

**Practical Guidelines for Boards of Nursing  
on Sexual Misconduct Cases**



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## **Practical Guidelines for Boards of Nursing on Sexual Misconduct Cases**

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## Mission Statement

The National Council of State Boards of Nursing, composed of member boards, provides leadership to advance regulatory excellence for public protection.

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# INTRODUCTION

The purpose of this booklet is to provide boards of nursing (BONs) with practical guidelines in making decisions about sexual misconduct cases in their mission of public protection. This resource is not only pertinent, but timely.

In 2007, Halter, Brown and Stone reviewed the published empirical literature on sexual misconduct. This review provides details in the areas of: the prevalence of sexual misconduct, the impact on patients, factors associated with sexual boundary violations and themes for future research. The researchers drew the following conclusions from the studies they reviewed:

- Clear sexual boundaries are crucial to patient safety.
- Specific education about this subject, delivered in conducive environments, changes health care providers' attitudes toward sexual contact with patients.
- Sexual boundary violations result in significant and enduring harm to patients.
- Reported incidence of sexual misconduct in health care is low, and is concentrated in general practice and psychological therapies.
- Patient vulnerability is associated with higher prevalence of sexual misconduct.

For the purposes of this document, the term nurse refers to a registered nurse (RN) or a licensed practical/vocational nurse (LPN/VN), except in instances that indicate otherwise.

## EXTENT OF THE PROBLEM

In NCSBN's analysis of 10 years of Nursys® data (NCSBN, 2009), 52,695 nurses were disciplined for 114,570 violations; of those violations, 659, or 0.57 percent, were included in the following categories: sexual misconduct—boundaries, other sexual misconduct, sexual abuse, sex with client or sexual language. Therefore, sexual misconduct is not a common complaint to a BON. The actual prevalence, however, is not known. Indeed, 38 to 52 percent of health care professionals report knowing of colleagues who have been sexually involved with patients (Halter et al., 2007).

The impact of sexual misconduct on patients is serious. The Council for Health Care Regulatory Excellence (2008) cites the following disorders and complaints as being resultant of sexual misconduct by a health care provider to a patient/client:

- Post-traumatic stress disorder and distress;
- Major depressive disorder;
- Suicidal tendencies and emotional distrust;
- High levels of dependency on the offending professional;
- Confusion and dissociation;
- Failure to access health services when needed;
- Relationship problems;
- Disruption to employment and earnings; and
- Use and misuse of prescription (and other) drugs and alcohol.

## USING THIS RESOURCE

The intent of this document is to provide a user-friendly resource that provides practical guidelines for BONs. This includes:

- Introductory information, statistics and a reference list with additional sources;
- Definition of terms;
- Guidelines for selecting evaluators for establishing sanctions and fitness for practice. These were either gleaned from the literature or they are examples from Member Boards. BONs can select the guidelines that best meet their needs;
- A detailed framework for deciding when and how to take action in sexual misconduct cases. This would be most helpful for those BONs that would like more consistency in the way they handle sexual misconduct cases;
- An easy-to-follow *Sexual Misconduct Pathway* to serve as a quick reference when handling sexual misconduct cases; and
- Four cases:
  - A high-profile case that highlights how to use the framework and pathway;
  - A long-term care case study that is typically seen in BONs with a discussion of how definitions can be helpful;
  - A hospital case study that integrates the fitness for practice guidelines; and
  - A case study of a member of a vulnerable population that details the use of the framework.

The information provided in this booklet has been derived from a variety of resources, including scientific reviews of the literature. Those interested in reading more about the research in this area, as well as an overview of the state of the science of professional misconduct, are referred to the work of Carr (2003), Elbogen and Johnson (2009), and Halter et al. (2007).

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## DEFINITIONS

Below are general definitions of sexual misconduct used by the BONs. The definitions below include language from BONs' laws and regulations and could be adapted by other BONs. See Case 2 at the end of this booklet to illustrate how definitions can be beneficial to BONs.

### Sexual Misconduct

1. Engaging in conduct with a patient that is sexual or may reasonably be interpreted by the patient as sexual; any verbal behavior that is seductive or sexually demeaning to a patient; or engaging in sexual exploitation of a patient or former patient.
2. A specific type of professional misconduct which involves the use of power, influence and/or special knowledge that is inherent in one's profession in order to obtain sexual gratification from the people that a particular profession is intended to serve. Any and all sexual, sexually demeaning, or seductive behaviors, both physical and verbal, between a service provider (i.e., nurse) and an individual who seeks or receives the service of that provider (i.e., client), is unethical and constitutes sexual misconduct.
3. Engaging in inappropriate sexual contact, exposure, gratification, or other sexual behavior with, or in the presence of, a patient. For purposes of this subsection, an adult receiving psychiatric nursing services shall continue to be a patient for one year after the termination of professional services. If the person receiving psychiatric nursing services is a minor, the person shall continue to be a patient for the purposes of this subsection for one year after termination of services, or for one year after the patient reaches the age of majority, whichever is longer (Wisconsin Board of Nursing).

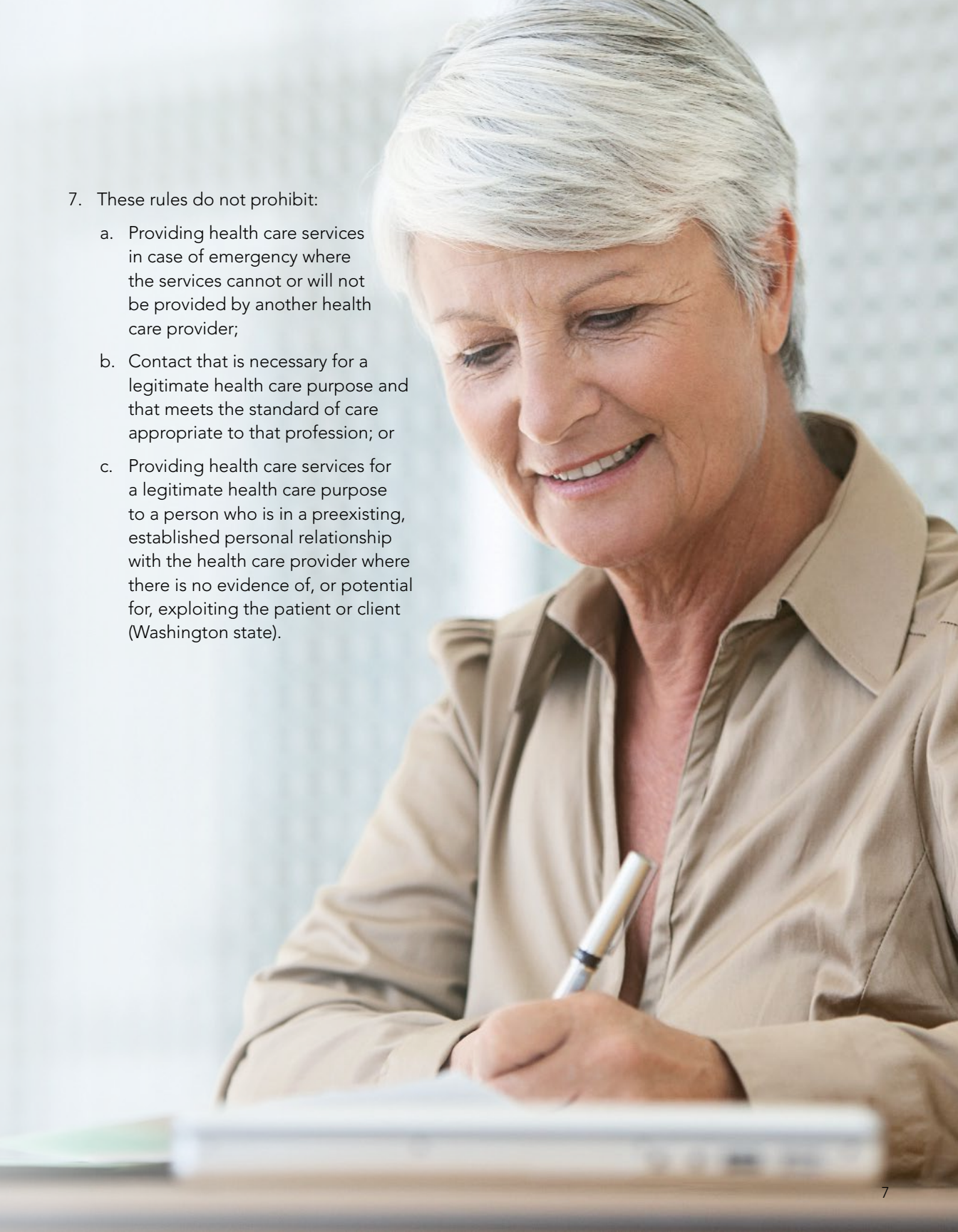
The following are more specific definitions of sexual misconduct designed for all health care providers:

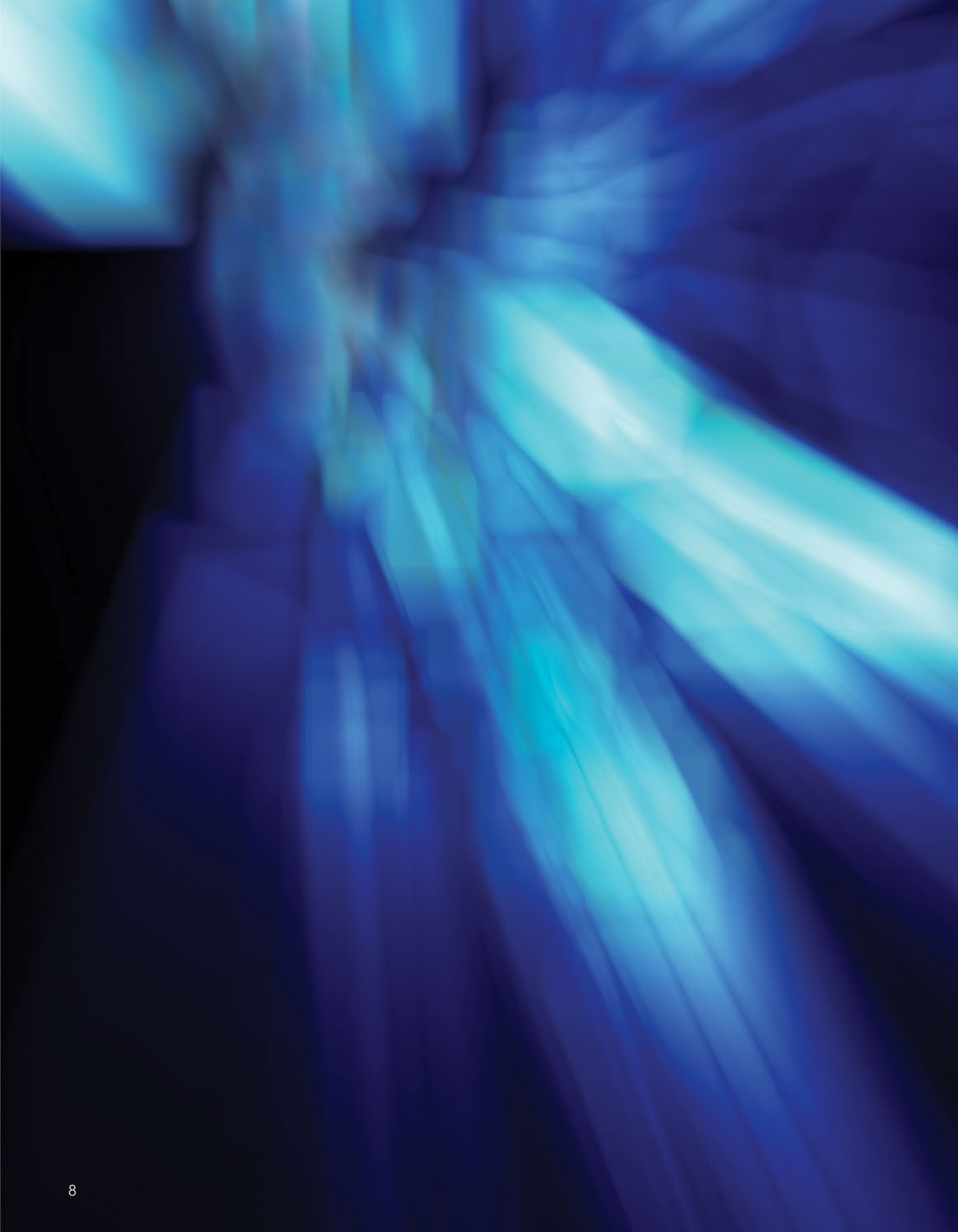
1. A health care provider shall not engage, or attempt to engage, in sexual misconduct with a current patient, client or key party\* inside or outside of the health care setting. Sexual misconduct shall constitute grounds for disciplinary action. Sexual misconduct includes, but is not limited to:
  - a. Sexual intercourse;
  - b. Touching of the breasts, genitals, anus or any sexualized body part, except as consistent with accepted community standards of practice for examination, diagnosis and treatment within the health care practitioner's scope of practice;
  - c. Rubbing against a patient, client or key party for sexual gratification;
  - d. Kissing;
  - e. Hugging, touching, fondling or caressing of a romantic or sexual nature;
  - f. Examination of, or touching, genitals without using gloves;
  - g. Not allowing a patient or client privacy to dress or undress, except as may be necessary in emergencies or custodial situations;
  - h. Not providing the patient or client with a gown or draping, except as may be necessary in emergencies;
  - i. Dressing or undressing in the presence of the patient, client or key party;
  - j. Removing a patient's or client's clothing, gown or draping without consent, emergent medical necessity or being in a custodial setting;
  - k. Encouraging masturbation or other sex acts in the presence of the health care provider;
  - l. Masturbation or other sex acts performed by the health care provider in the presence of the patient, client or key party;
  - m. Suggesting or discussing the possibility of a dating, sexual or romantic relationship prior to the end of the professional relationship;
  - n. Terminating a professional relationship for the purpose of dating or pursuing a romantic or sexual relationship;
  - o. Soliciting a date with a patient, client or key party;
  - p. Discussing the sexual history, preferences or fantasies of the health care provider;
  - q. Any behavior, gestures or expressions that may reasonably be interpreted as seductive or sexual;
  - r. Making statements regarding the patient, client or key party's body, appearance, sexual history or sexual orientation other than for legitimate health care purposes;
  - s. Sexually demeaning behavior, including, but not limited to, any verbal or physical contact which may reasonably be interpreted as demeaning, humiliating, embarrassing, threatening, or harming a patient, client or key party;

\*Key party refers to immediate family members and others who play a role in health care decisions of the patient or client.

- t. Posing, photographing or filming the body, or any body part of a patient, client or key party, other than for legitimate health care purposes; and
  - u. Showing a patient, client or key party sexually explicit materials, other than for legitimate health care purposes.
2. A health care provider shall not:
    - a. Offer to provide health care services in exchange for sexual favors;
    - b. Use health care information to contact the patient, client or key party for the purpose of engaging in sexual misconduct;
    - c. Use health care information or access to health care information to meet or attempt to meet the health care provider's sexual needs.
  3. A health care provider shall not engage, or attempt to engage, in the activities listed in subsection (1) of this section with a former patient, client or key party within two years after the provider-patient/client relationship ends.
  4. After the two-year period of time described in subsection (3) of this section, a health care provider shall not engage, or attempt to engage, in the activities listed in subsection (1) of this section if:
    - a. There is a significant likelihood that the patient, client or key party will seek or require additional services from the health care provider; or
    - b. There is an imbalance of power, influence, opportunity and/or special knowledge of the professional relationship.
  5. When evaluating whether a health care provider is prohibited from engaging or attempting to engage in sexual misconduct, the regulator will consider factors including, but not limited to:
    - a. Documentation of a formal termination and the circumstances of termination of the provider-patient relationship;
    - b. Transfer of care to another health care provider;
    - c. Duration of the provider-patient relationship;
    - d. Amount of time that has passed since the last health care services were provided to the patient or client;
    - e. Communication between the health care provider and the patient or client between the last health care services rendered and commencement of the personal relationship;
    - f. Extent to which the patient's or client's personal or private information was shared with the health care provider;
    - g. Nature of the patient or client's health condition during and since the professional relationship;
    - h. The patient or client's emotional dependence and vulnerability; and
    - i. Normal revisit cycle for the profession and service.
  6. Patient, client or key party initiation or consent does not excuse or negate the health care provider's responsibility.



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7. These rules do not prohibit:
    - a. Providing health care services in case of emergency where the services cannot or will not be provided by another health care provider;
    - b. Contact that is necessary for a legitimate health care purpose and that meets the standard of care appropriate to that profession; or
    - c. Providing health care services for a legitimate health care purpose to a person who is in a preexisting, established personal relationship with the health care provider where there is no evidence of, or potential for, exploiting the patient or client (Washington state).





## Sexual Impropriety

The term includes the following offenses:

1. Making sexually demeaning or sexually suggestive comments about or to a patient, including comments about a patient's body or undergarments.
2. Unnecessarily exposing a patient's body or watching a patient dress or undress, unless for therapeutic purposes or the patient specifically requests assistance.
3. Examining or touching genitals without the use of gloves when performing an otherwise appropriate examination.
4. Discussing or commenting on a patient's potential sexual performance, or requesting details of a patient's sexual history or preferences during an examination or consultation, except when the examination or consultation is pertinent to the issue of sexual function, dysfunction or reproductive health care. Discussion of a patient's sexual practices and preferences shall be fully documented in the patient's chart.
5. Soliciting a date from a patient.
6. Volunteering information to a patient about one's sexual problems, preferences or fantasies.

## Sexual Violation

The term includes the following offenses:

1. Sexual intercourse between a nurse and a patient during the professional relationship.
2. Genital-to-genital contact between a nurse and a patient during the professional relationship.
3. Oral-to-genital contact between a nurse and a patient during the professional relationship.
4. Touching of breasts, genitals or any other body part for any purpose other than appropriate examination or treatment.
5. Using prolonged or improper examination techniques or continuing examination techniques after the patient has refused or withdrawn consent.
6. Encouraging a patient to masturbate in the presence of the nurse or masturbating while a patient is present.
7. Providing or offering to provide drugs or treatment in exchange for sexual favors.
8. Using or causing the use of anesthesia or any other drug affecting consciousness for the purpose of engaging in conduct that would constitute a sexual impropriety or sexual violation (Pennsylvania State Board of Nursing).

## OTHER RELEVANT DEFINITIONS:

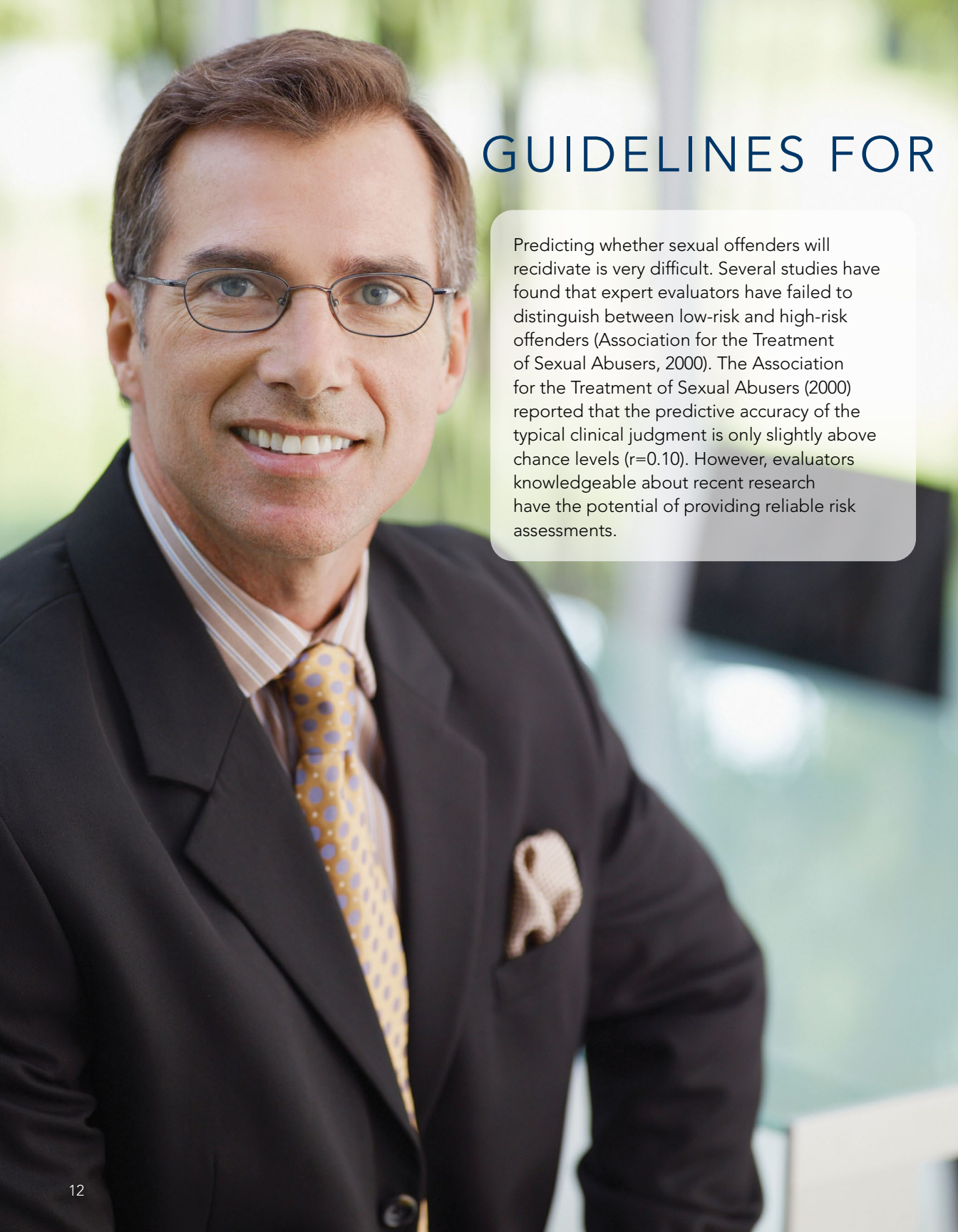
### Nurse-Patient Relationship

1. A nurse or unlicensed assistive personnel (UAP) shall not engage or attempt to engage a former client, or former client's, immediate family member or significant other, in sexual or romantic conduct if such conduct would constitute abuse of the nurse-patient relationship. The nurse-patient relationship is abused when a nurse or nursing technician uses and/or benefits from the nurse's professional status and the vulnerability of the client due to the client's condition or status as a patient.
  - a. Due to the unique vulnerability of mental health and chemical dependency clients, nurses and nursing technicians are prohibited from engaging in or attempting to engage in sexual or romantic conduct with such former clients, or their immediate family or significant other, for a period of at least two years after termination of nursing services. After two years, sexual or romantic conduct may be permitted with a former mental health or chemical dependency client, but only if the conduct would not constitute abuse of the nurse-client relationship.
    - i. The amount of time that has passed since nursing services were terminated;
    - ii. The nature and duration of the nurse-client relationship, the extent to which there exists an ongoing nurse-client relationship following the termination of services, and whether the client is reasonably anticipated to become a client of the nurse in the future;
    - iii. The circumstances of the cessation or termination of the nurse-client relationship;
    - iv. The former client's personal history;
    - v. The former client's current or past mental status, and whether the client has been the recipient of mental health services;
    - vi. The likelihood of an adverse impact on the former client and others;
    - vii. Any statements or actions made by the nurse during the course of treatment suggesting or inviting the possibility of sexual or romantic conduct;
    - viii. Where the conduct is with a client's immediate family member or significant other, whether such a person is vulnerable to being induced into such relationship due to the condition or treatment of the client or the overall circumstances; and
    - ix. Key party is defined as immediate family members and others who would be reasonably expected to play a significant role in health care decisions of the patient or client and includes, but is not limited to, the spouse, domestic partner, sibling, parent, child, guardian and person authorized to make health care decisions of the patient or client (Washington state).
  - b. Factors that the BON may consider in determining whether there was abuse of the nurse-client relationship include, but are not limited to:
    - i. The amount of time that has passed since nursing services were terminated;
    - ii. The nature and duration of the nurse-client relationship, the extent to which there exists an ongoing nurse-client relationship following the termination of services, and whether the client is reasonably anticipated to become a client of the nurse in the future;
    - iii. The circumstances of the cessation or termination of the nurse-client relationship;
    - iv. The former client's personal history;
    - v. The former client's current or past mental status, and whether the client has been the recipient of mental health services;
    - vi. The likelihood of an adverse impact on the former client and others;
    - vii. Any statements or actions made by the nurse during the course of treatment suggesting or inviting the possibility of sexual or romantic conduct;
    - viii. Where the conduct is with a client's immediate family member or significant other, whether such a person is vulnerable to being induced into such relationship due to the condition or treatment of the client or the overall circumstances; and
    - ix. Key party is defined as immediate family members and others who would be reasonably expected to play a significant role in health care decisions of the patient or client and includes, but is not limited to, the spouse, domestic partner, sibling, parent, child, guardian and person authorized to make health care decisions of the patient or client (Washington state).

## Professional Relationship

1. For a nurse not involved in providing mental health services, the relationship which shall be deemed to exist for a period of time beginning with the first professional contact or consultation between a nurse and patient and ending with the discharge from or discontinuance of services by the nurse or the nurse's employer. The administration of emergency medical treatment or transitory trauma care will not be deemed a professional relationship.
2. For a nurse involved in providing mental health services, the relationship which shall be deemed to exist for a period of time beginning with the first professional contact or consultation between the nurse and patient and ending two years after discharge from or discontinuance of services. For a patient who is a minor, a professional relationship shall be deemed to exist for two years or until one year after the age of majority, whichever is longer, after discharge from or discontinuance of services (Pennsylvania State Board of Nursing).





# GUIDELINES FOR

Predicting whether sexual offenders will recidivate is very difficult. Several studies have found that expert evaluators have failed to distinguish between low-risk and high-risk offenders (Association for the Treatment of Sexual Abusers, 2000). The Association for the Treatment of Sexual Abusers (2000) reported that the predictive accuracy of the typical clinical judgment is only slightly above chance levels ( $r=0.10$ ). However, evaluators knowledgeable about recent research have the potential of providing reliable risk assessments.



# SELECTING AN EVALUATOR

The following are criteria that BONs might consider when selecting an expert evaluator to conduct an evaluation of the nurse accused of sexual misconduct. At a minimum, evaluators should be selected on the basis of their membership in and adherence to the practice and ethical standards espoused by professional associations and BONs, such as the Association for the Treatment of Sexual Abusers (ATSA) or the American Psychology-Law Society (AP-LS). In addition:

- Consider a senior practitioner in his/her field: a psychologist, nurse, social worker or psychiatrist who has experience evaluating health care professionals.
- Consider an evaluator who uses a multidisciplinary approach to evaluating sexual misconduct cases. The multidisciplinary approach can include screening for co-morbid disorders, such as attention deficit hyperactivity disorder (ADHD), mood disorders, Axis II disorders, cognitive impairment, dementia, compulsivity, as well as any underlying physical disorder.
- Consider evaluators who are certified in performing neuropsychiatric testing.
- Look for demonstrated skill in setting up rehabilitation plans specifically for patients who are health care providers.
- Obtain references from those who have used the evaluator's services (ideally for third-party evaluations).

The prospective evaluator should:

- Have an understanding of public policy and safety issues, and know how to perform an evaluation for a third party (the BON). (An evaluator does not have to be a forensic psychologist, but does need to realize he/she is serving a different purpose than providing routine therapy services.);
- Be willing to review detailed descriptions of allegations;
- Be willing to broaden sources of evaluation, e.g., at least a brief phone interview with the complainant to assure a clear picture of what is alleged;
- Be committed to obtaining an understanding of the nursing field involved; and
- Be willing to consult with nurses, not only regarding the nursing field, but also the setting, to gain appreciation of the elements, potential risk and the ethical implications of the situation.

Many states have websites that provide information on the selection of experts for conducting assessments of sexual offender. An example of such a website is <http://www2.state.id.us/socb>. See Box 1 for the criteria cited on Idaho's Sexual Offender Classification Board (SOCB) website. See Case 3 in this booklet to illustrate how to use these guidelines to select an evaluator.

## Box 1

### Idaho State Website Suggestions for Evaluator Criteria for Sexual Misconduct Offenders

- Certified evaluator; and
- Licensed psychiatrist or licensed master's or doctoral level psychologist, social worker, counselor or marriage/family therapist.

#### Specialized Training

- Must have attended 200 hours of formal conferences, symposia or seminars related to the treatment and evaluation of adult sexual offenders. A list of the qualifying scope of training is indicated in the SOCB administrative rules or may be requested from the SOCB.

#### Experience Qualifications

- At least 2,000 hours of adult sexual offender treatment and evaluation experience within the preceding 10 years, including:
  - At least 250 hours of adult sexual offender evaluation experience; and
  - At least 250 hours of adult sexual offender treatment experience.

#### Understanding

- Should have a thorough understanding and a broad knowledge of sexuality in the general population.
- Should also have a good understanding of basic theories and typologies of sexual offenders and sexual assault victims.

#### Continuing Education Requirement

- Attendance of 40 hours at formal conferences, symposia or seminars related to the treatment and evaluation of adult sexual offenders within the preceding two years is required to maintain certification.
- Up to 10 of these hours may be obtained from online educational sources during a two-year period.

Please see Box 2 for the *Standards for Psychosexual Evaluations*, required by Idaho's Sexual Offender Classification Board website.

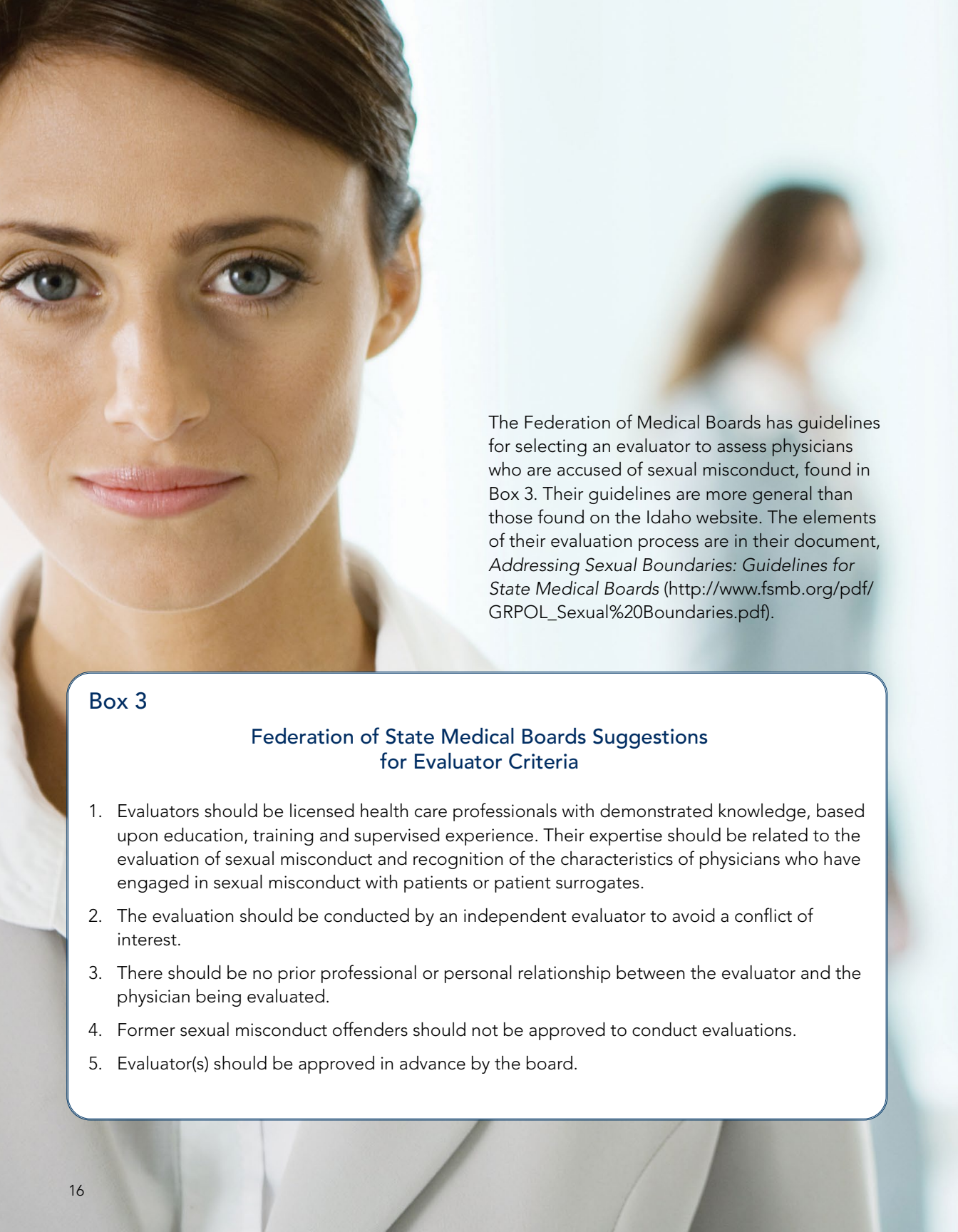
## Box 2

### Standards for Psychosexual Evaluations: Idaho State Website

Outlined below are required areas of mental health sex offense-specific evaluations. It is minimally required that evaluators use some type of offense-specific psychological testing. No single test should be seen as absolute or predictive; rather, results should be seen as contributing to the overall evaluation of the sex offender and his/her risk to the community. Effective evaluations must include multiple risk factors. The evaluator should be cognizant that an offender's self-report is demonstrated by research to be the least reliable source of information during the evaluation and shall take steps not to rely solely on self-report information.

1. Accurate identification of the offender, including his/her current legal status and reason(s) for conducting the evaluation.
2. A list of all sources of information utilized in the evaluation.
3. Results of all psychological, physiological, medical testing, and examinations, including a summary of the clinical interview and a complete DSM-IV diagnosis.
4. Background information to include family; medical; educational; military; interpersonal development; sexual; occupational; recreational; criminal; and as applicable, institutional history.
5. Offense history to include: specific descriptions of the convicting offense(s) as explained by the offender and the victim(s) or the victim(s) representative; number of victims; characteristics of victim(s); relationship of offender to victim(s); number of violations of each victim; seriousness of offense(s); and predatory nature of offense(s).
6. A sexual history provided by the offender. Verification by polygraph is highly recommended.
7. Assessment of offender's sexual behavior, general characteristics, including sexual deviances, and personality profile.
8. Risk of reoffense, risk to the community, amenability to treatment, intent of offender upon release to the community, and the basis for the assessed risk.
9. Recommendation if offender is an appropriate candidate for future violent sexual predator review and rationale for the recommendation. For offenders being reviewed by the Board, a recommendation for or against classification of offender as a violent sexual predator and rationale for the recommendation.

Polygraphy, physiological and/or viewing time measures are highly recommended, but not required. Those recommendations are found at: <http://www2.state.id.us/socb>.




The Federation of Medical Boards has guidelines for selecting an evaluator to assess physicians who are accused of sexual misconduct, found in Box 3. Their guidelines are more general than those found on the Idaho website. The elements of their evaluation process are in their document, *Addressing Sexual Boundaries: Guidelines for State Medical Boards* ([http://www.fsmb.org/pdf/GRPOL\\_Sexual%20Boundaries.pdf](http://www.fsmb.org/pdf/GRPOL_Sexual%20Boundaries.pdf)).

### Box 3

#### Federation of State Medical Boards Suggestions for Evaluator Criteria

1. Evaluators should be licensed health care professionals with demonstrated knowledge, based upon education, training and supervised experience. Their expertise should be related to the evaluation of sexual misconduct and recognition of the characteristics of physicians who have engaged in sexual misconduct with patients or patient surrogates.
2. The evaluation should be conducted by an independent evaluator to avoid a conflict of interest.
3. There should be no prior professional or personal relationship between the evaluator and the physician being evaluated.
4. Former sexual misconduct offenders should not be approved to conduct evaluations.
5. Evaluator(s) should be approved in advance by the board.





The American Psychology-Law Society released their *Specialty Guidelines for Forensic Psychology* on Sept. 2, 2008, (<http://www.ap-ls.org/links/92908sgfp.pdf>). Under Section 4, which outlines the competence of the evaluator, the following criteria are specified:

- Scope of competence;
- Gaining and maintaining competence;
- Representing competencies;
- Knowledge of the legal system and the legal rights of the individuals;
- Knowledge of the scientific foundation for opinions and testimony;
- Knowledge of the scientific foundation for teaching and research;
- Considering the impact of personal beliefs and experience;
- Appreciation of individual differences; and
- Appropriate use of services and products.

The ATSA set their practice standards in 2005 and their general training and qualification standards can be found in Box 4.

It is anticipated that BONs will review these criteria and choose those that would best serve their needs.

## Box 4

### General Training and Qualification: Association for the Treatment of Sexual Abusers

- Professionals providing clinical service, who do not have graduate or professional degrees, have had specific training and experience in working with individuals who sexually offend and are under the direct supervision of a qualified mental health professional.
- Professionals providing clinical services participate in a minimum of 2,000 supervised hours of face-to-face clinical contact with individuals who sexually offend before providing unsupervised clinical services.
- Professionals obtain and document annual continuing education in the field of sexual abuse. Continuing education includes courses, seminars, conferences, workshops, and other training experiences.
- Professionals have education, training, and experience in the evaluation, treatment, and management of individuals who sexually offend. Members working with a specialized population have education, training, and experience specific to that population (for example, clients with developmental disabilities, or clients with mental illness).
- Professionals complete courses, training, and/or gain experience in order to become knowledgeable about the following areas (the order does not indicate priority):
  - Assessment and diagnosis;
  - Cognitive therapy;
  - Counseling and psychotherapy;
  - Cultural/ethnic issues;
  - Ethics as applied to working with a forensic population;
  - Human development with special attention to sexual development;
  - Interviewing skills;
  - Knowledge of family dynamics as related to sex offending;
  - Psychometric and psychophysiological testing;
  - Psychopathology;
  - Relapse prevention;
  - Relationship and social skills training;
  - Risk assessment;
  - Sexual arousal control;
  - Social support networks; and
  - Victim awareness and empathy.

## GUIDELINES FOR ESTABLISHING SANCTIONS FOR SEXUAL ABUSERS

The expert evaluator that the BON hires will consider a range of risk factors. No single risk factor can be linked to recidivism of sexual offenders. The Association for the Treatment of Sexual Abusers (2000) reports on the strongest predictors of sexual offense recidivism, as obtained from a meta-analysis by Hanson and Bussière (1998). All of these factors have been replicated in at least four studies, thereby providing evaluators with some evidence upon which to base their decisions. The single strongest predictor was sexual interest in children as measured by phallometric measurement ( $r=0.32$ , with total sample size of 4,853 and a total of seven studies). While the correlations are weak, the following are also identified as risks, in descending order:

- Any deviant sexual preference ( $r=0.22$ ; sample size 570; five studies)
- Prior sexual offenses ( $r=0.19$ ; sample size 11,294; 29 studies)
- Treatment drop out ( $r=0.17$ ; sample size 806; six studies)
- Any stranger victims ( $r=0.15$ ; sample size 465; four studies)
- Antisocial personality ( $r=0.14$ ; 811 sample size; six studies)
- Any prior offenses ( $r=0.13$ ; sample size 8,683; 20 studies)
- Age of accused (young) ( $r=0.13$ ; sample size 6,969; 21 studies)
- Early onset of sexual deviance ( $r=0.12$ ; sample size 919; four studies)
- Any unrelated victims ( $r=0.11$ ; sample size 6,889; 21 studies)
- Any boy victims ( $r=0.11$ ; sample size 10,294; 19 studies)
- Single (never married) ( $r=0.11$ ; sample size 2,850; eight studies)
- Diverse sexual crimes ( $r=0.10$ ; sample size 6,011; five studies)

The Association for the Treatment of Sexual Abusers (2000) cautions that this list is not an exhaustive list, but an evidence-based starting point for evaluators. New items should be added as the evidence becomes available. Anger, for example, did not rank high enough in the meta-analysis to be included, though chronic hostility has shown to predict recidivism in other studies. Clinicians are also interested in dynamic life factors, rather than the listed static factors, though there has been less research in that area. Preliminary research, however, supports the following dynamic factors (Association for the Treatment of Sexual Abusers, 2000):

- Intimacy deficits – problems with forming satisfactory love relationships.
- Negative peer influences – peers with deviant lifestyles or inadequate coping strategies.
- Attitude tolerant of sexual offending – feeling that women like being raped or that adult-child sex is harmless.
- Problems with emotional/sexual self-regulation – feelings of sexual entitlement or the tendency to cope using sexual thoughts or behavior.
- General problems with self-regulation – poor self-control or unable to follow societal conventions.


Other dynamic factors include substance abuse, acute anger and lack of cooperation with community supervision. Scales have been developed that combine individual risk factors into summary scores, and examples can be found at <http://www.atsa.com/pdfs/InfoPack-Risk.pdf>. While there is agreement that evaluators should consider valid risk factors, disagreement arises on the best method to combine the factors.

Surowiec (2010), in reviewing the literature on past criminal behavior predicting recidivism, recommends three instruments for assessing criminality that evaluators might find useful.

See Figure 1 for the Washington state sanction schedule and refer to the following document for an example from the Texas Board of Nursing: <http://www.bon.state.tx.us/disciplinaryaction/pdfs/sexmis.pdf>.

Figure 1

## Washington's 2009 Mandatory Sanction Schedule Sexual Misconduct or Contact

SEXUAL MISCONDUCT OR CONTACT (including conviction for sexual misconduct)				
Severity	Tier/Conduct	Sanction Range		Duration
		In consideration of aggravating and mitigating circumstances		
		Minimum	Maximum	
least  greatest	<b>A.</b> Inappropriate conduct, contact or statements of a sexual or romantic nature.	Conditions that may include reprimand, training, monitoring, probation, supervision, evaluation, etc.	Oversight for three years, which may include reprimand, training, monitoring, supervision, evaluation, probation, suspension, etc.	Zero to three years
	<b>B.</b> Sexual contact, romantic relationship or sexual statements that risk or result in patient harm.	Oversight for two years, which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc.	Oversight for five years, which may include suspension, probation, practice restrictions, training, monitoring, supervision, evaluation, etc., or revocation.	Two to five years, unless revocation
	<b>C.</b> Sexual contact, including, but not limited to, contact involving force and/or intimidation.	One year suspension and oversight for five additional years, which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc., and demonstration of successful completion of evaluation and treatment.	Permanent conditions, restrictions or revocation.	Six years to permanent

## FITNESS FOR PRACTICE GUIDELINES

BONs must make difficult decisions about whether nurses are fit to practice after they've successfully completed a treatment program for sexual offenders. The following are some guidelines they might consider. See Case 3 to illustrate how these guidelines might be applied to a case. Carr (2003) suggests elements for professional sexual misconduct monitoring with physicians. Those have been adapted in Box 5 as possible elements of monitoring contracts with nurses.

### Box 5

#### Essential Elements of a Professional Sexual Misconduct Monitoring Contract

- Agreement for sexual abstinence outside of the primary relationship.
- Agreement for abstinence from any form of cybersex, including, but not limited to: accessing pornographic websites; soliciting sex from the Internet; texting sexual messages; taking inappropriate sexual photos; and e-mailing, blogging, Facebooking, Tweeting, Skyping, webcamming, instant messaging, posting, etc., sexual messages on the Internet.
- Abstinence from mood-altering drugs/alcohol, if indicated, with drug screens.
- Workplace monitoring with regular reports.
- Nurse's physician and therapist, if indicated, acceptable to the BON.
- Couples therapy, if indicated.
- Compliance with any prescribed medications.
- Mandates for ongoing training, such as ethical boundaries, if indicated.
- Notification of appropriate staff in the workplace of past issue(s). These personnel should not act as detectives, but should report concerns promptly.
- Patient surveillance forms disguised to look like patient satisfaction forms, if indicated.
- Use of informed, licensed chaperones.
- Group therapy with other professionals, if indicated.
- Sex Addicts Anonymous groups, if indicated.
- Other 12-step groups, as indicated.
- Relapse prevention plan.
- Peer practice monitor.
- Agreement for support and encourage recovery for spouse/significant family and other family.
- Agreement for targeted practice, if limited.
- Agreement for provisions for portability if nurse should move.
- Agreement to submit to polygraph, if warranted.
- Agreement to allow free exchange of information between all involved, including the BON.



Box 6 presents some possible general guidelines, gleaned from the substance abuse literature, that the expert evaluator will consider when deciding if the rehabilitated sex offender is fit for practice. Before considering fitness for practice guidelines, the following should have been documented to the BON:

- The nurse must have successfully participated in a treatment process;
- A specific relapse plan should be designed; and
- The nurse must provide the BON with documentation of adherence to the treatment plan.

## Box 6

### Guidelines for Fitness for Practice

- Global Assessment Functioning (GAF) of at least 70.
- Has adequate control of emotions (such as sadness, anxiety, anger, fear, etc.).
- Has adequate energy to perform eight hours of work per day.
- Has adequate cognitive capacity (in terms of ability to focus, concentrate, remember things and organize material).
- Has reached a comfort level in interpersonal interactions.
- Is not abusing substances or engaging in compulsive behaviors of any kind (overspending, overeating, sexual addictions, alcohol, gambling, etc.).
- Has reached a comfort level in coping with circumstances that led up to treatment.
- Is agreeable to transition into work hours and responsibilities (such as part-time work for the first one to two weeks).
- Has achieved competence to handle ethical and professional responsibilities.
- Is willing to participate in posttreatment surveillance (i.e., feedback forms from coworkers and patients, polygraphs).



Some further guidelines for regulators include:

- Ask the sexual abusers what they have learned to stop the behavior.
- What specific steps they are going to take to prevent it from ever happening again?
- Let the abusers know that they do not get credit for leaving themselves in harm's way.
- The abusers should be able to recognize and avoid the red flags (J. Tallant, personal communication, April 8, 2009).

There is evidence to support that health care professionals who violate sexual boundaries can successfully return to work without recidivism (Abel, Osborn, & Warberg, 1998). Abel, Osborn, & Warberg (1998) report that of the cases treated at the Behavioral Medicine Institute of Atlanta, 47.7 percent returned to practice with a recidivism rate of less than 1 percent in seven years. With the selection of an expert evaluator (Boxes 1-4) and when the offending nurse receives expert treatment, the BONs can use the information in Boxes 5 and 6 for ongoing surveillance of the offending nurse, in their very difficult job of protecting the public in sexual misconduct cases.





## FRAMEWORK FOR DECIDING WHEN/HOW TO TAKE ACTION IN SEXUAL MISCONDUCT CASES

This comprehensive framework will be valuable to BONs as they review complaints of sexual misconduct. See Cases 1 and 3 at the end of this booklet to illustrate how this framework might be used.

**FIRST CONSIDER: Should the complaint be opened for investigation in the first place? If it should, decide what priority it should be given (e.g., any potential emergency action is priority A and all other sexual misconduct is priority B).**

- How egregious is the misconduct alleged?
- Were there aggravating circumstances that warrant higher priority, such as force, intimidation, stalking or highly vulnerable patient (e.g., mental health patient, comatose)?
- What is the source of or nature of the complaint?
- Is it anonymous or possibly biased? Is it rumor and hearsay versus observation (e.g., "I heard that ...")?

- What is the alleged victim's condition/diagnosis? Is there any indication of cognitive impairment, temporary (postoperative) or otherwise (such as dementia)?
- Is there a history of similar allegations against other staff?
- Do we know anything about the alleged perpetrator? Is there any prior history such as an allegations in another place?

**NEXT CONSIDER: Once opened for investigation, can we develop the case and when will we have a case worth charging (*prima facie* case)? Where is the evidence located? What can I get? Where can I find it?**

- Is there forensic evidence (e.g., a rape kit)? Were there medical reports?
- If it occurred at a facility, was an internal investigation conducted? Can we get a copy of the report? (Note: has an initial investigation by the facility had a dilatory effect on our investigation?) We may have to obtain a subpoena.
- Were there witnesses to the incident or other relevant observations beyond the victim? Oftentimes people don't see the incident, but they may see other things, such as someone running out of the room, closing the door, etc.
- How credible are the alleged victim's allegations? Is the story consistent to various parties? Was there appropriate postincident behavior? Sometimes victims wait awhile and it might be appropriate, but the investigators must know about it. Did the victim report to someone right after the episode or provide credible reasons why not? How does the victim present as a witness generally?
- Consider the state's duty to report requirements. If none, consider contacting law enforcement anyway (see Law Enforcement Coordination section).

**ALSO CONSIDER:**

**What is the licensure status of the alleged perpetrator?**

- Is the alleged perpetrator still working at the facility?
- If he/she is fired or on administrative leave, is there a chance he/she is working elsewhere?
- Ask the licensee about work status when you interview him/her, as this is relevant to making an argument for imminent danger justifying a summary action.

- Presume the alleged perpetrator is working if he/she is actively licensed, regardless of what anyone says.
- Find out if the individual is licensed in more than one state; if so, where? Are there any applications open?
- Is the nurse amenable to having his/her license put on an inactive status, voluntarily, pending resolution?

**Law enforcement coordination: Is law enforcement involved? Should they be?**

Initiate coordination:

- At what stage is the investigation? You must know with whom to communicate. Does the alleged victim anticipate filing charges?
- If there is still an investigation, then reach out to the detective/special assault unit and ask for what information they have. Ask if you can shadow the officers as they conduct key interviews, especially when the alleged victim or licensee is to be interviewed. If the law enforcement investigation is stalled or stale, ask why. Acknowledge that they have different levels of proof and a different focus on their investigation.
- How much of the critical evidence is now tied up in police files? Will they release a copy?
- Can you rely on what was filed in criminal court alone? Usually mere fact of criminal charges does not equal professional misconduct. An Affidavit of Probable Cause is not evidence; instead it is the affiant swearing there is sufficient evidence in the police report to support the charges. Remember that it's double hearsay. Usually the investigating officer tells the prosecuting attorney what happened and then the prosecuting attorney reiterates that

to the judge in his affidavit. It still might be reliable enough to base the initial charges on. However, you will likely need to have the underlying police report and/or the officer, victim and other witnesses available to testify at the time of the expedited hearing, if you want a summary action.

Note: There are risks in getting ahead of a county prosecutor. If the police report is already filed with the prosecuting attorney for precharging review, reach out to the prosecuting attorney. Questions to ask include:

- Have you reviewed the file?
- Do you anticipate filing charges and for what sort of crimes?
- What are your proof concerns?
- Would you have a problem with us moving ahead and using evidence from the police report?
- If we file charges, it is likely that the licensee will receive a copy of everything relied upon, including what was obtained in confidence from the police investigation, such as contact information for witnesses. Will the regulatory action result in a release of the internal police investigation to the respondent precriminal charges? Will this spoil the authority's investigation against the licensee? Will it spoil your working relationship with the local authorities?

### **How should you best approach alleged victims/witnesses when it is appropriate to investigate?**

- Interview the victim separately in a safe environment whenever possible.
- Ask questions in a neutral, objective and nonjudgmental fashion.
- If possible, record the interview.
- A phone interview may be all that is available.
- Get the victim's statement in writing.
- Take notes as to what he/she says, transpose and go over the notes with him/her.
- Make sure victims/witnesses agree with every aspect of content and then have him/her sign the statement.
- Consider composing a memo to file by the investigator as to what he/she observed/heard, in addition to the alleged victim's statement; this is often helpful because subsequent legal review by the attorney will be used to aid the BON in determining sufficiency.
- It is beneficial to have two investigators. One investigator should ask questions – preferably this investigator is the same sex as the victim and has a calming disposition, if appropriate. The other investigator can record impressions, take careful notes of content and make accurate and detailed observations as to how well the victim presents as a potential live witness.

### **Are you legally barred from disseminating preconviction data?**

- If you are charging the licensee while he/she is still being investigated by the police or in the case of a deferred prosecution, take steps to bar further release of all preconviction data to the public, since you are relying on this information.
- Move for a protective order regarding the evidence and keep the fact the licensee is being investigated out of your pleadings or discussions with the media.
- Once criminal charges are filed, however, the licensee is entitled to discovery and usually gets most of the police report.
- If the authority is opposed to your BON getting ahead of the criminal matter, ask whether they would still be willing to share their investigative results so that you can prepare your case. Then once the local authorities are ready to file their charges, you can do the same in your forum.

**If we are barred from using police investigation materials or it's not advisable, can we, and when should we, develop our own investigation? Will this result in impeachable evidence?**

- The more you document the alleged victim's or other witnesses' story, the more you create opportunities for opposing counsel to point out inconsistencies.
- If you go to hearing before the prosecuting attorney does, do you create the risk that the defense counsel gets to pretry the criminal matter and test the case in advance to find weaknesses?
- Can you be sure fragile witnesses can stand two full hearings?
- What is the greater goal, taking the license or incarcerating the predator?

**Is the licensee incarcerated?**

- Arrested and released without charges or bail? Then the nurse is still free to practice and the law enforcement investigation remains nonpublic.
- Arrested, charged and on bail? The criminal information is public. Ask the prosecutor to request that the judge restrict the licensee from practicing, pending trial.
- In jail and has not posted bail? How high is bail set? They only need to come up with 10 percent of the bail amount and there is no way of knowing when he/she might post bail. How soon is the trial?



ANTICIPATE



# MEDIA RESPONSE

- Has the incident gone public or might it go public? Arrests/charges are a matter of public information; witnesses could go to the press at any point.
- Prepare a media release in anticipation.
- Consider developing, in every such case, a standard report sent from the frontline staff up the organization's hierarchy so that upper management won't be blindsided by outside inquiries or media reports.
- Rapid response to media inquiries is essential; you can't put them off. For example, you might say, "Let me give you the person who can give you the answers as soon as possible." Quickly ascertain the appropriate spokesperson and direct them to respond promptly.
- Decide on and stick with a consistent message during the investigation. For example:
  - "We take these sorts of complaints very seriously."
  - "Upon hearing of these allegations, we immediately opened a complaint on a priority basis."
  - "Allegations of this nature are serious and must be thoroughly investigated."
  - "We are still actively investigating this matter and are working in close coordination with local law enforcement."

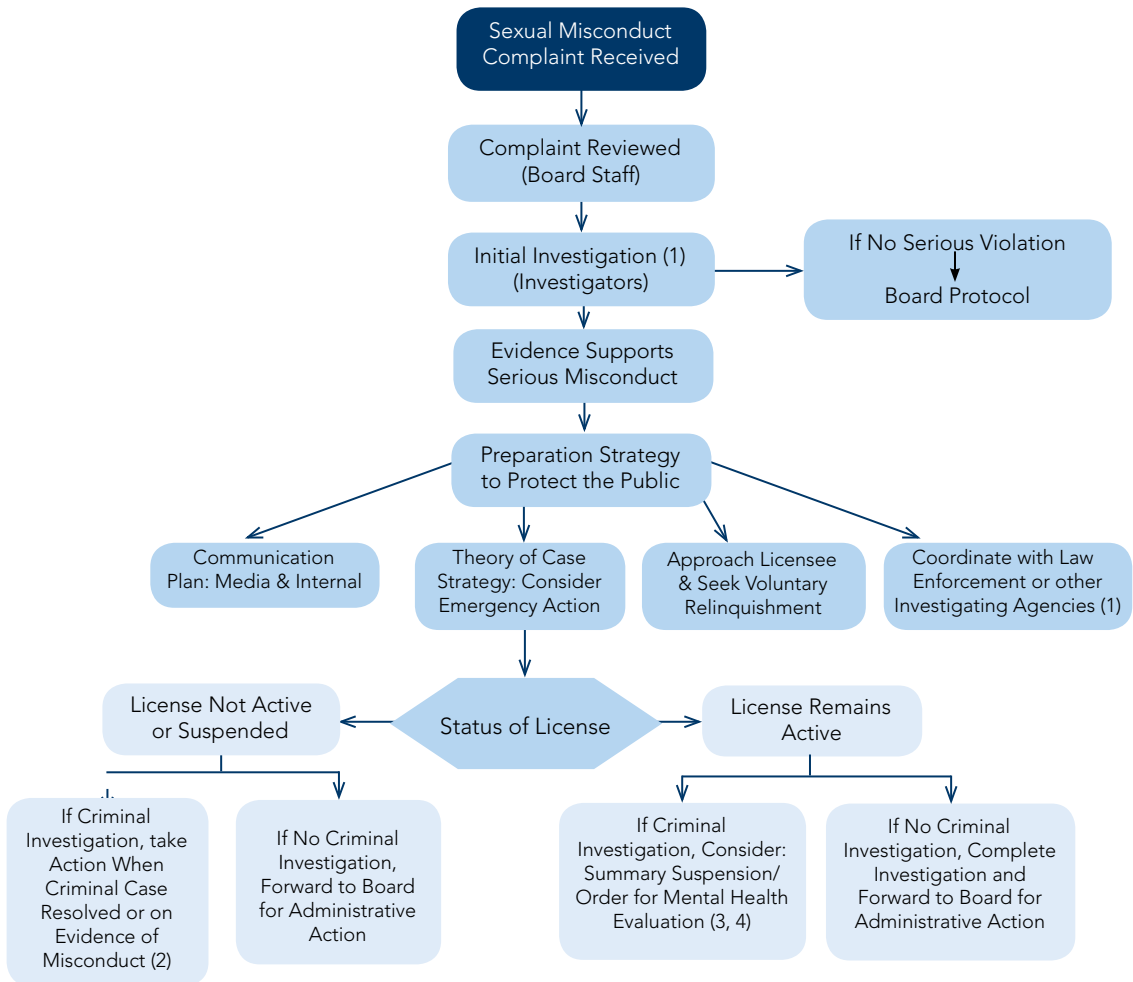
## **Summary (emergency) action or not?**

Once you have developed minimum legal sufficiency in terms of supporting evidence and have the green light from law enforcement, how should you proceed?

- Summary action or standard charges? Even if you have serious allegations and enough to charge, strategically, there are sexual misconduct cases where it would be more effective to not risk rushing to full hearing on an expedited basis. Instead, consider issuing standard charges and using discovery to build a better case and/or anticipate that the media coverage of the charges will result in more victims coming forward. Also, if the criminal matter resolves with a plea bargain, you can amend your charges to cite only the new conviction and avoid having to prove the underlying case.

## SEXUAL MISCONDUCT PATHWAY: BON MANAGEMENT

The following is a user-friendly summary of major points for BONs to consider when reviewing sexual misconduct cases. See Case 1 to illustrate how to use this pathway.



1. Administrative investigations become secondary to a criminal investigation. It is important to understand that law enforcement may need to protect evidence involving their investigation from becoming public knowledge. Offering assistance may help to involve the nursing board in the investigative process. It may also keep board investigators close to the criminal progression and details of the allegations. It is important that agencies understand what the board will need to proceed with action on the nurse's license.
2. If the nurse remains inactive from nursing practice it may be important to delay administrative action until criminal action has been completed or until reports are released by other agencies (police, courts, etc.). Many nursing board laws and rules include charges for levels of criminal prosecution.
3. To protect the public it may be necessary to take action prior to a criminal action (or in lieu of a criminal action) being completed realizing that the action may not include all possible charges by the board.
4. Consider making a formal request to the court or law enforcement for the licensee to make their license inactive (even if not granted).



## HIGH-PROFILE CASE ON SEXUAL MISCONDUCT

The following cases are based upon real incidents adjudicated by BONs. Some information has been changed to protect the anonymity of those involved.

### CASE 1

The investigator received a complaint that a male nurse (Mr. A) had been accused of a rape in a neighboring state. Mr. A had allegedly raped the wife of the complainant while Mr. A was hosting a swingers' party. The complainant attached nude photos of Mr. A and his wife (also an RN) from the Internet. The couple was active on a proswinger website and had elicited contact with other swingers.

The complainant noted that at the party, Mr. A had penetrated the complainant's wife while in the hot tub. He stated that it was discussed prior to the party that the rules forbid any sexual intercourse with others' spouses. The complainant went on to discuss specifics of swinger parties and rules that are laid out in advance.

The complainant also noted that his wife was given some liquor from Mr. A's bar that he believes was spiked with a narcotic. His wife complained of being drugged prior to the incident with Mr. A in the hot tub.

A police report had been filed, but the police noted that they did not have a criminal case. Members were at the party as swingers, they were in various stages of dress and there was noted alcohol use. The complainant stated he understood that there would probably not be criminal charges, but insisted his wife was raped by Mr. A and that the BON should monitor his behaviors.

The BON investigator continued to investigate these complaints and gathered police reports.

The BON was then contacted by a hospital in their state and told that Mr. A was being charged with rape of a patient. The patient claimed that Mr. A had drugged her with morphine and then forced her to have oral sex with him. The facility police reported that the bed sheet had been secured and sent for DNA testing. They had to get a court order to have Mr. A provide a DNA specimen and were able to get an oral swab from him.

Issues for the BON to consider:

- The nurse has an active license and he can still work; yet, he is facing possible first-degree felony charges.
- There are no charges against him. The police want to wait for the DNA results before charging him with a crime.
- There are very serious accusations, but the BON cannot go public with these because the police will not give them the report until the prosecutor releases it.
- The nurse also has licensure in an adjoining state.

## Discussion/Recommendations:

1. What can you do while the police are awaiting the results of the DNA results? In this case, the DNA is delayed because the state crime lab has a backlog of cases to complete. Contact the nurse and ask him to voluntarily go inactive. If he refuses to go inactive, the BON might order a mental health evaluation.
2. What should you do if you hear he is working at another hospital in the area as an agency nurse? Contact them and ask if he is working there, though you may be unable to tell them why you are asking.
3. Contact local facilities (hospitals, nursing homes) and local nursing agencies asking if he is employed with them. He could be connected to several other agencies. If you locate any employers, point them to available public records (such as court actions or police reports). Contact his agency, though he could be connected with another nursing agency and could be working elsewhere.

## Conclusion of Case

Mr. A is arrested and charged with a first-degree felony. The BON investigator contacts him again and asks him to go on inactive status. He agrees to go inactive, but states he must contact an attorney. Mr. A still insists he is innocent and that he will be found not guilty. He asks what the BON will do if he is found not guilty. He is told that the BON will still go forward with some form of action because his history shows that sexual activities (such as swinging, accessing pornographic websites) are a part of his lifestyle, and this concerns the BON. The investigator tells him that he expects the BON will still want a mental health evaluation and that they may still take administrative action.

The investigator makes contact with Mr. A's attorney (who had a history of working with the BON and had a good rapport with the investigator) and is told that Mr. A will go inactive. Days later, the investigator received another call from the attorney; Mr. A had committed suicide.

## Utilizing Consistent Guidelines

In order to provide consistent guidelines to BONs, the *Sexual Misconduct Pathway* or the Framework for Deciding When/How to Take Action in Sexual Misconduct Cases can be used to consistently make decisions in sexual misconduct cases.

In this case, using the pathway, we find that the complaint was reviewed and is serious. Strategies to protect the public were taken in this case by quick action of the BON to make sure he was put on an inactive status. The BON also checked his licensure status in an adjoining state. Coordination with law enforcement was outlined. A media plan, however, was not discussed and should be considered, as this could very well be a visible case. Referring to the framework we find that the BON should prepare a media release in anticipation. If there are calls to the BON, everyone should know to say, "Let me give you the person who can give you the answers as soon as possible." Then you get someone quickly to give that message and get back that same day.

## TYPICAL CASE STUDY IN SEXUAL MISCONDUCT: LONG-TERM CARE SETTING

### CASE 2

#### January 2006

An allegation was received from an administrator of a long-term care facility (Facility A) regarding inappropriate behavior of an LPN employee. The allegation was that the nurse had followed a female coworker into a medication room, closed the door, and started hugging and kissing her. She pushed him away and left the room. The nurse resigned before being terminated from Facility A for inappropriate sexual advances toward a coworker.

Upon investigation, there were no practice issues identified, the nurse denied the allegation and there was insufficient evidence for the BON to take action. The female coworker, however, did provide a statement that the offender trapped her in a corner, started hugging and kissing her, and told her that she was denying her needs for him. She stated that she kept pushing him away and was frightened by his behavior. She asked for an escort to her vehicle that evening when leaving the facility because she was concerned that he would continue to pursue her.

#### June 2006

A second allegation was received from a long-term care facility (Facility B) that the nurse was terminated after two residents complained of sexual misconduct. The allegations, however, could not be substantiated by internal investigations.

The first alleged incident occurred in April 2006. Resident T claimed the nurse felt all over her body looking for a Duragesic patch. When she informed him it was on her back, he allegedly asked her "What are you going to do for me since I did something for you?" Resident T had a history of Guillian-Barré syndrome, drug and alcohol abuse, and frequently made unfounded allegations against staff, particularly about not getting medication that she was supposed to have gotten. Resident T was asked to make a statement; she made an initial statement the next morning and then gave a second, very detailed statement. When contacted, her husband said she often has hallucinatory episodes, hears voices and makes accusations about not getting her medication.

Upon interview, the nurse said Resident T got angry because she alleged that the medication was not administered. Even though the nurse stated that he was trying to change a patch, he did not sign out a patch to administer.

Further investigation showed that Resident T had an order for a Duragesic patch to be changed every 72 hours; it had been applied earlier that morning and was not due to be changed. Resident T also had an order for Xanax four times

a day, which was on a 9 am, 1 pm, 5 pm and 9 pm schedule. The nurse signed out Xanax at 6 am, but did not document having administered the medication in the medication administration record or in the nurses' notes.

Resident T gave a very detailed statement about the nurse giving her some medication and rubbing her breasts. Further, the nurse rubbed her back and shoulders and asked her about a rash on her body. She told him it was psoriasis and that her husband brought some powder for it. He asked her where the powder should be administered and she showed him her stomach. The nurse asked where else, and she pointed toward her groin area. The patient claimed he then pulled her pants down and rubbed that area. The nurse then asked her what she was going to do for him since he had done something for her by giving her the medication.

While her husband verified that Resident T sometimes heard voices and had visual hallucinations, she had never made an allegation of sexual misconduct.

The second alleged incident occurred in June 2006.

Resident S claimed that the nurse came into her room, began feeling around her chest area and fondled her breasts. He then attempted to pull her pants down. Resident S, who is deaf and mute, has a history of dementia, psychosis, bipolar disorder, and problems with long- and short-term memory. She communicates with sign language, and can make her needs known and express herself.

The facility was instructed by their corporate office to terminate the nurse, who was still on probation, and to report the allegations to the BON.

Upon further investigation, the following information was provided:

1. A criminal background check that was done by Facility B came back with an arrest for rape in 1984, but the district attorney dropped the charges when the victim was unavailable.
2. The nurse applied for employment at a third long-term care facility (Facility C). Review of his application for employment at Facility C showed that he had failed to include his employment at Facility B on his work history. When interviewed, the nurse stated he was afraid he would not find employment because of false accusations, so he left his employment at Facility B off the application. He insisted that the allegations of sexual misconduct were unfounded. He said that the 1984 allegation of rape was made by an ex-girlfriend who was angry that he broke up with her and that the charges were dropped because a rape kit was negative for signs of rape. He also claimed to have been a police officer in New Orleans from 1984 through 1990, but Louisiana could find no records to verify this. He was terminated from Facility C for falsifying his application for employment.
3. A site visit of Facility B was made and both residents were interviewed. Both residents were consistent in their account of what happened and had never spoken with each other. The stories of what happened were similar; the director of nursing confirmed that neither resident had ever made an allegation of inappropriate sexual behavior against any other employee or resident.

A review of work history indicated the following:

April 2005–September 2005: resigned, failed to work out notice.

September 2005–January 2006: resigned before being terminated for inappropriate sexual advances toward a female nurse.

May 2006–June 2006: terminated after two residents complained of sexual misconduct. Review of application showed he claimed to work at a facility from 2000 through 2005 that closed in 1995.

August 2006: terminated for falsifying application.

At this point, the nurse's license was temporarily suspended based on the complaint by his female coworker and complaints of two residents, the falsification of employment application and signing out the Xanax at 6 am without an order. He was scheduled for an administrative hearing.

Further information was provided from the Department of Health by a health facility surveyor. The Department of Certification and Licensure had conducted a site survey and reported the following:

As part of the survey process, they request to hold a group session with residents cognizant enough to be interviewed. During that session, they ask questions of the residents about the facility and the care they receive. A male resident told them that there was something going on that they needed to know about and that needed to stop. He said that five different female residents had come to him and told him about a male nurse who was propositioning them. He refused to identify the residents. Other residents spoke up and informed them of a resident who is deaf and mute, who had been molested by this same nurse, and that the resident was given a whistle to wear around her neck in case the nurse in question ever came into her room again. The residents were frightened of the nurse, felt uncomfortable around him and felt that if he told them to do something, they had better obey. At that point, the surveyors conducted an investigation into the complaints of the residents and interviewed the resident with a whistle around her neck. The resident was able to communicate via sign language and shared explicit details about the incident, including a demonstration of the nurse raising her blouse, fondling her breasts and attempting to pull her pants down.

At the administrative hearing, testimony that was provided by the female coworker who was trapped in the medication room by the nurse was revealed by an investigator who had interviewed both residents and by two Department of Health facility surveyors who had conducted the group session with residents.

The BON's hearing panel found the nurse guilty of all charges and revoked his nursing license.

Issues to Consider:

- Employer/employee issue of charges by coworker of sexual harassment;
- Work history shows many short-term positions;
- Seeks vulnerable patients with credibility issues, history of dementia, substance abuse, difficulty with communication;
- Incidents occur at times when he is the only nurse on unit and is assigned to residents in question;
- Stories of victims are very similar in nature;
- Physically imposing presence, seeks to intimidate victims;
- Collaboration with other state agencies; and
- Based on a criminal background check, his story about why charges were dropped is different from what the record reflects.

There was no specific language about sexual misconduct in law, so charges were based on:

- Engaging in conduct likely to harm the public (three complaints of sexual misconduct);
- Making incorrect entries or failing to make essential records (falsified employment application); and
- Administering medication except as legally directed (signed out Xanax at time not ordered).

## Utilizing this Resource for this Case

A specific definition would have assisted the BON in this case. This booklet has several definitions for BONs to review and they might either select one of them or they might use one as a starting point for developing their own definition. There are two very detailed definitions and three more general ones. One of the detailed definitions would have probably been useful for this BON.



## SEXUAL MISCONDUCT CASE REVIEW: FITNESS FOR PRACTICE

### CASE 3

The BON received a report from a local hospital indicating they had terminated one of their nurses based on allegations by four female patients that this same male nurse had inappropriately touched them during their hospitalizations. The reported incidents occurred during the period June 29, 2005, to Oct. 30, 2006.

The 50-year-old male nurse, against whom the allegations were made, had been licensed as an RN for 10 years and had worked at the hospital where the alleged incidents occurred for over 14 years in various capacities. At the time of the alleged incidents, he was employed as the charge nurse on the night shift on a neurosurgical floor. Other staff on the floor included 16 female and four male nurses; eight female certified nursing assistants (CNAs); one male nurse apprentice/student; one male physician; and nine female and one male therapist.

Patient SS reported that the night following back surgery, after her husband had gone home for the night, she had become upset and panicky. She indicated that the night shift nurse entered her room and was attempting to comfort her. He pulled a pill from his pocket and told her to take it, which she did. He then began massaging her neck and shoulders and proceeded to massage her breasts under her gown. When SS attempted to pull her pillow up over her chest in an effort to get him to stop, he pushed the pillow down again. This happened a couple of times. When SS told the nurse to stop, he asked if he could massage her legs, to which she answered no. SS reported the incident to hospital administration. When interviewed, the nurse admitted giving back rubs to SS and admitted to giving medication to SS, and failed to document the medication he gave. He also admitted massaging SS's shoulders, neck and temple and that he stopped when SS asked him to do so. He denied ever touching her breasts. The hospital investigated the complaint and could not corroborate the patient's allegations. No further action was taken.

While recovering from surgery for a brain abscess, Patient CW awoke, under the influence of postoperative sedation, to find the nurse fondling her breasts. She asked him to stop, which he did only when another nurse came into the room. CW reported that the nurse was cupping her breasts in his hands and she felt he would not have stopped had another nurse not entered the room. CW reported the incident to hospital administration and filed a police report. The nurse initially denied that he had touched CW's breasts and then later admitted he had touched her while assessing for a pain response. Following this incident, the nurse was relieved of his charge nurse duties and was required to comply with various terms and conditions in order to retain his employment at the facility.

Following spinal fusion surgery, Patient ES was unable to lie on her back because of a drain that had been inserted at the surgical site. ES reported that the night following her surgery, the same nurse entered her room and she felt him run his hand from her ankle to her groin, at which time he asked

her, "Does this feel good?" ES began to cry and the nurse left the room. On interview, the nurse admitted that he gave ES thigh massages that night and that his hand may have brushed against her pubic area where the drain lines and catheter lines had become tangled. ES adamantly denied that the Jackson-Pratt drain line and her Foley catheter had in any way become entangled that night. ES reported the incident to hospital administration shortly after it occurred. Following this incident, the hospital terminated the nurse's employment and reported him to the BON.

Following receipt of the hospital report, a fourth patient, AG, contacted the hospital to report an incident that had occurred following her admission through the hospital emergency room when she experienced a transient ischemic attack (TIA). On her transfer from the emergency room to the floor, the same nurse gave her two pills for her complaint of a headache. During the night, AG awoke from a sound sleep to find the nurse sitting on her bed holding her left hand. The curtain was pulled around her bed. AG reported that she was very frightened by his unexplained presence in her room with the curtain drawn. She did not report the incident until she was later completing a patient satisfaction form received from the hospital.

Following receipt of the report from the hospital, the BON had received a call from AC, the nurse's niece, who reported that her uncle (the nurse under investigation) had sexually abused her as a child. That incident occurred when she lived in the nurse's home in 1991, at 11 years of age. The BON received police reports of the investigation into these allegations and was aware that the police had not pursued the case because of the length of time that had passed since the time of the alleged incidents.

All four women patients testified at a hearing that they were scared and upset by the nurse's conduct. The hearing officer for this case indicated that during the hearing, the testifying patients were still visibly upset when they described what had happened to them. The allegations made by the niece, AC, were not considered in the administrative hearing on this case.

### Investigation into the Allegations

1. Interviews with the nurse manager who filed the original report with the BON, as well as the hospital risk manager.
2. Interview with the nurse against whom the complaint was filed.
3. Interview with the nurse's niece, AC.
4. Interviews with patients ES, AG, SS and CW.
5. Review of police report on the allegations filed by AC.

### Complicating Factors

- There were no witnesses to any of the allegations against this nurse.
- During the course of the investigation, one of the alleged victims contacted the local newspaper, which ran her story and, on several occasions, contacted the BON for information about the case.
- At the time of the evidentiary hearing on this case, one of the patient's testifying was under indictment for use of methamphetamine.

## Final Order of the BON

The BON adopted in full the hearing officer's Findings of Fact and Conclusions of Law. The BON took further action to revoke the RN license of the respondent. The BON took further action to deny any application for reinstatement of the revoked license until two years from the date of the order. The BON took further action to condition any future consideration of reinstatement of license on the following:

1. Payment of all investigative and prosecution costs and attorney fees incurred by the BON in connection with the case proceedings;
2. Demonstration to the satisfaction of the BON that the respondent is no longer a danger to patients and is fit to practice nursing;
3. Respondent agreeing to all conditions, terms and restrictions the BON deems reasonable and necessary to place on respondent's license; and
4. Respondent complying with all other requirements for licensure imposed by BON statutes and rules.

## Utilizing Evaluator Guidelines and Fitness for Practice

The BON reviewing this case might select an expert evaluator for fitness to practice. The guidelines in this document provide some important criteria, including that the evaluator is a member of a professional board or association, such as the ATSA or the APLS. This professional should be licensed and preferably should be certified in evaluation of sexual misconduct cases. There are other criteria that the BON might select, such as numbers of hours educated on sexual offender treatment or hours spent in formal conferences. Some practical criteria might include being willing to review detailed allegations and commit to understanding the nursing field involved.

The evaluator and BON must consider guidelines for fitness to practice when the two years of license revocation is over and they might refer to the specific recommendations published in this resource. For example, has the nurse reached a comfort level with interpersonal relationships? Does he/she have an adequate control of emotions? Has the nurse achieved competence in handling ethical and professional responsibilities? The evaluator whom the BON chooses will help to make this difficult decision related to fitness to practice.

### CASE 4

Mr. R is a 32-year-old male who was diagnosed as mentally ill with a schizoaffective disorder. Mr. R was also diagnosed with post-traumatic stress disorder related to physical and sexual abuse endured as a child, and has a history of suicidal ideation and gestures. He was incarcerated in a residential health care unit of a state prison for attempted murder. In this particular residential health care unit, the state can accommodate up to 32 prisoners, while offering a full range of hospital services.

For about three months Mr. R was having explicit sexual conversations with a nurse while she was on duty in the unit. The nurse, Ms. B, talked about sexual experiences and watched Mr. R masturbate. Eventually, the two masturbated with each other and kissed. One of the custodial staff observed this behavior and reported it to the nursing supervisor.

In this particular state any employer of a nurse must report potential violations of the rules and law to the state board of nursing (BON).

The nursing supervisor, along with the state police, who are responsible for investigating any criminal activity in state prisons, reported the complaint to the BON. Eventually, after receiving permission from the courts, Mr. R was set up with a wire to record a conversation with Ms. B, which he did, thus confirming the sexual misconduct.

Ultimately, Ms. B admitted discussing sexual experiences with Mr. R, masturbating with him and kissing him. She denied ever touching his penis. The police concluded that although an inappropriate relationship occurred, there was insufficient evidence to charge her with sexual battery. However, the expert witness used by the police stated that there has been serious emotional harm done to this patient because the nurse took advantage of her powerful position. Ms. B was prosecuted for patient abuse and was terminated from her job. After a full investigation by the BON and a review of all the evidence, Ms. B's license was permanently revoked.

## Utilizing the Framework in this Case

Take the elements of this case through the *Framework for Deciding When/How to Take Action in Sexual Misconduct Cases* guidelines that are available in this booklet. For example, look at the items under **First Consider**. How egregious is the misconduct? While the authorities couldn't charge her with sexually battery, they did prosecute her with patient abuse. What is the alleged victim's diagnosis? The victim is clearly from a vulnerable population, being a prisoner, mentally ill and having a history of abuse. As mentioned earlier in this resource, sexual abuse in this population is more frequent than in other populations.

Then look under **Next Consider**. Can we develop the case? Where is the evidence? What evidence can be obtained? Where can it be found? In this case, while the patient's credibility could possibly be in question, the BON was able to review the legally obtained tape recordings and the nurse's confession to the police to validate the complaint. Further, their use of an expert witness verified that serious harm was done to the patient. In this state the mandatory reporting to the BON by the nursing supervisor was beneficial to protecting the public.

Questions under **Also Consider** would be evaluated next. During the BON investigation the nurse was terminated, but her license was still active. The BON should find out if the nurse was employed elsewhere and whether she was licensed in other states. According to the framework, they should presume that she is working since she was actively licensed. They should also inquire whether she is amenable to being put on an inactive status during the investigation. In this case, law enforcement authorities cooperated fully with the BON's investigation in their mission of public protection.

Because of the highly sensitive subject matter involved in this case, a statement may need to be prepared in anticipation of any media coverage. Develop a standard report for frontline staff to respond to media inquiries. Respond to the media directly and in a timely manner. Stick with consistent messages, such as "We are still actively investigating this matter and are working in close coordination with local law enforcement."





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## APPENDIX

### SUMMARY OF THE NCSBN'S 2009 SURVEY ON SEXUAL MISCONDUCT

In January 2009 a survey was electronically sent to those individuals listed on NCSBN's Discipline Knowledge Network. The survey was sent to executive officers of BONs in jurisdictions where no contact was listed. The purpose of the survey was to find out the needs of BONs related to their work with sexual misconduct cases. There were 26 boards that responded, and of those, 46 percent were definitely satisfied with how their BON handles sexual misconduct cases; 50 percent were somewhat satisfied; and

four percent (one BON) was not satisfied at all. The following are direct responses taken from these surveys offering some specific reasons BONs were satisfied:

- A two-pronged approach exists that involves a BON ordered evaluation by a center that specializes in diagnosis and treatment of sexual disorders, and/or BON action based upon evidence that is reliable, probative and substantial.
- Board members are actively involved in the disciplinary process to determine guilt or innocence in sexual misconduct cases.
- Excellent investigators and attorneys (two comments).
- The BON is very careful in investigating the cases, deliberating over the findings and determining appropriate outcomes.
- The law gives specific examples of what is considered sexual misconduct. We have guidelines to determine appropriate sanctions based on conduct, as well as aggravating and mitigating factors.

The following are direct responses taken from these surveys offering some of the problems or needs that the BONs have related to sexual misconduct:

- Problems occur when there is an ongoing criminal investigation and the BON cannot obtain evidence from law enforcement. In these cases the BON will request that the licensee place his/her license on inactive status.
- The BON is at a disadvantage when a stipulated agreement comes before them as they do not have all of the facts in the case. They have a difficult time determining whether or not the recommended discipline is adequate, given the amount of information available to accept the terms or reject them.
- Obtaining evidence, completing the investigation and developing a charge document for BON execution can be a lengthy process.
- Guidelines to provide consistency would be helpful (three comments).
- Need a definition.

- It depends on the administrative law judge who is assigned to the case. Some have standards with which we disagree. Also, if the petitioner seeks a writ, the superior court judge may rule on technicalities that are not favorable to consumer protection from our perspective.
- We do not have experts in sexual misconduct to whom we can refer licensees for evaluations, if the licensee has not already been evaluated.

Only 34.6 percent of the respondents reported that their BON has definitions of sexual misconduct.

Examples include:

1. Engaging in conduct with a patient that is sexual or may reasonably be interpreted by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning to a patient, or engaging in sexual exploitation of a patient or former patient.
2. A specific type of professional misconduct which involves the use of power, influence and/or special knowledge that is inherent in one's profession in order to obtain sexual gratification from the people a particular profession is intended to serve. Any and all sexual, sexually demeaning or seductive behaviors, both physical and verbal, between a service provider (i.e., nurse) and an individual who seeks or receives the service of that provider (i.e., client), is unethical and constitutes sexual misconduct.
3. Engaging in inappropriate sexual contact, exposure, gratification or other sexual behavior with, or in the presence of, a patient. For purposes of this subsection, an adult receiving psychiatric nursing services shall continue to be a patient for one year after the termination of professional services. If the person receiving psychiatric nursing services is a minor, the person shall continue to be a patient for the purposes of this subsection for one year after termination of services, or for one year after the patient reaches the age of majority, whichever is longer (Wisconsin).

When asked about guidelines, sanctions or mandatory schedules for sexual misconduct cases, no BON reported mandatory schedules. Some of the following guidelines were provided:

- Revocation for the most serious and fines for minor violations.
- Known sexual conduct with, or assault of, a patient would be a Priority I case and the investigation would be completed within five days. Verbally inappropriate conduct would be a Priority II.
- Suspension for one year or more, or revocation.
- Remedial education regarding boundaries, reprimand, probation; employer reports extend all the way up to revocation based on the scope and severity of the issues involved.
- Monetary fines, probation, suspension, community service, continuing education, counseling.
- Revocation is permanent in one state.
- Disciplinary guidelines for sexual misconduct: first offense carries a minimal punishment of a \$250 fine, probation and an evaluation by the Intervention Project for Nurses. The penalties increase with further offenses or aggravating factors. The BON can deviate from the guidelines when determining discipline by using mitigating or aggravating factors unique to the case.
- Nonthreatening, unsolicited conduct or physical contact that serves no diagnostic or treatment purpose can lead to reprimand, probation or suspension from zero to five years. Any personal relationship that violates professional boundaries can lead to probation or suspension from two

to seven years, or revocation. Any sexualized relationship or contact can lead to probation or suspension for two to seven years, or revocation. Sexual contact involving, but not limited to, force, intimidation or multiple victims leads to suspension for five years, indefinite suspension or permanent revocation.

Only four of the 26 states responding to the question had absolute bars. Related to fitness for practice, the BONs generally act on a case-by-case basis. Some specifically stated that they use psychiatric evaluations by qualified professionals when making fitness for practice decisions. One BON, when making fitness for practice decisions, replied, "The petitioner must submit convincing evidence of meeting the requirements set forth in the order and documentation of good character, stability of job and home. Initially, the petitioner must wait three years before returning to the BON to petition for reinstatement." Another BON uses the Intervention Project for Nurses to decide fitness for practice.

The BONs were asked about their experiences with cybersex/communication technologies and were asked to give examples. Seven of the 26 BONs reported cases related to cybersex/communication technologies and here were some of the examples:

- Nurse e-mailed photo of patient taken with personal cell phone camera;
- Nurse exchanged e-mails with patient that included photos;
- Viewing pornography at work;
- Soliciting sex via the Internet;
- Internet porn;
- Inappropriate behaviors involving e-mails;
- Text messages and cell phone photographs;
- Child pornography kept on a work computer;
- A nurse was convicted of multiple counts of possessing images of child pornography on his/her computer;
- A nurse had been convicted of making an arrangement for sexual contact with a child over the telephone; and
- A nurse used a coworker's camera phone to photograph a patient's genitals, then left the phone with the picture displayed for the phone's owner (also a nurse) to find.

Only two of the 26 BONs require sexual misconduct content in their nursing programs, though generally, it is assumed that this is discussed in ethics or other courses.

In summary, many BONs would like practical guidelines about how to make more consistent decisions in cases of sexual misconduct. This resource includes some actual definitions from BONs and some guidelines for selecting an evaluator, making decisions for fitness to practice and setting criteria for sanctions. The framework for making decisions and the *Sexual Misconduct Pathway*, as previously discussed, will also provide BONs with practical guidelines. Furthermore, the cases illustrate how to use the guidelines outlined in this booklet.







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