Home Study Program

Substance abuse among nurses—Defining the issue

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MANAGEMENT

AORN Home Study

Editor's note: *This is the first article in a two-part series.*

Alcohol and drug addiction are primary, chronic, progressive, and often, fatal health problems. United States society does not accept addiction as a disease, but instead views it as a moral failure or lack of will power.[1(p27)] Many nurses choose to remain silent about a colleague who may have a substance-abuse problem because of loyalty, fear of being a hypocrite, guilt, or fear of jeopardizing a colleague's license to practice. Addiction must be accepted as an illness so that nurses can help one another recognize and seek treatment for the problem.

This article discusses how society views addiction and the nursing profession, describes signs and symptoms of substance abuse, and explains why nurses should report an impaired colleague. The code of silence that exists among nurses also is discussed, as well as board of nursing jurisdiction in substance-abuse cases. Definitions related to addiction are given in Table 1.

Addiction in the General Population

Data from the 1999 National Household Survey on Drug Abuse indicated that 13.1% of the employed population in the United States were substance abusers.[2] Recent statistics from the National Institute on Alcohol Abuse and Alcoholism indicate that 14 million people in the United States (ie, one out of every 13 adults) abuse alcohol, and millions more engage in binge or heavy drinking that eventually can lead to alcoholism.[3] One author states that one out of every three employees reports being affected by a coworker's substance abuse problems.[4]

Statistics indicate that employed people who abuse substances are unreliable on the job.[2] Compared to nonusers, alcohol and illicit drug users are more likely to have

- changed jobs frequently,
- missed two or more days of work in the past month,
- resigned voluntarily from a job in the past year,
- been terminated by an employer in the past year, and
- been involved in a workplace accident in the past year.[2]

Addiction in the Nursing Population

The prevalence of alcohol and drug abuse in the nursing population has not been fully documented, but it is believed to parallel that of the general population. It is suspected that 10% of the

ABSTRACT

- **THE PREVALENCE OF SUBSTANCE ABUSE in the nurse population is believed to parallel that in the general population (ie, approximately 10%).**
- **NURSES WITH SUBSTANCE ABUSE problems need help. They are in danger of harming patients, the facility's reputation, the nursing profession, and themselves. The consequences of not reporting concerns can be far worse than those of reporting the issue.**
- **PART ONE OF THIS TWO-PART SERIES discusses how society views addiction and the nursing profession, signs and symptoms of substance abuse, reasons nurses should report an impaired colleague, the code of silence that exists among nurses, and board of nursing jurisdiction.** ***AORN J*** **82 (October 2005) 573-596.**

TABLE 1
Definitions[1-11]

Abuse
The level of alcohol or drug use that typically leads to adverse physical or psychological consequences.

Alcoholism
Alcohol is a central focus of the person's life and recovery usually requires treatment and support. Alcoholism is defined as
- a craving for alcohol;
- the inability to limit the amount of alcohol consumed; and
- physical dependence (ie, demonstrated by withdrawal symptoms) and tolerance (ie, requiring a greater intake to produce the same effect).

Binge drinking
Consuming five or more drinks on one occasion.

Chemical dependency
A primary, chronic, progressive disease that can be fatal if untreated.

Enabler
One who engages in behavior patterns that facilitate another's continued abuse of alcohol or drugs.

Impaired nursing practice
The inability of a nurse to perform the essential functions of his or her practice with reasonable skill or safety because of chemical dependency on drugs or alcohol or mental illness.

Intervention
A structured method of penetrating the delusional system of an impaired individual to help that person recognize his or her problem and the need to seek treatment immediately.

Licensure
Licensure is required when specialized knowledge and independent decision making are required, such as in nursing. Nursing licenses ensure that individuals have met minimum requirements for education, examination, and behavior in order to perform as a nurse.
- State agencies define the minimal level of competency for a specific scope of practice that an applicant must meet for safe practice.
- The agency is responsible for validating that the applicant has met these requirements and legally can perform the duties as defined in the scope of practice.
- If not, the license is not earned or is suspended or revoked. The agency also has the right to confer disciplinary actions when laws and regulations are violated.

nursing population has alcohol and/or drug abuse problems, and that 6% of nurses have problems that are serious enough to interfere with their ability to practice.[5] The American Nurses Association (ANA) has estimated that 6% to 8% of nurses use either alcohol or drugs to an extent sufficient to impair their professional judgment.[6] Among nurses, prescription-type medication use has been noted to be higher and marijuana and cocaine use has been noted to be lower than in the general population.[7,8] Statistics show that nurses are more likely to practice sobriety compared to people in other occupations.[9]

A major underlying reason for substance abuse among health care professionals is related to family histories that include emotional impairment, alcoholism, drug use, and/or emotional abuse that results in low self-esteem, overachievement, and overwork.[10] This environment can produce individuals who help troubled family members either in a positive (ie, nurturing) or negative (ie, enabling or co-dependent) manner.[10] It also has been noted that people in the helping professions, particularly nurses, have significantly

TABLE 1
Definitions[1-11] (continued)

Negligence in nursing practice
Occurs when a patient's life is harmed due to failure on the nurse's part to exercise reasonable and prudent behavior.

Prescription-type drug misuse
Using prescribed medications (eg, amphetamines, opiates, sedative/hypnotics, tranquilizers, inhalants) without a prescription, in greater quantities or more often than prescribed, or for reasons other than those prescribed.

Substance abuse
Overindulgence in or dependence on addictive substances, especially alcohol or drugs.

Substance use
The limited, controlled consumption of a drug without significant and adverse consequences to the user.

1. C West, " A person who is sick deserves the chance to get well," Michigan Nurse *(November 1997) 4-6.*
2. H W Chappell et al, "Nursing law violations: A threat to competent and safe nursing practice," Jonas Healthcare Law, Ethics, and Regulation *1 (September 1999) 25-32.*
3. D M Bush, J H Autry, "Substance abuse in the workplace: Epidemiology, effects, and industry response," Occupational Medicine *17 (January-March 2002) 13-25.*
4. M Kinsley, "A helping hand to freedom: Programs help nurses with substance abuse problems get back on the road to recovery," Nursing Spectrum *(Nov 15, 2004) 10-11.*
5. J B Bennett et al, "Team awareness for workplace substance abuse prevention: The empirical and conceptual development of a training program," Prevention Science *1 (September 2000) 157-172.*
6. A M Trinkoff, C L Storr, "Substance use among nurses: Differences between specialties," American Journal of Public Health *88 (April 1998) 581-585.*
7. A M Trinkoff, C L Storr, M P Wall, "Prescription-type drug misuse and workplace access among nurses," Journal of Addictive Diseases *18 (1999) 9-17.*
8. N B Fisk, D A Devoto, "The nurse employee who uses alcohol/other drugs," Nurse Managers Bookshelf *2 (December 1990) 110-129.*
9. P D Blair, "Report impaired practice—STAT," Nursing Management *33 (January 2002) 24-26, 51.*
10. P L Cerrato, "What to do when you suspect incompetence," RN *51 (October 1988) 36-41.*
11. D M Flook, "The professional nurse and regulation," Journal of PeriAnesthesia Nursing *18 (June 2003) 160-167.*

higher incidences of alcoholism in their families of origin.[11] In one study, family alcoholism contributed to alcohol abuse in approximately 80% of nurses who had an alcoholic family member.[12]

Many nurses are adult children of alcoholics and, therefore, are prone to interact with other dependent people in ways that are considered enabling. Although the enabler's behavior may be well intentioned or unwitting, the enabler ignores or covers up the signs that something is wrong and accepts unlikely excuses.[11] Indeed, children in alcoholic families learn that drinking alcohol to excess is normal behavior.[12] Health care professionals who fit this description may be attracted to nursing careers because of the opportunity to continue in a care-giving role.[10]

Stress in the workplace provides another explanation for why some nurses abuse substances. Increased workloads, decreased staffing, double shifts, mandatory overtime, rotating shifts, and floating to unfamiliar units all contribute to feelings of alienation, fatigue, and, ultimately, stress.[4,13] Substance abuse may be a way of coping in jobs perceived as alienating. Nurses may deal with these issues

because they have no choice or because they are workaholics and are addicted to their careers—they live, breathe, and sleep work.[1]

Finally, health care professionals are at risk for drug abuse because of the availability of medications in the workplace and the cultural acceptance within nursing that pharmacologic agents provide a desirable method to cure one's ills. Health care provides a permissible climate in which to use exogenous substances to correct internal feelings or illnesses.[14] Nurses have been taught that medications solve problems. They have seen medications alleviate pain, cure infections, and diminish anxiety. Not only are prescription medications accessible, but nurses also have a mistaken belief about their personal skills and level of knowledge to self-medicate without becoming addicted.[15,16] Self-medicating behaviors may only be viewed as inappropriate when the magnitude and regularity of these behaviors increases. Access creates a familiarity with controlled substances that can increase the likelihood that nurses will use them on their own. Nurses may erroneously believe that they have the ability to control and monitor their own use of medications because of their experience with administering medications and observing their effects on patients.[8] Some nurses "believe that they are immune to the negative consequences of drug use because they are so familiar with drugs."[7(p581)]

A health care professional's impairment can be further exacerbated by overwork, sleep deprivation, a poor social life, and financial problems.[10] Nurses who have been dependent on chemical substances have described some factors that led to their problem, including

- psychological or physical pain,
- emotional problems too complex to handle, and
- a demanding, high-pressure, and stressful work environment.[12]

Nurses also may have difficulty admitting their own problems. In general, nurses who abuse substances often are well-liked and respected, bright and highly skilled, and ambitious and achievement-oriented.[12] These nurses are in demanding jobs that involve responsibility and require commitment. Evidence demonstrates that nurses who abuse alcohol "tend to be achievement oriented people who strive to be 'super nurses' at work and 'superwomen' elsewhere."[12(p79)] Although nurses who abuse substances may seem to have everything under control, they often have a history of

- family problems,
- previous emotional or mental health problems,
- family members with chemical dependency, or
- sexual trauma.[5]

Some nurses may erroneously believe that they are immune to the negative consequences of drug use and that they have the ability to control their own medication use.

Although several studies have shown that nurses may not have a higher risk of abusing substances than the rest of society,[7] there may be subgroups within nursing that are more prone or vulnerable to abusing substances. Exposure to death and dying, demanding jobs, lack of education on alcohol and medication hazards, and burnout take their toll on nursing staff members.[7] Different nursing specialties have different personnel selection factors, demands in the work setting, and availability of controlled substances.

Nurses who work in critical care settings (ie, emergency departments [ERs], intensive care units [ICUs], ORs,

postanesthesia care units), for example, report more prescription-type substance abuse and easier access to substances in the workplace than non critical care nurses.[7] One study demonstrated that ER and ICU nurses were more likely than their peers to report using marijuana and cocaine and binge drinking.[7] A theory for this finding is that people who work in these departments are more likely to have a "sensation-seeking" personality trait that embraces exposures to crisis situations. This trait actually has been identified on the genetic marker as an impulsivity gene.[7]

Nurses who work in critical care settings (ie, emergency departments, intensive care units, ORs, postanesthesia care units) may be more prone to abusing substances than other nurses.

Other factors that may result in an increase in substance use for ER and ICU nurses include increased frequency of dealing with death, unpredictable work pace, the immediacy of the nursing intervention, reliance on pharmacologic agents, heavy work demands, and ready access to controlled substances.[7] Working on a critical care unit is technically and emotionally demanding. Patients die unexpectedly, which can make a nurse feel that he or she has failed. Work demands also can extend beyond the limits of a nurse's professional preparation, and on-the-job training can be insufficient to reassure him or her of competence, which results in high stress levels.[17]

Nurses who work in oncology also have high overall substance use rates, particularly with binge drinking.[7] One theory for this behavior is that alcohol consumption serves as a coping mechanism to help nurses distance themselves from the emotional pain they experience while working with patients who have cancer.[10] Psychiatric nurses also experience high levels of substance use, and this practice is heavily oriented around pharmacologic agents.[7] Nurses working in psychiatric areas may consider self-medication more acceptable because they work in a culture that accepts using psychotropic medications to cope with life. Additionally, psychiatric nurses may be more willing to report their use of substances than other specialty nurses because they perceive this as an acceptable form of treatment.[7]

Pediatric and women's health nurses report the lowest use of addictive substances.[7] This could be due to the lack of availability of these substances on their units, or it could be that this population of nurses is emotionally expressive. People who are able to express their feelings may have less need for substance use.[7]

Illness Versus Moral Failure

Recovering from chemical dependency is a life-long process, and some individuals require more than one round of treatment to be successful. Most states and employers recognize substance abuse as a disease that requires treatment.[18] Alcohol abuse and other drug addictions are recognized as medical conditions with corresponding ICD-9 codes. Despite this classification system and the growing awareness of the illness, shame is still associated with addiction. Nurses who abuse substances are stigmatized by their colleagues and society.[19] "Blaming, scolding, or punishing, however, really have no place in the treatment of any illness."[11(p128)]

The stigma that addiction is a moral failure or lack of willpower rather than a disease is pervasive and embedded in the fabric of US society, "and when the

addict is a nurse, the stigma is even greater."[1(p27)] Society, in general, views nurses as angels of mercy; nurturers par excellence; or the lily-white, starched presence of yesterday's movies. Being placed on such a pedestal has its consequences when a nurse becomes a "fallen angel." Society and other health care professionals are quick to demonize this fallen angel as a "'bad person' who now steals our grandmother's pain pills."[11(p111)]

Health care professionals are more harsh and punitive toward colleagues who abuse substances than they are toward others in the general population.[10] This phenomenon probably occurs because health care professionals are perceived to be highly educated, responsible people who have earned a position of trust with patients and patients' family members.[10] Nonabusing nurses often have moralistic, stereotypical, and pessimistic views about addiction. One explanation for this harsh view is that nurses expect perfection from themselves and their coworkers because they hold patients' lives in their hands.[1,20] One survey found that nurses perceive individuals who have substance abuse problems as immoral and as having character defects with low probability of recovery.[20] Nurses who have substance abuse problems, therefore, carry the stigma associated with this breach in professionalism.

Embracing the concept that addiction is a definable medical illness is imperative. Nurses are people with failings like everyone else. Removing the stigma associated with substance abuse will make it easier for nurses to seek treatment and disarm the code of silence that exists on nursing units.[19]

Signs and Symptoms

Although some nurses may be successful at disguising or hiding a drinking or drug problem, employees familiar with substance abuse are more likely to detect it in others.[4] Signs and symptoms exhibited by nurses who have substance abuse issues are listed in Table 2. Many of these signs and symptoms are general and nonspecific, but when an individual's behavior is analyzed over time, the picture becomes clearer.

Nurses who abuse substances become financial liabilities to their employers because of increased use of health benefits, absenteeism, workplace accidents and associated workman's compensation and disability claims, theft and security problems, and decreased productivity and high turnover rates. Serious relational (ie, hidden) costs include lower morale and poor communication within the department and diverted supervisory and managerial time.[2,4,21,22]

Embracing the concept that addiction is a definable medical illness is imperative to help remove the stigma associated with substance abuse, making it easier for nurses to seek treatment.

Nurses with alcohol dependency tend to drink before their shift, during lunch and coffee breaks, and in the bathroom.[5] Some nurses may abuse cough syrup and mouthwash, which are readily available on most units.[5]

Nurses who abuse drugs may support their addiction with prescription medications. Undiverted prescriptions are obtained when a nurse asks a staff physician to write a prescription. Nurses who abuse drugs also forge prescriptions.[5] Diverted prescription medications come either directly from patients or from the unit's medication dispensing system.[5] For example, sterile water or saline can be substituted for a patient's dose when the medication is

TABLE 2
Signs and Symptoms of Addiction in Nurses[1-6]

Alcoholism	Drug addiction	Both
Psychosocial		
• Family history	• History of back problems, migraines, serious injuries	• Fearful, anxious, panic attacks • Feelings of impending doom • Paranoid ideation • Shameful, guilty, lonely, or sad • Defensive (eg, denial, rationalization, projection) • Decreasing social life and social interactions and no interest in nonwork activities • Spiritual distress • Financial, marital, and family problems • Frequent emergency room visits and hospitalizations
Physical		
• Odor of alcohol or cover-ups (eg, mints, sprays, perfumes, chewing gum, mouthwash) on breath • Flushed and/or puffy face • Bloodshot or glassy eyes • Unsteady, stiff, or listing gait • Tremors, restlessness • Evidence of poor nutrition • Unusual medical history (eg, liver disease, gastritis)	• Runny nose, watery eyes • Very dilated or constricted pupils • Weight loss or gain • Goose flesh, diaphoresis • Dizziness or light headedness • Regular wearing of long sleeves • Sleeping on the job	• Gastrointestinal symptoms (eg, nausea, diarrhea) • Withdrawal symptoms (eg, hangovers) • Elevated blood pressure • Palpitations, tachycardia • Hyperventilation • Deteriorating personal appearance (eg, poor hygiene) • Increasing medical problems • Blackouts
Behavioral		
• Slowed, thick, or slurred speech • Use of inappropriate humor or persistent morosity • Reduced productivity • Errors in judgment	• Inappropriate laughter • Decreased concentration • Hyperactive or oversedated	• Impaired cognition • Increasing forgetfulness • Isolation or withdrawal from colleagues • Diminished alertness (eg, confused, preoccupied) • Frequent complaints of vague illnesses or injury • Mood swings (eg, erratic outbursts, emotionally labile) • Fails to keep appointments

clear. The nurse then gives the remaining dose to the patient and saves the difference for his or her own use later. The nurse also may administer a partial dose to a patient and save the difference for his or her own use. Nurses also may self-administer wasted medications, which can happen when a colleague cosigns the narcotics record regarding a wasted medication without actually witnessing the medication being wasted.[5]

Other ways to divert medications include signing out medications for patients who are transferred or discharged from the unit or signing out doses of as-needed medication for patients who have not requested the medication or who may have refused it.[5] Nurses also have been known to back date medication records, alter physicians' orders, or write a verbal order for a medication without a physician's authorization.[5]

TABLE 2
Signs and Symptoms of Addiction in Nurses[1-6] (continued)

Alcoholism	Drug addiction	Both
Substance-seeking behavior		
• Requests night shift • Requests jobs in less supervised settings (eg, long-term care) • Makes friends with an enabler • Makes frequent trips to obtain things from large handbag • Disappearance of cough medicine	• Volunteers to count narcotics • Volunteers to pick up controlled substances from pharmacy • Signs out medications for discharged or transferred patients • Signs out more controlled medications than coworkers • Makes frequent medication errors with or without altering records • Requests assignments as medication nurse • Discrepancies between physician orders, progress notes, and medication records • Fails to obtain cosignatures • Frequently requests other nurses to cosign at end of shift • Frequent unwitnessed medication loss, spills, or wasting • Evidence of tampering with vials or capsules • Opens narcotics box when alone • Overmedicates compared to other nurses (eg, excessive use of as-needed medications) • Volunteers to work with patients who receive pain medication • Prefers to care for patients with decreased levels of awareness • Patients complain of ineffective pain relief • Requests unsupervised evening or night shifts	
Job performance		
		• Excessive use of sick time especially after days off • Absence without notice or last minute time-off requests

REASONS TO REPORT AN IMPAIRED NURSE

Substance abuse issues in nursing usually are first noted by staff members. Whether a staff nurse acts on his or her knowledge or chooses to remain silent directly affects patient care and safety and the reputation of the institution. It also ultimately affects the impaired colleague's level of functioning. The path of least resistance (ie, dismissing a suspicion) is much easier to follow than contending with suspicious behaviors.[11] Nurses should understand that if addicted nurses are not helped, they are in danger of harming patients, the facility's reputation, the nursing profession, and themselves.[17] The consequences of not reporting concerns can be far worse than reporting these issues.

Problems related to substance abuse usually do not surface on the job until long after the problem has begun. By the time a nurse demonstrates negative

TABLE 2
Signs and Symptoms of Addiction in Nurses[1-6] (continued)

Alcoholism	Drug addiction	Both
Job performance		
		• Frequent tardiness • Frequent or unexplained disappearances from unit (eg, long breaks and lunches, frequent time in bathroom) • Decreased job performance • Negligence in patient care (eg, inattention, rudeness) • Increased difficulty meeting schedules or deadlines • Disorganized, illogical charting • Excessive mistakes (eg, errors of judgment in patient care) • Going on rounds at unusual or inappropriate hours • Elaborate, implausible excuses for behavior • Casually asks physicians for prescriptions • Inappropriate verbal or emotional responses (eg, snapping at colleagues) • Handwriting deterioration • Frequently requests colleagues to cover • Seems like a workaholic (eg, frequently works overtime, arrives early and stays late, does not take breaks, visits unit on days off)

1. J B Bennett et al, "Team awareness for workplace substance abuse prevention: The empirical and conceptual development of a training program," Prevention Science *1 (September 2000) 157-172.*
2. P D Blair, "Report impaired practice—STAT," Nursing Management *33 (January 2002) 24-26, 51.*
3. J Daprix, "The courage to care: Intervening with colleagues who demonstrate signs of impairment," The Florida Nurse *51 (September 2003) 28.*
4. N B Fisk, D A Devoto, "The nurse employee who uses alcohol/other drugs," Nurse Managers Bookshelf *2 (December 1990) 110-129.*
5. S Ponech, "Telltale signs," Nursing Management *31 (May 2000) 32-37.*
6. C West, "A person who is sick deserves the chance to get well," Michigan Nurse *(November 1997) 4-6.*

or inappropriate work habits, the problem already has reached a serious stage.[5,11] "Usually, by the time a nurse is caught and confronted, most of the people in the unit knew"[23(p148)] there was a problem. Nurses need to talk more among themselves and examine their complicit code of silence (ie, the "don't talk rule") that permeates their nursing units. In the long run, "perpetuating the code of silence will only undermine the public's trust in nurses."[24(p11)] It is incumbent upon institutions to create systems that allow for reporting and tracking substance-abuse incidents and provide education and support to help nurses participate in rehabilitation and avoid placing patients in harm's way.

Nurses have an ethical and legal obligation to report colleagues whose activities could or do harm patients. "Patients, who are vulnerable, have the right to safe, skilled care administered

by a nurse who is mentally and physically able to perform certain nursing duties."[25(p21)] Nurses also have an obligation to protect the organization in which they work by reporting impaired practice when it is observed.[25] In some states, remaining silent can result in charges against the nurse who knew something but did nothing because this nurse supported an environment that permitted a colleague's negligence or malpractice. Remaining silent violates a nurse's ethical duty to safeguard patient care.[18]

According to the ANA, nurses are responsible for responding when a colleague is exhibiting questionable practices. The ANA proposes that nurses help impaired colleagues obtain assistance by reporting suspicions or events to appropriate personnel in the employment setting. It is nurses' "responsibility to respond to a coworker's questionable practice as an advocate for the patient."[26(p24)]

A second major reason to report a nurse who behaves in a suspicious manner is to help that person. People who are entangled in their addiction sometimes need help acknowledging and accepting treatment. Reporting a colleague actually could help save his or her life. Another reason to report an impaired nurse is to help keep that nurse in the profession after he or she has gone through rehabilitation. On another level, nursing professionals, as members of the caring trade, should help one another overcome personal obstacles.

A survey demonstrated that the severity of an incident was an important piece of information nurses used in deciding whether to report a peer.[27] For example, if a patient did not receive his or her requested pain medication but was unharmed (eg, no increase in blood pressure or pulse with resulting symptoms), a nurse may be reluctant to report the incident. If, however, the patient then tried to get out of bed, fell, and was injured, this same nurse would feel compelled to report the incident to the manager. Additionally, the respondents stated that they also considered whether the nurse usually was a good care provider along with potential repercussions to the nurse if he or she was reported.[27] In other words, many nurses do not report behaviors they find suspicious because they do not believe that the incident was severe enough to report, or they believe that the nurse is a good care provider. Just as near misses should be reported, however, so should all suspicions about another nurse's behavior be documented and reported to the nurse manager. Only as time passes will the weight of the documentation be shown to be relevant or irrelevant. In the meantime, there is no harm in collecting information.

Remaining silent may result in charges against the nurse who knew something but did nothing because this nurse supported an environment that permitted a colleague's negligence or malpractice.

Reasons Nurses Do Not Report

An interesting question is why nurses who are aware of other nurses' substance abuse problems choose not to report or find themselves unable to intervene. First and foremost, friendship acts as a barrier to recognizing and addressing deviant nursing practice. Friendships makes it is easy to look the other way and deny that a problem exists. Loyalty can be a major obstacle to reporting incompetence, particularly in departments that have a strong team spirit.[17]

Some nurses may fear being a hypocrite, particularly if they also indulge in alcohol. Going out for a drink after work with nursing friends is an accepted social phenomenon in the United States.[17] A nurse who is suspicious of another nurse may feel guilty reporting a potential problem because he or she also is one of the group having a few drinks after work. The distinction, however, is the extent and degree to which a nurse drinks and the level of accountability associated with the behavior.[17]

One example in the literature shows how nurses dismiss concerns about a friend. These nurses told themselves that patients had not been harmed and that there was no failure of duty.[17]

Some nurses may not report a colleague because they fear retribution for reporting, such as having their own work scrutinized and criticized.

Many coworkers observe unsafe behaviors but are reluctant to report nurses with whom they work closely and whose personal/professional concerns they understand.[9(p38)]

This occupational subculture, in which employees either bend rules or view certain behaviors as normal rather than deviant, does persist.[4]

Nurses also may not report other nurses for fear of being perceived as snitches or labeled as whistle-blowers. These nurses may be concerned about retribution for reporting, such as having their own work scrutinized and criticized.[27] Some nurses do not want to become involved because confronting someone who may become angry, deny the problem, or plead for another chance can be difficult. Furthermore, nurses who know other people with substance abuse problems already are aware that impaired nurses are good at manipulating people and can distort relationships and block communication.[15] They may question the value of getting involved and expending energy dealing with the issue.

In one study, 91% of survey respondents said they would report an incident that either harmed patients or put them at risk. In reality, however, only about half actually reported all the incidents they had seen.[27(p37)] Most nurses are not educated about how to recognize or intervene with a nurse who is abusing substances. This lack of knowledge contributes to self-doubt about the scenario the nurse has witnessed. Insecurity fosters an environment that enables an abusing nurse to continue and prevents colleagues from documenting and reporting the suspicion.[6] This passive environment condones the code of silence.

Embedded in nursing culture is the practice of covering up for a colleague with a perceived problem, which can actually exacerbate the original problem rather than help the individual concerned.[28(p3)]

[This] *traditional avoidance of honest confrontation not only allows but encourages both the substance abuse and the degree of impaired practice to grow worse.*[17(p48N)]

Just as individuals deny problems, many health care facility administrators deny that alcohol or substance abuse is a significant problem in their organization.[11(p111)] Rather than deal with issues directly, many organizations dismiss or terminate employees with addictive issues without reporting them or providing treatment. These nurses then can apply for employment elsewhere, and their slate is wiped

clean. Even when contacted by the new place of employment, previous employers may leave out pertinent information about the employee being discussed.

> *Some employers say they have become reluctant to provide other employers with frank evaluations of former, and even fired, employees, for fear of libel suits. . . .*[24(p11)]

The result is that impaired nurses can move from job to job without being detected.

Other reasons nurses choose not to report an impaired colleague include fear of being sued, belief that the supervisor will dismiss the information provided, or self-doubt.[29] Compounding these issues is the fact that the law is not very forgiving. A nurse can be a good nurse for 25 years, but if he or she makes one serious mistake, the board of nursing may call it incompetence, which could culminate in the nurse losing his or her license. If the end result could be a termination of employment, arrest, or prosecution with prolonged loss of license, nurses will be less inclined to report an impaired colleague.[15] Reporting could bring shame and social disruption into that nurse's life and have a negative effect on the nurse's livelihood, family life, and career. There is a pervasive belief that reporting a nurse to the state board of nursing will only result in disciplinary action, not treatment.[11] Given the potentially serious consequences of reporting a colleague, some nurses question whether there are situations that justify not reporting.[27] Not surprisingly, reporting an impaired colleague is not a role that is easily embraced.

Boards of Nursing and Nurse Practice Acts

Professional practices, such as nursing, are licensed and regulated to prevent unqualified, incompetent, or unfit practitioners from functioning in the role of the nurse, thereby preventing harm to the public. Each state is given the power to regulate professionals within their own geographic boundaries.[27] Statutory law directs entry into nursing practice in each state, defines the scope of practice, and establishes disciplinary procedures. Statutory law is overseen by each state's board of nursing, which is responsible for protecting the public by determining nurses' competency to practice.[9] The National Council of State Boards of Nursing (NCSBN), the agency to which all boards of nursing belong, defines competency as the application of knowledge and the interpersonal, decision-making, and psychomotor skills expected for the

SIDEBAR

American Nurses Association's (ANA's) Stance on Substance Abuse

The ANA Code of Ethics encompasses compassion, conscience, commitment, and competence in caring for patients, patients' family members and others. The code of ethics also describes a nurse's personal and professional growth.[1] The intention of the code is "to safeguard the client and the public when health care and safety are affected by the incompetent, unethical, or illegal practice of any person."[2(p48I)] It is every nurse's responsibility to acknowledge the needs of an impaired nurse and to help him or her regain full professional capacities. An impaired nurse could have difficulty remaining accountable to himself or herself and to others for his or her actions.[2(p48L,48M),3] In 1982, the ANA passed a resolution to create nondisciplinary, peer-assisted programs for nurses across the country, thereby taking a less punitive and more reparative stance with nurses who abuse substances.[4]

1. "ANA unveils Bill of Rights for RNs," The American Nurses Association, http://nursingworld.org/tan/01sepoct/billrigh.htm *(accessed 18 Aug 2005).*
2. J M Supples, "My colleague, my friend: The impaired nurse," Nursing Management *21 (August 1990) 48I, 48L, 48M.*
3. P D Blair, "Report impaired practice—STAT," Nursing Management *33 (January 2002) 24-26, 51.*
4. S Trossman, "Nurses' addictions: finding alternatives to discipline," American Journal of Nursing *103 (September 2003) 27-28.*

TABLE 3
Boards of Nursing—Common Components

Defines and enforces minimum requirements for safe nursing practice.

Sets licensing requirements and validates licensee credentials.

Outlines and implements procedures for receiving, investigating, and resolving complaints concerning licensees, including taking appropriate disciplinary actions.

Defines standards of conduct, including protecting against unsafe and unethical behaviors.

Interprets and enforces the state nurse practice act.

Approves nursing education programs.

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TABLE 4
Elements of a Nurse Practice Act

Standards of nursing practice

Standards of professional conduct

Professional nurse reporting requirements

Disciplinary procedures

Delegation and supervisory roles and criteria

Continuing education requirements

Name and address notification requirements

Process and requirements for licensure and licensure renewal

Advance practice parameters

Structure and authority of the board of nursing

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nurse's practice role, within the context of public health, welfare, and safety.[13] Competence is the nurse's potential capability to perform in his or her role, along with an assessment of the nurse's actual performance (ie, clinical and technical skills) as it complies with the employer's standards of care.[13]

State boards of nursing use their professional expertise to adopt rules and regulations to implement and enforce the laws. Examples of common components found in state boards of nursing are noted in Table 3. Nurse practice acts are a form of state legislation that define the legal practices of nursing. Table 4 lists some examples of areas overseen by a nurse practice act. Nursing practice, therefore, is directed by two components—state rules and regulations (ie, administrative law) and the state's nurse practice act.

State boards of nursing license nurses and retain the power to suspend or revoke these licenses.[15] Nursing licenses are granted when specific conditions are met, and can be revoked when the nurse does not meet required standards. Nurses can be charged with misconduct, unprofessional conduct, incompetence, or being unfit to practice.[15]

When a nurse accepts employment at a facility, there is an implied agreement between the nurse and the employer that the nurse will carry out his or her duties as would any other reasonable and prudent nurse with the same training in the same or similar circumstances.[30] After meeting the basic requirements of licensure, a nurse is legally responsible for his or her practice and must abide by the conditions of the nurse practice act, as well as many other rules and regulations. A nurse's primary and most important role is that of patient advocate.[28] The nurse also is obligated to avoid any conduct that could cause reasonably, foreseeable injury to the patient. Failure to meet this standard is considered negligence.[30]

Under the authority of the state's nurse practice act, the board of nursing develops and enforces rules defining the scope of nursing practice. Anyone can file a complaint with a state board of nursing, including patients and their family members, nurses, other health care providers, and administrators. The complaint could involve allegations regarding a single incident or ongoing malpractice.[31] The most frequent complaints reported to boards of nursing are obtaining a license under fraudulent circumstances, being convicted of a felony, substance abuse, and conduct that is likely to harm a patient.[28]

Due process guarantees the nurse an investigation by the board of nursing and an opportunity to respond to the allegations and findings of the investigation.

The number of nurses reported varies by state and approaches taken by state boards of nursing also vary. For example, in New Jersey the nurse practice act requires that a nurse be reported to the board if there is evidence, proof, or suspicion of impairment.[19] Some states, on the other hand, require reporting only when direct evidence can be provided. The question that arises, therefore, is to what degree information should be shared between boards of nursing and employers. Does the board of nursing only share information if the nurse's license is suspended or revoked, or will the board of nursing also share information if the nurse is required to enter rehabilitation?

Board of Nursing Proceedings

Some state laws mandate that each complaint against a nurse be investigated while others leave this to the discretion of the board of nursing. The nurse is guaranteed due process, however, which includes an investigation by the board of nursing and an opportunity for the nurse to respond to the allegations and findings of the investigation. This may involve a hearing with or without legal representation.[28] It is sometimes advisable for a nurse to have representation from an attorney because the nurse's response could be used against him or her during the hearing. Investigators will contact witnesses for information and take statements. Investigators also can subpoena documents along with medical records and policies and procedures from the health care facility. If investigators are confident that the state can prove its case, charges will be filed.[31] Hearings can be conducted in front of the board of nursing, or serious claims, such as malpractice, could require a court appearance.

Hearings regarding licensure are considered administrative and investigative, not adversarial.[32] Board of nursing proceedings are less formal and restrictive than a courtroom trial. For example, evidence that would not be admissible in court might be admitted before the board. Another difference is that board members ask questions as the need arises, not according to a rigid protocol. After the investigation is completed and the evidence is furnished, the board openly discusses the matter. How a board arrives at a decision will differ by state. The board's authority over the nurse's license does not end with the hearing; the board can impose disciplinary action.[31]

When a decision is rendered, the nurse has the right to appeal.[31] Nurses should be protected from recriminations, unproven claims, and unsubstantiated charges.[1] The appeal process, however, goes through the civil court system, which requires the nurse's lawyer to prepare trial documents for a full-fledged courtroom appearance. It is best to use this route only if the nurse truly believes he or she has been

wronged by the board of nursing. The court will only overrule the board's decision if it can be demonstrated that the process was not followed or a gross mishandling of the case occurred. It is rare for the court to overrule a board decision when it is based on the merits of the case.[32]

Nurses can be found to be in violation of practice or they may be found guilty of unprofessional or unethical behavior. Penalties and disciplinary actions may be imposed, which includes fines, reprimands, probation, suspension from practice, or revocation of the license to practice nursing.[28] License suspension is the most common disciplinary action for nurses with chemical dependence.[9] When substance abuse is involved, the nurse also may be mandated to attend rehabilitation. There also can be civil and criminal penalties.[28]

Some state boards have developed nondisciplinary alternative programs that offer confidential, voluntary alternatives for nurses with substance abuse problems.

In general, state boards of nursing cases are backlogged. It can take more than a year for a case to be presented before the board. Court calendars are replete with numerous hearing dates, "particularly because of the rising numbers of impaired professionals and the desire of nursing boards to work with them."[32(p20)] Some boards are so overwhelmed with impaired nurse problems, the hearing procedure has been eliminated altogether so that the process can be expedited and help can be provided for the nurse.[32] Depending on circumstances, the nurse also might be allowed to continue working until the hearing date.

Disciplinary processes can be lengthy and expensive.[32] Grounds for discipline include fraud and deceit, criminal acts, substance abuse, mental incompetence, unprofessional conduct, incompetence due to negligence, and the inability to practice nursing with reasonable skills and safety. State boards of nursing also can discipline for willful misconduct (eg, diverting narcotics), misjudgment, or inappropriate action due to lack of knowledge or a lack in vigilance.[9]

Typically, board of nursing members are more in favor of helping nurses than juries tend to be. Boards of nursing generally are focused on rehabilitation, not looking to "strip nurses of their livelihood."[32(p21)] Juries, on the other hand, will find in the nurse's behalf only if there is an overwhelming preponderance of evidence to support the nurse's claim.[32]

A number of state boards have developed nondisciplinary alternative programs that offer confidential, voluntary alternatives for nurses with substance-abuse problems. It has been shown that both the nondisciplinary method and the traditional disciplinary approach are

> *equivalent in regard to continued use or abuse of alcohol and drugs by nurses with a substance-abuse disorder, including among those who returned to the work force, deterring recidivism, keeping impaired nurses from practice, and returning/retaining abstinent nurses in the workforce.*[33(p16)]

Along with the state board's primary goal of ensuring safe and effective nursing care for all patients, a secondary goal is to return a knowledgeable, skilled nurse who is impaired to being a productive member of society.[33]

Although drug or alcohol impairment provides grounds for disciplinary action under state licensure statutes, at least 37 states offer programs to provide rehabilitation for the nurse and forgo

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disciplinary actions.[26] Some of these programs are voluntary, without any threat of referral to disciplinary authorities; some are coercive with discipline withheld as long as the impaired nurse participates in the rehabilitation process. Some states require nurses to sign sworn statements of current sobriety or fitness. Other states allow for reporting to nursing peer assistance programs instead of reporting to the state board of nursing.[26] Although the focus on rehabilitation over discipline may be controversial, the rationale is to attain a higher rate of reporting and self-reporting of the impaired nurse in order to help him or her overcome the addiction.[26] Without early intervention, nurses with substance abuse problems can simply "job hop" from one facility to the next before getting help.[23]

State nursing associations in Georgia, Maryland, Ohio, and Tennessee were the first to initiate help for impaired nurses. California, Michigan, and Ohio have adopted voluntary, confidential compliance programs rather than formal disciplinary actions for impaired nurses.[23] By 1988, more than half of US states had begun offering some sort of assistance or prevention programs. In contrast, all 50 US states had programs for impaired physicians.[34]

Removing the Stigma

Recognizing that substance abuse is a medical illness that requires treatment is the first step in removing the stigma associated with it. Current philosophies of the ANA and boards of nursing support helping addicted nurses seek treatment and rehabilitation to become productive members of society and nurses again. Certainly, communication and information sharing are paramount for this process to be effective.

It is only logical that a nurse who is suspected of abusing substances should be reported. It is the emotional aspect that undermines the reporting process. Being fearful that a colleague may lose his or her job or terminate a friendship are powerful motivators to withhold or dismiss anecdotal or subjective information. As social beings, people are motivated by emotions; the ability of nurses to report a colleague would be less hampered, however, if one of their loved ones was being cared for by a nurse who was impaired. As patient advocates, this is the level of nursing at which all nurses should practice.

The second step is education. Understanding why nurses abuse substances humanizes the experience, which will ultimately prevent nurses from demonizing their colleagues who have this medical illness. To help people, nurses need to understand why people behave the way they do. Then processes, problems, and poorly designed situations can be repaired to help others recover.

Part II of this series will discuss how to confront and report a nurse suspected of substance abuse. Available remedial programs, return-to-work issues, and the continuing need for education regarding substance abuse among nurses also will be presented. ❖

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This article is dedicated to a nurse with whom the author once worked in hopes that she finds her way.

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Notes

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