

## RESEARCH ARTICLE OPEN ACCESS

# Facilitating Rehabilitation of Disciplined Practitioners: A Qualitative Analysis of Insights From Stakeholders in Aotearoa New Zealand

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**Received:** 11 June 2026 | **Revised:** 23 August 2026 | **Accepted:** 28 August 2026

**Keywords:** penalties | professional discipline | rehabilitation | thematic analysis

## ABSTRACT

When determining penalties for professional misconduct, penalty guidelines and principles usually require disciplinary bodies to consider rehabilitation to safe practice where appropriate, as well as the need to ensure public safety. However, little is known in Aotearoa New Zealand as to the barriers and facilitators of rehabilitation to safe practice. Our aim was to explore the views and experiences of rehabilitation in the teaching, health and legal professions in Aotearoa New Zealand to gain insight into the factors that facilitate such rehabilitation. We conducted five one-on-one interviews with disciplined practitioners and three focus groups with key stakeholders involved in ordering, monitoring and delivering rehabilitative conditions and analysed the data thematically. Four key thematic principles were developed that were necessary for rehabilitation of practitioners, namely: (1) instil pro-rehabilitation culture, institutions and processes; (2) craft conditions that restore and retain practitioners; (3) promote practitioner engagement and (4) create feedback mechanisms. These thematic principles underscore that professional discipline occurs as a system of interwoven institutions, systems, processes and individual actors. Key opportunities to operationalise these principles exist in improving communication across levels and stages, providing guiding principles and information on rehabilitation to key stakeholders, strengthening rehabilitation services and promoting a culture of rehabilitation. In doing so, disciplinary systems can balance public protection and safety with restoring practitioners to safe practice.

## 1 | Introduction

Statutory regulation of some professions affords many benefits, including allowing for disciplinary mechanisms in the event of professional misconduct. The effects of professional misconduct are widespread, including public safety, profession reputational damage and increased costs of regulation (Varaei et al. 2024). Disciplined practitioners themselves also may experience profound aftermath of discipline, including reputational harm, stress

and other impacts on health (Cunningham 2004; Stemwedel 2014; Verhoef et al. 2015).

Disciplinary outcomes are guided by explicit penalty principles, including the need for public protection, sanctioning of erring practitioners and rehabilitation of practitioners. Achieving this balance is not straightforward or without controversy (Case 2025). However, given the range of factors underpinning practitioner conduct, there have been calls for exploring more

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therapeutic processes and outcomes (Bradfield et al. 2023; Diesfeld et al. 2024; Price et al. 2025). Thus, questions arise regarding how disciplinary tribunals might balance the need to ensure public safety while also supporting eligible practitioners to return to safe practice where appropriate.

Accordingly, penalty guidelines used by disciplinary bodies in many jurisdictions specifically require them to consider the prospects of rehabilitation. For example, New Zealand's Health Practitioners Disciplinary Tribunal cites rehabilitation as a penalty principle (*Roberts v Professional Conduct Committee* [2012] NZHC 3354) as do guidelines in some other countries (e.g., *General Medical Council and Medical Practitioners Tribunal Service* (2023)). However, little guidance is given as to how rehabilitation principles and theories should be applied in this setting (Surgenor et al. 2023). This gap includes a relative lack of research exploring the barriers and facilitators of rehabilitation in the professional discipline context, including as experienced by practitioners and other stakeholders.

Bronfenbrenner's ecological theory has been applied to better understand the relationships, systems, environments and contexts in which healthcare professionals seek to undertake ethical and safe professional practice (Bronfenbrenner 1979; Davidson et al. 2018; Prendeville and Kinsella 2025). Guided by this approach, we conceptualise misconduct and subsequent professional discipline as occurring in an overall system with the practitioner at the centre of nested systems at different levels, including the practitioner's immediate circumstances; their relationships with other professionals and patients/clients; regulatory, work and professional environments; and broader social, economic and cultural contexts. Interactions between factors such as the practitioner's personal attributes and circumstances, disciplinary institutions and processes and overall disciplinary and professional culture will shape how professional discipline operates and how it is experienced by stakeholders.

Our notion of rehabilitation after misconduct centres on restoring registered practitioners to safe professional practice where appropriate. In Aotearoa New Zealand, the powers of the disciplinary tribunals to order conditions are set out in profession-specific regulatory legislation. Our analysis of the relevant legislation and prior research of disciplinary cases shows that the main rehabilitative conditions are: monitoring, supervision, education, training, assessment and treatment (Surgenor et al. 2023). Understanding the perspectives of a range of stakeholders about the ways in which these rehabilitation conditions are imposed, monitored and experienced is essential to contribute to our knowledge of rehabilitation processes, concepts and outcomes.

## 1.1 | Rationale and Aims

This analysis comprises part of a larger set of studies exploring rehabilitation in the context of professional discipline in Aotearoa New Zealand (Surgenor et al. 2023). The aim of this study was to identify barriers and facilitators to rehabilitation after disciplinary proceedings in selected New Zealand regulated professions. We drew on experiences and views of key stakeholders in three disciplinary contexts (the Health Practitioners Disciplinary Tribunal; Lawyers and Conveyancers Disciplinary

Tribunal and Teachers Disciplinary Tribunal). These Tribunals have similar regulatory legislation and disciplinary tribunal frameworks (Surgenor et al. 2024, 2025).

## 2 | Methods

### 2.1 | Research Design and Ethical Considerations

One-on-one interviews with practitioners who had undergone rehabilitative conditions were conducted, and separately, three focus groups were conducted with key stakeholders involved in ordering, monitoring and delivering rehabilitative conditions. Research participants were recruited through advertisements in the professional press, engagement with relevant professional bodies, lawyers who represented practitioners during disciplinary proceedings and through authors' personal networks. Interviews and focus groups were audio recorded and transcribed verbatim, providing rich qualitative data for analysis. Research protocols were reviewed and approved by the Auckland University of Technology Ethics Committee (AUTC, 22 May 2023 #23/140). All participants provided informed consent prior to inclusion in the study.

### 2.2 | Practitioner Interviews

Eligible participants were currently registered practitioners from the three registered sectors who had been given penalties (but not been deregistered) by their relevant Tribunal, which resulted in completed rehabilitative conditions between 1 January 2018 and 30 December 2022. Practitioners could not be undergoing new disciplinary investigations or current disciplinary orders/conditions, even if they had undergone and completed previous rehabilitation within our time frame. Nine practitioners expressed interest and five met the inclusion criteria. Their occupations were law (4) and medicine (1). A semi-structured interview guide was used to explore their experiences with rehabilitation conditions. This included: the perceived effectiveness of the conditions; cultural responsiveness of the conditions; facilitators and barriers to engagement and suggested improvements regarding rehabilitation conditions.

Interviews with practitioners were conducted by phone, online or in person between 12 March 2024 and 29 May 2024 (44–63 min, mean duration of 53 min). The one-on-one interviewing method supported confidentiality and provided an intimate environment for discussing a sensitive professional experience (Ward and Brown 2004).

### 2.3 | Focus Groups

Three focus groups were conducted: (i) with members of disciplinary tribunals from three regulated sectors (i.e., health practitioners, lawyers and teachers) who *order* conditions ( $n = 5$ ); (ii) with representatives of regulatory authorities who *monitor* completion of conditions ( $n = 7$ ) and (iii) with professionals who *deliver* rehabilitative conditions ( $n = 4$ ), described below as 'service providers'.

One focus group was conducted online, one in person and one in a mixed modality between October 2024 and May 2025, with an average duration of 2 h. All were moderated by LS and KD. The focus group protocol contained open-ended questions designed to explore diverse views regarding rehabilitation, including: principles, processes and values of rehabilitation, cultural responsiveness and barriers/facilitators to effective rehabilitation. This method facilitated interactions between participants from across the three regulated sectors as they discussed the issues and incorporated multiple perspectives regarding how decisions were made, for example, what the specific goals of rehabilitation were, and the methods that were used to achieve rehabilitation (such as education, monitoring or treatment).

2.4 | Analysis

Interview and focus group transcripts were analysed thematically following a thematic process (Braun and Clarke 2022). The six standard steps of this analysis are: data familiarisation; generating initial codes; theme searching; reviewing themes; defining themes and finalising themes to illuminate shared meanings/themes. In applying this approach, KK, MR, KD and LS reviewed the transcripts and developed a coding framework focusing on the barriers and facilitators to rehabilitation. All authors contributed to theme development.

The authors’ positionality as practitioners and academics in various areas of law, psychology and public health, plus their in-depth understanding of the disciplinary process in Aotearoa New Zealand, aided the iterative development of the themes.

Aotearoa New Zealand is a relatively small country (of approximately 5,342,000 as of 16 February 2026), with a correspondingly small number of disciplinary cases each year. To ensure confidentiality, the tribunal, regulatory authority and type of provider

was not specified below. Instead, focus group participants are referred to as tribunal member, regulatory authority member and service provider in the findings. Likewise, interview participants are referred to as a ‘disciplined practitioner’.

3 | Findings

Participants described the interplay of four key thematic principles they considered necessary for the rehabilitation of practitioners. The themes are: (1) instil pro-rehabilitation culture, institutions and processes; (2) craft conditions that restore and retain practitioners; (3) promote practitioner engagement and (4) create feedback mechanisms. These themes and corresponding sub-themes are set out in Table 1. The themes are framed as principles for facilitating rehabilitation after misconduct, and they reflect the theoretical underpinning that effective rehabilitation of disciplined practitioners occurs as a system of interwoven institutions, systems, processes and individual actors.

3.1 | Theme One: Instil Pro-Rehabilitation Culture, Institutions and Processes

This theme emphasised the importance of a profession’s culture and its institutions and processes in promoting rehabilitation.

3.1.1 | Promote Rehabilitation as a Valuable and Achievable Objective of Discipline

Many participants expressed that rehabilitation must be seen as integral to the disciplinary process. Despite this sentiment, some participants perceived that punishment was the focus of disciplinary proceedings. One disciplined practitioner (DP4), whose experience of discipline and a rehabilitation condition

TABLE 1 | Key thematic principles to facilitate rehabilitation to safe practice.

|                                                                                                                                                                                                                                                                                                                                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <div>Instill pro-rehabilitation culture, institutions and processes</div> <div><ul style="list-style-type: none"><li>Promote rehabilitation as a valuable and achievable objective of discipline</li><li>Establish legislation and organisational infrastructure for rehabilitation</li></ul></div>                                                              |
| <div>Craft conditions that restore and retain practitioners</div> <div><ul style="list-style-type: none"><li>Ensure expertise and resources when determining and implementing conditions</li><li>Provide adequate information to consider and underpin rehabilitation conditions</li><li>Match conditions to practitioner with appropriate input</li></ul></div> |
| <div>Promote practitioner engagement</div> <div><ul style="list-style-type: none"><li>Cultivate practitioner’s insight, remorse and buy-in</li><li>Encourage relationships of trust with service providers and colleagues</li><li>Alleviate shame and fear from disciplinary and rehabilitative processes</li></ul></div>                                        |
| <div>Create feedback mechanisms</div> <div><ul style="list-style-type: none"><li>Facilitate monitoring and feedback during and at the end of rehabilitation</li><li>Assess effectiveness of rehabilitation to improve future conditions</li></ul></div>                                                                                                          |

was largely negative, stated: “Their whole purpose is punitive. They have no care about us as a profession. ... It’s so punitive.”

This was echoed by tribunal members:

*And I know it’s not meant to be punitive process, but I fully see sitting on the Tribunal bench that it is hugely punishing. (T2)*

In another example, a tribunal member noted that while tribunals should refer to rehabilitation, that was not their tribunals’ primary purpose:

*[T]he more serious thing that I thought - rehabilitation is something that the [Tribunal] really needs to consider. I mean the purposes of it are maintaining the reputation of the profession, protecting clients, consumers of services and so on. ... The major purpose we have is really not to think about rehabilitation. (T5)*

Thus, even if rehabilitation was important, tensions may exist regarding tribunals’ potential to address rehabilitation and its practice.

Professional culture was also linked with the extent of a rehabilitative focus. One disciplined practitioner felt that their profession “is not supportive at all” (DP4), attributing it to the culture of their profession. Another observed that a key component for ensuring that rehabilitation strategies are part of the solution was a more humane disciplinary scheme:

*Trouble is it doesn’t matter how much you overhaul regulation ... until such time as you introduce humanity into the system, we’re not going to get anywhere. (DP2)*

The legal profession’s profit-oriented culture was offered as an example of how professional norms may undermine consideration of the rehabilitative needs of individual practitioners. For example, a tribunal member (T2) reflected:

*The profit model [in the profession] infiltrates us. We have big mega firms and mega deals and having something that’s rehabilitative for the little person in the corner trying to cope with their addiction, I just think we have to be realistic about what the profession would wear. (T2)*

By way of contrast, the tribunal governing health practitioners was described as having an implicit predisposition towards rehabilitation and well-being, attributing it to the culture of health restoration in the sector:

*In the HPDT, rehabilitation is ... very often a topic. ... There is potentially an inherent bias because you’ve got medical practitioners whose interest is in actually people’s wellbeing. So they’re kind of inclined to think that way. (T2)*

Thus, the HPDT was viewed as having a pro-rehabilitation orientation based on the members’ health expertise and the perceived value that they placed on health promotion.

### 3.1.2 | Establish Legislation and Organisational Infrastructure for Rehabilitation

Supporting rehabilitation was also linked with legislation and organisational infrastructure. Some participants identified that rehabilitation was not prioritised within their profession because of the current legislation limiting its promotion:

*I lament on the [Tribunal] that we really don’t have the tools either that [other] professionals have in their tribunal. ... We really struggled to find a way to fit [rehabilitation] within the wording of the Act, to do what was the right outcome, which could be achieved on [another Tribunal]. (T2)*

In other words, the participant sensed that the Tribunal might have been inclined to craft a rehabilitative option but was hindered by the governing legislation.

By way of contrast, participants referred to the beneficial ‘health pathway’ that was available to regulatory authorities for health practitioners prior to or alongside Tribunal proceedings:

*We obviously don’t have the health pathway. And that’s a real gap for us. For many cases there is an element with health issues [that] proceeded the conduct and was a contributing factor. ... We can’t compel people to undergo a competence assessment and medical reports. ... We have people with cognitive decline and no insight into it because of the condition. ... There’s very limited that we can do ... and so you have to go through the complaints and disciplinary process which is not necessarily fit for purpose. (R7)*

Thus, in the absence of a health pathway, which features in both health and teacher disciplinary processes, earlier rehabilitation opportunities for health-related rehabilitation linked with misconduct may be missed, as well as the potential for a tribunal itself to consider referral to this pathway.

*It’s not until we’re in the Tribunal that we actually learn how bad things have gotten or at a crucial moment. (RA7)*

*(W)hen a complaint is made ..., the Standards Committee then does a hearing on the papers and in a sense that cuts across any sort of organised approach to rehabilitation. It almost inhibits it. Well, no, it almost prohibits it. ... [T]he kind of thing that the police have been doing for years in terms of diversion and that sort of approach to an offence, which is an offence but doesn’t necessarily need to be career ending, um, just doesn’t exist. (T5)*

Participants made comparisons across professions and discussed the merits of diversion of unwell practitioners. Legislative reform for professions without a health pathway would provide an avenue to support struggling practitioners and potentially avoid discipline in appropriate cases.

## 3.2 | Theme Two: Craft Conditions That Restore and Retain Practitioners

A key theme was the need for 'return to practice' conditions to be suited to the individual practitioner and have rehabilitative potential through tribunal access to expertise and information.

### 3.2.1 | Ensure Expertise and Resources When Determining and Implementing Conditions

Members of regulatory authorities, tribunals and practitioners expressed the need for rehabilitation-specific expertise to craft and implement conditions. For example, a disciplined practitioner reported that the Tribunal members "don't appear to have a handbook or some clear understanding of what they're imposing and what they're requiring" (DP1). This illustrated a need for rehabilitation-specific knowledge.

Similarly, a tribunal member opined: "I'd love to know more about what actually works and have some kind of empirical basis for that" (T4). This view was echoed by another tribunal member:

*Yes, I mean, it'd be really useful to have a toolbox of really effective conditions and really effective courses that are going to work so that you've got something. I've got a committee at the moment that's really struggling to come up with something that's going to work. (T2)*

At multiple levels, participants called for expert, evidence-based rehabilitation information regarding services and strategies. Drawing on rehabilitation practice in other sectors, there was a recognition that rehabilitation theory and research could constructively inform disciplinary penalties and conditions. As a Tribunal member emphasised:

*I'm back to that question about a set of principles or a framework ... there's a medical speciality of rehabilitation medicine. Now I'm not saying that would be applied, but probably in that speciality there is evidence and principles and approaches that probably could be distilled into a set of principles that could be applied across various disciplines, you know, evidence-based. (T3)*

A tribunal member reflected upon the benefits of expert knowledge and assessment when practitioners' impairments were a concern prior to a tribunal crafting conditions:

*Imagine if we had a panel who can do the addiction assessment or 'on the spectrum' assessment or cognitive decline. So we are not asking them to come up with something, but we've actually got these six names on the panel.*

*You can go to them. That would be lovely. That would be lovely. (T2)*

However, there was caution against binding rules, which would restrict the ability to craft conditions tailored to individual circumstances. For example, a tribunal member stated: "give us guidance that would be helpful to us but wasn't binding because everybody's going to need to have their own context" (T4).

The existence of appropriate rehabilitation services was identified as a key consideration in imposing rehabilitative orders, including where mentors/supervisors were not available or training was not accessible: "... sometimes people need to do some academic retraining, and we can't make the universities accept them, or the papers, actually they're not available" (RA1). Requiring attendance at specific courses could be problematic if they have "limited entry or are already full to capacity" (RA2).

Access problems were linked with the tribunals' unwillingness to be overly specific in stating the conditions. A tribunal member noted:

*We've had ones where we ordered them to do a very specific course because everybody knew it was a good one. ... And then the company fell over and that course wasn't available. ... There's a problem with us being too specific in our orders. (T4)*

Other consequences related to 'inappropriate fit' regarding the rehabilitation needed to make meaningful change. One regulatory authority member explained the dilemma:

*I struggle ... there might be some entry level courses available which are sort of regarded as the default option, but actually they are very superficial and they're not necessarily going to get the practitioner to think about what the professional expectations are, where they deviated from that, and why they may have deviated or what they think needs to change. ... But then there's a question of cost and fairness and accessibility that comes into that. So yeah, that's probably the biggest challenge for us is actually making the conditions meaningful for change. (RA4)*

Inaccessibility may inadvertently shift the responsibility to the practitioner to locate rehabilitation providers. Often, the onus was on practitioners to locate providers. Most likely, this activity is at the practitioner's expense or voluntarily undertaken by members of the profession. One disciplined practitioner recalled difficulties with finding a supervisor: "[i]t was a miracle I found someone who could [supervise me with demanding conditions: supervision of 5 cases/week for 1 year]. It's an almost impossible task if you think about it" (DP5). As a solution, a legal regulatory authority member suggested "a pre-approved list of people who have agreed to act as mentor," rather than appointment of mentors being "reliant on the practitioners [to] have a bit of a network" (RA7).

This can also lead to difficulties with the appointment of unsuitable providers. As a pro bono mentor stated:

*A practical obstacle is obviously it is a voluntary role ... because the professional probably would not have the funds to pay for it ... and there's not regulatory funds to pay for it so you are relying on the goodwill and collegiality of the profession ... and the senior people are people who probably have the least time to be able to contribute. (SP3)*

Sometimes, disciplined practitioners may lack the necessary financial resources for mandated supervision or courses, especially those who have not had an income for some time awaiting their disciplinary outcome. The impact was raised by some tribunal members and one noted:

*We don't have our own resourcing ... we can't just say, okay, go off and do this course and we'll pay for it. It's really difficult for them to pay for some of those courses, particularly if it's been a long process and they've been out of work for some time by the time they make it to us. ... Some [practitioners] are well resourced to go off and do those things and some aren't. So there are some inequities. (T4)*

When resources are scarce, delays in the disciplinary process were noted as another barrier to rehabilitation, with the above Tribunal member also stating:

*The longer things take, the longer you are from when it happened, the less effective rehabilitation is likely to be, both in terms of delay in the cause of the problem but also in terms of getting people back into the profession. ... It's kind of too late in some ways. (T4)*

### 3.2.2 | Provide Adequate Information to Consider and Underpin Rehabilitation Conditions

Disciplined practitioners and tribunal members agreed on the importance of adequate background information about the circumstances surrounding the misconduct. Allowing for interactions between the tribunal members and practitioners during the hearing was important in this respect. For example, the notion of “forming a relationship with a person .... having them in person in front of you has so many advantages” (T2). Another noted that the “practitioner sits in a context that is broader than just themselves individually,” thus, a ‘papers-only’ proceeding “limits our ability to ask questions and to tease out what might be appropriate” (T4). The tribunal member further emphasised:

*The more we understand about them [practitioners], the more they can effectively participate in the process. I see it is crucially important to the goal [of rehabilitating], actually having people be heard and seen. (T4)*

Participants also discussed the importance of the Tribunal receiving timely information regarding the misconduct and appropriate rehabilitation steps. Such information can usefully come via

formal submissions. As a tribunal member emphasised, “more thought could go into the submissions that we receive on rehabilitation” and that providing existing reports would be “useful” (T4). They specifically noted:

*During the course of that process, did someone get a pre-sentence report? Have there been any psychological reports obtained? ... That could be very useful material. (T4)*

However, if a tribunal suspected a practitioner had a health impairment relevant to the charge, it was noted that there may be limits on information access:

*[It] can be quite challenging because we don't have the ability to require any sort of health assessment to find out what's actually going on. So we're treating it as a competence performance issue, but we have a real suspicion that it's something else. And then we don't really have enough information or basis to go on to address that. (RA7)*

Even if reports were furnished, these are only helpful if they contain sufficient explanatory information:

*And we did have one case where we were encouraging the person to get a psychological report at the time of penalty. And [they] went to a psychologist, who didn't provide a report with the level of robustness that was required. So, we were impotent to act on what the Tribunal had. (T2)*

However, another participant expressed a sentiment that the nature of the disciplinary hearing process itself may not be conducive to submission of these reports:

*But sometimes we are limited by the nature of the charges. ... We become aware during the proceedings of other factors that have contributed to the situation, particularly in a sort of health type situation ... but if it is not directly related to the charge, we are hampered in terms of what we can direct. (T3)*

Also, a practitioner may hesitate to submit a health report if it might be viewed as “tacit admission of culpability,” according to a tribunal member (T4).

Thus, identification of health impairments with sufficient supporting information was one factor that would aid decision-makers to design relevant rehabilitation conditions. However, appropriate processes needed to be established, and practitioners should not experience this as breaching their preferred privacy or jeopardising their ability to defend the charge.

### 3.2.3 | Match the Conditions to the Practitioner With Appropriate Input

Matching of the conditions to individual practitioner misconduct and their circumstances was identified as a key element for

effective rehabilitation. Customised conditions would promote rehabilitation, according to a service provider:

*Sadly, I think there's a lot of scope for a bit more focused, directed conditions. ... But it seems the defence is merely to survive the conditions. Or appease them rather than to engage in a dialogue. (SP1)*

Disciplined practitioners at times critiqued the type of conditions ordered or the occupations of the service providers who delivered the rehabilitation. For example, a disciplined practitioner claimed that the focus of the supervision was misguided because the disciplinary issue was their professional manner, not their competence: “[i]t was my attitude ... I’m very blunt, very direct, and uh, doesn’t match very much the culture here.” As a result, they stated: “It wasn’t a rehabilitation process for me. ... It didn’t address the issue that they claim was the issue, [which was] the attitude” (DP5).

As another form of mismatch, a disciplined practitioner reflected on the relevance of the penalty to their circumstances:

*This would have been really great if the supervision had been what it should have been... . It was the wrong type of supervision. ... I’m cynical because it was totally ineffective. (DP4)*

Yet, the process of crafting suitable conditions was acknowledged as complex, including accommodating factors such as a practitioner’s state of mind or unique psychological dispositions. Thus, matching conditions is “not just to the conduct but to the person ... someone might have low insight, someone may have high insight” (RA1). A Tribunal member reiterated:

*Among the 90% of the 10% of the population who get through to these higher qualifications that come through the Tribunal, people on the spectrum in my experience are overrepresented. And those people really need. ... It’s no point sending them to a course with those conditions. We actually need [to offer] them help, and recognising the different, um, neural makeup, and having a wrap-around apprentice model. And it’s just impossible for the Tribunal to achieve that. (T2)*

Involvement of regulatory authorities in the disciplinary process was considered important to ensure the most beneficial match of rehabilitation conditions. Close cooperation between stakeholders involved in the disciplinary process was suggested as facilitating this:

*... we are wanting to make sure that they [conditions] are meaningful and that they work for the practitioner. ... We sort of try to front foot it with the Tribunal and practitioners, so that by the time we have a penalty hearing everybody knows what’s on the table and what’s expected. (RA7)*

*[It would] be so much better if the [profession] Council was a party at that stage, helping to craft it and get it right. (T2)*

### 3.3 | Theme Three: Promote Practitioner Engagement

This theme concerns promoting practitioner engagement through cultivating a beneficial mindset and, where possible, alleviating shame and fear resulting from disciplinary processes.

#### 3.3.1 | Cultivate Practitioners’ Insight, Remorse and Buy-In

Not surprisingly, multiple participants emphasised that disciplined practitioners needed to perceive conditions as rehabilitative and beneficial, which was aided by practitioner remorse, insight and buy-in. For example, a tribunal member stated that “[rehabilitation] is nice to do, but it’s not actually going to be protective if you don’t have genuine remorse. Those things are very hard to assess.” (T4)

In a similar vein, this tribunal member expressed that “genuine remorse is likely to be relevant to the question of whether someone can effectively rehabilitate. Because if you don’t understand why (the conduct) is wrong, then you’re more likely to repeat it” (T4). Evidence of insight and buy-in included taking rehabilitative steps *prior* to the hearing and an example was provided by another tribunal member:

*A practitioner used a support group even before they got to us, had used their ‘fall from grace’ as an opportunity. And it was so helpful to us because they had really taken 100% ownership of their conduct. (T2)*

In turn, the actual or perceived absence of such qualities could be detrimental to rehabilitation. Practitioners who are not fully invested in the rehabilitation may be compliant simply to avoid “more severe consequences of suspension or even something more permanent” (SP2). For example, one practitioner described their intent regarding the conditions: “I’m just going to show up, and I’m just going to tick the box” (DP4).

Experiencing the process as punitive was also noted as potentially leading practitioners to not “fully engage”:

*A lot of practitioners will see [conditions] as punitive and therefore not fully engage. So it’s that they felt they have to do it so they go along with it, but they’re not actually gaining anything with it. So it also depends on their experience through that Tribunal. (RA6)*

Thus, participants appreciated that practitioners’ involvement, including expressing remorse/insight, was critical to a meaningful rehabilitative process.

#### 3.3.2 | Encourage Relationships of Trust With Service Providers and Colleagues

Disciplined practitioners and service providers emphasised the importance of a relationship of trust between them, which is facilitated by their independence from the disciplinary hearings. As one service provider stated:

*[I]n the supervision, the extra relationship matters. So in fact it is helpful to be separate (from decision-making) because at some level the supervision relationship, that in my case is usually to go over years, needs to be significantly supportive. ... It cannot just be punitive and therefore it is not just a matter of being just factual or checking. It needs to be also engaging and for that reason the separation [from the discipline procedure] is really helpful. (SP1)*

In reflecting on their own supervision experience, disciplined practitioners noted the benefit of a positive relationship with their supervisor. One disciplined practitioner expressed appreciation for their supervisor's support:

*I guess the real positive thing about supervision was there was someone there who had to sort of be attached to me, to look over my shoulder and then vouch for me. (DP3)*

Even if a disciplined practitioner did not believe the supervision was necessary, the supervisor's commitment to supporting their progress and its positive effect was acknowledged:

*Well it was the willingness of the supervisor to abide by those conditions that were quite demanding. ... And [they] really dedicated to that, [they] reviewed everything. [They] reviewed any cause of concern. [They] brought it up and met face to face to discuss everything. ... Well, look, any meetings with a colleague help. And I mean, it's a good thing for me. I'm very grateful that [they] agreed to do that because it would be very hard on [them] to find the time. I mean, it helps anybody. (DP5)*

As such, a lack of trust in supervisors or their reporting requirements compromised the rehabilitative effect. As one disciplined practitioner stated:

*I said: "I don't feel I can talk to you honestly because if you're going to then report it to the disciplinary tribunal. ... Who then may release it to the standards committee. I don't trust you." (DP4)*

### 3.3.3 | Alleviate Shame and Fear From Disciplinary and Rehabilitative Processes

Participants expressed that disciplinary processes and rehabilitation strategies could themselves be damaging and shaming to practitioners, thereby serving as a barrier to effective rehabilitation.

One service provider inquired: "How can we do this in a way that less damage is done to all involved, including the complainant?". They continued:

*In my experience, the people I've seen have come to me feeling quite beaten, drained and exhausted and quite*

*often feeling shame. ... Also, I have had a lot of questions about how the Tribunal actually treated them. So there is a lot of mixed feelings and painful feelings. (SP1)*

Similarly, another service provider observed the enduring effect of disciplinary processes on practitioners' lives, leading them to act beyond the strict boundaries of the ordered conditions and offer wider support:

*[I] sort of find myself in a situation where you're trying to be general almost like counsellor to them, in like working through issues that are not actually part of the (penalty) condition. ... It's not necessarily the strict application of the condition ... but it's the sort of global effect of what they've come sort of through in terms of the process and where they're headed ... does have a very serious and ongoing impact on ... their lives. (SP2)*

Disciplined practitioners spoke about how a negative Tribunal experience could interfere with potential rehabilitation. According to one practitioner, the process was "bruising" and "the fallout has been so hideous, I would never want to go back to [practice]" (DP4). Another practitioner experienced the process as punishing:

*When I got the judgement and realised what it was, I was nearly ready to give up. I nearly did. I decided that it was all not worth it. And maybe everybody had been right ... it was a very dark time. ... There was nothing positive about it. It was not sort of oh, great, look they found my faults. They're going to help me fix them ... I still think it was just a punishment. ... [The Tribunal] was not there to rehabilitate people, it was there to punish them. (DP2)*

While transparency is a central feature of discipline, such exposure for some practitioners was also accompanied by isolation:

*I kind of certainly felt like people were looking at me and talking about me. ... It really felt, it didn't feel inclusive. I didn't feel that people were supporting me. (DP3)*

One disciplined practitioner revealed the health impacts of the disciplinary process, which was accompanied by a sense of ostracism:

*They didn't restore your health because the stress made everything worse. ... Nobody wants to see you and you're in private practice, so you don't have support from anyone else ... and I can't believe they didn't know that, I mean, surely anybody with some common sense who works in the field would think, how is he going to manage that? (DP5)*

Thus, participants from multiple sectors appreciated a range of negative effects that disciplined practitioners experienced, which could impede rehabilitation back to safe practice.

### 3.4 | Theme Four: Create Feedback Mechanisms

A final theme focused on the benefits of increasing feedback across stages and levels of the disciplinary process. Also, participants reported benefits if the Tribunals considered the underlying causes of misconduct, including systemic factors, which could be constructively disseminated to the professions for appropriate industry-wide responses.

#### 3.4.1 | Facilitate Monitoring and Feedback During and at the End of Rehabilitation

The relative absence of information back to the Tribunal once conditions had been ordered was seen as inhibiting their ability to refine rehabilitative decisions and practices: “We sit and carefully craft these things, and then we never see the person again” (T4).

This was mirrored by calls for greater guidance and feedback for those who deliver rehabilitation services to the disciplined practitioners. The absence of direction for a supervisor was noted:

*Nobody really seemed to know exactly what was supposed to happen or was supposed to be done. I mean obviously [supervisor name] did [their] best and was really trying to encourage me to open up, be frank and anticipate stuff as it happened. But there really wasn't a lot of guidance provided to [them] about what [they were] supposed to do. [They] wrote ... reports... [they] never received any feedback. (DP3)*

This was reinforced by another tribunal member who commented that, following penalty orders, “[t]here’s no liaison or communication at all, is there?” (T2). They recommended: “[y]ou need to have a staff member at least who monitors it and makes it work. Who polices it. And you need to have that feedback loop” (T2).

Likewise, disciplined practitioners considered feedback at the completion of the rehabilitation conditions to be important. In their view, this lack of recognition reinforced their negative perspectives about rehabilitation conditions. As one disciplined practitioner stated, the lack of feedback “just added to my resentment, I suppose, at the process” (DP1). Another disciplined practitioner discussed this further:

*When I finished [supervision], it was kind of like a whole lot of nothing. You know, no one ever asked me. ... Um, like, having an endpoint [would be good]. An end meeting where everybody sort of says, you're there, you got there. It's all over. As far as we're concerned, you are just one of us, just as you always have been. (DP3)*

For conditions that order actions to be done for a certain time-frame (e.g., mentoring for 2 years), concern was raised that there is no mechanism to ensure that this has led to rehabilitation back to safe practice. Alternatively, a system for reviewing the efficacy of the rehabilitation conditions could also potentially include a

mechanism for conditions to be extended if concerns remained at the end of the mandated period. As noted by a regulatory authority member:

*In an optimal world, [there would be] the ability for the order to remain in place until there is a sort of substantive change because it is always defined by a particular time period. ... I always worry is that long enough for that person to actually engage and make meaningful change. Or are they just sort of going through the motions for that period of time because they know they have to? So we can't say forever but it would just be good to have a bit more flexibility to have it longer term so that it leads to real change. (RA7)*

Information sharing across Tribunals, regulatory authorities and service providers was viewed as a constructive reform to consider.

#### 3.4.2 | Assess Effectiveness of Rehabilitation to Improve Future Conditions

Participants noted that it would be beneficial to create a formal feedback loop regarding the practitioners’ performance and whether the conditions effectively addressed the misconduct. One tribunal member commented that despite the benefits of understanding how the conditions have worked, “[t]here isn’t much of a feedback loop,” stating:

*It's important that we maintain that independence and there's no inappropriate influence. But ... we have engaged with the person within Council that work to find out: Are there issues with enforceability of the conditions in term of not specific cases, but themes? ... That has been helpful because people can intend one thing when they make a direction and if it has a different outcome ... it is helpful to know. (T4)*

In the absence of routine feedback, information may come in an ad hoc way. A regulatory authority member stated, “[s]ometimes you get comments back in an unsolicited email” (RA3). Other regulatory authority members noted:

*I guess we have, on the odd occasion gotten feedback saying, I found this really helpful or this was a waste of my time. ... We don't have a formal way of finding. (RA5)*

*Yes, you get the occasional cases that are even prepared to write an anonymous or newsletter type of article in terms of demonstrating the benefit ... but that requires a Damascus moment. (RA4)*

Further, routine feedback may dispel concerns that volunteering feedback is met with risk and potential negative repercussions if criticism is raised. Despite valuing feedback as “really essential to enhance its quality and its effectiveness in terms of rehabilitation instead of punishment,” one of the service providers recounted:

*[S]ometimes the practitioners have said please don't say anything. Because they don't want to upset the board because they don't want more punitive measures to be in place. (SP1)*

## 4 | Discussion

This qualitative study explored facilitators and barriers to rehabilitation following professional misconduct, drawing on perspectives of 21 key stakeholders in Aotearoa New Zealand, including disciplined practitioners, tribunal members, regulatory authorities and providers of rehabilitation services. Our findings demonstrate that practitioner rehabilitation occurs in a complex system of institutions, processes relationships that combine to shape rehabilitation outcomes.

### 4.1 | Operationalising Rehabilitation as a Penalty Principle

Despite being cited as an important principle determining penalties, in Aotearoa NZ, the theory and advice on practical application of rehabilitation remains sparse (Surgenor et al. 2023). There are no recent studies on practitioner experience of disciplinary penalties in Australia or Aotearoa NZ. The nearest comparison in Aotearoa NZ is research on how doctors and nurses experience the complaints process (see Wilkinson and Marshall 2021 for a recent study and a summary of previous research). There is also a more fulsome international body of research on how practitioners experience adverse events and complaints (see also Wilkinson and Marshall 2021). This research highlights that health practitioners experience a range of persistent negative emotions and psychological responses (e.g., shame, depression and guilt) as a result of both complaints and adverse events and a lack of support, which may result in future damage to professional relationships.

Our study addressed the gap in how practitioners and other stakeholders experience the rehabilitation process and their views on barriers and facilitators to rehabilitation, highlighting that while rehabilitation may be a stated penalty principle, there are opportunities to enhance its application. Interviewed practitioners experienced feelings of shame, ongoing damage and lack of support when undergoing disciplinary conditions, and they doubted the efficacy of the conditions ordered. This was mirrored in the comments of regulatory authorities, tribunal members and service providers who have identified a number of recommended strategies and processes for facilitating rehabilitation at the individual, institutional and cultural levels.

As noted above, to ensure professional and ethical behaviour, a full understanding of relationships, systems, environments and contexts is necessary (Davidson et al. 2018). It is thus unsurprising that a disciplinary system that focuses on public safety has an approach that has conditions that are protective of the public together with a therapeutic view to rehabilitation of its practitioners, as noted by Kiel (2013). While the need to maintain public safety is paramount, a disciplinary system that facilitates

rehabilitation can enhance practitioner health and dignity, support professional sustainability and illuminate and address individual vulnerabilities and systemic issues.

Within disciplinary and justice contexts, researchers have argued for application of the principles of 'restorative justice' (Dekker and Breakey 2016), 'ethics of care' (Marshall 2019) and 'therapeutic jurisprudence' (Freckelton 2008). These concepts reflect the need for all parties in the process to have their needs met and for both the harm and the person who caused it to be 'repaired'. The opportunities for operationalising rehabilitation that we identify from our research reflect these principles—that, subject to ensuring public safety, rehabilitation penalties should be based on clear direction, evidence-supported principles for improvement back to safe practice, an open exchange of information and dignity and healing of the practitioner.

### 4.2 | Opportunities for Facilitating Rehabilitation

The four themes, framed as 'pro-rehabilitation' principles, highlight opportunities for facilitating rehabilitation at the level of experience of the individual practitioner, regulatory environments and processes, and the broader contexts of profession regulation and culture.

The findings suggest that rehabilitation may be constrained when disciplinary systems are primarily oriented towards individual accountability—in relation to the conduct and rehabilitation—without equivalent structural and cultural investment in professional safety and rehabilitation. To facilitate rehabilitation, it needs to be embedded as a legitimate and explicit objective across legislation, within institutional practices, and as an underpinning for professional cultures.

We now reflect upon four key opportunities to operationalise the above rehabilitation principles within the process of disciplining registered professionals in Aotearoa New Zealand.

First, increased communication across levels and stages of the disciplinary process was viewed as beneficial for rehabilitation. Information sharing between the practitioners, the tribunals, the corresponding regulatory authorities, and deliverers of rehabilitation services could improve rehabilitation prospects. This includes information about reasons for the conduct, about the practitioner and any health or impairment issues, and how the practitioner participates in and responds to the rehabilitation conditions. An additional constructive prospect was information flows between the tribunals, regulatory authorities and service providers to develop evidence-based rehabilitation principles, strategies, and options. Overall, feedback loops are essential throughout and at the end of rehabilitation to improve the opportunities for system learning and to facilitate practitioner engagement in the process. While it is the responsibility of the Tribunal to determine the conditions, our findings argue that this would greatly benefit the Tribunal to make conditions that match the conduct and the practitioner.

Decision-makers could facilitate rehabilitation by receiving very practical information (for example, reputable courses, evidence-based and effective rehabilitation programmes). Decision-makers

could also benefit from learning about systemic matters that would aid future practitioners (for example, barriers such as delays, the need for expert reports and the need for legal reform to establish a health pathway). These can be across professions and tribunals, especially in the cases of health impairment, where treatment or education may be standardised. Importantly, there also needs to be the ability for systemic issues within a profession contributing to problematic behaviour to be identified. This evidence would also assist in developing conditions that are relevant and tailored to the practitioner.

Decision-makers could assist practitioners to return to safe practice by understanding practitioners' perspectives, for example, whether they felt heard during the disciplinary process, whether they felt the conditions were suitably customised to support them, whether courses/supervision were available and affordable, whether they have achieved their rehabilitation goals and can be 'released from orders' early, and whether the decision-makers acknowledge that they have completed their conditions and are now returned 'to the fold'. As observed by participants across professions, practitioners' engagement is central to rehabilitation. Relational approaches that support trust between practitioners and service providers were valued.

Second, guidance on provision of professional rehabilitation is beneficial. Participants reported that they operated in a vacuum, without guiding principles. The absence of an explicit framework could result in inconsistencies. Factors such as guidance, evidence-based guidelines and principles for disciplinary rehabilitation were raised. This highlights the need for an explicit theoretical underpinning with objectives, guidelines and tools for all those involved in the process.

As professional regulation and discipline occupy the space between criminal justice and health systems, learnings can come from both contexts, including existing theoretical approaches. For example, aspects of criminal justice principles that focus on managing risk and recognising and restoring all parties in the process can be balanced against ideas of 'person-centred rehabilitation' that focus on recovery (Australian Commission on Safety and Quality in Health Care, 2011). Perhaps most importantly, these findings show that it is constructive to include a therapeutic lens that considers the psychological and longer-term impacts of both the process and penalty on the person ('therapeutic', Wexler (2000) and 'psychological', Sellers and Arrigo (2022) jurisprudence).

Examples of key factors for rehabilitation decisions might include: focus on restoration rather than punishment while maintaining public safety, customised conditions that correspond with the misconduct and the practitioner's characteristics and needs, least restrictive/invasive alternatives, conditions of the shortest duration, and monitoring to conclude the order when the rehabilitation has been 'achieved'.

Third, strengthening 'rehabilitation infrastructure', including the availability of providers and accessible supervision networks, particularly in rural and underserved contexts, would be beneficial. For supervisors/mentors, a system is needed to support these actors. Ideally, this would include consistent training and feedback, to the regulatory authorities at a minimum.

Last but not least, reducing the punitive, and promoting the rehabilitative, culture of disciplinary regimes was a recurring theme, in line with principles of therapeutic jurisprudence (Wexler 2000). Tribunals, service providers and practitioners reflected upon why the system is perceived as punitive. They understood the health impacts of a punitive culture. They explained how trust is fundamental to constructive relationships (e.g., with appointed supervisors). Explicit articulation of rehabilitative goals within the law and tribunal guidance could help support the recognition of rehabilitation and reduce potential concerns about its role relative to punitive goals within a disciplinary framework that places public protection at the forefront. The data suggests that practitioners and the three sectors have an appetite to improve the disciplinary regime with a rehabilitative focus (i.e., to restore practitioners to safe practice).

### 4.3 | Limitations

The pool of participants was small, despite multiple, lengthy and creative efforts to recruit. The low participation by disciplined participants in interviews is a measure of the stigma and discomfort many face, as reported by the five disciplined participants. We could have expanded the interview eligibility criteria (e.g., to more recent cases) but consciously had a time cushion to reduce the potential for retraumatising participants. We note that there may have been a bias towards disciplined practitioners who wanted to air their grievances. Despite these limitations, our interview data with disciplined practitioners were rich and candid, with multiple views expressed on their personal experiences as well as barriers and facilitators to rehabilitation.

Participants in the focus groups were also difficult to recruit. This may be in part because the professions are siloed (education, law and health) and potential participants felt uncomfortable speaking with counterparts from different professions. Potential participants may have hesitated to participate in focus groups because they are not accustomed to engaging in research and often have public-facing roles with perceived restraints around sharing system-level views. Also, they may have felt constrained due to the relatively small size of the disciplinary ecosystem in Aotearoa New Zealand.

Overall, however, our data set was sufficient to provide rich in-depth data across the three professions and provided insight into multiple perspectives from a range of different actors engaged in varying aspects of the professional discipline. While this was a qualitative study, findings are interpretive and do not allow for generalisation beyond similar regulatory contexts, our findings showed key themes across professions as to how rehabilitation can be facilitated, which may provide critical insights for other areas.

### 4.4 | Future Research

We see the value in future cross-disciplinary and international research. Cross-disciplinary research can increase transparency, pursue consensus and potentially achieve equity across the professions. The data also show the importance of exploring multiple stakeholder perspectives. A related research query is whether

disciplinary consistency with regard to rehabilitation is preferable, or achievable, across occupations.

Future research should examine the effectiveness of specific rehabilitative interventions within different disciplinary contexts, including supervision models, education-based conditions and health pathway alternatives. Longitudinal study designs could evaluate if, and how, rehabilitative conditions reduce recurrence of misconduct and support safe return to practice.

## 5 | Conclusion

This study demonstrates that rehabilitation following professional misconduct is shaped by a range of cultural, institutional, relational, individual and structural factors. Strengthening the role of rehabilitation across these elements offers a pathway towards disciplinary systems that better balance accountability, public protection and the restoration of professionals to safe practice.

## Acknowledgements

Open access publishing facilitated by The University of Auckland, as part of the Wiley - The University of Auckland agreement via the Council of Australasian University Librarians.

## Funding

This study was supported by Royal Society Marsden Fund. A rehabilitation model for professional discipline 22-AUT-015.

## Ethics Statement

Research protocols were reviewed and approved by the Auckland University of Technology Ethics Committee (AUTEC 22 May 2023 #23/140).

## Conflicts of Interest

The authors declare no conflicts of interest.

## Data Availability Statement

Research data are not shared.

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