# WISCONSIN DEPARTMENT OF REGULATION & LICENSING

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STATE OF WISCONSIN

BEFORE BOARD OF NURSING

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IN THE MATTER OF DISCIPLINARY :

PROCEEDINGS AGAINST : FINAL DECISION

: AND ORDER

PHILIP HICE, R.N., : LS0306041NUR

RESPONDENT. :

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The State of Wisconsin, Board of Nursing, having considered the above-captioned matter and having reviewed the record and the Proposed Decision of the Administrative Law Judge, makes the following:

ORDER

NOW, THEREFORE, it is hereby ordered that the Proposed Decision annexed hereto, filed by the Administrative Law Judge, shall be and hereby is made and ordered the Final Decision of the State of Wisconsin, Board of Nursing.

The Division of Enforcement and Administrative Law Judge are hereby directed to file their affidavits of costs with the Department General Counsel within 15 days of this decision. The Department General Counsel shall mail a copy thereof to respondent or his or her representative.

The rights of a party aggrieved by this Decision to petition the department for rehearing and the petition for judicial review are set forth on the attached "Notice of Appeal Information."

Dated this 5th day of September, 2003.

Linda Sanner

Chairperson

Board of Nursing

STATE OF WISCONSIN

BEFORE THE BOARD OF NURSING

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IN THE MATTER OF THE DISCIPLINARY :

PROCEEDINGS AGAINST :

: LS0306041NUR

PHILIP A. HICE, R.N., :

RESPONDENT :

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PROPOSED DECISION AND ORDER

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The parties to this action for purposes of §227.53, Wis. Stats., are:

Mr. Philip Hice

735 College Avenue

Winthrop Harbor, IL 60096

Board of Nursing

P.O. Box 8935

Madison, WI 53708-8935

Department of Regulation & Licensing

Division of Enforcement

P.O. Box 8935

Madison, WI 53708-8935

# PROCEDURAL HISTORY

A hearing in the above-captioned matter was held on July 14, 2003, before Administrative Law Judge Jacquelynn B. Rothstein. The Division of Enforcement appeared by attorney John R. Zwieg. Mr. Hice did not appear.

Based on the entire record in this case, the undersigned administrative law judge recommends that the Board of Nursing adopt as its final decision in this matter the following Findings of Fact, Conclusions of Law, and Order.

# FINDINGS OF FACT

1. Philip A. Hice, R.N. (dob 11/13/58) is duly licensed to practice nursing in Wisconsin (License #130956). His license was first granted on October 27, 1998.

2. Mr. Hice's most recent address on file with the Wisconsin Nursing Board is 735 College Avenue, Winthrop, Illinois.

3. Mr. Hice was employed by All Saints Healthcare and worked as a registered nurse on the Behavioral Health Unit at All Saints-St. Luke's Hospital in Racine, Wisconsin, from April 2001-January 17, 2002.

4. Ms. A, a 28-year-old married woman, had several admissions to the Behavioral Health Unit from April through August, 2001. Ms. A was diagnosed with Depressive Disorder, NOS, Post Traumatic Stress Disorder, anxiety, and Borderline Personality Disorder. She also had a history of self injurious behaviors.

5. Mr. Hice provided psychiatric nursing services to Ms. A during those admissions. On August 17, 2001, the day of one of Ms. A's discharges, Mr. Hice stopped to see Ms. A in her room and while there, knelt on the floor next to Ms. A's bed, leaned over, and kissed her on the cheek.

6. Following a Chapter 51 admission to Kenosha Memorial Hospital which resulted from an apparent overdose of medication and alcohol, Ms. A was transferred to the Behavioral Health Unit on September 9, 2001. During Ms. A's September 9, 2001, admission, Mr. Hice provided Ms. A with psychiatric nursing services and the following occurred:

a. Ms. A was sitting in a chair in the dayroom and Mr. Hice put his arm around her.

b. In response to Ms. A telling Mr. Hice she appreciated the sweet things he did for her, Mr. Hice smiled and put his hand on Ms. A's hand.

c. Later that same day, Ms. A was sitting on the bed and Mr. Hice was sitting in a chair in Ms. A's room. Mr. Hice took Ms. A's hands in his and told her that he was attracted to her. Ms. A stood up and bent over to kiss Mr. Hice on the cheek, but he turned his head and kissed Ms. A on the lips. Mr. Hice then stood up and kissed Ms. A's mouth passionately.

d. A few hours later, Ms. A asked to speak to Mr. Hice in her room. She closed the door when Mr. Hice came in. Mr. Hice stated that they should leave the door open but did not make any attempt to open it. Mr. Hice and Ms. A kissed passionately. Mr. Hice told Ms. A he wanted to keep in touch and Ms. A asked to see him outside of the hospital.

7. On September 17, 2001, Ms. A was discharged from the Behavioral Health Unit to the Kenosha Adult Residential Emergency (KARE) Center, in Kenosha, Wisconsin. After Ms. A arrived at the KARE Center, she and Mr. Hice arranged for him to visit her there.

8. On September 19, 2001, at about 3:00 p.m., Mr. Hice came to the KARE Center to visit Ms. A. Mr. Hice did not want to be seen by the other former patients of the Behavioral Health Unit who were at the KARE Center. For that reason, Ms. A met Mr. Hice and took him directly out to the backyard area where the following occurred:

a. Mr. Hice and Ms. A went around to the back of the building, away from the back door and window, and kissed.

b. While they were kissing, Mr. Hice unfastened Ms. A's jeans, placed his hand and fingers in Ms. A's vaginal area and caressed her, attempting to bring her to orgasm.

c. At the same time, Ms. A rubbed Mr. Hice's genital area, through his pants. They stopped because he told Ms. A he had ejaculated.

d. Mr. Hice said he had to leave to pick up his son and Ms. A let him out the back gate so that he would not be seen. Mr. Hice told Ms. A he wanted to see her again and asked her to call him at work.

9. Approximately one week later, after Ms. A's discharge from the KARE Center, Ms. A met Mr. Hice at a local beach where Ms. A got into Mr. Hice's car, they talked, they kissed, and Ms. A performed oral sex on him.

10. On a later date, Ms. A met Mr. Hice at a gas station in Zion, Illinois. Ms. A got into Mr. Hice's car and they drove to a nearby campground where Mr. Hice had already set up a tent. Mr. Hice, and Ms. A went into the tent and removed their clothes. Mr. Hice performed oral sex on Ms. A and unsuccessfully attempted sexual intercourse.

11. From October 2, 2001, until November 20, 2001, Ms. A received treatment at the Christian Recovery Center in Brooklyn Center, Minnesota. Ms. A came home for a weekend during her treatment program and called Mr. Hice. They then met at a park in Kenosha where Mr. Hice set up a tent. They removed their clothes and performed oral sex on each other. Ms. A asked Mr. Hice if he had ever done this with any other patient. Mr. Hice told Ms. A that she wasn't his patient, she was his lover.

12. After concluding her treatment at the Christian Recovery Center on November 20, 2001, Ms. A returned home. She met with Mr. Hice and told him that she did not think they should continue to see each other. They gave each other a last kiss.

13. Around Christmas, Ms. A called the inpatient unit at St. Luke's and spoke with Mr. Hice. They said they missed each other and agreed to meet when he got off work. She drove to the parking garage at the hospital, parked at the far end and waited for him. When Mr. Hice arrived, Ms. A got into his car and the following occurred:

a. Mr. Hice and Ms. A kissed, removed their pants and performed oral sex on each other.

b. Mr. Hice and Ms. A agreed that they wanted to continue their relationship.

c. Mr. Hice told Ms. A not to call him, that he would call her, because people at work were becoming suspicious of their relationship.

14. On January 2, 2002, Ms. A and her spouse had a serious argument. Ms. A locked herself in a bathroom and attempted to cut her wrists, making hesitation wounds. The police took her to the emergency room at St. Luke's Hospital under Chapter 51 for psychiatric evaluation and treatment. Upon her admission to the hospital, Ms. A reported to the staff that she had been involved in a sexual relationship with a nurse on the Behavioral Health Unit.

15. Following Ms. A's discharge on January 7, 2002, the Executive Director of All Saints Healthcare began an investigation of the allegation that Ms. A had a sexual relationship with a nurse. During the investigation, Ms. A identified Mr. Hice as that nurse.

16. On January 9, 2002, Mr. Hice was suspended from his employment as a registered nurse at St. Luke's Hospital, pending the investigation. Investigative staff met with Mr. Hice on January 9, 14, and 18, 2002. Mr. Hice initially denied having any contact with Ms. A outside the Behavioral Health Unit. Eventually Mr. Hice admitted meeting Ms. A in the hospital parking ramp and kissing her there, but only after being told that security cameras in the parking ramp had recorded that meeting. Mr. Hice continued to deny all other contacts and that he had any sexual contact with Ms. A.

17. On January 18, 2002, Mr. Hice was terminated from his employment with All Saints Healthcare/St. Luke's Hospital based on his admitted misconduct and his inappropriate relationship with a patient.

18. On June 25, 1988, Mr. Hice was granted license number 41247836 by the Illinois Department of Professional Regulation to practice as a registered nurse in Illinois.

19. In approximately 1996, Mr. Hice completed a hospital program for chemical dependency, which included random drug testing and counseling.

20. On July 23, 1998, Mr. Hice was employed at Victory Memorial Hospital in Waukegan, Illinois. On that date, all employees in Mr. Hice's work area had drug screens conducted. Mr. Hice's urine tested positive for marijuana.

21. On July 28, 1998, Mr. Hice applied for a license as a registered nurse by endorsement to the Wisconsin Board of Nursing. The application asked whether any state board of nursing had ever taken disciplinary action against him and whether any disciplinary action was currently pending against him. Mr. Hice accurately answered "no" to each of those questions.

22. On October 27, 1998, Mr. Hice was licensed as a registered nurse in Wisconsin.

23. On December 3, 1998, as a result of the July 23, 1998, positive urine screen, Mr. Hice appeared before the Illinois Department of Professional Regulation at an Informal Disciplinary Conference. Mr. Hice and the Illinois Department of Professional Regulation agreed to enter into a Consent Order. On February 25, 1999, the Director of the Illinois Department of Professional Regulation issued a Consent Order taking disciplinary action against Mr. Hice's license to practice as a registered nurse in the Illinois. The Illinois Department ordered that Mr. Hice's license to practice as a registered nurse in the State of Illinois be placed upon three (3) years probation. During the period of probation, Mr. Hice was required to adhere to the following:

a. Not ingest alcohol;

b. Not ingest mood or mind altering substances except those therapeutically prescribed by treating prescriber(s) whose patient records reflect that the treating prescriber knew of Mr. Hice's disease and ongoing recovery;

c. Attend a minimum of three (3) meetings per week of Alcoholics Anonymous and provide evidence thereof in manner and form acceptable to the Illinois Department's Nurse Investigative Unit;

d. Have random monthly urine screens in a manner and form acceptable to the Illinois Department's Nurse Investigative Unit;

e. Provide the Illinois Department of Professional Regulation with quarterly reports which include:

i. a copy of any performance evaluation completed by employer within the prior quarter and, at the beginning of probation, provide the Illinois Department of Professional Regulation with objective documentation as to the frequency of employee performance evaluations;

ii. a description of job duties, responsibilities, and name of immediate supervisor, if employed in a nursing related environment;

iii. a list of date and location of twelve step meetings attended;

iv. a copy of all incident reports within the prior quarter; and

v. a copy of all aftercare agreements, treatment plans, or any revisions thereto.

f. Notify the Illinois Department of Professional Regulation's nurse investigative supervisor in writing of any change in employment, and home address and telephone within five (5) days;

g. Provide institutional narcotic administration/dispensing records for random inspection by nurse investigators at least two (2) times per year during the term of probation; and

h. Agrees that any violation of paragraphs A 1, 2 or 5 of the Consent Order permits the Illinois Department of Professional Regulation to automatically and immediately suspend his license to practice nursing.

24. Mr. Hice complied with the terms and conditions of the Consent Order and completed his probation on March 26, 2002.

25. On July 10, 2002, Mr. Hice was employed as a registered nurse at St. Teresa's Hospital in Waukegan, Illinois, through the Favorite Nurses Agency. While in that employment, Mr. Hice diverted 1500 mg. of Demerol, a brand of meperidine, for his own use, without the order of a practitioner.

26. Mr. Hice has admitted to this diversion.

27. Illinois law prohibits possession of meperidine without the order of a practitioner.

28. Mr. Hice, by diverting the meperidine, obtained a drug other than in the course of legitimate practice.

29. On October 23, 2002, Mr. Hice was employed as a registered nurse at Pinnacle Health Care in Waukegan, Illinois.

30. The Pinnacle Health Care Pharmacy noted that a refill for Ritalin, a brand of methylphenidate, was premature and an investigation was conducted. Mr. Hice had signed out the Ritalin on two occasions as "borrowed" for another patient. The other patient did not have an order for Ritalin.

31. Mr. Hice was terminated from his employment at Pinnacle Health Care for mishandling narcotics.

32. Illinois law prohibits possession of methylphenidate without the order of a practitioner.

# CONCLUSIONS OF LAW

1. The Nursing Board has jurisdiction in this matter pursuant to §441.07, Wis. Stats.

2. By failing to file an Answer as required by § RL 2.09, Wis. Admin. Code, and by failing to appear at the hearing, Mr. Hice is in default under § RL 2.14, Wis. Admin. Code, and the Nursing Board may make Findings and enter an Order on the basis of the Complaint and evidence presented at the hearing.

3. Mr. Hice, by having engaged in inappropriate sexual contact, exposure, and gratification, with an adult receiving psychiatric nursing services within one year after the termination of those professional services, engaged in unprofessional conduct contrary § Nur 7.04 (11), Wis. Admin. Code.

4. Mr. Hice, by having had disciplinary action taken against his Illinois license to practice as a registered nurse by the Illinois Department of Professional Regulation, has engaged in unprofessional conduct contrary § Nur 7.04 (7), Wis. Admin. Code.

5. Mr. Hice, by having diverted meperidine, has engaged in unprofessional conduct contrary § Nur 7.04 (2), Wis. Admin. Code.

6. Mr. Hice, by having obtained the drug methylphenidate other than in the course of legitimate practice, has engaged in unprofessional conduct contrary § Nur 7.04 (2), Wis. Admin. Code.

# ORDER

**NOW THEREFORE IT IS HEREBY ORDERED** that the license of Philip A. Hice to practice nursing in the State of Wisconsin shall be **REVOKED**.

**IT IS FURTHER ORDERED** that the assessable costs of this proceeding be imposed upon Philip A. Hice, pursuant to sec. 440.22, Wis. Stats.

# OPINION

Section RL 2.14 of the Wisconsin Administrative Code provides that if a respondent fails to answer a complaint or fails to appear at a hearing, he or she is in default. If found to be in default, the disciplinary authority may make findings and enter an order on the basis of the complaint and other evidence against the respondent.

A Notice of Hearing and Complaint were sent to Mr. Hice both by certified mail and by regular U.S. mail at his last known address on file with the Wisconsin Department of Regulation and Licensing. However, Mr. Hice did not file an answer to the above-captioned complaint, nor did he appear at the scheduled hearing. As a result, Mr. Hice is in default and has effectively admitted all of the allegations contained in the complaint. A summary of those allegations follows below.

Beginning in April of 2001, Mr. Hice began treating Ms. A, a twenty-eight year old, married woman, when she was admitted to the Behavioral Health Unit at All Saints-St. Luke's Hospital in Racine, Wisconsin. Ms. A was diagnosed with Depressive Disorder, NOS, Post Traumatic Stress Disorder, anxiety, and Borderline Personality Disorder. She also had a history of self injurious behaviors.

In August of 2001, Ms. A was again admitted to the Behavioral Health Unit. During that admission, Mr. Hice engaged in sexual contact with Ms. A. Following a Chapter 51 admission to Kenosha Memorial Hospital which resulted from an apparent overdose of medication and alcohol, Ms. A was transferred to the Behavioral Health Unit on September 9, 2001. Mr. Hice provided Ms. A with psychiatric nursing services during that admission and also engaged in sexual contact with her while she was there.

On September 17, 2001, Ms. A was discharged from the Behavioral Health Unit to the Kenosha Adult Residential Emergency (KARE) Center, in Kenosha, Wisconsin. After Ms. A arrived at the KARE Center, she and Mr. Hice arranged for him to visit her there. During a visit Mr. Hice had with Ms. A on September 19, 2001, at the KARE Center, the two engaged in sexual contact.

In January of 2002, Ms. A was admitted to the Behavioral Health Unit at St. Luke's Hospital as a result of an apparent suicide attempt. While there, Ms. A reported to the staff that she had been involved in a sexual relationship with a nurse on the Behavioral Health Unit. On January 9, 2002, Mr. Hice was suspended from his employment as a registered nurse at St. Luke's Hospital, pending an investigation of his alleged conduct. Investigative staff met with Mr. Hice on January 9, 14, and 18, 2002. Mr. Hice initially denied having any contact with Ms. A outside the Behavioral Health Unit. Eventually, Mr. Hice admitted meeting Ms. A in the hospital parking ramp and kissing her there, but only after being told that security cameras in the parking ramp had recorded that meeting. Mr. Hice continued to deny all other contacts and that he had any sexual contact with Ms. A.

On January 18, 2002, Mr. Hice was terminated from his employment with All Saints Healthcare/St. Luke's Hospital based on his admitted misconduct and his inappropriate relationship with a patient.

On December 3, 1998, as a result of a positive urine screen, Mr. Hice appeared before the Illinois Department of Professional Regulation at an Informal Disciplinary Conference. Mr. Hice and the Illinois Department of Professional Regulation agreed to enter into a Consent Order. On February 25, 1999, the Director of the Illinois Department of Professional Regulation issued a Consent Order taking disciplinary action against Mr. Hice's license to practice as a registered nurse in the Illinois. The Illinois Department ordered that Mr. Hice's license to practice as a registered nurse in the State of Illinois be placed on three (3) years probation.

On July 10, 2002, Mr. Hice was employed as a registered nurse at St. Teresa's Hospital in Waukegan, Illinois, through the Favorite Nurses Agency. While in that employment, Mr. Hice diverted 1500 mg. of Demerol, a brand of meperidine, for his own use, without the order of a practitioner. Mr. Hice admitted to that diversion.

On October 23, 2002, Mr. Hice was employed as a registered nurse at Pinnacle Health Care in Waukegan, Illinois. The Pinnacle Health Care Pharmacy noted that a refill for Ritalin, a brand of methylphenidate, was premature and an investigation was conducted. Mr. Hice had signed out the Ritalin on two occasions as "borrowed" for another patient; however, the other patient did not have an order for Ritalin. Mr. Hice was subsequently terminated from his employment at Pinnacle Health Care for mishandling narcotics.

Because Mr. Hice has effectively admitted all of the allegations contained in the complaint, the question remains as to what the appropriate form of discipline is for him. Revocation of his license has been recommended. It is well established that the objectives of professional discipline include the following: (1) to promote the rehabilitation of the licensee; (2) to protect the public; and (3) to deter other licensees from engaging in similar conduct. *State v. Aldrich*, 71 Wis. 2d 206, 209 (1976). Punishment of the licensee is not an appropriate consideration. *State v. McIntyre*. 41 Wis. 2d 481, 485 (1969).

There is nothing in the record to suggest that imposing any discipline short of revocation would have a rehabilitative effect on Mr. Hice or that he even has an interest in being rehabilitated at this time. As to the deterrence of others, absent some mitigating evidence, imposing anything less than revocation would not aid in deterrence, but may instead wrongly encourage others to engage in similar conduct. Accordingly, revocation remains the only appropriate way in which to safeguard the public.

In addition, the imposition of costs against Mr. Hice is recommended. Section 440.22(2), Stats., provides in relevant part as follows:

> In any disciplinary proceeding against a holder of a credential in which the department or an examining board, affiliated credentialing board or board in the department orders suspension, limitation or revocation of the credential or reprimands the holder, the department, examining board, affiliated credentialing board or board may, in addition to imposing discipline, assess all or part of the costs of the proceeding against the holder. Costs assessed under this subsection are payable to the department.

The presence of the word "may" in the statute is a clear indication that the decision whether to assess the costs of this disciplinary proceeding against a respondent is a discretionary decision on the part of the Board of Nursing, and that the Board's discretion extends to the decision whether to assess the full costs or only a portion of the costs. The recommendation that the full costs of the proceeding be assessed is based primarily on fairness to other members of the profession.

The Department of Regulation and Licensing is a "program revenue" agency, which means that the costs

of its operations are funded by the revenue received from its licensees. Moreover, licensing fees are calculated based upon costs attributable to the regulation of each of the licensed professions and are proportionate to those costs. This budget structure means that the costs of prosecuting cases for a particular licensed profession will be borne by the licensed members of that profession. It is fundamentally unfair to impose the costs of prosecuting a few members of the profession on the vast majority of the licensees who have not engaged in misconduct. Rather, to the extent that misconduct by a licensee is found to have occurred following a full evidentiary hearing, that licensee should bear the costs of the proceeding.

Dated at Madison, Wisconsin, this 24th day of July, 2003.

STATE OF WISCONSIN

DEPARTMENT OF REGULATION & LICENSING

1400 East Washington Avenue

P.O. Box 8935

Madison, Wisconsin 53708

Telephone: (608) 266-5836

FAX: (608) 267-0644

Jacquelynn B. Rothstein

Administrative Law Judge