

# A Framework for Remediating Professional Ethical Lapses

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Nursing regulators, educators, practicing nurses, and the people they serve expect ethical standards of practice to be met in nursing and other healthcare professions. The reported incidence of professional discipline among nurses is low; however, some nurses (and other professionals) fail to demonstrate professional virtues and lose sight of professional ethical principles and duties. This article presents the types of issues that ultimately come to board attention, discusses the elements that may contribute to the issues, and describes an approach to help remediate professionals by equipping them with a framework to examine their reasoning and understand how and why they failed to uphold professional conduct. To help exemplify this approach, a case study on sexual boundary impingement and recommendations for regulatory boards are also presented.

*Keywords:* Professional boundaries, professional remediation, nursing ethics

## Objectives

- Identify ethical issues that come to board of nursing attention.
- Describe approaches to helping professional clinicians examine their reasoning and understand when they fail to uphold professional conduct.
- Discuss how ethics remediation can help clinicians develop the insights and habits essential to protecting the public as well as their ability to serve as licensed professionals.
- Explain how regulatory boards can make discipline impactful.

Although unprofessional conduct in healthcare takes many forms, there are almost always red flags and warning signs that, in retrospect, could have predicted future violations. Unfortunately, most professional lapses rise to board attention when they are egregious and harm has already been done—to the professional themselves, their patients, their families, their coworkers, their employers, and the reputation of the profession they represent.

Professionals in the fields of medicine, nursing, and psychotherapy are expected to hold patients' trust and confidence and maintain accountability. With this duty comes an obligation to serve others morally, ethically, and competently. To successfully uphold this fiduciary duty, professionals must possess an awareness of influences that can place them at risk for a violation (Holder & Schenthal, 2007).

Drawing from the author's nearly two decades of experience educating and remediating healthcare professionals in ethics, boundaries, and professionalism, this article presents the types of issues that come to board attention followed by a description of an approach to help clinicians examine their reasoning and understand how and why they failed to uphold professional conduct.

Specifically, this approach provides insight into the process of the violation; restores the clinician's professional mooring so they can protect themselves, their licenses, and their patients in the future; and prevents recidivism. This ethics remediation approach can help clinicians develop the insights and habits essential to protecting the public as well as improve their ability to serve as licensed professionals.

## Background

Nursing regulators, educators, practicing nurses, and the patients they serve expect ethical standards of practice in the nursing profession to be maintained. Nurses, like other clinicians, have a fiduciary duty to their patients. Society holds them to a higher standard of conduct than it holds others who are not members of the professions because of the trust placed in professionals by the vulnerable people who seek their care. But professional self-regulation can break down for many reasons, such as competing pressures, risk factors inherent in the type of practice, personal issues, and a lack of objectivity when it comes to their intentions and motivations.

## Incidence and Prevalence of Unprofessional Conduct

The reported incidence of professional discipline among nurses appears to be less than 1% per year and ranges from failure to renew one's license, to failure to report drug diversion, to sexual boundary violations (Kenward, 2009). However, accurate data collection on the prevalence of unethical or unprofessional conduct among clinicians is impeded by many factors. First, conduct of

TABLE 1

### Representative Sample of Infractions That Are Amenable to Remediation

- Sexual and nonsexual boundary violations
- Addictions
- Inappropriate prescribing
- Practicing outside scope
- Dual relationships
- Disruptive behavior
- Misrepresentation, falsification, cheating
- Financial improprieties
- Breaking laws
- HIPAA or confidentiality violations
- Practicing on an expired license
- Lax or irresponsible supervision
- Inappropriate conduct of a supervisee

Note. HIPAA = Health Insurance Portability and Accountability Act of 1996.

concern—whether it be relatively minor, such as an angry outburst at work or failure to call in when one will be late or miss a shift, or more troubling, such as bullying or falsifying a medical record—may be handled at the institutional level and may never be reported to a state regulator. Second, conduct of concern may never be reported to institutional administrators because those who consider reporting may fear workplace or legal retaliation, may fear a loss of anonymity, may not know how to make such reports, may find the reporting process time-consuming, or may not believe reporting will do any good (Rutledge, Retrosi, & Ostrowski, 2018). Moreover, many concerning actions—particularly drug diversion, sexual impropriety, and addictive behaviors—occur in private and are never witnessed by other professionals who have the ethical and often legal obligation to report. Patients or clients and their family members may be in a position to lodge complaints, but few do, perhaps out of shame, fear of alienating an important member of their healthcare team, or uncertainty about whether wrongdoing has actually occurred (DuBois et al., 2017).

Although a small subset of nurses who commit professional misconduct may lose their licenses, the majority respond successfully to appropriate, impactful discipline, including a program of remediation and a process of recovery. Good reasons exist to focus on preventing recidivism: first, to reduce regulatory boards' spending on remediation and rehabilitation efforts (Dilling & Miller, 2012), and second—and more importantly—to ensure the safety of patients, restore public trust in the nursing profession, and protect the remediated nurse's ability to continue to practice safely.

### Lapses That Come to Board Attention

In protecting the public, boards of nursing (BONs) are authorized to determine standards for licensure by their respective state nurse practice acts. Through a disciplinary process, BONs take action against a license (e.g., revoke, suspend) when a nurse has violated laws or rules, typically for reasons that fall under broad categories

such as unprofessional conduct, incompetent or unethical practice, or a criminal conviction.

Many unprofessional acts are amenable to remediation, generally through an intensive in-person course aimed at developing insight and a plan for avoiding recidivism. Table 1 provides a representative sample of such infractions. Other components of the remediation process can include monitoring, therapy or counseling, compliance with an impairment program if applicable, and other coursework to correct deficiencies in areas such as record keeping or prescribing.

Of note, not all infractions that rise to the level of professional discipline need to occur in the context of clinical care. Society expects its trusted healthcare professionals to behave responsibly in all domains of life—not merely in the clinical realm. If a clinician breaks a law, cheats on an examination, or lies on an application, for example, patients and regulators would be reasonably concerned the clinician may be willing to break laws or deceive in the context of patient care as well.

### Losing Sight of Professional Ethics

Many nurses, when asked why they went into nursing, will respond, “to help people.” But some fail to demonstrate professional virtues, lose sight of professional ethical principles and duties, or do not think through the consequences of their words or actions.

This premise—that every healthcare professional has the potential to commit an ethics or boundary violation—suggests that certain elements conspire at a certain time or in a certain context, such that the offense occurs. This premise also suggests that ethics and boundary violations are preventable by modification to those conspiring elements and that clues and red flags may pop up along the way, presenting an opportunity to provide corrective responses.

#### The 5 Conspiring Elements

There are five primary elements that conspire for a nurse to lose sight of professional ethics and commit an ethics or boundary violation: (a) risk factors, (b) vulnerabilities, (c) inadequate accountability measures, (d) resistance, and (e) catalyst (Holder & Schenthal, 2007).

*Risk factors.* These are features of one's work, such as the setting, practice type, patient population served, and clinical discipline. For example, nurses who work with patients who present challenging interpersonal dynamics, such as patients with personality disorders, are more at risk for succumbing to the pressures of those dynamics than nurses who work in an outpatient pediatric setting.

*Vulnerabilities.* These are the features of the nurse's personality, emotional make-up, upbringing, or life stresses, such as family illness, divorce, or financial pressures. It is easy to appreciate that a professional who is the sole supporter of his or her family, who is caring for a sick parent, who is going through a divorce,

or who has an addiction may fail to see that his or her judgment has become impaired. When personal issues compete with the primacy of patient welfare as one's guide for action, inappropriate thoughts and actions can result.

**Accountability measures.** Nurses who behave unprofessionally or unethically have failed in one of the essential features of being a professional—to hold oneself accountable or to self-regulate. Checks built into one's professional practice that demonstrate self-regulation include peer review, consultation, respecting one's scope of practice, keeping up with continuing education, and taking responsibility for remaining current on applicable laws and the policies and expectations of employers and regulators. To fail to hold oneself accountable in these and other ways is to remove an important protection against committing a violation.

**Resistance.** Clinicians who commit ethics or boundary violations often rationalize or justify their aberrant actions in ways meant to convince themselves they are not acting unprofessionally. "I never drink on the job because I'd never want to hurt a patient." "If I hadn't written that prescription for my mother, she would think I didn't love her. Besides, she gets better care from me." "I was too busy taking care of my patients to remember to renew my license." Pushing the boundaries or taking matters into their own hands resists the self-assessment that provides a clear-eyed view of clinicians' motivations, intentions, and actions. Denial, defensiveness, rationalization, and justification allow inappropriate conduct to snowball and interfere with the development of insight and ethical reasoning.

**Catalyst.** The right temptation or trigger at the right time or in the right place can propel an ethics or boundary violation. These temptations or triggers can be a patient who pushes one's buttons, a coworker who gets under one's skin, a crisis at home, or a transition in one's personal life.

The Ethics/Boundary Formula® depicts the interrelationship of these elements (Figure 1).

Although seemingly mathematical and quantitative, the Formula represents the qualitative interaction of several elements that, taken together, influence a clinician's violation potential. For example, violation potential is increased by the presence and nature of one's risk factors and/or vulnerabilities and inadequate accountability measures. Resistance exerts such a powerful effect on violation potential that it is depicted as an exponent. Some clinicians resist even recognizing or admitting that resistance played a role in their misconduct. For them, their resistance is again depicted exponentially. Finally, propelled by a catalyst, clinicians without accountability measures that are adequate to offset the burden of risk factors, vulnerabilities, and resistance will commit a violation.

## Ethics and Boundary Impingements

Most ethics or boundary violations do not occur full-blown without warning signs; rather, they are preceded by clues or red flags. In fact, ethics and boundary lapses occur along a continuum of

FIGURE 1

### The Ethics/Boundary Formula®

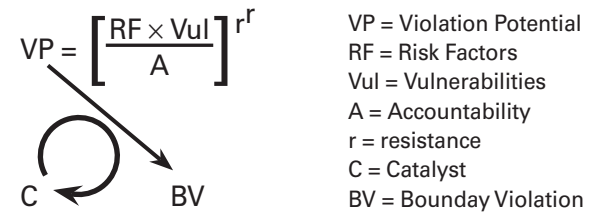
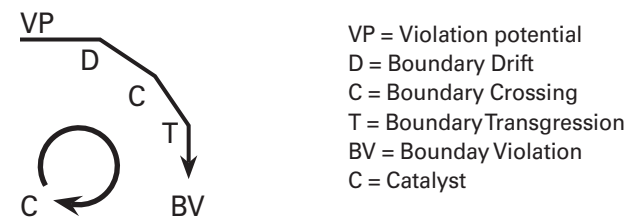


FIGURE 2

### The Slippery Slope



increasing severity and harm. They can be depicted in a familiar way—the proverbial “slippery slope” (Figure 2).

### The Gradations of Ethics and Boundary Impingements

Drifts (private thoughts) and crossings, transgressions, and violations (actions) are terms used to describe ethics and boundary impingements that represent increasing degrees of harm caused to the patient, the nurse, the clinical care, the workplace, and even the reputation of the nursing profession itself. These terms were defined by professionals from Acumen Institute (Lawrence, KS), and Professional Boundaries, Inc., (Jacksonville, FL) who sought to develop a nomenclature that would capture the progression of less harmful acts to frank boundary violations in the sanctioned healthcare professionals they treated and educated (Stacy, 2005).

**Drifts.** A drift is a private thought about another person—typically a patient, but it could also be a coworker or family member of a patient, for example—for the nurse's own pleasure, rather than in the service of patient care or professional work. Typically, drifts are sexual, romantic, rescue, or hero fantasies.

**Crossings.** These are indications the nurse is stepping outside of his or her professional role by deviating from the standard of care, typical practices, or office protocols. Actions that might cause a nurse to say, “Ordinarily I don't do this, but in your case, I will make an exception,” are considered crossings.

**Transgressions.** The sharing of personal information with a patient or with any other individual with whom the nurse does not have a personal relationship would be considered a transgression. Other examples include intentionally initiating nonclinical contact or a nonclinical relationship, such as a friendship or a business or legal relationship. A clue to a transgression is the nurse would not

have a relationship with the other person at all, but for the fact that the clinical relationship exists.

*Violations.* When a nurse exploits the trust, knowledge, influence, or emotions derived from the clinical or professional relationship, this is considered a frank ethics or boundary violation. In violations, harm comes at the very least to the patient, to the treatment, and to the offending nurse.

Bright lines do not exist between drifts, crossings, transgressions, and violations. The slope of the slippery line is not uniform but becomes increasingly steep. Those who already started to drift can grow accustomed to that as a new normal and can easily find themselves crossing. When the crossings become the new normal, particularly if there have been no repercussions, it becomes easier to commit a transgression. In this setting, flawed reasoning prevails, and, in the presence of a catalyst, a frank violation becomes all but inevitable.

## **Archetypes of Sexual Boundary Violators**

Researchers who have spent decades working with healthcare professionals who violated sexual boundaries with a patient, patient's family member, coworker, or subordinate found that most violators fall within six archetypes (Irons & Schneider, 1999; Gabbard, 1999). It is instructive to examine those six archetypes, as many of their features are common to professionals who have committed less egregious violations. Moreover, these features can serve as clues or red flags for professionals who may be susceptible to misusing their power, employing flawed reasoning, or failing to uphold their professional obligations. Furthermore, these types humanize wrongdoers, as they illustrate the kinds of personal vulnerabilities and work-related stresses that can lead nurses and other professionals who lack a strong accountability safety net to act inappropriately.

### **The Wounded Healer**

Many sexual boundary violators exhibit the traits of this archetype. The "wound" may be a serious unmet need, pain, or trauma from early life. The violator attempts to find ultimate healing not by addressing their wounds directly but through a re-enactment of saving others. Thus, these violators are overly committed to serving their patients and place their personal lives second. As they receive validation and feelings of self-worth from their professional work, they become emotionally isolated. Typically, there is no serious psychopathology, although these violators may also develop addictions. Their rehabilitation potential is good, especially with individual psychotherapy and group therapy with other healthcare professionals. A goal of the therapy is to help the professional identify his or her areas of pain or trauma so that they may learn how to heal their own wounds rather than looking for healing through the act of trying to save others. The treatment process also needs to help the professional gain insight into how trying to save

another through romance, and eventually sex, is a perversion of the professional-patient relationship.

### **The Naive Prince/Princess**

These clinicians are usually early in their careers and, as such, lack awareness of their authority and the power dynamic within the clinician-patient relationship, particularly if they lacked exposure to good role modeling or training in maintaining proper boundaries. There is a component of entitlement in that they enjoy the sense of power and invulnerability that accompanies their new role. Often the exploited patient or other person is an individual who is particularly challenging, intriguing, or provocative, as this typology can be easily seduced. They need assistance in understanding that not everyone has good intentions. This group responds well to counseling that addresses their naive narcissism, education about appropriate professional boundaries, and monitoring.

### **The Self-Serving Martyr**

These professionals share some similarities with the wounded healer in terms of being overly committed to serving their patients, but they differ in important ways. Typically in mid- or late-career, these nurses consume themselves with their professional duties as a way of getting their needs met, and they constantly sacrifice themselves, their personal growth, and their family life. As time goes on, they feel increasing anger, resentment, and self-pity over their professional burdens, develop a sense of entitlement, and become isolated. Many develop alcohol, drug, and/or behavioral problems. Recovery, albeit slow, is possible through developing better work-related boundaries, learning how to avoid over-extending themselves, and finding ways to meet their personal needs and avoid self-defeating outcomes. Gaining insight into anger and resentment over years of sacrifice is also a treatment goal.

### **The Lovesick**

These clinicians truly believe they have fallen in love with the patient or other inappropriate person. They collapse into the first person who makes them feel whole and become convinced that it is their destiny to engage in the relationship. Marked by illogical thinking, they seem to operate by an internal reality that differs from external reality. They believe this justifies exceptions to the rules and may indeed be curative for both the patient and the clinician. Even so, there may also be simultaneous feelings of great shame. These clinicians can be rehabilitated through education that increases their awareness regarding their level of neediness, vulnerability to seduction, and the social deficits in their personal lives.

### **The Masochistic Surrenderers**

The masochistic surrenderer archetype becomes overwhelmed by a particularly needy, demanding, or manipulative patient. A patient with a borderline personality disorder provides a good example with whom healthcare professionals can be particularly

ill-equipped to maintain appropriate professional boundaries. The clinician becomes everything to the patient, providing unrestricted access and accommodating every request. However, for the clinician, resentment and rage boil underneath. Not surprisingly, these clinicians have self-destructive tendencies and difficulty expressing anger, setting limits, or saying “no” in many other areas of life. The behavior trajectory of this type of clinician is one of increasingly greater boundary impingements, culminating in a sexual boundary violation as a vent for their anger. Although slow, recovery is possible for this group through individual psychotherapy, group therapy with other clinicians who have committed sexual boundary violations, and education. Like the self-serving martyr, this group of individuals needs to gain insight into anger and resentment.

### **The Dark Knight/Dame**

Fortunately, this group is the least commonly encountered, although possibly because they are the least likely to get caught. They are frequently featured in news media accounts of professional misconduct. This archetype may exhibit psychopathology or sociopathic personality traits, such as lack of empathy, lack of remorse, and disregard for societal norms. They consciously desire to control and dominate their victims, whom they manipulate and “groom” to meet their needs. Sexual exploitation is seen as a right, as sex is an expression of power, superiority, and dominance. Not surprisingly, this archetype has little, if any, rehabilitation potential, is resistant to treatment, and usually requires license revocation. Their prognosis is very poor.

### **Case Scenario**

The following case is drawn from real cases of professional misconduct. Details have been changed to preserve anonymity and permission to use this content has been granted.

*Kim is a 46-year-old nurse who has provided home care for several years. She is personable and often regards her patients as family, sharing photos of her family and other personal aspects of her life. This past year, Kim and her husband became empty-nesters when their youngest child left for college. They took that opportunity to downsize into a new home. Despite what should have been a happy new chapter in her life, Kim began to feel lonely and depressed. She grieved over not having her children at home any longer. Because she needed to earn more money to pay for the house, Kim increased her case load, keeping her away from home for longer hours.*

*At this time, the adult son of one of her new patients began to pay attention to her. It began with a cup of coffee in the kitchen, then a recommendation for a book, and finally an invitation to get together. Kim appreciated his kindness, and she eventually began to look forward to those home visits. In fact, Kim found herself scheduling that patient late in the day so she would not have to leave for*

*another appointment. She convinced herself that going out with the patient's son would provide valuable opportunities to learn more about her patient and deliver better care. Eventually, she and the son developed an intimate relationship. As a result, Kim often went above and beyond for the son's mother in ways she did not for her other patients. She even used her influence as a nurse to find a new physician to care for her patient.*

*Kim knew the relationship was wrong. She felt guilty and worried about what might happen to her patient if she cut off the relationship with the son. But the attention filled some of the emptiness she was feeling in her marriage and home. Unfortunately, Kim turned to alcohol to cope with her shame, sadness, and fear. After being charged with driving under the influence, Kim realized her behavior had to stop and reported her relationship with the patient's son to her employer.*

### **Case Discussion**

After her self-report, Kim's employer terminated her contract and reported her to the state nursing licensure board. As part of her negotiated settlement agreement with the board, Kim was ordered to attend an intensive, three-day professional boundaries and ethics course. In the course seminar, she learned about the archetypes, the Ethics/Boundary Formula, and the Slippery Slope model. One of the features of the course is its attention to each participant's situation and background. Thus, with the benefit of these conceptual frameworks and hindsight, Kim was able to identify the elements that elevated her violation potential, which she had been unable to appreciate at the time. A description of the specific elements that elevated Kim's violation potential follows. Table 2 provides additional examples of risk factors, vulnerabilities, and ways of demonstrating resistance and lacking accountability that can elevate one's violation potential.

#### **Kim's Risk Factors**

Kim identified being a home care nurse as a major risk factor. Trying to perform clinical work in a setting designed for personal and family activities requires skillful maintenance of a nurse's professional role. Kim's work separated her from colleagues and structures that could hold her accountable for maintaining appropriate interpersonal boundaries with her patients and this patient's son, as well as respecting the proper appointment length. Although many nurses are equipped to conduct themselves professionally in the home care setting, this was risky for Kim, whose tendency was to consider her patients like family and who developed a habit of sharing aspects of her personal life with them. These red flags suggest she had stepped out of her professional role and begun to commit boundary crossings and transgressions.

Kim was surprised to learn her age and length of career were also risk factors. The majority of ethics and boundary violations occur in a biphasic distribution: midcareer professionals

TABLE 2

## Examples of Elements That Can Elevate a Nurse's Violation Potential and Accountability Measures

### Risk Factors

- Patients' age
- Clinical conditions treated
- Allowing patients to text to the nurse's personal cell phone
- Solo practice
- Not wearing wedding ring
- Lack of a trained chaperone
- Lack of a trained translator
- Prescribing controlled substances
- Assuming a good reputation makes one immune from complaints
- Long appointments
- Prior history of a board action or lawsuit
- Financial involvement with patients or staff, such as borrowing or lending money or giving gifts

### Vulnerabilities

- Illness in self or loved one
- Being the caregiver for a sick loved one
- Financial insecurity
- Addiction
- Always feeling like one has to go above and beyond
- Professional self-image
- Being a people-pleaser; wanting to be liked
- Feelings of inferiority, regret, helplessness, disillusionment
- Seeking boosts to one's self-esteem
- Fatigue
- Being a single parent
- Marital difficulties/divorce

### Resistances

- Rationalization
- Justification
- Denial
- Repression
- Other-blaming
- Defensiveness

### Catalysts

- Crisis at home or at work
- Transition
- Trauma
- Loss
- People who "push your buttons"
- The right temptation at the right time
- Own psychiatric illness

### Accountability Measures

- Peer review
- Supervision
- Checking institutional policies regularly
- Checking professional guidelines and rules regularly
- Keeping up with continuing education requirements
- Compliance with impairment program, if applicable
- Use of chaperones
- Use of translators
- Communicating with patients only through office-based email and telephone systems
- Seeing patients only during regular office hours
- Adhering to appointment times
- Use of professionally trained office staff

in their mid-forties and those older than 60 years (Stacy, 2006). Professionals at these points in their careers often experience life transitions (e.g., children leaving home, parental illness or death, marital instability, their own illnesses, etc.). Moreover, they may feel sufficiently accomplished that they become complacent. Feeling at the top of their game, they may lose the vigilance they possessed early on and become lax in self-regulation. They may have committed relatively minor infractions and not gotten caught or may have indulged themselves in boundary drifts without considering their self-serving motivations. Over time, those lapses become normalized and can lead to more significant deviations from professional conduct. Kim did the right thing by reporting herself to her employer. In most cases, it is the disgruntled lover, the abandoned patient, the betrayed spouse, or the concerned coworker who files the complaint that results in BON action.

### Kim's Vulnerabilities

Kim has several vulnerabilities. She was destabilized by her transitions to an empty nest and a new home. Additionally, she felt financial pressure to work more to pay for the new house. Kim's withdrawal from her husband and her home life suggests she

seeks her own "care and feeding" at work and not in her personal life. Her story principally demonstrates the wounded healer type. Professional counseling may help her address issues of self-esteem.

For Kim to appreciate the dynamics of her violation, the course helped her review her story for red flags. For example, she took it upon herself to find a new doctor for her patient. Was that an appropriate clinical response to a care plan that did not seem optimized for this patient? Kim recognized she wanted to treat this patient as if she were "special," giving the patient the gift of her medical influence. Kim grew to realize she derived a lot of secondary gain out of treating this patient in special ways. It replaced the control she could no longer exert over her grown children, and it cemented her favorable impression on her patient's son. Additional red flags include her acceptance of the patient's son's small overtures. Had Kim been in a less vulnerable state, she might have maintained her professional role without exploiting the patient's son to meet her own needs.

### Kim's Accountability Deficits and Resistance

Many accountability measures available in a professional office are absent in the home care setting, as noted above. There are no peers

to provide a second opinion or feedback, and no on-site support staff for records, billing, appointments, and other administrative needs. It can be difficult to feel part of a profession without daily interaction with colleagues. The travel between patients' homes may make it difficult to attend meetings and conferences where clinical guidelines, procedures, and organizational policies are discussed.

With the help of feedback from the other participants in the course, Kim began to appreciate her resistances. One was how she rationalized working more hours. Another was that she justified socializing with her patient's son by telling herself it was for the patient's benefit. In Kim's situation, if she needed more information about her patient, it would have been far more appropriate for her to obtain the information from the patient herself, in the context of a formal family meeting, or from the patient's personal physician.

#### **Kim's Ethics Remediation Plan**

Kim, as a participant in the course, developed a remediation plan aimed at preventing future violations. In these comprehensive plans, course participants modify their risk factors, address vulnerabilities, bolster their accountability measures, and incorporate insights in the service of checking resistances. Components of the plans are stratified into three domains: (a) organizational, (b) professional, and (c) personal. For illustrative purposes, Kim's plan would include the measures described in the following paragraphs.

In the organizational domain, Kim would no longer practice in home care; she would practice in a setting surrounded by other nurses and support personnel. She would commit to quarterly reviews of her employer's policies and her BON's rules and updates. She would voluntarily take continuing education courses in ethics, boundaries, and professionalism beyond those required by her board.

Kim's professional domain would include measures such as refraining from showing personal photos to patients, discussing her personal life with them, and socializing with them or their family members. She would communicate with patients only through the office phone or patient portal system, and she would see patients only during regular office hours. She would commit to participating in the longitudinal follow-up component of the boundaries course she attended, which includes a weekly, faculty-led teleconference of professionals who are remediating and recovering from the disciplinary process. This participation would tether her to a supportive and understanding community during this especially challenging period and assist her in implementing her remediation plan.

Kim's personal domain would include measures such as personal psychotherapy, marital counseling, a substance addiction evaluation (and a commitment to abide by the recommendations), activities through which she could reconnect with her children and friends, and a period of exploration into other ways she could develop her self-esteem.

## **Discussion**

It is not unusual for victims of exploitation by healthcare professionals, particularly those whose emotional and sexual boundaries have been violated, to call for a zero-tolerance policy, whereby the licenses of offending clinicians are permanently revoked. Moreover, skeptics often ask whether remediation is even possible or if recidivism can be prevented. Based on our experience, the answers to those questions are intertwined.

As noted previously, and except for the Dark Knight type, the vast majority of errant healthcare professionals are well-meaning individuals who failed in their professional obligations for reasons that have to do with their practice situation, personal issues, impaired self-assessment, and/or flawed reasoning. Offending professionals stripped of their licenses would, indeed, be prevented from re-offending in the clinical realm. But they would be deprived of the opportunity to learn why and how they strayed. Without the benefit of introspection, insight, and individualized plans for change, it is plausible they could continue to offend in other areas of their lives.

Of course, victims never want what happened to them to occur to others. But revocation without remedial education and a recidivism protection plan provides no such guarantee. By contrast, an approach that regards the errant practitioner as ethically or professionally "impaired" could follow the model of nursing Alternative to Discipline programs (National Council of State Boards of Nursing, n.d.).

When clinicians are ordered to attend an ethics, professionalism, or boundary remediation course, they and their referring entities often have the misconception that attendance at the course will accomplish successful completion of the remediation. In fact, it is in the course where the remediation begins, precisely because remediation is a process initiated by the content of the curriculum. Learning the material is merely the first step in a road to recovery marked by rehabilitation and recommitment to the ideals of their profession. Having a specific personalized plan to prevent recidivism, revising that plan as situations and needs change, and remaining connected to a professional recovery community where they can grapple with their shame, embarrassment, fears, and self-doubts are critical components of successful professional remediation. Unchecked, professional isolation is a powerful risk factor for going astray.

However, unlike in the alternative-to-discipline programs for substance use violations, discipline is warranted for those nurses who committed ethical, professional, or boundary violations. The key here is for the discipline to be "impactful."

The following are some recommendations for regulatory boards to make discipline impactful.

- Consider the context of the infraction. When deciding on sanctions, many boards consider mitigating factors (eg, first-time offense, cooperation with the investigation) and aggravating factors (eg, misconduct involving multiple patients over a long period). This approach could lead to discipline that does not

provide an appropriate level of impact on the licensee. Moreover, appreciating differences among wrongdoers as illustrated by the archetypes may assist boards in developing a wider and more impactful repertoire of interventions and sanctions.

- Consider whether the infraction is part of a larger pattern of misconduct over time, suggesting ungovernability of the licensee or a global inability to abide by the rules of professional practice.
- Consider clarifying the language in negotiated settlement agreements rather than relying on the often broad, overarching terms from a state nurse practice act. Doing so enables licensees to understand specifically what about their conduct was unethical or unprofessional. This clarified language would also help more accurately track the prevalence of specific kinds of misconduct and the results of interventions (Caldicott & d'Oronzio, 2015).
- Consider consulting with other state nursing boards to achieve consensus about what constitutes an appropriate set of sanctions, titrated to the severity of the infraction.

## Conclusion

The privilege to care for patients is honored by most healthcare professionals. But healthcare professionals are human, subject to life stresses, distractions, emotional unfinished business, and other influences that can increase one's potential to commit a professional boundary or ethics violation. The explanation of the method for remediating professionals presented here is intended to equip practicing professionals with insight and a framework for thinking about how healthcare professionals conduct themselves as a guide to practicing safely. Ultimately, all of us—licensed clinicians, regulators, and educators—have the same goals: to serve and protect patients and to uphold the integrity of the healing professions.

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## A Framework for Remediating Professional Ethical Lapses

### Objectives

- Identify ethical issues that come to Board attention.
- Describe approaches to helping professional clinicians examine their reasoning and understand when they fail to uphold professional conduct.
- Discuss how ethics remediation can help clinicians develop the insights and habits essential to protecting the public as well as their ability to serve as licensed professionals.
- Explain how regulatory boards can make discipline impactful.



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Expiration: July 2022

## Posttest

Please circle the correct answer.

- 1. What is the nurse's responsibility for maintaining ethical standards of practice?**
  - a. Only regulators and educators are responsible for maintaining ethical standards of practice for the nursing profession.
  - b. Nurses do not have a fiduciary duty to their patients.
  - c. They are held to a higher standard of conduct by society.
  - d. There is no obligation for nurses to serve others morally or ethically.
- 2. How can professional self-regulation break down?**
  - a. There is objectivity when it comes to intentions and motivations.
  - b. There are competing pressures, risk factors inherent in the type of practice, or personal issues.
  - c. There is no societal trust placed in nursing behavior.
  - d. Boards of nursing have no control over this process.
- 3. Which of the following is true about the reported incidence of professional discipline among nurses?**
  - a. Reported incidents may include drug diversion, sexual boundary violations, or failure to renew one's license.
  - b. The reported incidence appears to be an average of 10% per year.
  - c. There are no impediments to accurate data collection on prevalence.
  - d. There is usually a witness who has the ethical/legal obligation to report.
- 4. What is a consideration, if any, to focusing on preventing recidivism?**
  - a. The vast majority of nurses who commit professional misconduct do not respond successfully to appropriate, impactful discipline.
  - b. Reduces regulatory boards' spending on remediation and rehabilitation efforts.
  - c. Ensures that the remediated nurse's license is revoked.
  - d. Nursing boards are not involved in taking action for unprofessional conduct or unethical practice.
- 5. Infractions that rise to the level of professional discipline need to meet which requirement?**
  - a. Breaking laws
  - b. Deceiving a supervisor
  - c. Lying on an application
  - d. Occurring in the context of clinical care
- 6. Which conspiring element to commit an ethics or boundary violation are features of one's work, such as setting, practice type, patient population served, and clinical discipline?**
  - a. Vulnerabilities
  - b. Accountability measures
  - c. Risk factors
  - d. Public health
- 7. The Ethics/Boundary Formula depicts the interrelationship of the conspiring elements as follows:**
  - a. The violation potential is increased by the presence and nature of one's risk factors and/or vulnerabilities and inadequate accountability measures.
  - b. Resistance does not exert any effect on violation potential.
  - c. A catalyst can only propel an ethics or boundary violation for nurses without accountability measures to offset the burden of risk factors.
  - d. Conspiring elements cannot be modified to prevent ethics and boundary violations.
- 8. Which of the following gradations of ethics and boundary impingements is not an action?**
  - a. Crossing
  - b. Drift
  - c. Transgressions
  - d. Violations
- 9. This archetype is resistant to treatment and requires license revocation:**
  - a. The Dark Knight/Dame
  - b. The Masochistic Surrenderer
  - c. The Self-Serving Martyr
  - d. The Wounded Warrior

**10. The following approach regards the errant practitioner as ethically or professionally "impaired":**

- a. The Ethics/Boundary Formula<sup>®</sup>
- b. The Slippery Slope model
- c. The Archetype Framework
- d. Alternative to Discipline programs

**11. Which of the following choices is not a characteristic of impactful discipline?**

- a. Considering the context of the infraction
- b. Relying on the Nurse Practice Act
- c. Considering whether the infraction is part of a larger pattern of misconduct over time
- d. Clarifying the language in negotiated settlement

**Evaluation Form (required)**

**1. Rate your achievement of each objective from 5 (high/excellent) to 1 (low/poor).**

- Identify ethical issues that come to board attention.  

1	2	3	4	5
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- Describe approaches to helping professional clinicians examine their reasoning and understand when they fail to uphold professional conduct.  

1	2	3	4	5
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- Discuss how ethics remediation can help clinicians develop the insights and habits essential to protecting the public as well as their ability to serve as licensed professionals.  

1	2	3	4	5
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- Explain how regulatory boards can make discipline impactful.  

1	2	3	4	5
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**2. Rate each of the following items from 5 (strongly agree) to 1 (strongly disagree):**

- The authors were knowledgeable about the subject.  

1	2	3	4	5
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- The methods of presentation (text, tables, figures, etc.) were effective.  

1	2	3	4	5
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- The content was relevant to the objectives.  

1	2	3	4	5
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- The article was useful to me in my work.  

1	2	3	4	5
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Comments: \_\_\_\_\_  
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