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

In the Matter of	)	
Audrey Eileen Small	)	OAH No. 09-0396-NUR
	)	Board Case No. 2304-05-001
In the Matter of	)	
Audrey Eileen Small	)	OAH No. 10-0057-NUR
	)	Board Case No. 2304-09-007

DECISION

I. Introduction

This is a consolidated action concerning the Advance Nurse Practitioner (ANP) and Registered Nurse (RN) licenses of Audrey Eileen Small. The hearing in this action addressed

(1) compliance with a 2008 consent agreement affecting Ms. Small's ANP license, and "automatic" suspension of her ANP license under that agreement;

(2) the later imposition of summary suspension of Ms. Small's RN license, and continued suspension of her ANP license, by the Board of Nursing; and

(3) new allegations of misconduct by Ms. Small concerning unauthorized practice and compliance with laws.

The Division of Corporations, Business and Professional Licensing proved through an evidentiary hearing that Ms. Small has been unable to comply with a supervision requirement of the 2008 consent agreement, but not that this failure constituted a violation of the terms of the agreement warranting disciplinary sanctions beyond enforcement of the agreement's supervision requirement or an alternative requirement if approved by the board.

The division, however, proved new misconduct warranting discipline. It proved that Ms. Small engaged in practice authorized for an ANP but not an RN after receiving notice that her ANP license had been suspended under an automatic suspension provision of the consent agreement. Ms. Small raised reasonable questions about the validity of the automatic suspension order, but she was not free to defy the order pending resolution of her challenge to it. The order resulted from an ambiguous provision of the agreement Ms. Small and her counsel negotiated with the division. Though the evidence supported a finding that the order was not issued by the appropriate entity, Ms. Small's obligation of good faith under the agreement and the professional conduct standards of her profession required that she comply with the order while pursuing her challenge to it through the hearing process. She claimed to have stopped practicing as an ANP immediately after receiving notice of the order. The evidence, however, proved that she

continued to issue, or cause to be issued, prescriptions and orders for diagnostic tests after that date.

The division also proved that Ms. Small issued prescriptions in violation of applicable federal regulations. Additionally, the evidence reinforced the board's summary suspension finding that Ms. Small posed a risk to public health and safety because of her unauthorized practice during the suspension period. Thus, the evidence showed that summary suspension of the RN license was proper and that grounds existed for continued suspension of her ANP license.

In addition to enforcing the requirements of the 2008 consent agreement, the board should impose disciplinary sanctions on both licenses because of the new violations. Ms. Small has engaged in unprofessional conduct repeatedly and at some risk to her patients. Under the particular circumstances of Ms. Small's case, considered in light of the board's disciplinary guidelines and prior decisions, appropriate sanctions are

1. revocation of the ANP license, including termination of Ms. Small's authority to issue prescriptions; and
2. revocation of Ms. Small's RN license.

Consistent with the board's practice in revocation cases, no fine should be imposed for the new misconduct. Unpaid fine amounts under consent agreements between Ms. Small and the division, however, are due in full because the new misconduct includes violation of laws triggering payment of previously suspended fine amounts under the agreements.

II. Facts

The facts in this section and elsewhere in this decision are drawn from the documentary record and testimony from a multi-day evidentiary hearing. All of the exhibits offered by the division and Ms. Small that were not withdrawn by the party who introduced them were admitted into evidence.[1] Thirty-three witnesses testified. Several had been patients of Ms. Small. They were assigned pseudonyms (e.g., Patient 1) to protect their privacy in the event they testified about medical conditions or treatment.[2] They are referred to in this decision by the pseudonyms.

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[1] The division's exhibits 1-9, 14-18, 20-29 and 31 were admitted. The division withdrew its exhibits 10-13, 19 and 30. For page references, the division's "AGO" numbers are used. Ms. Small's exhibits were page numbered consecutively, beginning with "Small 15" and ending with "Small 365," with gaps of unused numbers at pages 249-259 and 357. Small 15-202, 214-248, 260-356 and 358-365 were admitted. Ms. Small withdrew pages 203-213. Many exhibits, especially prescription copies, were redacted by removal of patient identification information. Others, such as patient affidavits, were ordered sealed to protect the privacy of patients.

[2] August 23, 2010 Order Regarding Confidentiality. The audio recordings of the hearing and any transcript made from them were ordered sealed to further protect the privacy of the patient-witnesses who testified about

A. BACKGROUND

Ms. Small has been a nurse since the 1980s and became a nurse-midwife in the mid-1990s, after completing a Nurse Midwifery Education Program at Bay State Medical Center, an affiliate of Tufts University.[3] Her course work included a pharmacology module containing a component on "Medical-Legal Issues of Prescriptive Privileges for Advance Nurse-Practitioners."[4]

Ms. Small obtained her Alaska RN and ANP licenses in 1998.[5] She worked as part of the OB/GYN group at Ketchikan General Hospital between 1998 and 2001.[6] After the hospital reorganized the OB/GYN practice, ending her employment there, Ms. Small opened A Woman's Place with a great deal of help from people in the community.[7] A Woman's Place is a nurse-midwifery business owned by Ms. Small at which she has emphasized women's health issues and treated hundreds of patient herself, until suspension of her ANP license recently led her to bring a nurse-midwife up from Minnesota to work in the practice.[8]

While she was with the hospital, Ms. Small worked with a physician who was a good practitioner but plagued with personal problems.[9] For a time, that physician's habit was to leave a basket of prescription blanks, pre-signed or stamped with her signature, on the counter.[10] After a young man stole a prescription pad and tried to use the prescriptions, the basket was removed.[11] In her testimony, Ms. Small claimed that it was the example of this troubled physician pre-signing/stamping blank prescriptions a decade ago that caused her to believe it is

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medical conditions or treatment because the parties and witnesses were not entirely successful in using only the pseudonyms during the hearing. *See* September 14, 2010 Order Sealing Additional Portions of Record at 1-2.

[3] August 27, 2010 Testimony of Audrey Eileen Small; Curriculum Vitae (CV) of Eileen Small (Small Exhs. 245-247); *also generally* Ms. Small Alaska Licensing Files for ANP Lic. 524 and RN Lic. 18582 (Div. Exhs. 1 & 2).

[4] February 14, 1998 Letter from Baystate Medical Center to Alaska Board of Nursing (Div. Exh. 1, AGO 1426-1427).

[5] Alaska RN Lic. No. 18582 (effective April 10, 1998) (Div. Exh. 1, AGO 1605); Alaska ANP Lic. No. 524 (effective April 10, 1998) (Div. Exh. 1, AGO 1405).

[6] August 27, 2010 Testimony of Audrey Eileen Small; CV of Eileen Small (Small Exh. 246).

[7] August 26, 2010 Testimony of Patient 4 (describing efforts to get A Woman's Place up and running); August 27, 2010 Testimony of Audrey Eileen Small.

[8] August 27, 2010 Testimony of Audrey Eileen Small.

[9] August 27, 2010 Testimony of Audrey Eileen Small (discussing the physician's apparent gambling addiction and the mental and physical health problems of two family members who died).

[10] August 26, 2010 Testimony of Patient 4 (describing the physician's family health and gambling problems, and habit of leaving signed/stamped prescriptions out until the theft).

[11] August 26, 2010 Testimony of Patient 4.

permissible to pre-write prescriptions (i.e., to complete some but not all required information, leaving blank parts to be filled in later). Her testimony on this point was not credible.[12]

Ms. Small is well-liked and appreciated by many patients for a variety of reasons. Many have found her more responsive and more willing to get to know them and their health concerns than physicians with whom they have dealt.[13] Some who saw her for obstetrical care valued having a pleasant, local alternative to in-hospital deliveries.[14] Some appreciated her diligence in getting them needed referrals or cooperating with their out-of-town treating physicians to tend the patients' needs in Ketchikan.[15] Some credit her with likely saving their lives.

- One patient recounted the story of Ms. Small listening to her when physicians had dismissed her symptoms, examining her thoroughly and finding a mass, and persisting in getting a physician to conduct the follow-up that confirmed a diagnosis of a particularly deadly form of cancer—anal cancer—that the patient believes would have gone untreated until she died if not for Ms. Small's intervention.[16]
- One patient described Ms. Small's efforts and persistence over the years that were instrumental in diagnoses of serious, potentially life-threatening conditions—i.e., uterine cancer; a 90% heart blockage; and diabetes.[17]
- One patient submitted an affidavit stating that Ms. Small detected a heart problem that two physicians had missed and, as a result, the patient was able to have surgery "to correct a major heart problem."[18]

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[12] Ms. Small said that she thought maybe there was a special local rule that applied in Ketchikan, the way that different states can have different regulations. When asked why she thought the federal Drug Enforcement Administration (DEA) would make a special exception for Ketchikan, Ms. Small became defensive and appeared nervous, as if caught trying but failing to come up with a plausible explanation for blaming the bad example of the troubled physician for her conduct years later.

[13] August 25-26, Testimony of Patients 4, 9, 11, 12, 15, 16 & 43; August 4, 2010 Affidavit (Small [sealed] Exh. 180); August 17, 2010 Affidavit (Small [sealed] Exh. 217).

[14] August 25, 2010 Testimony of Patient 15; August 26, 2010 Testimony of Patient 28.

[15] August 25, 2010 Testimony of Patient 9 (describing Ms. Small's persistence in getting a much-needed, possibly life-saving appointment with a physician); August 26, 2010 Testimony of Patient 12 (describing Ms. Small's collaboration with the patient's physicians in Southcentral Alaska and a Seattle oncologist); August 26, 2010 Testimony of Patient 16 (describing complex pain management need and Ms. Small's cooperation with Dr. Stinson); *also* August 30, 2010 Testimony of Lawrence W. Stinson, MD (discussing cooperative arrangement with Ms. Small for pain management of Patient 16).

[16] August 25, 2010 Testimony of Patient 9.

[17] August 26, 2010 Testimony of Patient 4.

[18] July 25, 2010 Affidavit (Small [sealed] Exhs. 167 & 202).

Two out-of-town physicians—one an OB/GYN and the other a pain specialist—called as witnesses by Ms. Small, with whom she collaborated over the years on care for Ketchikan-based patients, confirmed that she has been cooperative in follow-up care, easy to deal with, and acted appropriately and professionally.[19] The OB/GYN, who had been referred one to five of Ms. Small's patients for about eight to ten years, described interactions with Ms. Small for patients sent to Seattle for surgery and other treatment. The physician stated that it was common for her to have Ms. Small arrange for tests and lab work to be done before the patient traveled to Seattle.[20] That physician had not consulted with Ms. Small about a patient for a year-and-a half to two years before the hearing.[21]

The pain specialist testified based on interaction with Ms. Small concerning just one patient regarding which he recalled an initial conversation and one follow-up with Ms. Small. On cross examination the pain specialist testified about prescription-writing practices. In response to a hypothetical asking whether it would be acceptable for a provider to fill out a prescription form but leave the date blank for someone else to fill in later, he responded that this is unacceptable.[22]

B. DISCIPLINARY HISTORY

In November 2007, the division filed an accusation against Ms. Small stemming from a December 2004 delivery of an infant who died a short time after his birth.[23] Ms. Small and the division entered into a consent agreement in which Ms. Small neither admitted nor denied the facts recited in the agreement.[24] Ms. Small admitted only that if the facts recited had been proven, there would have been grounds for disciplinary sanctions against her.[25] She explained that she entered into the consent agreement, rather than going to hearing, because she could not afford the legal costs of a hearing.[26] The board approved the consent agreement on October 24, 2008.

The agreement imposed a six-month suspension on Ms. Small's licenses, with four months of the period suspended—effectively a 60-day suspension—and imposed a three-year

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19 August 25, 2010 Testimony of Ellen Wilber, MD; August 30, 2010 Testimony of Lawrence W. Stinson, MD (regarding Patient 16).

20 August 25, 2010 Testimony of Ellen Wilber, MD.

21 *Id.*

22 August 30, 2010 Testimony of Lawrence W. Stinson, MD.

23 October 24, 2008 Consent Agreement at ¶ 3 (Div. Exh. 4).

24 *Id.* (stating that "[r]espondent neither admits nor denies the following facts" recited in subparas. (a)-(x)).

25 *Id.* at ¶ 3, final sentence (following subpara. (x)).

26 August 27, 2010 Testimony of Audrey Eileen Small.

probation period.[27] The suspension period took effect 60 days after the board's October 24th approval of the agreement—i.e., on December 23, 2008.[28] As provided in the agreement, "at the completion of the 60 days suspension [Ms. Small's licenses were] reinstated and placed on probation for (3) three years from the effective date [October 24, 2008]."[29]

During the probation period, the agreement required "the deliveries of [Ms. Small's] patients to be supervised by Chia-Ling Tung, MD."[30] This did not require that Ms. Small "be under constant, direct observation by her supervisor."[31] Among other things, the supervisor was to "submit quarterly reports to the Board's agent regarding [Ms. Small's] performance, her method of handling stress, mental and physical health, professional responsibilities and activities, and personal activities."[32] In addition, at an unidentified point during the first year of probation (October 24, 2008-October 23, 2009), the supervisor was to select obstetric patient records and gynecologic patient records of Ms. Small for a random audit.[33] The agreement provided the following under the heading "noncooperation by reporting persons":

> If any of the persons required by this Order to report to the Board, fails or refuses to do so, and after adequate notice to Respondent to correct the problem, the Board may terminate probation and invoke other sanctions as it determines appropriate. All costs are the responsibility of the Respondent.[34]

The agreement also required Ms. Small to "participate in a psychological assessment administered by Ronald Weisner, MD in Ketchikan, Alaska."[35] The assessment and treatment recommendations were to be provided to the board.[36] It required that she "attend and satisfactorily complete" 40 hours of continuing education classes dealing with specified subject matters and approved in advance by "the Board's agent …."[37] It required that she "obey all laws pertaining to her license in this state or any other state."[38] It imposed a $10,000 civil fine, with $5,000 suspended and the remainder to be paid in two installments of $2,500 each, with the first

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27 October 24, 2008 Consent Agreement at A & B. The terms and conditions of the agreement are found in 17 sections lettered A through Q (Div. Exh. 4).
28 *Id.* at A.
29 *Id.* at B & p. 12, final paragraph (collectively providing for three-year probation period to run from the board's approval of the agreement).
30 *Id.* at K.
31 *Id.*
32 *Id.*
33 *Id.* at L.
34 *Id.* at F.
35 *Id.* at J.
36 *Id.*
37 *Id.* at M.

due within one year after the end of the suspension period—i.e., by February 21, 2010—and the second due six months prior to the end of the probation period.[39]

Regarding possible future violations, the agreement includes an automatic suspension provision which states:

> If Respondent fails to comply with any term or condition of this Consent Agreement her license may be automatically suspended. If Respondent's license is suspended under this paragraph, she will be entitled to a hearing and due process regarding the issue of the suspension. If Respondent's license is suspended, she will continue to be responsible for all license requirements pursuant to AS 08.68.276.[40]

This provision does not specify by whom the discretion to automatically suspend Ms. Small's license can be exercised, on what factual basis this could be done prior to a hearing at which noncompliance is proven, or who will make the initial factual determination. It also does not state whether the suspension will take effect after the factual basis for suspension has been tested through a hearing, if one is requested, or immediately, with due process afforded afterwards. The agreement provides that "[a]ll parties agree to act in good faith in carrying out the stated intentions of this Consent Agreement."[41]

Ms. Small entered into a second consent agreement with the division in 2009 arising from a September 2008 delivery.[42] Ms. Small admitted that grounds existed for possible disciplinary sanctions as a result of the facts recited in the agreement but neither admitted nor denied those facts.[43] The agreement imposed a two-year probation period, to run concurrent with the one from the 2008 consent agreement, a $1,500 civil fine (with $750 suspended), a reprimand, and a requirement to complete additional education in the form of three specified online courses.[44]

Regarding possible future violations, this agreement included a provision nearly, but not quite, identical to the one in the 2008 agreement. The only differences are that the 2009 agreement's provision speaks to suspension of and responsibility for license requirements of both licenses, leaves out the reference to due process in the sentence on the right to a hearing, and states that if Ms. Small fails to comply "her licenses shall [not may] be automatically

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38 *Id.* at D.
39 *Id.* at N.
40 *Id.* at C.
41 *Id.* at G.
42 April 1, 2009 Consent Agreement at 1 (Div. Exh. 23).
43 *Id.* at ¶ 3 & final sentence (following subpara. c).
44 *Id.* at A, J, K & L. The terms and conditions of the agreement are found in 12 sections lettered A through L.

suspended."[45] The 2009 agreement also took a different approach to the "compliance with laws" provision, stating that

> Respondent shall obey all federal, state and local laws, all statutes and regulations governing the licensee, and remain in full compliance with any court ordered criminal probation, payments and other orders, particularly the recent Consent Agreement/Board Order between the Respondent and the Board under case number 2304-05-001, which became effective October 24, 2008.[46]

C. COMPLIANCE WITH CONSENT AGREEMENTS[47]

Complying with the 2008 consent agreement posed several challenges for Ms. Small, some attributable to the way the agreement was written. It assigned roles and reporting responsibilities to Doctors Tung and Weisner, by name, without providing a contingency plan for replacing them if they became unable to perform their roles. That is what happened.

Dr. Weisner was not able to perform the psychological assessment.[48] His assessment and treatment recommendations could not be reported to the board, as required by the agreement. Though this presented a compliance challenge, it did not result in an allegation of noncompliance. Instead, the division approved a substitute for Dr. Weisner without taking the matter to the full board or formally modifying the agreement.[49]

A similar solution proved to be elusive for the supervisor role assigned to Dr. Tung. She served as Ms. Small's supervisor for a few deliveries before withdrawing from that role.[50] After giving notice in February, Dr. Tung left her employment with the hospital early in April 2009, having been advised by her employer that she should not function as Ms. Small's physician backup and that providing oversight for Ms. Small's deliveries was beyond the scope of employment and not covered by the hospital's medical malpractice insurance.[51] Dr. Tung moved away from Ketchikan.[52]

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45 *Id.* at B.

46 *Id.* at D.

47 Because the division's consent agreement noncompliance arguments focused on the 2008 agreement and the division made no assertion of noncompliance specific to the 2009 agreement, this decision addresses whether Ms. Small failed to comply with the 2008 agreement. Since the "compliance with laws" provision of the 2009 agreement required Ms. Small to remain in full compliance with the 2008 agreement, noncompliance with the 2008 agreement is also noncompliance with the 2009 agreement.

48 August 24, 2010 Testimony of JoAnna Williamson.

49 *Id.*

50 August 27, 2010 Testimony of Audrey Eileen Small; March 31, 2009 Letter from Hennessey to Tung, indicating that Dr. Tung's "signature of oversight" was noted in hospital records for Ms. Small's patients after October 14, 2008 (Small Exh. 260).

51 August 23, 2010 Testimony of Barbara Bigelow; March 31, 2009 Letter from Hennessey to Tung (Small Exh. 260); August 23, 2010 Testimony of Patrick Branco (confirming Dr. Tung's submittal of a resignation letter

Dr. Tung did not submit to the board any quarterly reports or a report of audit findings from patient records audits during the roughly five months between the effective date of the 2008 consent agreement and her April 2009 departure.[53] Since the agreement did not require the supervisor to conduct the audit at any particular time during the first year of probation, an audit report would not have been due by the time Dr. Tung ceased to serve as Ms. Small's supervisor. The agreement did not say when Dr. Tung's quarterly reports were due or otherwise specify how quarters should be measured.[54]

The division investigator monitoring Ms. Small's probation testified that she did not discuss with Ms. Small the need for a quarterly report at the time of Dr. Tung's departure because the first quarterly report was not due until May.[55] The investigator reasoned that "since [Ms. Small] was on suspension at the beginning part, that part would not be something the supervisor supervised."[56] The investigator's reasoning does not take into account the facts that (1) the 60-day suspension period did not begin to run until 60 days after the board's October 24, 2008 approval of the agreement, (2) Ms. Small was performing deliveries between that date and January 23, 2009, which she took to be the end of the first quarter,[57] (3) the supervision responsibilities are broader than just supervising deliveries (e.g., they include assessing stress handling and health issues), (4) the agreement does not provide a delayed effective date for the supervision requirement or explicitly allow for a reporting time-out to be taken during a suspension period, and (5) the investigator had declared the report to be past due in March.[58]

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dated February 2, 2009). Difficulty obtaining malpractice coverage proved to be an impediment to obtaining supervision from other practitioners, not just from Dr. Tung. According to Ms. Small's attorney, all practitioners approached about serving as a supervisor were concerned about malpractice coverage. August 19, 2010 Testimony of Barbara Norris.

[52] August 23, 2010 Testimony of Barbara Bigelow (explaining that Dr. Tung had submitted her letter of resignation in February, completed her serve in early April and moved away from Ketchikan).

[53] August 24, 2010 Testimony of JoAnna Williamson.

[54] *See* October 24, 2008 Consent Agreement at K (stating that the supervisor "shall submit quarterly reports to the Board's agent" and describing the content but setting no quarter end dates or deadlines) (Div. Exh. 4). In a more recent consent agreement involving a different licensee, the agreement set out a schedule for quarterly reports using standard calendar quarters—e.g., January 1-March 31, April 1-June 30, and so forth—and setting due dates as a one-week range immediately following the quarter's close—e.g., due April 1-7 for first quarter, due July 1-7 for second quarter, and so forth. *Matter of Michael J. Mohl*, Case No. 2350-09-008, at page 7 of January 27, 2010 Consent Agreement.

[55] August 24, 2010 Testimony of JoAnna Williamson.

[56] *Id.*

[57] *See* October 22, 2009 Letter from Small to Williamson and Sanders (asserting that Ms. Small "did 4 deliveries all of which Dr. Tung supervised" during the October 24-January 23 period) (Small Exh. 314; Div. Exh. 22 at AGO 137).

[58] March 16, 2009 Email from Williamson to Small (stating "I have it [the quarterly report] scheduled to be received no later than the beginning of this month") (Small Exh. 35).

By any reasonable measure, at least one quarter had elapsed by the time Dr. Tung's supervisor role ended about five months after the agreement took effect. Whether the end of the quarter is viewed as January 23, as Ms. Small has asserted, or strict calendar quarters are used, making a partial report due after December 31, and a full report due after March 31, the result is the same: one report was due before Dr. Tung ceased to act as supervisor. No quarterly report was submitted.[59]

In March 2009, shortly before Dr. Tung left her employment with the hospital, Ms. Small wrote to her in essence asking that she prepare a report for the board and describing the subject matter it should cover.[60] She did this in response to a request from the division to get Dr. Tung to submit the quarterly report that the division investigator had scheduled as due by the beginning of March.[61] A report responding to Ms. Small's request would have covered much—but not quite all—of the ground required by the agreement for a quarterly report.[62]

Several months later, Ms. Small obtained a copy of what purports to be a letter from Dr. Tung dated March 20, 2009.[63] The letter, which is directed to the "Medical Board," reports "minimal interactions with Ms. Small" but a "high level of professionalism" by Ms. Small in those interactions, and recommends continued supervision of Ms. Small regarding screening for low-risk patients suitable for out-of-hospital deliveries.[64] It does not discuss Ms. Small's handling of stress or mental and physical health, or provide much detail about Ms. Small's performance (which Dr. Tung had not directly observed, her observations being limited to

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59 August 24, 2010 Testimony of JoAnna Williamson.

60 March 17, 2009 Letter from Small to Ling [Tung] (Small Exh. 318).

61 *Id*. (referring to a request from the board for a report); March 16, 2009 Email from Williamson to Small (Small Exh. 35).

62 *Compare* March 17, 2009 Letter from Small to Ling [Tung] (Small Exh. 318) (asking that Dr. Tung address patient care, interactions between her and Ms. Small, how Ms. Small handled stress, professionalism, and whether supervision should continue) *with* October 24, 2008 Consent Agreement at ¶ K (requiring quarterly reports to address Ms. Small's "performance, her method of handling stress, mental and physical health, professional responsibilities and activities, and person activities") (Div. Exh. 4).

63 March 20, 2009 Letter from Tung to Whom It May Concern (Small Exh. 320). Ms. Small testified that the letter copy was slipped under her door by an anonymous gentleman caller in October of 2009 and that she deduced that he must have been an employee of the hospital. In correspondence to the division, Ms. Small pinpointed the date she received the letter copy, stating "October 9, 2009, someone from the hospital confidentially provided me with a copy of Dr. Tung's report on me up until she left." *See* October 22, 2009 Letter from Small to Williamson & Sanders (Small Exh. 316). She also memorialized in an email having received a letter a friend of hers from the hospital had located the first week of October, called her about it and then slipped it under her office door. October 11, 2009 Email from Small (Small Exh. 330).

64 March 20, 2009 Letter from Tung to To Whom It May Concern (Small Exh. 320).

review of handwritten notes). Ms. Small confirmed through email correspondence that Dr. Tung wrote the March 20 letter.[65]

Had the letter by Dr. Tung been submitted to the board in a timely fashion, it would have constituted a partial quarterly report. Since it does not cover all of the subjects required by the agreement to be addressed in the quarterly reports, however, its timely submission would not have constituted complete compliance with the quarterly report requirement. The supposition that someone prevented the letter from being sent to the board or provided to Ms. Small when written in March does not negate the letter's failure to satisfy all requirements for a quarterly report. Had it been submitted to the board when written in March, however, the board could have decided whether to treat it as timely and whether to request additional information from Dr. Tung, or whether to give Ms. Small notice and an opportunity to correct the problem under the "noncooperation by reporting persons" provision of the agreement.

Another compliance challenge Ms. Small had to overcome under both consent agreements was meeting the additional education requirements. The 2008 agreement identified acceptable subjects but left approval of specific course curricula to the board's agent.[66] (The agreement does not specify who the board's agent is.) Ms. Small experienced difficulty finding acceptable courses available through media she could access from Ketchikan.[67] She was able to satisfactorily complete the last of the additional education required in the 2008 consent agreement by March 27, 2009.[68] As to the 2009 agreement, the division agreed to waive the Nurse Practice Act course requirement on the strength of an investigator's decision, without seeking board approval or formally modifying that agreement.[69]

The final compliance challenge Ms. Small faced under the 2008 agreement was payment of the civil fine. The first installment—$2,500—which was due in February 2010, has not been paid. Ms. Small pointed this out during the hearing, explaining that she has been unable to pay the fine because she has been unable to work for eight months, due to the division's enforcement actions.[70]

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[65] October 20, 2009 Email from Tung to Small (Small Exh. 321). Dr. Tung was not called as a witness in the hearing, so neither the letter nor the email was conclusively determined as being written by Dr. Tung.

[66] October 24, 2008 Consent Agreement at ¶ M (Div. Exh. 4).

[67] August 27, 2010 Testimony of Audrey Eileen Small.

[68] August 24, 2010 Testimony of Joanna Williamson.

[69] *See* July 9, 2009 Emails between Williamson and Small (indicating that, after checking with the investigator who had selected the course, the requirement that Ms. Small take it was waived because the course was not available in Alaska) (Small Exh. 78).

[70] August 27, 2010 Testimony/Closing Statement of Audrey Eileen Small.

No quarterly reports have been submitted, the patient records audit has not been performed and reported, and the fine has not been paid. The primary compliance problem flows from the fact that, through no fault of her own, Ms. Small lost the only supervisor designated in the agreement and approved by the board. Though she and the division were able to work out substitute means of satisfying the psychological assessment and additional education requirements, they did not do the same as to the supervisor requirement before the automatic suspension provision of the 2008 agreement was invoked.

D. AUTOMATIC SUSPENSION

In April 2009, the division learned that Dr. Tung had ceased to serve as Ms. Small's supervisor.[71] The division notified Ms. Small that she needed to supply the name of another supervisor for approval within fifteen days.[72] Ms. Small and a division investigator communicated about possible alternatives, primarily discussing whether Ms. Small might simply stop doing deliveries, but Ms. Small did not propose a substitute supervisor within fifteen days.[73] They also communicated about Ms. Small possibly satisfying the supervision requirement by adding to her practice another ANP, whom the investigator stated could substitute for an employer-supervisor.[74] The investigator agreed to suggest to the board Ms. Small's proposal to "simply stop doing deliveries until [her] probation period is over …" and explained that the consent agreement would need to be amended regarding "the supervisor role as well as some other minor adjustment[.]"[75]

Ms. Small began working to find a substitute supervisor, or at least someone to perform the patient records audit and someone to join her practice to handle the deliveries, starting in April 2009.[76] Discussions between Ms. Small (and her counsel) and the division (and its counsel) about possible substitute supervisors or alternative ways to meet the need for supervision appear to have begun in earnest in August 2009, and to have continued through October 2009.[77]

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71 August 24, 2010 Testimony of JoAnna Williamson.

72 August 24, 2010 Testimony of JoAnna Williamson (regarding April 7, 2009 notice letter).

73 August 24, 2010 Testimony of JoAnna Williamson.

74 April 9, 2009 Email from Williamson to Small (Small Exh. 18).

75 April 9, 2009 Email from Williamson to Small (Small Exhs. 17 & 18-19).

76 *See, e.g.*, April 29-May 1, 2009 Email exchanges between Small and Rass (mentioning ad Small had placed prior to April 29 and discussing need for "some chart auditing … on an annual basis") (Small Exhs. 23-26).

77 August 2, 2009 Email from Kirsch to A Woman's Place (responding to position posting) (Small Exh. 73); August 14, 2009 Email from Montufar to A Woman's Place (responding to the "need for a CNM for a few months) (Small Exh. 72); August 14 and September 21-22, 2009 Email exchanges between Small and Keene (discussing Keene's negotiations on Small's behalf) (Small Exhs. 131-136 & 124-130); August 23, 2009 Email from Hale to

When Ms. Small had not provided a proposed substitute supervisor by the board's July 22-23 meeting, the division investigator assigned as Ms. Small's probation monitor conferred with the board in executive session about the matter.[78] The investigator discussed with the board the difficulty Ms. Small was having finding a substitute supervisor and the kind of ideas Ms. Small had come up with for alternatives to the supervision requirement in the agreement.[79] The board, either by general concurrence or possibly by vote, recommended that the investigator enforce the automatic suspension provision of the 2008 consent agreement.[80] The testimony was equivocal on this point. When asked if the board took a vote, the investigator responded: "I don't know if they officially voted; uh, yes, they did all give an opinion and voted 'yes'."[81] Why she self-corrected her answer is unclear. She could not recall how many of the board members had been present at the meeting, but she was certain that the direction was given in executive session, because this was part of her probation report to the board, and she was certain that the board did not go on the record to take a public vote.[82]

By certified mail letter dated July 29, 2009, Ms. Small was notified that her ANP license was suspended because she was "in violation of [her] probation, and … in violation of 12 AAC 44.730 …."[83] Ms. Small received that notice letter on August 3, 2009.[84] The July 29 letter was signed by the division's acting chief investigator. It purports to be a letter from the division, not the board; it does not mention that the board took a vote or directed the division to invoke the automatic suspension provision. It erroneously states "[y]ou have been in non-compliance with your Consent Agreement since its inception …."[85] It incorrectly asserts that Ms. Small has been

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Small (discussing possibility of Hale joining Ms. Small's practice) (Small Exh. 70); August 24, 2009 Email from Rass to Small (promising to send CV and letter agreeing to perform chart audits) (Small Exh. 27); August 28, 2009 Email exchange between Keene, Small's attorney, and Small (showing efforts to round up materials for alternative proposal) (Small Exhs. 29-31); August 25, 2009 Letter from Wynelle Snow, MD (committing to report to regulatory agencies on Ms. Small's "emotional status and ability to manage stress") (Small Exh. 33); August 31, 2009 Email from Keene to Hawkins, division's attorney, (discussing components of a possible three-person team—Rass, Snow and Hale—to collectively cover supervisor function) (Small Exh. 34); September 16, 2009 Letter from Keene to Hawkins (requesting reinstatement of Ms. Small's ANP license and describing two-person proposal using Rass and Snow to cover supervisor role); October 7, 2009 Email exchange between Keene, Williamson and Hawkins (regarding whether a new proposal will be submitted to the board) (Small Exh. 143); October 27, 2009 Email from Williamson to Keene (stating that board had voted "no" on a proposal to substitute Beth Langdon as Ms. Small's supervisor because Ms. Langdon had an unresolved disciplinary matter of her own) (Small Exh. 145).

78 August 24 & 25, 2010 Testimony of JoAnna Williamson.

79 August 24, 2010 Testimony of JoAnna Williamson.

80 *Id.*

81 August 25, 2010 Testimony of JoAnna Williamson (recording 6 at 02:29).

82 *Id.*

83 July 29, 2009 Letter from Howes to Small at 1 (Div. Exh. 5).

84 August 24, 2010 Testimony of Patient 2; August 27, 2010 Testimony of Small.

85 July 29, 2009 Letter from Howes to Small at 1 (third paragraph) (Div. Exh. 5).

unable to acquire a supervisor, rather than that she lost her supervisor.[86] It accurately indicates that no supervisor's reports have been submitted as required by paragraph K of the 2008 consent agreement, but also erroneously implies that the lack of a supervisor has resulted in noncompliance with paragraph L, the patient records audit requirement.[87] The annual audit report was not yet then due.

The July 29th letter was drafted by the probation monitor investigator who had met with the board.[88] The investigator's testimony did not establish whether she had discussed with the board members the same, sometimes erroneous, reasons for suspension she wrote in the letter. The letter informed Ms. Small that

> [a]lthough your license is suspended, you are still required to comply with all conditions of the Consent Agreement and you must continue to be responsible for all license requirements pursuant to AS 08.68.[89]

The letter also notified Ms. Small that she was "entitled to a hearing regarding the issue of this suspension."[90]

E. PRACTICE AFTER NOTICE OF SUSPENSION

Ms. Small received the July 29 notice of suspension letter on August 3, 2009.[91] That same day she emailed the division's investigator, stating that she (Ms. Small) stopped doing deliveries when Dr. Tung ceased to be available as her supervisor and asserting essentially that this was sufficient to keep her in compliance with the consent agreement such that the automatic suspension should not have occurred.[92] The investigator immediately responded that the board was firm that it would not accept discontinuing deliveries as a way to address the deficiency the consent agreement was meant to address.[93] The investigator admonished: "Whether you agree to the suspension or not, doesn't matter; it's automatic and in place."[94]

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86 *Id.* (second paragraph).

87 *Id.*

88 August 25, 2010 Testimony of JoAnna Williamson (stating in response to a question about who drafted the Howes letter "I probably put it together").

89 July 29, 2009 Letter from Howes to Small at 2 (Div. Exh. 5).

90 *Id*.

91 Return Receipt card showing signature date (by Patient 2) of August 3, 2010 (Div. Exh. 5, AGO 1063); August 3, 2010 Email from Small to Williamson (Small Exh. 346); August 27, 2010 Testimony of Audrey Eileen Small.

92 August 3, 2009 Email from Small to Williamson (Small Exh. 346).

93 August 3, 2010 Email from Williamson to Small (stating that Ms. Small "not doing deliveries would simply put [her] in a status where [she] receive[d] no training or ability for improvement [and thus] would be more unqualified at the end of [her] probation …") (Small Exh. 347).

94 *Id.*

Ms. Small testified that she honored the suspension order and stopped practicing as an ANP when she received the notice on August 3.[95] The testimony from Ms. Small and her coworkers indicated that she stayed home due to illness for some portions of July and August, and has not "seen" (examined or conferred with) patients in the office since then.[96] Some witnesses who have been patients of Ms. Small confirmed in their testimony that they have not been seen by Ms. Small since August 3, 2009.[97] Two, however, revealed that Ms. Small arranged for them to receive prescription medication during her suspension period.

When asked about the period August through December 2009, one patient-witness testified that Ms. Small "let me know ahead of time she'd be closing for a little while; she said she'd have everything set up for me" and "she'd have everything I needed prewritten for me so that I could continue with my care while she was gone[.]"[98] The patient stated that during that period, she would call the office once a month and speak to the receptionist to arrange a time to come by to pick up prewritten prescriptions for Percocet.

Another patient testified that she contacted Ms. Small in October 2009 about a medication called "Ursodiol," which is used to treat gall bladder problems and had been recommended to the patient by a physician.[99] The patient was having trouble getting an appointment with a local physician or information about the Ursodiol. The patient asked Ms. Small if she would be comfortable prescribing it and Ms. Small said yes. The patient received the Ursodiol from Island Pharmacy, where she understood Ms. Small to have phoned in the prescription.[100] A prescription by Ms. Small dated October 19, 2009, for Ursodiol 300 mg is among the prescription copies the division obtained from Island Pharmacy.[101] Ms. Small admitted that her signature appears on the prescription.[102]

Ms. Small did not notify the local pharmacies that her ANP license, and with it her authority to issue prescriptions, had been suspended until about four months after she received

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95 August 27, 2010 Testimony of Audrey Eileen Small (stating that she stopped seeing patients and even going to the office during business hours after receiving the notice letter).

96 *Id.*; August 24, 2010 Testimony of Patient 1; August 24, 2010 Testimony of Patient 2. The witnesses' testimony differed markedly about when her illness-driven absence began and ended, and how ill she was, but they were in general agreement that she was out for a large portion of July and at least some of August due to illness.

97 August 25-26, 2010 Testimony of Patients 9, 11 & 28.

98 August 26, 2010 Testimony of Patient 11.

99 August 25, 2010 Testimony of Patient 9.

100 *Id.*

101 *See* Div. Exh. 6 at AGO 1100.

102 August 27, 2010 Testimony of Audrey Eileen Small.

the notice of suspension. In late November or early December 2009, pharmacies received an undated letter signed by Ms. Small, stating the following:

> Dear Pharmacist:
>
> Due to a temporary license suspension, A Woman's Place, Inc./Eileen Small, CNM has ceased operations since July 28, 2009. We are not performing services or writing or renewing prescriptions, as we have been telling patients. Please take note as you should NOT be seeing any prescriptions coming in by phone or fax that have been legitimately authorized by me since that time. We will advise you when this licensing matter has been resolved[.] Please advise us if anyone is presenting prescriptions referencing this clinic that appear to have been authorized outside this time frame.
>
> I apologize for this inconvenience.[103]

Ms. Small admitted to writing and signing the letter but did not type it herself. Instead, she left it for a staff person to type and send out.[104] Ms. Small said that she wrote and signed the letter shortly after receiving the notice of suspension and implied that her staff had failed to send it out promptly. She was not credible on this point.

The staff person who typed the letter sometime in 2009 testified that she could not pinpoint it to a specific date or even a month.[105] She said she found it on her desk one morning and typed it. When asked what she did with it next and similar follow-up questions, she qualified her answers with phrases like "it's possible perhaps" and "perhaps I did it [gave the typed letter to the bookkeeper] because they [he and Ms. Small] live together." This type of hedging can be an indication the witness is uncomfortable giving straight answer because the witness is afraid of being caught in a lie or worried about contradicting what she thinks others may say in their testimony. This witness was uncomfortable testifying and evasive in her answers to the questions from the division's attorney, complained repeatedly that it was hard to remember things that happened a year earlier, tried at one point to break off the examination by refusing to answer any more questions, and ultimately asserted the privilege against self-incrimination to avoid answering certain questions about specific prescriptions.[106]

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103 Undated Letter from Small to Pharmacist (Div. Exh. 21); August 23, 2010 Testimony of Valentina Todd (confirming receipt by Safeway Pharmacy in late November or early December 2009); August 24, 2010 Testimony of Barry Christensen (confirming receipt by Island Pharmacy by fax found Monday morning when reopening after having closed at noon on Saturday, December 5, 2009).

104 August 27, 2010 Testimony of Audrey Eileen Small; *also* August 24, 2010 Testimony of Patient 1 (indicating that the handwritten text was found at the witness' workstation one morning and she typed it up).

105 August 24, 2010 Testimony of Patient 1.

106 *Id.*

Prior to the witness being called, in reaction to a question implying that the witness's testimony might contradict a fact favorable to Ms. Small, the bookkeeper blurted out words to the effect that "she's not going to say that." Later testimony by another witness ("co-worker") who had been employed at A Woman's Place during the fall of 2009 suggests that the witness who typed the letter had either been threatened or bribed to testify favorably to Ms. Small, and possibly was trying to intimidate the co-worker into doing so as well.[107] Whether the witness was in fact threatened or offered a bribe, and if so by whom, was not established. She may have simply been fearful of losing her job or possibly being subject to criminal prosecution. She had already been suspended from her employment at A Women's Place once, during the last half of November 2009, and had been interviewed by the police in December 2009. During the witness's testimony, Ms. Small objected to a line of questioning about prescriptions seemingly for the sole purpose of reminding the witness of a pending criminal investigation and suggesting that the witness should avoid answering the questions.[108]

Whatever the reason, the witness who typed the letter was not credible in her testimony. She had previously been interviewed by a detective and state trooper about prescription practices at A Woman's Place. The interview occurred in December 2009, much closer in time to the automatic suspension order, before the summary suspension order and new accusation were issued, and long before any possible witness tampering suggested by the co-worker's testimony would have occurred. What she told the detective and trooper, therefore, is more credible. She described a process used when Ms. Small was home ill for about three months beginning in August 2009: Ms. Small filled out and signed three to four prescriptions in each patient's file but left the date blank; then the witness would fill in the date when the patient came in for the prescription.[109] She also explained that the bookkeeper would take files home to Ms. Small when the prescriptions were running out and bring the files back the next day with new prescriptions ready to go.[110] Other testimony indicates that she said something similar to a pharmacist.[111]

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[107] August 26, 2010 Testimony of Patient 3 (describing incident in which the witness who had type the letter tracked Patient 3 down at her current place of employment, told Patient 3 that they needed to prepare their testimony, and that since Patient 3 had been subpoenaed she could be arrested, and that Ms. Small was planning the "throw her [Patient 3] under the bus," and said something about having been promised a vacation for the testimony).

[108] August 24, 2010 Testimony of Patient 1 (regarding employment suspension); *id*. (recording 3 at 01:08) (Small's objection); December 29, 2009 Ketchikan Police Department Report (Div. Exh. 24, AGO 204-205).

[109] December 29, 2009 Ketchikan Police Department Report at 2 (Div. Exh. 24, AGO 205).

[110] *Id*.

[111] August 24, 2010 Testimony of Barry Christensen (describing discussion in which Patient 1 led him to believe Patient 1 took files to Ms. Small at her home while she was ill so that Ms. Small could fill out prescriptions).

In her testimony at the hearing, the witness reluctantly confirmed that she had dated a prescription November 5, 2009, and that it appeared to have been signed by Ms. Small.[112] The witness invoked the privilege against self-incrimination in response to the question "who wrote in the date" on a September 3, 2009 prescription for Vicodin.[113] A reasonable inference can be drawn from her invoking the privilege that she (not Ms. Small) wrote in the date and thus that Ms. Small had left the date blank. This witness's description of the prewriting process and admission that the staff filled in dates on the prewritten prescriptions was corroborated by testimony of the co-worker, who explained that the witness had told her that they were to fill in the dates when the patients came in to pick up prescriptions.[114]

Evidence from Ketchikan pharmacies and area pharmacists also established that, more likely than not, Ms. Small wrote prescriptions dated during the suspension period and continued to practice after she received the notice of suspension on August 3. On October 12 and November 14, 2010, Ms. Small spoke with pharmacists at the Safeway pharmacy about prescriptions, one for a patient and one for herself.[115] On November 12, 2009, Ms. Small spoke with a pharmacist at Island Pharmacy about ordering an office-use supply of the sedative-hypnotic Diazepam.[116] On November 4, 2009, Ms. Small spoke with another pharmacist at Island Pharmacy to clarify a prescription for a patient for whom prescriptions for Orthotricyclen and Diazepam had been submitted.[117]

The Ketchikan pharmacies located of hundreds of prescriptions dated between August 3 and November 30, 2009, written on A Woman's Place/Eileen Small prescription forms appearing to have been signed by Ms. Small.[118] From one pharmacy alone—the one with the smallest

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112 August 24, 2010 Testimony of Patient 1 (regarding prescription found at Div. Exh. 6, AGO 1067).

113 August 24, 2010 Testimony of Patient 1 (regarding prescription found at Div. Exh. 8, AGO 727).

114 August 26, 2010 Testimony of Patient 3.

115 January 13, 2009 Note by Valentina Todd (Safeway Pharmacy) stating "[o]n 11-14-2009, I spoke directly with Eileen (over the phone) about a personal prescription (for herself) [and o]n 10-14-2009, our records indicated that Thomas Richards a temporary pharmacy technician from one of the Anchorage, AK stores spoke directly with Eileen (over the phone) about a prescription order") (Div. Exh. 28); August 23, 2010 Testimony of Valentina Todd.

116 January 13, 2010 Email from Christensen (Island Pharmacy) to Nelson (stating that on November 12, 2009 he "personally spoke with Eileen Small, CMN regarding placing an order for Diazepam 10 mg tabs for office use") (Div. Exh. 26); August 24, 2010 Testimony of Barry Christensen (explaining that Diazepam is a schedule IV sedative-hypnotic).

117 January 13, 2010 Email from Bright (Island Pharmacy) to Nelson (stating that Bright "spoke to Eileen Small via telephone on 11/4/09 for the purpose of verifying two prescriptions for the same patient [that were] for Orthotricyclen and diazepam") (Div. Exh. 27);. August 23, 2010 Testimony of Nancy Bright (stating that the January 13th email is accurate to the best of her recollection).

118 *See generally* Div. Exhs. 6 (Island Pharmacy), 7 (Downtown Pharmacy), 8 (Wal-Mart) & 29 (Safeway).

number of prescriptions found during the search (Downtown Pharmacy)—the prescriptions included, among others, the following:

- August 3, 2009 Xanax (#90 w/ 2 refills)
- August 4, 2009 Phentermine (#30)
- August 7, 2009 Percocet (#45, two separate prescriptions)
- August 7, 2009 Phentermine (#30)
- August 7, 2009 Vicodin (#30)
- August 17, 2009 Percocet (#45)
- August 28, 2009 Phentermine (#30)
- September 1, 2009 Methadone (#90)
- September 3, 2009 Valium (#45 w/ 2 refills) & Vicodin (#45 w/ 2 refills)
- September 14, 2009 Percocet (#45)
- September 18, 2009 Percocet (#45)
- October 7, 2009 Xanax (#90)
- October 14, 2009 Percocet (#90)
- October 21, 2009 Percocet (#30).
- October 21, 2009 Hydrocod+AP (#30 w/ 2 refills)
- October 21, 2009 Vicodin (#30)
- October 27, 2009 Vicodin (#45).
- October 27, 2009 Methadone (#90)
- October 28, 2009 Hydrocod+AP (#45 w/ 2 refills)
- October 29, 2009 Percocet (#60)
- October 30, 2009 Xanax (#90 w/ 2 refills) & Azethromycin (#6)
- November 3, 2009 Xanax (#90 w/ 2 refills)
- November 3, 2009 Vicodin (#60 /w 2 refills)
- November 4, 2009 Percocet (#45)
- November 9, 2009 Phentermine (#30).[119]

The range of medications prescribed and number of prescriptions (new and refills) issued were broader and higher with the other pharmacies. Among the hundreds of prescriptions from Island Pharmacy, in addition to eye drops, cough syrup, and vaginal creams, were the medications: Alprazolam, Ambien, Celebrex, Cipro, Diazepam, Diflucan, Duragesic patches, Hydrocodon, Hydrochlorothiazide, Lexapro, Levothyroxine, Lisinopril, Methadone, Omeprazole, Percocet, Phentermine, Prevacid, Promethazine, Tramadol, Tylenol 3, Ursodiol, Valium, Valtrex, Vicodin, Wellbutrin, Xanax, Yaz and Zolpidem, among others.[120] The range of

[119] Downtown Pharmacy Prescription Copies (Div. Exh. 7, AGO 257- 265, 267, 271- 274, 276 & 279-281).

[120] Island Pharmacy Prescription Copies (Div. Exh. 6, AGO 1070-1298).

medications was similar and the numbers were also large in the prescription copies from the Safeway and Wal-Mart pharmacies.[121]

Certainly, not all of the hundreds of prescription copies admitted into evidence were signed by Ms. Small. Some were telephone prescriptions. Some were not signed by Ms. Small but purported to have been ordered by one of her staff on her behalf. At least one appears not to have been written by Ms. Small in any respect. A November 12, 2009 prescription for Vicodin (#45 w/ 2 refills) does not bear Ms. Small's usual signature: the letters are different and the name is not followed by the characteristic "c" squiggle signifying "CNM" that appears on other documents signed by Ms. Small.[122] This prescription is dated about the time Ms. Small's employee (Patient 1) was suspended from work for vaguely described misconduct. Next to the date are that employee's initials and the date is written in the non-standard form that omits the zero from the year (i.e., 11/12/9, instead of 11/12/09) found in other dates initialed by the employee, including on the prescription she admitted to dating and initialing.[123] More likely than not, therefore, this prescription was written entirely by the employee, possibly with no knowledge by or direction from Ms. Small.

It is plausible that Ms. Small did not write other of the prescriptions dated after August 3, 2009. Most of the signed ones bear signatures similar to hers and she admitted to writing some specific ones.[124] She also admitted to prewriting prescriptions—that is to filling out everything except the date, leaving it blank to be filled in when it was time to issue the prescription. She said that she did not intend for her staff to date and issue the prescriptions in her absence. She said that she did not write any of them after she "went out on suspension" but rather prepared some in advance for patients she had on pain contracts and put the prescriptions in their charts.[125] She added that she relied on what a pharmacist had told her she could do to prevent disruption of medication supplies to patients during the 60-day suspension required under the consent

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121 Wal-Mart Pharmacy Prescription Copies (Div. Exh. 8, AGO 585-593, 640-658, 660-698, 701-861, 916-950, 952-958 & 960-1059); Safeway Pharmacy Prescription Copies (Div. Exh. 29, AGO 2810-2816, 2821-2832, 2910-3007, 3088-3092, 3094-3113, 3115-3204 & 3206-3207).

122 *Compare* November 12, 2009 Prescription for Vicodin (Div. Exh. 29, AGO 3271) *with* November 12, 2009 Prescription for Phentermine and Flexeril (Div. Exh. 29, AGO 3272).

123 Div. Exh. 6, AGO 1067; August 24, 2010 Testimony of Patient 1.

124 August 27, 2010 Testimony of Audrey Eileen Small (admitting that her signature appears on October 19, 2009 prescription for Ursodiol at Div. Exh. 6, AGO 1100 but that the date is not in her style; on August 7 & 8, 2009 prescriptions for Methadone and Percocet—both schedule II controlled substances—at Div. Exh. 6, AGO 1198).

125 August 27, 2010 Testimony of Audrey Eileen Small (recording 9 at 01:37).

agreement—i.e., that if they were written before the suspension period started, the pharmacies could fill them and any authorized refills during the suspension period.[126]

Ms. Small remained adamant that she did not write any prescriptions after she went out on suspension. She was not credible on this point. To believe that Ms. Small wrote all of the hundreds of prescriptions she signed that were dated between August 3 and November 30, 2009, before August 3, it would be necessary to believe two unbelievable things:

(1) in anticipation of an automatic suspension, she sat down sometime between receiving the April 7th 15-day notice and August 2, wrote out hundreds of undated but otherwise complete prescriptions, figuring out which patients would need prescriptions over an indefinite period with an unknown beginning date, and what they would need them for—not just the pain contract patients but the ones for whom she prescribed things like antibiotics, eye drops and cough syrup;

(2) the patient who remembered asking Ms. Small for an Ursodiol prescription in October lied or misremembered, even though her memory of the timeframe was corroborated by the October 19 prescription Ms. Small admitted signing.

The patient was credible. The Ursodiol prescription could not have been written before August 3. More likely than not, Ms. Small wrote other, possibly many, of the prescriptions bearing her signature and dated August 3-November 30, 2009, after she received notice of the automatic suspension of her ANP license.

Even if she did write many undated prescriptions for her pain contract patients before August 3, 2009, Ms. Small necessarily intended that someone would fill in the dates later, when the patients needed the next prescription. She intended that prescriptions be issued to those patients after August 3 and did nothing to prevent that from occurring once she received the notice of suspension. Because she did not secure or destroy any prewritten prescriptions after receiving the notice, more likely than not, Ms. Small intended that those prescriptions would be issued by her staff in her absence and, in effect, delegated tasks to her staff to enable her practice to continue operating while she supposedly honored the automatic suspension and no other ANP was available at the practice to see patients and perform needed follow ups.

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[126] A review of the testimony shows that the pharmacist's recollection is of discussing with Ms. Small how to issue a prescription with a delayed dispense date, such as when the prescriber is writing and dating the prescription on the first of the month for the patient to pick up on the fifteenth. Nothing in his testimony suggests he told Ms. Small to leave the date written blank but rather he remembered talking about how to note the delayed dispense date on a prescription dated the day written. August 24, 2010 Testimony of Barry Christensen (recording 3 at 02:30).

Ms. Small's management of her pain contract patients also calls into question whether to believe her testimony about when she wrote prescriptions, whether she intended her staff to date and issue them in her absence, and whether she was practicing—seeing or consulting with patients—after August 3, 2009. She requires these patients to come back in for follow up appointments, on average, every three months and their contracts provided that they get only a 30-day supply at a time.[127] Ms. Small and her contract nurse-midwife both testified to the vigor with which pain contract patients are monitored, including calling them in for pill counts. There would be no reason for Ms. Small in July or earlier to prewrite more than one prescription with two refills for such a patient unless she intended one of two things: (1) her staff would date and issue the prescription when the patient's 90 days were about up and would do so without Ms. Small first doing the required follow up or (2) she would have the required follow up with the patient and then the date would be filled in.

Take the example of a prescription dated November 12, 2009, by Ms. Small's staff but signed by her, prescribing Vicodin (#30 w/ 2 refills) and Xanax (#90 w/ 2 refills).[128] This patient's previous three-month follow up, at which the patient would have received the prescription that covered her till mid-November, would have been due in mid-August, a time when Ms. Small testified she was not seeing patients because of the suspension. Unless the prior prescription covered more than 90 days (something Ms. Small testified was rare), either Ms. Small saw this patient while on suspension or, in effect, prescribed medication without first doing the required follow up or new patient exam, if this was a new patient.

More evidence that Ms. Small was practicing as an ANP after August 3, 2009 is found in some of the orders for diagnostic testing. Ms. Small elicited testimony from one witness showing that patients sometimes put off going for routine diagnostic tests such as mammograms.[129] She suggested that a patient might come in for an annual exam and not yet be due for the mammogram, and thus might wait a few months to take the "chit" to the hospital and have the mammogram done. This kind of delay could explain why a requisition for a routine mammogram dated during the automatic suspension period might relate back to a pre-suspension office visit. Not all of the diagnostic testing orders issued by A Woman's Place were for routine screening

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127 August 27, 2010 Testimony of Audrey Eileen Small at 23:15.
128 *Id*. Div. Exh. 29, AGO 3268.
129 August 26, 2010 Testimony of Patient 43.

mammograms or similar procedures for which the patient's trip to the hospital might be delayed due to procrastination or scheduling problems:

- August 6, 2009 Requisition for Mammogram with diagnosis "needs additional imaging evaluation" with note of strong family history of breast cancer;
- August 18, 2009 Requisition for MRI with diagnosis "mammographic asymmetry & suspected nodule in R inferior breast";
- August 21, 2009 Requisition for Mammogram with diagnosis "needs additional imaging evaluation" with note for possible additional follow up if "asymmetry doesn't clear";
- August 25, 2009 Requisition for Ultrasound with diagnosis "pain above pelvis moving";
- September 2, 2009 Requisition for Guided Biopsy with diagnosis "suspicious abnormality" of the breast;
- October 12, 2009 Requisition for Mammogram with diagnosis "screening due to lump above nipple";
- October 13, 2009 Requisition for X-Ray "calf to ankle" with diagnosis "man with broken leg & crutches fell on [patient]";
- October 15, 2009 Requisition for X-Ray "back—lumbar spine" with diagnosis "severe back pain getting worse each day" for a walk-in patient;
- October 29, 2009 Requisition for Ultrasound with diagnosis "right side pain" for patient with history of colon cancer;
- November 6, 2009 Requisition for X-Ray "left arm wrist to elbow" with diagnosis "she may have possible fracture";
- November 10, 2009 Requisition for MRI with diagnosis "severe pain–disk degeneration."[130]

In addition, after August 3, 2009, dozens of laboratory requisition forms were issued to the hospital listing "E. Small" as the requesting physician and ordering tests for diagnoses such as possible pregnancy, yeast infection, strep throat, bladder infection, pin worms, vaginal discharge, thyroid dysfunction, STD exposure, and type 2 diabetes.[131] Most of the forms showed

[130] Diagnostic Test Orders (Div. Exh. 9, AGO 384, 392, 403, 404, 412, 414, 426, 436 & 437).
[131] *See generally* Laboratory Requisitions (Div. Exh. 9, AGO 464-533).

evidence of having been faxed from A Woman's Place. Though the forms are unsigned, many appeared to have been completed by Ms. Small's employee who uses the no-zero (e.g., 9/18/9) method of writing the year in a date.

It is reasonable to infer that someone from Ms. Small's practice requisitioned laboratory work for patients after August 3, 2009. Ms. Small offered no rebuttal except to point out that the forms are not signed by her and that the patient names have been redacted. Because there is no reason Ms. Small's staff would self-initiate laboratory requisitions for their own purposes, more likely than not Ms. Small directed them to prepare the forms, with or without seeing the patients first, or she failed to ensure that the staff had adequate training and supervision to prevent them from performing work that they were not licensed to perform.

F. SUMMARY SUSPENSION

On January 27, 2010, in response to a petition by the division, the board ordered Ms. Small's RN license summarily suspended and "also order[ed] the continued suspension of Small's ANP license."[132] The board's reason was that Ms. Small "poses a clear and immediate danger to the public health and safety if she continues to practice as a registered nurse."[133] The board's order references the petition, which in turn asserted that Ms. Small had issued hundreds of prescriptions and made dozens of referrals for diagnostic tests and laboratory work since the 2009 automatic suspension.[134]

G. NEW ACCUSATION

On January 27, 2010, the division issued a new accusation alleging professional misconduct and transmitted it to Ms. Small with a copy to her attorney.[135] The accusation alleges that between August 3, 2009, when Ms. Small received notice of the automatic suspension of her ANP license, and December 31, 2009, she signed 1,491 new prescriptions and 456 refills, ordered 56 diagnostic tests (mammograms, ultrasounds, MRIs and x-rays) and made 72 laboratory referrals.[136] It also alleged that in November 2009, Ms. Small spoke with pharmacists over the phone to verify or place prescription orders and did not inform them that her ANP license had been suspended.[137]

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132 January 27, 2010 Order (by the Board of Nursing).

133 *Id.*

134 January 27, 2010 Petition for Summary Suspension of Nursing Licenses at 1-2.

135 *See* January 27, 2010 Letter from Howes to Small (showing copy sent to Barbara Norris, Ms. Small's attorney).

136 January 27, 2010 Accusation at 2.

137 *Id.*

Shortly before the hearing, the division filed an amended accusation adding allegations of 385 prescriptions apparently issued by Ms. Small that were filled at the Safeway pharmacy after August 3, 2009.[138] Both the initial and this amended accusation asserted that Ms. Small should be disciplined for willful or repeated violations, unprofessional conduct, and conduct resulting in a significant risk to health or safety.

H. REMEDIAL EFFORTS

Ms. Small has made efforts to address compliance with the 2008 consent agreement and to remedy other problems identified through the disciplinary process. Some have been successful; some either have been unsuccessful or have been undermined to some extent by new problems.

- She stopped doing deliveries when she learned Dr. Tung would no longer serve as her supervisor;
- She tried to find a substitute supervisor or combination of professionals to cover the supervisor responsibilities;
- She notified local pharmacists that they should not accept prescriptions purporting to be from her and asked them to let her know if they were to receive any suspect ones, but she did not do this until months after receiving notice that her ANP license was suspended;
- She found another ANP to work in her practice and put that ANP under a two-year contract, but the ANP has not been approved to serve as Ms. Small's supervisor due to a still-too-recent disciplinary issue of her own;[139]
- She has arranged to transition to electronic prescriptions through the software vendor Quest, but this is a very recent improvement;[140]
- She has improved office procedures and security for prescriptions and medications maintained for office use, but she had not acquired a lock box for on-site medications at her current facility until it was revealed during the hearing that

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138 August 20, 2010 Amended Accusation at ¶ 12 & Count VI.

139 August 24, 2010 Testimony of JoAnna Williamson (indicating that rejection of Beth Langdon as a supervisor for Ms. Small was based on consultation with the then-chair, not the full board); August 26, 2010 Testimony of Beth Langdon (confirming that she is now handling ANP duties, including deliveries, prescriptions, and medication orders for the office, and discussing license disciplinary history in Minnesota and resulting problem with initial licensure in Alaska); August 27, 2010 Testimony of Audrey Eileen Small (describing contract with Langdon).

her contract ANP was securing a bottle of Valium by hiding it under a cup on a shelf;[141]

- She self-reported, during the hearing, that she is overdue on payment of the fine imposed by the 2008 consent agreement, explaining that she has been unable to pay because of the drain on her business resources from her inability to work as a provider;[142] and
- She hired a contract ANP and testified she intends never again to practice alone, without another ANP on staff, but she made this commitment after having introduced compelling evidence of how hard it is to get an ANP to move to Ketchikan and with knowledge that the current contract ANP is under a two-year contract with no certainty the ANP will agree to extend it.[143]

III. Discussion

The Board of Nursing is authorized to take a variety of disciplinary actions against nurses who fail to conform to applicable standards of professional conduct.[144] It can initiate such an action itself or ask the division to do so.[145] The 2008 and 2009 consent agreements are disciplinary orders of the board. The 2010 summary suspension order is a disciplinary action of the board. The accusation alleging new misconduct is, in effect, the division's request that the board take further disciplinary action against Ms. Small.

The division has argued that Ms. Small violated the terms of her probation by failing to comply with the 2008 consent agreement and has alleged that Ms. Small engaged in unprofessional conduct and violated federal law for which discipline can and should be imposed

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140 August 27, 2010 Testimony of Audrey Eileen Small (indicating that Quest was expected to complete the installation shortly after the August 23-27 hearing concluded).

141 August 26, 2010 Testimony of Beth Langdon (discussing prescription pad and medication handling practices, including the Valium storage method); August 27, 2010 Testimony of Audrey Eileen Small (explaining that after the facility changed locations, she had not made obtaining a lock box as financial priority because of the drain on her resources, but testified that she would acquire a small safe the weekend after the hearing and would limit access to the safe to Langdon as the practicing ANP and herself as the business owner).

142 August 27, 2010 Testimony of Audrey Eileen Small (confirming that she runs the business, doing the medical coding and supervising the office staff).

143 August 27, 2010 Testimony of Audrey Eileen Small.

144 AS 08.01.010(27) (making AS title 8, chapter 1 applicable to the Board of Nursing); AS 08.01.075(a) (listing eight disciplinary actions that may be taken singly or in combination by a board under title 8, chapter 1); AS 08.68.275 (empowering the board to revoke or suspend a license, censure a licensee, issue a reprimand, and impose a variety of restrictions or requirements). *Also* 12 AAC 44.720 (setting out disciplinary guidelines the board follows when a licensee fails to conform).

145 AS 08.68.100(b)(2) (permitting the board to ask the Department of Commerce, Community and Economic Development, of which the division is a subunit, to invoke disciplinary action).

under AS 08.68.275 and AS 08.01.075. Before reaching the question of what, if any, discipline should be imposed against Ms. Small, it is necessary to determine whether the division has met its burden of proof.[146] Specifically, it is necessary to determine

(1) whether Ms. Small's failure to comply with certain terms of the 2008 consent agreement constitutes a violation warranting additional discipline beyond enforcement of the terms she has not succeeded in satisfying;

(2) whether Ms. Small's conduct after receiving notice of the automatic suspension of her ANP license shows that she engaged in unprofessional conduct; and

(3) whether Ms. Small's prescription practices violated federal law.

Ms. Small's challenges to enforcement of the 2008 consent agreement and to the automatic suspension of her ANP license pursuant to that agreement, as well as whether the board's summary suspension of Ms. Small's RN license was proper, also must be addressed.

A. ENFORCEMENT OF CONSENT AGREEMENT

Ms. Small's arguments have, in essence, called into question whether the supervision-related provisions (paragraphs K and L) of the 2008 consent agreement can be enforced, without modification, since they became impossible to perform after Dr. Tung withdrew as Ms. Small's supervisor, and whether the automatic suspension resulting from loss of the supervisor is valid. The division, in effect, argued that Ms. Small has violated the terms of her probation because she lost the designated supervisor, has not obtained an acceptable substitute, and thus has not been able to satisfy the reporting requirements of paragraphs K and L, and therefore the automatic suspension is valid. Together, these argument raise issues about what the parties to, and approver of, a consent agreement can and must do when a change in circumstances makes some, but not all, of the terms impossible to perform as written.

1. Enforceability of Supervision Provisions

The 2008 consent agreement is both an agreement between Ms. Small and the division (the parties) and an order of the board possessing disciplinary authority over Alaska nurses. As such, contract law principles apply but with the overlay of the board's regulatory authority. If this matter involved an ordinary, two-party contract, without that regulatory authority overlay,

[146] The division bears the burden of proving its allegations by a preponderance of the evidence. AS 44.62.460(e)(1). The preponderance of evidence standard requires the party with the burden to prove that it is more likely than not that the facts alleged occurred. *See Safeway, Inc., v. Mackey*, 965 P.2d 22, 28-29 (Alaska 1998).

Ms. Small and the division would have several options for addressing the loss-of-supervisor problem, from formally modifying the agreement to eliminate or change paragraphs K and L, to agreeing to alternative performance (as they did when a different physician was substituted for Dr. Weisner to perform the psychological assessment), to waiving compliance with impossible-to-complete terms of paragraphs K and L (as the division did regarding the impossible-to-find Nurse Practice Act course), to even rescinding the agreement because strict performance of paragraphs K and L, as written, was impossible.[147]

Because the consent agreement is also a disciplinary order of the board, however, the division and Ms. Small were not free to make any of the changes described above without board approval. The division's practice of agreeing to minor modifications without obtaining board approval, as exemplified by substituting someone for Dr. Weisner and waiving the course requirement, may be practical but the changes might not be enforceable absent a delegation of the board's approval authority to the division. No such delegation was offered into evidence at the hearing. Moreover, the compliance problem needing resolution was Dr. Tung's "noncooperation" as a required reporter. The loss of Dr. Tung as supervisor and her failure to submit a quarterly report triggered the paragraph F "noncooperation by reporting persons" provision under which the board "may terminate probation and invoke other sanctions …." The board could take such an action only after Ms. Small received notice and an opportunity to correct.

As the direct parties to the agreement, therefore, the division and Ms. Small needed to act in good faith to present the board a proposal to modify the supervision provisions of the agreement, and it needed to be one designed to be acceptable to the board. Anything less would show a lack of good faith on both their parts. They worked toward this by discussing alternative ways Ms. Small might be able to get the benefit of supervision and satisfy the reporting requirements in Dr. Tung's absence. Whether those efforts completely satisfied the good faith requirement is questionable.

For her part, after receiving the 15-days-notice letter in April, Ms. Small began looking for a possible substitute supervisor, or a chart reviewer and someone to join her practice. Her efforts did not become diligent, and she did not submit a formal proposal, until after receiving notice of the automatic suspension more than three months later.

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[147] Rescission is the usual remedy when an agreement is impossible to perform. *City of Valdez v. Valdez Development Co.*, 523 P.2d 177, 180 (Alaska 1974).

For its part, the division (through its probation monitor investigator) appears to have limited its efforts after issuing the April 7th 15-days-notice letter to reacting to Ms. Small's ideas and running some past the then-chair of the board, through the executive administrator. Nothing was put before the full board until its July 22-23 meeting.

In April the investigator had agreed to suggest to the board (not the chair, the board) Ms. Small's idea to address the loss of Dr. Tung by doing no deliveries for the rest of her probation period; the investigator indicated that minor adjustments to the supervisor role would be necessary.[148] The investigator next met with the board, as a body, more than three months later, during the July 22-23 meeting. She met with the board in executive session—not unusual for probation reports since they can involve confidential subjects such as a licensee's health or substance abuse problem. But this left an empty record of what was actually put before the board for action—how the no-deliveries idea was characterized, whether accurate information was imparted (notwithstanding the investigator's highly inaccurate letter of July 29), whether the investigator advocated a specific position, and what else was discussed about Ms. Small's efforts to cure the loss-of-supervisor problem.

As a result, there is nothing more than the shaky memory of the investigator on which to determine whether the board in fact voted to automatically suspend the ANP license; if so, whether the decision was fully informed or possibly based on incomplete information; and whether the board was informed about its discretion to choose between enforcement options such as:

- requiring Ms. Small to report in person to the board under paragraph Q of the consent agreement for an interview about compliance concerns, to hear directly from her about efforts to find a substitute supervisor, before taking an action usually reserved for emergency situations and contemptuous behavior;
- terminating probation, and invoking sanctions if appropriate, under paragraph F, possibly allowing a work-out period rather than shutting the practice down immediately;
- automatically suspending Ms. Small's license under paragraph C for failure to comply with the supervision requirements.

The supervision provisions (paragraphs K and L) of the agreement are enforceable by the board through the "noncooperation of reporting persons" provision. It was within the board's

[148] April 9, 2010 Email from Williamson to Small (Small Exh. 17).

discretion to terminate Ms. Small's probation, after adequate notice and an opportunity to correct the problem, if the board was dissatisfied with her efforts to find a substitute supervisor or unwilling to approve an alternative means of achieving the goals of having a supervisor. Ms. Small signed the consent agreement containing the noncooperation provision that made it clear she was responsible for getting required reporters like Dr. Tung to perform, or else to find another way acceptable to the board to satisfy the requirement. She had notice of the need to find a substitute supervisor from the April 7th letter giving her fifteen days to do so.

That letter has not been made part of the record by either party. What specifically the letter said about how Ms. Small was to submit a proposed substitute supervisor, whether other alternatives would be considered and how proposals would be presented to the board, and whether the letter reminded Ms. Small of the board's authority to terminate her probation and impose appropriate sanctions under the noncooperation provision if she could not come up with an acceptable substitute, is not part of the record. The testimony established only that Ms. Small received 15-days notice to correct the problems resulting from the loss of Dr. Tung as her supervisor. Nevertheless, Ms. Small had notice of the need to correct the problem and an opportunity to do so, beginning in April 2009 and continuing through the alternative dispute resolution efforts she and her attorneys made.

Accordingly, at the point when the noncooperation matter concerning Dr. Tung and a proposal to correct the problem was properly placed before the board for official action, the board had authority to enforce the agreement—to reject a proposal that did not meet the remedial goals of the agreement and, if in its discretion it deemed necessary, to terminate probation and impose sanctions. One predicate for the consent agreement was that Ms. Small would have Dr. Tung—then a Ketchikan-based, physician OB/GYN—as a supervisor for three years, so that Ms. Small could improve her delivery risk evaluation skills. Ms. Small's idea of simply taking a three-year time out from doing deliveries would hinder a key remedial goal of the agreement and leave undone the other supervision duties. The board might fairly reject any ideas not including supervision by a physician or an ANP. The board could do that now, it could do that in October 2009, when it did not approve an ANP with a recent disciplinary problem of her own as substitute supervisor, or it could have done that at its July 2009 meeting, when the no-deliveries idea was presented.

The difficulty is that the division does not appear to have placed the matter before the board for official action.

2. Enforceability of Automatic Suspension Order

The board does not appear to have exercised its discretion under the consent agreement. The board acts as a body. A majority of the members must participate to meet the quorum requirement.[149] With some exceptions, official action is taken only in an open meeting, using a voting method through which the public can know the vote of each member.[150] General concurrence by members to a request or recommendation discussed in executive session is not official action. When a licensing body with disciplinary authority over a licensee pursuant to a consent agreement merely recommends or advises a course of action, but has not delegated its authority to the division, the division is powerless to suspend the license.[151]

The weight of the evidence shows that the division, not the board, ordered Ms. Small's license suspended. The July 29, 2009 suspension letter signed by the division's chief investigator does not purport to be conveying an order of the board. Though the probation monitor investigator testified that the board members directed the division to suspend the license in a vote taken in executive session, she initially said "I don't know if they officially voted." No meeting minutes recording a vote were offered into evidence. No order signed by the chair on behalf of the board, memorializing a vote by the board, was offered into evidence. It would be extraordinary for the board to take official action in an executive session without memorializing it formally after coming out of executive session, either on the oral record followed by minutes or in a written order such as the summary suspension order issued in January. There are good reasons for this.

Even if the board did vote to suspend the license, and could properly do that in executive session, the resulting lack of a public proceeding and record of what information was placed before the board makes it impossible to know whether the board was presented with information sufficient to justify automatic suspension on grounds other than failure of Dr. Tung to submit quarterly reports, or whether the board was really applying the "noncooperation by reporting persons" provision and invoking automatic suspension as a sanction the board deemed appropriate based on insufficiency of Ms. Small's efforts to correct the problem. What decision is being reviewed through the hearing that follows and the bases for the decision would be a mystery. Unlike the January 2010 summary suspension, for which there is a petition and an order

149 AS 08.68.090.
150 AS 44.62.310(a).
151 *In re Bevington,* OAH No. 10-0110-REC at 4-5 (Alaska Real Estate Comm'n May 27, 2010).

to memorialize the decision taken, an "automatic suspension" ordered in secret and memorialized in a follow-up letter essentially from the prosecutor cannot be effectively reviewed except through an entirely new (*de novo* review) hearing process on the propriety of invoking the automatic suspension provisions, which likely would consume a good deal of time, while the licensee remains forbidden to practice.

More likely than not, the investigator was mistaken when, after first saying she was not sure if the board formally voted, she changed her answer to say that the board voted in executive session to suspend Ms. Small's license during the July meeting. Her initial response was more credible, and it is more consistent with how the boards and commissions usually conduct such matters to conclude that the board probably advised or recommended that the division invoke the automatic suspension provision but did not vote to take that action itself in an executive session. For instance, in a recent Real Estate Commission case involving automatic suspension for alleged violation of a consent agreement, the evidence showed that the commission had merely recommended that the division proceed with suspension.[152]

Under Ms. Small's 2008 consent agreement, the board could not be merely an adviser or recommender; it had to be the decider for the automatic suspension sanction to be valid. Though the automatic suspension provision is vague as to who "may" automatically suspend the license, as well as silent on the process to use to decide whether Ms. Small has failed to comply, nothing in the agreement suggests that the parties agreed, and the board approved, the division exercising the board's disciplinary powers.

The noncooperation provision, however, is not ambiguous. It gives the board (not the division) discretion to "terminate probation and invoke other sanctions …" if a required reporter like Dr. Tung fails to report, and Ms. Small has been given "adequate notice" allowing an opportunity "to correct the problem[.]"[153] One of the "other sanctions" the board could invoke for failure to cure the problem would be automatic suspension. The compliance problem was Dr. Tung's failure to file quarterly reports and Ms. Small's lack of a current supervisor. The patient records audit and the fine were not yet due. The noncooperation provision was the most apt enforcement tool available for this problem. Instead, the division's July 29 letter purports to invoke automatic suspension.

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152 *Id.* at 3.

153 October 24, 2008 Consent Agreement at Order ¶ F (Div. Exh. 4).

The automatic suspension provision of the 2008 consent agreement suffers from three distinct problems. First, it is vague as to who has the power to automatically suspend the license. Second, it is silent as to how (what process, what information will be used) to determine whether Ms. Small has failed to comply with the agreement. Third, it entitles Ms. Small "to a hearing and due process regarding the issue of the suspension," after the license is suspended, but does not guarantee an expedited hearing process. This combination seems to have resulted in the prosecutor-equivalent (the division) declaring the respondent (Ms. Small) to be out of compliance, and thus forbidden to practice, with no possible relief in the form of a hearing available for weeks or months. That is essentially what happened to a real estate licensee under a similar suspension provision.[154]

In that case, the Real Estate Commission had before it "an after-the-fact hearing on the Division's finding of a violation and imposition of a suspension."[155] The real estate licensee received a letter from the chief investigator informing her that she had answered a question on her renewal application in a way that constituted a violation of her consent agreement and that, upon receipt of the letter, her license was "automatically suspended."[156] Before the letter was sent, a division investigator conferred with the commission by teleconference, informing the commissioners that three licensees had violated their consent agreements by submitting falsified applications and, based on the investigator's representations, the commission recommended that the investigator proceed with a suspension.[157]

The real estate licensee requested a hearing and one was held about two months after the suspension occurred. The Real Estate Commission's decision interpreted the consent agreement as "envision[ing] suspension after, not before, a hearing" with the decision being made by the commission, not by the division on recommendation of the commission.[158] The commission vacated the suspension "retroactive to its imposition" because the hearing established that no violation on which to base a suspension had occurred.[159] The licensee had been unable to practice for almost four months.

One difference between the real estate case and Ms. Small's is that the division did not contact the real estate licensee at all about alleged noncompliance before sending the suspension

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154 *In re Bevington*, OAH No. 10-0110-REC (Real Estate Comm'n May 27, 2010).
155 *Id.* at 4.
156 *Id.* at 3-4.
157 *Id.* at 3.
158 *Id.* at 5 & 6.

letter. In Ms. Small's case, the investigator had been in communication about the loss of Dr. Tung, and had sent the April 7th letter directing Ms. Small to propose a substitute supervisor, long before the automatic suspension order was sent. Ms. Small had notice and an opportunity to correct the alleged noncompliance before the suspension was imposed. Another difference is that the real estate consent agreement stated that a violation of the agreement "will result in the suspension of" the license.[160] Ms. Small's agreement states that her license "may be automatically suspended" for a violation. The real estate licensee had agreed to suspension as a certainty in the event of a violation; Ms. Small had agreed that the board, in its discretion, could suspend her license "automatically" in the event of a violation.

Ms. Small might have avoided suspension if she had been able to come up with a substitute supervisor in the time afforded her, or if the board had exercised its discretion to give her more time or not to impose a suspension. In contrast, the real estate licensee had no chance to avoid a suspension being imposed unless she was given a hearing before, rather than after, the suspension. The real estate licensee, therefore, had a greater need for a pre-suspension hearing but not necessarily a greater right to one. Because the division's consultation with the board prior to issuing the July 29 automatic suspension order took place in her absence, with no record, and no evidence that she was notified the board might be considering such an action, she was not in a position to ask the board for more time to find a substitute supervisor, or to ask the board to exercise its discretion not to suspend her license but instead to accept her no-deliveries alternative.

Discontinuing deliveries did not meet the remedial goals of the consent agreement, but it was a reasonable short-term response to the sudden loss of Dr. Tung. Had Ms. Small not been led by the investigator's email to believe that just a few changes to the supervisor role would be needed, and had she known the division might be discussing automatic suspension with the board at the July meeting, she might have asked for an interview with the board, so that she could try to persuade the board to exercise its discretion to give her more time and better direction on what alternatives might be acceptable to Dr. Tung as supervisor.

Instead, the board heard only the division's report before giving or concurring in a recommendation, giving advice, or perhaps casting an advisory vote to automatically suspend Ms. Small's license. That alone is not a fatal flaw. Summary suspensions authorized by statute

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159 *Id.* at 6 & 7.

160 *Id.*

occur this way. But with a summary suspension, the licensee is guaranteed a hearing within seven days.[161] Also, as illustrated by the summary suspension of Ms. Small's RN license, a summary suspension order and related documents usually reveal the specific bases for the suspension, thereby enabling the licensee to decide whether to insist on a quick hearing or to consent to a longer hearing track, perhaps to allow time to attempt alternative dispute resolution as Ms. Small did.

In the consent agreement, Ms. Small and the division agreed to a provision that did not address how quickly the hearing would be held once automatic suspension occurred. The division argued that any process concerns raised by the vagueness of the provision could be address at the office of administrative hearings level, by affording the respondent an expedited hearing.[162] With the concurrence of the parties, a judge of the office likely could treat an automatic suspension matter as a fast-track case and thereby expedite the hearing.[163] Without a hearing deadline set by the consent agreement, however, one party might not succeed in compelling the other to concur in fast tracking the case. Also, no matter how expedited the hearing might be, unless the board scheduled a special meeting to take up the matter, a final decision would not be required until the next regularly scheduled meeting of the board occurring at least 45 days after the judge issued the proposed decision.[164] Reaching a truly expedited final resolution, therefore, might be difficult. In the real estate case, for instance, it took almost four months to reach final resolution and allow the license return to practice.

Ms. Small's request for a hearing on the automatic suspension was referred to the office of administrative hearings the day after the division received it.[165] It might have been possible to expedite the hearing process. Instead, the parties asked to divert the matter to alternative dispute resolution, a rational choice since their obligation of good faith compelled them to look for other means acceptable to the board for Ms. Small to satisfy paragraphs K and L of the agreement. Because Ms. Small received notice of the compliance issue in April and, with benefit of legal

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161 *See* AS 08.01.075(c) & AS 08.68.275(c).

162 August 27, 2010 Closing Statement by Division's Counsel.

163 2 AAC 64.910 (providing that "the administrative law judge, for good cause shown or with the agreement of the parties, may shorten or extend a deadline established in this chapter or in an agency regulation"); 2 AAC 64.210(b) (stating that "[a]n administrative law judge assigned to hear a fast-track hearing may use reasonable means consistent with due process of law to meet the statutory or regulatory deadline, including combined prehearing and hearing procedures, negotiated stipulations, accelerated briefing and discovery schedules, oral motions, and expedited alternative dispute resolution efforts").

164 AS 44.64.060.

165 August 7, 2009 Case Referral Notice; August 4, 2009 Hearing Request from Small (showing receipt by the division on August 6, 2009).

counsel, chose to defer a hearing while pursuing other possible means to satisfy the supervision requirements, her situation is different from that of the real estate licensee. This, however, does not make her so different from the real estate licensee that the automatic suspension order should be treated as if properly issued.

The automatic suspension order was improperly issued because it was not issued by the proper authority—the board. Ms. Small's loss of the required reporter-supervisor (Dr. Tung) and inability to correct the problem could have justified suspension as an "other sanction," but this was a discretionary decision. Both the noncooperation and automatic suspension provisions use the discretionary "may" form. The proper authority did not exercise the discretion.

The question, therefore, is whether Ms. Small was required to comply with the order, and refrain from practicing as an ANP, while she challenged the order.

3. Compliance with Improperly Issued Order

Generally, an order must be complied with until vacated, even if the order's validity is challenged and the order ultimately is vacated.[166] A person sometimes can avoid penalties for violating an order by proving that the order was void from the beginning, for instance, if the order was issued without notice and an opportunity to be heard when such notice is required.[167] In the licensing context, even when the person is wrongly deprived of a license, "the person normally must pursue civil remedies to obtain or regain the license, instead of engaging in the regulated activity without a proper license."[168] There are exceptions.

For instance, in the case of a Maine attorney suspended for refusal to pay a licensing fee while he challenged the constitutionality of it, the state's supreme court itself suspended the attorney's license after first concluding that the bar overseers' suspension order was invalid because the overseers had not been delegated authority by the court to issue such orders.[169] The court noted that because the attorney's suspension was invalid, he could not be disciplined for practicing law during the interim between the overseers' invalid order and the court's own

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166 *See Jacko v. State*, 985 P.2d 1075, 1077-1078 (Alaska 1999) (explaining that even when an order is "factually unjustified … the persons subject to that order must nevertheless obey it until the order is vacated or reversed through process of law" and upholding conviction for violating domestic violence protection order even though it should not have been issued).

167 *Olson v. State*, 77 P.3d 15, 18 (Alaska 2003).

168 *Tenison v. State*, 38 P.3d 535, 539 (Alaska 2001) (noting an exception for licensing "laws that are unconstitutional on their face" but upholding conviction for driving without a license because "Tenison was not at liberty to ignore the law" she sought to challenge). The due process concerns raised by the automatic suspension provision challenge implementation of an agreement between the parties, not a law alleged to be unconstitutional on its face.

169 *Board of Overseers of the Bar v. Lee*, 422 A.2d 998, 1005 (Maine 1980).

order.[170] The same is not so regarding Ms. Small practicing nursing as an ANP after receiving the July 29, 2009 notice of suspension because her situation is different.

The key difference between Ms. Small's situation and that of the Maine attorney is that the bar overseers purported to exercise the court's power under a rule, not under a negotiated, mutually agreed order containing an ambiguous automatic suspension provision. Ms. Small, then represented by counsel, negotiated and entered into the 2008 consent agreement willingly, as a means of resolving a pending disciplinary action. She agreed to a provision allowing for automatic suspension, followed by a hearing. She agreed that noncooperation by a required reporter such as Dr. Tung could result in termination of her probation and imposition of other sanctions. She also agreed to act in good faith to carry out the agreement's intentions.

Ms. Small received notice of the suspension through the division's July 29 letter. She testified that she stopped practicing as an ANP immediately after receiving the letter on August 3, and she followed up with a hearing request the very next day. This indicates that she understood the suspension order to preclude her from practicing unless and until she succeeded in getting it lifted through the hearing process. She was not free to defy the order, however improper it may have been for the division to issue it.

In contrast to the real estate licensee, who complied with her improperly issued suspension order until it was found baseless and vacated, and did not commit new acts of misconduct during the suspension period, Ms. Small did not comply. Instead, she committed new acts of misconduct, by continuing to practice surreptitiously while claiming to be honoring the suspension order. This contravened the standards of conduct for her profession.

B. FAILURE TO CONFORM TO PROFESSIONAL STANDARDS

The professional standards of conduct for nurses in Alaska require compliance with applicable laws and prohibit "unprofessional conduct."[171] "Nursing conduct that could adversely affect the health and welfare of the public constitutes unprofessional conduct …."[172] Such conduct includes "failing to use sufficient … nursing judgment in the practice of nursing as defined by the level of licensure."[173] It also includes "knowingly delegating a nursing care function, task, or responsibility" to someone not licensed to perform it, if the delegation is

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170 *Id.* at n.13.
171 AS 08.68.270(7) & (8).
172 12 AAC 44.770.
173 12 AAC 44.770(1).

contrary to law or puts a patient at "substantial risk."[174] "[V]iolating state or federal laws regulating drugs" also is unprofessional conduct.[175]

1. Practicing After Notice of Suspension

A person may not practice nursing in Alaska without a valid license.[176] "It is a class B misdemeanor for a person to … practice nursing during the time that the person's license is suspended …."[177] A licensed ANP may be authorized to prescribe and dispense legend drugs and controlled substances, but a person holding only an RN license may not.[178] In short, an RN who performs work authorized for an ANP, but not for an RN, while the person's APN license is suspended violates state law, thereby engaging in unprofessional conduct. Because the July 29 automatic suspension order was improperly issued, Ms. Small probably did not engage in unprofessional conduct by practicing "without a valid license."

Continuing to practice after receiving notice of suspension, however, can constitute unprofessional conduct, even if the suspension order ultimately is proven to have been improperly issued. If the licensee is deceptive about licensure status and about compliance with the order, and the deception puts the licensee's patients at risk, the licensee has engaged in "[n]ursing conduct that could adversely affect the health and welfare of the public" and thus has engaged in unprofessional conduct under 12 AAC 44.770. If the method by which the person practices (and carries out the deception) after receiving notice of suspension involves using unlicensed staff to perform tasks only a licensee can lawfully perform, the licensee knowingly delegates a task to an unlicensed person, thereby engaging in unprofessional conduct if a patient is put at substantial risk.

Patients who might receive a prescription medication too early or too late because the date was left blank for an unlicensed person to write in are put at risk of possible overdose or of withdrawing too quickly, if the medication is one like Wellbutrin, Valium or Xanax with which abruptly cutting off the medication can be dangerous.[179] A person with an ANP level of licensure should have the nursing judgment not to issue undated prescriptions that might be misused to

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174 12 AAC 44.770(3).
175 12 AAC 44.770(9).
176 AS 08.68.160.
177 AS 08.68.350(a)(5).
178 *See* 12 AAC 44.440 & 12 AAC 44.445.
179 August 23, 2010 Testimony of Valentina Todd (regarding Wellbutrin and Valium); August 24, 2010 Testimony of Deborah Kiley (regarding Xanax).

create or feed addiction.[180] Because honesty is such an important trait for nurses,[181] such a person also should have the nursing judgment not to deceive the licensing authority about compliance with an order issued (however improperly) under a consent agreement authorizing such orders or to deceive pharmacists on whom the licensee's patients rely for an uninterrupted supply of necessary medications.

Ms. Small prewrote prescriptions for addictive controlled substances, leaving dates blank for her staff to fill in, as illustrated in subsection 2 below. She also wrote prescriptions after August 3, 2009, the date she received notice of the suspension of her ANP license. The October 19, 2009 prescription for Ursodiol is the clearest example of this, but more likely than not there were many others. She consulted with the patient by telephone before prescribing the Ursodiol but did not examine the patient or review any medical records concerning the patient's gall bladder problem the Ursodiol was meant to treat.

Ms. Small ordered diagnostic tests and lab work, or caused her staff to do so, after August 3, 2009, as well. Some of the tests were of a type that likely would be ordered only after examining, or at least talking with, the patient, and some would require follow up. The MRI ordered in November for the patient with severe pain and disk degeneration, the ultrasound ordered in October for the patient in pain and with a history of colon cancer, and the guided biopsy ordered in September for the patient with a suspicious breast abnormality stand out as examples of tests requiring follow up and not likely to be ordered without prior consultation between provider and patient. Similarly, ordering lab work for possible bladder infections, thyroid dysfunction and diabetes, for example, implies some degree of preliminary diagnosis by a qualified provider, not by the office staff, unless the unlicensed staff have been delegated functions they are not qualified to perform.

Poor or improperly delegated prescription practices can put patients at grave risk. Take the example of the August 12, 2009 prescription for Xanax and Wellbutrin (Division's Exhibht 6, AGO 1288) called out by ANP Deborah Kiley during the hearing. Both are medications dangerous to withdraw from quickly. According to Ms. Kiley, Xanax is an anti-anxiety drug usually prescribed by psychiatrists. Ms. Small prescribed this patient 90 Xanax and 30

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[180] Testimony of Deborah Kiley (describing prudent practices use to minimize risk of addiction and abuse).

[181] *In re Kimble*, OAH No. 06-0032-NUR at 10 (Alaska Board of Nursing 2006) (denying licensure to nurse who was deceptive about work history and "could not be trusted to own up to errors she might commit in patient care," explaining that "[h]onesty is a key trait in nursing" because of the importance of nurses accurately charting inevitable errors, such as medication dosage mistakes).

Wellbutrin with five refills each. With so many refills, this patient would not have to come in for follow up for several months. By the time this patient was due to get refill number three from the pharmacy in December, the pharmacy would have refused to refill an August 12 prescription by Ms. Small because by then the pharmacies had learned of the suspension order dating back to July. If it took this patient time to find another provider—the testimony was it often took two weeks to get an appointment with physician—the patient could have been endangered.

In short, to carry out the deception that she was complying with the July 29 order but continue to keep her practice operating, Ms. Small risked the health, safety and welfare of her patients. She did this by continuing to order tests and prescribe medication but without adequate control over her staff or assurance that necessary follow ups with patients would occur.

2. Prewriting Prescriptions

Under the regulations adopted by the board, an Alaska ANP with prescription authority must "comply with all applicable state and federal laws[.]"[182] That requirement applies equally to an ANP authorized to prescribe legend drugs and to prescribe controlled substances.[183] Among the many federal law requirements for issuing prescriptions is a mandate that "[a]ll prescriptions for controlled substances shall be dated as of, and signed on, the day when issued …."[184] That was the law when Ms. Small received the July 29, 2009 notice of suspension and it remains the law today.[185]

For purposes of this law, "controlled substances" include the schedule I, II, III, IV and V drugs in 21 U.S.C. chapter 13, part B.[186] Many of the prescriptions dated after August 3, 2009, and signed by Ms. Small were for schedule II controlled substances such as Percocet and some were for Methadone.[187] Schedule II controlled substances are among the most addictive and susceptible to abuse.[188] Vicodin is a schedule III controlled substance, and is very susceptible to

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182 12 AAC 44.440(d)(1).

183 12 AAC 44.445(b) (applying 12 AAC 44.440's requirements to controlled substance prescribers).

184 21 C.F.R. § 1306.05(a).

185 Prior to a 2010 amendment, the federal regulation had not been amended since 2005. *See* 21 C.F.R. § 1306.05(a) (Apr. 1, 2010) (history note showing amendments between 1971 and 2005). The 2010 amendment, which took effect June 1, 2010, did not change the portion of 21 C.F.R. § 1306.05(a) that mandates both signing and dating of a prescription on the day issued. *See* 21 C.F.R. § 1306.05(a) (Apr. 1, 2010) (displaying text of amended regulation taking effect two months later).

186 21 U.S.C. § 802(6) (defining "controlled substances"); 21 C.F.R. § 1306.02 (giving the terms used in the regulations the same means as in the statutory definitions found in 21 U.S.C. § 802).

187 August 23, 2010 Testimony of Valentina Todd (stating that Percocet is a schedule II controlled substance); August 24, 2010 Testimony of Deborah Kiley (identifying Methadone and Percocet, among others, as schedule II controlled substances).

188 August 24, 2010 Testimony of Barry Christensen.

being abused, partly because Vicodin prescriptions can be faxed.[189] Ms. Small prescribed Vicodin repeatedly throughout the prescriptions dated after August 3, 2010. Diazepam is a schedule IV controlled substance.[190] Ms. Small prescribed Diazepam in one or more prescriptions dated after August 3, 2009. Approximately three-quarters of the prescriptions from Island Pharmacy (Division's Exhibit 6) are for controlled substances.[191] The prescriptions from Safeway (Division's Exhibit 29) included controlled substances.[192]

Either Ms. Small wrote and dated these prescriptions after August 3, 2009, on the dates shown on them, or she wrote them sometime before August 3 and they were dated later—i.e., they were "prewritten." For instance, in Division's Exhibit 29 (at AGO 2831) is a prescription for Methadone—a schedule II controlled substance. It is dated "11/4/9" and contains a note below that date "may dispense on 11-4-09." More likely than not, Ms. Small wrote the prescription and the delayed dispense date notation, leaving the date blank, and her staff filled in the date.

The same exhibit also contains (at AGO 2830) a prescription for Percocet signed by Ms. Small with a notation "may dispense 11/3/09" but no date filled in the date blank. Also in the same exhibit (at AGO 2829) is another prescription for Percocet signed by Ms. Small. This one has a "may dispense on 10/16/09" and the date blank is filled in with "10/16/9" followed by the initials of Ms. Small's staff person referred to as "Patient 1" in this decision. This is the same staff person who admitted as to a prescription dated "11/5/9" (Division's Exhibit 6, AGO 1067) that she dated and initialed it.

Ms. Small candidly admitted to prewriting prescriptions for some of her pain contract patients. More likely than not some of those patients were receiving controlled substances. Her own admission and the evidence of the prescriptions themselves, therefore, show that Ms. Small violated the federal regulation which requires that a controlled substance prescription be dated when written.

In sum, Ms. Small violated federal law through her prescription practices and engaged in unprofessional conduct by performing, or causing/allowing her staff to perform, ANP-level functions while she understood her ANP license to be suspended, and she used deception to do these things. She engaged in conduct leading up to and after issuance of the suspension order that

189 August 24, 2010 Testimony of Deborah Kiley.
190 *Id.*
191 *Id.*

could adversely affect the health and welfare of the public, particularly that of her patients. She should be disciplined for unprofessional conduct.

C. DISCIPLINE WARRANTED

In January 2010, the board summarily suspended Ms. Small's RN license and directed that the automatic suspension of her ANP license remain in effect. Now that Ms. Small has had a hearing on those actions, and on the accusation alleging grounds for additional disciplinary action, the question is whether her licenses should remain suspended and, if so, for what period, or whether other sanctions are appropriate.

1. Summary Suspension

Two separate statutes authorize the board to summarily suspend the license of a licensee who "poses a clear and immediate danger to the public health and safety."[193] One is general; the other is specific to this board. Both authorize the board to take such an action before a hearing or while an appeal is pending. The one specific to this board speaks of summarily suspending "a license," while the general statute speaks of summarily suspending the "licensee from the practice of the profession[.]"[194] Together, they make clear that this board had the power to summarily suspend Ms. Small's RN license, and thereby prevent her from practicing the profession of nursing, if the board found that she posed "a clear and immediate danger to the public health and safety."

The board made such a find in its January 27, 2010 order. The finding was that Ms. Small would pose such a danger "if she continues to practice as a registered nurse[.]"[195] It was predicated on assertions in a petition by the division based on the high numbers of prescriptions ostensibly signed by Ms. Small and presented to Island Pharmacy, Downtown Drug Store, and Wal-Mart after the July 29 automatic suspension order had been issued and the many referrals for diagnostic test and laboratory work ostensibly from Ms. Small presented to the hospital during that period.[196] That finding has not been undermined, but rather has been reinforced, through the hearing process.

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192 August 23, 2010 Testimony of Valentina Todd.

193 AS 08.01.075(c) (setting out general disciplinary powers of several board which are made applicable to the Board of Nursing by AS 08.01.010(27)); AS 08.68.275(c) (setting out the disciplinary powers of the Board of Nursing specifically).

194 *Compare* AS 08.68.275(c) *with* AS 08.01.075(c).

195 January 27, 2010 Order (referencing Petition for Summary Suspension of Nursing License of same date).

196 *Id.*

Ms. Small succeeded in raising some doubt about whether all of the prescriptions and referral orders were issued after August 3, 2009. The division, however, proved through prescriptions, orders and other evidence that Ms. Small was practicing outside the scope of an RN license while she understood her ANP license to be suspended. In short, the division proved that at a minimum Ms. Small set in motion circumstances that caused prescriptions and referral orders to be issued in her name after she received notice of suspension.

Ms. Small put members of the public—primarily her patients—at risk in a number of ways. She put patients at risk of having their supplies of necessary medications cut off when the pharmacists learned that her prescriptions apparently were not valid. She left her patients relying on prewritten prescriptions during a suspension period with no established end date. She did this in a town where, according to Ms. Small's own testimony, it can take two weeks to get in to see another medical provider. She did not notify the local pharmacists of the July 29, 2009 suspension order for almost four months. Meanwhile, she permitted her patients to continue relying on her prescriptions—prewritten or otherwise—even though, according to her testimony and that of other witnesses, she was not "seeing" the patients—i.e., was not consulting with and examining them—at her office. This put any patients receiving medications for which prompt or frequent follow up is required at risk of taking the medication too long after they had been examined by a medical provider before they were next examined.

Ms. Small candidly admitted that she prewrote prescriptions by filling out the forms and leaving the date blank to be filled in when the forms were issued to the patients. Initially she maintained that she did not write/prewrite any after receiving notice of the suspension. The evidence did not bear this out, but even if true her version of events created substantial risk.

She asserted that she never meant for the prewritten prescriptions to be issued during the suspension period, arguing that but for the suspension order she would have had control of the charts containing the prewritten prescriptions such that her staff could not improvidently issue them. This admission and argument demonstrate Ms. Small's awareness of the risk that her staff might date and issue prescriptions in her absence if she did nothing to secure the charts or otherwise prevent issuance, such as voiding or destroying the prewritten prescriptions as soon as possible after receiving the notice of suspension. The suspension did not bar her from being present in the office or giving her staff instructions by telephone to destroy the prescriptions. Indeed, she testified that she continued to run the business and perform tasks such as coding the billings, and going into the office after hours to use the computer.

Operating under the understanding that her ANP license had been suspended and knowing that she had left undated, prewritten prescriptions in the charts, Ms. Small disregarded the risk to her patients that her staff might issue the prescriptions without proper direction for as long as the then-indefinite suspension lasted. She did not act to mitigate that risk by notifying the pharmacists of the suspension order and directing them not to accept further prescriptions for almost four months. Even if it were true that Ms. Small never directed her staff to date and issue a single one of the prescriptions issued after August 3, 2009, her decision to leave prewritten prescriptions where her staff could gain access to them, date them, and issue them, possibly at a medically inappropriate time in the patients' treatment, set in motion the events that put the public health and safety at risk.

Moreover, the evidence showed that she did continue to give directions about the care of some patients. Pharmacists testified to discussing questions about prescriptions with Ms. Small by telephone after August 3, 2009. Diagnostic tests like the MRI and guided biopsy were ordered. In short, whether or not Ms. Small filled out a prescription form or personally ordered a test or lab work after she received the July 29 notice of suspension, she continued to perform at least some work authorized for an ANP but not an RN after she received the notice. She claims to have stopped seeing the patients after receiving notice of the automatic suspension. She left the patients without a provider to provide or arrange for any necessary follow-up suggested by test results or reactions to medications. This put patients at risk of harm to their health and safety.

Accordingly, the board's decision to summarily suspend Ms. Small's RN license was well founded when made. The question, therefore, becomes whether continuing that open-ended suspension "until such time the Board determines that Small is able to practice nursing in a manner consistent with public safety" (as provided in the January 27, 2010 order) is appropriate or whether a different sanction should be imposed.

2. Appropriate Sanctions for Violations Proven

The disciplinary powers specifically set out for this board run the range from permanent revocation to reprimand.[197] They include the power to "suspend a license for a stated period of time" and to impose conditions or limits on practice, probation, peer review, and professional education requirements, as well as to accept the voluntary surrender of the license.[198] The general disciplinary powers held by this board and others add the authority to impose civil

[197] AS 08.68.275(a).
[198] AS 08.68.275(a)(2) & (5)-(9).

fines.[199] The board must seek consistency when applying sanctions and must explain significant departures from prior decisions involving similar facts.[200] The division has requested that the board revoke both licenses.

By regulation, the board has established disciplinary guidelines with the purpose "[t]o ensure that the board's disciplinary policies are known and are administered consistently and fairly …."[201] The guidelines provide direction and guidance on when the board should choose revocation over suspension as a sanction, and on the length of a suspension, but they do not address imposition of the other available sanctions such as reprimands, fines, additional education requirements, or placing conditions on the license.[202] The board is not prohibited from imposing greater or lesser sanctions than suggested by the guidelines.[203] A board's choice of disciplinary sanctions typically will be upheld if reasonable and explained with reference to evidence in the record.[204]

Under the guidelines, revocation of the license is reserved for the most serious violations. The guidelines suggest that the board may exercise discretion to revoke a license under nine circumstances, four of which may be pertinent to Ms. Small's situation.

> The board will, in its discretion, revoke a license if the licensee
> (1) commits a violation that is a second offense;
> (2) violates the terms of probation from a previous offense;
> * * *
> (7) intentionally or negligently engages in conduct that results in a significant risk to the health or safety of a client or injury to a client;
> (8) engages in unprofessional conduct, as described in 12 AAC 44.770, if the health, safety, or welfare of another person is placed at risk[.[205]]

The guidelines contain some overlap between revocation and suspension in that unprofessional conduct can be the basis for either sanction, as can repeat violations, but differences exist. Unprofessional conduct can be the basis for a one-year suspension even if the

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199 *See* AS 08.01.075(a) (authorizing numerous licensing boards to take disciplinary action similar to the ones set out for this board as well as to "impose a civil fine not to exceed $5,000").
Under AS 08.01.010(27), this board possesses these general disciplinary powers.

200 AS 08.68.275(f); AS 08.01.075(f).

201 12 AAC 44.700.

202 12 AAC 44.720.

203 12 AAC 44.710(b).

204 *Wendte v. Alaska Board of Real Estate Appraisers*, 70 P.3d 1089, 1094-1096 (Alaska 2003) (explaining that a licensing board "must exercise its discretion reasonably" and upholding a board's exercise of its discretion to impose sanctions because the decision was based on relevant and current information contained in the record and cited in the decision).

205 12 AAC 720(a).

conduct does not place another person at risk, though it would not trigger revocation in the absence of a risk.[206] A two-year suspension is justified under the guidelines when the licensee "willfully or repeatedly violates a statute in AS 08.68 or a regulation of the board[,]" whereas revocation is called for if the licensee's violation constitutes "a second offense."[207] The implication is that revocation would be appropriate if a prior disciplinary action resulted in a finding that the licensee had committed an offense, while a two-year suspension would be appropriate for repeated violations proven in the current disciplinary action if the licensee has not previously been found to have committed an offense. Because the board has the discretion to impose greater or lesser sanctions than suggested by the guidelines, however, it could impose the lesser sanction of suspension for a second discrete offense proven in an entirely new disciplinary action from the one involving the first offense, and it could impose the greater sanction of revocation based on repeated or multiple violations proven in a single disciplinary action.

Multiple Offenses. The division argued that Ms. Small's licenses should be revoked because she has committed a "second offense," asserting that a prior consent agreement should be treated as proof of a first offense. A consent agreement can establish a prior offense if, for instance, it shows that the respondent admitted to an offense or the board's order component of the agreement includes a finding of violation. Ms. Small's 2008 and 2009 consent agreements did not contain admissions that she had in fact committed offenses, and the board's order components did not enter findings of violation. Since the board is not constrained under the guidelines to issue a suspension if it determines that revocation is warranted, it is unnecessary to rest the sanction determination on the division's "second offense" theory relying on 12 AAC 44.720(a)(1).

For much the same reasons, it would be imprudent to treat the particular consent agreements Ms. Small entered into as establishing a "previous offense," justifying revocation for violating terms of probation. The consent agreements required Ms. Small to comply with terms she has not—to comply with federal law, for instance. But the guideline language speaks of a "previous offense," not of the failure to comply with a compromise and settlement of unproven allegations. Caution argues against resting the sanctions determination on violation of the terms of probation from a prior offense under 12 AAC 44.720(a)(2).

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206 *Compare* 12 AAC 44.720(c)(1) *with* 12 AAC 44.720(a)(8).

207 *Compare* 12 AAC 44.720(b)(2) *with* 12 AAC 44.720(a)(1).

Risk to Health, Safety or Welfare. Revocation is warranted in Ms. Small's case under 12 AAC 44.720(a)(7) & (8) for two distinct reasons: (1) she violated federal law on prescription practices; (2) she continued to practice as an ANP after receiving the July 29 notice of suspension and did so using deception. Each of these involved intentional or negligent conduct. Each of them constitutes unprofessional conduct. Each, standing alone, put patients' health, safety or welfare at risk. Each put some of the patients at *significant risk* (e.g., the risk of rapid withdrawal from Xanax). Thus, each separately is grounds under the guidelines for revocation of Ms. Small's licenses under section 720(a)(7) & (8). Together, they demand revocation because the deceit reflected in violating federal law and defying an order while claiming to be complying with it to keep her practice going raises serious questions about whether Ms. Small can be trusted to own up to errors in patient care.

Ms. Small's indisputable, even admitted, unprofessional conduct—prewriting prescriptions in violation of federal law—put patients at risk. Those violations of federal law are independent of the 2009 suspension. Whether her license was active or suspended, prewriting prescriptions was a violation. Whether the "automatic suspension" was valid or not, Ms. Small violated federal law on prescription writing practices. The challenges she fairly raised to the automatic suspension neither excuse nor mitigate the federal law violation. That the July 29, 2009 suspension order was improperly issued does not excuse or mitigate the risk Ms. Small took with her patients' health, safety or welfare by continuing to perform or causing her staff to perform ANP functions after August 3, 2009.

Revocation of Ms. Small's licenses—both the ANP and the RN—is consistent with the board's prior decisions.

In a 2007 decision, the board revoked the RN license of a nurse proven to have "engaged in unprofessional conduct which placed the health, safety and welfare of her clients and others at risk."[208] No other sanctions were imposed. The nurse had placed her patients at risk by failing to do necessary follow up and to maintain appropriate chart notes concerning their treatment for communicable diseases. Ms. Small put her patients at similar risk by keeping the notice of suspension secret and continuing to prescribe for them and order tests for them while not in a position to do the necessary follow up.

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[208] *In re Hamshar*, OAH No. 06-0555-NUR at 20 (Alaska Board of Nursing 2007).

In a 2004 decision, the board denied the application for authority to dispense and prescribe, and revoked the ANP and RN licenses, of a nurse who engaged in misconduct involving prescriptions and dishonesty.[209] The board also imposed a civil fine, explaining that it is rare to impose a fine when revoking a license.[210] The board observed that the nurse had "exhibited a disturbing pattern of reckless behavior toward the public interest and a blatant disregard for licensing authority."[211] The same could be said about Ms. Small's conduct. Although the range of violations the division proved as to Ms. Small is narrower than for the nurse in the 2004 case, the magnitude is not.

The nurse in the 2004 case misused drugs while treating himself for an attention deficit disorder, forged prescriptions and was proven to have committed 28 violations spanning several sections AS 08.68 and 12 AAC 44. Ms. Small's proven unprofessional conduct falls into just two categories: violating federal law and surreptitiously defying the July 29, 2009 order. The shear number of prescriptions and orders for tests and labs she issued, or caused or allowed her staff to issue, however, puts her behavior on par with that of the nurse from the 2004 case in terms of the magnitude of risk and in terms of its protracted and premeditated nature. Thus, her ANP license, and with it her prescriptive authority, should be revoked.

Consideration has been given to whether the RN license should be treated differently. The difficulty in carving out the RN license for a lesser sanction is that Ms. Small's lapse in nursing judgment that led her to keep prescribing and doing other things authorized for an ANP but not an RN is a concern for the RN license too, as are the deception and dishonesty involved. The board's prior decisions reflect an understandable intolerance for deception and dishonesty. In the 2004 case discussed above, for instance, the nurse's deception and dishonesty were factors in the board's decision to revoke the licenses. In another case, the board denied licensure to a nurse who had engaged in unprofessional conduct by being dishonest about her work history and who had failed to demonstrate that she was "fully rehabilitated from this misconduct."[212]

Though Ms. Small claims to have learned painful but valuable lessons from this process, and she presented evidence of efforts to remedy some of the problems revealed, the concern is whether Ms. Small could and would exercise the judgment not to perform functions outside an

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209 *In re Polon*, Case Nos. 2304-03-005, 2304-03-006, 2304-03-010, 2304-03-011, 2304-03-012, 2304-03-016 & 2304-03-017 (Alaska Board of Nursing 2004).

210 *Id.* at 30.

211 *Id*. at 29.

212 *In re Kimble*, OAH No. 06-0032-NUR at 12 (Alaska Board of Nursing 2006).

RN's scope of practice if the RN license were reinstated while the ANP license is revoked. The most telling thing about whether she would use better judgment as a result of this learning experience is that she does not seem to appreciate the risk she subjected her patients to and she does not take responsibility for the lapse in judgment.

During her argument at the hearing, Ms. Small alluded to a staff person she considers responsible for prescription handling problems by saying she had "a fox in the henhouse." She does not seem to acknowledge, however, that she is responsible for keeping the hens safe but instead has dug a hole under the fence and taught the fox how to raid the hen house.

Ms. Small blames the hospital for not letting Dr. Tung continue as her supervisor, even though Ms. Small's attorney also found that malpractice coverage concerns were an impediment to getting a substitute supervisor. She blames the division for not requiring Dr. Tung to perform, even though it was her responsibility to get required reporters to report or to cure the problem. She blames the troubled physician's bad example from a decade ago and the pharmacist who discussed delayed dispense orders with her for her own decision to violate prescription writing laws to keep her practice going while she understood her license to have been suspended. And she blames the fox she led into the henhouse. But she does not seem to blame her own lapse of nursing judgment that put patients at risk. That does not bode well for her ability to restrain herself to RN-only functions. The RN license should be revoked rather than suspended.

Revocation is not necessarily a permanent bar to practicing as a nurse. When a license has been revoked, the board may reinstate the license "if the board finds, after a hearing, that the applicant is able to practice with skill and safety."[213] One year after license revocation, a nurse can apply to the board for reinstatement.[214] The applicant must appear before the board and the board may impose conditions on reinstatement.[215] Thus, if an applicant for reinstatement can show rehabilitation sufficient to convince the board that, with or without conditions on licensure, the nurse can practice with skill and safety, the nurse might be able to return to licensed status after a year.

Civil Fines. For this board, it is rare, but not unheard of, to impose a civil fine when a license is being revoked.[216] In its most recent revocation case, the board did not impose a civil

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213 AS 08.68.275(d).
214 12 AAC 44.785(a).
215 12 AAC 44.785(b)&(c).
216 *In re Polon, supra,* at 30.

fine.[217] Because of this history, and because Ms. Small already owes substantial fines, no new fine should be imposed in this case. This does not preclude collection of fines now due under the consent agreements.

The 2008 consent agreement imposed a $10,000 fine, none of which has been paid. Under the terms of the agreement, the full fine amount—including the $5,000 suspended amount—is due upon a finding of violation. Such a finding has now been made.

The same is true as to any unpaid amount—including the $750 suspended amount—under the 2009 consent agreement.

IV. Conclusion

The 2008 consent agreement could have been more tightly written, as Ms. Small suggests. The division was not the proper entity to invoke automatic suspension. A better course might have been for the board to require Ms. Small to report for an interview and then decide whether to terminate her probation if no acceptable substitute supervisor could be found. None of that excuses Ms. Small's unprofessional conduct in her prescription practices and conduct after receiving notice of suspension.

The division met its burden of proof as to new misconduct warranting the disciplinary sanction of revocation as to both licenses. No additional sanctions are warranted, but the civil fine agreed upon in the October 24, 2008 Consent Agreement and any unpaid portion of the $1,500 fine agreed upon in the April 1, 2009 Consent Agreement will be due upon adoption of this decision by the Board of Nursing, and at the same time:

1. Audrey Eileen Small's Advance Nurse Practitioner License No. 524 shall be revoked; and
2. Audrey Eileen Small's Registered Nurse License No. 18582 shall be revoked.

DATED this 4th day of October, 2010.

By: *Signed*
Terry L. Thurbon
Chief Administrative Law Judge

[217] *See generally In re Hamshar, supra.*

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

In the Matter of	)	
Audrey Eileen Small	)	OAH No. 09-0396-NUR
	)	Board Case No. 2304-05-001
In the Matter of	)	
Audrey Eileen Small	)	OAH No. 10-0057-NUR
	)	Board Case No. 2304-09-007

DECISION OF THE BOARD

After due deliberation in executive session at its October 27-29, 2010 meeting, in accordance with AS 44.64.060(e)(1), the Board of Nursing adopts the administrative law judge's October 4, 2010 proposed decision in this matter, which recommends revocation of Audrey Eileen Small's Advance Nurse Practitioner (ANP) and Registered Nurse (RN) licenses, with the following additional explanation:

1. Ms. Small's late-filed proposal for action was given due consideration, along with the proposal filed by the Division of Corporations, Business and Professional Licensing.
2. The standard of proof applicable to this matter is preponderance of the evidence. (AS 44.62.460(e).) Facts do not need to be proven to a certainty or beyond a reasonable doubt but rather must be more likely than not. As such, it was not necessary to prove that Ms. Small wrote every prescription admitted into evidence or personally ordered tests and lab work reflected in the referral orders admitted into evidence. It also was not necessary to know the identity of the persons for whom the prescriptions or orders were issued, or to reference those persons' medical charts, to determine whether, more likely than not, Ms. Small engaged in activities authorized for an APN but not for an RN after receiving notice of suspension, and that she issued undated prescriptions. Ms. Small's own testimony and that of other witnesses, together with the documents themselves, support the findings.
3. Though the administrative law judge found that, more likely than not, the division issued the July 29, 2009 automatic suspension order and concluded that the division was not the proper entity to do that, the board does not conclude, as Ms. Small's proposal for action suggests, that this means Ms. Small's only violation was a technical violation of federal law regarding prewriting prescriptions. The professional standards and disciplinary

guidelines applicable to nurses in Alaska are meant to protect public health, safety and welfare. Dishonesty and deceit about compliance with a suspension order which disguises or misleads about nursing activity regarding patient care cannot be tolerated. It puts the public at risk. Actual harm need not occur before disciplinary action is warranted. Instead, the enforcement tools should be used to minimize the risk of harm and, when possible, prevent harm from occurring.

4. The violation of federal law Ms. Small admitted is not a minor matter. Her proposal for action suggests that prewriting prescriptions is a common practice and results in only a technical violation. The evidence did not establish that it is a common practice. The *Jacobs* case from the District of Columbia, cited in Ms. Small's proposal for that proposition, has no evidentiary value in this matter. The second-hand account of what a witness testified was common more than 30 years ago in D.C. is of no value today in Alaska. Furthermore, in the *Jacobs* case, the criminal conviction of the physician who had given a paramedical assistant a pre-signed prescription pad was upheld.[218]
5. Ms. Small waited more than a week (until September 7, 2010) to report to the administrative law judge that she had received a box of documents from the division's counsel on Monday, August 30, after the in-person hearing had concluded the Friday before. Ms. Small described the box as containing preliminary witness and exhibit lists and exhibits, and some discovery materials. The judge gave Ms. Small until September 10, 2010, to complete her review of the box and, if she thought it necessary, to ask that the record be reopened.[219] On September 10, 2010, Ms. Small reported that she had "decided to just stop [searching the box] and advise the court that [she had] nothing more to submit."[220] Though she complained that she had run out of time, she did not ask for more time.
6. The board is not persuaded that possible culpability of Ms. Small's employees in issuing prescriptions after August 3, 2009, mitigates Ms. Small's own culpability as the licensee. Ms. Small is the owner of A Woman's Place and was the sole practitioner there at the time. She was responsible for supervising her employees. She left them with access to

[218] *Jacobs v. United States*, 436 A.2d 1286, 1289-91 (D.C. Court of Appeals 1981) (upholding conviction for aiding and abetting unlicensed practice of the healing arts).
[219] September 7, 2010 Recording of Status Conference (discussion beginning at approximately 8 minutes & 30 seconds).
[220] September 10, 2010 Letter from Small to Judge Thurber [sic] and Karen Hawkins, AG.

prescriptions she admits to signing but not dating, which she placed in the charts. She took no steps to prevent her employees from completing the dates and issuing the prescriptions. Leaving someone without supervision, who is also without the necessary education and skill, and proper licensure, in a position to perform nursing functions they are not qualified to perform puts the public at risk and hampers the board's ability to effectively regulate the practice of nursing to protect public health.

This Decision of the Board and the October 4, 2010 decision document shall constitute the final decision of the Board of Nursing in this matter, as adopted by a vote of the board this 27th day of October, 2010.

By: *Signed*
Beth Farnstrom, Chair
Alaska Board of Nursing

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