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CHARACTERISTICS OF HEALTH PROFESSIONALS IN A MANDATED ETHICS TUTORIAL AFTER VIOLATING SEXUAL BOUNDARIES WITH PATIENTS

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I. INTRODUCTION

Most, if not all, health professions have ethical standards regarding sexual boundaries between providers and clients or patients.[1] Such standards may also be

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reflected in the statutes and regulations of state licensing boards.[2] When an allegation of a sexual boundary violation is proven, a licensing board may impose certain sanctions.[3] Although serious violations could result in revocation of a license, a board may impose certain rehabilitation measures when warranted.[4] Licenses are often suspended during this period, or the licensee, typically referred to as the respondent, would be on probationary status.

Rehabilitative measures imposed by licensing boards may include such things as psychiatric evaluation and therapy, if indicated, education in professional ethics, clinical supervision, restricted practice, or any combination of these.[5] There has been some controversy about the appropriateness and effectiveness of such measures, and there is little research documenting the nature or effectiveness of such programs.[6] Most authors agree, however, that the wide variety of offenders and offenses, as well as characteristics of individual cases, often justify sanctions short of outright revocation of a license.[7] Some experts in this field have

1. *See generally* MARILYN R. PETERSON, AT PERSONAL RISK: BOUNDARY VIOLATIONS IN PROFESSIONAL-CLIENT RELATIONSHIPS 25–27 (1992) (discussing characteristics of professional-client boundary violations in numerous professions).

2. *See, e.g.*, MD. CODE REGS. 10.36.05.07(C) (2013) (prohibiting sexual relationships between psychologists and current patients and outlining restrictions on such relationships with former clients); *see also* FED'N OF STATE MED. BDS., ADDRESSING SEXUAL BOUNDARIES: GUIDELINES FOR STATE MEDICAL BOARDS 1, 3 (2006) (suggesting guidelines for state boards in handling sexual misconduct violations); S. Michael Plaut & Barbara Hull Foster, *Roles of the Health Professional in Cases Involving Sexual Exploitation of Patients*, *in* SEXUAL EXPLOITATION OF PATIENTS BY HEALTH PROFESSIONALS 5, 11 (Ann W. Burgess & Carol R. Hartman eds., 1986) (noting that numerous professions have codes of ethics and licensing laws related to sexual misconduct).

3. *See, e.g.*, MD. CODE ANN., HEALTH OCC. § 14-404(a)(3) (LexisNexis 2009 & Supp. 2012) (demonstrating that Maryland can impose sanctions, including revoking a license, if a physician is found guilty of immoral or unprofessional conduct).

4. *See* FED'N OF STATE MED. BDS., *supra* note 2, at 9, 10 (offering guidelines for state medical boards in disciplining physicians for sexual misconduct); *see also* ALISON J. COULTER-KNOFF, MINN. CTR. AGAINST VIOLENCE & ABUSE, RECOMMENDATIONS TO STATE MEDICAL BOARDS FOR IMPROVING THE MANAGEMENT OF PHYSICIAN SEXUAL MISCONDUCT CASES: EMPOWERMENT OF VICTIMS (1995) 1, 13–14 (noting that a decision to revoke a physician's license requires a weighted determination of many factors).

5. ANDREA CELENZA, SEXUAL BOUNDARY VIOLATIONS 145–76 (2007); *see also* S. Michael Plaut, *Sexual Misconduct by Health Professionals: Rehabilitation of Offenders*, 16 SEXUAL & RELATIONSHIP THERAPY 7, 7 (2001) (discussing the different types of rehabilitation available).

6. *See* Andrea Celenza & Glen O. Gabbard, *Analysts Who Commit Sexual Boundary Violations: A Lost Cause?*, 51 J. AM. PSYCHOANALYTIC ASS'N 617, 631 (2003) (questioning whether rehabilitation actually works due to the lack of follow up data); John Thomas, *Rehabilitation or Punishment, Newspaper Series Ponders*, NAT'L PSYCHOLOGIST (Jan. 1, 2000), http://nationalpsychologist.com/2000/01/rehabilitation-or-punishment-newspaper-series-ponders/10435.html (questioning the appropriateness of certain sanctions and the lack of severity of sanctions throughout the country).

7. *See, e.g.*, Celenza & Gabbard, *supra* note 6, at 618–19 (clarifying that there are different types of offenders whose motivations and harms cover a wide range); COULTER-KNOFF, MINN. CTR. AGAINST VIOLENCE & ABUSE, *supra* note 4; Andrea Celenza, *Rehabilitation of Sexual Boundary Transgressors: A Humane and Knowledge-Based Approach*, PSYCHIATRIC TIMES, Apr. 1, 2008, at 1, 2, 5 (noting that there is more than one type of offender, and that rehabilitation is usually a viable option for treatment of first-time offenders).

recommended targeted educational experiences as an important component of a rehabilitation program, especially since many respondents have received little or no education in this area as a part of their training.[8]

A. Tutorial Format

Based on his expertise in the area, one of the co-authors of the present paper, S. Michael Plaut, PhD, conducted tutorials in ethics education, particularly regarding professional-client sexual boundary issues, from the late 1980s until 2008, while serving on the faculty of the University of Maryland School of Medicine.[9]

A tutorial experience has a number of advantages over a classroom course, because a single instructor works with a single respondent for whatever period of time it may take for assigned material to be covered. In such a situation, readings can be customized for the individual respondent and his or her specific situation. It allows the tutor to better understand the conduct that resulted in the board's action, the respondent's perspectives and experiences, and how those perspectives may change over the course of the tutorial experience. It also may give the tutor access to additional information related to the case, such as psychiatric evaluations or investigative reports that would not normally be available to the classroom instructor.

B. Observations and Research Questions

Certain consistent patterns of behavior were observed over these years of conducting tutorials: (1) It appeared that certain personal and professional factors may have put providers at greater risk for committing a sexual boundary violation. (2) There appeared to be certain defense mechanisms at work that paved the way for a violation to occur, for example, a tendency to rationalize a behavior that the respondent knew to be unethical.[10] Other behaviors exhibited by many of the respondents were denial, externalization, and entitlement.[11] These behaviors

8. *See* Glen O. Gabbard, *Patient-Therapist Boundary Issues*, PSYCHIATRIC TIMES (Oct. 1, 2005), http://www.psychiatrictimes.com/display/article/10168/52646 (noting that "many analytic therapists have limited training in boundary violations" and that education may be included in rehabilitation plans).

9. Plaut, *supra* note 5, at 11–13.

10. *Rationalization* is the attribution of one's actions "to rational and creditable motives without analysis of true and especially unconscious motives." MERRIAM-WEBSTER.COM, http://www.merriam-webster.com/dictionary/rationalization (last visited June 10, 2013).

11. *See infra* Part II.D (providing the results of the study). *Denial* is "a psychological defense mechanism in which confrontation with a personal problem or with reality is avoided by denying the existence of the problem or reality." MERRIAM-WEBSTER.COM, http://www.merriam-webster.com/dictionary/denial (last visited June 10, 2013). *Externalization* is the invention of "an explanation for (an inner problem whose actual basis is known only subconsciously) by attributing to causes outside the self." MERRIAM-WEBSTER.COM, http://www.merriam-webster.com/dictionary/ externalize (last visited June 10, 2013). *Entitlement* is "a belief that one is deserving of or entitled to certain privileges."

sometimes continued well into the rehabilitation period. (3) Respondents typically experienced additional consequences of their actions over and above the sanctions imposed by a licensing board, such as divorce or loss of hospital privileges. (4) In a small number of cases, respondents were known to have committed additional violations after they had successfully completed their rehabilitation program.

Considering the relative lack of research in this area, selected cases were reviewed, focusing especially on these apparent patterns of behavior and experience and whether any of these patterns might be possible predictors of recidivism. Of specific interest were the following questions: (1) What characteristics were seen in the respondents that may constitute risk factors for violating sexual boundaries? (2) What was the impact of the disciplinary process on the respondents, above and beyond the sanctions imposed by their respective boards? (3) To what extent did respondents exhibit defensive behaviors as described above throughout the course of the tutorial experience? (4) To what extent were respondents judged to be cooperative with the educational program and to show that they had gained insight into the concepts being taught? To what extent did they offer resistance to the program? (5) To what extent were respondents found by their respective boards to once again be in violation of professional standards after their rehabilitation program had commenced or ended? (6) To what extent may certain respondent behaviors or characteristics appear to be predictive of recidivism?

An understanding of these factors may lead to developments or improvements in educational programs or board policies that could serve to reduce the incidence of such violations.

II. METHOD

This project was approved with exempt status by the Institutional Review Board of the University of Maryland Baltimore, and later by that of the University of North Carolina Wilmington, after the principal investigator, S. Michael Plaut, PhD, moved to that institution.

A. Inclusion Criteria

In order for a case to be included in the study, it had to have resulted from a formal disciplinary action of a licensing board that made findings of sexual misconduct. These cases typically resulted in a public order following a hearing either before an administrative law judge or before the board, or a case resolution conference in which sanctions were agreed to by the board and the attorneys involved in the case. One case that was included was the result of a non-public letter of admonishment rather than a formal public order. In all cases, among other

MERRIAM-WEBSTER.COM, http://www.merriam-webster.com/dictionary/entitlement (last visited June 10, 2013).

sanctions, the board mandated that the respondent complete a course in professional ethics pertaining to professional-client boundaries.

B. Structure of the Tutorial

In response to an initial contact by the respondent, the tutor sent a letter to the respondent describing the tutorial and requirements for completion. A single tuition fee was expected on first visit, although payments were permitted over a period of time in cases of financial hardship.[12] After a review of the board's order and related documents and an initial interview, certain readings were recommended.[13] The respondent was invited to meet with the tutor as often as necessary, but no more than once per week, to discuss the readings and any other relevant issues. Extended discussion by e-mail or phone was not permitted.

A major requirement of the course was a paper, prepared in a professional manner,[14] which included the following sections: (a) a discussion of the factors that led to the need for the course; (b) the respondent's understanding of the relevant ethical and clinical issues, especially pertaining to his or her situation; (c) a discussion of what he or she would do in the future if confronted by the situation that led to the need for the course; and (d) a recommendation of what might be done in general (e.g., by the profession) in order to minimize the incidence of the behavior in question. In completing part (b) of his or her paper, the respondent was expected, at a minimum, to address the following issues: (1) the basis for the need for professional-client boundaries, including considerations of power, vulnerability, and consent; (2) risk factors for both patients and providers that tend to lead to boundary violations; and (3) potential harm to both providers and patients resulting from boundary violations.

C. Study Sample

Six health professions were represented in the initial group of thirty-four respondents: medicine (67%), psychology (12%), physical therapy (9%), dentistry (6%), acupuncture (3%), and social work (3%).[15]

Within the group of physicians, eight specialties were represented: psychiatry (30%), obstetrics-gynecology (22%), internal medicine (13%), family medicine (9%), general surgery (9%), urology (9%), plastic surgery (4%), and anesthesiology

12. This practice eliminated the possibility that the tutor might be seen as delaying completion of the tutorial for financial gain.

13. Plaut, *supra* note 5, at 10, 13 (mentioning that resources are given by the tutor based on the situation and providing an appendix of appropriate resources).

14. *Id.* at 10–11 (describing in detail the requirement of the course paper).

15. The preponderance of physicians in this group in no way reflected the incidence of boundary violations in that profession. Certain boards, compliance officers, and prosecuting attorneys tended to recommend a tutorial as a way of meeting the board's educational requirement. Therefore, the distribution of professions here is most likely an artifact of the referral pattern.

(4%). It has previously been shown that psychiatry, obstetrics-gynecology, general internal medicine, and family medicine are the specialties in which the greatest proportion of sexual boundary violations have been reported,[16] and the present data reflected a similar pattern.

As has been shown in other studies, most sex-related offenses occurred in mid-life, but with a wide age range.[17] The mean age of respondents in this sample was 45.2 years, ranging from 30 to 66 years. The ethnic distribution of our respondents was Caucasian, 53%; Hispanic, 20%; Filipino, 15%; African American, 9%; and Asian, 3%.

D. Review of Data

The case files included the board orders, notes from the tutor's meetings with the respondents, drafts of the papers written by the respondents, correspondence, and, sometimes, results of psychiatric evaluations, investigative reports, and other confidential data that was released to the tutor from the board under provisions of the order.

Certain characteristics of the respondents (e.g., age and gender of both respondent and victim) were documented, as were violations cited and sanctions imposed by the boards. Also noted were the number of drafts of the paper and the number of months required to complete the tutorial, as well as the number of face-to-face sessions with the tutor.

Based on informal observations over the course of conducting these tutorials, four behavioral constructs were identified that constituted defensive responses of the respondents to their status: Denial, Rationalization, Externalization, and Entitlement. It is not unusual to see such responses in professionals who have violated sexual boundaries, at least early in the rehabilitation process.[18] Also observed was evidence of cooperation, insight, and resistance. Factors were noted that may have put respondents at risk for a sexual violation. Such risk factors have been discussed in previous published reports, and include such things as problems in one's primary relationship, professional isolation, and a tendency to cross non-sexual boundaries with patients.[19]

16. Christine Dehlendorf & Sidney Wolfe, *Physicians Disciplined for Sex-Related Offenses*, 279 JAMA 1883, 1886 tbl.4 (1998); Nanette K. Gartrell et al., *Physician-Patient Sexual Contact: Prevalence and Problems*, 157 W.J. MED. 139, 140 tbl.2 (1992) (reporting a higher prevalence of sexual contact with patients among physicians in such specialties).

17. *See, e.g.*, CELENZA, *supra* note 5, at 215–16 tbl.A.1; Dehlendorf & Wolfe, *supra* note 16, at 1887 tbl.5; Gartrell et al., *supra* note 16, at 140 tbl.1.

18. *See* CELENZA, *supra* note 5, at 111–28; Celenza & Gabbard, *supra* note 6, at 621 (discussing how transgressors tend to "rationalize or defend" their behavior).

19. *See* CELENZA, *supra* note 5, at 170–71; *see also* Margarita Baca, *Sexual Boundaries: Are They Common Sense?*, 5 J. NURSE PRAC. 500, 502 (2009) (discussing major life events that can lead to an increased risk of sexual boundary crossing); Donna M. Norris et al., *This Couldn't Happen to Me: Boundary Problems and Sexual Misconduct in the Psychotherapy Relationship*, 54 PSYCHIATRIC SERVS. 517, 518–22 (2003) (discussing how such factors increase risk of sexual misconduct occurring in the

The respondents often described additional consequences of the disciplinary process over and above the sanctions imposed by their boards, and these were documented as well. Such consequences have been referred to as "collateral damage" by Celenza.[20] Finally, boards were contacted for any evidence of recidivism. Respondent behaviors were then examined to determine if any behavioral patterns might be predictive of recidivism.

III. RESULTS

A. Violations Reported

Violations cited by the various boards most often included either consensual or non-consensual sexual contact between provider and patient.[21] Violations that were non-consensual typically included physical examinations, touch, patient exposure, or verbal communication that was considered outside professional standards for a given situation. For example, one respondent brought medication to the home of a female patient in distress in the late evening and suggested that he do another examination at that time before possible hospitalization. He then performed an ungloved vaginal "examination," which included fondling of other areas of the patient's body as well.[22]

In other cases, a provider would, without clinical justification, ask a patient to remove certain items of clothing or would unsnap her bra or lift her sweater without asking permission. Some providers asked clinically inappropriate questions about a patient's sexual practices or relationships, or made comments about the color and style of their undergarments.

In some cases, nonsexual boundary crossings, such as accepting expensive or personal gifts, lending money, caring for the pet of a patient on vacation, or socializing outside the practice setting, were cited by the boards as well. Certain

psychotherapy relationship); Larry H. Strasburger et al., *The Prevention of Psychotherapist Sexual Misconduct: Avoiding the Slippery Slope*, 46 AM. J. PSYCHOTHERAPY 544, 545–47 (1992) (discussing how non-sexual violations often lead to sexual violations in patient care).

20. CELENZA, *supra* note 5, at 111–28.

21. *See infra* Table 1. It is a well-established professional standard that the power differential between provider and patient places the client in a vulnerable position, so that a sexual relationship between them is considered unethical with or without consent. See STEVEN B. BISBING ET AL., SEXUAL ABUSE BY PROFESSIONALS: A LEGAL GUIDE 803–07 (1995).

22. In accordance with MD. CODE ANN., HEALTH OCC. §1-212 (LexisNexis 2005), each health occupation board in Maryland is required to adopt regulations that prohibit sexual misconduct and provide for the discipline of a licensee who is found to be guilty of sexual misconduct. Section 1-212 provides a definition of "sexual misconduct" which at a minimum meets certain defined behaviors. Each health occupation board has adopted regulations to further define sexual misconduct. For example, the State Board of Physicians defines sexual misconduct to include sexual impropriety and sexual violation, both of which are defined in the regulation. See MD. CODE REGS. 10.32.17(A)(2) (2000). Board members may rely on the regulations specific for a given health occupation, as well as on expert testimony, and their own specialized knowledge and experience in the profession, in determining which acts constitute sexual misconduct. See MD. CODE ANN, STATE GOV'T. §10-213(i) (LexisNexis 2005).

nonsexual boundary crossings are often seen as precursors to sexual boundary violations,[23] and these will be discussed in greater detail as possible risk factors.

The fact that the violations listed in Table 1 far exceed 100 percent reflect the fact that boundary crossings are typically seen in patterns; the same respondent may, for example, exchange gifts and greeting cards with a patient, express feelings of love, socialize with her outside the practice setting, and become sexually involved with her as well. A board order will specify all of the respondent's behaviors that are deemed inappropriate.

Consistent with previous research,[24] we found that eighty-eight percent of the cases involved male providers and female patients.[25] All four gender combinations, however, were represented (male-male, 3%; female-male, 3%; and female-female, 6%). The mean number of victims referred to in each board order was 1.82, with a range of one to six per respondent.

TABLE 1. VIOLATIONS CITED BY LICENSING BOARDS

Type of Violation	**Percentage of Respondents**
"Consensual" Sexual Relationship	44
Inappropriate Touch or Exposure	47
Verbal Disclosure or Invasive Questions	56
Sexual Harassment	29
Inappropriate Clinical Procedure	56
Nonsexual Boundary Violations*	56
Falsification of Records or Documents	32
Other Violations	9

* For example, gift exchange, personal disclosures, meeting outside of office, "nonsexual" touch outside standard of practice.

B. Sanctions Imposed by the Boards

Sanctions are shown in Table 2. In two cases, licenses were revoked with conditions to be met before reapplication could take place.[26] Almost all the respondents were placed on probation and most received suspensions as well. If respondents were permitted to practice during a period of probation, restrictions were sometimes placed on their practices. Restrictions included such things as

23. *See* Strasburger et al., *supra* note 19, at 546–47.

24. Gartrell et al., *supra* note 16, at 140.

25. For this reason, and for simplicity of discourse in this paper, offenders are generally referred to using the male pronoun and patients are referred to using the female pronoun.

26. *See infra* Table 2.

chaperones for examination or treatment of female patients, denial of prescription privileges for controlled substances, and denial of all patient care.

TABLE 2. SANCTIONS IMPOSED BY LICENSING BOARDS

Sanction	Percentage of Respondents
Revocation*	9
Suspension (Range: 0.5–5.0 years)	68
Stayed Suspension**	41
Probation (Range: 2–5 years)	86
Fine (Amounts: $2,500, $7,500)	9
Practice Limitations	29
Other (e.g., random chart review)	9

*Certain rehabilitation measures required prior to reapplication
**Suspension placed on "hold" contingent on compliance with probationary conditions

C. Rehabilitation Measures

As noted in Table 3, below, all respondents in this study were required to undertake some form of ethics education and most were also required to undergo psychiatric evaluation with therapy if indicated. Most respondents were also expected to practice under supervision during their probationary period.

TABLE 3. REHABILITATION MEASURES REQUIRED

Measure	Percentage of Respondents
Ethics Education	95*
Therapy as Indicated	77
Clinical Supervision	59
Public Service	4.5
Other	18

*One respondent was asked by his board to do the tutorial only after completing other probationary requirements.

Although all respondents in this study were required to undertake an ethics course, specific conditions varied widely, as shown in Table 4. For some, a tutorial as opposed to a classroom course was required, while for others it was optional. Specific requirements, such as prior approval by the board and specified onset and deadline dates, were required for some respondents but not for others. In some cases, the tutor was given access to additional confidential information, such as psychiatric evaluations, and was permitted to communicate with the mental health professionals doing the evaluations. The tutor was sometimes required to report to the board on a regular basis. In a few cases, final versions of the respondents' papers were to be submitted to the board.

TABLE 4. EDUCATIONAL PARAMETERS

Parameter	Percentage of Respondents
Ethics Course Required	100
Tutorial Required	77
Tutorial Optional	23
Specified Educational Resource(s)	23
Prior Board Approval Required	64
Confidential Disclosures to Tutor	45
Communication Amongst Rehab Personnel	50
Onset Date Specified	18
Deadline Date Specified	50
Periodic Reporting to Board	18
Paper to be Submitted to Board	23

D. Completion of Tutorial

Twelve of the original thirty-four respondents did not complete this tutorial. Two respondents left the state, one left the profession, and one surrendered his license. One respondent committed suicide. Seven respondents refused to meet the tutor's performance criteria and found another board-approved way to meet their educational requirement. For example, a respondent's defense attorney might have suggested that the respondent not admit in writing any wrongdoing, which was a requirement of the paper. Some foreign-born respondents had never written a paper before, especially in English.

Remaining data will reflect the twenty-two respondents who successfully completed the tutorial experience. Those respondents took an average of 11.27 months to complete the tutorial with a range of two months to almost six years. The average number of visits with the tutor was 5.68, with a range of three to ten. The mean number of drafts of the paper submitted before approval was 3.45, ranging from one to nine.

E. Additional Consequences

Over the course of the tutorial, most respondents reported circumstances in their lives resulting from their violation beyond the sanctions imposed by their respective licensing boards, as noted in Table 5. Most of them experienced difficulties in personal relationships, some of which were already problematic before the offense had occurred, as shown in Table 6. One respondent told the tutor that his child came to him and said, "Daddy, your name is in the paper."

Many of the respondents experienced employment problems, such as termination from practice groups, loss of hospital privileges, and interpersonal difficulties. Suspended licenses often resulted in serious financial problems as well.

TABLE 5. ADDITIONAL CONSEQUENCES

Consequence	Percentage of Respondents
Relationships with Partner, Children, or Extended Family	77
Loss of Income and/or Home	36
Employment Problems	45
Loss of Patients	27
Loss of Hospital Privileges	18
Damage to Reputation	14
Dismissal From Practice Group	9
Loss of Malpractice Insurance	9
Damage to Interpersonal Relationships at Work	9
Other (e.g., risk of deportation, criminal charges, heart attack)	18

F. Expressions of Remorse

Observations of additional consequences were reflected in spontaneous expressions of remorse. Some respondents (23%) expressed concern about the patients they had harmed or the impact their actions may have had on the image of their profession. However, nearly twice as many respondents (41%) spontaneously expressed concern over the impact that the disciplinary process had on their professional status and reputation.[27] Celenza and Gabbard have referred to this second type of remorse as "narcissistic mortification," rather than true remorse.[28]

G. Possible Risk Factors

Certain experiences and behavioral characteristics are often considered risk factors for sexual boundary violations.[29] Table 6 shows descriptions of each type of possible risk factor observed:

27. This difference was statistically significant by Chi-Square test with Yates correction for continuity ($X^2 = 6.32$; $p < .05$). Such statistical tests are used in order to demonstrate that differences or relationships could have occurred by chance with a probability (p) less than that shown in the test results. In the result just reported, for example, that probability would be less than five percent.

28. Celenza & Gabbard, *supra* note 6, at 629.

29. CELENZA, *supra* note 5, at 170–71; *see also* Baca, *supra* note 19, at 502; Norris et al., *supra* note 19, at 518–22; Strasburger et al., *supra* note 19, at 545–46.

TABLE 6. POSSIBLE RISK FACTORS

Condition	Percentage of Respondents
Progression of Boundary Crossings	77
Perception of Standard of Practice	68
Relationship Problems or Loss	64
Inadequate Collegial Consultation or Role Modeling	59
Professional Isolation	41
Depression (self-report)	36
Need to Rescue	32
Reports of Early Trauma	23
Neglect of Personal Life	23
Substance Abuse	12
History of High Stress	12
Disdain for Professional Standards	9
Acceptance of Serial Relationships	4.5

1. Progression of Boundary Crossings

Certain behaviors tend to precede sexual boundary violations and are thus often referred to as a "slippery slope."[30] These included such things as making personal disclosures, socializing and/or becoming intimate with patients, making sexually suggestive remarks toward patients, and providing special treatment for only certain patients (e.g., taking a patient on trips, accepting personal or expensive gifts, or meeting with certain patients after hours and/or weekends).

2. Perceptions of Standards of Practice

Some respondents exhibited poor insight into the impropriety of their conduct, cited inadequate training, demonstrated a lack of awareness regarding boundaries, or displayed a poor understanding or disregard for ethical standards. In fact, almost half of the respondents (forty-one percent) claimed spontaneously that they had never been made aware of professional standards regarding professional-client boundaries.

3. Relationship Problems

These included loss of a spouse by either death or divorce, lack of sexual activity due to the illness of a spouse, marital difficulties, abuse by the spouse, and infidelity by the spouse.

30. Strasburger et al., *supra* note 19, at 546–48.

4. Inadequate Collegial Consultation or Role Modeling

These included inadequate supervision, awareness of boundary violations by their own clinical supervisors, and not seeking consultation with colleagues.

5. Professional Isolation

These included such things as having a solo practice, especially in a less populated area of the state, feeling degraded by colleagues, and seeing patients without other staff present, often by design.

6. Depression

These were self-reports by the respondents that included reaching a low point in their lives, feeling needy, having poor self-esteem, experiencing a midlife crisis, and expressing a fear of getting old.

7. Need to Rescue

This was expressed by such behaviors as lending money, caring for patients' pets, giving personal items of clothing to a patient, or hiring a patient who needed work. One respondent, who was not a psychotherapist, felt an obligation to comfort patients regarding their personal problems.

8. Reports of Early Trauma

Some respondents reported a history of sexual or physical abuse during their youth.

9. Neglect of Personal Life

Some respondents appeared to have practiced while under personal distress, been burdened by family caretaking responsibilities, or consistently placed their personal life secondary to their professional life.

10. Substance Abuse

This included alcohol and drug use, which may have included either illicit or prescription drug abuse.

11. High Stress

This included feeling "deeply stressed," angry, impulsive, or inadequate, having psychological and psychiatric disorders or an explosive temper, and being physically violent.

12. Disdain for Professional Standards

Two respondents exhibited a consistent, conscious defiance of professional standards in general.

13. Acceptance of Serial Relationships

One respondent saw no problem having personal relationships with successive patients.

H. Respondent Behaviors

Incidence of all four defensive behaviors decreased sharply and significantly over the course of the tutorial experience, as shown below in Figure 1.[31] As Celenza has pointed out, it is to be expected that a respondent might be defensive initially after the imposition of disciplinary sanctions.[32] One would expect, however, that a person who took responsibility for his or her actions would display fewer such responses over time.

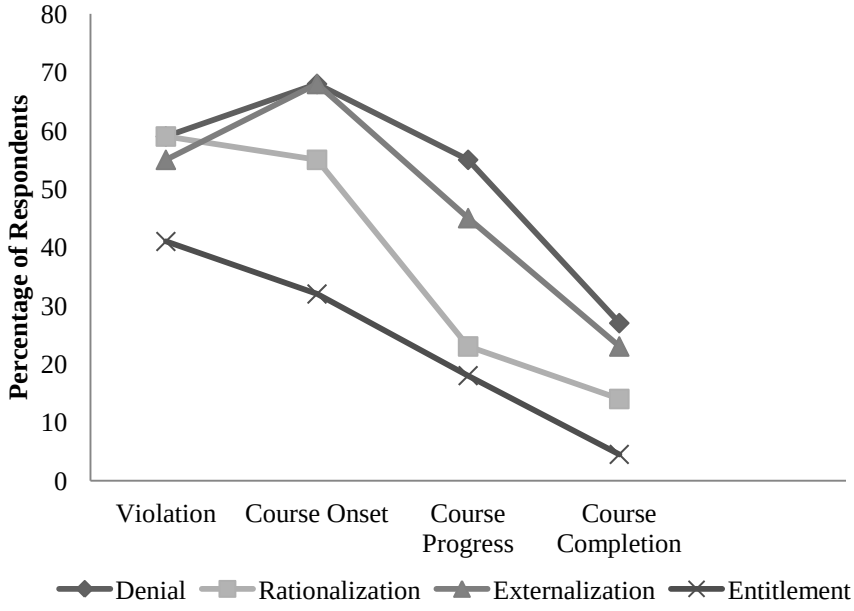

Figure 1. Incidence of observed behaviors apparent at the time of the violation and throughout the tutorial course.

31. The statistical significance of these changes was tested by Chi-Square analysis. SIDNEY SIEGEL, NON-PARAMETRIC STATISTICS FOR THE BEHAVIORAL SCIENCES (2d ed. 1988). Results were: Denial, $X^2 = 8.2$; $p < .04$; Rationalization, $X^2 = 19.6$; $p < .0002$; Externalization, $X^2 = 9.7$; $p < .02$; Entitlement, $X^2 = 9.2$; $p < .03$.

32. CELENZA, *supra* note 5, at 112.

1. Denial

As an example of denial, one respondent had intercourse with an inmate in a prison treatment room, within earshot of the guard standing outside the door. Another respondent insisted that his patient's allegation of a sexual relationship was "just her perspective." A third respondent insisted that patting his patient's thighs while her pants were down was not a sexual act. In addition, a number of the respondents initially failed to write their names on the papers they wrote for the tutor or wrote about their offenses in the third person, thus failing to acknowledge personal responsibility for their actions.

2. Rationalization

Respondents often rationalized their unethical behavior. For example, one respondent stated that consensual sex should be acceptable if the intent was marriage. Another respondent did not understand why engaging in sex outside the treatment room was inappropriate.

3. Externalization

Some respondents had a tendency to blame others, rather than taking responsibility for their own transgressions, thus externalizing responsibility.[33] At times, there was a tendency for respondents to blame co-workers, their own attorneys, the board, or the victim for the fact that they had gotten into trouble.

4. Entitlement

Finally, some respondents displayed a sense of entitlement and thought that their special status somehow exempted them from the need to comply with professional standards or that their offense should have resulted in a milder sanction.

5. Insight and Cooperation

While these defensive reactions decreased sharply over time, it was also noted that ratings of insight increased significantly over time.[34] Cooperation was rated uniformly high throughout the experience and resistance was rated low for the most part, as show in Figure 2. As described earlier, those respondents who had actively resisted the tutorial requirements and refused to cooperate all eventually left the program.

33. *See* Celenza & Gabbard, *supra* note 6, at 629 (noting that many transgressors feel "traumatized" by the adjudicatory process for their sexual misconduct and view themselves as victims).

34. $X^2 = 7.7$; $p < .02$.

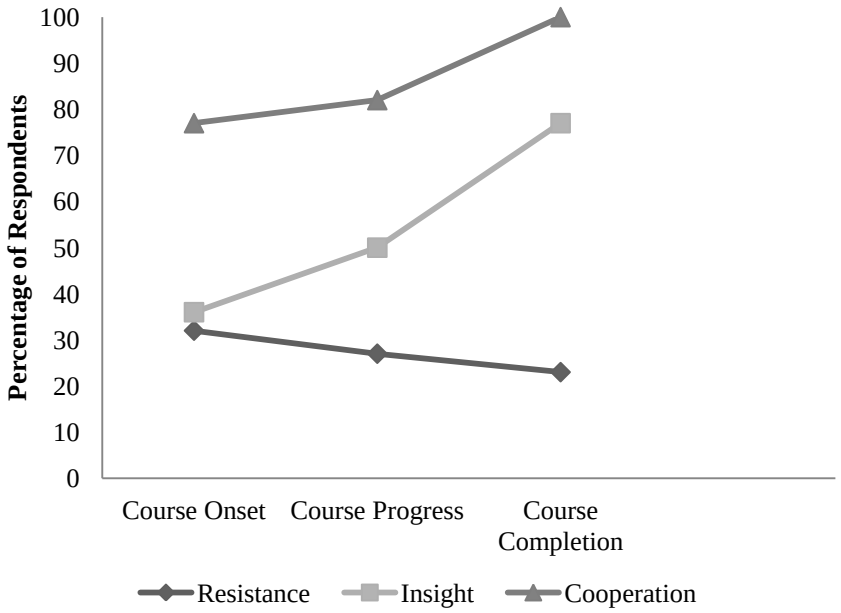

Figure 2. Incidence of Resistance, Insight and Cooperation observed throughout the tutorial course.

I. Recidivism

Three of the twenty-two respondents were found to have reoffended when the boards were consulted after some time had passed. One respondent once again crossed sexual boundaries and his license was revoked. The other two respondents violated other provisions of their licensing statutes and were given additional periods of probation, but are currently in good standing. One respondent violated probation by practicing while his license was suspended. The other had a non-qualified assistant working in his practice.

A number of factors were found to be characteristic of some or all of the recidivists. For example, as noted in Figure 3, the three recidivists all showed significantly higher frequencies of defensive behaviors throughout the tutorial experience.[35]

35. These differences were significant for Denial, Rationalization, and Entitlement. Statistical significance was tested by Mann-Whitney U-test, and the results were as follows: Denial, $U = 0$; $p < .002$; Rationalization. $U = 5.5$; $p < .05$; Externalization, $U = 11$; ns; Entitlement, $U = 1.5$; $p < .02$. SIEGEL, *supra note* 30, at 116–27 (describing the Mann-Whitney U-test).

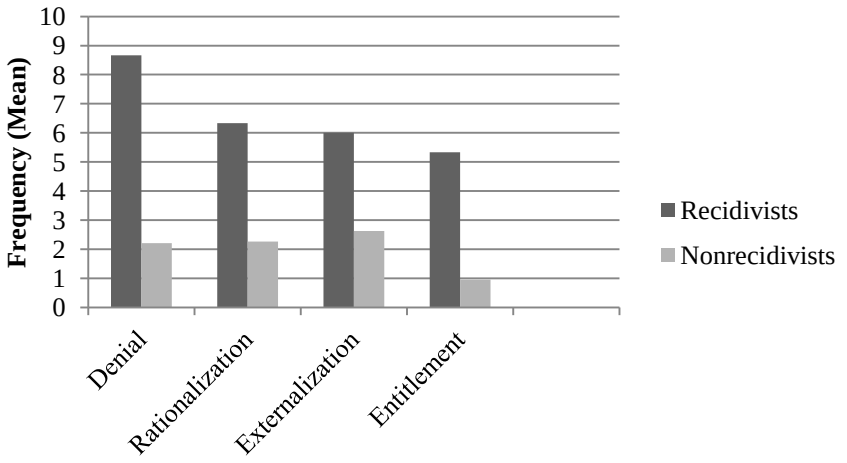

Figure 3. Frequency of behaviors observed in recidivists and nonrecidivists at the time of violation and throughout the tutorial course.

It was also noted that, when looking at possible risk factors, both respondents who exhibited a disdain for professional standards were among the three recidivists.[36]

In two of the three cases of recidivism, the tutor had, in a letter to their respective boards, expressed reservations about the pupils' ability to apply what they had learned without further therapy or clinical supervision. Such reservations had not been expressed for any other respondents. The respondent who once again violated sexual boundaries with a patient was also one of the two respondents whose licenses were initially revoked with conditions for reapplication.

IV. DISCUSSION

This study documented certain characteristics and experiences of health professionals who had engaged in sexual misconduct and who had then been required to undergo a tutorial ethics course as part of a condition of probation. This tutorial experience, in concert with other experiences during the rehabilitation period, appeared to produce positive behavioral change with a low level of sexual recidivism.[37] As noted in Table 4, there was substantial variability in the specific

36. *See infra* Table 6. $X^2 = 7.3$; $p < .01$.

37. Comparisons with appropriate control groups, (e.g., a group of health professionals who had not violated sexual boundaries, or violators undergoing a different type of rehabilitation experience) would have allowed for more definitive statements about the validity of certain characteristics, such as risk factors or the role of a tutorial versus other teaching formats. Since use of such control groups was not possible in this retrospective study, the validity of these results is limited to this extent. In addition to the absence of a control condition in this study, it must be noted that the behavioral observations were not "blind," in that the raters were aware that certain behaviors (e.g., denial, insight) were likely to occur in this situation. At the same time, no predictions had been made about the incidence of these behaviors at various points in time or whether recidivists and nonrecidivists would differ in any other respect.

aspects of the educational requirement. For example, some respondents had a deadline for either initiating or completing the course, while others did not. In some cases, confidential information was available to the tutor and in other cases, it was not. The impact of such factors on outcome is not known. However, it may be helpful for licensing boards and administrative prosecutors to at least be aware of these factors and to consider their possible relevance to outcome, so that such sanctions may be imposed in a more consistent and effective manner.

A. Respondent Behaviors

Although defensive behaviors were seen in most respondents at the beginning of their tutorial experience, this may be considered a natural tendency, given the rather sudden and unexpected impact of events on their personal and professional lives.[38] Over the course of the tutorial experience, these defensive behaviors decreased sharply and significantly, while the level of insight increased. Cooperation was high and resistance low throughout the experience.

B. Predictors of Recidivism

Certain respondent behaviors observed during the tutorial experience may be predictive of further unprofessional conduct as evidenced in three of the twenty-two respondents who completed the tutorial experience. Recidivists showed a higher rate of defensive behaviors overall than was seen in nonrecidivists. In addition, there was a tendency for recidivists to show a disdain for professional standards in general. In two of the three cases of recidivism, the tutor remained concerned enough about the extent to which their learning had been internalized that he suggested to their respective boards that further therapy or clinical supervision might be warranted. Only one of the three recidivists committed an additional sexual boundary violation, at least as of the time of this writing.

Licenses of two of the twenty-two respondents had been revoked by their respective boards, with certain conditions required before reapplication would be permitted. One of these was the recidivist who once again violated a sexual boundary. The other revoked licensee was compliant with probationary requirements and was eventually relicensed, not only in Maryland, but in another state a number of years later.

In determining sanctions, licensing boards typically consider a number of "aggravating" and "mitigating" factors, including rehabilitation measures.[39] Therefore, it may not always be possible to make these determinations with anything but limited predictability. Perhaps this could be made easier if further studies helped identify additional predictors of outcome.

38. See CELENZA, *supra* note 5, at 112 (commenting that transgressors facing the consequences of their actions often react in a defensive manner).

39. *See* sources cited *supra* note 4.

C. Expression of Remorse

There was a strong tendency for most respondents to focus on immediate desires and consequences, at the expense of generally accepted professional standards. As has been known for some time, certain risk factors increase the likelihood of a boundary violation.[40] As much as one might like to think that they will adhere to the highest standards of ethical behavior, everyone is vulnerable to succumbing to immediate needs and personal crises.[41] Under such stressful conditions, a provider may be more likely to deny the reality of the situation with which he is confronted or to rationalize his behavior.[42] In addition, most of the respondents appeared to be more concerned during the rehabilitation period with the "collateral damage" to their lives and careers than with the harm they might have caused to their patients and to the image of their profession.

It is clear to some people who work with boundary violators that some of them never understand and accept the ethical standards with which they are expected to comply.[43] It was also apparent in the present study that many of the respondents claimed to be totally unaware of the standards regarding professional-client boundaries with which their professions expected them to comply.[44] Ignorance of the law is never a valid excuse for breaking a law, but if the message is not getting through, it may be important to think about the implications of that for educational policy and, ultimately, patient welfare.

D. Compliance Motivation

How, then, can the likelihood that health professionals become aware of ethical and legal standards regarding sexual boundaries with patients, and comply with those standards, be increased? A number of authors from different disciplines have addressed this issue.[45] Feldman defines five patterns of "compliance

40. *See* sources cited *supra* note 19 and accompanying text.

41. See Celenza & Gabbard, *supra* note 6, at 633–35 (suggesting that many transgressors are not drastically different from boundary-abiding professionals).

42. CELENZA, *supra* note 5, at 116.

43. *See, e.g.*, Gary R. Schoener, *Assessment of Professionals Who Have Engaged in Boundary Violations*, 25 PSYCHIATRIC ANNALS 95, 95 (1995) (noting that some scholars do not agree that rehabilitative efforts are effective).

44. Respondents' claims appear to be supported by a number of studies on physician-patient sexual contact education. *See* Gartrell et al., *supra* note 16, at 142 (finding that more than half of transgressors did not receive education on physician-patient sexual contact boundaries in medical school or during residency); Gary R. Schoener, 24 J. SEX EDUC. & THERAPY 209, 209 (1999) (describing professional and consumer concerns about the lack of training regarding professional boundaries).

45. *See, e.g.*, Peter J. May, *Compliance Motivations: Affirmative and Negative Bases*, 38 LAW & SOC'Y REV. 41, 61–64 (2004) (noting that identifying individuals' negative or affirmative motivations can help in controlling their behavior and actions); James Q. Wilson, *The Rediscovery of Character: Private Virtue and Public Policy*, NAT'L AFFAIRS, Fall 1985, at 3, 14–16 (suggesting that schools, families, and society can play a role in encouraging good conduct behaviors at early ages that would continue throughout an individual's lifetime); Yuval Feldman, *Five Models of Regulatory Compliance Motivation: Empirical Findings and Normative Implications* 2–6 (Bar-Ilan Univ. Law Sch., Pub. Law &

motivation" with regard to laws or regulations.[46] Some people, he writes, are driven by a sense of fairness and morality, while the reason-driven individual needs to be convinced of the wisdom of engaging in a certain behavior.[47] A third group goes along with the dominant compliance motivation in his social environment, while a fourth complies simply because "it is the law."[48] Finally, there are those who weigh the relative risks and benefits of compliance.[49] May distinguishes between affirmative and negative compliance motivations.[50] The former, he writes, "emanate from good intentions and a sense of obligation to comply," while the latter "arise from fears of the consequences of being found in violation . . . ."[51]

While one might like to think that all health professionals will be in the affirmative group, this is simply not the case, any more than it is the case with those who comply with speed limits for either affirmative or negative reasons. How often do people find themselves weighing the risk of "getting caught" against the desire to get to an appointment on time, with little or no conscious thought about the reasons that speed limits exist in the first place?

E. Measures of Prevention

For all these reasons, methods of teaching health professionals about ethical and legal standards regarding sexual boundaries needs to be comprehensive, addressing not only the principles themselves, but risk factors and consequences for both patient and provider.[52] Such teaching should be included during pre-degree training[53] and continuing education opportunities should be offered if not required

Legal Theory Working Paper No. 12–10, 2010), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1633602 (arguing that there are five individual patterns of motivation, and that identifying which one a particular individual has can aid in deterring certain conduct).

46. Feldman, *supra* note 45, at 2–6 (defining the five categories of compliance motivation).

47. *Id.* at 1.

48. *Id.*

49. *Id.* at 2.

50. May, *supra* note 45, at 61–64.

51. *Id.* at 61.

52. Gregg Gorton et al., *A Pilot Course for Residents on Sexual Feelings and Boundary Maintenance in Treatment*, 20 ACAD. PSYCHIATRY 43 (1996); *see also* FED'N OF STATE MED. BDS., *supra* note 2, at 6 (explaining that comprehensive evaluations are valuable for a medical board because they enable the board to assess potential risks to patient safety).

53. Educational accrediting bodies may set standards of professional behavior that influence curriculum and disciplinary activities. For example, the Liaison Committee on Medical Education makes the following statement about expectations of professional behavior of medical students:

> The medical education program should ensure that medical students receive instruction in appropriate medical ethics, human values, and communication skills before engaging in patient care activities. As students take on increasingly more active roles in patient care during their progression through the curriculum, adherence to ethical principles should be observed, assessed, and reinforced through formal instructional efforts. In medical student-patient interactions, there should be a means for identifying possible breaches of ethics in patient care, either through faculty or resident observation of the encounter, patient reporting, or some other appropriate method. The phrase "scrupulous ethical principles" implies characteristics that include honesty, integrity, maintenance

by state licensing boards, especially considering that some professionals trained abroad may not have had any training on this topic.[54] Licensing boards might even consider examining applicants on certain ethical issues as a prerequisite to licensure, as some boards already do.[55] At the very least, licensing statutes and regulations should clearly define sexual misconduct, rather than leaving it up to a board to define on a case by case basis what may constitute "immoral behavior" or "unprofessional conduct."[56]

Papadakis et al., in a study of graduates from a number of U.S. medical schools, have shown that medical students who display problems with professional behavior during their medical school years are more likely to be disciplined by licensing boards later on.[57] Additionally, the ability to practice ethically requires a certain level of self-insight and accurate self-assessment. However, research indicates that medical providers who function at the lowest competency levels may be least accurate in their self-assessments.[58] Therefore, the earlier these issues are addressed, the less likely such problems are likely to arise, especially if faculty are seen to be modeling appropriate professional behavior.[59]

Celenza has emphasized the importance of process as much as content in designing the teaching of ethical principles.[60] Discussion of clinical vignettes

> of confidentiality, and respect for patients, patients' families, other students, and other health professionals. The program's educational objectives may identify additional dimensions of ethical behavior to be exhibited in patient care settings.

LIAISON COMM. ON MED. EDUC., FUNCTIONS AND STRUCTURE OF A MEDICAL SCHOOL: STANDARDS FOR ACCREDITATION OF MEDICAL EDUCATION PROGRAMS LEADING TO THE M.D. DEGREE 10 (2012), *available at* http://www.lcme.org/functions.pdf.

54. *See* COULTER-KNOFF, *supra* note 4, at 6–7 (recommending continuing education programs to address issues in the area of sexual misconduct); *see also* Dehlendorf & Wolfe, *supra* note 16, at 1887–88 (arguing that medical education to promote proper boundaries and professional ethics will help physicians be more willing to take corrective action against offenders; *see also* Gartrell et al., *supra* note 16, at 142–43 (surveying physicians and finding that only three percent of respondents participated in a continuing education course focusing on this issue, pointing to the need for medical ethics training).

55. *See, e.g.*, MD. CODE REGS. 10.36.01.06 (2011) (outlining Maryland's requirement that psychologists pass an examination on the Code of Ethics and Professional Conduct).

56. *See* Richard W. Thoreson et al., *Sexual Contact During and After the Professional Relationship: Attitudes and Practices of Male Counselors*, 71 J. COUNSELING & DEV. 429, 429 (1993) (explaining that sexual misconduct is not always well-defined and noting the different views among mental health care professionals on unethical behavior).

57. Maxine A. Papadakis et al., *Disciplinary Action by Medical Boards and Prior Behavior in Medical School*, 92 J. MED. LICENSURE & DISCIPLINE 11, 11 (2006).

58. *See* Mira Brancu & Lisa Page, *Recognizing Boundary Violations as an Issue of Self Care: A Graduate Student Perspective*, 60 N.C. PSYCHOLOGIST 5, 12 (2008); Brian Hodges et al., *Difficulties in Recognizing One's Own Incompetence: Novice Physicians Who Are Unskilled and Unaware of It*, 76 ACAD. MED. S87, S87 (2001) (finding that the lowest performers in a group of family medicine residents were the most inaccurate in their self-assessments).

59. *See* COULTER-KNOFF, *supra* note 4, at 6 (opining that physicians should receive education on sexual misconduct and boundaries early in their training because it is "best learned when it is role-modeled and practiced over time").

60. *See generally* CELENZA, *supra* note 5.

focusing on "slippery slope" issues[61] will allow students to engage in what has been called "progressive boundary analysis,"[62] so that they might more easily anticipate problem areas during early stages of boundary crossing. Johnson et al. also recommend developing and maintaining ongoing peer consultation groups whereby colleagues could help with assessing and identifying problem areas and offer support to their colleagues in addressing them.[63] This would also target one of the risk factors discussed in this paper: professional isolation.[64]

V. SUMMARY

A customized tutorial course appears to be an effective component of a rehabilitation program for health professionals who have violated sexual boundaries with patients. Such programs have the potential to assure the tutor and, ultimately, licensing boards, that respondents have accepted responsibility for their transgressions and understand what is needed to avoid future violations. Certain respondent behaviors and attitudes during the course of the tutorial experience, if not before, may serve as predictors of recidivism. Respondents undergoing such rehabilitation programs appear to gain an increased awareness of factors that may have put them at risk for boundary violations while also experiencing personal and professional consequences above and beyond the sanctions imposed by their licensing boards. Almost half of the respondents, however, felt that they had not been adequately prepared to address these challenges of clinical practice.

These findings strongly suggest that standards regarding provider-patient boundaries may need to be more clearly defined. In addition, education of health professionals in this area needs to be an important component of both pre-degree and post-degree education, and must address not only ethical principles, but risk factors and consequences as well. In short, if our ultimate objective is protection of the patient, preventive measures need to reach providers in a comprehensive manner and at all levels of professional experience.

61. *See* Nancy A. Bridges, *Managing Erotic and Loving Feelings in Therapeutic Relationships: A Model Course*, 4 J. PSYCHOTHERAPY PRAC. & RES. 329 (1995); Norris et al., *supra* note 19, at 478 (outlining a scenario in which a physician may "slip with familiar ease" into unethical behavior).

62. One of the authors presented this process in a previous work. S. Michael Plaut, *Understanding and Managing Professional-Client Boundaries*, *in* HANDBOOK OF CLINICAL SEXUALITY FOR MENTAL HEALTH PROFESSIONALS 21, 32 (Stephen B. Levine et al. eds., 2d ed. 2010) (describing "progressive boundary analysis" as a process where an individual considers crossing a professional-client boundary).

63. W. Brad Johnson et al., *The Competent Community: Toward a Vital Reformulation of Professional Ethics*, 67 AM. PSYCHOLOGIST, 565–66 (2012).

64. *See supra* Part III.G.5 (defining professional isolation).