle. Any prudent practitioner

would readily appreciate that storing such medications in that manner would not be generally effective against diversion and/or theft.

The Panel discounts Respondent's urgence it was appropriate to store the various medications in his personal vehicle because Respondent believed those items would be subject to diversion and/or theft by an individual having access to them in Respondent's office. Even were Respondent's belief well founded, it was nevertheless wholly inappropriate for him to store the medications in his personal vehicle where they could then be subject to theft or diversion in multiple ways by various individuals.

§58-37-6(4)(a) of the Utah Controlled Substances Act provides a controlled substance license may be placed on probation, suspended or revoked if the licensee has:

(vi) violated any division rule that reflects adversely on the licensee's reliability and integrity with respect to controlled substances.

R156-37-502 further defines unprofessional conduct to include:

(4) failing to maintain controls over controlled substances which would be considered by a prudent practitioner to be effective against diversion, theft or shortage of controlled substances.

The Panel finds and concludes Respondent's unprofessional conduct violative of that rule reflects adversely on his reliability and integrity as to controlled substances.

§58-17b-102(56) defines the practice of pharmacy to include:

- (c) compounding, packaging, labeling, dispensing, administering, and the coincident distribution of prescription drugs or devices  
. . . .

§58-17b-301(1) provides a license is generally required to engage in the practice of pharmacy. §58-17b-501 defines unlawful conduct to include:

- (7) filling [or] refilling . . . prescriptions for any consumer or patient residing in this state if the person is not licensed:
  - (a) under this chapter, or
  - (b) in the state from which he is dispensing.

Based on the substantial evidence, the reasonable inferences drawn therefrom and the expert testimony presented during the hearing, the Panel readily finds and concludes Respondent engaged in the unlicensed practice of pharmacy - violative of §58-17b-301(1) - and further engaged in unlawful conduct when he filled prescriptions for patients as violative of §58-17b-501(7).

The Code of Medical Ethics of the American Medical Association, as revised in 2001, provides as follows:

I. A physician shall be dedicated to providing competent medical care, with compassion or respect for human dignity and rights.

II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

IV. A physician shall respect the rights of patients, colleagues, and other health professionals and shall safeguard patient confidences and privacy constraints of the law.

The Panel finds and concludes there is a lack of sufficient evidence to find Respondent violated any of the just-quoted principles as to the medical services he provided to A.S. and her son. The Panel duly notes Respondent failed to document all medical services which he provided to A.S.'s son. Moreover, the Panel acknowledges Respondent improperly advised A.S. to administer a medication to her son which had been prescribed for her.

The Panel does not question whether the above-quoted broad principles generally apply to all physicians. However, there is no sufficient evidence to find Respondent did not generally provide competent medical care, that he did not uphold the standards of professionalism or that he failed to respect the rights of A.S. or her son.

Opinion 8.14 of the Code of Medical Ethics of the American Medical Association, which addresses sexual misconduct in the practice of medicine, was adopted in December 1990 and updated in March 1992. That Opinion thus states as follows:

I. Sexual contact that occurs concurrent with the patient-physician relationship constitutes sexual misconduct. Sexual or romantic interactions between physicians and patients detract from the goals of the physician-patient relationship, may exploit the vulnerability of the patient, may obscure

the physician's objective judgment concerning the patient's health care and ultimately may be detrimental to the patient's well-being.

II. If a physician has reason to believe that non-sexual contact with a patient may be perceived as or may lead to sexual contact, then he or she should avoid the non-sexual contact. At a minimum, the physician's ethical duties include terminating the physician/patient relationship before initiating a dating, romantic, or sexual relationship with a patient.

. . . .

IV. Sexual or romantic relationships between a physician and a formal patient may be unduly influenced by the previous physician/patient relationship. Sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions or influence derived from the previous professional relationship.

The Panel readily finds and concludes a sexual and romantic relationship commenced between Respondent and A.S. shortly prior to or within a few days after Respondent was present in a professional setting when A.S. received care from Dr. Civish. A romantic relationship between A.S. and Respondent continued for a number of days thereafter and they maintained a dating relationship until early August 2006.

The relationship between Respondent and A.S. shifted from an initial dating relationship to one of a sexual and romantic nature, back to a dating relationship and then to a very good friendship as Respondent came to provide medical care for A.S. and her son on a more frequent basis between August 2006 and

December 2006. Based on the credible evidence and the reasonable inferences drawn therefrom, the Panel finds and concludes Respondent violated the ethical duties identified in Opinion 8.14(I).

The Panel finds and concludes Respondent engaged in unprofessional conduct violative of §58-1-501(2)(b) and (g) when he advised A.S. to administer medication to her son which had been prescribed for her. Moreover, Respondent engaged in negligent unprofessional conduct when he failed to make and/or maintain clinical records to properly document the medical services which he provided to A.S.'s son.

§58-37-6(7)(o) of the Utah Controlled Substances Act provides:

A person licensed under this chapter may not furnish false or fraudulent material information in any application, report, or other document required to be kept by this chapter or willfully make any false statement in any prescription, order, report or record required by this chapter.

The Panel finds and concludes Respondent violated that statute when he issued various prescriptions on forms which falsely identified his address as the Hensley Family Medical Center. Respondent thus engaged in unprofessional conduct violative of §58-1-501(2)(a).

The Panel finds and concludes Respondent violated the August 26, 2003 Order and he thus engaged in unprofessional conduct, as violative of §58-1-501(2)(a), when he failed to submit a

triplicate copy to the Division of the prescription which he issued to L.J. for testosterone.

The Panel finds and concludes Respondent engaged in unprofessional conduct violative of §58-1-501(2)(d) when his license to practice medicine in Nevada was subject to disciplinary action because he failed to inform the Nevada licensing authorities of prior disciplinary action taken on his Utah licenses. The same conduct which prompted disciplinary action in Nevada would also provide a proper factual and legal basis to take disciplinary action as to Respondent's licensure in this state.

With due regard for the expert testimony presented during the hearing, the Panel finds and concludes Respondent's misconduct as to: (1) his storage of various medications in his personal vehicle; (2) his dispensing practices regarding those medications; (3) his failure to maintain appropriate control over expired medications; and (4) his failure to properly dispose of or maintain control over a recalled medication collectively represents a serious failure to comply with fundamental standards governing his medical practice and the proper scope of his authority to administer and prescribe controlled substances.

Given the expert testimony presented during the hearing, the Panel finds and concludes Respondent's decision to remove the original packaging for medication samples and loosely store those medications in his personal vehicle without being properly

labeled, coupled with his failure to maintain due documentation to identify each medication, their lot number or expiration date, also reveals a substantial departure from standards governing his medical practice. Based on the inappropriate manner whereby Respondent stored those medications, which necessarily compromised the potency of those medications and the safety by which such medications could be used by any patient, the unwarranted nature of his misconduct is evident and should have been obvious to Respondent.

Respondent's decision to allow the course of his initial romantic relationship with A.S., which included sexual contact with her, to intersect with his professional relationship to both A.S. and her son reflects a serious and disturbing exercise of bad judgment. Simply put, Respondent's professional standing toward A.S. commenced while there was still a romantic and sexually charged relationship between them.

The Panel duly notes Respondent's relationship with A.S. shifted in nature during the following six months as the frequency of medical care which he provided to her and her son increased. Nevertheless, Respondent failed to exercise good judgment by either failing to terminate his personal and social contacts with A.S. as of June 5, 2006 or declining to provide any medical services for her or her son after that time.

Respondent failed to comply with the standards governing his practice when he advised A.S. to administer Klonopin to her son

when that medication had initially been prescribed for A.S. Respondent also failed to properly document the medical services he thus provided to A.S.'s son.

It appears Respondent acted out of expedience when he elected not to duly prescribe the medication in question directly for A.S.'s son. Respondent's failure to document any of the medical services he provided for A.S.'s son was unwarranted and represents a serious departure from proper medical practice.

Respondent's use of prescription forms bearing an inaccurate address was clearly dubious as an error of omission that could have been easily avoided. Respondent's failure to submit a triplicate copy of a prescription on one occasion reflects an obvious violation of the August 26, 2003 Order governing his controlled substance license.

Respondent also violated the August 26, 2003 Order when he engaged in unprofessional conduct due to his nondisclosures which lead to the entry of a disciplinary sanction by Nevada licensing authorities. Respondent failed to candidly disclose the fact of disciplinary action taken as to his Utah licenses when he sought renewal of his Nevada medical license. He compounded the nature of that nondisclosure when he failed to duly inform licensing authorities in this state of the disciplinary action which had been entered in Nevada.

Respondent's urgence that his nondisclosures were merely a mistake is not credible. Given the foreseeable adverse impact

that full disclosure of his license status may have had in both in Nevada and Utah, the Panel finds and concludes Respondent consciously chose to conceal those disciplinary actions. It was incumbent upon Respondent to continuously deal with licensing authorities in a completely honest and forthright manner.

Respondent's unprofessional and unlawful conduct collectively reveals repeated instances of negligent behavior. The Panel readily acknowledges there is no evidence that actual injury was caused by Respondent's misconduct. Nevertheless, the potential for injury is strikingly clear.

There are certain aggravating circumstances which should be considered as to the disciplinary sanction warranted in this proceeding. Respondent has been subject to prior disciplinary actions. He has engaged in multiple offenses and his misconduct reveals a pattern of negligence, coupled with inexplicably bad judgment in various degrees of severity.

Moreover, Respondent has been licensed to practice medicine and to administer and prescribe controlled substances for a substantial time. None of Respondent's unprofessional or unlawful conduct should be attributed to any lack of knowledge borne of inexperience. Some of Respondent's explanations as to his misconduct are largely self serving and essentially dubious.

There is one mitigating circumstance which should be noted. Respondent recognizes he acted inappropriately in certain respects as to the sample medications which he dispensed.

However, Respondent's limited acknowledgement of such misconduct pales in comparison to the fundamental concern that he used his private vehicle as a mobile office and pharmacy.

The Panel thus finds and concludes the aggravating circumstances in this case significantly outweigh the just stated mitigating factor. Given the nature of Respondent's unprofessional and unlawful conduct, and with particular regard for the serious departure from well recognized professional practice and ethical standards, the Panel finds and concludes an appropriately severe sanction should be entered in this proceeding.

Were Respondent's unprofessional or unlawful conduct confined to one or two of the less weighty matters set forth herein, it is arguable that appropriate probationary terms could sufficiently address those concerns. That would be particularly true if Respondent had not been subject to prior disciplinary action. However, Respondent's misconduct must be viewed in its entirety. Moreover, the prior disciplinary action taken as to Respondent's licenses should be duly considered.

Accordingly, the Panel is not convinced a proper basis exists to again place Respondent's licenses on probation or to enter a suspension regarding those licenses. Rather, the Panel finds and concludes due protection of the public health, safety and welfare mandates the Recommended Order set forth below.

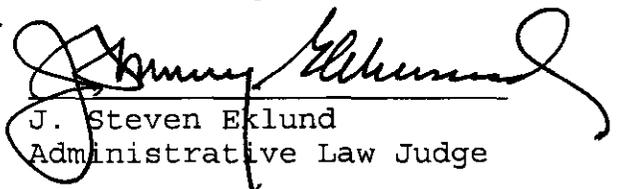
One final issue should be addressed. The Panel duly notes that various and substantial fines could be assessed as to Respondent's unprofessional and unlawful conduct. However, the Panel is also mindful of the thoroughly impactful disciplinary action recommended herein. The Panel finds and concludes no necessary purpose would be served to fine Respondent and it would also be punitive to do so under these circumstances. Thus, the Panel declines to recommend the assessment of any fine in this proceeding.

**RECOMMENDED ORDER**

WHEREFORE, IT IS ORDERED that Respondent's license to practice as a physician/surgeon in this state shall be revoked. It is also ordered that Respondent's license to administer and prescribe controlled substances shall also be revoked. It is further ordered that no fine shall be imposed in this proceeding.

The revocation of Respondent's licenses shall become effective on the date this Recommended Order may be adopted by the Division.

On behalf of the Panel, I hereby certify the foregoing Findings of Fact, Conclusions of Law and Recommended Order were submitted to F. David Stanley, Director of the Division of Occupational and Professional Licensing on the 28<sup>th</sup> day of January 2009 for his review and action.

  
J. Steven Eklund  
Administrative Law Judge