BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS ON REFERRAL FROM THE ALASKA STATE MEDICAL BOARD

In the Matter of:	)	
	)	
GARY STEVEN GERLAY, M.D.,	)	
	)	
Respondent.	)	OAH No. 05-0321-MED
	)	Board Nos. 2803-028 *et al*.

REVISED DECISION AND ORDER

I. Introduction

This administrative proceeding is a disciplinary action against Dr. Gary Steven Gerlay. The Division of Occupational and Professional Licensing ("division") initiated an investigation of Dr. Gerlay in 2003 and filed a petition for summary suspension of his physician's license and an accusation seeking the imposition of disciplinary sanctions on April 19, 2005. The Alaska State Medical Board ("board") granted the petition and issued an order summarily suspending his license to practice medicine effective April 21, 2005.

Dr. Gerlay requested a hearing on the summary suspension. The formal hearing was conducted before Administrative Law Judge ("ALJ") David Stebing over the course of five days in June 2005. ALJ Stebing issued a proposed decision on August 1, 2005; the proposed decision was adopted by the board on August 10, 2005, sustaining the summary suspension of Dr. Gerlay's license.[1]

On March 26, 2006, the division filed an amended accusation. On April 12, 2006, Dr. Gerlay and the division entered into a stipulation regarding proceedings on the amended accusation for imposition of disciplinary sanctions. Under the terms of the stipulation, the prior decision is acknowledged to have established the violations of Counts I, II, IV-VII, X and XI "as originally alleged" in the initial accusation, as subsequently amended. Dr. Gerlay does not admit those allegations or violations, but he did stipulate and agree to the preparation of a proposed decision "based on the…violations …the testimony…, the exhibits…and the findings made at

[1] Summary suspensions require that the board make a finding that the licensee poses a clear and immediate danger to the public health and safety if the licensee is allowed to continue to practice. AS 08.64.331(8) (c).

the prior summary suspension hearing"…"regarding the sanctions to be imposed pursuant to AS 08.64.331."[2]

Based on the violations previously established, the findings previously made, and the testimony and exhibits from the prior hearing, and upon consideration of the board's decisions in prior cases, ALJ Stanley[3] recommended sanctions as follows:

> (T)he Board should continue the suspension of Dr. Gerlay's license for an additional three years. At the conclusion of that three-year period, or sooner at the discretion of the Board, the license may be reinstated at the discretion of the Board upon such evidence of fitness as the Board deems satisfactory, with such conditions and limitations as the Board, in its discretion, deems appropriate. Evidence of fitness to practice shall include, but not be limited to, three drug tests with negative results administered at random as determined by the Board, or its delegate. If and when Dr. Gerlay's license is reinstated, he shall not accept or treat female patients for a two year period from and after reinstatement. Prior to reinstatement, Dr. Gerlay shall pay a civil fine of $7500. For a two year period following reinstatement, random and unannounced chart reviews of Dr. Gerlay's patients, including all records of prescribing controlled substances, may be conducted at the discretion of the board. [4]

The Board met on July 19, 2007, rejected the proposed decision and order as allowed under AS 44.62.500 (c), and then remanded the case to the ALJ to receive additional evidence on the following issues:

> Full psychiatric and physical examination by persons of the Board's choosing, examination to include supervised drug testing including ETG and hair testing for a period of six (6) months, all examinations and testing at respondent's expense. Results to be reported to the ALJ for review and consideration with new proposal (proposed decision) offered to Board.

The Executive Administrator ("administrator"), acting at the behest of the board, sent a letter to Dr. Gerlay on August 24, 2007 reminding him that the board had originally required him to submit to examination and testing in August of 2005, but that he had failed to do so. The administrator further reminded Dr. Gerlay that the board, at its July 19, 2007 meeting, had ordered him to submit to a complete evaluation and that the board had selected Drs. Rawlings

[2] P. 3, Stipulation Regarding The Need For An Additional Evidentiary Hearing, dated April 12, 2006.
[3] ALJ Stebing left the Office of Administrative Hearings in 2006; this case was reassigned to ALJ Stanley.
[4] Pp. 19-20, proposed Decision and Order, dated July 6, 2007.

and Maurer of Pacific Psychological Services, Seattle, Washington to perform the examinations.[5]

Dr. Gerlay argued in his letter to the Administrator dated September 6, 2007, that there are competent physicians and psychologists in New Mexico (where Dr. Gerlay resides) and that he should not be required to travel to Seattle for the examinations. Dr. Gerlay then stated, "I will be evaluated by board approved doctors within 30 days if you fail to notify me of your selection of evaluators in my region."[6]

The division filed a Notice of Respondent's Continuing Violation of the Board's July 19, 2007 Order on February 4, 2008. The division requested that the ALJ prepare a revised decision. On February 25, 2008, the division filed a Second Notice of Respondent's Continuing Violation of the Board's July 19, 2007 Order alleging that Dr. Gerlay "has no intention of ever complying with the July 19, 2007 board order…" and requesting that a decision be issued which revokes Dr. Gerlay's medical license.

The ALJ issued a Notice of Intent to Treat Requests as a Motion on March 7, 2008. The notice provided, in pertinent part, that "(T)he ALJ herewith gives notice that he intends to issue a revised Decision and Order which shall take into consideration that Dr. Gerlay has not complied with the board's order of July 19, 2007. If Dr. Gerlay believes that there is a good reason not to issue a revised decision, he shall file such opposition by March 31, 2008." Dr. Gerlay did not file an opposition, but did file on March 20, 2008 a single sentence stating, "I, Gary Steven Gerlay, MD, do affirmatively state that I am not seeking reinstatement of my license to practice medicine in Alaska."

II. Facts

The hearing in this case occurred over a five-day period. The following witnesses testified under oath and were subjected to cross-examination in the following sequence:

1. Debra Luker
2. Leon Chandler, M.D.
3. K. P.
4. D. E.
5. S. V.
6. James Portch
7. W. M.

[5] Because the record before the ALJ is devoid of information about Drs. Rawlings and Maurer, this order expresses no opinion as to the qualifications or credentials of doctors designated to examine Dr. Gerlay.
[6] Dr. Gerlay's use of "Board approved" appears to mean *board certified*.

8. Bradford Hare, M.D., Ph.D.
9. Michael F. Beirne, M.D.
10. R.R.
11. S. L.
12. R. G.
13. J. P.
14. Wayne Anthony Ross
15. Blake Call
16. Gregory Erkins
17. Janice Monigold
18. Deanna Houston
19. Dorothy Belleau
20. Viann Nations
21. Carla Lien
22. Janice Roberson
23. Mark Jones
24. Dan Rednall
25. Nancy Murphy

Dr. Gerlay did not testify. The division's exhibits 1 through 66 and Dr. Gerlay's exhibits "A" through "J" were admitted as evidence. References were made in the summary suspension decision findings of fact to the audiocassette tapes comprising the record made at the hearing. A complete transcript (1036 pages) of the hearing was prepared on August 16, 2005 (after the summary suspension was sustained.)

The following findings are based on the record compiled in this case.

1. Gary S. Gerlay graduated from medical school at the Universidad Autonoma de Guadalajara in 1979. He served a medical residency in anesthesiology at Baylor University Hospital during 1981-82. He was licensed by the New Mexico Board of Medical Examiners on November 15, 1982, and thereafter he began practicing medicine in New Mexico. The New Mexico Board of Medical Examiners disciplined Dr. Gerlay in 1985 for unprofessional conduct involving controlled substance violations and personal abuse of controlled substances. He had written prescriptions of Demerol for himself. His privileges for prescribing controlled substances were restricted. Dr. Gerlay successfully participated in a drug treatment program. (Cross-examination of Chandler; Exhibits 17, 21 [New Mexico stipulation and order attached as Appendix "A" to Exhibit 21], 22).

2. After Dr. Gerlay's suspension and probation terminated on June 11, 1987, he remained in good standing with the New Mexico Board of Medical Examiners and worked as a

physician in that state. He practiced family medicine in the Deming, New Mexico, area from 1990-94. On November 8, 1994, Dr. Gerlay applied for a locum tenens permit (temporary license) to practice medicine in Alaska. An October 28, 1994, a written statement accompanying his application stated, "In 1982 I had a brief encounter with Demerol. This event was short-lived and appropriately treated. During this period I voluntarily surrendered my license [in New Mexico]." Alaska's medical board granted Dr. Gerlay a locum tenens permit on July 15, 1995, and he began working as a physician in Anchorage. He applied for a permanent license on August 25, 1995. His locum tenens permit was extended on September 14, 1995. Effective January 3, 1996, Dr. Gerlay was granted a permanent medical license in Alaska. He thereafter was employed as a physician in Anchorage. (Direct examination of Luker; direct and cross-examination of V.; direct examination of Beirne, direct examination of P., direct examination of Jones; Exhibits. 8, 9, 22, 29, 30)

3. During the summer of 2001, Dr. Gerlay worked as a physician in Ketchikan, Alaska. Beginning in September 2001, Dr. Gerlay was under contract with Dr. Michael Beirne at Northern Lights Clinic in Anchorage. Dr. Gerlay eventually became an employee at the clinic and he had discussions with Dr. Beirne about purchasing the clinic from Dr. Beirne who was planning to retire. However, the business relationship failed and Dr. Gerlay left employment at the clinic on June 14, 2002. In November 2002, Dr. Gerlay took over the medical practice of Dr. Michael Taylor known as the Aurora Pain Management Clinic. Dr. Gerlay worked there as a physician exclusively in the pain management field until April 21, 2005, when his license to practice medicine in Alaska was summarily suspended by the State Medical Board following an investigation by the division of occupational licensing. The division initially investigated patient complaints about their medical treatment beginning in 2002. By subpoena dated August 17, 2004, the division sought medical records from Dr. Gerlay for thirty-one of his patients. The scope of the investigation broadened when female patients complained about alleged sexual misconduct by Dr. Gerlay. The division's Petition for Summary Suspension alleged that Dr. Gerlay was a clear and immediate danger to the public health and safety if he continued to practice medicine. Dr. Gerlay was alleged to have engaged in unprofessional conduct by having a personal substance abuse problem, by failing to meet the standard of care for prescribing controlled substances, and by having sexual relationships with at least two patients and committing sexual improprieties with other patients. (Direct examination of Luker; direct

examination of Beirne; Exhibits. 1, 8, 24, 25 [Dr. Beirne memo attached as Appendix "B" to exhibit 25]; 29, 30, 44)

4 K. P. saw Dr. Gerlay as a patient in New Mexico beginning in 1990. Ms. P. was a registered nurse. After she became a patient of Dr. Gerlay, he requested that she begin working for him full-time in his medical practice. She worked for Dr. Gerlay until May 1994, when he closed his solo practice in Deming, New Mexico. Ms. P. remained friends with Dr. Gerlay. In 1997, they became sexual partners. Ms. P. lived in Dr. Gerlay's home in Santa Fe, New Mexico. Throughout the course of time that Dr. Gerlay and Ms. P. were in a sexual relationship, Dr. Gerlay continued to treat her by prescribing medications. In August 2001, Ms. P. relocated from New Mexico to Ketchikan to live in the same household with Dr. Gerlay. Ms. P. had the understanding that she was in an exclusive sexual relationship with him. At various times in Dr. Gerlay's Santa Fe and Alaska residences, Ms. P. took care of Dr. Gerlay's child while he worked. Ms. P. testified that during a period extending from 1995 into 2002, Dr. Gerlay wrote many prescriptions in her name for controlled substances, including Wellbutrin, oxycodone,[7] Dextrostat, Vicoprofen, Ambien and Actiq. Although some prescriptions were ostensibly for Ms. P., they were intended for Dr. Gerlay and Ms. P. gave the drugs to him. According to Ms. P., the scheme was Dr. Gerlay's idea.[8] Dr. Gerlay treated Ms. P. as a patient when he worked at Northern Lights Clinic in 2001 and 2002. He introduced Ms. P. to Dr. Beirne as "my wife," although they never married. During the investigation in this case, Dr. Gerlay boldly denied to a division investigator that Ms. P. was his patient during the time he was in a relationship with her and she was taking care of his daughter; the weight of evidence at the hearing proved this statement by Dr. Gerlay to be false[9]. Ms. P. offered credible testimony confirming her status as a patient and sexual partner of Dr. Gerlay. Her relationship with Dr. Gerlay ended in turmoil in October 2002, with cross-allegations of domestic violence. Ms. P. re-established her residency

[7] Oxycodone is an opioid analgesic medication synthesized from thebaine; it is sometimes called oxycotin.

[8] Dr. Gerlay denied to a division investigator that he ever issued a prescription that was intended for his personal use. Ms. P.'s testimony under oath and subject to cross-exam and her statement to the investigator was more credible than Dr. Gerlay's written denial.

[9] On September 23, 2002, Dr. Gerlay notified the executive administrator of the State Medical Board that he first became "boyfriend/girlfriend" with Ms. P. when she moved to Ketchikan, that Ms. P. had psychiatric problems, and that she obtained a domestic violence order against him in Alaska. (Exhibit 14) His December 4, 2002, response to a division questionnaire acknowledged that Ms. P. was a patient beginning in 1990. Revealing his very personal involvement with the patient, he described her as an "exceedingly toxic individual" and "a very hostile and potentially dangerous individual, who suffers from delusions, hallucinations, paranoid psychosis . . . and personality disorders." (Exhibit 17) Dr. Gerlay admitted in a conversation with Ms. Luker that he had a sexual relationship with Ms. P. (Direct examination of Luker, Exh. 16)

in New Mexico. Dr. Gerlay represented to the executive administrator of the board that Ms. P. took her medical records and "hid them from him." At the hearing, Ms. P. denied that she ever had possession of her medical records and provided convincing testimony that Dr. Gerlay refused to send them to her.[10] When Ms. P. departed Alaska in October 2002, she was dependent on Actiq suckers. (Direct and cross-examination of P.; direct examination of Beirne; re-direct examination of Roberson; Exhibits 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 20, 24, 45)

5. In December 2002, W. M. began seeing Dr. Gerlay as a patient at Aurora Pain Management Clinic for back problems and complications from abdominal surgery. She had previously been a patient of Dr. Taylor at the clinic, and she also received treatment from Dr. Peter Marbarger. According to Ms. M., Dr. Gerlay made several inappropriate comments of a flirtatious nature when she was in his office for treatment. While Ms. M. was partially disrobed in the treatment room with her pants down and her blouse pulled up, Dr. Gerlay stated to her while, administering a shot into her back, that a little more sex might relax her a little bit better and that she was "not getting enough [sex]." According to Ms. M., as she was leaving the clinic that day, Dr. Gerlay followed her outside the office into the parking lot and asked for her phone number. He later called Ms. M. on the phone. Eventually, they went to dinner together at his request. As their relationship developed, Dr. Gerlay called Ms. M. from his phones at the office, at home, and from his cell phone. (Direct and cross-examination of M.; Exhibits 44, 45, 46, 47, 48, 49, 50)

6. During the summer of 2003, Ms. M. and Dr. Gerlay became involved in a consensual sexual relationship. Their sexual relationship persisted over a period of four months. During that time, Ms. M. saw Dr. Gerlay almost every day. According to Ms. M., "we went everywhere" and "we did everything together." Ms. M. was an accountant. She helped Dr. Gerlay manage the clinic's business books, both at the office and while at Dr. Gerlay's home; she received no compensation for these services. She paid bills for the clinic and handled its banking matters. She had a joint membership account with Dr. Gerlay at Costco where she purchased personal items and business items for the clinic. Throughout the course of their romantic relationship, Ms. M. continued to see Dr. Gerlay as a patient about once a month. Dr. Gerlay prescribed Valium for her and according to Ms. M., "he ended up getting [the Valium]."

[10] Although Dr. Beirne provided Ms. P. with her medical records, records for Dr. Gerlay's treatment of her were not provided. (Direct examination of P.; Exh. 9)

In late 2003, Dr. Gerlay gave Ms. M. "a big bottle" of the drug Kadian without a prescription. During a one-year period beginning in December 2003, Ms. M. received Kadian by prescription from Dr. Gerlay as well as prescriptions for Hydromorphone, Ambien, Provigil, Lidoderm, Hydrocodone, Alprazolam and Daizepam. According to Ms. M., Dr. Gerlay cut back on her post-abdominal surgery pain medication dosages in order to punish her for discussing matters with one of his employees against his wishes. Dr. Gerlay also prescribed medication for Ms. M. that was intended and used for his dog who had stomach problems. Ms. M. witnessed Dr. Gerlay fall asleep or nod off a few times while standing and once while sitting at a Thanksgiving dinner. Dr. Gerlay would catch himself before he fell over. Although the sexual part of their relationship only lasted four months, Ms. M. and Dr. Gerlay saw each other outside of his work setting for approximately one year. They stopped seeing each other socially in September 2003. (Direct and cross-examination of M.; exhibits. 29, 31, 44, 45, 46, 47, 48, 49, 50)

7. S. A. L. began seeing Dr. Gerlay for chronic back pain on a monthly basis as a patient at Aurora Pain Management beginning in December 2002. She is married and has five children. She previously received treatment at the clinic from Dr. Robert M. Swift, and later from Dr. Taylor. Dr. Gerlay never conducted a physical examination of Ms. L. At the hearing, Ms. L. characterized Dr. Gerlay's medical treatment of her as becoming "too personal." In the course of providing treatment to Ms. L., Dr. Gerlay eventually invited her to work for him and travel with him to Las Vegas and Hawaii; if she accepted the offer, he agreed to provide her with free health care. He asked Ms. L. to transport his daughter to karate lessons. He offered to provide her with a cell phone for their exclusive use (between her and him). Dr. Gerlay took a photo of her in his office contrary to her express request.[11] According to Ms. L., while treating her in his office, Dr. Gerlay stated to her that "his dog needed to get some [sex] and so did he." While providing Ms. L. medical treatment, Dr. Gerlay gave her an unmarked envelope containing Lortab (approximately 20 pills) without a prescription;[12] Dr. Gerlay and Ms. L. were in his private office at the time. When he gave her the Lortab, Dr. Gerlay told Ms. L. not to tell anyone about it. (Direct and cross-examination of L.; exhibits 52, 53, 54 [L. prescriptions attached as Appendix "C" to Exhibit 54], 55, 56)

[11] Patient records in this case reflect that photos of patients may have been taken as a matter of practice for inclusion in each file.

[12] The standard of care allows a physician to give sample pills to a patient if the pills are clearly labeled and tracked. (Cross-examination of Hare, tape 9A) The Lortab that Ms. L. was given was not a manufacturer's sample.

8. At various times while being treated by Dr. Gerlay, Ms. L. was taking the following drugs prescribed by Dr. Gerlay: Methadone, oxycotin, Duragesic, Actiq, Kadian, and Morphine Sulfate. During the one-month period from February 13, 2003, to March 13, 2003, Dr. Gerlay prescribed 240 tablets of 40 mg Methadone and 40 disks of 40 mg Methadone for Ms. L.[13] Ms. L. would occasionally go to the pain clinic to see Dr. Gerlay and make a payment (usually $200); [14]a prescription was occasionally handed to her by staff without a physician seeing her. On August 24, 2004, Dr. Gerlay told Ms. L. that a 40 mg Methadone prescription given to her was an error, and that the dosage should have been 10 mg.[15] Ms. L. testified that Dr. Gerlay was lying about this, and stated, "I had always gotten the 40 milligrams." While an undated and unsigned chart note accompanying the August 24, 2004, prescription indicates, "10 mg was changed to 40," Dr. Gerlay's first prescription of Methadone to Ms. L. on December 13, 2002, was for 40 mg, and she received 40 mg Methadone prescriptions from him for over a year and a half. Ms. L. stopped seeing Dr. Gerlay in December 2004. At that point, in time, she described herself as addicted to drugs that Dr. Gerlay had prescribed for her. In January 2005, she went through drug withdrawal and lost 20 pounds. Ms. L. testified that withdrawal was very difficult and it scared her and her family. Investigator Luker described Ms. L.'s demeanor at her interview with the division as follows: "She was crying, she was shaking. She was angry at herself for becoming a victim again;" and "She trusted a doctor and she had been used." (Direct and cross-examination of Ms. L.; Exhibits. 52, 53, 54, 55, 56)

9. S. V. worked for Dr. Taylor at Aurora Pain Management Clinic and later for Dr. Gerlay for about one and a half years. She performed billing, reception duties and "just about everything." She described the practice as very busy and that she worked very closely with Dr. Gerlay. Ms. V. stopped working at the clinic in August 2004. She testified that Dr. Gerlay used pre-signed prescriptions "a couple of times." Some patients received prescriptions without seeing Dr. Gerlay. More than one patient reported to Ms. V. that Dr. Gerlay was falling asleep as he provided treatment to them. Dr. Gerlay was seen sleeping while standing and swaying

[13] The following prescriptions from Dr. Gerlay were also provided to Ms. L. during this same time period: Kadian (100 mg) / 360 tab, Neurontin (100 mg) / 180 cap, Neurontin (300 mg) / 150 cap, Effexor (150 mg) / 120 cap, Carisprodol (350 mg) / 120 tab, Actiq (800 mcg) / 60 lozenge, Provigil (200 mg) / 60 tab.

[14] According to Ms. L., Dr. Gerlay did not accept personal checks in payment for his services. (Exhibit 52, p. 2900032)

[15] Dr. Gerlay wrote on the August 24, 2004, prescription that the dosage "was changed after I signed it. She [L.] probably filled it at a non-Medicaid pharmacy and paid cash." *See* Exhibit 55, pp. 2900064.

back and forth. According to Ms.V., "there would be times when he couldn't even stand up." Some patients complained to Ms.V. that they had to pay "fines" imposed by Dr. Gerlay if they lost their medication and had to replace it. Ms. V. stated that Dr. Gerlay once was concerned about Drug Enforcement Administration (DEA) authorities coming to the office and "he came out of – out of one of the back rooms . . . where he, he saw patients, with a box of pills. Bottles of pills. And I couldn't believe he had that many – that much medication in there. . . . And he started dumping it down the toilet and flushing it." Ms. V. also stated that Dr. Gerlay always kept a gun and a metal baseball bat in his office. (Direct and cross-examination of V.; Exhibits 29, 30)

10. Bradford Hare, M.D., is a physician licensed in Utah. He received a Ph.D. in pharmacology and a medical degree from the University of Utah; he teaches at the university's medical center in Salt Lake City. Dr. Hare is board certified in anesthesiology with a subspecialty certification in pain management, which he acquired from a fellowship at the University of Washington's pain management clinic. Dr. Hare practices medicine solely in Utah in the areas of pain management and operating room anesthesia. The Division of Occupational Licensing contacted Dr. Hare and requested his opinions about Dr. Gerlay's conduct. Dr. Hare reviewed patient records and witness statements obtained during the investigation, provided written reports to the division, and testified at the hearing in this case. (Direct, cross and re-direct examination of Hare; Exhibits 1, 17.)

11. According to Dr. Hare, Dr. Gerlay's unprofessional conduct presented a clear and immediate danger to the public for the following reasons:

- "It is highly likely that Dr. Gerlay has a personal substance abuse problem that has been interfering with his ability to safely and appropriately treat patients."
- Dr. Gerlay had sexual relationships with patients.
- Review of Dr. Gerlay's medical records of the patients he treated indicated an inappropriate pattern of prescribing controlled substances including insufficient patient evaluations and histories.

(Direct, cross and re-direct examination of Hare; Exhibit 1)

12. Dr. Hare recommended that Alaska licensing authorities obtain unannounced samples of urine, blood and hair for toxicology analysis to confirm Dr. Gerlay's use of controlled and illegal substances. The board's summary suspension order dated April 21, 2005, required

Dr. Gerlay to "submit to psychiatric/psychological and medical evaluations, including the submission of biological specimens as deemed appropriate, to determine his ability to practice medicine in a manner consistent with public safety in Alaska." By letter dated April 27, 2005, Dr. Gerlay was advised that the medical board designated Drs. Irwin Dreiblatt and Charles Maurer of Seattle to conduct evaluations of him during the week of May 16, 2005. Dr. Gerlay did not make himself available for evaluations to comply with the board's order during the week of May 16, 2005; Dr. Gerlay did not make arrangements for evaluations at any other time. At the hearing, Dr. Gerlay filed an exhibit and provided it to the division for the first time. The exhibit was a report of his toxicology screening that was conducted May 25, 2005. Results were reported by the lab on May 31, 2005; his blood and urine specimens from the tests were negative for evidence of drug abuse. The hearing in this case commenced on June 1, 2005, and the lab report was admitted into evidence over objection when it was introduced during Dr. Chandler's cross-examination.[16] According to Dr. Chandler, a key element for effective testing is random administration of tests. Dr. Gerlay's May 25 tests were not random. (Direct examination of Luker; direct and cross-examination of Hare; Exhibits 1, 2, J)

13. Leon Chandler, M.D., is an anesthesiologist who practices strictly in the area of pain management through his medical practice, A.A. Pain Clinic, Inc., in Anchorage. Dr. Chandler provided treatment to Dr. Gerlay beginning on July 11, 2002. Dr. Gerlay had previously seen Dr. Michael Beirne for pain management treatment. Dr. Chandler testified at the hearing and his records for treatment provided to Dr. Gerlay were admitted as evidence. Dr. Chandler's initial consultation report for Dr. Gerlay documented complaints of back and hip pain and noted that the patient had a history, which included lumbar and cervical problems as well as a basilar skull fracture from an injury. According to Dr. Chandler, Dr. Gerlay had "very well documented back disease on MRI." Dr. Gerlay also had bowel and bladder dysfunction, and he sometimes had difficulty sleeping. At the time of the consultation, Dr. Gerlay was taking oxycodone and Dexedrine under prescription. Dr. Chandler's treatment included prescribing medications, some of which were refills, including Dexedrine, Desoxyn, oxycotin, Sonata, Provigil and Valium. Dr. Chandler noted on October 14, 2002, that Dr. Gerlay "is on high dose narcotics and amphetamines, which he has taken for years through a physician in New York."[17]

[16] The filing deadline for exhibits was May 23, 2005.

[17] After numerous attempts to contact the New York physician to confirm Dr. Gerlay's treatment, Dr. Chandler was unable to confirm information about Dr. Gerlay's amphetamine prescription.

Dr. Chandler also recorded that Dr. Gerlay "has two urines that are abnormal. Prescriptions written for him for pain control did not show up in his urine. He had altered urine, also. This is a physician and he certainly knows not to do this. . . . At the next visit, he must do a UA [urinalysis] and if the narcotics do not show up in the UA, we have a problem." (Direct and cross-examination of Chandler; Exhibits 19, 20)

14. Dr. Gerlay told Dr. Chandler that he took nutritional supplements, including anti-aging medication, and vitamins. Dr. Chandler testified that there is nothing illegal about using such substances. A list prepared by Dr. Gerlay identified 56 vitamins, nutrients, supplements and medications that he consumed. On November 1, 2002, Dr. Chandler terminated Dr. Gerlay as a patient because of increasing concerns he had about Dr. Gerlay's drug use. Dr. Chandler's concerns arose from his inability to document Dr. Gerlay's treatment history for amphetamines from the New York physician, and because urinalysis was an inadequate method to monitor Dr. Gerlay for use of controlled substances. (Direct and cross-examination of Chandler; Exhibit 20)

15. All patients of Dr. Chandler at A.A. Pain Clinic, including Dr. Gerlay, were required to sign a pain management contract. In response to the question in the contract asking whether the patient "ever had any medical or legal problems with alcoholism, drug abuse (including marijuana), addiction or drug trafficking?"[18] Dr. Gerlay answered "no." After terminating him as a patient, Dr. Chandler learned via an internet search about Dr. Gerlay's 1985 disciplinary action against his medical license in New Mexico; disciplinary action was taken based upon conduct involving controlled substances and personal abuse of controlled substances. (Direct and cross-examination of Chandler; Exhibit 20)

16. Dr. Chandler testified that eighty percent of patients identify pain as their chief complaint. According to Dr. Chandler, there are no medical schools in the country that have a program addressing chronic pain management, and these patients "are the hardest patients in the world to treat."[19] According to Dr.Chandler, "people who are flooding into this specialty [pain management] are inadequately trained, particularly in narcotics." He testified:

> Anesthesiologists who have been using medications of this nature throughout their entire career and nurse anesthetists who have done the same thing understand the responses of medications and titrations. Other subspecialists who are getting into this, particularly physical medicine and neurology and

[18] Emphasis added.

[19] Consistent with Dr. Chandler's comments regarding difficult patients, Dr. Gerlay was physically attacked in the office by a patient he fired. Police came to his office due to the altercation. (Exhibit 29, pp. 3000931-32)

> even psychiatry have no comprehension of narcotic pain management until they start into this at some format, because they have not taken people to the brink of death and brought them back every day of their lives with narcotics or other anesthetic agents.
>
> (Direct and cross-examination of Chandler)

17. Patients, employees, friends and business acquaintances of Dr. Gerlay testified at the hearing in his support. They opined that, to the best of their knowledge, Dr. Gerlay had no problems with alcohol or drug abuse and they never saw him impaired by alcohol or drugs. None of the witnesses testified that they heard Dr. Gerlay make an inappropriate sexual comment to a patient. (Direct examination of Ross; direct examination of Call; direct examination of Erkins; direct examination of Monigold; direct examination of Houston; direct examination of Belleau; direct examination of Nations; direct examination of Lien; direct examination of Roberson; direct examination of Jones; direct examination of Rednall; direct examination of Murphy)

18. The Division of Occupational Licensing initiated an investigation of Dr. Gerlay in April 2002, based on concerns that he was impaired by drugs. Division investigator Debra Luker was assigned to Dr. Gerlay's case. The investigation expanded to include concerns about patient care. Ms. Luker testified at the hearing about her presentation to the medical board supporting the Petition for Summary Suspension, but she refused to testify about matters discussed in the board's executive session, claiming the discussions were privileged.[20] According to Ms. Luker, Dr. Gerlay was not fully responsive to the division requests for medical records of his patients. According to Ms. Luker and Dr. Hare, patient records provided by Dr. Gerlay were often responsive as to treatment by other physicians but did not include Dr. Gerlay's treatment of the patient.[21] During the course of the investigation by Ms. Luker, Dr. Gerlay denied that K. P. was his patient at the time he became involved in a sexual relationship with her. Ms. Luker recounted that all pain management physicians sporadically fire patients and sometimes become the target of patient complaints filed with the division. On this point, Ms. Luker testified that more complaints have been filed against Dr. Gerlay than any other physician in her experience. Although Dr. Hare expressed concerns to Ms. Luker about Dr. Gerlay's possible impairment due

[20] Matters discussed among board members in executive discussion are privileged. However, no opinion is expressed in this instant decision as to whether the testimony of investigator Luker, apparently given to the board while in executive session, is privileged.

[21] (Exhibits 4, 6) Some of the undisclosed documents were not under his control.

to drug use, no Alaska physician reported to Ms. Luker that Dr. Gerlay was impaired. (Direct and cross-examination of Luker; Exhibits 6, 16)

19. J. P. was trained as a medical assistant. She does not have a license under AS 08.64 (medical board) or AS 08.68 (board of nursing). She worked as the equivalent of an office manager for Dr. Beirne and later in that capacity for Dr. Gerlay. Every patient of Dr. Gerlay received a blood work-up and a urinalysis at the lab. While employed for Dr. Gerlay, in addition to performing administrative tasks, Ms. P. drew blood from patients and took vitals as well as doing drug screens. According to Ms. P., Dr. Gerlay would write prescriptions for controlled substances to some patients without seeing them. Although the office sometimes saw 25 patients per day,[22] all of whom were taking or seeking to take pain medication, there were days that Dr. Gerlay saw only 2 to 3 patients. On more than one occasion, Dr. Gerlay wrote prescriptions, signed them and put them in patient charts for use in future days when he anticipated being absent from the office over a holiday period. Dr. Gerlay also would sometimes take schedule II medications away from patients as a punishment for violating their patient contracts or "fine" them for losing medication;[23] the "fines" were payable in cash only. In 2004, while trying out a new patient drug-testing device for office use, Ms. P. tested Dr. Gerlay and the results were positive for cocaine. (Direct and re-direct examination of V.; direct and cross-examination of P.; Exhibits 1, 29, 31)

20. As set forth in Section I above, Dr. Gerlay failed to comply with a board order to submit to examination and testing.

21. Dr. Gerlay has provided additional evidence that has been considered in the drafting of this revised decision and order. On January 15, 2008, Dr. Gerlay signed and sent a letter to the Executive Administrator of the board, which stated, "I am no longer interested in Re-instatement." On March 20, 2008, Dr. Gerlay signed and sent a letter to Administrative Law Judge Stanley, which stated, "I, Gary Steven Gerlay, MD, affirmatively state that I am not seeking reinstatement of my license to practice medicine in Alaska."

III. Discussion

A. *Effect of the Parties' Stipulation*

[22] Some patients complained of waiting 3 to 6 hours at the office to see Dr. Gerlay.

[23] A sign posted in the office window stated $250 for the first time, $400 for the second time, and the third time the patient is fired.

Dr. Gerlay's post-hearing brief argues at length that the prior decision's findings of facts are not supported by the testimony and evidence, or that the facts as found in the prior decision are insufficient to support a conclusion that the relevant statutes were violated. Notwithstanding Dr. Gerlay's post-hearing argument, the parties have stipulated, for the limited purpose of the imposition of a sanction in this proceeding,[24] to the existence of violations of AS 08.64.326(a)(5), (6), (7), (8)(A), (9) and (10), as alleged in Counts I, II, IV-VII, X and XI. By the terms of the stipulation, the ALJ must base his decision regarding sanctions not only on the testimony and evidence, but also on the findings made and the violations established in the Decision on Summary Suspension. In light of the terms of the stipulation, the ALJ will not now consider whether the testimony and evidence support the prior findings, or whether those findings support a legal conclusion that the specified violations occurred; rather, consistent with the parties' stipulation, testimony and evidence from the prior proceeding will be considered when it is relevant to the nature of the appropriate sanction. For example, the testimony and evidence from the prior proceeding will be considered to establish the severity of the offense, the licensee's experience and professional record, and other relevant considerations in the imposition of a disciplinary sanction, but not for the purpose of revisiting or reweighing the factual findings and legal conclusions previously reached.

B. *Legal Standards*

The facts as found by the ALJ clearly establish that the board has discretion to impose a disciplinary sanction under AS 08.64.331(a) because Dr. Gerlay violated multiple provisions of AS 08.64.326(a), as described in the preceding section. The sanctions available include revocation, suspension, censure, reprimand, probation, imposition of limits or conditions, a civil fine of not more than $25,000, or any combination of those sanctions.[25]

The existence of grounds for discretionary imposition of a disciplinary sanction does not in itself establish that a sanction should be imposed, or the nature of the sanction that is appropriate. Following an administrative hearing, the board makes an individualized determination based on the entire record. In making its decision, the board must seek to maintain consistency in the application of disciplinary sanctions, and must explain any significant

[24] Under the terms of the stipulation, "Dr. Gerlay is not admitting that the state in fact proved any of [the allegations of Counts I-XI] or that the hearing officer was correct in any decision he made in the hearing." Stipulation at 2.
[25] AS 08.64.331(a)(1)-(8).

departure from a prior case involving similar facts.[26] For purposes of consistency, sanctions imposed in prior contested cases involving similar facts are directly comparable; sanctions imposed by memorandum of agreement in cases involving similar facts are reviewed as a general guide, but are not directly comparable.[27]

The board may consider the record as a whole in determining an appropriate sanction and may exercise its discretion accordingly. When exercising its discretion with respect to a sanction, the board may consider: (1) the nature and circumstances of the conduct at is issue; (2) the licensee's experience and professional record; (3) any other relevant information; and (4) its actions in prior similar cases.[28]

1. Nature and Circumstances of the Conduct

(a) AS 08.64.326(a)(5)

AS 08.64.326(a)(5) provides that the board may impose a disciplinary sanction if a licensee has "procured, sold, prescribed, or dispensed drugs in violation of a law regardless of whether there has been a criminal action." Only Count VII in the amended accusation alleges a violation of this particular provision. Count VII alleges, and by the terms of the parties' stipulation, it is established for purposes of this decision, that Dr. Gerlay violated this provision of law by "dispensing controlled substances to Ms. L. and Ms. M. without a prescription [in] violation of federal law." The ALJ concluded that this violation was proven on the ground that "Dr. Gerlay dispensed controlled substances to… [Ms. L.] (Lortab) and to [Ms. M.] (Kadian, Valium) either without prescription or with a prescription in the patient's name but intended for his use and used by him."[29] Specifically with respect to Ms. M., the ALJ found that "[i]n late 2003, Dr. Gerlay gave [Ms. M.] a 'big bottle' of the drug Kadian without a prescription"[30] and

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[26] AS 08.01.075(f).

[27] *See Hawthorne v. State*, No. 3AN-04-10154 CI (Superior Court, December 5, 2006).

[28] *See* 12 AAC 40.055(b) for a description of the information that the medical board considers when it receives a license application.

[29] Decision at 13. The Decision on Summary Suspension does not identify the federal statute or regulation violated, as alleged in Count VII. However, the parties' stipulation that this conduct was in violation of AS 08.64.326(a) (5) is accepted for purposes of the imposition of sanctions.

The Decision on Summary Suspension also concludes that that a violation of AS 08.64.326(a)(5) was shown based on other instances in which Dr. Gerlay prescribed or dispensed controlled substances. *Id.*, page 13. However, because those other instances are not specified in the accusation as grounds for finding a violation of AS 08.64.326(a)(5), they are disregarded for purposes of this decision, which is limited to consideration of the violations that are both specified in the accusation and acknowledged in the stipulation as established for purposes of this proceeding.

[30] Decision at 5, ¶6.

that "Dr. Gerlay…prescribed medication for [Ms. M.] that was intended and used for his dog."[31] With respect to Ms. L., the ALJ found that "Dr. Gerlay gave [Ms. L.] an unmarked envelope containing Lortab (approximately 20 pills) without a prescription."[32]

Dr. Gerlay's post-hearing brief argues that the testimony supporting the findings of dispensing controlled substances without a prescription is of limited credibility. Dr. Gerlay argues that even if the testimony is true, Dr. Gerlay's conduct did not constitute a violation of AS 08.64.326(a)(5) because the underlying incidents involved the routine distribution of free samples, a common practice in the medical field.[33]

As previously noted, the sufficiency of the testimony and evidence with respect to this violation will not be revisited. Dr. Gerlay's argument that it is a common practice for physicians to dispense medications as free samples, rather than by prescription, may be true but it fails to take into account that the drugs at issue in this count were controlled substances, and that their distribution is subject to strict limits under both federal and state law.[34] That family practitioners routinely dispense free samples of some medications that are ordinarily available only upon prescription does not mean that a pain clinic practitioner's unrecorded, unprescribed distribution of controlled substances is a minor record-keeping transgression. The alleged violation has been established; distributing drugs without a prescription is a serious breach of applicable law.

(b) AS 08.64.326(a)(6)

AS 08.64.326(a)(6) provides that the board may impose a disciplinary sanction if the license "intentionally or negligently permitted the performance of patient care by persons under the licensee's supervision that does not conform to minimum professional standards even if the patient was not injured." Only Count VI of the amended accusation alleges a violation of this particular provision. Count VI alleges, and by the terms of the parties' stipulation, it is established for purposes of this decision, that Dr. Gerlay violated this provision of law by "allowing his unlicensed employee, J.P., to provide patient care to Dr. Gerlay's patients in lieu of

[31] Decision at 6, ¶6.
[32] Decision at 6, ¶7.
[33] Post-Hearing Brief of Respondent Gary Steven Gerlay, M.D. [hereinafter, Dr. Gerlay Post-Hearing Brief] at 29-30, *citing* Symm, Barballee, "Effects of Using Free Sample Medications on the Prescribing Practices of Family Physicians", *19 JOURNAL OF THE AMERICAN BOARD OF FAMILY MEDICINE* 443-449 (2006) [this article is accessible online at www.jabfm.org]. None of the prescription drugs studied by the authors was one of the controlled substances that Dr. Gerlay dispensed. *Id*., Table 1 at 445.
[34] *See* AS 17.30.020, *et seq*, (regulation of manufacture, distribution, prescription, and dispensing of controlled substances).

Dr. Gerlay providing the care himself."[35] The Decision on Summary Suspension concludes that a violation of AS 08.64.326(a)(6) was established because Dr. Gerlay allowed "his employee J. P. – who was not adequately licensed for the work delegated to her – to provide care to patients in lieu of Dr. Gerlay providing the care." Specifically, the decision finds that Ms. P. "drew blood from patients and took vitals as well as doing drug screens."[36]

Dr. Gerlay argues that Ms. P. was a "certified medical assistant who received her state license [in another state] in 1998, and a national certification in 1999," and that all of the duties she performed for Dr. Gerlay were within the scope of her license and did not constitute the practice of medicine. The division argues that Ms. P. was not licensed in Alaska under AS 08.64 or AS 08.68, and that revocation of Dr. Gerlay's license is warranted because he allowed her to prepare prescriptions, which he signed without seeing the patient.[37]

To the extent the parties' arguments address the existence of a violation of AS 08.64.326(a)(6), the terms of the parties' stipulation govern; the violations are established as set out in the amended accusation and in the Decision on Summary Suspension. The division has not cited any evidence in the record indicating that Ms. P.'s manner of drawing blood, taking vitals, or administering drug tests failed to meet the standard of care, and the division has not cited to any authority for the proposition that Ms. P. was required to have a license under AS 08.68[38] or AS 08.64 in order to draw blood, take vitals or administer drug tests. The focus of the division's argument with respect to Count VI is Dr. Gerlay's practice of relying on Ms. P. for the purpose of issuing prescriptions.

The conduct of Ms. P. is governed by AS 08.64.326(a) (6). In the absence of more specific findings relating to licensing requirements under Alaska law or Ms. P.'s qualifications

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[35] The division argues that Dr. Gerlay also violated this section by allowing Ms. P. to prepare prescriptions. Division's Post Hearing Brief at 7. However, Dr. Gerlay's practice of providing prescriptions without examining a patient is addressed elsewhere. For this reason, and because the parties have stipulated to a violation as alleged, it is not necessary to consider whether drafting prescriptions for a doctor's signature constitutes providing "patient care" within the meaning of AS 08.64.326(a)(6).

[36] Decision at 11, ¶19.

[37] Division's Post Hearing Brief at 7, *citing Kolnick v. Director, Board of Medical Quality Assurance,* 161 Cal. Rptr. 289 (Cal. App. 1980).

[38] AS 08.68 addresses the licensing of nurses.

under another state's laws, the alleged violation of AS 08.64.326(a)(6) by Dr. Gerlay appears to be of minimal severity.[39]

(c) AS 08.64.326(a)(7)

AS 08.64.326(a)(7) provides for the imposition of a disciplinary sanction for "failure to comply with [AS 08.64], a regulation adopted under [AS 08.64], or an order of the board. Counts V, VIII and XI allege conduct in violation of AS 08.64.326(a)(7). The parties have stipulated that the Decision on Summary Suspension established violations of all three counts as alleged in the amended accusation. The decision's findings and conclusions relating to AS 08.64.326(a)(7) involve the failure to: (a) "prepare and maintain [for at least seven years] accurate, complete, and legible records…for each patient and to make those records available" as required by 12 AAC 40.967(9) and (10); (b) "create and maintain a complete, clear, and legible written record of care" concerning patients for whom Dr. Gerlay prescribed controlled substances, as required by 12 AAC 40.975; and (c) comply with a board order for a mental and physical examination.

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[39] AS 08.64.326(a)(6) is not a blanket prohibition on the use of an unlicensed person to provide "patient care." The statute prohibits intentionally or negligently permitting a person under the licensee's supervision (which could be another licensee) to provide patient care "that does not conform to minimum professional standards." Arguably, as the board and the superior court concluded in a prior case, this subsection allows the imposition of a disciplinary sanction for the negligent supervision of a person providing patient care, without regard to whether the patient care meets minimum professional standards. *See Shimotsu v. State, Department of Commerce and Economic Development*, No. 3AN-00-03717 CI at 9-10 (Superior Court, December 10, 2001).

Beyond AS 08.64.326(a), the board's regulations prohibit the use of unlicensed employees to "practice a profession," the delegation to an unqualified person the performance of "professional practice responsibilities," and "facilitating the practice of a profession licensed under AS 08.64 by a person who is not licensed, incompetent, or…unable to practice safely." *See* 12 AAC 40.497(6), (7), (21). Violation of one of those regulations would be in violation of AS 08.64.326(a)(9), regardless of whether the patient care provided meets minimum professional standards, and regardless of whether the *Shimotsu* interpretation of AS 08.64.326(a)(6) is correct.

Count VI does not allege that Dr. Gerlay's employee provided patient care that did not conform to minimum professional standards. The findings adopted for purposes of this decision establish that J. P. "drew blood from patients and took vitals as well as doing drug screens." Decision at 11, ¶19.

At page 15, the decision states that "Dr. Gerlay…provided substandard care by allowing his employee, J. P. – who was not adequately licensed for the work delegated to her – to provide care to patients in lieu of Dr. Gerlay providing the care." Assuming that a license under AS 08.64 is required in order to draw blood, take vitals, or perform drug screens, this statement relates to 12 AAC 40.497(6), (7) and (21), and hence to AS 08.64.326(a)(9) ("unprofessional conduct"), but it does not indicate that Ms. P. provided patient care that did not meet minimum professional standards, except in the sense (also articulated at page 23) that she should not have been providing that sort of "patient care" at all, which is what 12 AAC 40.497(6), (7) and (21) address.

Despite these concerns, consistent with the board's prior interpretation of AS 08.64.326(a) as affirmed in *Shimotsu*, and consistent with the parties' stipulation, ALJ accepts it as established that Dr. Gerlay violated AS 08.64.326(a)(6) by permitting Ms. P. to draw blood, take vitals, and perform drug screens, regardless of whether she performed those tasks in accordance with minimum professional standards, and regardless of whether a professional license was required for any of those tasks. Dr. Gerlay's argument to the contrary goes to the existence of grounds for imposition of a disciplinary sanction.

(i) Inadequate Patient Records [12 AAC 40.967(9), (10)]

12 AAC 40.967(9) and (10) require a licensee to prepare and maintain adequate patient records and to make them available for investigative purposes. The Decision on Summary Suspension concludes that in some cases, Dr. Gerlay violated 12 AAC 40.967(9) and (10) by failing to prepare his own patient records, and that he failed to make available those records that he did prepare.[40] Specifically, the decision finds that according to testimony at the hearing, "Dr. Gerlay was not fully responsive to division requests for medical records of his patients" and "patient records provided by Dr. Gerlay were often responsive as to treatment by other physicians but did not include Dr. Gerlay's treatment of the patient."[41] In light of these findings, it is the failure to produce patient records, not the failure to prepare or maintain them, that underlies this violation.

Dr. Gerlay argues, based on the testimony of his office assistant, Ms. P., that he produced all of the patient records in his possession or control, and that he should not be sanctioned for the non-production of records in the possession or control of Dr. Beirne,[42] in whose clinic Dr. Gerlay practiced from September 2001, until June 14, 2002.[43]

Dr. Gerlay's argument is directed to the sufficiency of the evidence to support the findings and to the sufficiency of the evidence to support conclusion that the cited regulations were violated. As previously noted, those arguments will not be considered in connection with the imposition of a sanction. The decision makes no specific findings regarding the failure to prepare patient records with respect to 12 AAC 40.967(9); the findings (as quoted above) with respect to the failure to produce records are also unspecific. In the absence of any specific findings to establish with specificity the records that Dr. Gerlay had in his possession or control, yet failed to produce such records, this violation appears to be of minimal severity. The failure to produce records upon receipt of a proper demand raises the inference that the records may not have prepared or maintained as required by regulation.

(ii) Inadequate Prescription Records [12 AAC 40.975(1), (2), 4)]

12 AAC 40.975(1) mandates that a licensee's records must include "a patient history and evaluation sufficient to support a diagnosis." The Decision on Summary Suspension concludes

[40] Decision at 16.
[41] Decision at 11, ¶18.
[42] Dr. Gerlay Post-Hearing Brief at 31-36.
[43] Decision at 3, ¶3.

that Dr. Gerlay violated regulation 12 AAC 40.975(1) "by failing to make written records of 'a patient history and evaluation sufficient to support a diagnosis' for many patients."[44] Specifically, the decision concludes that "Dr. Gerlay's diagnosis of rheumatoid arthritis for patient [H.B.] was not adequately supported by the medical records."[45] Dr. Gerlay does not assert that his own written records contain a patient history and evaluation sufficient to support a diagnosis of rheumatoid arthritis for [H.B.]; rather, Dr. Gerlay argues that he properly relied on prior doctors' diagnoses of rheumatoid arthritis.[46]

To the extent that Dr. Gerlay suggests that the evidence is insufficient to support the alleged violations, the argument is disregarded. To the extent that Dr. Gerlay's argument is advanced in mitigation, it is not persuasive; the cited regulation expressly provides that the licensee must create the record evidencing a patient history and evaluation. Whether Dr. Gerlay's diagnosis is adequately supported is not at issue with respect to this violation; the issue is whether Dr. Gerlay himself created a record sufficient to support his own diagnosis. Even if there is evidence in the record to support the diagnosis, it does not lessen the severity of the record-keeping violation that occurred; it is the record, not the diagnosis, which is at issue.

12 AAC 40.975(2) mandates that a licensee's records must include "a diagnosis and a treatment plan for the diagnosis." The decision concludes that Dr. Gerlay "violated 12 AAC 40.975(2) by not providing a specific diagnosis for [Ms. L.]."[47]

Dr. Gerlay's post-hearing brief does not specifically address the lack of a diagnosis and treatment plan for Ms. L. The lack of a diagnosis and treatment plan for Ms. L. is afforded significant weight in determining the appropriate sanction, in light of the specific finding that "Dr. Gerlay never conducted a physical examination of [Ms. L.]"[48] and the large number of prescription drugs he prescribed for her.[49]

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[44] Decision at 16. The decision implicitly identifies numerous examples of a lack of written records establishing a satisfactory patient history and diagnosis, in concluding that Dr. Gerlay failed to obtain a medical history, to examine the patient, or to make an adequate diagnosis: "Dr. Gerlay never conducted a physical examination of [Ms. L.]." (Decision at 6, ¶); Dr. Hare…indicated that Dr. Gerlay's examination and evaluation of [Ms. L.] was inadequate, lacking a specific diagnosis." (Decision at 14-15); "According to Dr. Hare, Dr. Gerlay's diagnosis [for R.P.] of 'chronic pain' was substandard as lacking in specificity." (Decision at 17).

[45] Decision at 16.

[46] Dr. Gerlay Post-Hearing Brief at 19-22.

[47] Decision at 16. The lack of any diagnosis, of course, is not the same as an inadequately supported diagnosis, or an inappropriately unspecific diagnosis. Those types of concerns are dealt with elsewhere. *See* note 17, *supra*.

[48] Decision at 6, ¶7.

[49] Decision at 6-7, ¶8.

12 AAC 40.975(4) mandates that a licensee's records must include "a record of drugs prescribed, administered, or dispensed, including the type of drug, dose, and any authorized refills." The Decision on Summary Suspension concludes that Dr. Gerlay violated 12 AAC 40.975(4) when he "failed to keep a record of drugs for patients [Ms. M.] and [Ms. P.]."[50]

Dr. Gerlay's post-hearing brief does not specifically address the lack of records for patients, Ms. M. and Ms. P., except insofar as he argues that the relevant records were in the possession of others. However, that argument does not pertain to Ms. M. who became Dr. Gerlay's patient after November 2002, when Dr. Gerlay assumed control of the Aurora Pain Management Clinic.[51] Nor does that argument pertain to Ms. P., who, according to the specific findings in the decision, was provided prescription drugs from 1995 to 2002; Ms. P. credibly testified that Dr. Gerlay had possession of her medical records and refused to provide them to her.[52] In any event, the argument is directed to the sufficiency of the evidence, rather than to mitigation or to any other considerations relevant to the imposition of a sanction. Because of the important role that record keeping serves to insure that drugs are not improperly diverted, this violation is afforded significant weight, especially in light of the evidence of improper delivery of drugs to both Ms. M. and Ms. P.

The multiple violations of 12 AAC 40.975 are not mere isolated record-keeping offenses. The violations are indicative of ongoing improper prescription practices. As such, these are comparatively serious within the range of possible violations of 12 AAC 40.975 and should be considered in the imposition of a disciplinary sanction.

(iii) Failure to Comply with Board Order

Count XI alleges that Dr. Gerlay failed to submit to a board-ordered evaluation, in violation of AS 08.64.326(a)(7). The Decision on Summary Suspension finds that the board ordered Dr. Gerlay to submit to evaluations,[53] that it designated two physicians to conduct evaluations of Dr. Gerlay during the week of May 16, 2005, and that Dr. Gerlay "did not make himself available for [those] evaluations…or make arrangements for evaluations at any other time."[54]

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[50] Decision at 16.
[51] Decision at 3, ¶3.
[52] Decision at 4, ¶4
[53] Testifying for the division, Dr. Bradford Hare recommended drug testing for Dr. Gerlay. Decision at 18, *fn* 35.
[54] Decision at 8-9, ¶12.

There is ample evidence in this case to raise deep and serious concerns about Dr. Gerlay's status as an impaired physician. His failure to submit to the board's order compromised the division's ability to effectively investigate those concerns. In light of the possibility of physician impairment, Dr. Gerlay's failure to comply with this board order is a serious violation of AS 08.64.326(a)(7). In the absence of an exam, the evidence that Dr. Gerlay is impaired is unrebutted.

(d) AS 08.64.326(a) (8)(A)

AS 08.64.326(a)(8)(A) provides for the imposition of a disciplinary sanction for "professional incompetence." The applicable regulation has defined professional incompetence as "lacking sufficient knowledge, skills, or professional judgment in that field of practice which the physician…concerned engages, to a degree likely to endanger the health of his or her patients."[55]

Counts V, VI, VIII and X allege conduct in violation of AS 08.64.326(a)(8)(A).[56] The parties have stipulated that the Decision on Summary Suspension established violations of all four counts as alleged in the amended accusation. The Decision concludes that, "[i]n summary, [Dr.] Gerlay engaged in professional incompetence and repeated negligent conduct…based on his failure to obtain histories and conduct adequate evaluations for [H.B.], [R.P.], [Ms. L.] and other patient files Dr. Hare addressed."[57] These general grounds, and the specific allegations of Counts V and VIII, are addressed in connection with related grounds for imposition of disciplinary sanctions under AS 08.64.326(a)(7); the specific allegations of Count VI are addressed in connection with AS 08.64.326(a)(6). Count X, which specifically addresses "writing prescriptions for patients without seeing them, and…presigning prescriptions," is the only one of the four counts that is limited to AS 08.64.326(a)(8)(A) as a ground for imposition of a disciplinary sanction.

The failure to meet professional standards for prescription of controlled substances is a serious violation of AS 08.64.326(a)(8)(A). With respect to Count X, the Decision finds that Dr. Gerlay wrote prescriptions for multiple patients without seeing them, and wrote pre-signed

[55] 12 AAC 40.970.
[56] Count V also references AS 08.64.326(a)(7), but does not specifically allege any record-keeping violations. Rather, it alleges a failure to conduct "proper evaluations and physical examinations." To the extent that the conduct at issue in Count V concerns record-keeping violations, they are addressed in connection with Count VIII of the accusation.
[57] Decision at 17-18.

prescriptions.[58] Both practices, according to testimony at the hearing, are below the minimum standard of care and constitute professional incompetence.[59]

Dr. Gerlay's post-hearing brief suggests that his prescription practices were the result of inadequate office procedures, which Dr. Gerlay can avoid in the future by instituting better office procedures.[60] For purposes of imposition of a disciplinary sanction, this argument is not persuasive. It presumes that the entire litany of offenses by Dr. Gerlay constitutes nothing more than inadvertence and poor case management. To the contrary, the record as a whole suggests that Dr. Gerlay's prescription practices are not inadvertent or negligent, but rather were intentional and deliberate; the findings establish that Dr. Gerlay on multiple occasions prescribed controlled substances without first examining the patient, that he utilized pre-signed prescriptions, that he dispensed controlled substances without making records of those transactions, and that he failed to support the dispensation or prescription of controlled substances with appropriate diagnoses. In character and number, these offenses suggest intentional disregard for the minimal standards of professional practice, with potentially serious effects on patient health and well-being; they are serious violations of AS 08.64.326(a)(8)(A).

(e) AS 08.64.326(a)(9)

AS 08.64.326(a)(9) provides for the imposition of a disciplinary sanction for a licensee who engages "in sexual misconduct, or in lewd or immoral conduct in connection with the delivery of professional services to patients." Counts I, II and IV allege sexual misconduct, and the Decision on Summary Suspension finds that the evidence at the hearing established all three instances. The first instance involves Ms. P., who was a patient of Dr. Gerlay's before their sexual relationship began in 1997,[61] and who cohabited with Dr. Gerlay for a portion of the time from 1997 to 2002. The second instance involves Ms. M., who was a patient of Dr. Gerlay's

[58] S. V. "testified that Dr. Gerlay used pre-signed prescriptions 'a couple of times'. Some patients received prescriptions without seeing Dr. Gerlay." (Decision at 7, ¶5); according to [J.] P., Dr. Gerlay would write prescriptions for controlled substances to some patients without seeing them….On more than one occasion, Dr. Gerlay wrote prescriptions, signed them and put them in patient charts for use in future days…" (Decision at 11, ¶19).

[59] Decision at 13 -14 (citing testimony by Dr. Hare). *See, e.g., Matter of Brudenell*, No. 2900.04.055 (July 21, 2005).

[60] Dr. Gerlay Post-Hearing Brief at 59.

[61] Dr. Gerlay's Post Hearing Brief refers to testimony by Ms. P. to this effect. Dr. Gerlay Post Hearing Brief at 10, citing Tr. 226. Dr. Gerlay argues that because the couple was already in a sexual relationship before Dr. Gerlay was licensed in Alaska, the board lacks authority to impose discipline on the ground of a violation of AS 08.64.326(a)(9). Dr. Gerlay Post-Hearing Brief at 11-12. The board has previously rejected that argument. Decision on Summary Suspension at 21. In any event, the parties' stipulation establishes the violation for purposes of the imposition of disciplinary sanctions.

beginning in December, 2002, and was in a sexual relationship with him for about four months in 2003, while still in a doctor-patient relationship with him. The third instance involves Ms. L., to whom Dr. Gerlay made a lewd comment.

Dr. Gerlay argues that the first two instances were not in violation of AS 08.64.326(a) (9) because the sexual relationship predated the doctor-patient relationship (for Ms. P.), or because the evidence of a sexual relationship was insufficient (for Ms. M.). Both arguments go to the existence of grounds for imposition of a disciplinary sanction; pursuant to the parties' stipulation, the violations are taken as established. To the extent that Dr. Gerlay argues that the violations were mitigated, the argument is not persuasive; both relationships involved not only sexual relations, but also independent professional misconduct in the prescription and delivery of controlled substances. While the relationships were consensual, they were particularly serious violations of the prohibition on sexual relations with a patient because of the associated drug-related misconduct.[62]

The third instance is relatively minor. Dr. Gerlay's lewd comment to Ms. L. was inappropriate, but standing alone, it was not grounds for any substantial disciplinary action.

2. Licensee's Experience and Professional Record

Dr. Gerlay has been a licensed physician for nearly 26 years, and he was once previously disciplined for unprofessional conduct involving controlled substances and for abuse of controlled substances. There was substantial testimony from individuals personally acquainted with Dr. Gerlay to the effect that those individuals had no knowledge of drug abuse by Dr. Gerlay, and no finding has been made in this case that Dr. Gerlay is a drug abuser, or that he has ever engaged in the practice of medicine while impaired by alcohol or drugs. However, the board need not make a specific finding of drug abuse or impairment in order to consider substantial evidence that strongly suggests the possibility of such a status when fashioning an appropriate disciplinary sanction based on other grounds. This is particularly true when, as in this case, those other grounds directly relate to inadequate record-keeping regarding controlled substances and improper prescription practices generally, and where the physician has a prior history of drug abuse and has been subjected to professional discipline on that ground and subsequently failed to submit to a board-ordered evaluation. In light of such evidence, Dr.

[62] *See* Decision on Summary Suspension at 22.

Gerlay agrees that, if his license is not revoked, it should at the least be conditioned or limited and he should be placed on probation.[63]

3. Other Relevant Circumstances

Dr. Gerlay argues that the charges in this case were poorly investigated, overstated, and stale by the time of the hearing, and that these circumstances warrant leniency in the imposition of a disciplinary sanction.[64] To the extent that Dr. Gerlay relies on the legal doctrine of laches in making this argument, the doctrine does not apply.[65] To the extent that Dr. Gerlay asserts that the investigation was inadequate or incompetent, or that the investigator was biased, the hearing in this case has provided the necessary opportunity for reasoned and deliberate consideration of the charges, and the parties have stipulated to the existence of the violations as alleged; any issues regarding the manner in which the investigation was conducted are moot for purposes of the imposition of a disciplinary sanction.

4. Other Cases

Review of the board's actions since 1997[66] shows that the board has on numerous occasions considered the imposition of disciplinary sanctions on licensees for (a) improper record keeping related to controlled substances or prescription drugs; (b) improper prescription or other delivery of controlled substances or prescription drugs; or (c) sexual misconduct. The board has in one case imposed discipline for (d) permitting unsupervised patient care.

(a) Record Keeping

In six cases since 1997, and in one prior reported case, the board has imposed disciplinary sanctions based on failure to maintain appropriate records for prescription drugs (in four of the cases, the licensee also was found to have improperly prescribed or delivered those drugs): in *Sorenson*,[67] the board revoked a license, issued a reprimand, and imposed a fine of $2,500 on a licensee who was convicted of a felony for knowingly making false records of transactions involving controlled substances; in *Herold*,[68] the board issued a reprimand and imposed of fine of $2,500 on a licensee who prescribed controlled medications without

[63] Dr. Gerlay Post-Hearing Brief at 55-56.
[64] Dr. Gerlay Post-Hearing Brief at 63. *See* generally, *State v. Schell*, 8 P.3d 351 (Alaska 2000).
[65] *See State v. Schnell*, at 359, for the proposition that the doctrine of laches does not bar claims due to adjudicatory delay.
[66] The board's prior actions are summarized at www.commerce.state.ak.us/occ/pmed4.htm (links to "Board Actions Before August 1997" and "Board Actions After August 1997") (accessed June 12, 2007). As of May 9, 2007, the summary report contains brief descriptions of more than 200 board disciplinary actions.
[67] *In re Kurt E. Sorenson*, No. 2808-04-001 (October 13, 2006) (Mobile Intensive Care Paramedic).
[68] *In Re William L Herold*, No. 2800-02-9 (January 15, 2004).

maintaining proper records; in *Davidhizar*,[69] the board placed a licensee on probation for two years, issued a reprimand, and imposed a civil fine of $5,000 because the licensee who prescribed drugs without maintaining appropriate records, and left presigned scripts used inappropriately by a physician's assistant; in *Brockman*, [70] the board issued a reprimand and imposed a civil fine of $5,000 on a licensee who prescribed drugs without maintaining appropriate records, for a person with whom he had a personal relationship; in *Rapoport*,[71] the board issued a reprimand and imposed a civil fine of $5,000 ($2,000 suspended) on a licensee who failed to maintain records and prescribed drugs to a person with whom he had a personal relationship; and in *Halter*,[72] the board imposed a civil fine of $3,000 and two years probation on a licensee who failed to appropriately chart prescriptions in numerous instances.

The foregoing cases are comparable to Dr. Gerlay's insofar as they involve faulty record-keeping. Only in the case involving a criminal conviction did the board revoke the license; in none of the other cases did the board suspend the license; in all cases, the board issued a reprimand.[73] In the three cases which involved improper non-criminal prescription or other wrongful dispensing of drugs (*Davidhizar, Brockman,* and *Rapaport*), in addition to record-keeping matters, the board imposed a civil fine of $5,000 or more; in *Herold* and *Halter,* the cases that involved only record-keeping problems, the board imposed civil fines of $2,500 and $3,000, respectively.

(b) Improper Prescription, Administration or Delivery

The board has imposed disciplinary sanctions in approximately sixteen cases involving the improper prescription, administration or delivery of controlled substances (in addition to the three cases previously mentioned that also involved record-keeping problems). In four of those cases, the licensee was convicted of a related criminal offense; in three of the four cases the license was revoked or surrendered; in the fourth case the license was suspended. In *Van*

[69] *In Re Lavern R. Davidhizar*, Nos. 2802-00-002, 2802-99-001 (October 27, 2000).
[70] *In Re Ronald Brockman*, No. 2802-00-004 (October 27, 2000).
[71] *In Re Dov Rapoport*, No. 2800-99-054 (August 4, 2000).
[72] *Halter v. State, Department of Community and Economic Development, Medical Board*, 990 P.2d 1035 (Alaska 1999).
[73] One case involving alleged record keeping violations remained pending, according to the record. *In Re Lisa Carole Routh*, No. 2800-99-120. Somewhat different are cases in which the board imposed disciplinary sanctions on licensees who lacked the appropriate authority to administer or prescribe drugs. *See In Re Susan K. Fenn*, No. 2804-00-002 (January 18, 2001) (failed to renew DEA registration, continue to prescribe drugs for ten years); *In Re Marciano D. Bautista*, No. 2802-02-31 (December 20, 2002) (expired DEA registration); *In Re Ashley F. Marquardt*, No. 2806-05-002 (April 21, 2005) (expired DEA registration); *In Re Matthew S. McCorkle*, No. 2809-05-001 (July 21, 2005) (administered Schedule II controlled substances without valid paramedic license).

Houten,[74] the board summarily suspended and later accepted the surrender of the license of a physician who failed to sufficiently evaluate patients for prescription of controlled substances and engaged in other similar prescription-related substandard practices allegedly contributing to patient addiction and death, and who was convicted of multiple counts of health care fraud. In *Gottlieb*,[75] the board revoked the license of a licensee convicted on 234 counts of health care fraud, forgery, perjury, theft, and misconduct involving controlled substances in the third degree, AS 11.71.030(a)(2). In *Palmer*,[76] the board accepted the voluntary surrender of the license of a licensee who, on probation for violating a permanent prohibition against prescribing Schedule II controlled substances resulting from a 1978 felony conviction, was convicted of attempted third degree misconduct involving a controlled substance. In *Ok*,[77] the board issued a reprimand, imposed a civil fine of $10,000 ($5,000 suspended), obtained relinquishment of the licensee's federal registration, and suspended the license for one year. The licensee had sold controlled substances, including morphine, and was convicted of misdemeanor theft. The presence of a criminal conviction, and the absence of associated sexual misconduct, distinguishes those cases from Dr. Gerlay's case; *Van Houten* and *Gottlieb* are also distinguished by the substantially greater number of alleged instances of misconduct.

The other twelve cases did not involve criminal convictions and the board did not revoke or suspend licenses; in all cases, it issued a reprimand. In two cases, *Aaron*[78] and *McKinley*,[79] the licensee was placed on probation; in both of those cases, the licensee had improperly distributed drugs for their own or a personal acquaintance's use. By contrast, in *Craddick*[80] and *Brudenell*,[81] the board did not place these licensees on probation because their conduct was seemingly less objectionable.

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[74] *In re Jay D. Van Houten*, (August 28, 2002, November 12, 2002 & October 21, 2004).
[75] *In Re Jeffrey Gottlieb*, No. 2800-00-018 (January 16, 2004).
[76] *In Re Martin Palmer*, No. 2800-03-005 (August 7, 2003 & May 3, 2005).
[77] *In Re Tae Duk Ok*, No. 2806-03-007 (October 21, 2004).
[78] *In Re Deborah L. Aaron*, No. 2800-02-037 (August 2, 2002) (probation, reprimand, $5,000 fine with $4,500 suspended; licensee (MD) wrote controlled substances prescriptions for a person, not her patient, with whom she had a personal relationship).
[79] *In Re Gena K. McKinley*, No. 2800-02-045 (October 24, 2002) (probation, reprimand, $10,000 fine with $5,000 suspended; licensee (MD) forged controlled substances prescriptions for her personal use).
[80] *In Re Steven L. Craddick*, No. 2806-99-006 (January 20, 2000) (reprimand, $5,000 fine with $3,000 suspended; licensee (PA-C) removed controlled substances from his place of employment and administered them to his dying sister).
[81] *In Re Ross N. Brudenell*, No. 2800-04-055 (July 21, 2005) (reprimand, $10,000 fine with $6,000 suspended; licensee (MD) prescribed Schedule II controlled substances without direct patient contact).

In six of the twelve cases, the board imposed a civil fine of $5,000 or more.[82] In three cases, the board imposed a civil fine of $2,500,[83] and in three cases a lesser fine was imposed, or no fine.[84] In all of these cases, the licensee prescribed controlled substances for use by individuals, without authority or in an improper manner. Of these twelve cases, *Aaron* and *McKinley* are most similar to the Dr. Gerlay fact situation, although the number of incidents in Dr. Gerlay's case appears to be greater than in the *Aaron* and *McKinley* cases, and those cases did not involve associated sexual misconduct. In both cases, the licensee was placed on probation and a fine was imposed; in no case was a license suspended or revoked.

(c) Sexual Misconduct

The board has not previously imposed a disciplinary sanction in a contested case for consensual, non-criminal sexual misconduct. It has in twelve cases summarily suspended a license, imposed a sanction, or accepted surrender of a license by a memorandum of agreement. In three cases, a license was surrendered following convictions for sexual assault.[85] In eight other cases, a license was suspended summarily or by memorandum of agreement or surrendered

[82] In addition to *Aaron, McKinley*, *Craddick*, and *Brudenel*l, these cases are: *In Re Nancy Marlene Mackey*, No. 2806-99-003 (April 27, 2000) (reprimand, $5,000 fine with $2,000 suspended; licensee (PA-C) issued prescriptions for Schedule II controlled substances); *In Re Winnona Gay Petro*, No. 2806-02-009 (October 21, 2004) (reprimand, $5,000 fine with $1,500 suspended; licensee (PA-C) issued prescriptions for Schedule II controlled substances).

[83] *In Re Carl Lester Brown, Jr.*, No. 2806-02-003 (April 1, 2004), *In Re Donna Jean Hanson*, No. 2806-02-002 (April 1, 2004), *In Re Jennifer Jan Oxford*, No. 2806-02-004 (April 1, 2004) (reprimand, $2,500 fine; licensees used pre-signed forms to prescribe Schedule II controlled substances).

[84] *In Re Kami Rae Jowlett*, No. 2806-04-002 (June 9, 2004), *In Re David Paul Wonchala*, No. 2806-04-003 (June 9, 2004) (reprimand, $1,000 fine; licensees (PA-C) unlawfully prescribed Schedule II controlled substances); *In Re Sylvia A. Wyatt*, No. 2806-0101 (January 18, 2001) (reprimand, no fine; licensee (PA-C) authorized use of Schedule II controlled substance without proper authorization by physician).

[85] *In Re Glen W. Straatsma*, No. 2800-98-21 (April 16, 1999) (conviction of second degree sexual assault on patient; license surrender; license reinstated in 2001 by Memorandum of Agreement); *In Re Gary J. Baker*, No. 2806-97-01 (February 24, 1999) (physician assistant; misdemeanor conviction for sexual assault of patients; license surrender following summary suspension); *In Re Clarence Bullock*, No. 2806-02-08 (April 18, 2003) (physician assistant; license surrender; convicted of sexual assault on patients; petition to restore license denied, April 1, 2004).

following an allegation of sexual misconduct.[86] In one case, a licensee was reprimanded, but the license was not suspended, after allegations of sexual misconduct.[87]

(d) Unsupervised Patient Care

In one case, the board ordered a 60-day suspension and imposed a $6,000 fine on a licensee who allowed a high school student to place and inflate a Foley catheter, inject the patient, and suture a wound and left the student unsupervised.[88]

C. *Appropriate Discipline*

In this case, a factually similar case would be a case with the components of: inappropriate prescription practices; inadequate or non-existant medical records; sexual misconduct with a patient; allegations of physician impairment; failure to follow an order of the board; and, the absence of a criminal conviction. No prior contested case demonstrates that confluence of facts. One prior case, which was resolved by memorandum of agreement, is similar; that case is *In Re Frank Joseph Illardi* in which the licensee voluntarily surrendered his license during the course of the hearing.[89]

In the absence of factually similar cases, the board is relegated to considering the facts of this case in comparison to the outcome in dissimilar cases. In contested cases, in the absence of a criminal conviction, inappropriate prescription practices have typically resulted in a reprimand and a fine, with the amount of the fine reflecting the degree of wrongdoing. In contested cases,

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[86] *In Re Alvin P. Cormack*, No. 2800-98-43 (January 22, 1999) (alleged sexual exploitation of patient); *In re Stephen W. Grandstaff*, Nos. 2800-98-3, 2800-99-25 (June 16, 1999) (alleged sexual misconduct); *In Re Ronald Hannon*, No. 2800-99-012 (August 29, 2000) (license surrender while under investigation for sexual misconduct with a patient and unauthorized practice); *In Re William Leach*, No. 2800-00-43 (January 18, 2001) (license suspended following suspension in another state for allegations of sexual misconduct); *In Re Jayesh D. Makim*, No. 2850-01-008 (May 25, 2001) (surrendered license while under investigation for allegations of sexual misconduct; Memorandum of Agreement for 5-year probation with conditions, allowing reinstatement); *In re Jim E. Lewis*, Nos. 2802-98-02, 2802-98-07 (October 26, 2001) (sexual misconduct; license surrender in other states; summary suspension; requirements for medical, psychological, psychiatric evaluations before petitioning for reinstatement); *In Re Stanley H. Schurig*, Nos. 2802-00-08, 2802-02-17, 2802-21 (November 7, 2002 & January 30, 2003) (Memorandum of Agreement for 24 month suspension, $40,000 fine with $10,000 suspended, permanent surrender of DEA license; professional incompetence, failure to maintain records, permitting substandard patient care by employee, improper prescriptions, alleged sexual contact or impropriety with patient); *In Re Frank Joseph Ilardi*, Nos. 2800-03-039, 2800-04-023 (October 13, 2006) (license surrendered while in hearing for sexual misconduct, unprofessional misconduct in connection with delivery of professional services and prescription of controlled substances without evaluation, examination, diagnosis or treatment plan).

[87] *In Re George L. Stewart*, Nos. 2800-00-31, 2800-02-34 (December 20, 2002) (Memorandum of Agreement for reprimand and $10,000 fine, $7,000 suspended). Dr. Stewart subsequently voluntarily surrendered his license while under investigation for sexual misconduct and substance abuse. *In Re George L. Stewart*, No. 2800-05-072 (November 22, 2005).

[88] *In Re Grace E. Shimotsu*, No. 2800-94-14 (July 7, 2000).

[89] Alaska State Medical Board Cases No. 2800-03-039 and 2800-04-023, (January 24, 2006).

in the absence of a criminal conviction, sexual misconduct has typically resulted in a suspension with conditions or limitations, a reprimand, and a fine.

The division has recommended revocation of Dr. Gerlay's license. The division observes that misconduct involving controlled substances is a serious licensing violation; the division cites to three prior board decisions, *Gottlieb, Jones,* and *Van Houten.*[90] The division also refers to numerous decisions from courts in other jurisdictions, in which another board's discretionary decision to revoke a license was affirmed on appeal. *Gottleib* and *Van Houten* involved criminal convictions, which have uniformly resulted in license revocation in prior contested cases; the absence of a criminal conviction in this case distinguishes those cases, as does the substantially greater number of specific instances of wrongdoing identified at Dr. Gerlay's hearing. More typically, in prior contested cases involving misconduct involving controlled substances, but without criminal conviction, the board has declined to revoke the license and has imposed a lesser sanction.[91] *Jones* involved an internet practitioner, licensed in 23 states, whose license had been the subject of adverse actions in at least seven of those states and whose application to practice in Alaska was fraudulent; the facts of that case are dissimilar to this one. Given the factual differences between those three cases and Dr. Gerlay's case, none of the three cited cases is a persuasive precedent for revocation under the particular facts of this case.

Dr. Gerlay argues that the appropriate sanction is a two-year suspension, retroactive to the date of summary suspension, with conditions and limitations. Dr. Gerlay's argument rests on Dr. Hare's stated prioritization of concerns: first, substance abuse, second, sexual misconduct, and third, improper prescription practices, coupled with the absence of any finding of actual substance abuse, and the small number of instances of sexual misconduct. This argument portrays Dr. Gerlay as a physician who presents a manageable risk of harm to a patient, and suggests that the board can adequately protect the public by imposing conditions and limitations. This suggested approach has been typical of the board's reaction to physicians presenting less serious substance abuse concerns.

The division's argument and Dr. Gerlay's argument do not adequately address Dr. Gerlay's combination of misconduct presented in this case. Not only has Dr. Gerlay engaged in inappropriate prescription practices, but he has also engaged in sexual misconduct. The

[90] Division's Post-Hearing Brief at 5-6.
[91] *Supra*, notes 50-54.

combination of those features, coupled with the ample evidence of substance abuse, militates for much more than conditions or limitations on Dr. Gerlay's practice to safeguard the public. In its July 19, 2007 Order, the board established conditions that Dr. Gerlay must satisfy to be considered for reinstatement. Dr. Gerlay has not satisfied any of the board's requirements even though he has had almost one year to do so.

D. *The Board's Authority*

The board has the authority to designate examining doctors. The board is created by statute and the governor appoints its members.[92] The board is charged with several important duties, including imposing sanctions on persons who violate provisions of AS 08.64 or the regulations or *orders of the board*.[93] The board may **not** reinstate a suspended license until it *finds*, after a hearing, *that the applicant is able to practice with reasonable skill and safety.*[94]

In its order of July 19, 2007 requiring Dr. Gerlay to be examined by doctors of its choosing, the board is doing exactly what the law requires—attempting to determine through examining physicians (whom it knows to be competent) whether Dr. Gerlay is able to practice medicine with skill and safety. Given that charge, the board found in 2005 that Dr. Gerlay posed "a clear and immediate danger to the public health and safety" such that it summarily suspended his license. The board is fulfilling its statutory mandate and duty to protect the public when it carefully selects doctors to examine Dr. Gerlay. The selection of Drs. Rawlings and Mauer was a proper exercise of the board's authority and consistent with its July 19, 2007 order.

E. *Consequences of Refusing to Follow a Board Order*

Dr. Gerlay's refusal to be examined justifies license revocation. The division asked in it Motion for Rule of Law whether or not Dr. Gerlay's refusal to be evaluated by Drs. Rawlings and Mauer "…is in violation of the Board's July 19, 2007 order." For several months following the board's order, Dr. Gerlay's refusal might be characterized as a violation, but it was more correctly characterized at that time as a failure to satisfy a condition, which would effectively preclude his consideration for license reinstatement. Now, almost a year after the board's order was issued, Dr. Gerlay's failure to submit to examination by doctor's of the board's choice should and does carry much graver consequences.

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[92] AS 08.64.010.
[93] AS 08.64.101(3).
[94] AS 08.64.331(d).

Medical and psychiatric examinations of Alaska-licensed physicians can be ordered by the board under the authority of AS 08.64.338. When medical and psychiatric examinations are ordered by the board in conjunction with a summary suspension, the examination requirement becomes "limitations or conditions on the practice of a licensee" which are allowed by AS 08.64.331(a)(6).[95] Dr. Gerlay had choices, but substituting his testing preferences for the board's clear and reasonable directive was not an option if he ever wished to be considered for reinstatement.[96] Keeping in mind that this matter involves medical licensing in Alaska, Dr. Gerlay provides no authority or persuasive evidence of why he is entitled to be examined in New Mexico, rather than Seattle (or Alaska). Accordingly, Dr. Gerlay's unexcused failure to meet the terms and conditions of the board's legitimate order supports revocation of his medical license in Alaska.[97]

IV. Conclusion

In light of the nature of the multitude of clearly established serious violations and Dr. Gerlay's refusal to comply with a lawful order of the board, the board should revoke Dr. Gerlay's medical license.

V. Order

Upon adoption of attached Option 1, IT IS ORDERED that the medical license of Gary Steven Gerlay, M.D., is REVOKED

DATED this 26th of June 2008.

By: *Signed*
James T. Stanley
Administrative Law Judge

[95] *In Matter of Schurig*, Case No. 2802-00-8 (January 30, 2006 Memorandum of Agreement), a physician's failure to submit to evaluations under AS 08.64.338 was a ground supporting summary suspension. *In Matter of Kirk*, Case No. 2800-90-1 (April 12, 1990), licensure was denied when the applicant refused evaluation for alleged habitual overuse of alcohol and other drugs.

[96] 12 AAC 40.967(5) deems attempts to subvert the process relating to an examination required under AS 08.64 to be "unprofessional conduct".

[97] AS 08.64.326(a)(7).

Board Action on Proposed Decision

The board having reviewed the proposed decision and order of the hearing officer in the matter of **Gary Steven Gerlay, M.D.,** OAH Case No. 05-0321- MED, Board Nos. **2803-028 *et al.***, hereby

Option 1: adopts the proposed decision in its entirety under AS 44.62.500(b).

Date: 24 July 2008 By: *Jean M. Tsigonis*
Chairperson

Option 2: under AS 44.62.500(b), adopts the Proposed Decision except for reducing the proposed penalty or sanction as follows:

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_____

_____

Date: _____ By: _____
Chairperson

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[This document has been modified to conform to technical standards for publication.]