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Assessing the Risk of Recidivism in Physicians with Histories of Sexual Misconduct

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ABSTRACT: Physicians who engage in sexual conduct with patients usually cause serious harm and have a high rate of recidivism. Although offending physicians may lose their privilege to practice, they have the right to appeal for restoration of the license. Yet medical licensing board members do not currently have any clear standards by which to predict whether a given physician is likely to abuse again. Using New York as a paradigm, this paper offers practical, clinically based guidelines for assessing the risk of restoring an offending physician's license. These guidelines are derived from psychoanalytic theories of character, the insights of therapists who have worked with abusive physicians, and the psychiatric model of assessing dangerousness. Recognizing character patterns and psychological vulnerabilities of physicians with histories of sexual misconduct will help board members identify those who are at high risk of abusing again if their licenses are restored.

KEYWORDS: forensic science, physician, sexual misconduct, medical license, dangerousness, recidivism, psychoanalytic

Introduction

Goal—The American Medical, Psychiatric, and Psychoanalytic Associations all clearly prohibit sexual contact between physicians and patients (1–3). This has its roots in ancient tradition: the Hippocratic oath states, "Into whatever house I enter, I will go . . . for the benefit of the sick and will abstain from . . . seduction of females or males . . ." (4). Within psychiatry such restraint is implied as well by Freud's rule of abstinence, which requires the therapist to refrain from gratifying himself at the expense of his patient (5).

In recent years the public has become increasingly concerned about health professionals who have sexual contact with their patients. This paper will focus on one aspect of the debate, namely, how to assess the advisability of restoring the license of a physician whose privilege to practice was revoked for sexual misconduct.

Since physicians who engage in such misconduct usually cause serious harm and have a high rate of recidivism, restoring an offending physician's license is at best a high risk endeavor. Yet medical licensing boards do not have any clear standards by which to predict whether a physician is likely to abuse again. Using New York as a paradigm, this paper offers hearing panel members practical, clinically based guidelines for assessing the risk of restoring an offending physician's license.

The guidelines proposed are derived from the literature on the treatment of sex offenders, psychoanalytic theories of character, the insights of therapists who have worked with abusive physicians, and the psychiatric model of assessing dangerousness. In New York, hearing panels consist of three individuals who are current or past physicians, or public members of the New York State Board for Medicine, which is nested within the New York State Education Department. At least two panel members must be physicians; because they can practice in any specialty, most are not psychiatrically trained. In the broadest sense, then, this paper attempts to apply psychoanalytic and psychiatric concepts in a way which will help non-psychiatrists identify dangerous physicians. The hope is that this will help licensing board members to protect the public while allowing physicians who are now safe to practice to resume the work for which they were extensively trained.

Incidence—Good data on the actual incidence of physician/patient sexual contact do not exist. According to many estimates, fewer than 5% of victims report it, perhaps because of continuing emotional ties to the physician and the trauma of pursuing a complaint (6). Of note, less than 5% of these allegations are found to be false (7). Furthermore, over 90% of psychiatrists who subsequently treat an unreported abused patient do not report the abuse (6).

Consequently, most of the data on incidence come from questionnaire surveys which depend on anonymous self-disclosure. A significant percentage of physicians do not return these questionnaires and those who do may not always admit to sexual contact with patients. Overall 7 to 12% of male physicians, and about 3% of female physicians admit anonymously to such contact (8,9). Some commentators have estimated the actual incidence may be as high as 15 to 25%, however (5). In a review of the literature conducted in 1990, Pope found no significant difference between the incidence of identified sexual misconduct by psychiatrists and by physicians in other specialities such as family practice, internal medicine, obstetrics-gynecology, and surgery (10,11). Although the percent of physicians admitting misconduct has decreased slightly in recent years, many writers believe this reflects concern about increasing sanctions rather than a real decrease in incidence (12).

Eighty-five to ninety-five of abusive physicians are men and the vast majority of their victims are women (6,13). For convenience, therefore, the physician will be referred to throughout as "he" and the patient as "she." Intercourse has been found to occur in roughly 40 to 85% of cases of sexual contact (14).

Recidivism—Multiple studies indicate abusive physicians are often recidivists. Herman and Gartrell found 33% of psychiatrists

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who admitted sexual misconduct had been involved with two to twelve patients (16). In another study, Holyroyd and Brodsky found 80% of abusive psychologists were recidivists (15). Similarly, according to the Ontario Task Force on Sexual Abuse of Patients, numerous physicians with a known history of sexual misconduct were charged with abusing patients again after being allowed to return to practice (16).

Although several rehabilitation programs have recently been developed for health professionals with a history of sexual misconduct, it is not clear whether these decrease recidivism. At this time there are no controlled outcome studies (17–19). Furthermore, the effectiveness of therapy is not known. In some cases, it may be limited, either because the physician is deterred from frankness by the prospect of presenting a progress report to the licensing board, or because he feels coerced into treatment, for example by an attorney who thought it would improve a malpractice defense. At times the effectiveness of therapy may be limited because of countertransference problems in the therapist (20).

Some authors, such as Pope, argue that physicians with a known history of sexual misconduct should never be allowed to practice again because they pose too great a risk to the public even after getting treatment (21). However, licensing boards currently have to consider the appeals of offending physicians and decide on a case-by-case basis whether rehabilitation has been effective. Before restoring the license of an offending physician, Board members, in the words of Schoener, "(need) to be prepared to answer the question: 'Would you have any qualms whatsoever if your spouse or child went to see this person . . . ?' " (22).

Model for Assessing the Risk of Sexual Misconduct

When someone with a known history of sexual misconduct appeals for restoration of his license, Board members ask, in essence, "why did this physician have sex with his patients and has he changed enough so he won't do it again?" This requires targeted change. A physician who has a paraphilia, for example, does not need to show he's actually been cured, but only that he will no longer act on his paraphiliac impulses with his patients.

Panel members need to make a common sense assessment of character change to determine whether the physician would still be dangerous to the public if restored to practice. This assessment is based on the severity of the offense, the physician's activities since loss of his license, observations of the physician during the appeal, and any character witnesses presented by him. The physician is not required to submit a psychiatric report. However, it is the physician's burden to demonstrate that he has changed, a prospect that will appear less credible in the absence of evidence of successful treatment.

The model for assessing dangerousness can be usefully applied to sexual misconduct. According to most estimates, abusive physicians cause serious psychological, if not physical, damage in at least 90% of cases (23). Abused patients generally do not get adequate psychiatric help for the problems which originally brought them into treatment. In addition, these patients may develop difficulty in subsequent sexual relationships, depression with suicidal feelings, intense anxiety, and symptoms of post-traumatic stress disorder like flashbacks or sleep disorders (24,25). Many abused patients do not get treatment for these problems because they no longer trust doctors. As Glen Gabbard has pointed out, a patient who has had sexual contact with a physician is damaged as a result of realistically internalizing the doctor as an exploitative, destructive, abusive object (26). The patient's dependent relationship with her doctor often activates transferential feelings associated with early caretakers, usually parents. Consequently, if she is exploited sexually by her physician, she may experience the abuse as if she were a victim of incest (27,28).

Engaging in sexual contact with patients is clearly harmful to them. A physician is dangerous if he is likely to do it again. As Mulvey noted, "dangerousness is not a psychiatric disorder like depression. It is a legal judgement based on social policy [that the level of risk is sufficient to justify preventive action]" (29,30).

This judgment depends in part on the social agency making the decision. In the criminal justice system, for example, significant individual liberty rights are balanced against the public interest in safety. Great efforts are made to ensure that we do not deprive someone of his rights without due process of law. When a panel considering license restoration assesses dangerousness, however, the balance is different. The physician does not have any right to resume practice. On the other hand, the Board has great public responsibilities. These include preserving the integrity of the medical profession, deterring others from similar offenses, and protecting the public.

If the panel's task is to assess the risk posed by a given physician, it may not matter whether the panel contains any psychiatrist members. Studies show psychiatrists are no better than many other people at predicting dangerousness, especially when dealing with distant, infrequent events (31).

Of note, many of the characteristics which should be taken into account by hearing panel members when assessing the risk of sexual misconduct are the same characteristics which should be taken into account when assessing what has traditionally been called dangerousness, or the risk of violent behavior. Just as the best predictor of violence is a history of violence (32), the best predictor of professional sexual misconduct may well be a history of abusing patients in the past (33). Furthermore, personality traits which are associated with a risk of violent behavior are associated as well with a risk of sexual misconduct. An offender's motivation to abuse people may rest on a sense of entitlement, and a tendency to dehumanize others (34). At the same time he may have difficulty inhibiting his aggressiveness in part because of a lack of empathy for others, a failure to accept responsibility for his actions, and impulsiveness (35).

Before restoring a physician's license, Board members must be confident he's either less likely to *want* to have sexual contact with patients and/or more likely to be able to control himself.

Motivational Risk Factors

Although the vast majority of physicians report feeling sexually attracted at least occasionally to a patient (36–38), most do not act on these feelings. Gabbard notes that physicians who act on sexual feelings for patients are usually trying to gratify needs which are, psychodynamically speaking, "pregenital" rather than "truly sexual" in the adult sense; these include "a longing to be loved, a fear of being alone and abandoned, [and] a fragile self-esteem that depends on his being idealized and adored by others" (39). Psychoanalysts such as Gabbard and Kernberg consider unresolved narcissistic pathology the major cause of sexual misconduct (40,41).

Offending physicians often fit Kohut's description of "mirror-hungry personalities" who "thirst for . . . admiring responses to . . . nourish the famished self" (42). In the mildest form, this may mean the physician needs to be idealized by patients in order to feel better about himself. Alternatively, he may have such a strong need to feel special that he becomes grandiose and entitled. Finally, the

predatory physician feels he is the only person with any legitimate claims. He uses other people as objects to satisfy his needs, sexual and otherwise.

Although predatory physicians are the most deliberately destructive, many leaders in the field believe all physicians who engage in sexual misconduct harbor strong sadistic impulses (39,43). As Marmor says, sexually exploitative therapists have a secret, and often unconscious, "sadistic need to exploit, humiliate, and ultimately reject" their patients (44). Acting on sexual feelings with patients is highly self-destructive as well, since it can lead to severe penalties. Possible penalties include a malpractice suit, loss of a license, dismissal from professional organizations through the action of ethics committees, and, in some states, criminal prosecution (45).

Hearing panel members do not have access to the kind of in-depth information necessary for a subtle assessment of the sadomasochistic impulses and narcissistic vulnerabilities common to abusive physicians. Asking the physician certain questions may help licensing board members uncover gross pathology, however. What does the physician like about being a doctor? What was his best relationship with a patient, and why? Why would readmitting him be in the public interest? The physician's answers may show a preoccupation with power, suggesting he is predatory, or excessive pride and the conviction he should not be held accountable to others, suggesting he is entitled and grandiose. A physician who values patients primarily because their admiration makes him feel good may be dangerously needy.

Although all motivational risk factors reflect deep character traits which are difficult to change, needy and masochistic physicians are generally the most amenable to rehabilitation, while entitled or predatory physicians may well abuse again.

Masochistic Physicians—Someone who is particularly masochistic may feel badgered and intimidated by an aggressive patient into a sexual relationship if, for example, she threatens to commit suicide without it. This physician has difficulty setting limits on patients because of problems managing his own aggression. As Apfel and Simon have suggested, he may be unconsciously motivated to seek punishment for a variety of misdeeds, many of them imagined (46). A masochistic physician usually feels very guilty, is relieved when the relationship ends, and wants treatment to ensure it never happens again (47).

Needy Physicians—According to a study by George Vaillant, many physicians did not feel loved enough as children, and became doctors as a way of giving to others what they did not receive themselves (48,49). This may disguise a powerful wish to be loved by one's patient, however (40).

In addition, physicians who sexually abuse their patients often harbor a sense of social and sexual inadequacy. Marmor has suggested that sexually exploitative therapists use reaction formation to defend against feelings of masculine inadequacy (44), that is, they may feel unsure of their masculinity and be driven to prove it by sexual conquests of women. Abusive physicians may lack the skills to develop ongoing healthy relationships with appropriate adult partners. Some suffer from sexual difficulties such as impotency (24).

In Gabbard's words, physicians who feel very needy or inadequate, have "a desperate need for validation by patients, a hunger to be loved and idolized, and a tendency to use patients to regulate their own self-esteem" (47).

These physicians may have a heightened vulnerability during times of personal difficulties. Someone who is undergoing a divorce, for example, may experience this as a blow to his self-esteem which can be mitigated by the patient's idealization. Physicians who are at risk for sexual misconduct are often isolated middle-aged men going through personal difficulties which trigger a need for nurturance (50). They may fantasize they will be cured by being loved (40).

Needy physicians often try to excuse their behavior by saying they were under stress at the time. Although a satisfying personal life may well be protective, many physicians endure personal setbacks without abusing their patients.

It is not enough for the offending physician to show his external problems have been resolved. As Pope says, "what evidence do we have [he] won't do this next time life deals him a rough hand?" (51). A physician who claims he is now safe to practice medicine must show he has changed by developing new coping mechanisms for handling stress.

Entitled Physicians—Some physicians believe they have such special qualities as healers that they alone are entitled to use innovative methods like sex to cure others. They may be seen as "charismatic gurus" (52). Excessive self-confidence makes them more likely to get into trouble—and less likely to seek help if they find themselves on the brink of misconduct again.

An entitled physician may insist he was grossly mistreated by revocation of his license. Even though he knows this is not the most persuasive way to approach Board members, he cannot help expressing a pervasive sense of injustice. He cares more about maintaining his lofty self-image than regaining his license.

Predatory Physicians—Predatory physicians are highly skilled at seducing patients and covering their tracks. Many avoid detection altogether and those who are caught often escape severe penalties (47). Manipulative and ruthless, these physicians are at once the most dangerous and the most difficult to detect. A physician whose past behavior with patients was particularly egregious is probably predatory. How many patients have accused him of abuse? This may be a gross underestimate, given the predatory doctor's skill at concealment and the prevalence of under-reporting. Did he have sexual contact with any particularly vulnerable patients such as minors? To what extent did he use force rather than seduction? Some physicians ply their victims with alcohol or drugs before engaging in forcible sex. What lengths did he go to to hide his misconduct? How calculated was his behavior? As Schoener and Gonsiorek note, predatory physicians "tend to be far more deliberate and cunning in their exploitation of clients. Typically they are cool, calculating and detached . . ." (53).

To determine if a physician is predatory, it is helpful to examine collateral information for evidence of other sociopathic activity. He may have narrowly avoided being fired from a residency training program or have a long history of inappropriate behavior such as sexual harassment (52). He may have lied on job applications about his previous work history, or been disciplined in other states and lied about it here. Checking the National Practitioner Data Bank could reveal information about out-of-court settlements, or malpractice payments.

Board members should confront the physician with any discrepancies between his testimony and the collateral data. It can be helpful to listen to someone suspected of lying without looking at him, because the physician's frank demeanor may be misleading. Watching people can be misleading: when manipulative people are correctly accused of cheating, they often deny it, invent a plausible explanation, and look their accusers right in the eye (54,55). It is

easier to detect lying by listening alone. Someone who lies to Board members is probably predatory.

Abusive physicians are certainly not unique in having predatory, entitled, needy, or masochistic impulses. What differentiates them is that they act on these traits through sexual misconduct—in part because of weak inhibitory controls.

Failure of Inhibitory Controls

Superego Deficits—All abusive physicians share a willingness to exploit others, while rationalizing their behavior and blaming their victims. In a major study by Gartrell et al., most offenders admitted "they engaged in sexual contact with patients for their own . . . gratification" (8). Some have superego lacunae, that is, they are usually ethical but occasionally willing to ignore the demands of conscience in the interests of getting what they want, a sexual or romantic relationship. Other more predatory physicians have a sweeping failure of superego development. They actively relish victimizing and experience the patient's helplessness and vulnerability as an opportunity. Common superego deficits include a lack of empathy and refusal to accept responsibility.

Lack of Empathy—More than 90% of physicians who have sexual contact with their patients use denial and rationalization to justify their behavior (36,56). This enables them to see themselves as caring and responsible while continuing sexual exploitation. Offenders often convince themselves the patient has experienced sexual contact as caring or therapeutic (8). They may believe sex has bolstered the patient's self-esteem and served as a corrective emotional experience.

Although Board members often look for evidence of remorse, research has shown many of these physicians don't regret their behavior at all. In Gartrell's study, 40% regretted the sexual contact, 35% had mixed feelings, and 25% of the offenders were pleased about it (8). Physicians who regret their behavior generally do so only because of the price they've had to pay (36).

A sense of remorse which entails empathy for one's victims deters sexual misconduct in the future (23). The Ontario Task Force recommends that a physician applying for restoration of his license be required to demonstrate understanding of the harm done by his abuse (16), and rehabilitation programs uniformly require this (22,57).

Some physicians may develop empathy through therapy. Occasionally someone may come to understand his patient's sufferings after losing his license and suffering himself. If a physician who is appealing for restoration of his license still does not believe his patients were harmed by sexual contact, he probably is not safe to practice medicine (33).

Failure to Accept Responsibility—Many physicians blame patients for seducing them—yet even if the patient was seductive, the physician alone bears moral responsibility for sexual contact. As Pope points out, sexual contact never occurs by mistake; it is always intentional—and only the physician is bound by an ethical prohibition (58). While the physician has a fiduciary duty toward his patients, in the words of Simon, "There is no standard of conduct . . . for patients to maintain" (59).

Other physicians insist the sexual relationship was a voluntary activity between consenting adults rather than deeply informed by the power dynamics of the physician-patient relationship. Simon, Gabbard, and other leading writers in the field agree the patient cannot give true consent because of unequal power (59–61). While the offending physician generally has a higher status than his victim and is on average 16 years older, the patient is often particularly vulnerable, in many cases a prior victim of incest or rape (62–64). Furthermore, the patient's need for professional help and her powerful transference feelings gives the physician undue influence over her (65). There is wide consensus the physician must accept responsibility for his sexual misconduct before he can be considered safe to practice. At a minimum the physician must admit the charges against him. An American Psychiatric Association district branch ethics committee concluded after reviewing the supervision of physicians over a period of ten years, "rehabilitation. . . . [leading to] changes in practice patterns appears to be highly unlikely where supervisees fail to admit the charges against them" (66).

Board members need to assess whether the physician not only accepts responsibility for his behavior but also has gained enough insight to recognize the warning signals for next time.

Writers such as Simon stress the importance of having the physician recognize behavioral warning signs (67). A physician who engages in boundary violations such as failing to charge a patient or disclosing current personal problems to her is at higher risk of sexual misconduct (68,69).

Gabbard and others insist on the importance of having the offending physician recognize psychodynamic themes which may serve as early warning signs of vulnerability (39). Of note, studies of dangerousness have shown that an inability to identify one's thoughts and feelings at the time of the prohibited activity is a poor prognostic sign (70). A physician who realizes he acted out of loneliness last time might be able to catch himself and take preventive steps next time he feels lonely and finds himself fantasizing about a patient.

Yet insight alone is not sufficient. In a major study of sexual misconduct by psychiatrists, Gartrell found offenders were more likely than non-offenders to have had psychotherapy or psychoanalysis. Psychoanalysts are just as likely as other therapists to be offenders (8). Perhaps physicians who have been in psychodynamic treatments are more willing to acknowledge sexual contact with patients in anonymous surveys because of long practice in self-disclosure. They may also be more likely to engage in the kind of intense, intimate psychotherapy work with patients which is conducive to a sexual relationship.

Even so, self-knowledge alone is clearly not fully protective. In the words of Simon, "powerful countertransference feelings may weaken the will to resist" (5). A physician may have a sneaking suspicion he is headed for sexual contact with a patient and yet want this so much that he ignores the warning signs. The physician must be motivated to act on his knowledge of himself to make the necessary behavioral changes.

Ego Deficits—As Gabbard has noted, some abusive physicians have "ego lacunae," or deficits, as well as superego lacunae, that is, they have difficulty modifying their behavior to meet the constraints of the outer world (71). Many physicians insist they'll never engage in sexual misconduct with patients again because the price is too great. Even if they are sincere, however, they may not be able to control themselves, particularly if they are chronically impulsive, do not anticipate consequences, or abuse substances.

Impulsiveness—Someone who used sex with patients as a "quick fix" to reduce unpleasant feelings is a poor candidate for rehabilitation, according to Schoener and Gonsiorek (53). It is important to determine current impulse control. Is the physician a reckless driver, for example, a gambler, or a binge drinker? If the physician is chronically impulsive, his claim he will never abuse patients sexually again is not credible. This is someone who acts before he thinks.

Failure to Anticipate Consequences—While many people are hindered from acting on their sexual wishes with patients in part by fear of sanctions (36), abusive physicians often fail to keep these in mind. On rare occasions this is due to psychosis, or naivete (22). A needy physician may understand the necessity of maintaining appropriate boundaries with most patients but show serious deficiencies of judgment with the patient he loves (40).

Substance Abuse—Physicians who use controlled substances, excessive alcohol, and/or illegal drugs are at increased risk of abusing patients because of impaired judgment. If the appealing physician has a history of substance abuse, he should provide a report from the treating psychiatrist or program indicating the results of periodic random urine toxicology screens.

Opportunity

Physicians who are professionally isolated are at increased risk of sexual misconduct with their patients (24). They are less likely to be aware of professional norms and the consequences of violating them, and less likely to be caught.

It may be particularly risky to be professionally isolated within a private practice in psychodynamic psychotherapy or psychoanalysis. As Marmor has noted, in psychotherapy, "the therapist and patient are alone in an office and the patient . . . is encouraged to bare her most personal feelings and thoughts. A special quality of emotional intimacy inevitably evolves under such circumstances" (44). Psychotherapy, in the words of Stone, is "an extremely intimate human experience . . . often erotic in tone . . ." (72). Most abusive physicians should not go back to private practice (40).

A physician may argue he can be trusted now because he will no longer have the opportunity for sexual misconduct. He may for example have decided to work in a public setting or to get a supervisor. Such initiatives are important primarily as an indication of the physician's motivation to avoid risky situations. There are always ways to circumvent these restrictions, for example, by withholding information from supervisors or lying to them about sexual misconduct.

If Board members feel a physician is at risk of relapse, they can grant a probationary licence which limits the conditions of practice. At best, this is a temporary solution. Sooner or later the physician must demonstrate durable character change in order to be eligible for a full restoration of his license.

Conclusion

Restoring a physician's license to practice medicine after revocation due to sexual misconduct is a troublesome decision. Limiting a physician's opportunity to engage in sexual misconduct with his patients is the easiest intervention but also the least reliable. Deep character change affecting motivational risk factors is the most reassuring, but the hardest to find. It is more common for a physician to show improved inhibitory controls—and this may be sufficient. Recognizing the character patterns and psychological vulnerabilities of physicians with known histories of sexual misconduct will help panel members identify those who are at high risk of abusing again if their licenses are restored.

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ERRATA

Erratum/Correction of Hill S. Review of: *Enclosure fire dynamics.* J Forensic Sci 2000 Nov.;45(6):1364.

On page 1364 in the reference section. The book's primary author last name was spelled incorrectly as Karisson.
The author's correct last name is Karlsson.

The Journal regrets this error. Note: Any and all future citations of the above-referenced paper should read: Hill S. Review of: *Enclosure fire dynamics.* [published erratum appears in J Forensic Sci 2001 March;46(2)] J Forensic Sci 2000 Nov.;45(6):1364.

Erratum/Correction of Tillinghast E, Cournos F. Assessing the risk of recidivism in physicians with histories of sexual misconduct. J Forensic Sci 2000 Nov.;45(6):1184–89.

On page 1184, the title for co-author Francine Cournos is inadvertently printed as *M.Sc.* The correct title should be *M.D.*

The Journal regrets this error. Note: Any and all future citations of the above-reference paper should read: Tillinghast E, Cournos F. Assessing the risk of recidivism in physicians with histories of sexual misconduct. [published erratum appears in J Forensic Sci 2001 March;46(2)] J Forensic Sci 2000 Nov.;2000;45(6):1184–89.

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