INTRODUCTION

Sexual contact between health care professionals and their patients is a long-standing serious public health problem (Dehlendorf & Wolfe, 1998) that causes considerable and enduring harm to patient victims (Luepker, 1999), damaging their self-esteem and emotional well-being (Sarkar, 2004), and shattering their trust in health care professionals (Galletly, 2004). Because the relationship between a health care professional and his or her patient is asymmetrical—with the health care professional holding significant power over the patient—the latter is vulnerable to exploitation by the former (Hughes & Farrow, 2005).

The National Council of State Boards of Nursing (2009) and the Federation of State Medical Boards (2006) classify professional sexual misconduct against patients into two types. The first type, sexual violation of patients, entails physical sexual contact including, but not limited to, intercourse, romantic or sexual kissing, or touching any sexualized body part for purposes other than appropriate examination. The second type, professional impropriety, includes behaviors, gestures, or expressions that are seductive, sexually suggestive,
disrespectful of patient privacy, or sexually demeaning to a patient but do not involve physical sexual contact.

The scope of this problem has not been investigated adequately (Swiggart, Starr, Finlayson, & Spickard, 2002), especially in nursing (Manfrin-Ledet, Porche, & Eymard, 2015), a profession in which the risk of sexual misconduct is high because nurses often spend long hours with their patients and the care that they provide often involves close proximity to patients (Bachmann et al., 2000; Griffith & Tengnah, 2013). This prolonged closeness may make it more difficult for nurses other than health care professionals to maintain clear roles and boundaries (Bachmann et al., 2000).

The National Practitioner Data Bank (NPDB), a federal web-based database established under the Health Care Quality Improvement Act of 1986, provides information about health care professionals, including nurses, who have adverse state licensing actions or malpractice payouts. This information is required by law to be reported to the NPDB by state licensing boards, medical malpractice payers, and others.

We analyzed nurse reports in the NPDB to address four main research objectives: to (a) compare the number and characteristics of nurses with sexual-misconduct-related reports with those of the general U.S. nurse population; (b) compare the types of disciplinary actions taken against nurses with sexual-misconduct-related reports of adverse state nursing board licensure actions (licensure reports) with those taken against nurses with licensure reports for other offenses; (c) determine the proportion of nurses with malpractice-payment reports related to sexual misconduct who were not disciplined by state boards of nursing; and (d) compare the characteristics, including the setting and severity of injury, of victims in nurse sexual-misconduct-related malpractice-payment reports with those of victims in nurse malpractice-payment reports for other offenses.

2 | METHODS

2.1 | Design and population

This cross-sectional study analyzed deidentified data of both licensure reports and malpractice-payment reports that pertain to nurses in the NPDB’s public use file from January 1, 2003, to June 30, 2016. We also obtained deidentified nurse sex and modified age group variables through a data use agreement with the U.S. Department of Health and Human Services.

2.2 | Identification and classification of reports

“Sexual misconduct” has been listed in the basis-for-action codes for the NPDB’s licensure reports only since September 2002. It also has been an option in the specific malpractice allegation codes for malpractice-payment reports since January 2004. Therefore, our study period for licensure reports starts on January 1, 2003, and for malpractice-payment reports starts on January 1, 2004. For both report types, our study period ends on June 30, 2016 (the end date for the latest NPDB data available when we initiated this study).

Using the practitioner’s field of license variable, we selected reports for registered nurses (RNs), advanced practice nurses (e.g., nurse anesthetists and nurse practitioners), and licensed practical nurses (LPNs) or licensed vocational nurses (LVNs). We excluded licensure reports that were limited to action restorations, modifications, reductions, or reinstatements. We also excluded nurse licensure reports that had missing values in all five basis-for-action variables and nurse malpractice-payment reports that had missing values in both of the variables for specific malpractice acts or omissions. We then classified all remaining nurse licensure reports as “sexual-misconduct-related” if they had a “sexual misconduct” code in any of the basis-for-action variables and all remaining nurse malpractice-payment reports as sexual-misconduct related if they had a “sexual misconduct” code in either of the variables for specific malpractice acts or omissions. All other remaining reports were classified as “other-offenses-related.”

2.3 | Measures

We determined nurse age groups and sex at the nurse level based on the corresponding values in the earliest sexual-misconduct-related report.

For licensure reports, we examined the reported types of disciplinary action taken by the state boards of nursing. Because these reports may include up to five licensure actions, we calculated the number of reports that included each type of licensing action, regardless of the order in which the action was listed. We also classified these actions as either serious or nonserious, as presented in Table 3.

For malpractice-payment reports, we examined the following four variables that are not included in licensure reports: (a) victim’s age group, (b) victim’s sex, (c) malpractice setting (categorized by the NPDB as outpatient, inpatient, both inpatient and outpatient, or unknown), and (d) severity of the alleged malpractice injury, classified by reporters to the NPDB using codes adopted from the malpractice insurance industry (see Table 4).

We obtained the population counts of the types of nurses included in our study in 2010, the median year in our study period, from the U.S. Bureau of Labor Statistics (2011), in order to compare the age groups and types of nurses who had sexual-misconduct-related reports with those of the general U.S. nursing population.

Most of our analyses were at the report level. However, analyses of the types of sexual-misconduct-related reports and nurse characteristics were at the nurse level.

2.4 | Analytic strategy

Our descriptive analyses included frequencies and percentages. We performed two-sample, two-tailed z-tests to test differences in proportions for the age-group and nurse-type distributions between nurses with sexual-misconduct-related reports and the general nurse population. We used chi-square or Fisher exact tests to test
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3 | RESULTS

Of the 150,033 unique nurses who had licensure or malpractice-payment reports that met our study criteria during the study period, 882 (0.6%) had one or more sexual-misconduct–related reports. Most nurses with sexual-misconduct–related reports (96.3%) had only licensure reports, whereas 1.8% had only malpractice-payment reports (Table 1). The remaining 1.9% had both licensure and malpractice-payment reports. Nearly 13% of the nurses had two or more reports of the same type: 12.2% had two or more licensure reports and 0.7% had two or more malpractice-payment reports.

3.1 | Characteristics of all nurses with any sexual-misconduct–related reports

Nurses between the ages of 35–44 accounted for 32.5% of the nurses with sexual-misconduct–related reports, although nurses in this age group made up 24.9% of the U.S. general nurse population (p < 0.001) (Table 2). Similarly, nurses between the ages of 45 and 54 accounted for 30.6% of the nurses with sexual-misconduct–related reports, although only 26.6% of the general nurse population were in this age group (p = 0.007). In contrast, fewer nurses between the ages of 25 and 34 had sexual-misconduct reports, compared with their representation in the general nurse population (16.6% vs. 21.7%, respectively; p < 0.001). The proportion of nurses between the ages of 55 and 64 years with sexual-misconduct–related reports (17.8%) was similar to this age group’s representation in the general nurse population (18.7%) (p = 0.488). Fewer nurses aged 65 or older

### TABLE 1 Nurses with sexual-misconduct–related NPDB reports, U.S., January 2003–June 2016 (nurse-level results)

| Groups of nurses based on number and type(s) of reports | No. (%)a |
|---------------------------------------------------------|----------|
| Nurses with ≥1 sexual-misconduct–related report of any type | 882 (100.0) |
| Nurses with only one type of sexual-misconduct–related report | 865 (98.1) |
| ≥1 licensure report | 849 (96.3) |
| ≥1 malpractice-payment report | 16 (1.8) |
| Nurses with both licensure and malpractice-payment reports related to sexual misconduct | 17 (1.9) |
| Nurses with ≥2 sexual-misconduct–related reports of the same type | 113 (12.8) |
| ≥2 licensure reports | 108 (12.2) |
| ≥2 malpractice-payment reports | 6 (0.7) |
| Nurses with ≥1 sexual-misconduct–related malpractice-payment report | 33 (3.7) |
| Nurses with ≥1 sexual-misconduct–related malpractice-payment report but no sexual-misconduct–related licensure reportsb | 16 (48.5) |

### TABLE 2 Comparison of age-group and nurse-type distributions of nurses with sexual-misconduct–related reports during the study period with the U.S. general nurse population, January 2003–June 2016 (nurse-level results)

| Nurse characteristics | Nurses with sexual-misconduct–related reports | General U.S. nurse populationb | Expected nurses with sexual-misconduct–related reports | p |
|-----------------------|---------------------------------------------|-------------------------------|------------------------------------------------------|---|
| All                   | 882 (100.0)                                 | 3,415,000 (100.0)             |                                                      |   |
| Age group             |                                             |                               |                                                      |   |
| ≤24 years             | 4 (0.5)                                     | 148,000 (4.3)                 | 38                                                   | <0.001 |
| 25–34 years           | 146 (16.6)                                  | 740,000 (21.7)                | 191                                                  | <0.001 |
| 35–44 years           | 287 (32.5)                                  | 852,000 (24.9)                | 220                                                  | <0.001 |
| 45–54 years           | 270 (30.6)                                  | 907,000 (26.6)                | 234                                                  | 0.007 |
| 55–64 years           | 157 (17.8)                                  | 639,000 (18.7)                | 165                                                  | 0.488 |
| 65+ years             | 18 (2.0)                                    | 129,000 (3.8)                 | 33                                                   | 0.007 |
| Nurse type            |                                             |                               |                                                      |   |
| LPNs and LVNs         | 340 (38.5)                                  | 572,000 (16.7)                | 147                                                  | <0.001 |
| RNs and advanced practice nurses | 542 (61.5) | 2,843,000 (83.3) | 735                                                  | <0.001 |

Notes. LPNs: licensed practical nurses; LVNs: licensed vocational nurses; RNs: registered nurses.  
*aPercentages may not add up to 100 due to rounding. bSource: U.S. Bureau of Labor Statistics. Unpublished Results Using the 2010 Current Population Survey Microdata Samples. 2011.  
*cExpected counts assume the same age percentage distribution for nurses with sexual-misconduct–related reports as in the general U.S. nurse population.
had sexual-misconduct-related reports, compared with their representation in the general nurse population (2.0% and 3.8%, respectively; \( p = 0.007 \)).

Overall, RNs and advanced practice nurses accounted for a lower proportion of nurse sexual-misconduct-related reports compared with their representation in the general nurse population (61.5% vs. 83.3%, respectively; \( p < 0.001 \)). In contrast, LPNs and LVNs accounted for a higher proportion of these reports compared with their representation in the general nurse population (38.5% vs. 16.7%, respectively; \( p < 0.001 \)).

The majority (63.2%) of nurses with sexual-misconduct-related licensure reports were male and 30.1% were female (sex was not reported for the remaining 6.8% of nurses) (results not shown in tables).

3.2 | Nurse licensure actions

There were 988 sexual-misconduct-related licensure reports involving 866 unique nurses, representing only 0.5% of all nurse licensure reports during the study period. In contrast, there were 207,023 other-offenses-related reports involving 142,746 unique nurses. Serious licensure actions, as specified in Table 3, made up a significantly larger proportion of the licensure actions taken in sexual-misconduct-related licensure reports than in nurse licensure reports related to other offenses (90.8% vs. 74.8%, respectively; \( p < 0.001 \)).

License revocation was the most frequent serious action reported in sexual-misconduct-related reports, occurring in 26.9% of these reports, compared with only 10.6% of the other-offenses-related reports (\( p < 0.001 \)). Voluntary surrender of license was the second most common action taken in sexual-misconduct-related licensure reports, occurring in 19.7% of these reports, compared with only 10.9% of the other-offenses-related reports (\( p < 0.001 \)). License suspension and license probation actions were each taken in approximately one-seventh of nurse sexual-misconduct-related licensure reports, compared with nearly a quarter of nurse other-offenses-related reports (\( p < 0.001 \) for both comparisons). Summary or emergency suspension actions were reported in 8.3% of the nurse sexual-misconduct-related licensure reports, compared with 2.4% of reports for other offenses (\( p < 0.001 \)).

Conversely, nonserious licensure actions were noted in significantly fewer nurse sexual-misconduct-related reports compared with reports for other offenses. Monetary penalties (fines) that are made known to the public were noted in 7.8% of nurse sexual-misconduct-related licensure reports and in 19.4% of other-offenses-related reports (\( p < 0.001 \)). Similarly, reprimand or censure actions were noted in 6.9% of the nurse sexual-misconduct-related licensure reports and in 15.2% of reports for other offenses (\( p < 0.001 \)).

3.3 | Nurse malpractice-payment reports: victim characteristics and setting

There were 47 sexual-misconduct-related malpractice-payment reports for 33 unique nurses, representing only 0.6% of all nurse malpractice-payment reports during the study period (Table 4). The proportion of victims between 20 and 39 years of age in sexual-misconduct-related reports was higher than that for those in the same age group for other-offenses-related malpractice reports (36.2% vs. 20.8%; \( p = 0.010 \)). Only 8.5% of the victims in the sexual-misconduct-related reports were under the age of 20, whereas 20.6% of the victims in the other-offenses-related reports were in this age group (\( p = 0.041 \)). Similarly, only 10.6% of the victims in the sexual-misconduct-related reports were 60 or older, whereas 27.4% of those in other-offenses-related reports were in this age group (\( p = 0.010 \)). The proportions of victims between 40 and 59 years of age were not significantly different between sexual-misconduct-related reports and other-offenses-related reports (29.8% vs. 26.5%, respectively; \( p = 0.613 \)). Three-quarters of the victims in the nurse sexual-misconduct-related malpractice-payment reports were female, whereas slightly more than one half (53.5%) of the victims in other-offenses-related reports were female (\( p = 0.004 \), Table 4).

Slightly more than half of the nurse sexual-misconduct-related malpractice-payment reports concerned incidents in the outpatient setting, whereas approximately one-third of the other-offenses-related reports concerned incidents in this setting (\( p = 0.002 \)). Conversely, fewer sexual-misconduct-related malpractice-payment reports pertained to incidents in the inpatient setting compared with other-offenses-related malpractice-payment reports (38.3% vs. 57.8%, respectively; \( p = 0.007 \)). Only about 4% of both nurse sexual-misconduct-related and nurse other-offenses-related reports concerned incidents that occurred in both inpatient and outpatient settings.

3.4 | Severity of alleged injury cited in malpractice-payment reports

“Emotional injury only” was reported as the severity of malpractice injury among victims in 91.5% of sexual-misconduct-related reports, compared with just 2.4% of other-offenses-related reports (\( p < 0.001 \)) (Table 4). There were two nurse sexual-misconduct-related reports with insignificant (physical, as opposed to emotional) injuries, one with minor temporary injury, and one with major temporary injury. Although there were no reported serious severity outcomes (including death; quadriplegic, brain damage, lifelong care; and major or significant permanent injuries) for nurse sexual-misconduct-related reports, these outcomes were reported in 65.2% of malpractice victim injuries in nurse other-offenses-related reports.

3.5 | Inaction by licensing boards for nurses with malpractice-payment reports

Of the 33 nurses with sexual-misconduct-related malpractice-payment reports, 16 (48.5%) had no sexual-misconduct-related licensure reports, indicating that these nurses were not disciplined for sexual misconduct by any state board of nursing during the study period (Table 1).
| Licensure actions<sup>a</sup> | Sexual-misconduct-related reports (n = 988)<sup>b</sup> | Other-offenses-related reports (n = 207,023)<sup>c</sup> | p |
|---|---|---|---|
| Reports with one or more serious licensure disciplinary actions | 897 (90.8) | 154,754 (74.8) | <0.001 |
| Specific types of serious licensure disciplinary actions | | | |
| Revocation of license | 266 (26.9) | 22,007 (10.6) | <0.001 |
| Revocation of multistate license | 3 (0.3) | 260 (0.1) | 0.131 |
| Probation of license | 142 (14.4) | 49,603 (24.0) | <0.001 |
| Probation of multistate license | 1 (0.1) | 142 (0.1) | 0.494 |
| Suspension of license | 147 (14.9) | 50,915 (24.6) | <0.001 |
| Suspension of multistate license | 1 (0.1) | 204 (0.1) | 0.623 |
| Summary, emergency limitation, or restriction of license | 14 (1.4) | 301 (0.1) | <0.001 |
| Summary, emergency limitation, or restriction of multistate license | 1 (0.1) | 17 (0.01) | 0.082 |
| Summary or emergency suspension of license | 82 (8.3) | 4,899 (2.4) | <0.001 |
| Summary or emergency suspension of multistate license | 1 (0.1) | 35 (0.02) | 0.158 |
| Voluntary surrender of license | 195 (19.7) | 22,511 (10.9) | <0.001 |
| Voluntary surrender of multistate license | 4 (0.4) | 120 (0.1) | 0.003 |
| Voluntary limitation or restriction on license | 1 (0.1) | 521 (0.3) | 0.528 |
| Voluntary limitation or restriction on multistate license | 0 (0.0) | 3 (0.001) | NA |
| Limitation or restriction on license or practice | 37 (3.7) | 8,609 (4.2) | 0.516 |
| Limitation or restriction on multistate license or practice | 0 (0.0) | 29 (0.01) | NA |
| Denial of license (renewal only) | 5 (0.5) | 1,654 (0.8) | 0.302 |
| Denial of initial license | 26 (2.6) | 3,354 (1.6) | 0.012 |
| Voluntary agreement by nurse to refrain from practicing or suspension of license PCI | 1 (0.1) | 229 (0.1) | 1.00 |
| Cease and desist | 0 (0.0) | 74 (0.04) | NA |
| Prescriptive authority | 0 (0.0) | 49 (0.02) | NA |
| Reports with one or more nonserious licensure actions | 188 (19.0) | 80,429 (38.9) | <0.001 |
| Specific types of nonserious licensure disciplinary actions | | | |
| Reprimand or censure license | 68 (6.9) | 31,388 (15.2) | <0.001 |
| Reprimand or censure of license nurse multistate action | 0 (0.0) | 124 (0.1) | NA |
| Publicly available fine or money penalty licensure action | 77 (7.8) | 40,249 (19.4) | <0.001 |
| Multistate publicly available fine or money penalty action | 0 (0.0) | 104 (0.1) | NA |
| Publicly available negative action or finding | 2 (0.2) | 986 (0.5) | 0.212 |
| Multistate publicly available negative action or finding | 0 (0.0) | 43 (0.02) | NA |
| Other licensure (not classified) action | 84 (8.5) | 27,232 (13.2) | <0.001 |
| Other action nurse multistate license action | 2 (0.2) | 267 (0.1) | 0.366 |

Notes. NA: not applicable; PCI: pending completion of an investigation.

<sup>a</sup>Each report can have up to five actions. We excluded reports that included only the following actions: licensure restored or reinstated (complete); license restored or reinstated (conditional); license restored or reinstated (partial); license reinstatement denied; reduction in previous licensure action; extension of previous licensure action; modification of previous licensure action; nurse multistate license privileges restored/reinstated, complete; nurse multistate license privileges restored/reinstated, conditional; nurse multistate license privileges restored/reinstated, partial; nurse multistate license privileges restoration/reinstatement denied; reduction in previous nurse multistate license privileges action; extension of previous nurse multistate license privileges action; and modification of previous nurse multistate license privileges action.<sup>b</sup>Reports are for 866 unique nurses with sexual-misconduct-related licensure reports.<sup>c</sup>Reports are for 142,746 unique nurses with other-offenses-related licensure reports.
4 | DISCUSSION

Similar to a recent study of physician reports in the NPDB (AbuDagga, Wolfe, Carome, & Oshel, 2016), this study showed that only a small fraction, 0.6%, of the nurses who were reported to the NPDB due to licensure actions taken against them or malpractice payments paid on their behalf during the study period had licensure or malpractice-payment reports related to sexual misconduct. In comparison, 1.0% of all physicians reported to the NPDB had licensure actions or malpractice payments related to sexual misconduct (AbuDagga et al., 2016).

Likewise, the National Council of State Boards of Nursing found that just 0.5% of the nurses who were disciplined by state boards of nursing from 1996 to 2006 had committed sexual misconduct or abuse violations with their patients (Kenward, 2009).

Although the actual prevalence of nurse sexual misconduct is unknown, the above findings are much lower than previous estimates of the prevalence of such misconduct. For example, a survey of psychiatric nurses found that 11% of female nurses and 17% of male nurses reported having had sexual contact with their patients (Bachmann et al., 2000). Similarly, physicians’ surveys have shown that 3%–10% of the respondents reported engaging in sexual relationships with their patients (Swiggart et al., 2002).

The disparity between our findings and information from previous surveys can be explained, in part, by the fact that many sexual violations against patients go unreported because these victims are often reluctant to complain due to feelings of guilt and shame, fear they will not be believed, and, occasionally, continued concern for the offending health care professional (Galletly, 2004). Concern for offending a nurse (or the nurse’s employer) on whom they are dependent for care may be a particular problem for nursing home patients. Additionally, abused patients or their families may not know that they can complain to a licensing board or how to do so even if they know it can be done. Furthermore, complaining to state boards of nursing and participating in the investigation and legal proceedings of these cases can be very stressful. Although 38%–52% of health care professionals report knowing of colleagues who have been sexually involved with patients (Halter, Brown, & Stone, 2007), there is a “conspiracy of silence” about this problem because health care professionals tend to be reluctant to report their colleagues (Peternelj-Taylor & Yonge, 2003). When patients have filed complaints against health care professionals, “nothing happened” to the alleged perpetrator in 55% of cases (Bouhoutsos, Holroyd, Lerman, Forer, & Greenberg, 1983).

It is troublesome that nearly half of the nurses with sexual-misconduct-related malpractice-payment reports had no adverse licensure actions for this behavior despite two procedural realities: (a) health care employers and malpractice insurers are required to send copies of the reports they submit to the NPDB to nursing boards in their respective states, and (b) nursing boards can query the NPDB to obtain access to all malpractice-payment reports for nurses who have these reports. Thus, any nurse licensing board could have initiated a licensing action against these nurses. This problematic finding also has been noted in prior research for sexual misconduct and other types of offenses involving physicians (AbuDagga et al., 2016; Levine, Oshel, & Wolfe, 2011).

Our study showed that the majority of the nurses with sexual-misconduct-related reports (63.2%) were men. This fact is striking considering that nursing is a predominantly female profession; for example, male nurses account for fewer than 10% of RNs (Budden, Zhong, Moulton, & Cimiotti, 2013). Prior research also shows that nurses who commit sexual misconduct with their patients are primarily male (Chiarella & Adrian, 2014). Nurses between the ages of 35 and 54 accounted for a majority of the nurses with sexual-misconduct-related reports, which is consistent with previous research (Campbell, Yonge, & Austin, 2005).

Our study found that LPNs and LVNs accounted for 38.5% of nurse sexual-misconduct-related reports, although these nurses comprise only 16.7% of the general nurse population (U.S. Bureau of Labor Statistics, 2011). This finding is consistent with the results of a prior study, which reported that even among registered nurses, those with associate degree prelicensure preparation had a higher incidence of disciplinary actions by a nursing board due to boundary violation than that for nurses with bachelor degree prelicensure preparation (Jones, Fitzpatrick, & Drake, 2008). Therefore, the higher representation of LPNs and LVNs with respect to sexual misconduct may be partially attributed to curricular differences between the associate nursing education level and higher levels.

Although “emotional injury only” accounted for most of the reported severity of victim injuries in malpractice-payment reports, it is important to keep in mind that this variable, which is determined by the reporting entity, may not reflect the victims’ perceptions of their injuries. In addition, research shows that the legal classification of the type of sexual assault can be meaningless to survivors because even sexual offenses that are legally classified as “minor” can have serious damaging effects for victims (Muldoon, Taylor, & Norma, 2016).

Furthermore, even a single sexual predator nurse can be a serious threat for a large patient population. For example, a nurse anesthetist was convicted in 2011 of sexually assaulting 19 female patients in health care facilities in the Atlanta metropolitan area (Stevens, 2015).

Our study has several limitations. First, because it was limited to that subset of nurses who have been disciplined by state boards of nursing or had malpractice payments due to sexual misconduct, its findings are not representative of the full scope of sexual misconduct in the entire nursing profession in the U.S. In addition to under-reporting of sexual misconduct by patients, the effectiveness of the states’ boards of nursing has been criticized because the resources available to these boards—particularly funding—vary across states (Clevette, Erbin-Roesemann, & Kelly, 2007). Furthermore, some of these boards may not have developed guidelines that supplement their individual state regulations and laws concerning sexual misconduct by nurses (Clevette et al., 2007). In fact, it is not possible to accurately estimate the actual frequency of sexual violations in health care (DuBois et al., 2017). Therefore, this study can be considered as potentially capturing only a portion of the actual sexual misconduct...
among licensed U.S. nurses, similar to the small portion represented in NPDB reports involving physicians. Second, we excluded nurse aides and nursing assistants. Third, we had no data about the practice area of the nurses included in our study. Fourth, our data did not include information about the nature of the sexual misconduct.

Future research is needed to understand the full extent of sexual misconduct by nurses in a variety of settings, specialty areas, and type of prelicensure education and to determine the risk factors and most effective solutions to this problem.

Nonetheless, our findings should stimulate regulatory entities, professional organizations, and peer-review committees that oversee the performance of health care professionals to investigate and address the reasons behind the low rate of disciplinary action in response to nurse sexual misconduct.

### TABLE 4

| Victim characteristics | Sexual-misconduct-related reports (n = 47)\(^a\) | Other-offenses-related reports (n = 8,257)\(^b\) | p |
|------------------------|---------------------------------------------|---------------------------------------------|---|
| **Age group**          |                                             |                                             |   |
| 1–19 years             | 4 (8.5)                                     | 1,697 (20.6)                                | 0.041 |
| 20–39 years            | 17 (36.2)                                   | 1,715 (20.8)                                | 0.010 |
| 40–59 years            | 14 (29.8)                                   | 2,190 (26.5)                                | 0.613 |
| 60–79 years            | 5 (10.6)                                    | 2,266 (27.4)                                | 0.010 |
| Unknown/missing        | 7 (14.9)                                    | 389 (4.7)                                   | 0.006 |
| **Sex**                |                                             |                                             |   |
| Female                 | 35 (74.5)                                   | 4,417 (53.5)                                | 0.004 |
| Male                   | 12 (25.5)                                   | 3,741 (45.3)                                | 0.007 |
| Unknown                | 0 (0.0)                                     | 99 (1.2)                                    | NA |
| **Setting**            |                                             |                                             |   |
| Inpatient              | 18 (38.3)                                   | 4,769 (57.8)                                | 0.007 |
| Outpatient             | 26 (55.3)                                   | 2,824 (34.2)                                | 0.002 |
| Both inpatient and outpatient | 2 (4.3) | 318 (3.9) | 0.703 |
| Unknown/missing        | 1 (2.1)                                     | 346 (4.2)                                   | 0.723 |
| **Severity of malpractice injury\(^d\)** |                                           |                                             |   |
| Emotional injury only  | 43 (91.5)                                   | 199 (2.4)                                   | <0.001 |
| Insignificant injury   | 2 (4.3)                                     | 151 (1.8)                                   | 0.215 |
| Minor temporary injury | 1 (2.1)                                     | 959 (11.6)                                  | 0.043 |
| Major temporary injury | 1 (2.1)                                     | 756 (9.2)                                   | 0.123 |
| Minor permanent injury | 0 (0.0)                                     | 654 (7.9)                                   | NA |
| Significant permanent injury | 0 (0.0) | 769 (9.3) | NA |
| Major permanent injury | 0 (0.0)                                     | 834 (10.1)                                  | NA |
| Quadriplegic, brain damage, lifelong care | 0 (0.0) | 693 (8.4) | NA |
| Death                  | 0 (0.0)                                     | 3,092 (37.4)                                | NA |
| Cannot be determined from available report/missing | 0 (0.0) | 150 (1.8) | NA |

Notes: NA: not applicable.

\(^a\)Reports are for 33 unique nurses with sexual-misconduct-related malpractice-payment reports.

\(^b\)Reports are for 7,389 unique nurses with malpractice-payment reports related to other offenses.

\(^c\)Percentages may not add up to 100 due to rounding.

\(^d\)Only one type of injury code is permitted in malpractice-payment reports.
4.1 Implications for public health nursing

Sexual misconduct by nurses—or any other health care professionals—against patients is a serious ethical problem and should not be tolerated. Such unethical behavior in health care should be designated as "never events": No patient should ever experience any form of sexual misconduct, or fear of being subjected to such behavior, by any type of health care professional. Ethical arguments to support a zero-tolerance standard for sexual contact between physicians and patients already have been described (Cullen, 1999). We believe that these arguments apply to nurses as well.

A nurse or any health care professional who has committed sexual misconduct with a patient should face serious consequences because such exploitive behavior damages the public trust and erodes confidence in health care professionals. These consequences should include revoking the licenses of the offending health care professionals, especially if the misconduct involved any sexual violations (particularly those that entail sexual physical contact with patients) or repeated sexual impropriety against patients.

We call on both the health care community and the legal system to take sexual misconduct by health care professionals more seriously and to discipline those who are found to have exploited their patients sexually. In particular, we would welcome a zero-tolerance standard against the most egregious forms of sexual misconduct: those involving physical sexual contact with patients.

Clear definitions of sexual misconduct need to be incorporated in health care professionals’ education, professional codes of conduct, and state laws. This behavior needs to be viewed as a “foreseeable” hazard against which precautions need to be taken (Banja, 2014). Although educating health care professionals are an important part of the solution to this problem, certain professionals may not be deterred (Nadelson & Notman, 2002). Therefore, it is incumbent upon the health care community and regulators, especially professional licensing boards, to rid the health care system of this public health problem.

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**How to cite this article:** AbuDagga A, Wolfe SM, Carome M, Oshel RE. Crossing the line: Sexual misconduct by nurses reported to the National Practitioner Data Bank. *Public Health Nurs*. 2019;36:109–117. https://doi.org/10.1111/phn.12567