BEFORE THE BOARD OF PHARMACY EXAMINERS
OF THE STATE OF IOWA

	)	Case No. 2006-063
Re:	)	
Pharmacist License of	)	**STATEMENT OF CHARGES**
ERIC BOEL	)	
License No. 19434,	)	
Respondent.		

COMES NOW, the Complainant, Lloyd K. Jessen, and states:

1. He is the Executive Secretary/Director for the Iowa Board of Pharmacy Examiners and files this Statement of Charges solely in his official capacity.

2. The Board has jurisdiction in this matter pursuant to Iowa Code Chapters 155A and 272C (2005).

3. On September 14, 2004, the Board issued Respondent, following examination, a license to engage in the practice of pharmacy as evidenced by license number 19434, subject to the laws of the State of Iowa and the rules of the Board.

4. Respondent's Iowa pharmacist license is current and active through June 30, 2008.

5. Respondent's current address is 1000 N. Park Circle, Grimes, Iowa 50111.

6. Respondent was, at all times material, employed as the pharmacist-in-charge at Medicap Pharmacy, 250 Gateway Drive, Grimes, Iowa 50111.

A. CHARGES

COUNT I – LACK OF PROFESSIONAL COMPETENCY

Respondent is charged with a lack of professional competency, in violation of Iowa Code § 155A.12(1) (2003) and 657 Iowa Administrative Code § 36.1(4), as demonstrated by willful and repeated departures from, and a failure to conform to, the minimal standard and acceptable and prevailing practice of pharmacy in the state of Iowa.

COUNT II – ENGAGING IN UNETHICAL CONDUCT

Respondent is charged with engaging in unethical conduct in violation of Iowa Code §§ 155A.12(1) and 155A.12(2) (2005) and 657 Iowa Administrative Code §§ 8.11(1), 8.11(8),

6.7(3) and 36.1(4)(c) by, among other things, falsifying prescription information, falsifying dispensing records and falsifying insurance claims.

COUNT III – DISPENSING WITHOUT A PRESCRIPTION

Respondent is charged with distribution of drugs for other than lawful purposes in violation of Iowa Code § 155A.12(1) (2005) and 657 Iowa Administrative Code § 36.1(4)(h), including diversion and distribution of prescription drugs in the absence of a prescription.

COUNT IV – INADEQUATE RECORD KEEPING

Respondent is charged with inadequate record keeping, including inadequate record keeping relating to controlled substances, in violation of Iowa Code ' ' 124.308(3), 155A.12(4), 155A.12(5), 155A.27 (2005) and 657 Iowa Administrative Code ' ' 6.2, 6.8, 8.15 & 36.1(4)(ac) and 21 CFR 1304.11 & 1306.22(b)(3), due to Respondent's failure to maintain accurate records of prescription medications dispensed.

COUNT V – WILLFULLY MAKING FALSE STATEMENT

Respondent is charged with willfully making false statements in connection with prescriptions, reports and records required by Iowa Code chapter 155A (2005), in violation of Iowa Code §§ 155A.12(1) and 155A.23(2) (2005), and 657 Iowa Administrative Code §§ 36.1(4)(j), by falsifying prescription records and insurance claims related to the purchase of Temodar and Lovenox.

COUNT VI – SUBVERTING A BOARD INVESTIGATION

Respondent is charged with attempting to subvert a Board investigation, in violation of Iowa Code chapter 155A.12(1) (2005) and 657 Iowa Administrative Code §§ 36.1(4)(z), by denying knowledge of falsified prescription records and insurance claims related to the purchase of Temodar and Lovenox.

B. CIRCUMSTANCES

Circumstances supporting the above charges are set forth in Attachment A.

WHEREFORE, the Complainant prays that a hearing be held in this matter and that the Board take such action as it may deem to be appropriate under the law.

LLOYD K. JESSEN
Executive Secretary/Director

On this 16 day of January 2007, the Iowa Board of Pharmacy Examiners found probable cause to file this Statement of Charges and to order a hearing in this case.

MICHAEL J. SEIFERT, Chairperson
Iowa Board of Pharmacy Examiners
400 SW Eighth Street, Suite E
Des Moines, Iowa 50309-4688

cc: Scott M. Galenbeck
Assistant Attorney General
Hoover State Office Building
Des Moines, Iowa

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BEFORE THE BOARD OF PHARMACY
OF THE STATE OF IOWA

IN THE MATTER OF:	)	**CASE NOS: 2005-83, 2006-063**
	)	**DIA NO. 06PHB007**
Pharmacist License of	)	
ERIC BOEL,	)	**FINDINGS OF FACT,**
License No. 19434	)	**CONCLUSIONS OF LAW,**
Respondent	)	**DECISION AND ORDER**

On January 26, 2006, the Iowa Board of Pharmacy (Board) found probable cause to file a Statement of Charges against Respondent Eric Boel, a licensed pharmacist. The Statement of Charges alleged that Respondent:

> COUNT I: Violated Iowa Code section 155A.12(1) and 657 IAC 36.1(4), by a lack of professional competency as demonstrated by willful and repeated departures from, and a failure to conform to, the minimal standard and acceptable and prevailing practice of pharmacy in the state of Iowa.
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> COUNT II: Violated Iowa Code sections 155A.12(1) and (2) and 657 IAC 8.11(1) and (8), 6.7(3), and 36.1(4)"c," engaging in unethical conduct, by being party to a deceitful practice in pharmacy and engaging in sexually harassing behaviors.
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> COUNT III: Violated Iowa Code section 155A.12(1) and 657 IAC 36.1(4)"z" by, among other things, attempting to conceal the fact that prescription medications were being dispensed by non-pharmacists in the pharmacy where Respondent served as pharmacist-in-charge.
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> COUNT IV: Violated Iowa Code section 155A.12(1) and 657 IAC 6.7(3) and 36.1(4)"aa" by improper delegation to supportive personnel of pharmacist functions such as filling, providing final verification of and dispensing prescriptions.

Attachment A set forth the factual Circumstances supporting the Statement of Charges. A hearing was initially scheduled for June 6, 2006 but was later continued.

On January 16, 2007, the Board found probable cause to file a second Statement of Charges, alleging that Respondent:

COUNT I: Violated Iowa Code section 155A.12(1) and 657 IAC 36.1(4), by a lack of professional competency as demonstrated by willful and repeated departures from, and a failure to conform to, the minimal standard and acceptable and prevailing practice of pharmacy in the state of Iowa.

COUNT II: Violated Iowa Code sections 155A.12(1) and (2) and 657 IAC 8.11(1) and (8), 6.7(3), and 36.1(4)"c," engaging in unethical conduct, falsifying prescription information, falsifying dispensing records, and falsifying insurance claims.

COUNT III: Violated Iowa Code section 155A.12(1) and 657 IAC 36.1(4)"h" by distributing drugs for other than lawful purposes, including diversion and distribution of prescription drugs in the absence of a prescription.

COUNT IV: Violated Iowa Code sections 124.308(3), 155A.12(4), (5), 155A.27 and 657 IAC 6.2, 6.8, 8.15, and 36.1(4)"ac" and 21 CFR 1304.11 & 1306.22(b)(3) by failure to maintain accurate records of prescription medicines dispensed.

COUNT V: Violated Iowa Code sections 155A.12(1), 155A.23(2) and 657 IAC 36.1(4)"j" by falsifying prescription records and insurance claims related to the purchase of Temodar and Lovenox.

COUNT VI: Violated Iowa Code section 155A.12(1) and 657 IAC 36.1(4)"z" by denying knowledge of falsified prescription records and insurance claims related to the purchase of Temodar and Lovenox.

A Notice of Hearing was issued setting the hearing for March 13, 2007, but the hearing was continued. On or about August 1, 2007, the hearing on both Statements of Charges was rescheduled for September 10, 2007 at 1:00 p.m. The hearing commenced on September 10, 2007 and continued on September 11, 2007. The following members of the Board served as presiding officers for the hearing: Paul Abramowitz, Chairperson; Vernon H. Benjamin; Leman Olson; Susan Frey; DeeAnn Wedemeyer Oleson; and Margaret Whitworth. Attorney Steven Kaiser represented Respondent. Assistant Attorney General Scott Galenbeck represented the state. The hearing was open to the public at Respondent's election, in accordance with Iowa Code section 272C.6(1). Respondent's Motion in Limine was denied by the Board.

Administrative Law Judge Margaret LaMarche assisted the Board in conducting the hearing and was later instructed to prepare the Board's written Decision and Order for their review, in conformance with their deliberations.

THE RECORD

The record includes the Statements of Charges; Notices of Hearing; Rescheduling Orders; Motion in Limine; Resistance To Motion in Limine; the testimony of the witnesses, State Exhibits A-K, and Respondent Exhibits 2-26 (Respondent Exhibit ##1, 20, and 24 were not offered).

FINDINGS OF FACT

Overview - Respondent Licensure and Employment History

1. On September 14, 2004, the Board issued Respondent license number 19434, to engage in the practice of pharmacy in the state of Iowa, subject to the laws of the state and the rules of the Board. Respondent's pharmacist license was renewed on July 3, 2006.

Respondent previously owned two Medicap Pharmacies, which were located in West Des Moines and Grimes, Iowa. On or about April 28, 2006, Respondent sold the patient files and a portion of the inventory for the West Des Moines Medicap Pharmacy to Walgreens. Respondent moved the fixed assets, remaining inventory, and remaining records from the West Des Moines Medicap to the Grimes Medicap, which he continued to own and operate. A number of pharmacy records from the West Des Moines pharmacy were placed in an off-site storage facility. On or about June 17, 2006, Respondent sold the assets (pharmacy files and equipment) of the Grimes Medicap Pharmacy to Mike Taylor.

At all times relevant to both of the Statements of Charges, Respondent was the owner and pharmacist-in-charge at Medicap Pharmacy, 250 Gateway Drive in Grimes, Iowa. At the same time, Respondent also served as a volunteer firefighter/paramedic with the Grimes Fire Department and as a part-time paid firefighter/paramedic with the West Des Moines Fire Department. In or about January 2007, Respondent became employed as a staff pharmacist by a retail pharmacy in Des Moines. (Testimony of Respondent; State Exhibit B)

First Statement of Charges

Improper Delegation of Pharmacist Functions/Unethical Conduct/Subverting a Board Investigation

2. The preponderance of the evidence established that Respondent improperly delegated pharmacist functions, i.e. the dispensing of prescription drugs to patients and patient counseling, to employees who were not licensed pharmacists. This was established by the testimony of credible witnesses, a prescription receipt, and consistent hearsay statements from former employees and student interns. However the state failed to establish, by a preponderance of the evidence, that Respondent intentionally or actively participated in a specific ruse involving a duplicate prescription in order to subvert the Board's investigation.

a. The Board's investigation initially began after the Board received an anonymous complaint. The complainant stated that Respondent left the Grimes pharmacy on an accident call on August 10, 2005, that he did not return until after the store closed, and that interns and technicians filled and dispensed prescriptions in his absence. The complainant further stated that employees had been told that they could take care of patients if they knew them but to offer delivery of prescriptions if they did not know the patient. Pharmacy Board investigator Jean Rhodes was assigned to investigate the complaint. (Testimony of Jean Rhodes; State Exhibit B)

b. Jean Rhodes interviewed and obtained written statements from a number of Respondent's current and former employees and student interns, inspected the Grimes Medicap Pharmacy on September 8, 2005, and issued an inspection report on September 12, 2005. (Testimony of Jean Rhodes; State Exhibit B; B-D to B-J; B-N) The current employees all denied personally dispensing prescriptions without a pharmacist present, although one employee had heard that pharmacy technician Jody Laird had dispensed a prescription. (State Exhibits B-D; B-E; B-F; B-G) Rebecca Fairbanks, who was a former employee, reported that while she was a pharmacy student on rotations she was never told not to dispense prescriptions when Respondent was absent and she felt pressured to allow refills to go out the door. Fairbanks further reported that when she spoke to Respondent about her concerns, he told her that he was going to do what he wanted. (State Exhibit B-I)

A student who served a clinical rotation at the pharmacy in June and July 2005 reported that she witnessed technicians and student interns dispense prescriptions when Respondent was absent. (State Exhibit B-J) Two other pharmacy students who had served rotations at the pharmacy reported witnessing prescriptions being dispensed while Respondent was absent. (Testimony of Jean Rhodes; State Exhibit B)

On September 20, 2005, Rhodes spoke to Denise Soltis, R.Ph., the Director of Experiential Education at Drake University. A few days earlier, the university had removed the Grimes Medicap Pharmacy from its site list for pharmacy student rotations. Soltis explained that the decision was made for a number of reasons, including that Respondent was leaving a lot on rescue calls and that students reported that the language was pretty "racy" in the pharmacy. (Testimony of Jean Rhodes; State Exhibit B)

c. After the September 8, 2005 pharmacy inspection, Respondent gave his pharmacy staff written procedures to be followed when he was out of the pharmacy on a fire call. The procedures included placing the "Pharmacist Temporarily Out" sign on the counter, advising patients that prescriptions could be delivered after Respondent returned, and closing the store if Respondent was absent for more than two hours. The written procedures included Board rules 657 IAC 6.7(2) and (3), which address the temporary absence of a pharmacist and activities prohibited in the absence of the pharmacist. Employees were required to sign the written procedures. Respondent testified that all employees had been verbally notified of these procedures prior to the September 8, 2005 inspection, but that he decided to put the procedures into writing following the inspection. However, the Board was not convinced that all employees had been verbally informed of these procedures prior to September 8th, nor was the Board convinced that the procedures were followed. (State Exhibit B-M; Respondent Exhibit 18; Testimony of Jean Rhodes; Respondent)

d. On September 28, 2005, Jean Rhodes was driving north on Highway 141 near Grimes when she saw a Grimes fire/rescue truck go by. Rhodes decided to drive to the Medicap Pharmacy, and saw that Respondent's vehicle was not in the parking lot. Rhodes purchased lunch at the nearby McDonalds and then parked where she could observe the pharmacy. Rhodes observed a van approach the pharmacy's drive up window and several minutes later saw a package passed from the pharmacy to the driver of the van. Several minutes later, Rhodes saw a woman enter the

pharmacy and exit a short time later. Rhodes recorded the license plates of both customers' vehicles.

Rhodes then entered the Medicap Pharmacy and observed that pharmacy technician Jodie Laird was the only employee present. Laird admitted that Respondent was away from the pharmacy.[1] When asked what she had sold to the woman at the drive-up window, Laird quickly responded "Tylenol-no prescription items." In fact, Laird had dispensed a prescription medication, K-Dur, to the patient at the drive-up window. Laird truthfully told Rhodes that the second customer only inquired about flu shots.

As soon as Rhodes left the pharmacy, Laird called Respondent and informed him of Rhodes' visit and that she told Rhodes that she sold the patient Tylenol. Laird was not sure whether she specifically admitted to Respondent that she had given the patient her prescription, but she assumed Respondent realized what she had done since he had filled the prescription for the patient before leaving the pharmacy. Laird admits that after Rhodes left the pharmacy, she prepared a duplicate K-Dur prescription for the patient and left it in the prescription pick up area.

After obtaining their names and addresses from the Department of Transportation, Rhodes called the two customers[2] that she had seen at the pharmacy while Respondent was gone. The customer who had been at the drive-up window told Rhodes she picked up K-Dur, which is a potassium supplement available only by prescription. The customer told Rhodes that she dropped the prescription off to Respondent at the drive-up window and then later picked it up from a lady after shopping for groceries. The customer denied that she bought any Tylenol.

Rhodes returned to the Medicap Pharmacy at approximately 3:30 p.m. and spoke with Laird and Respondent, who had reportedly returned to the pharmacy at approximately 2:30. Rhodes told Respondent that she had concerns that the customer's prescription had been dispensed while he was away on fire call. Respondent then located the duplicate K-Dur prescription that was purportedly waiting for customer pick-up. Laird told Rhodes that the customer had dropped her prescription off while Respondent was gone, that she had offered to have the

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[1] At the disciplinary hearing, Jodi Laird testified that Respondent was at his attorney's office, but she did not correct Rhodes when she asked if he was at an emergency call. (Testimony of Jodi Laird) It is irrelevant where Respondent was during his absence from the pharmacy.

[2] One customer confirmed that she had only inquired about flu shots.

prescription delivered, but that the customer said she would return to pick it up later. Laird suggested that the customer had some Alzheimer's.

Rhodes left the pharmacy and at approximately 4:30 p.m. and went to the home of the patient with the K-Dur prescription. The patient appeared lucid and showed Rhodes the prescription that she had picked up and her receipt that was date and time stamped September 28, 2005 at 12:45 p.m. The prescription label matched the prescription waiting for pick up, which Respondent had earlier shown to Rhodes.

Rhodes returned to the Medicap Pharmacy for the third time that day. The duplicate K-Dur prescription was still in the pharmacy waiting to be picked up. Laird continued to insist that the patient had never picked up the prescription. At hearing, Laird admitted that it was possible she did not tell Respondent that she made a duplicate prescription until after Rhodes' third visit. (Testimony of Jean Rhodes; Jodi Laird; Respondent; State Exhibit B)

e. On September 29, 2005, Respondent placed Jodi Laird on suspension pending investigation, and he eventually suspended her for a total of eighty hours. Laird continued to be paid during her suspension, although Respondent maintains that this was vacation pay that she had previously earned. On January 26, 2006, the Board filed a Statement of Charges against Jodi Laird. Respondent terminated Jodi Laird's employment in May 2006, purportedly for her actions in dispensing prescriptions in his absence.

On January 9, 2007, Laird and the Board entered into a Stipulation and Consent Order suspending her registration as a pharmacy technician for a period of six (6) months, followed by a five year period of probation. Laird is no longer employed as a pharmacy technician and has been employed as a legal secretary for the past year. (Testimony of Jean Rhodes; Respondent; Jodi Laird; State Exhibit D; Respondent Exhibit 25)

3. Respondent employed Jody Laird as a full-time pharmacy technician at the Grimes pharmacy from August 2003 until her termination in May 2006. When Respondent left the pharmacy, Laird was usually left in charge as the most senior employee. The number of fire calls varied but Laird estimated that Respondent was called away an average of 2-3 times a week for periods of time ranging from 15 minutes to several hours. Laird or other employees sometimes dispensed prescriptions while

Respondent was away from the pharmacy, if Respondent had already checked the prescription for accuracy before he left. While Laird does not recall Respondent specifically telling her or other employees to dispense prescriptions in his absence, she was certain that he was aware that employees sometimes dispensed prescriptions while he was gone, and assumed that she had discretion to do so, so long as she knew the patient. Pharmacy students sometimes complained to her about the practice of dispensing prescription without a pharmacist present.

Laird was aware that the pharmacy was "in trouble." Her payroll check had bounced more than once, and the pharmacy sometimes did not have certain drugs because vendors were owed money. Laird felt that patients would be upset if she did not dispense prescriptions while Respondent was gone. Some patients had transferred their prescriptions out of the pharmacy, and Laird wanted to keep the patients that they had.

Laird also provided some counseling to patients, although she did not characterize her communications to them as counseling. Laird asked patients if they had questions about their medications and would tell patients how to take their medications by reiterating the instructions that were printed on the label of the bottle. If the patients had additional questions, Laird would refer them to Respondent. If Respondent was present, he would usually be able to overhear Laird as she provided this information to patients.

While Jody Laird has lied to the Board's investigator in the past to protect both herself and Respondent, with whom she had a close relationship, her testimony at hearing was credible and was corroborated by statements from Respondent's former employees and student interns. Laird's own disciplinary case was resolved and provided no motivation for her to fabricate testimony adverse to Respondent. (Testimony of Jodi Laird; Jean Rhodes; State Exhibit B)

Sexual Harassment/Inappropriate Sexual Comments

4. The preponderance of the evidence in the record established that Respondent engaged in sexually inappropriate verbal and physical conduct as the pharmacist-in-charge at the Grimes Medicap Pharmacy. The credible testimony of Jody Laird was corroborated by statements from former employees and pharmacy students. As the pharmacist-in-charge, Respondent was responsible for ensuring that all pharmacy business, including

his interactions with his employees and student interns, was conducted in a professional and ethical manner.

a. During her investigation, Jean Rhodes interviewed several former female employees or pharmacy students who reported inappropriate behavior by Respondent. A female pharmacist reported that Respondent joked about sex a lot and made comments to her and others that were not appropriate, including comments made over the speaker phone for everyone in the pharmacy to hear. Another female pharmacist reported that Respondent would walk by and "touch her butt." When confronted and asked if it was intentional, Respondent would reply "I'll never tell." A third female pharmacist reported that sexual comments or innuendos were commonplace during her employment at Grimes Medicap Pharmacy and generally came from Respondent. While she did not take the comments as "sexual harassment" she felt that they were unprofessional and inappropriate for a workplace. (Testimony of Jean Rhodes; State Exhibit B; B-I)

b. Drake pharmacy students serving rotations at Grimes Medicap Pharmacy reported to the Director of Experiential Education that Respondent made inappropriate personal remarks and used racy language in the pharmacy. Drake subsequently removed the Grimes Medicap from its list of approved rotation sites. (Testimony of Jean Rhodes; State Exhibit B)

c. Jodi Laird and Respondent had a good "brother-sister type" relationship while she worked at the pharmacy, and their families socialized together on weekends. According to Laird, Respondent occasionally slapped or patted the buttocks of female employees. In addition, Respondent participated in making sexual comments, jokes, and innuendos, e.g. concerning Viagra or similar prescriptions. Laird admitted that she purchased a sign for Respondent, as a joke, that stated: "NOTICE SEXUAL HARRASSMENT IN THE AREA WILL NOT BE REPORTED. HOWEVER, IT WILL BE "GRADED." The sign was posted in the back of the pharmacy near Respondent's private office, where it was visible to employees but probably could not be seen by customers. Laird could not recall if she posted the sign or Respondent posted it. Regardless of who posted the sign, its presence in the pharmacy is very significant evidence that Respondent tolerated and promoted an unprofessional and sexually charged atmosphere in the pharmacy. In addition, the sign's presence in the pharmacy could discourage employees from complaining about inappropriate behavior or language. (Testimony of Jodi Laird; Respondent; Jean Rhodes; State Exhibit B; B-K)

Second Statement of Charges

False Prescriptions and Billing

5. On or about May 10, 2006, Respondent entered into a Purchase Agreement to sell the Grimes Medicap Pharmacy to Mike Taylor. As part of the purchase agreement, Respondent agreed to assign his accounts receivable to Mike Taylor for the purpose of collecting the accounts on Respondent's behalf. The Purchase Agreement further provided that the buyer and seller would create a mutually agreeable reconciliation method requiring Taylor to remit to Respondent the amounts collected, no less frequently than bi-weekly, reduced by three percent to cover the costs of collection. All accounts receivable that remained uncollected after six months became Respondent's responsibility. The closing was scheduled to take place at the close of business on Saturday, June 17, 2006. (Respondent Exhibit 4; Testimony of Respondent; Mike Taylor)

6. Mike Taylor hired Andrew Funk to assume the duties of pharmacist-in-charge at the Grimes pharmacy following the sale. Sometime prior to June 16, 2006, Andrew Funk went to the pharmacy to leave copies of his driver's license and social security card for Mike Taylor, but Funk accidentally left the originals of his identification cards in the copy machine. One of the employees found the cards, put a purple paper clip on them, and left them on the pharmacy "speed" shelf for Andrew Funk to pick up.

Relief pharmacist Deb Smith[3] was scheduled to work for Respondent on the last two days that he owned the pharmacy. Smith thought that she opened the pharmacy on Friday, June 16, 2006 and closed the pharmacy at approximately 6:00 p.m.[4], but it is likely that Smith had to leave an hour or so early, and that Respondent actually closed the pharmacy on June 16th. Ryan Ruggles was the pharmacy technician who worked with Deb Smith the afternoon

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[3] Respondent paid Smith paid $55.00 an hour. Her final paycheck showed that she worked 12 hours during the week of June 11-17, 2005. (Testimony of Respondent; Deb Smith; Respondent Exhibit 26)

[4] The pharmacy's security company maintains an electronic record that shows whose pass code was used to open or close the pharmacy. Those records indicate that Pharmacy Intern Andrew Knorr opened the pharmacy on June 16, 2006 at 8:48 a.m. and that Respondent closed the pharmacy at 6:01 p.m. The use of Respondent's pass code, by itself, does not establish that Respondent was the person who closed the pharmacy because a number of persons working at the pharmacy, including Deb Smith, knew and sometimes used Respondent's pass code. (State Exhibits B-J, G; Testimony of Respondent; Deb Smith; Christine Smith)

of June 16th. Smith and Ruggles both recalled that Andrew Funk's social security card and driver's license were still on the speed shelf and Respondent's posters were still hanging on the wall of the consulting room when they left the pharmacy that evening. Sometime after Deb Smith left the pharmacy on June 16, 2006 and before she returned to the pharmacy the following morning, Respondent removed the posters and other personal items from the pharmacy and also took Funk's identification cards. (Testimony of Deb Smith; Mike Taylor; Jean Rhodes; Respondent; State Exhibits F-G, F-H)

7. The preponderance of the evidence established that Respondent opened the Grimes Medicap Pharmacy on June 17, 2006 at approximately 7:16 a.m. and entered eight prescriptions into the pharmacy's prescription computer, four for himself and four for his fiancée, Christine Boston. When prescriptions are entered into the computer, they are automatically submitted to the insurance company as claims. According to the insurance company's records, checks were issued to pay for the eight prescriptions. (State Exhibit F-O) The eight prescriptions included four legitimate prescription refills, as follows:

- RX 6653396 for Azelex (Christine Boston)
- RX 6655207 for Differin (Christine Boston)
- RX 6653288 for Effexor XR (Respondent)
- RX 6652454 for fexofenadine (Respondent)

As well as four prescriptions that were not legitimate:

- RX 6655206 for Temodar (Christine Boston)
- RX 6655207 for Lovenox (Christine Boston
- RX 6655204 for Temodar (Respondent)
- RX 6655205 for Lovenox (Respondent)

Temodar is a treatment for brain tumors, and Lovenox is an injectable anti-coagulant used to prevent leg blood clots. Neither Respondent nor Christine Boston had a prescription for either of these two drugs and neither suffered from a medical condition requiring these two drugs. The pharmacy did not have these drugs in its inventory at the time the prescriptions were entered into the computer and purportedly dispensed although the drugs had previously been stocked at the pharmacy for two different patients. The claims submitted to the insurance company for the Temodar and Lovenox prescriptions totaled $9838.64. (Testimony of Jean Rhodes; Respondent; State Exhibits F, G)

a. Respondent worked a 12-hour shift at the West Des Moines Fire Department from 7:00 p.m. on June 16, 2006 to 7:00 a.m. on June 17, 2006. The Grimes Medicap Pharmacy was approximately a 15 minute drive from the West Des Moines fire station, giving Respondent sufficient time to arrive at the pharmacy at approximately 7:16 a.m. (Testimony of Respondent; State Exhibit F-J)

b. Respondent admits processing two $2500 credits from the pharmacy's account to his two personal credit card accounts at approximately 8:00 a.m. on June 17, 2006.[8] (State Exhibit F-L; F-M) The Board did not believe Respondent's claim that he could not have been in the pharmacy on June 17th at 8:00 a.m. because the credits to his credit cards were entered over the internet from his home computer. Even assuming that the credits were entered over the internet and not through the pharmacy cash register as asserted by Respondent, the Board believes that Respondent could have completed the credit card transaction from the pharmacy. Despite Respondent's testimony to the contrary, his own records show that he paid for internet access and listed it as a pharmacy expense. (Testimony of Respondent; Christine Boel; Respondent Exhibits 9-11)

c. According to the pharmacy's prescription computer, the prescriptions for Respondent and his fiancé were entered at approximately 8:58 a.m. (State Exhibit F-K) However, Respondent conceded that the time on the prescription computer was not accurate, and there is persuasive evidence in the record that the prescription computer's clock was ahead by nearly an hour. (Testimony of Respondent; Jean Rhodes; State Exhibits F-L; G)

d. Respondent's claim that a disgruntled employee or his ex-wife may have retained a key to the pharmacy, used his pass code the morning of June 17th, and entered the four false prescriptions, as well as the four legitimate refill prescriptions, was neither credible nor plausible. (Testimony of Respondent; Respondent Exhibits 2, 3)

8. Respondent and his wife, Christine (Boston) Boel, testified that Respondent came home at approximately 7:30 a.m. on June 17, 2006, ate breakfast with his family, worked on the computer in

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[8] Respondent had been issuing credits from the pharmacy account to his personal credit card accounts for some time, ostensibly as reimbursement for business expenses that he had paid for with his own credit cards. (Testimony of Respondent, Christine Boel; Respondent Exhibits 9-12; State Exhibits F-L, F-M, F-N)

the basement, unpacked the truck that he had loaded with personal items at the pharmacy the night before, showered, and dressed. Christine Boel further testified that after working on the computer, Respondent came back upstairs and told her he had entered two $2500 credits on his credit cards. Respondent and his wife further testified that they went to the pharmacy at approximately 10:00 a.m.

The Board believes that Respondent was lying about the time he arrived at home that day and that he actually went to the pharmacy prior to going home. Christine Boel was either lying to protect her husband or else she was mistaken about the time that he arrived home that morning. The preponderance of credible evidence established that Respondent actually arrived home close to 8:30 a.m. and that he did not return to the pharmacy until close to 11:00 a.m. (Testimony of Respondent; Christine Boel; Mike Taylor; Deb Smith; State Exhibits F-J; F-I; G)

9. After arriving at the pharmacy, Respondent and his wife loaded her car with items from the pharmacy and then returned home. Andrew Funk arrived at the pharmacy and discovered that his identification cards were gone. Deb Smith and Ryan Ruggles both recalled that they had been on the speed shelf with the purple paper clip when they left the pharmacy the previous evening. The paper clip was still on the shelf, but the identification cards were gone. Mike Taylor asked Respondent if he had picked up the cards. Respondent denied picking up the cards but called home to his wife to have her check the boxes that he had unloaded in his garage that morning. She looked but could not find the cards. Eventually, Respondent went home, and he found Funk's identification cards in one of the boxes. Respondent insists that he inadvertently picked up the cards while packing. (Testimony of Respondent; Mike Taylor; Deb Smith; Christine Boel; State Exhibit F)

The closing was completed at approximately 2:00 p.m. on June 17, 2006. The locks were changed on the pharmacy, and Respondent gave Mike Taylor his pass code to the security system. Taylor did not immediately realize that he needed to obtain his own pass code from the security company, and he used Respondent's pass code to open and close the pharmacy for a period of time. (Testimony of Mike Taylor; Respondent)

10. On Tuesday, June 20, 2006, Respondent was contacted by someone from the Grimes pharmacy[8] and asked about the Temodar and Lovenox prescriptions that had been entered into the pharmacy's computer on June 17, 2006. Respondent replied that the prescriptions were not legitimate and the insurance claims should be reversed. Later that week, Respondent went through the pharmacy's drive through and asked for a printout of the prescriptions for himself and his wife. After looking at the list, Respondent realized that the Temodar and Lovenox prescriptions had not yet been reversed. The prescription claims were later reversed after pharmacy investigator Jean Rhodes contacted the insurance company. If the insurance claims had not been reversed and had been paid, Respondent would have eventually received the money for the claims, minus 3%, pursuant to the terms of the purchase agreement. At the hearing, Respondent admitted that he did pick up the four refill prescriptions for himself and his wife that had been entered at the same time as the Temodar and Lovenox prescriptions. (Testimony of Respondent; Jean Rhodes; Mike Taylor; State Exhibit F; Respondent Exhibit 4)

11. The Board's investigation revealed three additional prescriptions that had been dispensed from the Grimes Medicap Pharmacy to Respondent for which Respondent did not have a legitimate prescription.

a. On January 10, 2003, 30 tablets of Celebrex 200mg were dispensed to Respondent. According to the pharmacy printout for Respondent, Dr. Sop authorized the prescription by telephone with no refills. However, refills were issued on April 10, June 2, July 21, November 17, and February 6, 2003. Jean Rhodes was unable to locate Dr. Sop. The address listed on the telephoned prescription for Dr. Sop was for a medical center in Pennsylvania that did not have a record of him. The phone number was for an elderly woman who did not know Dr. Sop. (Testimony of Jean Rhodes; State Exhibit F)

At the hearing, Respondent submitted the affidavit of Dr. Aaron Sop, who states that he is a doctor licensed in California but currently resides in Pittsburgh, Pennsylvania. Dr. Sop states that he telephoned a prescription for Celebrex with 11 refills for Respondent to the Grimes Medicap Pharmacy on January 10, 2003. (Testimony of Respondent; Respondent Exhibit 6) The

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[8] In a written statement dated July 10, 2006, Respondent states that Mike Taylor contacted him (State Exhibit F). In his testimony at hearing, Respondent stated that pharmacy technician Melissa Carateens contacted him.

Board was not persuaded by Dr. Sop's affidavit and were not convinced that Respondent and Dr. Sop, who is apparently not licensed in Iowa and does not reside here, have a legitimate physician-patient relationship to support the issuance of the Celebrex prescriptions.

b. On August 30, 2004, 60 tablets of Allegra D were dispensed to Respondent. According to a pharmacy printout for Respondent, Dr. Blomberg authorized the prescription. However, there was no written record of a prescription within the pharmacy. The clinical manager for Dr. Blomberg's office verified that Dr. Blomberg last saw Respondent on June 8, 2003, and there was no notation in the clinical record of a prescription for Allegra D. (Testimony of Jean Rhodes; State Exhibit F)

c. On August 30, 2004, 30 tablets of Hydrocodone/Ibuprofen 7.5/200mg (a schedule III pain medication) were dispensed to Respondent. According to Respondent's pharmacy printout, Dr. Goldstein authorized the prescription. Dr. Goldstein's nurse reviewed Respondent's office chart and determined that Dr. Goldstein had discharged Respondent back to normal activity (following laparoscopic surgery) and to Dr. Bussey's care on February 18, 2004. Dr. Goldstein's file had no record of a prescription on August 30, 2004, and there was no prescription found in the pharmacy file. (Testimony of Jean Rhodes; State Exhibit F; F-C)

At the hearing, Respondent submitted a letter from Dr. Bussey, who had no record and no recollection of ever prescribing narcotic Vicoprofen for Respondent. Dr. Bussey stated it was possible that he gave a verbal order and neglected to enter it into the chart, but the Board concluded that this was unlikely. The pharmacy records purportedly list Dr. Goldstein as the prescribing physician, not Dr. Bussey. Moreover, if a verbal order had been provided by Dr. Bussey, there should have been a written record of the prescription at the pharmacy. (Respondent Exhibit 21)

Alleged Improper Substitution of Generic Fentanyl

12. In or about January 2006, Title XIX changed its formulary to require its patients to be dispensed the brand name Durogesic patches rather than the generic fentanyl patches. Jody Laird testified that after the formulary changed, Respondent dispensed the generic drug fentanyl but billed for the brand name drug durogesic on multiple occasions. Laird reported that she had

difficulty with printing the labels after the formulary change and frequently asked Respondent for assistance. She recalled that Respondent would enter a "DAW" or Dispense as Written and would get a Durogesic label, which he would place on a fentanyl box. (Testimony of Jody Laird; State Exhibit J)

Respondent denied ever billing for the brand name while dispensing the generic. Respondent testified that after the formulary change, a number of Title XIX patients still specifically requested fentanyl, either because they did not want to pay the higher co-pay for the Durogesic or because they felt the fentanyl patches worked better or stayed on better. Respondent testified that he called Medicaid and was told that he could put a "DAW 5" code on the label, which would indicate to them that the brand name was dispensed as a generic, and that the billing would go through the Title XIX system as the generic. (Testimony of Respondent)

The state failed to prove by a preponderance of evidence that Respondent billed or was paid for the brand name durogesic while providing the patient with the generic fentanyl. While the Board felt Jody Laird's testimony was sincere, it was not convinced that she sufficiently understood the labeling and billing process to determine whether Respondent was billing Medicaid improperly. There was insufficient evidence in the record to establish that Respondent was paid for the brand name medication when he dispensed the generic.

Remaining Allegations Related to Record Keeping

13. Based on the limited evidence and testimony pertaining to these issues in this record, the Board was unable to conclude that Respondent's pharmacy had significant shortages of controlled substances, that he failed to complete a required biennial controlled substance inventory, or that he lacked required DEA Form 222 documentation for the controlled substances transferred from the West Des Moines Medicap Pharmacy to the Grimes Medicap Pharmacy. It appears that these issues were eventually resolved after additional records were examined. (Testimony of Jody Laird; State Exhibits B, C; Testimony of Respondent; Respondent Exhibits 14-17)

CONCLUSIONS OF LAW

I. *Relevant Statutes and Rules*

Iowa Code section 155A.12(2005) provides, in relevant part:

155A.12 Pharmacist license-grounds for discipline.
...The board may refuse to issue or renew a license or may impose a fine, issue a reprimand, or revoke, restrict, cancel, or suspend a license, and may place a license on probation, if the board finds that the applicant has done any of the following:
1. Violated any provision of this chapter or any rules of the board adopted under this chapter.
2. Engaged in unethical conduct as that term is defined in rules of the board.
...
4. Failed to keep and maintain records required by this chapter or failed to keep and maintain complete and accurate records of purchases and disposal of drugs listed in the controlled substances act.
5. Violated any provision of the controlled substances Act or rules relating to that Act.

Iowa Code section 155A.23(2)(2005) provides, in relevant part:

155A.23 Prohibited acts.
A person shall not:
...
2. Willfully make a false statement in any prescription, report, or record required by this chapter.

Iowa Code section 155A.27(2005) provides the requirements for all prescription drug orders issued or filled in this state. Iowa Code section 155A.27(4) provides, in relevant part, that upon receipt of an oral prescription, the pharmacist shall promptly reduce the oral prescription to a written format by recording the information required in a written prescription.

657 IAC 36.1(4) provides, in relevant part:

36.1(4) *Grounds for discipline.* The board may impose any of the disciplinary sanctions set out in subrule 36.1(2) when the board determines that the licensee... is guilty of any of the following acts or offenses:
...
b. Professional incompetency. Professional incompetency includes but is not limited to:
...
(4) A willful or repeated departure from, or the failure to conform to, the minimal standard or

acceptable and prevailing practice of pharmacy in the state of Iowa.

c. Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of pharmacy or engaging in unethical conduct or practice harmful or detrimental to the public. Proof of actual injury need not be established.

...

h. Distribution of drugs for other than lawful purpose. The distribution of drugs for other than lawful purposes includes, but is not limited to, the disposition of drugs in violation of Iowa Code chapters 124, 126, and 155A.

...

j. Violating a law or statute of this state, another state, or the United States, without regard to its designation as either a felony or misdemeanor, which statute or law relates to the practice of pharmacy or the distribution of controlled substances, prescription drugs, or nonprescription drugs.

...

z. Engaging in any conduct that subverts or attempts to subvert a Board investigation.

...

ac. Failing to create and maintain complete and adequate records as required by state or federal law, regulations, or rules of the board.

657 IAC 6.2 sets out the following responsibilities of the pharmacist-in-charge relevant to record keeping:

12. Maintaining records of all transactions of the pharmacy necessary to maintain accurate control over and accountability for all drugs as required by applicable state and federal laws, rules, and regulations;

13. Establishing and maintaining effective controls against the theft or diversion of prescription drugs and records for such drugs;

...

657 IAC 6.7(3) provides, in relevant part:

657-6.7(124,155A) Security. While on duty, each pharmacist shall be responsible for the security of the prescription department...

> **6.7(3)** *Activities prohibited in absence of pharmacist.* Activities which shall not be designated and shall not be performed during the temporary absence of the pharmacist include:
>
> *a.* Dispensing or distributing any prescription drugs or devices to patients or others.
>
> *b.* Providing the final verification for the accuracy, validity, completeness, or appropriateness of a filled prescription or medication order.
>
> ...

657 IAC 6.8 provides, in relevant part, that all prescriptions shall be dated and assigned a unique identification number that shall be recorded on the original prescription. The original prescription, whether transmitted orally, electronically, or in writing shall be retained by the pharmacy filling the prescription...

657 IAC 8.11 provides, in relevant part:

> **657-8.11(147,155A) Unethical conduct or practice.** The provisions of this rule apply to licensed pharmacies, licensed pharmacists and registered pharmacist-interns.
>
> **8.11(1)** *Misrepresentative deeds.* A pharmacist shall not make any statement intended to deceive, misrepresent, or mislead anyone, or be a party to or an accessory to any fraudulent or deceitful practice or transaction in pharmacy or in the operation or conduct of a pharmacy.
>
> ...
>
> **8.11(8)** *Unprofessional conduct or behavior.* A pharmacist shall not exhibit unprofessional behavior in connection with the practice of pharmacy... Unprofessional behavior shall include, but not be limited to, the following acts: verbal abuse, coercion, intimidation, harassment, sexual advances, threats, degradation of character, indecent or obscene conduct, and theft.

II. Professional Incompetency

In both of the Statements of Charges, Respondent was charged with professional incompetency, as demonstrated by willful and repeated departures from, and a failure to conform to, the minimal standard and acceptable and prevailing practice of pharmacy in the state of Iowa. [Count I] The preponderance of

the evidence establishes that Respondent was professionally incompetent, in violation of Iowa Code section 155A.12(1)(2005) and 657 IAC 36.1(4)"b"(4), when he:

- Improperly delegated and allowed unlicensed supportive personnel to dispense prescription medications while he was absent from the pharmacy and allowed unlicensed personnel to provide patient counseling;
- Dispensed prescription medications to himself for which he did not have a valid prescription on file;
- Entered four prescriptions and insurance claims for himself and his fiancé for two different prescription medications for which neither had a valid prescription.

III. Unethical Conduct

In both of the Statements of Charges, Respondent was charged with unethical conduct. [Count II] The preponderance of the evidence established that Respondent engaged in unethical conduct, in violation of Iowa Code section 155A.12(1) and 155A.12(2)(2005) and 657 IAC 8.11(1), 8.11(8), 6.7(3), and 36.1(4)"c" when he:

- Exhibited unprofessional behavior in the pharmacy by slapping female employees on the buttocks, engaging in sexual conversation and joking, and allowing a sign to be posted in the pharmacy that implies sexual harassment is tolerated in the pharmacy;
- Entered four prescriptions and insurance claims for himself and his fiancée for two different prescription medications for which neither had a valid prescription.
- Dispensed prescription medications to himself for which he did not have a valid prescription on file.

IV. Improper Delegation of Pharmacist Functions

Count IV of the first Statement of Charges charged Respondent with improper delegation of pharmacist functions. The preponderance of the evidence established that Respondent violated Iowa Code section 155A.12(1)(2005) and 657 IAC 6.7(3) when he permitted unlicensed supportive pharmacy personnel to perform pharmacist functions, including dispensing prescriptions when a pharmacist was not present and providing patient counseling.

V. Dispensing Without A Prescription

Count III of the second Statement of Charges charged Respondent with dispensing without a prescription. The preponderance of the evidence established that Respondent violated Iowa Code section 155A.12(1)(2005) and 657 IAC 36.1(4)"h" when he dispensed three drugs to himself without a valid prescription and when he entered four prescriptions (for Temovar and Lovenox) into the pharmacy computer when neither he nor his fiancée had prescriptions for the medications.

VI. Inadequate Record Keeping

Count IV of the Second Statement of Charges charged Respondent with inadequate record keeping, including inadequate record keeping relating to controlled substances, and failure to maintain accurate records of prescription medications dispensed. The preponderance of the evidence established that Respondent violated Iowa Code section 155A.12(4), 155A.27(4)(2005) and 657 IAC 6.2 and 36.1(4)"ac" when he failed to maintain accurate records of prescription medications dispensed from the pharmacy (i.e. the records concerning the Temodar and Lovenox) and failed to have valid prescriptions on file for three different medications that he dispensed to himself. The preponderance of the evidence failed to establish that Respondent's controlled substance records showed a substantial shortage of controlled substances or that Respondent failed to complete a required biennial controlled substances inventory or failed to maintain DEA Form 22 documentation for controlled substances transferred from the West Des Moines Medicap to the Grimes Medicap.

VII. Willfully Making False Statement

Count V of the second Statement of Charges charged Respondent with willfully making false statements in connection with prescriptions, reports, and records. The preponderance of the evidence established that Respondent violated Iowa Code section 155A.12(1), 155A.23(2)(2005) and 657 IAC 36.1(4)"j" when he falsified prescription records and insurance claims related to a purported purchase of Temodar and Lovenox.

VIII. Subverting A Board Investigation

The Board was unable to conclude, by a preponderance of the evidence, that Respondent subverted a Board investigation by participating in a ruse involving a duplicate prescription in order to conceal the fact that prescription medications were

being dispensed by non-pharmacists during his absence from the pharmacy. (First Statement of Charges, Count III) The Board was unable to conclude that Respondent's denial of knowledge of falsified prescriptions and insurance claims for the purchase of Temodar and Lovenox constituted a separate violation of subverting a board investigation. (Second Statement of Charges, Count VI)

IX. Sanction

In other disciplinary cases involving fraud or deceit, the Board has usually imposed a significant license suspension of at least six months. While Respondent backed out of the fraudulent transactions involving the Temador and Lovenox before any financial gain was realized, the Board still believes that Respondent's violations merit at least a stayed suspension. In addition, the number and nature of the violations in this case strongly support the conclusion that Respondent should not be permitted to own a pharmacy or serve as a pharmacist-in-charge until he has completed additional continuing education and has successfully completed a five year period of probation.

DECISION AND ORDER

IT IS THEREFORE ORDERED that pharmacist license number 19434, issued to Respondent Eric Boel, is hereby SUSPENDED for a period of six (6) months. IT IS FURTHER ORDERED that the six month suspension is immediately STAYED, and Respondent's pharmacist license is hereby placed on PROBATION for a period of five (5) years, subject to the following terms and conditions:

1. Respondent shall complete six (6) hours of pre-approved continuing education on the topics of sexual harassment and professional ethics. Respondent shall submit verification of his completion of the required continuing education no later than six months from the date of this Decision and Order. These hours of continuing education may not be used for license renewal.

2. Respondent shall notify all prospective pharmacy or pharmacy-related employers, including any pharmacist-in-charge, of the terms, conditions, and restrictions imposed on Respondent by this Decision and Order. Within fifteen (15) days of undertaking new employment as a pharmacist or in a pharmacy-related business, Respondent shall cause his employer to report to the Board in writing, acknowledging that the employer has read this document and understands

it.

3. Respondent shall not own or manage a pharmacy, shall not serve as the pharmacist-in-charge of a pharmacy, and shall not serve as a preceptor.

4. Respondent shall file written, sworn quarterly reports with the Board attesting to his compliance with all the terms and conditions of his probation. The reports shall be filed no later than March 5, June 5, September 5, and December 5 of each year of Respondent's probation. The quarterly reports shall include Respondent's place of employment, current home address, home telephone number, or work telephone number, and any further information deemed necessary by the Board from time to time.

5. Respondent shall make personal appearances before the Board or a Board Committee upon request. Respondent shall be given reasonable notice of the date, time and location for such appearances.

6. Respondent shall obey all federal and state laws, rules, and regulations substantially related to prescription drugs, controlled substances, or nonprescription drugs; with Iowa Code chapters 124, 124A, 124B, 126, 147, 155A, and 205; and shall comply with the Board's rules.

7. Should Respondent leave Iowa to reside or practice outside this state, Respondent must notify the Board in writing of the dates of departure and return. Periods of residency or practice outside the state shall not apply to reduction of the probationary period.

8. Should the Respondent violate or fail to comply with any of the terms and conditions of probation, the Board may initiate action to revoke or suspend Respondent's Iowa pharmacist license or to impose other discipline as authorized by Iowa Code chapters 272C and 155A and 657 IAC 36.1.

IT IS FURTHER ORDERED, pursuant to Iowa Code section 272C.6 and 657 IAC 36.18(2), that Respondent shall pay $75.00 for fees associated with conducting the disciplinary hearing. In addition, the executive secretary/director of the Board may bill Respondent for any witness fees and expenses or transcript costs associated with this disciplinary hearing. Respondent shall

remit for these expenses within thirty (30) days of receipt of the bill.

Dated this 25th day of October, 2007.

Paul Abramowitz, Chairperson
Iowa Board of Pharmacy

cc: Scott Galenbeck, Assistant Attorney General
Steven Kaiser, Attorney for Respondent

Any aggrieved or adversely affected party may seek judicial review of this decision and order of the board, pursuant to Iowa Code section 17A.19.