Reporting Colleague Misconduct in Advanced Practice Nursing

Mary E. Burman, PhD, APRN, FNP, BC, FAANP, and Lynne M. Dunphy, PhD, APRN, FNP, BC

Advanced practice registered nurses (APRNs) experience significant moral distress when they witness colleague misconduct, although many hesitate to report it. APRNs have clear ethical obligations to report based on the American Nurses Association Code of Ethics; however, legal reporting requirements vary from state to state: Some only require institutions to report terminations of nurses; others require nurses to report possible colleague misconduct. This article was prompted by a particular case and examines barriers to reporting and managing colleague misconduct, discusses legal and ethical reporting requirements, and offers recommendations to facilitate management of problematic and potentially unsafe colleague behavior.

Terri Hodges, an advanced practice registered nurse (APRN) in adult health, practices in a private clinic with several other APRNs and primary care clinicians. She has been in practice for 5 years and is popular in the community. However, in the last 1 to 2 years, her APRN colleagues have become increasingly concerned about her practice, specifically her prescribing practices and the number of patients she sees in a day. For example, several colleagues are concerned because she has prescribed medications that are contraindicated for the conditions diagnosed, raising concerns about her diagnostic workup and her approach to treatment. Several colleagues believe their concerns are significant enough to be reported to the board of nursing (BON), but they are uncomfortable reporting her. Some APRN colleagues say they have no direct knowledge of her care and therefore cannot report her because they believe the BON only addresses complaints supported by direct information. Other APRNs who work more closely with her have not reported her because they think or hope someone else will do it. A new APRN has not filed a complaint because she fears a backlash in the community that would affect her practice. Also, some APRNs who considered reporting Ms. Hodges say that they do not know how to report a colleague to the BON. None of the APRNs have directly confronted Ms. Hodges about their concerns, although several have talked to her employer. The employer, who is not a nurse, has not taken any action.

This case and ones similar, prompted this article, which identifies and explores barriers to reporting and managing colleague misconduct; discusses legal, ethical, and institutional reporting requirements; and makes recommendations about managing problematic and potentially unsafe colleague behavior in advanced practice nursing. The article also has implications for nursing regulation, especially in relation to standardization of language regarding reporting of professional misconduct. Because so much has been written about problematic colleague behavior related to drug or alcohol impairment, this article focuses on professional misconduct, including incompetence, such as inappropriate or questionable diagnosis, treatment, and follow-up, as well as unethical and illegal behavior. APRNs will play an increasingly pivotal role in providing health care. With the Institute of Medicine’s report on the future of nursing (2010) emphasizing that all nurses practice to the full scope of their licensure, the regulatory implications of professional misconduct are more critical than ever.

Encountering Misconduct

Though APRNs encounter professional misconduct, very little data-based research has been published on this topic. Studies of disciplinary cases involving nurses and APRNs provide some perspective on the types of misconduct APRNs encounter. In a 10-year examination of nursing disciplinary data conducted by the National Council of State Boards of Nursing (NCSBN) (2009), violations included the following:

- Failure to maintain minimal standards
- Unsafe practice
- Failure to assess
- Failure to follow orders
- Incompetent practice.

Out of more than 114,000 reported violations, 6,272 involved failure to maintain minimal standards. Kenward (2008) also reviewed disciplinary cases involving nurses from 1996 to 2006 and found that of the 52,297 nurses disciplined, less than 1% were APRNs. The review did not distinguish among types of APRNs.

Hudspeth (2007) examined the incidence of APRN disciplinary actions by BONs. Violations were categorized as chemical impairment, acts exceeding the scope of practice, unprofessional conduct, and safety or abuse of patients. Reports from 38 of 51 BONs indicated 688 disciplinary actions involving 512 APRNs in a total population surveyed of 125,882 APRNs. Based on this evidence, the author concludes that APRNs experience a low
rate of disciplinary actions in these four categories. In another study, Hudspeth (2009) reported that the most frequent reasons for APRN disciplinary action were patient abuse, abandonment, and boundary violations, followed by discipline for reasons not associated with clinical practice. Whether the low rates of disciplinary action, especially those related to misconduct, are because APRNs are disciplined infrequently or because colleague misconduct is reported infrequently is unknown and was intended to be addressed by these studies.

Other research has examined the moral distress that APRNs experience when they encounter ethical violations, including colleague misconduct. Laabs (2005) undertook a descriptive study of the ethical issues APRNs face in primary care. Almost half of the 71 APRNs reported that they occasionally or commonly had to deal with clinical decisions made by others and that doing so was one of the most highly distressing situations they face. Similarly, Winland-Brown, Chiarenza, and Dobrin (2010) reported that nurses, including APRNs, found handling professional incompetence morally distressing.

Research on the beliefs about reporting violations among other health-care professionals provides some insight into APRN beliefs. Campbell et al. (2007) found that 96% of physicians agreed that they should report impaired or incompetent colleagues. In a recent survey of physicians, DesRoches et al. (2010) found that less than two-thirds of physicians agreed that they should “report all instances of significantly impaired or incompetent colleagues…” (p. 190). Unfortunately, studies on physicians have found significant gaps between beliefs about reporting and actual reporting. Campbell et al. (2007) found that only 45% of physician respondents who reported having direct knowledge of an impaired or incompetent colleague actually reported the colleague.

**Barriers to Reporting Misconduct**

Many factors may account for the gap between beliefs about reporting misconduct and behavior. Little research has addressed the barriers APRNs face in identifying, managing, and reporting problematic colleague behavior. Beckstead (2002) examined decision making in reporting peer-wrongdoing and found that nurses believed working under the influence of any substance was a serious offense. Nurses combined incompetence and substance-abuse cues in complex ways; for example, permissive attitudes about substance abuse and positive attitudes about substance abuse treatments were related to nurses’ intention to report impaired colleagues, while moralistic attitudes were not related to intention.

Nurses may also fear reporting misconduct because of widely publicized cases of retaliation against nurses who reported misconduct. For example, an anonymous nurse (1989) detailed her whistle-blowing experience in which she spoke up about the incompetence of two staff surgeons. She eventually had to defend her job and her reputation. The more recent case of a Texas nurse who reported a physician to the state board of medicine for practicing unsafe medicine sent shock waves throughout nursing. She was fired and charged with a felony; however, she was later exonerated.

Overstreet (2001) notes that reporting is often uncomfortable and may be taboo in some cultures. In a review of literature focusing on psychologists, Baggio, Duffy, and Staffelbach (1998) found these obstacles to reporting misconduct: loyalty to colleagues and institutions, personal costs or repercussions, and misunderstanding of or lack of knowledge about ethics and conduct.

Fisch (2009) highlights the tension between reporting a colleague to protect the public and defaming a colleague by making “unknowing or unjustifiable disparaging statements….” This author stresses the need for personal experience with a colleague rather than a judgment based on hearsay. Personal experience or firsthand knowledge of colleague behavior is necessary before professionals can step forward with complaints to a licensing board, peer review, or ethics committee.

DesRoches et al. (2010) reported that the most common reason physicians failed to report was that they thought someone else was taking care of the problem. Other reasons included a belief that nothing would happen based on the report, fear of retribution, concern about excessive punishment, lack of knowledge about how to report, and a belief that reporting could easily happen to them as well.

**Ethical Obligations and Self-Regulation**

Professionals hold special knowledge often not shared with or understood by those outside of the profession. Often, only members of the profession are qualified to evaluate how that knowledge is applied in clinical situations, and members of the profession may disagree about the standard of care or selection of interventions. Thus, a profession must regulate itself. Professional misconduct damages not only patients but the profession as a whole (Overstreet, 2001).

The American Nurses Association’s (ANA) *Code of Ethics for Nurses* explicitly addresses “incompetent, unethical, illegal, or impaired practice by any member of the health-care team or the health-care system or any action on the part of others that places the rights or best interests of the patient in jeopardy” (American Nurses Association, 2001, p. 14). The code is clear that whenever a nurse “is aware of inappropriate or questionable practice in the provision or denial of health care, concerns should be expressed to the person carrying out the questionable practice…. If indicated, the problem should be reported to an appropriate higher authority within the institution or agency or to an appropriate external authority” (p. 14). The interpretive comments recommend that institutions have official channels for reporting. Employers and professional organizations must recognize the risk of reprisal and have a responsibility to “pro-
In an increasingly litigious society, institutions have developed institutional policies and procedures to handle professional misconduct. When a practitioner is reported for being incompetent or unethical or for engaging in illegal conduct, an institution has a legal duty to investigate and take appropriate steps to protect patient safety (Northrop, 1986). Institutional requirements may be buttressed by accreditation requirements. For example, the Joint Commission requires health-care staffing services to have a process for handling professional misconduct.

Johns Hopkins School of Medicine (2010) provides a good example of institutional policies and procedures. They have developed definitions and standards as well as procedures on how to respond to evidence or complaints of unsatisfactory performance of professional duties or unacceptable behaviors. The procedures direct a person who believes he or she observed professional misconduct to discuss the concerns with the relevant department director in confidence. (If the complaint is about the conduct of the relevant department director, the person should go to the next-level supervisor.) The initial responsibility for reviewing the complaint lies with the relevant director or supervisor. At this stage, the method for resolution may be an informal process with minimal record-keeping requirements. If the situation cannot be resolved, a written report goes to the next level of responsibility for formal review and adjudication. An ad hoc investigation committee may be convened to give the matter a full review.

Issues of competency are often best assessed by an appropriate peer review board rather than another individual practitioner. However, there is no documentation of how common, and effective, these institutional policies are. Moreover, when the practitioner is an employee, it is inevitable that questions of loyalties arise. Although codes of ethics, as noted earlier, are overall clear in the mandate for nurses to report incompetent and unethical colleagues, when the colleague of concern is an employer or a fellow employee within an institution, the challenges to reporting are significant and may contribute to underreporting to avoid a possible job loss or reassignment. If the APRN who filed the complaint is not satisfied, or uncomfortable with the institutional response, he or she always has the option of informing the licensing board and appropriate professional associations. This again highlights the need for clarity of reporting policies and processes on the regulatory level.

State-to-State Variations
The NCSBN (2009) provides a clear statement of reporting responsibilities: “Any person who has knowledge of conduct by a licensed nurse that may violate a nursing law or rule or related state or federal law may report the alleged violation to the state board of nursing where the situation occurred.” However, significant variations in reporting requirements, the mechanisms for reporting, and the processes for following up on complaints exist from state to state. For a listing of violations in a particular state, the NCSBN recommends looking in the Grounds for Discipline section of the nurse practice act.

### Table 1

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<thead>
<tr>
<th>Addressing Colleague Misconduct in Codes of Ethics</th>
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<tr>
<td>The available codes of ethics address colleague misconduct. However, they do not clearly describe what constitutes professional misconduct, nor do they specify how to handle it.</td>
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<td>The American Nurses Association and American College of Nurse Midwives (ACNM) codes are the most explicit, but still do not provide specific details consistent with their overall focus on ethical principles. The ACNM’s code (American College of Nurse Midwives, 2008) addresses colleague misconduct by stating that midwives will “protect women, their families, and colleagues from harmful, unethical, and incompetent practices by taking appropriate action that may include reporting as mandated by law” (pg. 12). This code emphasizes the responsibility of midwives to protect their patients and the patients of their colleagues, but midwives must also “protect themselves and their colleagues from practices or behaviors that cause harm” (pg. 12).</td>
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<td>The code of ethics of the American Association of Nurse Anesthetists mentions colleague misconduct but does not provide specifics about addressing it. This code states, “The certified registered nurse anesthetist (CRNA) takes appropriate action to protect patients from health care providers who are incompetent, impaired, or engage in unsafe, illegal, or unethical practice” (American Association of Nurse Anesthetists, 2010, pg. 1).</td>
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<td>APRN organizations have not consistently addressed how to handle colleague misconduct in their codes of conduct. Both the American College of Nurse Midwives and the American Association of Nurse Anesthetists have codes that reference colleague misconduct. (See Table 1.) A code of ethics could not be found for the National Association of Clinical Nurse Specialists. The American Academy of Nurse Practitioners and the American College of Nurse Practitioners do not have codes of ethics. Peterson and Potter (2004) proposed one for nurse practitioners (NPs) that includes: “The NP shall not engage in fraud or deception and shall report any other health care provider that engages in such activities.” This code has not been accepted by any APRN organization. The National Association of Pediatric Nurse Practitioners refers its members to the ANA code of ethics.</td>
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### Institutional Policies and Procedures

In an increasingly litigious society, institutions have developed detailed policies and procedures for dealing with professional misconduct. When a practitioner is reported for being incompetent or unethical or for engaging in illegal conduct, an institution has a legal duty to investigate and take appropriate steps to protect patient safety (Northrop, 1986). Institutional requirements may be buttressed by accreditation requirements. For example, the Joint Commission requires health-care staffing services to have a process for handling professional misconduct.

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Examining the laws of several states illustrates the variation in legal and regulatory requirements for reporting and handling colleague misconduct. Wyoming, for example, has no requirement to report colleague misconduct; however, employers must report the names of nurses who have been terminated voluntarily or involuntarily, which may or may not involve misconduct (Wyoming State Board of Nurses, 2010).

In Rhode Island, grounds for discipline include being unfit, incompetent, or guilty of professional misconduct, but there is no specific requirement to report colleague misconduct. The BON has an Advanced Practice Nurse Advisory Committee that meets at least twice a year to review problematic advanced nursing practice under a variety of provisions. However, nothing addresses the need for the individual APRN to report professional misconduct, though employers are instructed to report (Rhode Island Department of Health, 2010).

In other states, the BON is more explicit about reporting professional misconduct. A Colorado BON policy says that “licensees or certificate holders whose continued practice may pose a risk of harm” to their patients must be reported to the BON (Colorado Board of Nursing, 2010). Complainants do not need to report an incident when all of the following conditions are present:

- The potential risk of physical, emotional, or financial harm to patients from the incident is low.
- The incident is a single event without any pattern of poor practice.
- The licensee or certificate holder demonstrates accountability and a conscientious approach in his or her practice relative to the incident.
- The licensee or certificate holder appears to have the knowledge and skill to practice safely (Colorado Board of Nursing, 2010).

The Colorado BON also outlines information that should be reported, such as failure to meet appropriate standards of patient care that results in serious harm or risk to patients; disciplinary actions, such as termination, by an employer because of substandard care; and conviction of a felony that affects the nurse’s ability to practice safely. The BON outlines the process for following up, but the focus is on what happens after the BON receives the complaint, not on what the complainant does.

In New Mexico, the BON requires reporting. The rules explicitly state that nurses must report “incompetent and unprofessional conduct to the appropriate authorities” and “violations of the Nursing Practice Act and administrative rules of the board of nursing to the board of nursing” (New Mexico Board of Nursing, 2010, pg. 10).

Failure to report can have consequences. In South Carolina, an employer or nursing supervisor must report misconduct or incapacity to the BON within 15 business days of discovering the misconduct or incapacity. A nurse supervisor who fails to do so may be subject to disciplinary action and civil sanctions (South Carolina Code of Laws, 2010). An employer who is not licensed by the BON and who fails to report misconduct or incapacity within the time limit may be ordered to pay $1,000 per violation.

**Standardizing Policies**

In an age of increasingly accurate outcome tracking, emphasis on transparency, and the move toward payment for performance, standardizing a set of criteria for reporting colleague misconduct must be a priority. Clarity, accessibility, and transparency of reporting requirements and processes are critical to creating a safe and ethical practice environment in a jurisdiction.

Mandatory reporting is one approach to increasing reports of colleague misconduct. Though some states require reporting, no evidence shows whether or not this increases reporting. Clinicians may not view mandatory reporting favorably. In a study of hospital physicians in New Zealand, less than half favored mandatory reporting (Raniga, Hider, Spriggs, & Ardagh, 2005).

A critical issue in developing standardized reporting language is protecting those who appropriately report others. Fear has been identified as a significant barrier in other professional groups, such as physicians. Given several public cases of reprisals against nurses who have reported others, such fear is very real.

Another issue is self-reporting when a professional realizes that he or she is not competent or has behaved unethically or illegally. A review of the ethical literature leaves no doubt that self-reflection and self-regulation are important aspects of ethical behavior and standards. Yet, this review has not unearthed any sources that address self-reporting from an ethical or legal standpoint.

Finally, at least one state mandates content on nursing impairment. The Rhode Island nurse practice act states that curricula should include “ethical and legal aspects of nursing, including identification and intervention of the chemically-dependent student/professional registered nurse and those whose practice is impaired due to mental illness” (Rhode Island Department of Health, 2010, p. vii). However, there is no evidence of the effectiveness of mandating specific content. Moreover, mandated content on ethics, professional misconduct, and regulation of same may be counterproductive if nursing programs simply provide the minimum information without engaging students in deep learning. Continuing education in this area could be mandated, as many states did with education on medication errors; however, there is no evidence that this would enhance the management of professional misconduct.

**Recommendations for APRNs**

Overstreet (2001), a mental health professional, recommends the following when confronted by potential misconduct by a colleague:

- **Recommendations for APRNs**
Know the reporting requirements of the state where you practice.

Be objective so you can fully understand the situation.

Explore all options for resolution from talking to the colleague to reporting the misconduct to the appropriate authorities.

Choose the most appropriate action based on the reporting requirements and an objective assessment of the situation.

Lowell and Massey (1997) developed a Reportable Occurrences Decision-Making Tree that outlines steps to take when confronted with possible professional misconduct. First, an APRN would consider how to clarify the behavior or incident with the colleague. Next, the APRN would determine to whom he or she should report the behavior or incident. The APRN would also consider when to report the behavior or incident. If patient safety is compromised or at risk of being compromised, the APRN would report the behavior or incident immediately and the APRN would clearly document the nature of the professional misconduct.

We recommend using guidelines based on the approaches to handling professional misconduct by Overstreet (2001) and Lowell and Massey (1997), our review of the literature, and our professional experience (see Figure 1). Depending on the situation, an APRN may or may not go through the steps sequentially. For example, an APRN may go back and forth between documenting the incident and exploring options for resolution.

On a broader level, APRN professional organizations should more clearly address the ethical obligations for handling colleague misconduct in their codes of ethics or support the ANA Code of Ethics and other statements regarding professionalism.

Education on colleague misconduct must be carefully thought out. Winland-Brown and colleagues (2010) found that 41.1% of their nurse, NP, and physician respondents who had formal ethics training described an increase in their perceptions of colleague misconduct and associated moral distress. The likely explanation is that ethics training makes a person more aware of what one ought to do. Through the creative use of case studies, role playing, and participation in misconduct processes, such as state BON disciplinary hearings, APRN students could increase their understanding of colleague misconduct and develop skills for handling it.

The colleagues of Terri Hodges never did report her misconduct to the BON. However, after several colleagues talked to her employer, she discussed her concerns with Ms. Hodges. Ultimately, Ms. Hodges decided to close her practice. Unfortunately, several patients were upset because they lost their primary-care provider. Had her colleagues discussed their concerns with her sooner and more directly, or if she had been reported to the BON, perhaps Ms. Hodges may have been able to change her behavior and stay in practice, providing much needed adult health care.

Conclusions

The discussion of professional misconduct in advanced practice nursing raises several issues, including using standardized language and ensuring that APRNs know what misconduct is and how to handle it. The need for heightened vigilance and sensitivity to this issue should be viewed as providing opportunities for positive change. Professional misconduct and the moral distress it can create in APRNs may promote professional growth and enable APRNs to engage in more compassionate care (Corley, 2002). APRNs must be able “...to go home at night knowing that they did all they could while making a difference in someone’s life [and] keeping their moral integrity intact” (Winland-Brown, Chiarenza, & Dobrin, 2010, p.12). The discussion of

![Figure 1: Guidelines for Reporting Professional Misconduct](image-url)

**Guidelines for Reporting Professional Misconduct**

The following guidelines will help you effectively respond to evidence or complaints of unsatisfactory performance of duties or unacceptable professional behaviors by a colleague. Taking these steps and managing the interpersonal communications can be challenging, but they are critical to ensure safe and appropriate patient care.

- Know the ethical standards related to reporting professional misconduct.
- Know what constitutes professional misconduct in your state.
- Know the institutional and state reporting requirements.
- When you witness an incident, be objective so you can fully understand the situation.
- Clearly document the incident. Include dates and the nature of the misconduct.
- Explore options for resolution and choose the most appropriate course of action.
- If the behavior poses a risk to patient safety, immediately report it to the appropriate authority in the institution.
- Discuss the incident directly with the colleague.
- If the behavior continues, report the incident to the appropriate authority in the institution’s chain of command (if that has not already been done).
- If neither of these steps resolves the situation, you are obligated to report the person to the appropriate state authorities.
professional misconduct may also assist organizations in creating
caring ethical environments with clearer, more supportive
structures for reporting and following up on professional mis-
conduct. And the discussion may help regulatory bodies come
together in meaningful and consistent ways to protect the health
and safety of the public.

Recommendations issued from many quarters call for re-
deﬁned roles for primary-care physicians, NPs, and physician
assistants and standardized professional regulations across states
to achieve meaningful and comprehensive delivery of primary
care (Pohl, Hanson, Newland, & Cronenwett, 2010, p. 5). All
standardized, professional regulations must include clear deﬁni-
tions of professional misconduct as well as concise, fair, clear, and
transparent policies and procedures on reporting it. The diverse
strands of professional misconduct must be pulled through all
phases of LACE (the new model for APRN regulation that brings
together the four dimensions of licensure, accreditation, certiﬁca-
tion, ad education). Only then can regulatory reform achieve its
true aim of safe patient care.

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