

DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING
Heber M. Wells Building
160 East 300 South
P O Box 146741
Salt Lake City UT 84114-6741
Telephone: (801) 530-6628

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

IN THE MATTER OF THE LICENSES OF :
GREGORY J GULSO : **NOTICE OF AGENCY ACTION**
TO PRACTICE AS A :
PODIATRIC PHYSICIAN AND TO :
ADMINISTER AND PRESCRIBE :
CONTROLLED SUBSTANCES :
IN THE STATE OF UTAH : **Case No. DOPL-2012-497**

THE DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING TO
Gregory J. Gulso, ("Respondent"), 415 S Medical Dr, STE C200,
Bountiful UT 84010:

The Division of Occupational and Professional Licensing
("the Division") hereby files this notice of agency action. Said
action is based on the Division's verified petition, a copy of
which is attached hereto and incorporated herein by reference.

The adjudicative proceeding designated herein is to be
conducted on a formal basis. It is maintained under the
jurisdiction and authority of the Division as set forth in §58-1-
401(2). **Within thirty (30) days of the mailing date of this
notice, you are required to file a written response with this
Division.** The response you file may be helpful to clarify,
refine or narrow the facts and violations alleged in the verified
petition.

Your written response, and any future pleadings or filings,
which are a part of the official file in this proceeding, should
be mailed or hand delivered to the following:

Signed originals to:
Division of Occupational
and Professional Licensing
Attn: Disciplinary Files
(by mail): PO Box 146741

A copy to:
Judith A. Jensen
Assistant Attorney General
Heber M. Wells Building
(by mail): PO Box 140872

Salt Lake City UT 84114-6741
(by hand delivery):
160 East 300 South, 4th floor
Salt Lake City, Utah

Salt Lake City UT 84114-0872
(by hand delivery):
160 East 300 South, 5th floor
Salt Lake City, Utah

You may represent yourself or, at your own expense, be represented by legal counsel at all times while this action is pending. **Your legal counsel shall file an entry of appearance with the Division after being retained to represent you in this proceeding.** Until that entry of appearance is filed, the Division, its counsel, and the presiding officer will communicate directly with you.

The presiding officer for the purpose of conducting this proceeding will be Jennie Jonsson, Administrative Law Judge, Department of Commerce, who will preside over any evidentiary issues and matters of law or procedure. If you or your attorney may have questions as to the procedures relative to the case, Judge Jonsson can be contacted in writing at P O Box 146701, Salt Lake City, UT 84114-6701; by telephone at (801) 530-6706; or by electronic mail at jjonsson@utah.gov.

Pursuant to a determination previously made by the Division which generally governs proceedings of this nature, the Division is providing the relevant and nonprivileged contents of its investigative file to you, concurrent with the issuance of this notice.

The Division is also providing its witness and exhibit list to you, concurrent with the issuance of this notice. The witness list identifies each individual the Division expects to present as a witness and includes a brief summary of their testimony at the hearing. The exhibit list identifies each anticipated document which the Division expects to present at the hearing. The Division is also providing a copy of any document to you that has not been otherwise made available to you through the investigative file.

Concurrent with your filing of a written response, you should provide to the Division a copy of any documents you have which relate to this case. Further, you should provide your witness and exhibit list to the Division. The witness list should identify each individual you expect to present as a witness and include a brief summary of their anticipated testimony. The exhibit list should identify each document you expect to present at the hearing.

If you fail to file a response within the 30 days allowed or fail to attend or participate in any scheduled hearing, Judge Jonsson may enter a default against you without any further notice to you.

After the issuance of a default order, Judge Jonsson may cancel any prehearing conference or hearing scheduled in the Division's verified petition, conduct any further proceedings necessary to complete the adjudicative proceeding without your participation and determine all issues in the proceeding.

If you are held in default, the maximum administrative sanction consistent with the verified petition may be imposed against you. That sanction in this case is revocation of license [and a total administrative fine of].

Counsel for the Division in this proceeding is Judith A. Jensen, Assistant Attorney General, State of Utah. Ms. Jensen may be contacted in writing at P.O. Box 140872, Salt Lake City, UT 84114-0872 or by telephone at (801) 366-0310. You may, subject to the deadlines established herein, attempt to negotiate a settlement of this proceeding by contacting counsel for the Division.

Any stipulation in lieu of a response should be jointly signed by yourself and the Division and filed within the time that a response would otherwise be due. Alternatively, any stipulation to resolve this case in lieu of the hearing shall be jointly signed by the parties and filed no later than one (1) week prior to the scheduled hearing.

Unless this case is resolved by a stipulation between the parties in lieu of the filing of a response, a prehearing conference will be conducted as follows:

Tuesday, January 22, 2013 at 11:00 A.M.
Room 2B, Floor 2
Heber M Wells Building, 160 East 300 South
Salt Lake City, Utah

During the conference, Judge Jonsson will address and resolve any further discovery issues. A schedule for the filing of any prehearing motions shall also be established.

Subject to the Department of Commerce Administrative Procedures Act Rules which govern this proceeding, the evidentiary hearing shall be conducted within 180 calendar days from the date of issuance of the notice of agency action.

You are entitled by law to an evidentiary hearing to determine whether your licenses to practice as a podiatric physician and to administer and prescribe controlled substances in the State of Utah should be revoked, suspended or subjected to other disciplinary action. Unless otherwise specified by the Director of the Division, the Podiatric Physician Board will serve as fact finder in the hearing. **The hearing will be conducted as follows:**

Wednesday, April 17, 2013 at 9:00 A.M. Room To Be Determined
160 East 300 South
Salt Lake City, Utah

During the evidentiary hearing, you will have the opportunity to present an opening statement, submit evidence, conduct cross-examination, submit rebuttal evidence and offer a closing statement to the fact finder. After the close of the hearing, the Board will take the matter under advisement and then submit its Findings of Fact, Conclusions of Law and a Recommended Order to the Division for its review and action.

Dated this 7th day of December, 2012.



Dan S. Jones
Bureau Manager

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Assistant Attorney General
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Counsel for Agency
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BEFORE THE DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING
OF THE DEPARTMENT OF COMMERCE
OF THE STATE OF UTAH

IN THE MATTER OF THE LICENSES
OF **GREGORY J. GULSO**
TO PRACTICE AS A PODIATRIC
PHYSICIAN AND TO ADMINISTER
AND PRESCRIBE CONTROLLED
SUBSTANCES IN THE STATE OF
UTAH

VERIFIED PETITION

Case No DOPL-2012-497

PRELIMINARY STATEMENT

These claims were investigated by the Utah Division of Occupational and Professional Licensing (the "Division") upon complaint that Gregory J Gulso ("Respondent") has engaged in acts, practices, and omissions which constitute violations of the Division of Occupational and Professional Licensing Act, UTAH CODE ANN. § 58-1-101 through § 58-1-507 (West Supp 2012), the Podiatric Physician Licensing Act, UTAH CODE ANN § 58-5a-101 through § 58-5a-501 (West Supp 2012), the Utah Controlled Substances Act, UTAH CODE ANN § 58-37-1 through § 58-37-21

(West Supp 2012), the General Rule of the Division of Occupational and Professional Licensing, UTAH ADMIN CODE RULE R156-1-101 through R156-1-503 (2012), and the Utah Controlled Substances Act Rule, UTAH ADMIN CODE RULE R156-37-101 through R156-156-37-610 (2012).

The allegations against Respondent are based upon information and belief arising out of an investigation conducted by the Division under its authority as set forth in Utah Code Ann § 58-1-106 (West Supp 2012)

Each count in this Petition shall be deemed to incorporate by reference the allegations set forth in the other paragraphs of the Petition

PARTIES

- 1 The Division is a division of the Department of Commerce of the State of Utah as established by Utah Code Ann § 13-1-2(2)(a) (West 2010)
- 2 On May 13, 2005, Respondent obtained licensure in the State of Utah to practice as a podiatric physician and to administer and prescribe controlled substances, License Numbers 295236-8907 and 295236-0501 Respondent was so licensed at all times material to the allegations herein

STATEMENT OF ALLEGATIONS

- 3 At all times material hereto, Respondent engaged in practice as a podiatric physician and maintained a clinical office in Bountiful, Utah

4. RESPONDENT'S TREATMENT OF PATIENT M:

In and between 2007 and 2010, Respondent provided services as a podiatric physician for Patient M (name withheld to protect confidentiality) to treat conditions affecting the foot and ankle and pain associated with these conditions. Respondent, in the course of providing treatment to Patient M, engaged in acts, practices, and omissions including the following

- a Respondent prescribed controlled substance pain medications for Patient M including Percocet, Lortab, Norco, and Oxycodone IR
- b On multiple occasions in 2008, 2009, and 2010, Respondent issued early prescriptions for Patient M for controlled substance pain medications. Said prescriptions issued early include, but are not limited to, approximately 50 prescriptions for Percocet, Lortab, and Norco that Respondent issued 5 to 21 days early for Patient M in and between January 2008 and May 2008
- c Respondent, in issuing early prescriptions, engaged in acts and practices including the following
 - (1) Respondent repeatedly provided Patient M access to controlled substance pain medications in quantities that exceeded the amount required for the patient to comply with Respondent's dosage directions
 - (2) Respondent in 2008 repeatedly provided Patient M access to prescription acetaminophen in quantities that exceeded the maximum dose recommended by the U S Federal Drug

Administration ("F.D.A.") of 4,000 mg of acetaminophen within a 24-hour period Respondent engaged in said prescribing practice when consumption of acetaminophen in doses over 4,000 mg/day increases the risk of overdose and adverse effects including severe liver injury, acute liver failure, and death.

(3) Respondent in 2009 provided Patient M access to prescription acetaminophen in quantities that exceeded the dosing guidelines recommended by the Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain (Utah Department of Health, February 2009) of 2,500 mg of acetaminophen per day for long-term treatment continuing for 10 days or more Respondent engaged in said prescribing practice when the Utah Clinical Guidelines warn that, in the case of acetaminophen combination products, "hepatotoxicity can result from prolonged use or doses in excess of recommended maximum total daily dose of acetaminophen including over-the-counter drugs "

d Respondent did not advise Patient M of the risks of acetaminophen overdose and did not instruct Patient M to limit his total daily acetaminophen consumption to the F D A recommended maximum daily dose, and/or Respondent did not document such advice or instruction

e Respondent prescribed controlled substance pain medications containing opioid analgesics for Patient M during periods in which the patient was being treated with Suboxone prescribed by another practitioner

Suboxone contains an opioid antagonist and is commonly used to treat opioid addiction. Suboxone may also be used to treat pain. During the patient's treatment with Suboxone, Respondent continued to prescribe opioid analgesics for pain management and engaged in the following acts, practices, and omissions

- (1) Respondent did not consider contraindications, and/or document having considered such contraindications, regarding the simultaneous treatment of Patient M with opioid analgesics and Suboxone, including the diminished effectiveness of the opioid analgesics in pain management and the risk of precipitating withdrawal symptoms.
- (2) Respondent did not document justification for prescribing opioid analgesics for Patient M when he was being treated with Suboxone
- (3) Respondent did not consult or coordinate Patient M's treatment with the practitioner who prescribed Suboxone and/or did not document such consultation or coordination of treatment
- (4) Respondent did not screen Patient M for a history of drug abuse or addiction when Patient M was being treated with Suboxone, an indicator of a possible history of drug abuse or addiction, and/or did not document such screening

f Respondent, on multiple occasions, issued prescriptions for Lortab and Percocet for use during the same period of treatment. Respondent did not

consider contraindications, and/or document such contraindications, regarding simultaneous treatment with Lortab and Percocet, including the heightened risk of tolerance Respondent did not document justification for simultaneous treatment with these medications.

g Respondent engaged in the acts, practices, and omissions as provided herein in his treatment of Patient M when the patient's prescription record and conduct indicated current drug abuse, misuse, and/or diversion and a high risk of future drug abuse, misuse, and diversion, including the following

- (1) Patient M, on multiple occasions, obtained prescriptions for controlled substance pain medications from Respondent in quantities that exceeded the amount required for the patient to comply with Respondent's dosage directions,
- (2) Patient M, on multiple occasions, obtained prescriptions from Respondent for controlled substance pain medications containing acetaminophen in quantities that exceeded the limits for safe use,
- (3) Patient M, on multiple occasions, obtained prescriptions for controlled substance pain medications from practitioners other than Respondent, and
- (4) Patient M obtained prescriptions from another practitioner for Suboxone, a drug commonly used to treat opiate addiction and an indicator of a possible history of drug abuse or addiction

5 RESPONDENT'S TREATMENT OF PATIENT L:

In and between February 2009, and June 2010, Respondent provided services as a podiatric physician for Patient L (name withheld to protect confidentiality) to treat conditions affecting the foot and pain associated with these conditions. Respondent, in the course of treating Patient L, engaged in acts, practices, and omissions including the following.

- a. Respondent prescribed controlled substance pain medications for Patient L including methadone, methadose, Oxycodone IR, Oxycodone ER, Oxycontin, and Lortab
- b. On and between February 24, 2009, and April 12, 2010, Respondent issued multiple prescriptions for Patient L for methadone and methadose in doses exceeding 100 mg/day. Respondent, in issuing his first prescription for methadone for Patient L, ordered a 30-day supply of methadone to be taken at the rate of 250 mg/day. Respondent issued 17 subsequent prescriptions for Patient L for methadone/methadose, including 12 prescriptions for methadone/methadose in doses between 120 and 300 mg/day
- c. Respondent, on multiple occasions, issued early prescriptions for methadone and methadose that provided Patient L with access to the medications in quantities that exceeded the amount required for the patient to comply with Respondent's dosage directions
- d. Respondent, on multiple occasions, issued a prescription for methadone for Patient L for use during the same period for which the patient had

previously obtained a prescription for methadone/methadose from another prescriber Respondent continued to issue prescriptions for methadone for Patient L when the patient obtained methadone/methadose prescriptions from Respondent and as many as 2 other prescribers for use during overlapping time periods

- e Respondent prescribed methadone for Patient L in quantities exceeding the starting methadone dose recommended by the Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain (Utah Department of Health, February 2009) of 5 mg tid for a healthy adult with dose increments of 5 mg tid every 5 to 7 days Respondent did not document justification for ordering, in his initial prescription for methadone for Patient L, a 30-day supply of methadone to be taken at the rate of 250 mg/day, and Respondent did not document justification for deviating from the Utah Clinical Guidelines on Prescribing Opioids recommended dosage and titration procedures
- f Respondent continued to prescribe methadone for Patient L when the patient informed Respondent that he had consumed methadone prescribed by Respondent at the rate of 400 to 500 mg/day, doses greatly in excess of Respondent's dosage directions
- g Respondent continued to prescribe methadone for Patient L when Respondent was informed that the patient obtained hospital emergency treatment for consuming in two days, the quantity of methadone Respondent had prescribed for a two-week period

- h Potential risks of methadone and methadose include the following**
- (1) Methadone and methadose inhibit cardiac potassium channels resulting in prolongation of the QTc interval and risk of life-threatening cardiac arrhythmias Adverse cardiac conduction effects are associated with, but are not limited to, higher dose treatments of 200 mg/day or greater and/or treatments for pain with large, multiple daily doses of methadone or methadose**
 - (2) Methadone and methadose may decrease pulmonary ventilation The respiratory depressant effects of methadone and methadose tend to occur after, and last longer than, the peak analgesic effects of the drug with the result of a heightened risk of overdose during the initiation of pain treatment and during dose titration**
- i Respondent did not warn, and/or document having warned, Patient L of the potential risks of methadone and methadose use and of the potential delay of 5 to 7 days in the development of side effects including respiratory depression**
- j Respondent failed to document justification for prescribing methadone and methadose for Patient L for the treatment of pain**
- k Respondent did not perform or consider performing, and/or document having considered performing, medical supervision and monitoring of Patient L including.**

- (1) obtaining electrocardiogram evaluations to assess the patient's rate-corrected QT interval prior to and during the course of said methadone and methadose treatment and
- (2) evaluating the patient's condition approximately 5 to 7 days subsequent to Respondent's initial prescription of methadone for Patient L and subsequent to episodes in which the patient increased his rate of methadone consumption

l In January 2010 and March 2010, Respondent prescribed the antibiotic ciprofloxacin for Patient L during periods in which the patient was also treated with methadone/methadose without obtaining information sufficient to identify contraindications to the proposed treatment. Simultaneous treatment with methadone/methadose and ciprofloxacin is contraindicated given the inhibitory effect of ciprofloxacin on the rate of methadone/methadose metabolism and the risk of adverse effects including respiratory depression and death. Respondent issued said prescriptions without knowledge of the interaction of methadone/methadose and ciprofloxacin, the serious risks for the patient caused by alteration of methadone/methadose metabolism, and antibiotics that could be safely prescribed for use with methadone/methadose.

m In April 2010, Respondent issued a prescription for a 2-week supply of methadone with the intent that half of the medication would be dispensed to Patient L in two weekly allotments. In May 2010, Respondent issued a prescription for a 4-week supply of methadone with the intent that one

quarter of the medication would be dispensed to Patient L in 4 weekly allotments Respondent failed to write prescriptions in the form required to effect such dispensation with the effect that, on the date of filling each prescription, the patient obtained the entire quantity of methadone ordered.

n Respondent engaged in the above-listed acts, practices, and omissions in the course of treating Patient L when the patient's prescription record and conduct indicated current drug abuse, misuse, and/or diversion and a high risk of future drug abuse, misuse, and diversion, including the following:

- (1) Patient L, on multiple occasions, obtained prescriptions for methadone/methadose from Respondent in quantities that exceeded the amount required for the patient to comply with Respondent's dosage directions,
- (2) Patient L, on multiple occasions, obtained prescriptions for controlled substance pain medications from practitioners other than Respondent,
- (3) Patient L was discharged as a patient of a pain management clinic on grounds that he violated the terms of his treatment contract with the clinic by obtaining prescriptions for pain medication from Respondent,
- (4) Patient L, after discharge from the pain management clinic, delayed securing treatment at another pain management clinic for several months,

- (5) Patient L informed Respondent that he had thought about obtaining heroin for his foot pain;
 - (6) Patient L informed Respondent that he was consuming methadone at the rate of 400 to 500 mg/day, doses greatly exceeding Respondent's dosage directions, and
 - (7) Patient L obtained hospital emergency treatment for consuming in two days, the quantity of methadone Respondent had prescribed for a two-week period
- o Respondent prescribed methadone and methadose for Patient L when Respondent was not familiar with the risks and appropriate use of the medications and when Respondent was not prepared to conduct the necessary careful monitoring

6. RESPONDENT'S TREATMENT OF PATIENT G:

In and between April 2009 and September 2010, Respondent provided services as a podiatric physician for Patient G (name withheld to protect confidentiality) to treat conditions affecting the ankle and pain associated with these conditions. Respondent, in the course of treating Patient G, engaged in acts, practices, and omissions including the following.

- a Respondent prescribed controlled substance pain medications for Patient G including Lortab, Norco, and Fioricet
- b Respondent did not discuss, and/or did not document having discussed, the risks and benefits of the use of opioid/acetaminophen medications in the treatment of pain before initiating treatment and failed to discuss,

and/or document having discussed, "abuse potential" with the patient until January 6, 2010

c On multiple occasions, Respondent issued early and duplicate prescriptions for controlled substance pain medications containing acetaminophen in combination with an opioid. Respondent, in issuing said early prescriptions, engaged in acts and practices including the following.

- (1) Respondent repeatedly provided the patient with access to controlled substance pain medications in quantities that exceeded the amount required for the patient to comply with Respondent's dosage directions
- (2) Respondent repeatedly provided the patient with access to prescription acetaminophen in quantities that exceeded the F D A. recommended maximum dose of 4,000 mg of acetaminophen within a 24-hour period.
- (3) Respondent repeatedly provided the patient with access to acetaminophen in quantities that exceeded the maximum total daily dose of acetaminophen recommended by the Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain (Utah Department of Health, February 2009) of 4,000 mg/day for short-term use (less than 10 days) and 2,500 mg/day for long-term use
- (4) Respondent engaged in said prescribing practice when consumption of acetaminophen in doses over 4,000 mg/day

increases the risk of overdose and adverse effects including severe liver injury, acute liver failure, and death

(5) Respondent engaged in said prescribing practice when "hepatotoxicity can result from prolonged use or doses in excess of [the Utah Clinical Guidelines] recommended maximum total daily dose of acetaminophen including over-the-counter drugs "

(6) Respondent did not instruct Patient G to limit his total daily acetaminophen consumption to the F D A recommended maximum daily dose, and/or Respondent did not document such instruction

d Respondent issued prescriptions to Patient G for Lortab for 11 months before recommending the patient seek treatment through a pain management clinic, and Respondent continued to issue prescriptions to the patient for Lortab for 6 months after making said recommendation

e Respondent engaged in the above-listed acts, practices, and omissions in the course of treating Patient G when the patient's prescription record and conduct indicated current drug abuse, misuse, and/or diversion and a high risk of future drug abuse, misuse, and diversion, including the following

(1) Patient G, on multiple occasions, obtained prescriptions for controlled substance pain medications from Respondent in quantities that exceeded the amount required for the patient to comply with Respondent's dosage directions,

- (2) Patient G, on multiple occasions, obtained prescriptions from Respondent for controlled substance pain medications containing acetaminophen in quantities that exceeded the limits for safe use,
- (3) Patient G, on multiple occasions, claimed loss or destruction of his prescriptions or prescribed pain medications; and
- (4) Patient G, on multiple occasions, declined or delayed alternative treatments or procedures suggested by Respondent including use of a Unna boot, icing his ankles, surgery, X-ray computed tomography, and treatment by a clinic or physician specializing in pain management

7. TREATMENT OF PATIENT M, PATIENT L, AND PATIENT G:

- a Respondent, prior to treating Patient M, Patient L, and Patient G with controlled substance pain medications, did not perform an appropriate patient evaluation or obtain the patients' informed consent to treatment with controlled substance pain medications including the following procedures
 - (1) Respondent did not screen the patients for history of substance abuse and addiction and/or did not document such screening,
 - (2) Respondent did not discuss with the patients the risks and benefits of the use of controlled substance pain medications and/or did not document such discussion, and

- (3) Respondent did not obtain the patients' informed consent to treatment with controlled substance pain medications and/or did not document such informed consent
- b Respondent, during the course of treating Patient M, Patient L, and Patient G with controlled substance pain medications, did not incorporate appropriate safeguards in his practice to minimize the risk of drug abuse, misuse, and diversion including the following
 - (1) when the patients were at high risk for medication abuse, Respondent did not consider, or document having considered, the use of a written agreement between Respondent and the patients outlining patient responsibilities, including
 - (a) the patients' compliance with urine/serum medication levels screening when requested,
 - (b) the patients' adherence to Respondent's treatment plan including number and frequency of all prescription refills, and
 - (c) reasons for which drug therapy may be discontinued, including violation of the terms of said agreement
 - (2) Respondent did not require the patients to receive prescriptions from one physician and one pharmacy whenever possible
 - (3) When the patients repeatedly violated Respondent's dosage directions and pain management plan, Respondent did not timely refer the patients for additional evaluation and treatment in order to achieve treatment objectives

- (4) When the patients were at risk for medication misuse, abuse, and diversion, Respondent did not appropriately monitor, and/or document having monitored, the patients' medication use, the patients' compliance with the treatment directions, the patients' risk of drug overdose, and/or the risk of diversion
- (5) Respondent did not periodically review the patients' prescription records through the Utah Controlled Substance Data Base during the course of treatment to determine whether the patients were obtaining controlled substance pain medications from other practitioners.
- (6) When the patients were at risk for medication misuse, abuse, or diversion, Respondent did not timely consult with or refer the patients to an expert in the management of patients at risk, and/or Respondent did not document such consultation or referral
- (7) Respondent did not terminate treatment of the patients with controlled substance pain medications when the patients demonstrated dangerous and/or illegal behavior

Count 1

**Prescription of dosages of a controlled substance
in excess of medically recognized quantities necessary
to treat the patient's ailment, malady, or condition**

UTAH CODE ANN § 58-37-6(7)(i)

8 At all times material to the allegations herein, Utah Code Ann § 58-1-501(2)(a) defined "Unprofessional Conduct" in relevant part as violating any statute regulating an occupation or profession under Title 58

- 9 At all times material to the allegations herein, the Utah Controlled Substances Act, UTAH CODE ANN § 58-37-6(7)(i), prohibited a practitioner licensed under Chapter 37 from prescribing dosages of a controlled substance in excess of medically recognized quantities necessary to treat the patient's ailment, malady, or condition
10. As further described in Paragraphs 4, 5, and 6 herein, Respondent issued early prescriptions for controlled substance pain medications for Patient M, Patient L, and Patient G and prescribed said medications in quantities that exceeded the amount required for the patient to comply with Respondent's dosage directions
- 11 As further described in Paragraphs 4 and 6 herein, Respondent prescribed acetaminophen for Patient M and Patient G in quantities that exceeded the maximum dose recommended by the F D.A and the Dosing Guidelines of the Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain
- 12 As further described in Paragraph 5 herein, Respondent engaged in conduct including the following.
- a Respondent prescribed methadone/methadose for Patient L for treatment of pain in dosages that exceeded the Dosing Guidelines of the Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain and Respondent failed to document justification for prescribing said dosages,
 - b Respondent prescribed methadone for Patient L during periods in which Patient L obtained additional quantities of methadone/methadose through prescriptions issued by other prescribers, and Respondent failed to document justification for prescribing said duplicate dosages, and

- c Respondent prescribed methadone/methadose for Patient L in doses between 120 and 300 mg per day when high doses are associated with risk of serious adverse effects and when Respondent failed to document justification for prescribing said high doses
- 13 Based upon the foregoing, Respondent prescribed controlled substances for Patient M, Patient L, and Patient G in excess of medically recognized quantities necessary to treat the patients' pain in violation of UTAH CODE ANN § 58-37-6(7)(i) and engaged in "Unprofessional Conduct" as defined by Utah Code Ann. § 58-1-501(2)(a).
- 14 Pursuant to UTAH CODE ANN § 58-1-401(2)(a), sufficient bases exist for imposing disciplinary sanctions against Respondent's licenses to practice as a podiatric physician and to administer and prescribe controlled substances in the State of Utah

Count 2

**Issuing a prescription for a drug without first obtaining information sufficient to identify contraindications to the proposed treatment
Utah Code Ann. 58-1-501(2)(m)(i)**

15. At all times material to the allegations herein, Utah Code Ann § 58-1-501(2)(m)(i) defined "Unprofessional Conduct" in relevant part as, unless Subsection (4) applies, issuing a prescription for a drug without first obtaining information in the usual course of professional practice that is sufficient to identify contraindications to the proposed treatment ¹

¹ In 2011, UTAH CODE ANN § 58-1-501(2)(m) was amended to delete the phrase, "unless Subsection (4) applies " Prior to 2011, Subsection (4) provided, "Notwithstanding Subsections (1)(f) and (2)(m), the division may permit a person licensed to prescribe under this title to prescribe a legend drug to

- 16 As further described in Paragraphs 4 and 6 herein, Respondent prescribed acetaminophen for Patient M and Patient G in quantities that exceeded maximum dose recommended by the F D A and the Dosing Guidelines of the Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain without first identifying the potential adverse effects of said treatment including severe liver injury, acute liver failure, and death
- 17 As further described in Paragraph 4 herein, Respondent prescribed opioid medications for Patient M when the patient was also being treated with Suboxone without first identifying the potential adverse effects of said treatment including precipitation of withdrawal symptoms and diminished analgesic potency of the opioid medications
- 18 As further described in Paragraph 4 herein, Respondent prescribed Lortab and Percocet for Patient M for use during the same period of treatment without first identifying the potential adverse effects of said treatment including the development of tolerance
- 19 As further described in Paragraph 5 herein, Respondent prescribed Methadone and Methadose for Patient L in high doses without first identifying the potential adverse effects of said treatment including respiratory depression, QTc interval prolongation, and serious cardiac arrhythmia

a person located in the state if the division in collaboration with the appropriate professional board has permitted the specific prescriptive practice of the legend drug by rule. The statutory change does not affect the present action as the conduct alleged herein occurred prior to 2011 and no allegations are raised regarding the prescription of legend drugs

- 20 As further described in Paragraph 5 herein, Respondent prescribed ciprofloxacin for Patient L when the patient was also being treated with methadone/methadose without first identifying the potential adverse effects of said treatment including inhibition of the rate of methadone/methadose metabolism, respiratory depression, and death
- 21 Based upon the foregoing, Respondent issued prescriptions for drugs without first obtaining information sufficient to identify contraindications to the proposed treatment in violation of Utah Code Ann. 58-1-501(2)(m)(i) and engaged in “Unprofessional Conduct” as defined by Utah Code Ann § 58-1-501(2)(a)
- 22 Pursuant to UTAH CODE ANN § 58-1-401(2)(a), sufficient bases exist for imposing disciplinary sanctions against Respondent’s licenses to practice as a podiatric physician and to administer and prescribe controlled substances in the State of Utah

Count 3

**Prescribing a controlled substance without taking into account the potential for abuse, dependence, nontherapeutic use, diversion, and an illicit market for the drug
UTAH ADMIN CODE RULE R156-37-603(2)**

- 23 At all times material to the allegations herein, Utah Code Ann. § 58-1-501(2)(a) defined “Unprofessional Conduct” in relevant part as violating any rule regulating an occupation or profession under Title 58.
- 24 At all times material to the allegations herein, the Utah Controlled Substances Act Rules, UTAH ADMIN CODE RULE R156-37-603(2), prohibited a practitioner licensed under Chapter 37 from prescribing a controlled substance without taking into account the drug's potential for abuse, the possibility the drug may lead to

dependence, the possibility the patient will obtain the drug for a nontherapeutic use or to distribute to others, and the possibility of an illicit market for the drug.

25. As further described in Paragraphs 4, 5, and 6 herein, Respondent repeatedly prescribed controlled substance pain medications for Patient M, Patient L, and Patient G in quantities that exceeded the amount required for the patients to comply with Respondent's dosage directions.
26. As further described in Paragraphs 4, 5, and 6 herein, the prescription records and conduct of Patient M, Patient L, and Patient G indicated current drug abuse, misuse, and/or diversion and a high risk of future drug abuse, misuse, or diversion, based upon the following
 - a. Patient M, Patient L, and Patient G, on multiple occasions, obtained prescriptions for controlled substance pain medications from Respondent in quantities that exceeded the amount required for the patient to comply with Respondent's dosage directions;
 - b. Patient M and Patient G, on multiple occasions, obtained prescriptions for controlled substance pain medications from Respondent in quantities that exceeded the limits of safe use,
 - c. Patient M and Patient L, on multiple occasions, obtained prescriptions for controlled substance pain medications from practitioners other than Respondent,
 - d. Patient M obtained prescriptions from another practitioner for Suboxone, a drug commonly used to treat opiate addiction and an indicator of a

possible history of drug abuse or addiction, and Respondent did not document screening the patient for history of opiate addiction,

e Patient L was discharged as a patient of a pain management clinic on grounds that he violated the terms of his treatment contract with the clinic by obtaining prescriptions for pain medication from Respondent,

f Patient L, after discharge from the pain management clinic, delayed securing treatment at another pain management clinic for several months;

g Patient L informed Respondent that he had thought about obtaining heroin for his foot pain,

h Patient L informed Respondent that he was consuming methadone at the rate of 400 to 500 mg/day, doses greatly exceeding Respondent's dosage directions,

i. Patient L obtained hospital emergency treatment for consuming in two days, the quantity of methadone Respondent had prescribed for a two-week period,

j Patient G, on multiple occasions, claimed loss or destruction of his prescriptions or prescribed pain medication; and

k Patient G, on multiple occasions, declined or delayed alternative treatments or procedures suggested by Respondent

27 As further described in Paragraph 7 herein, Respondent failed to perform appropriate patient evaluation, obtain the patients' informed consent to treatment with controlled substance pain medications, or incorporate appropriate

safeguards in his treatment of Patient M, Patient L, and Patient G to minimize the potential for drug abuse, misuse, and diversion

28 Based upon the foregoing, Respondent prescribed controlled substance pain medications for Patient M, Patient L, and Patient G without taking into account the potential for abuse, the possibility of dependence, the possibility the drugs would be obtained for nontherapeutic use or diversion, and/or the possibility of an illicit market for the drugs, in violation of UTAH ADMIN CODE RULE R156-37-603(2).

29 Based upon the foregoing, Respondent engaged in “Unprofessional Conduct” as defined by Utah Code Ann § 58-1-501(2)(a), and pursuant to UTAH CODE ANN. § 58-1-401(2)(a) sufficient bases exist for imposing disciplinary sanctions against Respondent’s licenses to practice as a podiatric physician and to administer and prescribe controlled substances in the State of Utah

Count 4
**Failing as a prescribing practitioner to follow
the Model Policy for the Use of Controlled Substances
for the Treatment of Pain**
UTAH ADMIN CODE RULE R156-1-501(6)

30 At all times material to the allegations herein, UTAH ADMIN CODE R156-1-501(6) defined “Unprofessional Conduct” in relevant part as failing as a prescribing practitioner to follow the “Model Policy for the Use of Controlled Substances for the Treatment of Pain”, 2004, established by the Federation of State Medical Boards

31 As further described in Paragraphs 4, 5, 6, and 7 herein, Respondent, in the course of his practice as a podiatric physician and as a prescribing practitioner, failed to follow the Model Policy for the Use of Controlled Substances for the Treatment of Pain by engaging in acts, practices, and omissions including the following

- a. Respondent, prior to treating Patient M, Patient L, and Patient G with controlled substance pain medications, did not screen the patients for history of substance abuse and/or did not document such screening
- b. Respondent, prior to treating Patient M, Patient L, and Patient G with controlled substance pain medications, did not discuss, and/or document having discussed, the risks and benefits of the use of the controlled substance pain medications with the patient
- c. Respondent, prior to treating Patient M, Patient L, and Patient G with controlled substance pain medications, did not obtain, and/or document having obtained, the patient's informed consent to treatment with controlled substance pain medications.
- d. Respondent did not require the patient receive prescriptions from one physician and one pharmacy whenever possible
- e. When Patient M, Patient L, and Patient G were at high risk for medication abuse and/or had a history of substance abuse, Respondent did not consider, and/or document having considered, the use of a written agreement between Respondent and the patient outlining patient responsibilities, including

- (1) urine/serum medication levels screening when requested,
- (2) number and frequency of all prescription refills, and
- (3) reasons for which drug therapy may be discontinued,
including violation of the terms of the agreement

f. When Patient M, Patient L, and Patient G repeatedly violated Respondent's dosage directions and treatment plan, sought early prescriptions for controlled substance pain medications, and consumed medications in excess of the quantities required to comply with Respondent's treatment plan and in excess of safe levels of drug use, Respondent

- (1) failed to review the course of his pain treatment plan and to evaluate the patient's progress toward the objectives of the treatment plan and/or to document such review and evaluation,
- (2) failed to assess, and/or document having assessed, the appropriateness of continued use of the current treatment plan and the use of other therapeutic modalities, and
- (3) failed to timely refer the patients for additional evaluation and treatment in order to achieve treatment objectives

g. When the prescription records and conduct of Patient M, Patient L, and Patient G indicated current drug abuse, misuse, and/or diversion and a high risk of future drug abuse, misuse, and diversion, Respondent failed to perform appropriate monitoring and documentation and failed to obtain consultation in treating the patients, including the following

- (1) Respondent failed to monitor the amounts of controlled substance pain medications the patients obtained through prescriptions issued by Respondent and other practitioners,
- (2) Respondent failed to monitor urine/serum medication levels for indications of drug abuse or diversion,
- (3) Respondent failed to limit the number and frequency of prescriptions issued to those prescriptions required to comply Respondent's dosage directions and treatment plan, and Respondent failed to document justification for any change in Respondent's dosage directions and treatment plan including justification for increases in the amount and rate of medication to be used by the patients,
- (4) Respondent failed to require prescriptions for controlled substance pain medications be obtained from Respondent and through one pharmacy whenever possible, and
- (5) When the patients repeatedly sought to obtain greater quantities of controlled substance pain medications than would be required to comply with Respondent's dosage directions by requesting early or duplicate prescriptions and/or by obtaining additional prescriptions for controlled substance pain medications from other practitioners, Respondent failed to consult with or refer the patients in timely manner to an expert in the management of patients demonstrating substance abuse

32 Based upon the foregoing, Respondent engaged in "Unprofessional Conduct" as defined by UTAH ADMIN CODE RULE R156-1-501(6), and pursuant to UTAH CODE ANN § 58-1-401(2)(a) sufficient bases exist for imposing disciplinary sanctions against Respondent's licenses to practice as a podiatric physician and to administer and prescribe controlled substances in the State of Utah

Count 5
Violating any generally accepted professional standard
UTAH CODE ANN. § 58-1-501(2)(b)

33 At all times material to the allegations herein, Utah Code Ann. § 58-1-501(2)(b) defined "Unprofessional Conduct" in relevant part as violating any generally accepted professional standard applicable to a profession regulated under Title 58

34 The Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain, promulgated by the Utah Department of Health and published in February 2009, establish generally accepted professional standards in the State of Utah for the prescription of opioid pain medications and provide that departures from these recommendations should be justified and documented

35 As further described in Paragraphs 4, 5, 6, and 7 herein, Respondent, in the course of his practice as a podiatric physician and as a prescribing practitioner, failed to follow the Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain by engaging in the following acts, practices, and omissions, and Respondent failed to justify and document said departures from the Utah Clinical Guidelines

- a Respondent prescribed opioid medications for Patient M, Patient L, and Patient G for the treatment of chronic pain without obtaining and documenting the patients' history of substance use, addiction, or dependence, in violation of Recommendation 1 1 of the Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain
- b Respondent prescribed opioid medications for Patient M, Patient L, and Patient G for the treatment of chronic pain without informing and counseling the patients, and/or without documenting having informed and counseled the patients, of the risks and benefits of the use of opioid pain medications, the appropriate use of the medications, possible adverse effects, and the risks of developing tolerance, physical or psychological dependence, and withdrawal symptoms, in violation of Recommendation 5 1 of the Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain
- c Respondent prescribed opioid medications for Patient M, Patient L, and Patient G for the treatment of chronic pain without documenting the treatment plan for each patient defining the clinician's responsibilities and the patients' responsibilities including properly obtaining, filling, and using prescriptions, and adherence to the treatment plan, in violation of Recommendation 5 3 of the Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain
- d Respondent prescribed opioid medications for Patient M, Patient L, and Patient G for the treatment of chronic pain without establishing a treatment

plan containing goals of treatment, guidelines for prescription refills, agreement to submit to urine or serum medication level screening upon request, reasons for possible discontinuation of drug therapy, and provision that continuing failure by the patient to adhere to the treatment plan will result in escalating consequences, up to and including termination of the clinician-patient relationship and of opioid prescribing by the clinician, in violation of Recommendation 5.4 of the Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain

- e. Respondent, in violation of Recommendation 8.1 of the Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain, prescribed opioid medications for Patient M, Patient L, and Patient G for the treatment of chronic pain without regularly monitoring the patients for aberrant and possible drug abuse-related behavior including, but not limited to, the following
 - (1) the patients' conduct in seeking controlled substance pain medications from Respondent in quantities that exceeded the amount required to comply with Respondent's dosage directions,
 - (2) the patients' conduct in obtaining controlled substance pain medications from practitioners other than Respondent, and
 - (3) the patients' drug abuse and/or diversion through urine/serum screenings

- f Respondent, in violation of Recommendation 8.2 of the Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain, prescribed opioid

medications for Patient M, Patient L, and Patient G for the treatment of chronic pain without checking, and/or without documenting having checked, the patients' prescription records through the Utah Controlled Substance Data Base at intervals during treatment appropriate to monitor the conduct of high risk patients and patients exhibiting aberrant behaviors.

- g Respondent, in violation of Recommendation 10 1 of the Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain, prescribed opioid medications for Patient M, Patient L, and Patient G for the treatment of chronic pain and failed to discontinue opioid treatment of Patient M, Patient L, and Patient G when the patients demonstrated dangerous or illegal behaviors
- h Respondent, in violation of Recommendation 12 1 of the Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain, prescribed opioid medications for Patient M, Patient L, and Patient G for the treatment of chronic pain without considering consultation, and/or without documenting having considered consultation, when the patients showed evidence of current drug addiction and/or abuse and/or when Respondent was not confident of his abilities to manage the treatment
- i Respondent, in violation of Recommendation 13 1 of the Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain, prescribed methadone and methadose for Patient L when Respondent was not

familiar with its risks and appropriate use and when Respondent was not prepared to conduct the necessary careful monitoring

- 36 Based upon the foregoing, Respondent engaged in "Unprofessional Conduct" as defined by Utah Code Ann § 58-1-501(2)(b), and pursuant to UTAH CODE ANN § 58-1-401(2)(a) sufficient bases exist for imposing disciplinary sanctions against Respondent's licenses to practice as a podiatric physician and to administer and prescribe controlled substances in the State of Utah

Count 6

Practicing as a podiatric physician through gross incompetence, gross negligence, or a pattern of incompetency or negligence

UTAH CODE ANN § 58-1-501(2)(g)

37. At all times material to the allegations herein, Utah Code Ann § 58-1-501(2)(g) defined "Unprofessional Conduct" in relevant part as practicing a profession regulated under Title 58 through gross incompetence, gross negligence, or a pattern of incompetency or negligence
- 38 As further described in Paragraphs 4, 5, 6, and 7 herein, Respondent engaged the acts, practices, and omissions as alleged in Counts 1 through 5.
39. Based upon the foregoing, Respondent practiced as a podiatric physician through gross incompetence, gross negligence, or a pattern of incompetency or negligence and engaged in "Unprofessional Conduct" as defined by Utah Code Ann § 58-1-501(2)(g)
- 40 Pursuant to UTAH CODE ANN § 58-1-401(2)(a) sufficient bases exist for imposing disciplinary sanctions against Respondent's licenses to practice as a podiatric

physician and to administer and prescribe controlled substances in the State of Utah

Count 7

**Gross incompetency in the practice of podiatry
UTAH CODE ANN. § 58-5a-102(4)(f)**

41. At all times material to the allegations herein, UTAH CODE ANN § 58-5a-102(4)(f) defined "Unprofessional Conduct" in relevant part as gross incompetency in the practice of podiatry
42. As further described in Paragraphs 4, 5, 6, and 7 herein, Respondent engaged the acts, practices and omissions as alleged in Counts 1 through 5
43. Based upon the foregoing, Respondent practiced as a podiatric physician through gross incompetency and engaged in "Unprofessional Conduct" as defined by UTAH CODE ANN § 58-5a-102(4)(f)
44. Pursuant to UTAH CODE ANN § 58-1-401(2)(a), sufficient bases exist for imposing disciplinary sanctions against Respondent's licenses to practice as a podiatric physician and to administer and prescribe controlled substances in the State of Utah

Count 8

**Practicing as a podiatric physician beyond the scope of the licensee's
competency, abilities, or education
UTAH CODE ANN. § 58-1-501(2)(i)**

45. At all times material to the allegations herein, UTAH CODE ANN § 58-1-501(2)(i) defined "Unprofessional Conduct" in relevant part as practicing as a podiatric physician beyond the scope of the licensee's competency, abilities, or education

- 46 As further described in Paragraphs 4, 5, 6, and 7 herein, Respondent prescribed controlled substance pain medications for Patient M, Patient L, and Patient G in the course of his practice as a podiatric physician and engaged in the acts, practices, and omissions as alleged in Counts 1 through 5
- 47 Based upon the foregoing, Respondent practiced as a podiatric physician beyond the scope of his competency, abilities, and/or education and engaged in “Unprofessional Conduct” as defined by UTAH CODE ANN § 58-1-501(2)(i)
- 48 Pursuant to UTAH CODE ANN § 58-1-401(2)(a), sufficient bases exist for imposing disciplinary sanctions against Respondent’s licenses to practice as a podiatric physician and to administer and prescribe controlled substances in the State of Utah

WHEREFORE, the Division requests an order granting the following relief

- 1 Determining that Respondent engaged in the acts, practices, and omissions alleged herein,
2. Determining that, by engaging in the above acts, practices, and omissions, Respondent violated the terms of the provisions of the Utah Code, the Utah Administrative Code, and the professional standards applicable to the profession of the podiatric physician, which are particularly referenced above,
3. Imposing appropriate sanctions on the licenses of Respondent to practice as a podiatric physician and to administer and prescribe controlled substances

in the State of Utah in accordance with UTAH CODE ANN § 58-1-401(2)(a)

DATED this 7th day of December, 2012

MARK L SHURTLEFF
ATTORNEY GENERAL

Judith A Jensen
JUDITH A JENSEN
Assistant Attorney General

VERIFICATION

STATE OF UTAH)
 ss.
COUNTY OF SALT LAKE)

Brittany Butsch, being first duly sworn, states as follows

1 I am an Investigator for the Bureau of Investigation, Division of Occupational and Professional Licensing, Department of Commerce, State of Utah, and have been assigned to investigate this case

2. I have read the foregoing Verified Petition and am familiar with the contents thereof All of the factual allegations in the Petition are true to the best of my knowledge, information, and belief

Brittany Butsch
BRITTANY BUTSCH

SWORN TO AND SUBSCRIBED before me this 7th day of December, 2012.

Jody L Woolf
NOTARY PUBLIC

