BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS ON REFERRAL FROM THE BOARD OF NURSING

IN THE MATTER OF:	)	
	)	
THOMAS DAVID HERWICK	)	OAH No. 08-0244-NUR
	)	Board Case No. 2301-08-001

DECISION

I. Introduction

Thomas David Herwick voluntarily surrendered his Alaska Registered Nurse license on March 9, 2005.[1] On April 24, 2007, Mr. Herwick applied for reinstatement of his license. The Alaska Board of Nursing denied his application on the basis of unprofessional conduct as defined by board regulations. Specifically, the Board focused on Mr. Herwick's actions over several days in December 2003 while employed as a registered nurse at the Yukon-Kuskokwim Health Corporation Regional Hospital (YKHC) in Bethel, Alaska. These actions hastened the death of a terminally ill patient, R.L.

As permitted by statute, Mr. Herwick requested a hearing. A hearing took place on October 14, 2008 and November 14, 2008.[2] The Division of Corporations, Business and Professional Licensing of the Department of Commerce, Community and Economic Development defended the preliminary decision of the Board to deny the application. Both the division and Mr. Herwick were represented by counsel.

The record developed at the hearing consists of testimony from eight witnesses; division exhibits A through R and Herwick exhibits 1 - 7,[3] admitted in bulk at the hearing without objection.

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[1] Mr. Herwick signed his surrender on February 4, 2005 and it was adopted by the Board on March 9, 2005. Exhibit A at 56, 57.

[2] At hearing it was agreed that because many of the exhibits and testimony identify the patient and discuss the patient's medical condition(s), the exhibits and proceedings have been designated as confidential and subject to a protective order. This order shall remain in effect until modified, superseded, or terminated by order of the Administrative Law Judge or a court.

[3] Some documents are duplicated in several different exhibits. For example Exhibit O, Medical Records of R.L., contain many of the same documents submitted as Exhibit Q, Medical Records of R.L. obtained from YKHC. Although a document may be found in several places throughout the record, only one citation will be referenced.

Mr. Herwick, because he is requesting review of the Board's decision to deny his application, has the burden of proving by a preponderance of the evidence that he is competent to resume practice as a registered nurse with skill and safety.[4] This means that Mr. Herwick needs to put evidence in the record or point to evidence already in the record showing that he is competent to resume nursing. The evidence relied upon by Mr. Herwick was unpersuasive. Therefore, the denial of his application for licensure is affirmed.

II. Facts

A. *Mr. Herwick's Practice of Nursing and the Patient, R.L.*

Mr. Herwick has been a registered nurse in Washington since 1993.[5] He obtained a temporary license in Alaska and began working for YKHC in December 2002. On January 10, 2003, he obtained a license to practice as a registered nurse in Alaska by endorsement.[6] On December 19, 2003, Mr. Herwick's employment with YKHC was terminated in response to an investigation into his nursing practices regarding a patient, R.L., and the events leading up to her death. YKHC concluded that Mr. Herwick acted outside the scope of his nursing privileges when he administered a controlled substance, morphine, without valid orders, failed to follow proper wasting procedures for the narcotic, and removed R.L.'s life support without a doctor's order.[7]

R.L., a 77 year old female weighing 63.6 kg, was admitted to YKHC on December 4, 2003 with end stage metastatic nasopharyngeal carcinoma and pneumonia. The effect of the cancer was to restrict R.L.'s nose and throat, affecting her ability to breath.

Jonathan Stallkamp, M.D., was R.L.'s physician and responsible for R.L.'s treatment. Mr. Herwick was the day nurse assigned to provide nursing care to R.L.

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[4] When a license has initially been denied or not issued, the applicant has the burden of poof by a preponderance of the evidence. AS 44.62.460(e)(2). *See also* 2 AAC 64.290(e) ("Unless otherwise provided … the burden of proof and of going forward with evidence is on the party who requested the hearing …, and the standard of proof is preponderance of the evidence….") To prove a fact by a preponderance of the evidence, Mr. Herwick must show that the fact more likely than not is true.

[5] Exhibit A at 113.

[6] Exhibit A at 111. In general, the Board may license a nurse by endorsement on the basis of an active license in another state, provided the applicant has worked as a nurse within the last five years (or otherwise shows continuing competency to the satisfaction of the Board) and the applicant meets all other requirements for licensing in Alaska. AS 08.68.200.

[7] Exhibit P at 9, 10.

consistent with Dr. Stallkamp's instructions. The plan of treatment was to administer antibiotics, oxygen and morphine for respiratory comfort.

Nurses are required to record their assessments and medications given in several logs. At YKHC, medications received PRN (as needed) are recorded on a patient's PRN Medications record. A nurse's assessment of a patient is recorded on that patient's Daily Nursing Assessment record, when a nurse administers a controlled substance it is logged on another form. Doctor's orders are recorded on yet another form, which is required to be signed by the physician. It is not uncommon for a nurse to receive a verbal order (VO) from a physician and for the physician to later sign off on the VO.[8] The order should be charted as stated and if the order is vague, it is the nurse's responsibility to get clarification from the physician.[9]

Upon admittance, Dr. Stallkamp ordered R.L.'s morphine to be administered using two methods of delivery: an intravenous (IV) push also referred to as a bolus and an IV drip. He ordered a 1 mg per hour morphine drip with an additional bolus of 2 mg every hour and allowed for the drip to be increased by 1 mg/hour as needed to manage pain.[10] The unchallenged testimony established that, with a patient such as R.L., it would be an accepted standard to titrate (increase or decrease) in 1 mg increments.[11] By 18:30 the day of admittance, Dr. Stallkamp ordered an increase in the IV drip to 4 mg and the bolus to 4 mg every 2 hours as needed.[12]

The next morning, December 5, 2003, Dr. Stallkamp reduced the morphine drip to 1 mg per hour with instructions to titrate up for pain and respiratory distress.[13] Mr. Herwick recorded Dr. Stallkamp's order in the chart.[14] At 10:00 and again at 12:30 Mr. Herwick administered 4 mg boluses.[15] At 14:00 he titrated the drip by 1 mg, increasing the dosage to 2 mg/hr.[16]

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[8] Testimony of Herwick; Testimony of Joseph Klejka, M.D.; Testimony of Stallkamp.
[9] Testimony of Herwick; Testimony of Tina DeLapp, BSN, MS, EdD.
[10] Exhibit Q at 25, 31.
[11] Testimony of Joseph Klejka, M.D.; Testimony of Stallkamp.
[12] Exhibit Q at 23.
[13] *Id.*
[14] *Id.*
[15] Exhibit Q at 31.
[16] *Id.*

As reflected in the Daily Nursing Assessment completed by Mr. Herwick, at 17:30, before leaving for the evening, he increased the drip by a further 1 mg to 3 mg/hr and gave a 4 mg bolus, which he noted gave relief to R.L.[17] Mr. Herwick recorded the increase in the drip on the PRN Medications record but did not record the 4 mg bolus.[18]

At 20:00 the night nurse observed that R.L. was semi-comatose and appeared comfortable.[19] At 23:30 the morphine drip was titrated down to 2 mg per hour and R.L.'s facial expression remained calm throughout the rest of the night.[20]

By early morning December 6, 2003, R.L. began to have increased difficulty breathing and her condition was changing.[21] Mr. Herwick requested he be assigned to another patient because he was becoming too emotionally involved with R.L.[22] Mr. Herwick had cared for end of life patients in the past but this was the first time he had been assigned to a patient for long-term care. He had recently been diagnosed with cancer and was finding this to be a difficult situation. His request for reassignment was denied.

In response to R.L.'s respiratory distress, Mr. Herwick increased her morphine in excess of the PRN order dosage and frequency:[23]

- at 11:00 Mr. Herwick increased the drip by 2 mg per hour to 4 mg per hour and administered a 4 mg bolus;
- thirty minutes later, at 11:30, he increased the drip to an unknown amount;
- he waited an additional thirty minutes before he administered another 4 mg bolus at 12:00;
- one hour later, at 13:00, he administered a 10 mg bolus;
- and at 14:00, R.L. expired.

Mr. Herwick rationalized his actions. He testified that he understood from Dr. Stallkamp that the goal was to make the family and the patient comfortable so there was no upper morphine limit; he could give as much as he felt was appropriate. Both Mr.

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[17] Exhibit Q at 12.
[18] The controlled substance log reflects that at 18:00 on December 5, 2003, Mr. Herwick removed 10 mg of morphine, administering 4 mg to R.L. and wasting 6 mg. Morphine is pre-measured in a syringe from the manufacturer in quantities of either 4 mg or 10 mg. Exhibit Q at 31, 32.
[19] Exhibit Q at 12.
[20] Exhibit Q at 12; Exhibit Q at 31.
[21] Exhibit Q at 12.
[22] Testimony of Herwick.
[23] Exhibit Q at 31 (One 4 mg bolus every 2 hours, as needed, and 1 mg per hour morphine drip titrate up for pain in 1 mg increments).

Herwick and Dr. Stallkamp were busy with additional patients that day. Dr. Stallkamp was working in the emergency room. Mr. Herwick recalled that Dr. Stallkamp asked him not to call him any more because he was busy with other patients and R.L. was at the end of life.[24] Dr. Stallkamp disagrees with Mr. Herwick's recollection and testified that he spoke with Mr. Herwick several times that day, providing verbal orders for R.L.[25]

Mr. Herwick recorded only one doctor order for December 6, 2003. It reads "1200 V.O. Dr. Stallkamp MS bolus + ↑rate. Titrate to respiratory rate/pain."[26] Mr. Herwick believes he administered the morphine according to his understanding of Dr. Stallkamp's order to make R.L. and her family comfortable. Dr. Stallkamp denies that he ever gave Mr. Herwick such an open-ended order or would have ordered an increase in the bolus from 4 mg to 10 mg.[27] Regardless, Dr. Stallkamp did eventually confirm the VO several weeks after R.L.'s death as evidenced by his signature.[28] Dr. Stallkamp believed this chart note was Mr. Herwick's attempt to record a compilation of several verbal orders Dr. Stallkamp gave through out the morning of December 6, 2003.

Sometime between 12:00 and 14:00 Mr. Herwick asked R.L.'s family if they would like to have the oxygen mask removed.[29] He told the family that removal would hasten her death. The family agreed and he removed the oxygen mask without a physician's order. While he was not consulted, Dr. Stallkamp stated that had he been asked, he would have authorized the removal of the oxygen mask. R.L. expired at 14:00 December 6, 2003.

Mr. Herwick began the process of cleaning up. He removed the IV drip and "wasted" what was remaining in the IV bag down the sink. Contrary to accepted practices and hospital policy, he did not have anyone witness the wasting nor did he

[24] Testimony of Herwick; Exhibit 4 at 9, Finding of Fact ¶ 1.13 *IMO Thomas D. Herwick, R.N.*, Docket No. 06-04-A-1051 RN (Wash. Nursing Care Quality Assurance Commission June 2007).
[25] Testimony of Stallkamp.
[26] Exhibit Q at 22.
[27] Exhibit O at 9; Testimony of Stallkamp.
[28] Testimony of Stallkamp; Exhibit Q at 23.
[29] Testimony of Herwick; *Cf:* The Washington proceeding found that Mr. Herwick removed the oxygen mask from R.L.'s face in response to a request from the family and friends. Exhibit 4 at 9, Finding of Fact ¶ 1.14 *IMO Thomas D. Herwick, R.N.*, Docket No. 06-04-A-1051RN (Wash. Nursing Care Quality Assurance Commission June 2007).

return the bag to the pharmacy.[30] In the last hours of her life, it is known that R.L. received in excess of the written order of morphine, but since Mr. Herwick did not follow proper wasting procedures it cannot be determined exactly how much morphine R.L. received nor can the hospital be sure that the morphine was not diverted.[31]

Mr. Herwick admits that he did not follow proper wasting procedures, did not properly chart his observations and treatments, and that he removed R.L.'s oxygen mask without a physician's order. Mr. Herwick testified that when he administered the boluses to R.L. on December 6, 2003, he was following Dr. Stallkamp's orders.

The YKHC medical director, Joseph A Klejka M.D., testified that he would have concerns if Mr. Herwick were to be licensed as a nurse because he questioned if Mr. Herwick would follow a physician's orders. He also thought Mr. Herwick was more concerned with treating R.L.'s family than R.L. Dr. Klejka was not personally involved with R.L.'s care and has not worked with Mr. Herwick, but he recalls the incident and had recommended the matter be referred to corporate counsel.[32] Mr. Herwick's actions did not cause R.L.'s death but they hastened her death.[33]

Dr. Stallkamp completed his residency in 2003 and had taken a traveling physician position at YKHC, where he was employed for just over six months. He is now employed at an academic hospital in Philadelphia. He is board certified in internal medicine and is a hospitalist.[34]

Dr. Stallkamp refreshed his recollection by reviewing R.L.'s medical record and the transcript of the interview he gave to the division as part of its initial investigation. Dr. Stallkamp did not recall Mr. Herwick asking him to sign off on the verbal order on December 6. He did recall signing the December 6, 2003, verbal order at the end of January 2004 or in February. Dr. Stallkamp was getting ready to leave YKHC and was required to have completed all paperwork as a condition of payment, which included signing this order. Dr. Stallkamp recalled that on December 6, 2003, he was working in the emergency room and that Mr. Herwick called him several times. Dr. Stallkamp

[30] Testimony of Herwick; Exhibit C at 21 (Undated letter from YKHC staff pharmacist, Steve Schaber, Pharm-D, contained in division investigative file).
[31] *See generally* Testimony of DeLapp.
[32] Exhibit P at 12.
[33] Testimony of Klejka.
[34] An internist who only takes care of patients in the hospital.

testified that at no time did he tell Mr. Herwick not to call him anymore. Dr. Stallkamp explained that if he approved increasing the amount of morphine given, it would have been by one or two mg; he would not have ordered a 10 mg bolus.[35]

It was Dr. Stallkamp's opinion based on his work experience, observations and Mr. Herwick's care of R.L., that Mr. Herwick should not be licensed as a nurse in Alaska unless he received "massive amounts" of reeducation and retraining. He characterized Mr. Herwick's actions in the last hours of R.L.'s life as an "egregious error" caused by Mr. Herwick's being very upset and worried about the patient. Dr. Stallkamp hypothesized that Mr. Herwick must have panicked at the last minute and increased the morphine without fully realizing what he was doing. He bases his hypothesis on the fact that he could not understand why anyone would give that much morphine all at one time unless someone just wanted the patient to die. Dr. Stallkamp did not think that Mr. Herwick had a "Dr. Kevorkian approach," but that he simply panicked and couldn't handle the situation.[36]

Dr. Stallkamp's concerns regarding Mr. Herwick's nursing abilities were not limited to the events surrounding R.L.'s death. He had expressed prior concerns regarding patient care to Mr. Herwick's nursing supervisor because it was not "standard."[37] He observed that Mr. Herwick displayed a level of anxiety and depression that was not observed in other nurses. As an example, Dr. Stallkamp noted that Mr. Herwick was easily upset by little changes and would focus on unimportant items.[38] It was Dr. Stallkamp's opinion that Mr. Herwick should undergo a thorough psychiatric evaluation as a condition of licensure.

Dr. Stallkamp confirmed that Mr. Herwick was correct that the goal of treatment was to make R.L. comfortable. However, the amount of morphine given and the removal of the mask hastened death and that was not the goal.[39] Dr. Stallkamp felt that any nurse

[35] It is unclear if the increase was for a bolus or the drip.
[36] Testimony of Stallkamp.
[37] Dr. Stallkamp did not expand on what he meant by "standard." There is no record of Dr. Stallkamp's concerns in Mr. Herwick's personnel file, Exhibit P.
[38] Dr. Stallkamp did not expand on his description, but it is reasonable to presume that he was referring to Mr. Herwick's care of patients.
[39] Testimony of Stallkamp.

should know the effect of that amount of morphine given in a short period of time to a patient.

Doris J. Unterseher, RN, BSN, MN(c), testified for Mr. Herwick. She is the Director of Emergency at Gray's Harbor Community Hospital, his present employer. Ms. Unterseher testified consistent with her letter of February 12, 2007, submitted in support of his application for reinstatement.[40] She hired Mr. Herwick in March 2005 as a per diem nurse for the Emergency Department. Mr. Herwick is a valued employee with no restrictions. She has not observed him "make his own judgment to provide care outside accepted or defined physician guidelines or order."[41] There have been no issues related to the acquisition, administration and documentation of narcotics. In his role as an emergency room nurse he has cared for end of life patients. There have been no observed discrepancies in his care of these patients. Mr. Herwick is well respected by his peers and physicians and is often used to train new graduate nurses.

Although she did not testify, another co-worker, Jayne Binnig, RN, MSN, ARNP, wrote a letter in support of Mr. Herwick.[42] Ms. Binnig describes Mr. Herwick as "a clinically competent and compassionate nurse" who puts the patients' needs foremost on his list of priorities.[43] She asserts that he has "excellent critical thinking skills and is adaptable to an often stressful and chaotic environment" and that when in doubt he "takes the initiative to clarify physician orders including medication, treatments and diagnostic tests."[44]

B. *Disciplinary Proceedings and Herwick's Licenses in Other States.*

On January 21, 2004, the division was notified of Mr. Herwick's actions and commenced its own investigation which resulted in Mr. Herwick surrendering his license on March 9, 2005. At the time of surrender, Mr. Herwick was licensed in Washington and seeking licensure in California by endorsement. California denied his application based upon Mr. Herwick's decision to surrender his license in lieu of further disciplinary

[40] Exhibit A at 22, 23. This letter was addressed to the Washington State Nursing Care Quality Assurance Commission and submitted in support of Mr. Herwick's application for reinstatement in Alaska..
[41] Exhibit A at 22.
[42] Exhibit A at 25. This letter was addressed to the Washington State Nursing Care Quality Assurance Commission and submitted in support of Mr. Herwick's application for reinstatement in Alaska.
[43] *Id.*
[44] *Id.*

action on March 9, and his failure to notify the California Board of this adverse action.[45] Washington suspended Mr. Herwick's license and charged that he had engaged in unprofessional conduct.

The Washington Nursing Care Quality Assurance Commission held a hearing on May 17, 2007. Mr. Herwick and Dr. Stallkamp testified. Additionally, the commission considered Mr. Herwick's surrender, R.L.'s medical records, a transcript of the division's investigator's interview with Mr. Herwick, a performance evaluation, verification of continuing education courses, and letters from Ms. Binnig and Ms Unterseher.[46] The Washington commission found that as defined by statute Mr. Herwick's surrender of his license to practice in Alaska was unprofessional conduct and ordered probation with conditions.[47] It reinstated Mr. Herwick's license and immediately placed it on probation for twelve months, during which time Mr. Herwick was to submit a typewritten report of at least 1,000 words explaining what he would do differently if confronted with the same situation, and submit performance evaluations from his nurse supervisor every three months.[48] At the time of hearing in this matter, Mr. Herwick had completed all probationary requirements but had not yet received a new unrestricted Washington license.

Mr. Herwick's report to the Washington Commission is presented in three sections: "Mistakes Made," "Lessons Learned," and "The Proper Way." Under "Mistakes Made," Mr. Herwick writes that in the case of R.L. "a verbal order was taken and written down but it was misunderstood and the manner in which it was given was forgotten, creating the conflict that has resulted in some legal disputes." [49] He emphasizes that a "practical nurse would have noted the discrepancies [in the verbal order] and asked the physicians for parameters and clarification."[50] As to the removal of the oxygen mask without an order, "regardless of whether the physician would have

[45] Exhibit S.
[46] *IMO Thomas D. Herwick, R.N.,* Docket No. 06-04-A-1051 RN (Wash. Nursing Care Quality Assurance Commission June 2007) Exhibit 4 at 3 – 16.
[47] Under RCW 18.130.180(5) suspension, revocation or restriction of an individual's license to practice nursing is unprofessional conduct.
[48] *IMO Thomas D. Herwick, R.N.,* Docket No. 06-04-A-1051 RN (Wash. Nursing Care Quality Assurance Commission June 2007) Exhibit 4 at 13 – 15.
[49] Exhibit 5 at 3.
[50] *Id.*

approved it after the fact[, this] was a major concern. An order should have been obtained before any procedure was done."[51] Mr. Herwick also characterizes as a mistake the fact that he had no documentation to support his version of events making it more difficult to defend himself.[52] The final mistake he identifies was not disposing of a controlled substance according the policy and procedures of the institution.

Under "Lessons Learned" and "The Proper Way", Mr. Herwick's comments can be placed into two categories, lessons learned about charting and lessons learned about emotions. Regarding charting, he notes that the purpose of "nursing documentation is to record the patients condition and nursing actions in order to provide the best possible care" and identifies the type of information that should be contained in proper charting and recording of events[53] Mr. Herwick notes that while R.L. "got excellent care, any nurse reading the chart could not tell by the narrative."[54] He also provides some hypothetical chart notes as examples of proper charting which he characterizes as "punitive" but necessary if he is to avoid a "contest of one person[']s word against another."[55]

Regarding the proper way to deal with emotions, Mr. Herwick writes that if a nurse can maintain proper boundaries and maintain a professional distance, then the nurse should be able to objectively carry out his or her duties and he does "not see a problem with sharing in strong emotions."[56] He has learned that he "should take care though when I am in such an emotional state that I make sure all my duties are not compromised and that I ask for assistance to make sure all policies and procedures are followed regardless of my emotional state… the day I cannot cry or share in a family's grief is the day I am done with nursing."[57]

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[51] Exhibit 5 at 4.
[52] *Id.*
[53] Exhibit 5 at 5.
[54] Exhibit 5 at 4.
[55] "While the way it is written is objective and does not place blame it still points to a bigger problem that is best dealt with through other channels. The purpose of nursing documentation is to record the patients condition and nursing actions in order to provide the best possible care. However as I have learned you must put aside your prejudices and chart exactly what has occurred otherwise it becomes a contest of one person[']s word against another. Add to this that all verbal orders should be read back and documented as such." Exhibit 5 at 5.
[56] Exhibit 5 at 5.
[57] Exhibit 5 at 5, 6.

III. Discussion

Under AS 08.68.270 the Board has the discretion to deny a license if it concludes that the applicant falls within any one of ten disqualifying conditions found at AS 08.68.270.[58] It is important to note that the Board is not required to deny a license when it concludes that an applicant's activities have been proscribed. Rather, the Board exercises its discretion to grant or deny the license depending on the circumstances. The Board may, depending on the circumstances, select from a range of actions including probation or the placing of limitations or conditions on a license.[59]

Mr. Herwick voluntarily surrendered his license. When he did so Mr. Herwick understood that as a prerequisite to reinstatement he would have to prove to the Board that he was "competent to resume practice, and am able to do so with skill and safety."[60] Mr. Herwick's notice of surrender acknowledged that the division was involved in an active investigation concerning allegations that Mr. Herwick had negligently practiced beyond the scope of his license, had written a physician's order for and increasing the amount of morphine without an actual physician's order, had failed to properly chart the problems and interventions for a patient, and had discontinued R.L.'s oxygen without an order, hastening her death.[61]

On April 24, 2007, the division received Mr. Herwick's application for reinstatement. The Board denied his application at its April 2, 2008 meeting.[62] Denial was based on the single ground of AS 08.68.270(7), that his actions surrounding the events of December 6, 2003 rose to the level of "unprofessional conduct as defined by

[58] *See* AS 08.68.270, Grounds for denial, suspension, or revocation. AS 08.68.270 is the statutory statement of policy regarding proscribed actions for a nurse. The Board's regulation, 12 AAC 44.770, is its statement of policy regarding unprofessional conduct by a nurse. The APA differentiates between pre-licensing and post licensing actions by who carries the burden of proof. AS 44.62.460(e). Therefore, when applying AS 08.68.270 to an application for reinstatement after voluntary surrender of a nursing license, the applicant has the burden of proving that it is more likely than not that they did not engage in or perform one of proscribed behaviors listed at AS 08.68.270.

[59] The Board's disciplinary powers derive from AS 08.68.275 and AS 08.01.075.

[60] Exhibit A at 57.

[61] Exhibit A at 56-57. Mr. Herwick testified that at the time he signed the surrender he was under the impression that Dr. Stallkamp had not signed the verbal order of December 6, 2003. This is irrelevant because there were numerous allegations unrelated to whether Dr. Stallkamp had signed the verbal order that were being investigated that served as the basis of this denial, including removal of a life support system and improper wasting. These allegations, if proven, would have been grounds for revocation or suspension.

[62] The Board of Nursing Meeting Minutes are contained at Exhibit B. They are marked draft. However, at hearing it was established for the relevant sections of the minutes were subsequently approved.

regulations adopted by the board."[63] When the Board denied the application it did not have the benefit of either the Washington Commission's order or Mr. Herwick's report. Mr. Herwick exercised his right to a hearing to more fully explore the basis for denying him a license. In advance of the hearing, the division notified Mr. Herwick in an Amended Statement of Issues that, in addition to AS 08.68.270(7), it would argue three additional grounds for denial: AS 08.68.270 (5), (8) and (9).[64] Specifically, the division asserted as a grounds for denial in the Amended Statement that Mr. Herwick:

- had intentionally or negligently engaged in conduct that resulted in a significant risk to the health and safety of R.L.;
- had engaged in unprofessional conduct as defined by 12 AAC 44.770 by:
  - failing to use sufficient knowledge, skills or nursing judgment in the practice of nursing as defined by the level of licensure; …
  - failing to perform acts within the nurse's scope of competence which are necessary to prevent substantial risk or harm to a client; …
  - violating state or federal laws regulating drugs, including but not limited to forging prescriptions or unlawfully distributing drugs or narcotics;
  - failing to maintain a record for each client which accurately reflects the nursing problems and interventions for the client, or falsifying a client's records or intentionally making an incorrect entry in a client's chart; …
  - removal of a patient's life support system without appropriate medical or legal authorization;
- had willfully or repeatedly violated the rules and regulations governing the practice of nursing; and
- is professionally incompetent i.e.: does not possess the skills, knowledge, and awareness of his limitations and abilities to safely practice nursing.

The crux of Mr. Herwick's argument is that his application should be approved because the Board should focus on the present, not the events of the past — specifically whether the evidence presented regarding his present skills and abilities demonstrates that

[63] April 9, 2008 letter from Sanders to Herwick re: Denial of Application.

[64] **Sec. 08.68.270. Grounds for denial, suspension, or revocation.** The board may deny, suspend, or revoke the license of a person who…
(5) has intentionally or negligently engaged in conduct that has resulted in a significant risk to the health or safety of a client or in injury to a client;…
(7) is guilty of unprofessional conduct as defined by regulations adopted by the board;
(8) has willfully or repeatedly violated a provision of this chapter or regulations adopted under it;
(9) is professionally incompetent;…
The Board has adopted 12 AAC 44.770 to define unprofessional conduct.

he is competent to resume nursing. He believes people can change; his actions in the past do not define his present ability to perform the duties of an registered nurse; and that a preponderance of the evidence establishes that he is competent to resume to the practice of nursing in Alaska with skill and safety.

Mr. Herwick's closing statement argues that the division has "failed to provide any evidence that Herwick does not currently possess the skills, knowledge and awareness of limits of practice necessary to be professionally competent as a nurse."[65] This statement misses the mark. Mr. Herwick has the burden of proving that it is more likely than not that he is competent to resume practice, and is able to do so with skill and safety. The burden does not "shift" to the division to prove the negative. Mr. Herwick must prove the positive. Therefore, Mr. Herwick's argument that the division has failed to provide any evidence that he does not presently possess the skills, etc. to practice nursing in Alaska is unpersuasive.

Similarly unpersuasive is Mr. Herwick's argument regarding the Board's ability to rely upon the events of the past as a valid concern in the future. The Board does not need to resolve the details of what happened in 2003. What is significant is that he surrendered his license under justifiable suspicion, and he admits that his practice was substandard. It is Mr. Herwick's burden to establish that it is more likely than not that the grounds raised by the division do not exist today and that they will not impact his ability to presently practice nursing with skill and safety. He may do this by placing evidence in the record or pointing to evidence in the record that establish it is more likely than not that he can resume the practice of nursing in Alaska with skill and safety. In Mr. Herwick's case, this means that he must persuade the Board that he understands his scope of competence, that he no longer engages in conduct that places clients at risk, and that he is professionally competent.

The evidence presented and relied upon by Mr. Herwick (his testimony, testimony of Ms. Unterseher, his recent work history, the Washington Commission's Decision, and Mr. Herwick's written statement to the Washington Commission) are insufficient to meet Mr. Herwick's evidentiary burden. It is a start but it does not establish that it is more likely than not that when placed in the same or similar circumstance, Mr. Herwick would

[65] Herwick Closing Statement at 1, 2 (emphasis in original).

respond differently. It does not demonstrate that Mr. Herwick's present nursing skills and practices meet Alaska nursing standards.

It is undisputed that Mr. Herwick failed to properly maintain R.L.'s records in a manner that accurately reflected the nursing problems and interventions for the client, that he administered a controlled substance in excess of the written orders, that he improperly wasted controlled substances, that he became emotionally involved with R.L. and her situation, and that he removed her life support (oxygen mask) without a physician's order.

In his report to the Washington Commission, Mr. Herwick acknowledges the deficiencies in his record keeping, but he has not demonstrated that he understands the importance of proper record keeping. His report focuses on the defensive role of proper record keeping rather than its role in providing the information necessary to assure proper care to the client. A patient record follows the patient, not the provider. A record must be written in a manner that permits any provider to pick up the record and understand, without further explanation, the history of the patient. Failure to do otherwise results in a significant risk to the health and safety of a client. It is not "punitive."

Mr. Herwick provides specific examples of what he considered to be proper record keeping in his report. Ms. Unterseher did not express dissatisfaction with his record keeping. But this is does not establish that it is more likely than not that he presently charts according to Alaska standards. What would have been more persuasive is objective evidence in combination with his testimony, such as a random sample of his chart notes over the past several years and evidence that he had completed course work on proper charting.

Mr. Herwick presented testimony that his performance in the emergency room is satisfactory. Ms. Unterseher gave Mr. Herwick a good evaluation and in her capacity as his supervisor, she has enough faith in his nursing abilities to have Mr. Herwick act as a mentor to student nurses. However, this does not establish by a preponderance of the evidence that Mr. Herwick possess the ability to perform acts within the scope of his competence which are necessary to prevent a substantial risk or harm to a client in a non emergency room setting.

Nursing in an emergency room is different from nursing in a long term care or progressive care unit. An emergency room nurse does not care for the same patient day after day. Mr. Herwick's report acknowledges his ability to become emotionally involved with a patient and the danger to a client if a provider loses objectivity because of his or her emotional involvement. Dr. Stallkamp testified that when he observed Mr. Herwick he had concerns regarding Mr. Herwick's ability to carry out his nursing duties with skill and safety. These observations were made in a non-emergency room setting. Mr. Herwick's behavior regarding the care provided to R.L. and his actions after her death corroborate Dr. Stallkamp's observations. By restricting himself to emergency room work, Mr. Herwick appears to understand his emotional limits. However Mr. Herwick has applied for a license without restrictions and he has not established by a preponderance of the evidence that he is competent to resume the unrestricted practice of nursing in Alaska with skill and safety.

IV. Conclusion

While Mr. Herwick has presented some evidence in support of his application for reinstatement, he has failed to meet his burden of presenting persuasive evidence that it is more likely than not that he is competent to resume the practice of nursing in Alaska with skill and safety. Accordingly the denial of his request for licensure is affirmed.

DATED this 5th day of January, 2009.

By: *Signed*
Signature
Rebecca L. Pauli
Name
Administrative Law Judge
Title

Adoption

The Alaska Board of Nursing adopts this decision as final under the authority of AS 44.64.060(e)(1). Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with AS 44.62.560 and Alaska R. App. P. 602(a)(2) within 30 days after the date of distribution of this decision.

Dated this 23rd day of January, 2009.

By: *Signed*
Signature
Catherine A. Giessel
Name
Board Chair
Title