02-03-023

COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES
JUDICIARY COMMITTEE

In re: House Bills 1465 and 1466
Psychotherapist Sexual Abuse

* * * * *

Stenographic report of hearing taken in Majority Caucus Room, Main Capitol, Harrisburg, Pennsylvania

Thursday
March 17, 1988
10:00 a.m.

HON. H. WILLIAM DEWEESE, CHAIRMAN

MEMBERS OF JUDICIARY COMMITTEE

Hon. Kevin Blaum
Hon. Michael E. Bortner
Hon. Thomas R. Caltagirone
Hon. Gerard A. Kosinski
Hon. Joseph A. Lashinger, Jr.
Hon. David J. Mayernik
Hon. Paul McHale
Hon. Terrence McVerry
Hon. Jeffrey E. Piccola
Hon. Christopher R. Wogan

Also Present:

John. J. Connelly, Jr., Esquire, Special Counsel
Michael P. Edmiston, Esquire, Chief Counsel
Susan Germanio, Research Analyst

Reported by:
Dorothy M. Malone, RPR

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1 CHAIRMAN DEWEESE: Good morning, ladies and
2 gentlemen. On behalf of the Committee and staff, I would
3 like to welcome those present to our Judiciary Committee
4 meetings and public hearing concerning House Bill 1465 and
5 1466, Psychotherapist Sexual Abuse. I would like to share
6 with you today, we will explore some issues surrounding
7 the questions what individuals in a patient role should
8 expect from certain licensed professionals and what rights
9 and redress of/a patient should have against a professional
10 who fails to practice in an ethical, moral and legal manner.
11 Before we begin I would like to recognize
12 Ms. Jo Sterner, Executive Director of Rape Crisis Division,
13 the Greater Harrisburg YWCA. Jo, please rise. I'll ask
14 her to be recognized when she gets in here.
15 I would also like to indicate for the press
16 and for the record that on February 18th we invited the
17 district attorneys to participate, the District Attorneys
18 Association to participate in this event. They were not
19 even polite enough to get back with us. Tom Previc
20 of the Trial Lawyers was also asked to visit with us and
21 is most cordially welcome.
22 To commence our procedure, and I apologize for
23 being a couple minutes late. There are a couple other
24 hearings in the building and we are anticipating other
25 members to be joining us off and on during the hearing.

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But anyway to begin, I would like to welcome Mary Beth Backenstose, Registered Nurse, President of the Central Pennsylvania Coalition Against Abuse by Professionals. Could you please pull both mikes as close to you, three or four inches. Welcome.

MS. BACKENSTOSE: Mr. Chairman, members of the House Judiciary Committee, the Central Pennsylvania Coalition Against Abuse by Professionals wishes to thank you for this opportunity to provide testimony in support of House Bills 1465 and 1466. Sexual exploitation of patients by health-care professionals has become a serious problem across the United States. In the past five years, insurance carriers have paid out over $3,000 in claims against counselors, with half the claims and two-thirds of the payments being for sexual misconduct. (Psychotherapy Finances, 1987, Vol. 14, No. 5, p. 8) Psychologists have also experienced an increase in sexual misconduct claims against them. Surveys show that about ten percent of all reporting psychologists and psychiatrists engage in sexual relations with their patients, and the coalition has reason to believe, based on reports of sexual exploitation which we receive, that this percentage can apply to all health-care professionals. Eighty percent of reporting offenders acknowledge having sexual contact with more than one patient. Sixty-five percent of reporting psychiatrists report treating patients

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1 who had been previously sexually involved with reporting
2 therapists. Over 95 percent of reporting psychiatrists
3 who treated sexually exploited patients assessed the previous
4 contact as always harmful to their patients. However,
5 only eight percent of the respondents filed reports with
6 professional associations or legal authorities.
7 A distinct clinical syndrome has recently been
8 identified for patients who have been sexually exploited
9 by health-care professionals called 'Therapist-Patient Sex
10 Syndrome'; the most distressing symptom is that the patient
11 develops suicidal tendencies. However, 11 percent of these
12 people are hospitalized due to being sexually exploited by
13 a therapist and one percent of these people commit suicide
14 due to the therapist/patient sex syndrome.
15 The coalition was formed in the fall of 1985
16 by a group of psychotherapists in order to address the
17 problem of sexual exploitation of patients by health-care
18 professionals. Our membership is made up of professionals,
19 consumers, and abused patients. We have three goals.
20 They include educating professionals, abused patients
21 and consumers about this problem. Secondly, to provide
22 support to those persons who have been abused by health-
23 care professionals and those support systems include
24 therapy or referral to a legal counsel or that sort of thing.
25 The third goal is pursuing legislation aimed at stopping

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1 such abuses. Hence, these two bills are being proposed
2 as a first step to that third goal.
3 With the enactment of these bills, we predict
4 that 50 to 75 percent of all abusing psychotherapists
5 will discontinue these unethical and criminal activities.
6 The remaining 25 to 50 percent should be prosecuted to
7 the fullest extent of the law, expelled from all
8 professional organizations, and never permitted to
9 practice again.
10 Thank you.
11 CHAIRMAN DEWEESE: Thank you. The Chair
12 would like to recognize the presence of Michael Bortner
13 from York County, State Representative, and Paul McHale
14 from Lehigh County.
15 Before you leave, ma'am. Are there any
16 questions from Mr. Bortner or Mr. McHale, from staff?
17 (No response.)
18 Thank you very much. The next folks that will
19 be testifying is Ms. Doris Grove and Ms. Shelly Knis.
20 Do please keep those microphones as close as possible.
21 The other lady, for the record?
22 MS. CLOUGH: This is Doris Grove. I am
23 Attorney Joanne Clough. I am Doris Grove's private
24 attorney. She has submitted a written statement for the
25 Committee today for their consideration and I will be

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1 speaking on her behalf because she is involved in an
2 administrative complaint process right now as well as
3 a civil lawsuit against the physician involved.
4 Approximately three years ago Doris G. went
5 to a physician's office to be treated for a severe migraine
6 attack. She had been to the physician about five times
7 before the night in question. She was very sick to her
8 stomach and had to have a neighbor drive her there because
9 she was so nauseous. When the neighbor and she arrived
10 at the doctor's office for the first time, there was no
11 nurse on duty. Just the physician was there. He took her
12 back into the treating room. He gave her an injection
13 as he normally did with the treatment.
14 The neighbor became very nervous waiting in
15 the waiting room because it took so long. The visits
16 usually only took about 15 minutes. Finally the physician
17 came out acting rather nervous and told the neighbor
18 that Ms. G. was very ill and he would have to treat her
19 some more and instructed her to leave the building and he
20 said he would drive her home on his way home. The neighbor
21 was very concerned and wanted to see Doris before she left
22 the building. She did see Doris and Doris indicated that,
23 yes, the doctor had promised to drive her home. The
24 neighbor had to pick her child up at computer class and
25 finally, reluctantly agreed to leave the physician's office.

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1 She waited in the parking lot. She was a little
2 nervous. The doctor came outside the building, looked at
3 the neighbor with his hands on his hips. She finally
4 believed herself to be overreacting and she left.
5 Approximately two hours later the doctor did
6 return Doris to her home. After the neighbor left the
7 office, he gave her a second and third injection, and
8 because of the nature of the legal actions Doris is
9 involved in, we won't go into the specific details, but
10 she was sexually abused by the physician. She had been
11 given a sufficient amount of medication that she was not
12 physically capable of escaping or fending off sexual
13 advances. After the physician was finished sexually abusing
14 her, he acted as if nothing had occurred and he told her
15 to get dressed and he would drive her home. She was very
16 fearful he would kill her simply because he had behaved
17 in this manner. After he drove her home, she didn't tell
18 it, she told one individual that night what had occurred.
19 She waited about a week before she reported it to the police.
20 Doris is here today because she is very well
21 aware of the avenues that are available and not available
22 to victims under these circumstances. She tried to press
23 criminal charges against the doctor, the police and the distric
24 attorney's office said, because there was only one victim,
25 they never had any other reports about this physician,

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1 there was not enough evidence to go to trial.
2 She then tried to file an administrative
3 complaint with the Licensure Board for this particular type
4 of physician. She filed like two years ago. She has been
5 through three prosecuting attorneys investigating her claim.
6 The first two left their jobs to go onto other legal
7 pursuits. The second one finally recommended formally
8 prosecuting this physician for this behavior. He then
9 too resigned his position. She now has been appointed
10 a third prosecuting attorney who, after three years, is
11 starting an investigation all over again. Reinterviewing
12 all the witnesses to decide if she believes she should
13 recommend prosecuting this man.
14 Doris then turned to the civil process to
15 civilly sue this physician for doing this to her. She
16 retained me to help her in that after going to countless
17 attorneys' offices that would not help her.
18 We filed a Writ of Summons against this
19 physician and shortly thereafter were notified his
20 insurance company is in bankruptcy. Now we are going
21 through an entire process of trying to figure out how to
22 resolve this case in light of that development. She is
23 coming upon the third year anniversary of the date of that
24 awful incident that happened to her and she is here today
25 to say that the legal system, as it exists in Pennsylvania,

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1 is not adequate to help people in Doris' circumstances.
2 Her recommendations to this Board is that House Bill 1465
3 and 1466 be expanded to include not only victims of
4 psychotherapist sexual abuse but also victims of physicians
5 and other health-care practitioners. She thinks the
6 legislation needs to be expanded because you simply cannot
7 go after these people under the present rape and sex crime
8 laws in Pennsylvania. She asks that you consider that
9 here today.
10 CHAIRMAN DEWEESE: Ms. Knis.
11 MS. KNIS: My name is Shelly Knis. I am 17
12 years old and live in New Wilmington, Pennsylvania. When
13 I was 15 years old I was molested by an optometrist while
14 being fitted for contact lenses. Here is a short summary
15 of what happened to me then and since then. It all started
16 in the summer of 1985 when I went to a local optometrist
17 to receive my first pair of contact lenses. All together
18 there were five appointments in which he made sexual
19 advances towards me.
20 On each appointment he progressed into things
21 that would insult me more and more. During this time he
22 got away with it because of the fact he was a doctor and
23 he had a family. He told me that he was such a great
24 doctor and such a well respected man in the community that
25 if I did go to tell anybody, that they would not believe me

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and nobody would do anything about it. He also threatened me, to kill me and my family if I went and told anybody. But he mostly used the fact that he was a doctor and a well respected man.

I held this in for a year because I was afraid of what would happen if I told anyone. So finally after a year, a girlfriend got it out of me and I went to a preliminary hearing. At the preliminary hearing I won on three counts. Six months later I took it to a criminal case. During that time about 30 some other victims that he had done it to came forward. We took it to a criminal suit and there is no way possible that I can explain to you what they did to me in this case. It was the worst experience of my life. And again because he was a doctor he got off on everything. And the judge allowed no/ other evidence in and it was just really terrible. I was on trial the whole time. He never once got up on trial to say anything.

Presently I'm taking it to a Licensing Board hearing in May which doesn't look so positive either. I'm allowed to bring in the evidence, but there is no law saying what he did to me was wrong. It was just so unfair. Because he was a doctor he got off on everything. I went to court and because he was a doctor people listened to his word over mine and mine was totally discredited because I was 16 years old at that time.

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1 And many questions, I have many questions about
2 our legal system, and I was thinking if we truly have such
3 a great law, then why are we the victims treated as guilty
4 when we do take it to court. Why are there no laws saying
5 what happens to me and so many others is wrong. Are we
6 to believe that it wasn't wrong and that it was right and
7 that we should just go on? When do we, the victims, get
8 to see the right? Where does our punishment end? So far
9 not in the law system. I certainly hope today we pass
10 a law that would help future victims in the law system.
11 CHAIRMAN DEWEESE: Counsel, do you have any
12 comments to amplify those that were already made?
13 MS. CLOUGH: I have nothing to add to either
14 statement.
15 CHAIRMAN DEWEESE: Members of the Committee,
16 do you have some questions? The Chair would like to
17 recognize at least, since the commencement of our hearing,
18 Mr. Lashinger from Montgomery County, Mr. Wogan from the
19 City of Philadelphia, Mr. Piccola from Dauphin County have
20 also joined us. Mr. McHale.
21 REPRESENTATIVE McHALE: Thank you, Mr. Chairman.
22 BY REPRESENTATIVE McHALE: (To Ms. Clough)
23 Q Counsel, forgive me. I did not catch your
24 last name.
25 A Clough, Joanne Clough.

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Q I was concerned about a number of aspects of the testimony which you presented on behalf of your client. Is it Mrs. or Miss Grove?

A Ms.

Q Forgive me. My wife would have corrected me on that. There are a number of things I think stood out in your testimony. You indicated I believe that despite the fact a complaint was made to the police officers involved in the jurisdiction where this event allegedly occurred, there was a conclusion reached that there was insufficient evidence for an arrest and prosecution.

A Yes, that is correct. She had some clothes that were forwarded to the State Police Crime Lab which had sperm samples on them, but unfortunately she had taken them off that evening and tied them in a plastic bag and she didn't give them to the police until several weeks after the incident. And they decided, based on the fact that it came down to, as all these cases do, the word of the victim against the word of the physician, they did not have enough to prosecute.

She did have a very strong witness, her neighbor, who has stood by her through this, and I might add, has also suffered psychological torment because she, herself, experiences incredible guilt that she left her that evening, that night at the office.

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1 Q Who reached that conclusion that because it was
2 a matter of credibility there was insufficient evidence
3 for prosecution? The reason that I ask that is it has been
4 a long time since I have done any amount of criminal
5 defense work, but it strikes me as very clearly sufficient
6 evidence for an arrest and prosecution with the question
7 of credibility then to be resolved by a jury. Not by a
8 police officer who declines to make an initial arrest.
9 A Unfortunately, that is how these cases happen
10 all too frequently. I spoke with the investigating police
11 officers, obtained their files as well as spoke with the
12 district attorney that had looked into the case and all of
13 them said, I think it was kind of a process the police
14 didn't think there was enough to go forward and perhaps
15 did not believe my client's story and the district attorney's
16 office determined there wasn't enough.
17 Q I am astonished by that. That is not their
18 prerogative to make that decision. That is a decision
19 to be made by a jury if your client chooses to go forward
20 with a criminal prosecution. Under the circumstances
21 you have described, an arrest should have been made and
22 a prosecution should have occurred. Has the statute of
23 limitations run on this particular offense?
24 A I think so. If it is two years, yes, it
25 has.

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1 Q Which county was this?

2 A Lancaster County.

3 Q I don't meant to belabor it. If your client

4 was alert and at least aware during this particular offense

5 and she was prepared to present testimony to that effect

6 to a jury, I for one cannot understand why there was not

7 an arrest and a prosecution with a jury then deciding

8 whether or not your client was telling the truth.

9 Moving onto the next area, could you briefly

10 review for us the history of events before the Bureau of

11 Professional and Occupational Affairs, what complaint was

12 made, when was it made? And although you indicated I think

13 a period of time that has elapsed, have you been kept

14 informed? Was there investigation ongoing? Just give

15 us a thumbnail sketch, if you would, of that experience.

16 A I'm going to let Doris tell you when she first

17 initially filed a complaint with the administrative people.

18 MS. GROVE: I think it was three months,

19 possibly two or three months after the incident. I got

20 no response for a long time.

21 BY REPRESENTATIVE McHALE: (To Ms. Grove)

22 Q How long ago was that?

23 A This happened in '85.

24 Q And you filed a formal written complaint with

25 the Bureau of Professional and Occupational Affairs.

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1 A Yes.

2 MS. CLOUGH: As a matter of fact, I don't

3 think it was until we actually had a speaker from the

4 Bureau of Professional and Occupational Affairs speaking

5 at one of our coalition meetings that Doris raised the

6 fact that she had made a complaint and hadn't heard anything.

7 She then got some response out of the board. The particular

8 type of physician involved, the board has had a huge

9 turnover in staff and it was simply what they explained

10 to us, a bureaucratic situation, that they were shorthanded

11 and couldn't get to the complaints fast enough.

12 REPRESENTATIVE McHALE: Was this physician

13 a general practitioner?

14 MS. CLOUGH: Yes.

15 BY REPRESENTATIVE McHALE: (To Ms. Grove)

16 Q What happened after you made the complaint

17 and then apparently there was some follow up? You indicated

18 you had not received a response. Then finally there was

19 a response. What happened after that?

20 A A girl from that district, she interviewed

21 myself and my neighbor. Me, with my attorney, Joanne Clough,

22 and nothing came out of that. So Joanne Clough looked into

23 it and then this girl left her place of employment. So

24 Joanne --

25 Q Was the person you referred to as this girl,

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1 is that an attorney or a --

2 MS. CLOUGH: I believe at this level it was

3 an investigator in the Licensure Bureau.

4 MS. GROVE: So at that point Joanne Clough

5 contacted them again and they sent a man this time, a

6 different person. I had to go through the same questioning

7 that I already went through. My neighbor had to go through

8 it also.

9 REPRESENTATIVE McHALE: Are we still back in

10 1985 or is this 1986?

11 MS. CLOUGH: At this point 1986, early 1987.

12 MS. GROVE: Now I understand that he has left

13 his position and that I have to go through this again

14 with another investigator.

15 BY REPRESENTATIVE McHALE:

16 Q Attorney Clough, I assume you have notified

17 the Bureau you are representing Ms. Grove?

18 A Yes. The attorney, the investigating attorney

19 before Dennis Buckley, had informed me he recommended full

20 prosecution in front of the Board. I saw him, actually I

21 bumped into him at a restaurant and he came over to the

22 table and made a point of letting me know he believed my

23 client and he had recommended full prosecution.

24 Then we didn't hear anything. I finally

25 contacted them to ask why. He no longer worked there.

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1 The new investigating attorney called me back and said she
2 can't go back on the say so of somebody else. She thought
3 the case was a big story. She would have to interview
4 everybody herself and come to her own determination. So
5 we are now almost three years from the incident and Doris
6 is back to the place she was in when she first filed the
7 complaint.

8 Q Other than a chance meeting in a restaurant
9 has the Bureau kept you up to date on what has been
10 happening?

11 A No, I don't think that is their pattern up
12 there to do that with private attorneys. Actually, they
13 were very polite to me. I think a lot of the times they
14 don't want you interfering in their case, but they knew
15 I was helping Doris make sure they monitor it because I
16 was representing her as well in the civil situation.

17 Q I will have some questions later in the morning
18 when we have witnesses from the Bureau here in front of us.
19 But I am concerned a three-year period of time would
20 elapse without a thorough investigation either clearing
21 the doctor or going forward with a vigorous prosecution.
22 That period of time to elapse, again, to me is incredible.

23 You indicated that in the civil suit that you
24 had filed, after you initiated that suit by a praecipe
25 for a Writ of Summons, you determined that the doctor's

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1 insurance company had gone bankrupt?

2 A We had received a notice that the insurance

3 company had filed for bankruptcy. Now we are going through

4 the process, the defense attorney doesn't know if he is

5 still the defense attorney for the physician in question

6 and we have kind of stopped work to give him a little bit

7 of time to figure out where he is in this procedurally.

8 So we have kind of had a little bit of a roadblock in

9 the civil process as well.

10 Q When did the company go bankrupt?

11 A I received notice of it approximately in January

12 of 1988. I don't know without my file in front of me.

13 Q You may or may not know the answer to this

14 question. Under Pennsylvania law every physician is

15 required to carry a minimum amount of insurance which

16 if exhausted is then supplemented by the CAT Fund. Do

17 you know if under state law currently there's a requirement that

18 would obligate either the company to give notice or the

19 physician to obtain new insurance in the event that a

20 company goes bankrupt so there isn't a gap in coverage?

21 A My understanding is Pennsylvania has a

22 guaranteed insurance fund to handle this specific problem

23 and that is where Doris' claim will eventually have to be

24 handled.

25 Q I see. So because the company went bankrupt

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1 that doesn't necessarily leave your client out in the cold.
2 A No, most insurance companies try to defend
3 on these cases and say that they are not liable for coverage
4 under this because it is an intentional act anyhow. So that
5 there is not always a guarantee that they would actually
6 pay a claim.
7 REPRESENTATIVE McHALE: I see. I appreciate
8 your answers. Thank you, Mr. Chairman.
9 CHAIRMAN DEWEESE: Certainly. Questions?
10 Michael Bortner, York County.
11 REPRESENTATIVE BORTNER: Thank you, Mr. Chairman.
12 BY REPRESENTATIVE BORTNER:
13 Q I guess I would like to direct my questions
14 to you, Attorney Clough. Let me just start out by saying
15 that I have been an assistant district attorney and I have
16 advocated for a lot of victims. Certainly nobody would
17 diminish the seriousness of either of these cases or try
18 to minimize the effect on the victim. But frankly, your
19 testimony underscores what has been my problem with these
20 bills and I would like to put that question to you. I
21 don't see how either of these bills would help either of
22 these women in the cases that you have described.
23 A Well, the way they are drafted right now, you
24 are correct. The bills that are drafted are doing the
25 psychotherapist specifically and not other health-care

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1 professionals. If you are speaking in general terms of
2 psychotherapists, I think it would, at the present time you
3 have to educate a jury. I am sure you are aware that in
4 taking these kinds of cases, it is not a typical rape case,
5 it is not a date rape case, which is a hard rape case to
6 prove. It is, in some cases with psychotherapists now not with Shelly or Doris'
7 situation, but with psychotherapists the victims are patients
8 that seemingly agree to sexual activity. So you are stuck
9 with a situation of trying to educate a jury, that under
10 our present sex crime laws in Pennsylvania, that these
11 people really don't lack the ability to give a legal
12 consent because of the therapeutic relationship and
13 therefore we should be able to charge them under our rape
14 statute. I think the legislation is needed to spell out
15 this is a specific crime. If this type of health-care
16 professional, whether we end up adding physicians into
17 the bill or leaving it with psychotherapists, if this
18 person has sex with this person during treatment that is
19 a crime. All you have to prove is sex. Not that it is
20 wrong to do it. Not with what you have to prove right now
21 under the current law. And that is why I sympathize with
22 prosecuting attorneys and police with the difficulty
23 in bringing these cases forward. That is why they want
24 a list of victims. They don't want warrants. They want
25 a list. That's not really fair. If you are the first

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1 victim, nothing happens.

2 Q That is absolutely correct. As I read this

3 law, I think it requires more than just showing that there

4 was sex. As I read the law, you have got to prove that

5 patient was emotionally dependent upon that professional.

6 A That is only for former patients. Emotional

7 dependency needs only be established for former patients

8 under this legislation the way it is drafted right now.

9 Q Well isn't that going to usually be the case?

10 A No.

11 Q By the time the incident is brought to the

12 attention of the police.

13 A No, but we are talking about patient, about

14 former patient relationship is determined at the time of

15 the sexual activity. If they were a former patient at

16 the time of sexual activity. In other words, someone

17 that had been treating with a therapist, stopped treating

18 with them and then had sex with them. In order for that

19 to be a crime, the DA would have to be able to establish

20 that former patient at the time of the sexual activity was

21 psychologically or emotionally dependent upon the therapist.

22 The patient/nonpatient status is determined at the time of

23 the sexual activity.

24 Q Well, in my view, I guess I would like your

25 comment, the real problem is what you have put your finger

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1 on and that is the problem of proof. That is almost by
2 their very definition these incidents occur where the
3 only people present are the victim and the professional.
4 It is essentially a question of who is the most credible,
5 who is going to be believed. And in a criminal case that
6 requires proof beyond a reasonable doubt. I guess I don't
7 see how this legislation moves anywhere beyond the problem
8 or the obstacle that is presented by a criminal case.
9 Whether you call it a third degree felony or a first
10 degree felony, that problem will exist.
11 A Yes. I think we heard those same arguments
12 when people in the Legislature were arguing against the
13 marital rape statute and the law in Pennsylvania used to
14 be that you had to rape somebody other than your wife for
15 it to count as rape and a crime. I don't think the
16 difficulty of proving a crime should determine that we
17 don't make that conduct illegal in Pennsylvania. If we
18 tell these people out there, psychotherapists and health-
19 care practitioners, hey, we can't prove it so keep doing it.
20 We are going to have -- I can't tell you the number of
21 victims coming to meetings when we have a meeting that
22 come out and say, hey, this happened to me. And yes, it
23 is difficult to prove. There are only two people present,
24 but that doesn't mean that it isn't wrong and it doesn't mean
25 that if there wasn't some more legislation in this area,

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1 the legislation itself would be a deterrent and the victims
2 would feel that there is a law on the books and then can
3 go in there just like any other rape victim. These rapists
4 don't use a pipe or a knife. They use their authority
5 figure, situation with the client and use their sense of
6 a psychotherapist, their training. They know which people
7 are weak. They know Shelly was 14 when she came to their
8 office. They know Doris has horrendous migraine problems
9 and had a lot of problems in her life and they pick people
10 like that. They don't pick a strong victim. They pick
11 somebody they think they can do it to for that very reason,
12 that that person will not look credible against them in a
13 hearing.
14 Q I don't think there is any question about that.
15 Let me ask you a question on the civil cause of action
16 that I am even more confused by. Obviously, there is a
17 civil cause of action that exists. You have indicated
18 your client is pursuing one. The problem, as you pointed
19 out with her case, not being able to bring a cause of
20 action but in fact the professional no longer carries
21 insurance, doesn't have assets to pay any judgments. I'm
22 aware of a number of cases brought successfully against
23 professionals. Why are you advocating for legislation
24 that would put into law something that in my opinion exists
25 under common law?

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1 A Well, I think that is the next stage we are
2 going to see gone. I'm going to speak on the criminal bill
3 and Robert Claraval, an attorney here is going to be
4 speaking on the civil bill. So perhaps we should wait
5 to address that when we give our presentations on that.
6 REPRESENTATIVE BORTNER: I will be happy to
7 do that. Let me just say, as I said, my problem in looking
8 at this is whether I think it is effective. I think the
9 real answer is putting teeth in the Bureau of Professional
10 and Occupational Affairs where I think more can be done
11 to protect future victims. You don't have to worry about
12 the burden of proof which has to be beyond a reasonable
13 doubt. As you know, the administrative level of standards
14 is much, much lower. The rules of evidence are relaxed
15 and where I think it is going to be much easier to put
16 somebody out of business that is victimizing people and
17 make sure that they don't continue to do that in the future.
18 Thank you.
19 CHAIRMAN DEWEESE: Joe Lashinger, Montgomery
20 County.
21 REPRESENTATIVE LASHINGER: Thank you, Mr.
22 Chairman.
23 BY REPRESENTATIVE LASHINGER:
24 Q For Attorney Clough, we started in 1985 after
25 an acquittal in Montgomery County, you might remember the

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1 Espostalitis case, working on that issue. The acquittal
2 in the Commonwealth vs. Espostalitis where the Trial Judge
3 wrote to members of the committee then saying you need fact patterns
4 in most of these cases that made them impossible to successfully
5 prosecute. Came to us with a version of the Rhode Island statute that
6 attempted to deal with the problem. Did you have an
7 opportunity to look at that? It is embodied in House Bill
8 347 now which is in front of the General Assembly.
9 A No, we reviewed the language of the Minnesota
10 and Wisconsin statutes in helping Representative DeWeese's
11 office in drafting the present bill. I have not had an
12 opportunity to review what you are speaking of.
13 Q We have had a problem in trying to find, as
14 Representative Bortner said, I don't know if we are ever
15 going to be able to perfect the language that is necessary
16 and it might lead to where we ended up in marital rape
17 in negotiating down the charge just in order to successfully
18 prosecute some of these cases. It might not be in the
19 rape statute. It might be in a separate freestanding
20 section of the Crimes Code that deals with this problem
21 when talking about health-care practitioners. Do you
22 think that is a wise path to travel at this point?
23 A Well, of course, I would prefer to see as strong
24 a criminal sanction as possible, but I really am concerned
25 that my attitude as an attorney and a private practitioner

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1 is that victims should have three avenues of relief available
2 to them. They should be able to have a criminal avenue
3 of relief because this behavior is criminal. There should
4 be a better administrative avenue of review and to say
5 to allow the administrative avenue to handle it totally,
6 these are these gentlemen and ladies and these professionals'
7 peers that make a decision. And you don't have a jury of
8 12 people. You have a board of physicians deciding. And
9 the civil avenue should also be available. These victims
10 should not have to say, oh well, he could lose his license.
11 It is a crime and they should have a criminal avenue
12 available to them.

13 Q There is an existing case now before the board
14 that ironically also grows out of Montgomery County. The
15 board has yet to render an opinion and I am sure you are
16 familiar with involving another medical health professional
17 in Montgomery County. It is almost the same fact pattern
18 as the Espostalitis case.

19 Right now under the rape statute you really
20 have to pervert the enforceable compulsion provision to
21 make it work for health-care professionals, don't you?

22 A Yes.

23 Q Isn't that how you would successfully prosecute
24 a case?

25 A And that is why I think we need the statutory

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language in there simply so the jury is educated this is the law in Pennsylvania. This kind of behavior is wrong. It is a crime.

Q The language that we have, I will just read it to you briefly, first on the statute, we put it in the rape statute and we talked about it applying to all of the practitioners of the healing arts. You are now including everything. That is problematical. I am saying politically that is problematic. That is the way it was originally designed. But to get around this perversion of enforceable compulsion definition we put language, "If the accused is a practitioner of the healing arts and engages in the treatment or examination of the other person for the purpose of", this is the language, "sexual arousal, gratification or stimulation." Again, I don't think that is perfect language but it does prevent the necessity of looking at the forcible compulsion language. Do you think that would apply to these cases?

A I think that would apply to these cases and also, our organization, I am a board member of Central Pennsylvania Coalition Against Abuse by Professionals, we would be very active in supporting that type of legislation.

REPRESENTATIVE LASHINGER: Thank you.

CHAIRMAN DEWEESE: I would like to welcome

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1 Representative David Mayernik from Allegheny County and
2 Representative Gerry Kosinski from Philadelphia. The final
3 questions will come from State Representative Jeff Piccola,
4 Dauphin County.
5 REPRESENTATIVE PICCOLA: Thank you, Mr. Chairman.
6 BY REPRESENTATIVE PICCOLA:
7 Q Preliminarily let me just indicate I share
8 the concerns expressed by Mr. Bortner about this legislation.
9 Ms. Clough, are you familiar with the case of the
10 Commonwealth vs. Rhoads?
11 A I have it in my abuse file but the facts
12 are not before me. I know the caption.
13 Q It seems pertinent, particularly on the issue
14 of forcible compulsion, which Mr. Lashinger raised,
15 and it would appear from my reading of a brief of that
16 case that the holding of the Pennsylvania Supreme Court
17 in that case would permit prosecution of these cases
18 and finding of forcible compulsion. Because the court
19 held that forcible compulsion under the rape statute
20 includes not only physical force or violence but also
21 moral, psychological or intellectual force used to compel
22 a person to engage in sexual intercourse against that person's
23 will.
24 And they also said that the finder of fact
25 should use -- should make a finding based on the totality

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1 of the circumstance with respect to the mental and physical
2 conditions of the victim and the accused, the atmosphere
3 and physical setting in which the incident was alleged to
4 have taken place and the extent to which the accused may
5 have been in a position of authority.

6 Don't you think that case makes it immensely
7 more realistic for a prosecutor to pursue the types of
8 cases we are talking about today?

9 A No, I don't think it is enough because with
10 the totality of circumstances tests, you still have to prove
11 under all the circumstances as existed at the time it was
12 wrong and criminal for the therapist or physician to act
13 that way.

14 Whereas, if we have House Bill 1465 enacted
15 it clearly says sex with a patient is a crime. You don't
16 have to have a test. Did the sex take place? Yes. It
17 is a crime. You don't have to go through the totality of
18 circumstances test. I don't think that is enough help
19 for the victims in Pennsylvania.

20 Q Do you see the problem raised by Mr. Bortner
21 in what most of these cases are probably going to come
22 down to and that is a swearing contest because no one else
23 will have been present. There probably won't even be
24 any physical evidence whatsoever. Because they won't be
25 brought until months if not longer after the alleged

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1 incident. Don't you have, as an attorney, don't you have
2 a basic problem with creating a crime that basically boils
3 down to one person saying it happened and another person
4 saying, no, it didn't happen?
5 A That is true. I think a lot of times in most
6 rape cases, unless there is a lot of violence or marks
7 on the person, I understand as an attorney what Mr. Bortner
8 is talking about. The difficulty in proving these type
9 of crimes and by saying sex with a therapist is a crime,
10 it doesn't take away the whole case is going to be that
11 victim's word against that professional's. And that most
12 law enforcement people or district attorneys will be
13 a lot more confident if they had more than one victim
14 to go after people like that. I don't think it alleviates
15 that. But I think it is better than what we have under
16 the current state law and the case decision that you just
17 cited where we have those totality circumstances tests.
18 Because at least the jury can be told and the court can
19 emphasize it is a crime to do this. They don't have to
20 prove that in each case that it is wrong for a psychotherapist
21 to do this because they are violating their ethical
22 standards and this person relied on their profession.
23 At least we can simply streamline that process by saying
24 that this behavior is criminal. Now let's talk about
25 did it happen.

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1 Q Under the proposed statute does a DA have to
2 bring a charge if a victim comes in and merely alleged
3 that it occurred and there is no other evidence?
4 A There is no requirement in the legislation as
5 it is drafted right now to compel the DA to do anything
6 any different than he does in any other reviewing of a
7 criminal report or a complaint. The only reporting or
8 mandatory behavior required the district attorney's office
9 under the act is a reporting requirement upon the
10 conviction of anybody under the act, you must notify,
11 the DA must notify the U.S. Department of Health in
12 Washington, that the person was convicted of this as well
13 as any licensing board that applies for that particular
14 person's license.
15 Q So what you are saying is that prosecutorial
16 discretion continues in force and effect and if the
17 district attorney gets a complaint, gets one complaint
18 about one therapist, first complaint, don't you think the
19 odds are he is not going to bring a charge if there is
20 just one allegation by one victim? That he probably won't
21 start to bring charges until there has been two or three
22 or more even with this new statute?
23 A Based on my experience you may be right. But
24 I would hope if the law was on the books, it would give
25 them more of an inclination to try to go forth against these

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1 people. At least, particularly in Shelly's incident,
2 where she had the courage to come forward and bring criminal
3 charges against this person, he was acquitted. It was
4 a horrible circumstances for her to see him acquitted.
5 If he does it again, they are going to remember. She
6 knows that and that is why she continues forward with the
7 administrative process and the rest of it. Because it is
8 hard to prove doesn't mean people shouldn't take the cases
9 against them.

10 REPRESENTATIVE PICCOLA: Thank you.

11 CHAIRMAN DEWEESE: Certainly. Chief Counsel of
12 our Committee, Mike Edmiston.

13 BY MR. EDMISTON: (To Ms. Knis)

14 Q I just have two questions. One is in what
15 county did prosecution take place in Ms. Knis' case?

16 A Lawrence County.

17 Q Lawrence County.

18 A Yes.

19 BY MR. EDMISTON: (To Ms. Clough)

20 Q The other question I have has to do with your
21 commentary at the beginning, Ms. Clough,on behalf of Ms.
22 G regarding the use of medication in her experience. From
23 your work in this area and the research that has been done
24 do you have any idea how extensive the use of medication is
25 in --

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1 A In these problems?

2 Q Yes.

3 A Doris is the only client that I have encountered
4 that was medicated when it happened. From doing my
5 research, and my colleagues and other psychotherapists
6 and psychologists concerned with these problems has
7 counseled a lot of other people. It is not unusual that
8 physicians give medication. She was getting medication
9 treatments from him for a migraine condition. This night
10 she got an extra shot in the base of her skull that she had
11 never had before and after that she was in and out of
12 consciousness for most of the rest of the time.

13 MR. EDMISTON: Thank you.

14 CHAIRMAN DEWEESE: A final question from Paul
15 McHale.

16 BY REPRESENTATIVE McHALE:

17 Q Attorney Clough, you indicated in Ms. Grove's
18 case where it came down to a question of credibility between
19 physician and client, the police officers declined to make
20 an arrest and the prosecutor declined to go forward with
21 prosecution. I indicated earlier that bothers me a great
22 deal that that took place. I think an arrest should have
23 been made under those circumstances. In your experience
24 is that happening in other jurisdictions?

25 A Yes.

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1 Q Based on an application of prosecutorial
2 discretion where a complainant is prepared to testify through
3 all the elements of defense, the police and prosecutors
4 are not going forward.
5 A Yes. I have not had personal experience with
6 it, but I have read articles like it said about victims
7 complaining of the same thing. In Doris' case it is
8 even worse. As far as our knowledge to this date, no one
9 even questioned the physician. The police decided there
10 was insufficient evidence to even ask the doctor his
11 explanation for what happened.
12 She also, everybody keeps referring to it is
13 only her word against his. She had a neighbor who was
14 there with her. She told her neighbor's daughter that
15 evening what the doctor did to her when the neighbor's
16 daughter was helping put her to bed. She told the neighbor's
17 husband. So she did have some other witnesses that were
18 familiar. And she has a heck of a circumstantial case at
19 least as far as a physician volunteering to drive you home
20 at night and ordering your friend to basically leave the
21 building, telling her she couldn't use the phone to call
22 her husband. I mean, I think she had a lot of the facts
23 in her favor that maybe, say -- we don't know what happened.
24 Maybe the police didn't believe what Doris said had
25 happened. But something happened out of the ordinary that

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1 night at that doctor's office. And that is very clear to me.
2 REPRESENTATIVE McHALE: Taking the facts that
3 you have presented in the abstract without weighing them
4 as they apply to your specific client under these kinds of
5 facts in a hypothetical, if they were proven to be true,
6 I am very greatly concerned that there was not an arrest
7 and a prosecution. The only other point I would make is
8 that although the bills now before us would not change the
9 scope of prosecutorial discretion, I think it would be a
10 very unfortunate day that we would reach when prosecutors
11 would wait for a second or third complaint before they
12 would take action in a criminal prosecution. It seems to
13 me when there is a first offense alleged, credible testimony
14 is prepared to be presented to a finder of fact, typically
15 a jury, that under that circumstance there is very little
16 prosecutorial discretion. There ought to be an arrest,
17 a prosecution and then a jury decides who is telling the
18 truth. For police officers to make that decision at the
19 beginning of the process, I think is a serious mistake.
20 Thank you.
21 CHAIRMAN DEWEESE: Thank you. And Doris and
22 Shelly, thank you very much for your testimony this morning.
23 Attorney Clough will be joined at this time by Attorney
24 Robert Claraval to discuss the civil and criminal aspects
25 of the legislation. I would ask you summarize your

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1 perspectives. We are running a little bit behind schedule.
2 That would be helpful I think for our process. Before you
3 do that, I would like to ask Jo Sterner, the Executive
4 Director of the Rape Crisis Center of the Greater Harrisburg
5 YWCA to please stand and be recognized. Counsel, you can
6 proceed.

7 MS. CLOUGH: I think I already covered a lot
8 of points in my prepared speech that I made this morning
9 in the question and answer session. But I think it is
10 important to understand, when I came into contact with
11 this concept and the topic approximately three years ago
12 I was asked to speak at the first meeting which is called
13 Stop ABC, Stop Abuse By Counselors. About what legal
14 avenues were available to victims of sexual abuse by
15 a doctor or a therapist. I gave a very nice speech on
16 how they can bring criminal charges, how they can file
17 an administrative complaint. If this type of professional
18 is required to be licensed or how they could sue them
19 civilly for assault and battery, for intentional affliction
20 of emotional distress and try to recover monetary damages.

21 No sooner than I finished speaking there was
22 an outburst of outrage in the room by the victims. And I
23 think being an attorney, all too frequently, I still am
24 surprised by members of the general public taking it out
25 on me, particularly their dissatisfaction with the system.

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1 Suffice it to say, the victims told me my speech was very
2 nice and very pat and very sweet but that wasn't what
3 happens. I met Doris at that meeting. She went to the
4 police, she went to the DA. She tried to file a complaint
5 and look what happened to her.
6 And one thing that became apparent that evening
7 and since my continuing involvement with the organization
8 representing the clients and/I now represent in my private
9 practice, our system is not sufficient to handle this
10 problem. They aren't getting -- the problem is not getting
11 properly addressed criminally. It is not getting properly
12 handled administratively and it is not being properly
13 handled in the civil process either. I have been asked
14 to speak mainly on the criminal aspects of the proposed
15 legislation. Mr. Claraval will speak on the civil.
16 I really think there is a need, and I have
17 already told you why, to have House Bill 1465 because it
18 is simply too hard to jam this type of crime into definitions
19 of the rape and sex crimes we have on the books right now.
20 The legislation has been drafted to fit in right under
21 the marital rape section and the rape sections right now
22 in the Pennsylvania Crimes Code.
23 Under current law in Pennsylvania, as members
24 on the panel have even more information than I, having been
25 previous district attorney, they understand how difficult

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1 it is to go after somebody under the Pennsylvania statutory
2 sex crime laws for this type of behavior. In my research
3 I found in some states, in California, they actually tried
4 to prosecute some psychotherapists for prostitution that
5 do this. Because these individuals have the client come
6 in their office for a 50-minute session. They have
7 intercourse with them and they charge them $75. Some
8 district attorneys have actually tried to prosecute them
9 for prostitution. They are collecting money for sex.
10 You can laugh, but it is not funny. Why does the DA think
11 that argument up? Because the laws on the books are not
12 sufficient to handle it. Other district attorneys have
13 tried to go after them for like fraud or theft of services.
14 There is some type of theory that you are defrauding the
15 people by saying you are counseling them when in actuality
16 you are not only failing to counsel them, being negligent
17 in your counseling of them, but you are really messing them
18 up by becoming sexually involved with them. The person
19 ends up worse off than before they got there and their
20 insurance company or you, yourself, are paying to be treated
21 this way by this professional.
22 I think that those are clear examples that the
23 laws we have right now are not enough criminally to help
24 handle this problem. The bill as it is drafted right now,
25 I think would streamline the process of prosecuting these

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1 people by simply making that sexual contact is a crime.
2 You don't have to prove it anymore in every case. You
3 just have to prove, which is still difficult, that sex
4 took place, and I think it is necessary. The act basically
5 has three or four parts. The first part, I think the
6 objectives, first of all, they tell psychotherapists
7 in the ten percent particularly that are frequently doing
8 this to their patients, that this is now a crime in
9 Pennsylvania and we can get you for it. The second thing
10 is that it gives the district attorney's office at least
11 somewhat of an easier process in educating the jury that
12 this is a crime because the statute says it is. The bill
13 itself prohibits sexual conduct between psychotherapists
14 and present patients or former patients that are emotionally
15 dependent. It also has provisions regarding consent that
16 if a patient supposedly consents, in other words, if they
17 participated in a sexual activity without force, that is
18 not a defense. The sex with a patient is a crime.
19 It also has some evidence protection provisions
20 regarding the victim's past. We have asked that there be
21 some type of evidentiary hearing before you bring in the
22 victim's whole psychiatric, psychological and sexual past.
23 It also has mandatory reporting requirements
24 which are stated. The district attorney, upon conviction,
25 would be required to report this nationally and to any state

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1 boards that license this person.

2 It also requires other psychotherapists, when

3 they have obtained the consent of the victim, to report

4 the behavior to licensure boards and law enforcement

5 authorities.

6 I have also added to the end of my speech some

7 proposed changes to the house bill that my organization that

8 I belong to is recommending and I won't outline those for

9 you. It is easier to read them and look at them, but I

10 do ask that you do look at them. But that is my concern

11 from the criminal standpoint that what we have doesn't work

12 and we need something.

13 CHAIRMAN DEWEESE: Attorney Claraval.

14 MR. CLARAVAL: Thank you, Mr. Chairman. As

15 Representative Bortner stated, there are a lot of civil

16 cases currently in progress. I have had occasion to handle

17 several of them and I have reviewed several other cases.

18 The current state of common law is that if a patient can

19 prove the existence of a therapeutic relationship and can

20 then prove that sex occurred, then that is a violation

21 of standard of care. All the experts in the field agree

22 that that is impermissible treatment.

23 If there is a break in therapy and the

24 relationship begins two weeks later or six months later

25 or a year later, the authorities are also in agreement that

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1 that is a violation of standard of care. So from a civil
2 case standpoint, once those elements are met, we can then
3 proceed with the civil case and have a jury award damages.
4 It is somewhat easier, although not by any
5 stretch of the imagination easy, it is somewhat easier in
6 a civil case because generally we have a long-term affair
7 consisting of weeks, months or years in some cases. So
8 it is not like a rape case where it occurs one time.
9 We ordinarily have proof such as hotel bills, telephone
10 bills and things like that that add corroborating evidence
11 to the victim's testimony.
12 The purpose of 1466, which is the civil legislation,
13 is to plug three or four holes which exist in the common
14 law. The first hole is that not all therapists are covered
15 or included within the common law or within the standard
16 of care that we use. Ministers, social workers, etc., are
17 not apparently covered, at least according to one opinion
18 by a judge in Lebanon County, and we would include those
19 professionals within the civil statute making it a civil
20 wrong.
21 The most important things that I want to talk
22 about, at least from the standpoint of a civil lawyer that
23 is involved in this a lot of my time, the statute of
24 limitations issue. Ordinarily in Pennsylvania we have a
25 two-year statute of limitations for a physical injury. This

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1 is clearly a physical and emotional injury that occurs
2 to these victims. We need some guidance from the Legislature
3 on when the statute of limitations runs and how long it is.
4 If the statute begins with the first sexual exploitation,
5 then it almost always expires before the victim comes to
6 see an attorney or see another therapist. So it is our
7 suggestion that a longer statute of limitations be included
8 in the legislation and that it begin to run when the last
9 sexual exploitation occurs. That way the victim will have
10 a chance to undergo additional therapy and consult with a
11 lawyer and find out what her rights are. I think that is
12 *a crucial portion of the bill.*
13 The second crucial portion, as Representative
14 McHale mentioned, is insurance coverage. Insurance carriers
15 have come up with different ways of avoiding payments
16 for this malpractice by psychiatrists and psychologists.
17 The first method was simply to say we don't cover it. That
18 sexual exploitation falls outside the realm of your practice,
19 therefore, you have no coverage. Well that didn't work
20 because it was plaintiffs' attorneys were able to plead that
21 because of the actions by the psychotherapists, they were
22 within the realm of medical care. For example, if a
23 therapist had sex with a patient and refused then to
24 refer the patient to another therapist, that was abandonment
25 which was clearly action for malpractice. So the carrier

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1 could not avoid coverage.

2 The next step the carrier said was, well, we
3 will cover it but only up to $25,000 and that is a common
4 term that I have seen in policies. That way they have
5 limited their losses. Now, as Representative McHale
6 pointed out, there is a CAT Fund which would kick in after
7 the initial insurance policy was paid. But I don't believe
8 that kicks in until after $200,000 was paid. So you could
9 have a victim which would have a provable case, which
10 a jury believes and which awards the victim $150,000 for
11 the wrong and it could go uncollected.

12 The psychotherapist would presumably lose his
13 license, therefore, have no funds to pay the judgment.
14 The insurance carrier would pay the 25,000 limited by the
15 policy and that would be it. So the psychotherapist's
16 assets could not be attached if he were married. So that
17 is a definite problem. So the statute of limitations
18 and the insurance issue are two crucial problems that the
19 bill covers and some of the amendments that have been
20 offered would cover.

21 The third area that I want to go over is
22 prohibited defenses. The psychotherapist should not be
23 permitted to say that because there was a break between
24 the last date of therapy and the first date of sexual
25 exploitation, that there was no wrong. There was no civil wrong;

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1 I think that simply because there was a break does not mean
2 that the court should dismiss the complaint. It should be
3 a jury issue. The jury should decide whether or not that
4 break lessened the victim's damages but not because simply
5 there was a break the victim had no right to bring the
6 action in the first place. I think that is an important
7 defense that should be prohibited and the act does that.
8 The elimination of consent in the civil case,
9 I think this is important. The psychotherapist cannot say
10 that the victim consented to the sexual exploitation. The
11 medical literature in the field indicates that when you have
12 a good psychotherapeutic relationship that a transference
13 occurs. That the victim often times falls in love with
14 the therapist and that is part of the treatment. How then
15 can a therapist come into court and say, well, I didn't
16 do anything wrong because she consented to it. That doesn't
17 make any sense logically and it serves to cloud the issue
18 in front of the jury. The purpose of this bill is to make
19 it more streamline for a victim to bring a civil cause of
20 action and I think eliminating that defense would go a long
21 way toward that.
22 The bill also imposes some liability on the
23 employer of the psychotherapist. There is, of course,
24 now common law liability for the acts of your employees
25 and agents. The bill goes a little further than that. It

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1 says that the employers have to take affirmative action
2 to inform prospective employers of this psychotherapist.
3 That this problem exists with this person and that they
4 may bear some civil liability for that if they don't.
5 Those are the four issues that I think are
6 the most crucial. The common law as written, or not as
7 written, as existing is pretty good. With a few changes,
8 it can be streamlined and very helpful to victims and I
9 think they need some help. I have reviewed a lot of these
10 cases recently. Some we don't bring. As you all know,
11 civil lawyers work generally on a contingency fee basis.
12 If it is not a good case, we don't take it. We don't want
13 to spend the time and the money and lose. And if it
14 just comes down to a swearing contest as Representative
15 Piccola said, it is pretty tough. You normally turn those
16 cases down. You have to have evidence, corroborating
17 evidence, it has to be very substantial before you go ahead
18 with it. Those would be my comments and my testimony,
19 Mr. Chairman.
20 CHAIRMAN DEWEESE: Thank you very much. Members
21 of the Committee, I would like you to hold it to one
22 question each, two or three minutes if at all possible.
23 We are running significantly behind schedule. Members of
24 the Committee, questions on the criminal and civil remedies
25 being offered today. Mr. Bortner.

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1 BY REPRESENTATIVE BORTNER: (To Ms. Clough)

2 Q I have a question I asked the first time around

3 and I will follow it up now. In the case of a criminal

4 prosecution you are urging a ten-year statute of limitations

5 not going to, not computed from the day of prosecution

6 initiated but totally when the report is made, is that

7 correct?

8 A I don't have my copy of the bill in front of me.

9 Q Well assume that is correct for purposes of

10 this question. My question is very simple. That is how

11 do you --

12 A I'm not sure which page it is on.

13 Q Page 7, line 20.

14 A I found it. Thank you. Now your question is?

15 Q That is so far different than anything else that

16 exists under criminal law, what is your justification for

17 that?

18 A We figured it would be negotiated down to

19 a shorter period of time. So we recommended ten years to

20 have some room to move on it. I think it is probably our

21 actual explanation of that. We thought it should be ten

22 years because, and from a realistic standpoint, I don't

23 mean to be too facetious about it, we thought it was unlikely

24 if this bill gets passed, ten years would remain in the

25 final version of the actual legislation. But if you are

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involved with victims of these crimes, sometimes after three, four, five, six years of therapy that they are able mentally to go after the person that did this to them. So it is a real problem. It is different than in other types of cases.

Q Well, I am not sure it is and let me give you one example where I think it is very similar, where we don't have a long statute of limitations is the case of a child that is a victim of sexual abuse. That child is held to the same statute of limitations which would be the five-year statute in the case of involuntary deviate sexual intercourse or rape. But it seems to me that this would be more consistent if it had that same five-year statute of limitations. That is why I asked the question.

A Well, I would certainly urge to have it at least the same as for a child. I think that would be appropriate. As a matter of fact, when we were drafting the reporting provisions and the consent sections of the act, we were patterning it after child abuse reporting requirements as well So if it were changed to that, that would seem to me to be the suitable way to change it.

BY REPRESENTATIVE BORTNER: (To Mr. Claraval)

Q One quick question, is it your intention from the legislation you presented to create, and I want to get a handle on what you feel we need to provide protection for,

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1 to create a cause of action that would allow someone to
2 sue in the case where there has been a relationship
3 established a substantial period of time after the actual
4 therapy has taken place.
5 A That is right.
6 Q That would be your intention.
7 A That currently exists. We would not be
8 creating, of course, a cause of action by statute. But
9 under the common law, that does exist. We would, in the
10 ordinary case, produce expert testimony that even after
11 a five-year break from the date of the last therapy of
12 the first sexual exploitation, that that is a wrong. I
13 think the Ethics Committee notes that I have read indicate
14 that you simply can't do it.
15 Q Except under the current law the statute of
16 limitations would not allow that.
17 A It is a close question. It is a discovery
18 issue. When the patient discovered, when should she have
19 known there was a wrong. So simply by saying the sexual
20 act occurred in 1982, therefore the statute has expired,
21 may not work because she did not realize she was harmed
22 until 1986 or '87. That is what we need some help from
23 you, some legislation on, to tell us when it does run.
24 REPRESENTATIVE BORTNER: Thank you. That is a
25 good lawyer's answer too.

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1 CHAIRMAN DEWEESE: The Chair would like to
2 welcome Tom Caltagirone from Berks County. And collectively
3 thank the Committee for a very good attendance this morning.
4 Special Counsel to the Committee, Mr. Connelly, has a
5 question.
6 BY MR. CONNELLY: (To Mr. Claraval)
7 Q Bob, under common law right now who are defendants
8 available to be sued, only physicians?
9 A The common law that we have used applies to
10 even more limited to that, at least in my experience,
11 has been psychiatrists, psychologists. I believe that
12 we could expand it to counselors, ministers and so on.
13 I don't have any experience with suing dentists,
14 chiropractors and so on. I don't know how that applies.
15 Q Under the existing civil legislation is the
16 common law as broad as the definition in the civil area?
17 A I don't think so.
18 Q So you are expanding it to be certain to include
19 those who provide this type of counseling?
20 A That is right. And the difference is that a
21 psychiatrist commits malpractice per se when he has sex
22 with his patient and all of the experts will agree with that.
23 Does a dentist commit malpractice when he does that,
24 that is a little closer question. I'm not sure you could
25 line up 15 dentists to say that is malpractice. They would

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1 all say it is wrong, and an ethical violantion, but is it
2 malpractice, I don't know that.
3 Q Secondly, the cap you mentioned in coverage,
4 the $25,000, how is that worded? Where is --
5 A There is a specific, what used to be an
6 exclusion in the policy saying we don't cover sexual
7 conduct now says we don't cover sexual conduct, but if you
8 are found liable for sexual contact we will pay up to $25,000.
9 Q How does this legislation assist you in
10 pursuing excess verdicts above the limits in these policies?
11 A We haven't addressed that issue. What we have
12 said in the amendments that you may not have, that we
13 attach to my testimony, is that that exclusion should be
14 eliminated. That the carrier should not have the right
15 to do that. That they should provide full coverage for
16 the psychotherapist for all his wrongdoings. And not say
17 we are going to give you 25,000 if it is sexual exploitation
18 and other amounts for other things. So that the
19 psychotherapist would have $200,000 worth of coverage from
20 his carrier and then the CAT Fund would kick in.
21 MR. CONNELLY: Thank you.
22 CHAIRMAN DEWEESE: Representative McHale.
23 REPRESENTATIVE McHALE: Thank you, Mr. Chairman.
24 BY REPRESENTATIVE McHALE: (To Mr. Claraval)
25 Q Mr. Connelly touched on the very question that

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1 I intended to raise. Has that $25,000 cap ever been tested?
2 As you and I indicated earlier, under current Pennsylvania
3 law, every physician has to carry a minimum amount of
4 insurance. What I believe is currently a figure of $200,000.
5 That the CAT Fund kicks in after that to guarantee
6 supplemental coverage. Has anyone ever tested whether
7 or not public policy is violated by the $25,000 exclusion
8 written in these policies?
9 A I don't know. It would be interesting if
10 a verdict came in at 150,000 would the CAT Fund pick up
11 the excess over the 25,000. I don't know. I have seen
12 that particular exclusion in the last policy which I looked
13 at, which was on psychologists, that was written in 1987
14 is when I saw the language.
15 REPRESENTATIVE McHALE: I would just indicate
16 very briefly that I have great concerns about that. It
17 seems to me that the insurance carrier should not be able
18 to pick and choose what their limits of liability will be
19 short of the statutory minimum $200,000. They may try to
20 write in $25,000 exclusions, but I think that language
21 would be construed to be ineffective if judicially challenged,
22 at least I hope so. Thank you, Mr. Chairman.
23 CHAIRMAN DEWEESE: Thank you, Mr. McHale. Mr.
24 Lashinger.
25 REPRESENTATIVE LASHINGER: Thank you, Mr. Chairman.

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1 BY REPRESENTATIVE LASHINGER: (To Claraval)

2 Q On the criminal side, I am not sure what
3 training causes me to ask this. I understand though on
4 the criminal side that consent being a prohibitive defense.
5 I am not sure it being a prohibited defense on the civil
6 side is an absolute prohibition. Is that something that
7 you have thought through? I am not sure why I think it is
8 okay to prohibit as a defense on the criminal side and not
9 on the civil side. Maybe because I see this more as a
10 clear criminal problem than I do a civil problem. On the
11 civil side I see it more as a medical now and then an
12 administrative problem.

13 A I think one of the purposes behind the bill
14 was to streamline the ability of the patient to bring the
15 action. If you say that it is wrong per se to have sex
16 and the defendant cannot say that person consented to it,
17 then you eliminate the need for expert witnesses at least
18 on the side of the plaintiff saying that this was mal-
19 practice and you wouldn't need an expert witness to say,
20 no, the plaintiff could not consent to it. So from that
21 standpoint, it lowers the cost and it streamlines it.
22 You would need expert witnesses to testify about damages,
23 of course, and harm to the patient, but you eliminate the
24 standard of care. I think what you are doing here is
25 legislatively imposing a standard of care. Once you do that,

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1 you don't need experts to come in anymore and testify as
2 to what it is.
3 Q Part, just let me understand your answer,
4 one of your theories you are operating under is to reduce
5 the cost of litigation?
6 A Right.
7 REPRESENTATIVE LASHINGER: I am not sure that
8 that's one member's opinion. It is something that I agree
9 we should be concerned about. But given the sensitivity
10 of the problem, I am not sure it is the primary reason
11 to remove it as a defense. Thank you.
12 CHAIRMAN DEWEESE: Thank you, counselors.
13 The Chair would recognize S. Michael Plaut, Ph.D.,
14 University of Maryland School of Medicine. That is our
15 next witness. He is an Associate Professor of Psychiatry
16 and Pediatrics at the University of Maryland School of
17 Medicine. The Chair would welcome you and thank you for
18 being part of our hearing.
19 DR. PLAUT: Thank you, Mr. Chairman. I have
20 been invited today by the sponsors of these bills who have
21 asked me to explain to you the characteristics of the
22 therapeutic relationship that makes sexual involvement
23 between therapist and patient so unique as to warrant the
24 kind of consideration we are giving it today. In the
25 interest of time, with your permission, Mr. Chairman, I

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1 will dispense with the second paragraph of my statement
2 which simply defines my characteristics and background in
3 this area. Everyone should have a copy of this statement.
4 I think we can all agree that having sexual
5 feelings toward another person in virtually any social
6 setting is a perfectly normal and acceptable human
7 phenomenon. However, I think that most of us would also
8 agree that there are certain situations in which the
9 expression of such feelings in the form of sexual acts
10 would be indiscreet at best and extremely damaging at worst.
11 Sexual acts may easily compromise any professional
12 relationship, but the potential for harm is especially
13 great in the psychotherapeutic setting.
14 It may be easier to understand why this is so
15 if we think of these relationships as having characteristics
16 that make it especially important that certain boundary
17 conditions between provider and patient be maintained.
18 We might think of these characteristics in terms of four
19 levels that are superimposed upon one another. (In my
20 discussion, incidentally, I will refer to providers as
21 masculine and to patients as feminine, since this is the
22 gender relationship that occurs in about 90 percent of
23 reported cases of sexual exploitation in the mental health
24 professions.)
25 The first and most basic level of consideration

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1 involves a certain amount of distancing that is important
2 to many professional relationships. In many cases,
3 professional peer relationships do not function as well
4 when people become too close on an emotional level, because
5 a necessary level of objectivity and control has been lost.
6 The need for distancing becomes even more
7 apparent at our second level of consideration which involves
8 a power differential between two individuals. This is a
9 characteristic that we find in many kinds of relationships
10 in the professional arena -- teacher-student, employer-
11 employee, supervisor-subordinate, doctor-patient, and so on.
12 In each case, the second person is dependent on the first
13 in some important way -- for grades, evaluations, salary
14 raises, promotions, or competent, objective care, as the
15 case may be. When such relationships become too personal,
16 the professional may be seen as exerting some potentially
17 coercive control over the other, more vulnerable, party,
18 and objectivity is seriously compromised. I am sure that
19 many of us would be cautious about condoning excessively
20 intimate relationships in these kinds of situations. The
21 relatively more extreme level of dependency in the
22 psychotherapeutic relationship leads many professionals
23 to consider excessive intimacy in that setting to be
24 basically incestuous in nature.
25 In the health care setting, the provider-patient

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1 relationship takes on two additional characteristics that
2 comprise our third level of consideration. We might call
3 these characteristics disclosure and clinical intimacy.
4 The patient, either voluntarily or in the course of
5 providing relevant historical material, will tell things
6 to her health care provider that she may have told no
7 one else, and these often include sexual problems,
8 incidents involving sexual abuse or trauma, or relationship
9 difficulties. In addition, she may, for purposes of
10 examination or treatment, expose parts of her body that
11 might otherwise be seen by one or two people in her
12 personal life. As illustrated in the comic strip below
13 on my statement, a patient's willingness to engage at
14 that level of intimacy involves a necessary level of
15 trust that the relationship will be unilateral. It is
16 an implicit contract between provider and patient which
17 must be upheld by the provider if necessary levels of
18 trust, confidence and objectivity are to be maintained.
19 To illustrate briefly how medical professionals
20 feel about those boundaries, two colleagues at the
21 University of Maryland and I are conducting a study
22 assessing attitudes of health professionals to various
23 levels of intimacy in the clinical setting. I will be
24 reporting some of our initial data in New York tomorrow
25 at the annual meeting of the Society for Sex Therapy and

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1 Research. Our data show that 99 percent of those asked
2 to respond to specific clinical examples felt that
3 genital contact with a patient was not ethically appropriate
4 when a medical procedure was not directly involved. When
5 asked about a provider's disclosure to a patient that he
6 or she was having relationship difficulties, 70 percent
7 of our sample felt that even this level of disclosure
8 was a violation of appropriate boundary conditions.
9 Our fourth and final level of consideration
10 is specifically relevant to the mental health setting,
11 where relationships already include the characteristics
12 of the first three levels - distancing, dependence,
13 vulnerability, disclosure and clinical intimacy. We now
14 add three additional characteristics, which I will call
15 intensity, isolation, and need. Psychotherapeutic
16 relationships typically function on a regular basis for
17 a period of time that may range from a few weeks to a
18 few years. This intensive contact enhances the levels of
19 clinical intimacy and disclosure discussed earlier, and
20 brings with it an emotional intensity that rarely exists
21 in other professional relationships. As we all know,
22 positive intense relationships are more difficult to
23 terminate because of the feelings of loss involved.
24 Secondly, therapist and patient are more often and
25 necessarily alone than are people in other professional

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1 relationships, which provides a greater opportunity for
2 sexual feelings to get out of hand. Finally, a patient
3 often comes to the therapist with great emotional need.
4 She may be lonely, depressed, or distraught. She may
5 have been a prior victim of sexual or other form of abuse.
6 She may have difficulty asserting herself in close
7 relationships or may have learned over the years that she
8 can get things from men by being seductive. Feelings
9 she has had toward other men may become projected onto
10 the therapist. He may become something of a father
11 figure as part of a phenomenon that we call transference.
12 The therapist, in turn, may develop protective feelings
13 toward the patient, representing a related phenomenon
14 called countertransference.
15 It is here that the critical element of the
16 psychotherapy comes in. It is the therapist's job to
17 use the trust and intimacy of the therapeutic relationship
18 to help the patient work through the problems she came
19 in with, so she can eventually leave that relationship
20 in a more stable, confident, appropriately assertive
21 condition. However, when he violates boundary conditions
22 by being excessively disclosing, by responding to the
23 patient's seductive behavior or by making sexual overtures,
24 she is essentially being asked or permitted to participate
25 in what may have been a life-long pattern of behavior that

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she came there to resolve. She may take advantage of the therapist's willingness to be a protective parent for some period of time, either not wanting to give up a closeness she has never experienced, or not knowing how to extricate herself from yet another turn in a vicious cycle. When the relationship ends, often at the volition of the therapist, she may feel hurt, confused, angry and abandoned.

It is because of the potentially devastating nature of sexual relationships in the psychotherapeutic setting that all three major mental health professions -- psychiatry, psychology and social work -- include strict prohibitions against sexual intimacy in their ethical codes. A therapist may violate that code because of a well-intended belief that it will be in the patient's interest or because of his own unmet emotional or sexual needs. He may even genuinely fall in love with a patient. Whatever the motivation, however, the potential risk for the therapeutic relationship and for the patient is great enough that the prohibition remains justified in the eyes of the professions.

In summary, many professional relationships can be easily and seriously compromised when certain boundary conditions are not maintained. To the extent that such relationships involve a power differential, high

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1 levels of intimacy and personal disclosure, isolation from
2 third party observers, great emotional intensity and a
3 high level of need in one or both participants, the
4 potential for harm to the less powerful participant is
5 especially great. The psychotherapeutic relationship
6 includes all of these characteristics. It is for this
7 reason that those responsible for regulating the health
8 professions -- whether inside or outside those professions --
9 need to take the responsibility to ensure that boundary
10 violations are minimized. The bills we are discussing
11 today comprise one possible method of assuming that
12 responsibility. Thank you for your attention.
13 CHAIRMAN DEWEESE: Professor, thank you very
14 much. I'm going to excuse myself for five minutes. The
15 questions will be handled by our Subcommittee Chairman,
16 Mr. Kosinski from Philadelphia. I will be back in five
17 minutes. Are there questions from the membership? Mr.
18 Lashinger is recognized.
19 REPRESENTATIVE LASHINGER: Thank you, Mr.
20 Chairman.
21 BY REPRESENTATIVE LASHINGER:
22 Q Very briefly, if the gentleman would refer
23 on page 2 of his testimony, I am fascinated by -- I
24 appreciate your testimony, number one. It was fascinating.
25 You talk about when asked about a provider's disclosure to

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1 a patient that he or she was having relationship
2 difficulties, 70 percent of your sample felt that even
3 this level of disclosure was a violation of appropriate
4 boundary conditions.
5 I read that sentence a different way. I am
6 more surprised that 30 percent said that it was okay to
7 exceed that boundary. That it was appropriate to speak
8 to a patient about marital difficulties, is that what that
9 means, that they were having personally?
10 A Yes, two different levels. This was a multi-
11 point scale. That doesn't mean that there was an absolute --
12 but, yes. These were people -- I was being conservative.
13 These were people that did not think it was absolutely
14 inappropriate to make those kind of disclosures. These
15 are people not in a psychotherapeutic setting but in a
16 medical setting. I think if you asked psychotherapists
17 the same question, you would get a higher percentage of
18 the people who would feel that this was in fact a violation
19 of boundary conditions.
20 Q The question had nothing to do with their
21 treatment of the patient, is that correct?
22 A Yes.
23 Q Their relationship, their own personal
24 relationship has to do with the treatment?
25 A Exactly.

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1 Q Is that a surprising statistic for you? That
2 only 70 percent thought that that exceeded boundaries.
3 A As you become less and less explicitly sexual,
4 what happens is that the boundaries become fuzzy. And
5 there is more disagreement among professionals as to where
6 to draw the lines. One example that we discussed this
7 morning, for example, is how long after a therapist and
8 patient should not have sexual contact. If you ask a
9 psychoanalyst that question, he or she will say never.
10 Once a patient always a patient. But then there are some
11 people who would say once you terminate the relationship,
12 it is fine. I disagree with that. Most therapists would
13 disagree with that, but there are some who feel that way.
14 So you'd get responses across the board on that particular
15 issue.
16 REPRESENTATIVE LASHINGER: Thank you.
17 ACTING CHAIRMAN KOSINSKI: Any further
18 questions?
19 BY REPRESENTATIVE BORTNER:
20 Q I would just like to follow up on that statement.
21 I still am not clear on what that means and I would like to
22 understand it. Instead of using he or she use a noun,
23 a proper noun, so I know who you are referring to.
24 A Oh, in the 70 percent statistics?
25 Q Yes. That is confusing.

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1 A Is it okay for me, a provider, to tell you,
2 my patient, that my wife and I are having marital difficulties.
3 Q You are talking about your own personal?
4 A Exactly, my own personal situation. Because
5 sometimes in a psychotherapeutic setting that is an
6 overture to such an involvement, and also the therapist
7 is expected to maintain much greater distance than that.
8 But a person who can -- and these particular responses,
9 by the way, I should say came from physical therapists.
10 That is the first population that we studied. People in
11 that kind of situation have a much more informal
12 relationship with their patients. I would expect a higher
13 percentage than 70, say, from internists or gynecologists
14 than I would from physical therapists. But that remains
15 to be seen in the rest of the data we collect.
16 Q I would like to sum this up. So what you are
17 saying is that even in very innocently the counselor is
18 saying, well, you shouldn't feel bad. My wife and I have --
19 70 percent of the people felt that even that kind of a
20 situation is inappropriate?
21 A That is correct.
22 REPRESENTATIVE BORTNER: Thank you.
23 ACTING CHAIRMAN KOSINSKI: Further questions?
24 BY ACTING CHAIRMAN KOSINSKI:
25 Q I have one. Doctor, earlier we saw a videotape

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1 regarding the case of Sharon Murphy who came to the
2 Maryland Psychology Board during the time you were with
3 that board. This case went on for two years at which time
4 the psychologist's license was revoked in Maryland. What
5 if that psychologist moved to another state? What protections
6 do we have to stop him from practicing there or what
7 would you recommend should be done to protect the prospective
8 patients in other jurisdictions where an abusive practitioner
9 moves in?
10 A It's a good question because, of course,
11 every state asserts its sovereign rights to control
12 professionals as they see fit. But I will say there are
13 some measures that are being taken. I believe the U.S.
14 Senate, in fact, passed a law last year or two years ago
15 which would withhold federal reimbursement for people
16 who had committed a sexual violation. So this would be
17 irrespective of what state they were in.
18 When boards of examiners entertain an
19 application for a licensure in this state, at least in
20 Maryland, they ask whether they have ever been convicted
21 of a felony or found guilty of any professional offense
22 in any other state, and of course, it is a violation for
23 them to speak untruthfully on the application. Other
24 things that happen are, I am speaking from my own
25 profession, because I know the American Psychological

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1 Association annually distributes a list to all of its
2 members of all licensure actions, of all suspensions and
3 dismissals from membership. And the reason for that is
4 so that if, for example, a person had their license revoked
5 because of a sexual offense in any state, every member
6 of the American Psychological Association would know about
7 it within a year. The American Society of State Psychology
8 Board, which is the umbrella body, which at least in a
9 professional sense helps boards of examiners in all the
10 states to relate to each other. Publishes a list annually
11 of all revocations and suspensions. So that the boards
12 have that information in front of them.
13 In Maryland I can say that we are doing more,
14 at least the time I was chairman of the board, to make these
15 findings public through the press. And if they knew
16 somebody was going somewhere else, we would let them know
17 because we felt it was our public obligation.
18 Q In other words, the information is out there
19 if another jurisdiction wants it?
20 A Yes. I am not sure it is enough. We need to
21 do more in that respect. I don't see that we are doing
22 all we can, but I think more has been done in recent years.
23 Q You discussed concepts in your statement. Do
24 they apply outside the medical profession and do they
25 apply, let's say, to attorney-client relationships and so

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1 on and so forth, other professions?

2 A To the extent, for example, that an attorney/
3 client relationship could be considered to have a power
4 differential and there are certain confidences that are
5 exchanged, I would say theoretically yes. I don't know
6 if you want me to comment more about that. But I think
7 each profession has to determine for itself where its
8 boundary conditions ought to be. And if they don't,
9 then it is up to a body like this to help them make that
10 decision in the public interest. By the way, since you
11 brought up the West 57th Street, I know it is a sensitive
12 issue because I was the target in that particular program.
13 I will be happy to answer other questions about that
14 because I was part of that case. And some people may want
15 some issues clarified about it.

16 ACTING CHAIRMAN KOSINSKI: Any further
17 questions?

18 (No response.)

19 Doctor, thank you very much. Our next witness
20 is Dr. James Pedigo, M.D., from Villanova, Pennsylvania.
21 And before the doctor speaks I turn the gavel back over
22 to Bill Deweese. Mr. Chairman.

23 CHAIRMAN DEWEESE: Welcome, Doctor. You are,
24 for the record, Medical Director of the Joseph J. Peters
25 Institute.

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1 DR. PEDIGO: That is correct.
2 CHAIRMAN DEWEESE: Thank you for joining us.
3 DR. PEDIGO: Thank you for inviting me here
4 to testify. I would like to begin by introducing myself
5 a little further. I'm a medical doctor, I am concerned
6 about the rights of the patients and I am also concerned
7 that we keep the medical profession as clean as we can.
8 I am here not only as Medical Director of Joseph J. Peters
9 Institute, which is an agency that treats sex offenders
10 and victims of sexual offenses and has a program for
11 treating professionals who are unethically involved with
12 their patients or clients. I am also here as a board
13 member of an organization that is concerned about client/
14 patient exploitation. And I am an Assistant Professor
15 of Psychiatry at the University of Pennsylvania.
16 I am a member of the American Medical Association,
17 the American Psychiatric Association, the American
18 Psychoanalytical Association and their local affiliates.
19 I am concerned about our professional problems in this
20 area.
21 I have worked at the agency, the Joseph Peters
22 Institute, the agency that treats sex offenders and victims
23 of sexual offense since completing my residency in 1964.
24 So that is close to 25 years. I have been the Medical
25 Director there for about five years. This agency treats

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1 approximately 120 sex offenders at any one time, approximately
2 60 of them are incarcerated at the Eastern Pennsylvania
3 State Prison and 60 of whom are on probation or parole.
4 At any one time we treat approximately 50 to 60 victims
5 of sexual offense.
6 For the past few years we have had a program
7 for treating professionals, not just therapists, but
8 other professionals too who get sexually involved in an
9 illegal or unethical manner with their patients or clients.
10 As part of the background for this I surveyed 50 or 60
11 of the largest clinical organizations in the U.S. that
12 provide treatment for clients or patients, not just
13 psychotherapists, all kinds of treatments such as the
14 American Medical Association, American Nursing Association,
15 all the big organizations.
16 What I found was that 12 of them absolutely
17 prohibit any sexual involvement with patients or clients.
18 They mention it specifically and they say specifically it
19 is wrong, and I have those 12 listed here. I won't,
20 because of time, read these 12. I found that those
21 organizations that do not relate specifically to psycho-
22 therapy but other treatment such as the American Medical
23 Association, the American Nursing Association do not
24 prohibit sexual involvement with patients or clients.
25 In fact, they don't even mention anything that can be

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1 construed as sexual involvement. They do have phrases
2 such as treating the patient with due respect and treating
3 them in their own best interest. The Hippocratic Oath
4 does specifically mention it, which is an oath many M.D.s
5 take, does specifically mention that doctors shall not
6 be sexually involved when they are in the homes of their
7 patients. And that is an oath that many, many doctors
8 would agree with, but it is not part of the American
9 Medical Association's code of ethics.
10 Thus, the organizations in terms of their own
11 policing, seem to split in terms of sexual involvement with
12 a patient between those that are specifically related to
13 psychotherapy and those that aren't. Those that relate
14 to psychotherapy universally proscribe it. They mention
15 it in their codes of ethics and say you shall not. It is
16 never okay.
17 I'll focus in my talk to you today in my
18 presentation on the perpetrator because many of the others
19 here are focusing on victims. We work at my institute
20 with victims also, but we do work with perpetrators and
21 that is what I want to talk about today.
22 CHAIRMAN DEWEESE: Excuse me. You work with
23 some of the professionals?
24 DR. PEDIGO: That is right. I have a program
25 that treats professionals who get sexually involved with

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1 their patients or clients.

2 CHAIRMAN DEWEESE: Thank you.

3 DR. PEDIGO: And approximately my findings,

4 like the others who testified before you today,

5 approximately ten percent of therapists will admit on

6 an anonymous questionnaire that they have had sexual

7 involvement with patients. So the problem is of fair

8 size in terms of numbers. I won't dwell on damages of

9 the victims because others have talked about that.

10 I will talk a little bit about the dependency

11 because I think that is an important part of this law

12 and in terms of treatment I think it is important. I

13 think that the primary reason for the sexual relationship

14 being an unethical one in psychotherapy is that

15 psychotherapy is set up in such a way that patients become

16 dependent on the therapist. That is part of the treatment

17 technique and it is a very helpful part of the treatment

18 technique. Patients begin to relate to the therapist

19 in ways such as they related to other important authority

20 figures in their lives and that is a helpful part of

21 therapy. However, it also means they can be exploited.

22 This dependency impairs their judgment and that is one

23 of the reasons for the distancing that Dr. Plaut talked

24 about. That therapists not get into dual relationships

25 with patients so that they don't own the businesses together.

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1 Therapists don't do those sort of things ethically because
2 a patient cannot enter into this kind of relationship
3 as a peer because of this dependency. This leads a patient
4 in something of the position of a child in that for a
5 child to enjoy sex with a parent and to feel good about
6 it doesn't justify it. It doesn't make it okay. As
7 I think is similar with a patient that the boundaries
8 need to be set by the parent in the parent/child situation
9 or by the professional in a professional/patient/client
10 situation.
11 Sex offenders, even more than most offenders,
12 are very reluctant to face the drive, the urges they feel
13 which lead them to become sexually involved and are very
14 reluctant to seek help before some outside mandate exists
15 to push them in seeking help. They almost never self-
16 refer themselves for treatment when they begin to get
17 into situations like this. They justify to themselves
18 that the behavior really is okay. Often they justify
19 it by feeling that they are falling in love with the patient
20 and that because of falling in love, that makes the
21 behavior that they are beginning to engage in all right.
22 In many ways the relationship that a therapist
23 develops between him or herself in a patient or client
24 is like a father/child situation or an authority/child
25 situation. Many of the dynamics that exist in the treatment

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1 of Pedophilia, child abuse, and the treatment of incest
2 are very appropriate in the treatment of these professionals
3 who become sexually involved with their patients or clients.
4 And similarly, the fact that a mandate is needed to
5 coerce the pedophile or incest offender to treatment
6 because they almost never voluntarily come into treatment.
7 Similarly, we need a mandate to coerce the professional.
8 In the program that I run, I don't accept professionals
9 into that program unless they are willing to sign a
10 release for me which permits me to get into touch with
11 the organizations to which they belong and to the licensing
12 board that certifies or licenses them. So that I have
13 some mandate in order to hold them into treatment. Because
14 I found without that, they come briefly into treatment
15 and when the pressure is on, they work on the impression
16 and anxiety without working on the sexual problem. And
17 once the pressure is off, they stop treatment and they
18 refuse to permit the treating therapist to release the
19 information that they have stopped treatment. The mandate
20 to hold them in treatment is a necessary part of the
21 treatment and I think it is an important part of the bill
22 that is up before us today.
23 Professional associations, like the American
24 Psychiatric Association which I belong, the American
25 Psychological Association and others have done a lot to

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1 police themselves much more in recent years than in the
2 past. It is not enough. One of the problems with that is
3 that those who are the officials in these organizations
4 are almost all on a volunteer basis. They turn over
5 fairly frequently on their committees. When professionals
6 feel their license and way of life is threatened, they
7 become very threatening themselves. Volunteers who work
8 on these committees do not want to expose themselves to
9 lawsuits. Because it is very hard for them to then press,
10 particularly if the therapist is a prominent member of
11 the collegial community, it is very difficult for them to
12 press and to have hearings and to enforce sanctions against
13 these men. That is not to say that they don't and they
14 do more and more in recent years than in the past. But if
15 ten percent of the therapists will voluntarily admit
16 on anonymous surveys, and they do admit on anonymous
17 surveys, that they have been sexually involved with patients,
18 and for all those ten percent it is unethical, according
19 to their codes of ethics, then the numbers of sanctions
20 from the American Psychiatric, American Psychological,
21 American Psychoanalytical Assocations are very, very small
22 compared to that ten percent.
23 I would like to speak a little bit about post-
24 treatment sexual behavior. None of the codes of ethics
25 mention that is sexually inappropriate or unethical for a

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member to be involved with ex-patients or clients. None of the codes of ethics even consider that. Now many courts of law have and many defendants have been found guilty even though their defense has been, when we had the therapeutic relationship, we didn't have sex. It was only afterwards. It has not been a very successful defense in the court. But in the codes of ethics, it is not an ethical violation for me to be sexually involved with an ex-patient as a member of the American Psychiatric Association or Psychoanalytic Association as it is for me to be sexually involved with a current patient. I think that concludes the primary.

My primary concern is that in this bill there be a mandate for treatment for these professionals so that there can be a screening process in which the professionals, who are not treatable can be, their certification or license can be removed, and those who are treatable can have conditions imposed upon them that require treatment and hopefully successfully return to practice eventually. Treatment is not only helpful for the profession and the professional, but it is also probably the only way we are going to learn much about what makes people get involved in this kind of unethical and illegal behavior. It is within treatment that that kind of information comes out. Therefore eventually, hopefully, we will be able to teach

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1 professionals in such a way that this kind of behavior
2 can be minimized. Thank you.
3 CHAIRMAN DEWEESE: Thank you, Doctor. Questions?
4 Mr. Lashinger.
5 BY REPRESENTATIVE LASHINGER:
6 Q Doctor, the professionals that you are treating,
7 that you have treated, have any been licensed in
8 Pennsylvania?
9 A Yes.
10 Q Without disclosing --
11 A Most have been licensed and most have been
12 in Pennsylvania. I have treated other states.
13 Q You indicate you get a waiver from them to
14 notify the Licensure Board that you are treating them?
15 A That is right.
16 Q What type of communication do you get back
17 from the Licensure Board when you notify them you have
18 them in treatment?
19 A So far I have only gotten back acknowledgement
20 of my letter. The primary reason I do that is so I can
21 have some way of keeping the professionals in treatment.
22 Not necessarily so that I involve the Licensing Board
23 so I have the right to do that.
24 Q Are these all voluntary, I don't want to say
25 commitments, have these people all voluntarily joined your

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1 treatment program?

2 A None of them have come in on their own volition.

3 They have all been mandated to come in either by a court;

4 some of them are criminals that have been prosecuted in

5 criminal court. Others have been mandated in other ways,

6 but all of them have been mandated in some way.

7 Q Might have been going in the wrong path and

8 in most cases the Licensure Board already knows about these

9 people you have in treatment?

10 A Some have and some have not.

11 Q If they come through the court system.

12 A If they come through the court system then they

13 are likely --

14 Q What others wouldn't have?

15 A I have a professional now who is a religious

16 professional. He is not a therapist. And his religious

17 order required that he be in treatment. I have a teacher

18 who is in treatment, who is a professional and is in

19 treatment, and he has not been criminally prosecuted.

20 So that there are other professionals other than therapists

21 who are in the program and some of them are not mandated

22 by licensing boards.

23 REPRESENTATIVE LASHINGER: Thank you.

24 CHAIRMAN DEWEESE: Mr. Caltagirone from Berks

25 County.

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1 REPRESENTATIVE CALTAGIRONE: Thank you, Mr.
2 Chairman.
3 BY REPRESENTATIVE CALTAGIRONE:
4 Q Can you explain to this Committee when, in
5 your opinion, you think a person has been treated and is
6 cured and whether or not that person will go back into
7 the profession afterwards?
8 A I can tell you the criteria I use. When a
9 professional can talk openly about his or her own responsi-
10 bilities in the sexual acts they were involved with with
11 their patients or clients, can recognize but needs those
12 acts were fulfilling in themselves and have alternative
13 ways that they have shown me that they can successfully
14 meet those needs, those are the three major criteria that
15 I use. So it requires that they be able to recognize their
16 responsibility for this. That they talk openly about their
17 own needs and that they develop skills which will let
18 them meet those needs in socially acceptable ways. That
19 takes several years. And of course, it is not a guarantee
20 that given bad circumstances where their lives would go
21 wrong, that they might not eventually go back to that
22 same behavior. There is not that kind of guarantee in
23 the treatment field.
24 Q So we really don't know what lies ahead of
25 those people that are actually being treated now that are

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either practicing in the profession or three months or years go back to that profession?

A No, it would be nice if we had a crystal ball, but I don't.

Q The part that I am interested in, we are drafting legislation, looking at these people that have had this kind of a problem. Then why should they be allowed to practice? Why should they not also lose their license forever?

A Many of them I think should lose their licenses forever. Many I think are not treatable. But I don't think that is true for all. I think there are professionals who get into situations in their own life where they are very depressed, where their marriage is failing, where maybe financial problems occur, where the patient begins to satisfy the therapist's need for dependency where the therapist was quite depressed. That kind of therapist can often be treated and often returns successfully to practice.

The exploitive kind of therapist, who has sexual relations with many of his patients and gets involved in other exploitive ways with his patients and sees that that may be unethical by the profession but there is really nothing wrong with it. That kind of therapist can rarely be treated successfully and should not

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1 be in the field of psychotherapy.

2 Q One other, you surveyed a small sample of

3 these professionals. You extrapolated that information.

4 The projection of all these professionals was comparable.

5 What would be your highest percentage of people in those

6 professions that finally have intimate relations with their

7 clients or patients on this survey?

8 A The survey shows pretty consistently about

9 ten percent have admitted. If ten percent have admitted,

10 then probably a percent, maybe there is an equal percent

11 who won't admit it. That amounts to a huge number, maybe

12 20 percent. That is a very large number.

13 REPRESENTATIVE CALTAGIRONE: Thank you. Thank

14 you, Mr. Chairman.

15 CHAIRMAN DEWEESE: Thank you, Doctor. The

16 court reporter will have a minute here to change her paper.

17 I don't want to take a recess in our proceeding now.

18 I call on the Bureau of Professional and

19 Occupational Affairs to be next in their testimony due

20 to some other scheduling obligations that they have.

21 Michael Barrett, Esquire, Chief Prosecutor; Barbara Shore,

22 Ph.D., my long-time acquaintance and friend from Pittsburgh,

23 Dr. Joshua Perper, John Alcorn, Esquire, Counsel to the

24 Board of Medicine.

25 MR. ALCORN: Thank you, Mr. Chairman. I am

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1 John Alcorn, Counsel to the State Board of Medicine. I
2 just thought I would mention, unfortunately, Dr. Barbara
3 Shore was unable to be here today. She will not be
4 presenting and I will not be presenting. The presenters,
5 on behalf of the Bureau, will be Dr. Perper and Mr.
6 Barrett.
7 CHAIRMAN DEWEESE: Thank you, kindly. Dr.
8 Perper, et al, will somebody please introduce everybody
9 and we will get started.
10 MR. ALCORN: Thank you, Mr. Chairman and
11 members of the Committee. I am John Alcorn, I am Counsel
12 to the State Board of Medicine. Unfortunately this morning
13 Dr. Barbara Shore was unable to be here and she will not
14 be presenting nor will I be presenting. Rather Dr. Joshua
15 Perper, member of the State Board of Medicine and Michael
16 Barrett, Chief Prosecutor for the Bureau of Professional
17 and Occupational Affairs, will be making the presentations.
18 With that, I call on Dr. Perper.
19 CHAIRMAN DEWEESE: Doctor, welcome.
20 DR. PERPER: Thank you. Good afternoon.
21 On behalf of the Board and myself I would like to thank
22 Chairman, Representative DeWeese and the members of the
23 Committee for the opportunity of having my views heard in
24 relation to Bill 1465.
25 It is the firm and clear understanding of the

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1 Board of Medicine of the Commonwealth of Pennsylvania that
2 a physician is held to a particular position of trust in
3 relation to his patient. This particular status requires
4 the physician not only to provide competent professional
5 care but also obligates him to abstain from any personal
6 action which may harm the patient's interests be they social,
7 economic or emotional. Furthermore, it is self-evident
8 that a physician is forbidden to take advantage of or
9 exploit this special relationship in order to further his
10 own interests, be they professional or personal, beyond
11 the legitimate enrichment of his medical experience and
12 the receipt of reasonable compensation for his services.
13 There is no doubt in our minds that this position
14 is shared by the vast majority of the physicians practicing
15 in this Commonwealth, and for this matter by any ethical
16 practitioner of medicine.
17 There is no question that the shield of ethical
18 protection provided to the patient includes the right to
19 be safe from improper influence in emotional and sexual
20 matters. The 2400 year old Hippocratic Oath, which guides
21 physicians to this very day clearly states: "Whatsoever
22 house I enter, there I will go for the benefit of the
23 sick, refraining from all wrongdoing or corruption and
24 especially from any act of seduction of male or female,
25 of bond or free." I may add, this is not something we

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1 discovered today or 50 years ago. It is a standard for more
2 than 2400 years.
3 It is both unfortunate and fortunate that the
4 House has to consider such legislation covering sexual
5 relations between therapist and patient. Unfortunate,
6 because the enactment of such legislation implicity and
7 unavoidably casts a dark shadow of doubt over the
8 reputation of the many decent and honorable psychiatrists,
9 psychologists and allied professions. Fortunate, because
10 this legislation is clearly needed to prevent sexual
11 harassment and abuse of patients by unethical professionals.
12 True the offenders are representing only a small percentage
13 of the health-care providers, nevertheless this serious
14 ethical offense has strong criminal overtones and its
15 prosecution must be forceful effective and fair.
16 There is not and cannot be full, adequate
17 and free consensual sex between a physician and his or
18 her patient. The physician dressed in the reassuring and
19 shining armor of authority and expertise, faces a patient
20 stripped by anxiety and disease, who seeks solace and
21 professional help. One confidently issues medical orders,
22 the other follows them obediently, sometimes diffidently,
23 but almost always with little capability for challenge.
24 How can be there a voluntary romantic meeting of two
25 free people, or a fair encounter between equals on the

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1 sexual field? One actually has the authority of a competent
2 adult, the other virtually has the standing of a minor,
3 a ward or an incompetent person. This being said, the
4 question is whether or not the ethical sexual barrier is
5 to forever stand between the psychotherapist and the
6 patient, even after cessation of therapy. The proposed
7 bill has chosen to answer this question in the negative,
8 and it has set a "cooling off period" of two years. This
9 is an acceptable approach to which I concur, although
10 perhaps a one-year interval following therapy might be
11 more reasonable. Furthermore, the bill does not precisely
12 define in its context the significance of the therapeutic
13 relationship which I believe should be defined as a
14 "substantial relationship". Otherwise, a single five-
15 minute conversation or interview may trigger very serious
16 consequences of criminal conviction for a minimal and
17 nonsequential professional contact. By the same token,
18 if the counseling is substantial, then the provisions of
19 the bill should be effective regardless whether the
20 therapist is a psychotherapist, a para-psychotherapist
21 or a general practitioner. I would like also to add that
22 I believe that the definition of substantial relationship
23 might be more helpful and easy to prove than the emotional
24 dependence which might be quite difficult to prove and
25 may be much easier to challenge.

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In conclusion, the State Medical Board supports this legislation, which I believe should be strengthened and expanded in order to include not only the psycho-therapists and para-psychotherapists as listed in the bill, but also all physicians involved in substantial counseling of their patients.

Thank you very much for your attention.

CHAIRMAN DEWEESE: Yes, sir. You are very welcome. I now recognize Michael Barrett, Chief Prosecutor for the Bureau of Professional and Occupational Affairs. And then we'll open up to questions. One thing before you get started, how long have you been there?

MR. BARRETT: I have been Chief Prosecutor for approximately 18 months.

CHAIRMAN DEWEESE: And the only other question, what is an average length of time that someone in your position would be around state government before that man or woman would move on to another assignment?

MR. BARRETT: That is hard to say. My position is relatively new in terms of there being a Chief Prosecutor. My predecessor was there for five years. All I can say is I have no present intention of moving on.

CHAIRMAN DEWEESE: Thank you. You may commence with your remarks.

MR. BARRETT: Thank you, Mr. Chairman. My

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1 comments this morning really are from the perspective of
2 a prosecutor and it is based on the experience I have had
3 with cases before the Licensing Board here as
4 well as a prosecuting attorney in the United States Air
5 Force dealing with sex offenses.
6 The most important thing I think I can say here
7 today, both personally and on behalf of the bureau, I
8 am strongly in favor of this legislation. It is something
9 that is, unfortunately, desperately needed given the nature
10 of the patient-therapist relationship and additionally the
11 number of cases that apparently occur. My comments really
12 are directed primarily to House Bill 1465. Although I
13 support the bill, I would suggest there are some changes
14 that perhaps would make this legislation even more
15 effective. The first one that I would propose would be
16 to either include or otherwise amend the provisions of
17 the appropriate licensing statutes that govern the various
18 boards and medical,osteopathic,psychology,social worker
19 boards that would be involved here. To provide for the
20 automatic suspension of an individual's license upon
21 conviction of an offense under this bill. We have that
22 provision currently for convictions, for felony offenses
23 under the Controlled Substance, Drug, Device and Cosmetic
24 Act. The procedure in those cases is very simple. Once
25 the individual is convicted and we obtain certified copies

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of the conviction, an order is issued without a hearing suspending the individual's license. The license is then suspended for a minimum period equal to that of an individual whose license has been revoked. The period of time for which an individual's license has been revoked and come back and asked for the board to consider the reinstatement of the license.

The reason I suggest that is twofold. One, I think it is recognition of the seriousness of the offenses that we are dealing with here and the other is recognition of the action that the boards have taken in the past. We have had several cases like this not dealing with the conviction, obviously, but dealing with the underlying sexual misconduct. And in every event, in every case, the only issue involved, the only real issue involved has been one of credibility. Once the board has determined that, yes, in fact this conduct did occur, their action has been swift and sure and that has been to revoke the individual's license. Typically these actions are taken pursuant to the board's emergency temporary suspension powers.

Given that result, I would suggest we could accomplish the same thing more expeditiously if a similar procedure would be provided for conviction under this bill. There is already going to be a judicial determination of the

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1 facts in the criminal court, which of course, is a higher
2 standard of proof than we are held to in the administrative
3 arena. So we have something pretty convincing we can
4 present to the board and I would suggest that the best
5 thing to do then is simply say the individual has been
6 adjudged guilty of this offense, he or she no longer has
7 the right to practice in this Commonwealth for the stated
8 minimum period of time. Just as an aside, I would also
9 say I cannot point to any particular statistical studies
10 or anything like that, but it has been my experience with
11 cases like this that certainly the ones that come to our
12 attention are not talking about an individual who has made
13 an error in judgment and slipped off the wagon with one
14 individual. But these are repeat offenders. We find more
15 and more frequently that someone makes a complaint about
16 activity of this kind with a therapist and during the
17 course of the proceedings, based on that individual's
18 complaint, more and more people come out of the woodwork.
19 I am just not personally aware of one case where there has
20 only been one person and we haven't been able to determine
21 there were others.
22 Another change that I would propose deals with
23 the mandatory reporting provisions in the bill which I am
24 strongly in favor of but I would suggest that they be
25 strengthened even more so. The language in the bill

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1 presently necessitates the consent of the patient before
2 the currently treating therapist or whomever files a
3 report. Unfortunately, the problem in these cases is that
4 the victim often feels not like a victim but rather like
5 a guilty party in the proceeding and often does not want
6 to come forward out of embarrassment or shame or perhaps
7 simply out of the fear of being further victimized by the
8 legal process which, unfortunately, is something that
9 often, I have to admit, occurs.
10 Given that, I would suggest that making it
11 contingent on the consent of the patient would still
12 allow too many victimizers to get off because their
13 patients or former patients are not going to be willing
14 to come forward. I would suggest instead that the
15 mandatory reporting provisions be just that with a safe-
16 guard that if the current treating physician or therapist
17 determines that it is not in the best medical interest
18 of the patient, then he or she is absolved from the
19 reporting requirement at that time and until such time
20 as that diagnosis or whatever no longer applies. That
21 is a similar standard as currently applies to the release
22 of medical records, physicians have to release medical
23 records unless they determine that the release to the
24 patient is not of the best medical interest.
25 In line with the reporting requirements, this

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1 is really minor but I would just suggest for consistency's
2 sake district attorneys presently have to report felony
3 offenses in general by health-care practitioners to our
4 bureau. They have 30 days to do that. And I would suggest
5 changing to 15 days in this bill to 30 to make it
6 consistent so that there would be more uniformity in the
7 reporting. I also, unfortunately, have to point out that
8 in most of the cases we find out about felony convictions
9 don't come from reports by district attorneys.
10 The next area that I think needs to be looked
11 at, I believe this bill intends to include a psychotherapist
12 or in the definition of psychotherapist someone who
13 practices. Whether that is all they do 40 hours a week
14 or whether it is a minor part of the practice. But an
15 argument could be made under the language that it only
16 applies to full-time psychotherapists and there are many
17 medical people who encompass some element of that,
18 psychotherapy or counseling, in the treatment of patients
19 such as the family practitioner, the gynecologist or
20 obstetrician. And I would suggest that that element of
21 the patient-therapist relationship being present, the
22 patient is at the same degree of risk and the physician
23 should be held to the same standards. So I would suggest
24 that something just be included to make it clear that
25 whether or not this is the entirety of the physician's

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1 practice. If it contains an element of therapeutic
2 counseling relationship with the patient, then the same
3 provisions apply.
4 And finally, my only other comment would be,
5 although I don't personally believe it has any impact on
6 the illegality of the conduct, but a question was raised
7 during our discussion about the possibility of someone
8 perhaps subsequently marrying a patient. And does that
9 somehow ameliorate the offense or absolve the therapist
10 from any liability. My response, my thinking is that
11 it does not. As a practical matter, I would imagine if
12 somebody marries their therapist, they are not going to
13 come forward and be a willing witness against them. So
14 I don't know that it will help in prosecuting any cases.
15 But a statement that a subsequent marriage does not,
16 in some way, lessen the criminality of the offense might
17 aid in preventing further abuse of patients by therapists
18 who mistakenly believe that, gee, I did something wrong
19 but maybe I can get away with it by marrying the person.
20 I think that truly would be an additional form of abuse.
21 I don't think it is beyond the realm of possibility.
22 Thank you very much.
23 CHAIRMAN DEWEESE: Thank you.
24 BY CHAIRMAN DEWEESE: (To Mr. Barrett)
25 Q When Governor Casey took the reins, he asserted

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1 that there was a crisis in the licensing boards and lamented
2 that there were some cases that have taken up to ten years
3 to solve. What have the new people in the Casey Administra-
4 tion done across the board to rectify this problem?
5 A The Casey Administration has been very
6 supportive by enabling us to get the additional funding
7 for positions and hiring people to fill the need that has
8 existed, in my opinion, long before I arrived on the scene.
9 When I came on board in September of '86, the Prosecution
10 Office was authorized 14 attorneys. We had 12 at the time.
11 We are now authorized 19 and we are staffed with 19
12 attorneys effective the 1st of July assuming that the
13 budget passes. That will go to 21 attorneys. So that
14 is a virtual 50 percent increase in prosecuting attorneys
15 just in my office. Likewise there have been additional
16 staffing increases in areas of board counsel, law
17 enforcement, administrative staff for the board. I can't
18 speak to numbers for other areas, but I know additional
19 staffing has resulted in additional case disposition within
20 my own area. As a matter of fact, rather substantially.
21 February of this year, which is a short month, we
22 disposed of more cases than ever has been disposed of
23 in the past four and a half years which is the amount of
24 time that we track them.
25 Q In a single month?

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1 A In a single month, yes. Additionally, we
2 are simply not throwing cases out as quickly as we can.
3 The number of disciplinary actions have increased. The
4 number of automatic suspensions have increased. The
5 number of emergency temporary suspensions have increased.
6 So with the additional people we are able to take a more
7 aggressive stand, posture against the erring practitioner.
8 Q I have another question and then I will come
9 back with a couple more later on after some of the members
10 ask. How is it possible for Dr. Perper and a group of
11 others, and I want to ask you this question, a group of
12 doctors, say, ten, twelve doctors or real estate agents
13 or barbers or anybody else, how can people really be
14 as effective, as aggressive, as objective with their peers
15 on these boards? How can they be objective? Especially
16 doctors, that's what we're talking about today primarily.
17 A I can only answer that from that my direct
18 experience and it may perhaps be contingent on the
19 individuals involved with different boards. But my
20 experience has been the individuals here are very concerned
21 about, and this applies to all the boards, not just
22 physicians, about the quality and level of competence,
23 etc., of practitioners who are serving the citizens of
24 this Commonwealth. They take that role very seriously.
25 They certainly seem aware of the appropriate standards to

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1 be applied and are not hesitant to apply them. I don't see
2 that it is a question of one group judging its own and
3 therefore being somehow suspect. I think at times perhaps
4 the reverse may be true. I think that may be evident in
5 the fact that when these type of cases that I spoke about
6 earlier arise, there doesn't seem to be any mollycoddling
7 of the respondent. The answer is, hey, you are revoked.
8 We won't tolerate this kind of conduct. So my answer
9 would have to be based on what I have seen, they do a
10 very good job because they take their role very seriously.

11 CHAIRMAN DEWEESE: Doctor, do you have
12 something to say and then we will go on to Mr. McHale?

13 DR. PERPER: Thank you, Mr. Chairman. I
14 would first like to correct the misconception that I speak
15 for the State Board of Medicine because I am not familiar
16 with the other boards. It is composed only of physicians
17 or peers. Only half of the board are physicians. The
18 others are members of the general public.

19 I believe, however, that one of the very
20 difficult problem exists and I believe that you, Mr.
21 Chairman, are really touching on this particular problem.
22 The problem is not that they have a problem in judging
23 their peers, but the boards have a very serious problem
24 in applying legal concepts to the various offenses. The
25 Board of Medicine has hearing examiners. And basically the

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1 hearing examiner conducts something which is very close to
2 a formal hearing with testimony taken, recorded, with the
3 general rules of law applied and so on. Now, once the
4 hearing examiner makes a decision, the appeal court for
5 the decision of the hearing examiner in a way is the
6 board itself. The members of the board sit practically
7 and appeal or they have to approve the decision of the
8 hearing examiner. They have to go through a considerable
9 amount of stacks, I receive them myself, large, thick
10 stacks of thousands of pages and they have to pass
11 basically what is legal judgment on reviewing the record,
12 on the reliability of the evidence, the credibility of
13 the evidence and so on. In my opinion, I do not believe
14 that the vast majority of the board, I would venture this
15 applies to other boards with the exception of the boards
16 of the legal board, really have the capability of making
17 this kind of determination. And therefore, it seems to
18 me that in those cases are probably much more effective
19 and fair and probably both to the prosecution and to the
20 defense would be to have some kind of administrative
21 process of flow in which a determination whether to take
22 a license away or not should be decided obviously with
23 standards of proof as was mentioned before are lower than
24 beyond a reasonable proof in a criminal case. Thank you,
25 Mr. Chairman.

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1 CHAIRMAN DEWEESE: Thank you. Mr. McHale.
2 REPRESENTATIVE McHALE: Thank you, Mr. Chairman.
3 BY REPRESENTATIVE McHALE: (To Dr. Perper)
4 Q Dr. Perper, how many licensed physicians are
5 there in Pennsylvania?
6 A I am afraid I cannot answer the question --
7 about 40,000.
8 Q About 40,000?
9 A That is correct.
10 BY REPRESENTATIVE McHALE: (To Mr. Barrett)
11 Q Mr. Barrett, how many medical licenses were
12 revoked by the bureau last year?
13 A To be honest with you, I looked at those
14 figures recently and I don't recall.
15 Q Could you estimate?
16 A I can assure you that it was less than 20.
17 It may be in the area of eight to ten. I am not sure.
18 I can give you an exact figure fairly quickly.
19 Q I ask those questions for an obvious reason.
20 We have 40,000 physicians in the state. The administrative
21 agency, which has a responsibility for guaranteeing the
22 ethical conduct and professional conduct of those physicians,
23 last year revoked approximately ten licenses.
24 A That is correct. Although one other thing I
25 would like to point out, the question is how many licenses

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1 were revoked. That is not the only measure of disciplinary
2 action that can be imposed.
3 Q I understand.
4 A Although I have to say in all fairness that
5 when you compare the number of disciplinary actions taken
6 in toto, be it from a reprimand to revocation and anything
7 in between, compare that number to the 40,000 population,
8 the number is still, admittedly, very small.
9 Q Why is that?
10 A For several reasons, one, I think the foremost
11 reason is the very nature of the way we do business in
12 terms of finding out about the erring practitioner. We
13 are reliant, on the most part, for some kind of consumer
14 or patient complaint to be lodged with the bureau.
15 Q If I may interrupt at this point. How many
16 complaints do you get per year?
17 A Well, that number is increasing substantially
18 as the awareness of the public of our bureau goes up.
19 Q How many last year?
20 A Last year there were nearly 2800. That is
21 an increase from the year before of over 1900. At the
22 present time we have received over 700 and some complaints
23 for this year.
24 CHAIRMAN DEWEESE: Is that just for the medical?
25 MR. BARRETT: No, I'm sorry, I am speaking for

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1 the entire bureau.

2 BY REPRESENTATIVE McHALE: (To Mr. Barrett)

3 Q How many for licensed physicians?

4 A Again, I would have to go back and check to

5 give you an exact figure as to how many were received

6 last year. I know there was --

7 Q More than a thousand?

8 A Oh, no. I would say more than 200. I know

9 there are presently something in the area of 450 case

10 files dealing with physcians presently in the bureau.

11 Q Again, not to be unfair, I will certainly

12 afford you every opportunity to discuss the broader

13 picture if you think that is helpful. 40,000 licensed

14 physicians, a current caseload of about 450 files and

15 you revoke ten licenses per year. Let me tell you, and

16 I don't mean to cut you off and I will afford you a full

17 opportunity to respond in a moment. I am asking those

18 questions and contrasting those numbers because I've got

19 to tell you that I have received many, many complaints

20 concerning the effectiveness and responsiveness of the

21 bureau. We heard some, at least tangential complaint

22 this morning, regarding one case that has now dragged on

23 for apparently three years. Last week, when we had

24 hearings on tort reform we heard similar complaints

25 indicating that we, as a Commonwealth, are not effectively

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1 investigating and prosecuting allegations against misconduct,
2 particularly against physicians. If those complaints are
3 not warranted, I would like an explanation. If they are
4 warranted, I would like to know what we can do to correct
5 the problem?

6 A I think those complaints are warranted to a
7 certain extent. I think part of the problem exists,
8 as I was saying, in the fact that we are limited, I
9 almost want to say hamstrung in our extent -- in the extent
10 of our ability to ferret out the erring practitioner.
11 Relying primarily on individuals complaining and the
12 subject matter here today may be the most extreme situation.
13 But I have seen studies that indicate as many, psychiatrists
14 indicate as many as 40 to 60 percent of their patients
15 indicate some form of illicit contact or inappropriate
16 contact between them and a previous therapist. Yet they
17 are not coming forward to us. And quite honestly, to go
18 out and somehow dig that up on our own, if I knew a way
19 to do it, I would do it. If someone else could suggest
20 a good way to me, I would be glad to pursue that. This is
21 part of it though.

22 Part of the responsiveness problem is a result
23 of many things I think have existed in the past that have
24 been corrected or are in the process of being corrected,
25 but we are still dealing with the problems of the past.

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1 If I could have chucked every case that was on my books the
2 day I walked in the door, I could assure people that
3 anything coming into our bureau presently would be finally
4 resolved within six months. But unfortunately I still
5 have something in the area of, I would say, nearly 1800
6 cases that exist from 1986, '85, '84 primarily that we are
7 still trying to deal with. Part of the problem is we want
8 to deal with those cases appropriately. We don't want to
9 say, well, it is an '84 case, forget it. If someone has
10 done something wrong, we want to ensure that appropriate
11 action is taken. But that still requires some time to do it.
12 I think we are getting better. I think the amount of time
13 it takes to dispose a case is going down. Unfortunately,
14 I am not in a position to realistically say that that is
15 going to be fixed tomorrow, but I think it will be fixed
16 soon. My definition of soon is probably a year to 18
17 months.
18 Q Mr. Barrett, I want to emphasize the pointedness
19 of my question is not directed towards you at all. I have
20 every reason to believe you do a very competent job in
21 the position you are in. But I have had sufficient
22 information brought to my attention regarding your bureau
23 that I have great concerns about the bureau's effectiveness.
24 How long does it take from the time a complaint is made
25 in a medical practitioner case until that complaint is

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1 finally resolved? When somebody comes to you has evidence
2 which is presented, is fully cooperative, seeks an
3 investigation in an administrative adjudication. How
4 long does that process take?
5 A Depending on what is necessary in that case.
6 Rarely do we have a case where somebody comes in and
7 presents a complaint with all the factual evidence that
8 is necessary at that point.
9 Q So you have investigators.
10 A So we have investigators.
11 Q How many do you have, sir?
12 A They don't work directly for me. It is
13 something in the area of 33, 35 throughout the four regional
14 offices in the state.
15 Q They cover what kind of cases, just medical
16 cases?
17 A No, they cover virtually every type of case.
18 Although there is a division among the investigators.
19 There are health investigators and business investigators
20 and I believe the division is, roughly, 50-50.
21 Q How many investigators do we have, as a
22 Commonwealth, who gather information on behalf of the
23 public in cases of alleged improprieties involving medical
24 practitioners?
25 A Well, I don't want to put a hard number on it

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1 because it is potentially the entire staff.

2 Q Realistically on a daily basis.

3 A Realistically I'd say about half of that. So

4 I would say 16 to 18.

5 Q Statewide?

6 A That is correct.

7 Q You indicated an attorney staff of, I think,

8 potentially 21 with the new funding, is that correct?

9 A That is correct.

10 Q Are they full-time lawyers for you?

11 A Yes.

12 Q Do you have any part-time attorneys?

13 A No, I don't.

14 Q I don't mean to take up anymore time. We are

15 a little bit behind schedule, but your appearance today

16 dovetailed not only with the bills under consideration this

17 day but also the comments that were made to us a week to

18 a week and a half ago on tort reform and I have got to

19 tell you there is considerable dissatisfaction with the

20 responsiveness and the effectiveness of the bureau. I

21 bring that to your attention without any personal criticism

22 meant towards you as an individual. But simply to give

23 you heads up that perhaps there is some administrative

24 tightening that has to be done. Perhaps there are some

25 additional resources that we have to provide to you. But

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1 for whatever reason, I think the numbers with which you
2 started your testimony, at least in response to my
3 questions, raise some very serious matters. When we
4 simply talk about the number of physicians, the number of
5 complaints and the number of annual revocations, I think
6 those numbers carry a message that is extremely important.
7 And I want to bring it to your attention today that at
8 least one member of this Committee, I think frankly all
9 members of this Committee, have heard considerable
10 testimony that a consumer's complaint brought to your
11 bureau is not handled efficiently and effectively.
12 A If I may, I just want to say this. I
13 certainly don't take your comments personally because in
14 fact I share these very same concerns. I think that there
15 is a lot that has been done in the last 18 months, and
16 particularly in the last year, to improve the efficiency
17 there. I am not misguided enough to say that we are
18 perfectly set and there is nothing more that can be done.
19 As a matter of fact, there are numerous things that I can
20 think of that I would like to have done. Some of which
21 are coming and some of which we are still fighting for.
22 But I do share your concerns. I think exactly.
23 REPRESENTATIVE McHALE: Thank you. Thank you,
24 Mr. Chairman.
25 CHAIRMAN DEWEESE: Mr. Caltagirone, Mr.

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1 Lashinger and then Mr. Bortner.

2 REPRESENTATIVE CALTAGIRONE: Thank you, Mr.

3 Chairman.

4 BY REPRESENTATIVE CALTAGIRONE: (To Mr. Barrett)

5 Q First of all, what is your total budget that

6 you operate under for the bureau?

7 A To be quite honest, I cannot answer that

8 question. I don't have anything to do with that other

9 than minor input from --

10 CHAIRMAN DEWEESE: Possibly Mr. Alcorn could

11 get back with us. Are you talking about the Board of

12 Medicine or the --

13 REPRESENTATIVE CALTAGIRONE: No, the entire

14 operation.

15 CHAIRMAN DEWEESE: The Bureau of Professional

16 and Occupational Affairs.

17 MR. ALCORN: Unfortunately, I don't have those

18 numbers.

19 CHAIRMAN DEWEESE: Could you get that for the

20 Committee if you would please?

21 MR. ALCORN: Yes.

22 BY REPRESENTATIVE CALTAGIRONE: (To Mr. Barrett)

23 Q Also, the percentage of increase that you

24 requested in this year's allocation, I'm curious. Because

25 I think, as you pointed out and quite rightly so, that if

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1 you are lacking the proper resources to do the job, that
2 we are getting hit upon. We are in the front line. We
3 are right there in the trenches dealing with the public
4 every day in our district offices. What happens is when
5 those kinds of complaints come into our offices, we are
6 not getting an adequate or reasonable type of response in
7 the time that I think we have to look at that. We are in
8 the budgetary process right now. If in fact you need
9 additional resources, then I think it is incumbent upon
10 us to try to provide those type of resources to you in
11 the areas that you are working in. Let's look at the
12 process, the complaints. Is there a standardized complaint
13 form?
14 A Yes, there is.
15 Q Where are they?
16 A They are kept in the bureau. We have the
17 complaint's office which operates a toll-free number
18 so that anyone can contact them and the complaint form is
19 sent out.
20 Q Are they accessible to the legislators so that
21 we can have them in our district offices or do you only
22 mail them as they are requested to a certain person who
23 makes a formal complaint?
24 A No. In fact, if anyone wants them, we will
25 be glad to supply them. Because we do not necessitate in

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1 a particular form in order to instigate a complaint. If
2 we get a letter from someone who makes a complaint, we
3 will pursue that without the appropriate SPOA form,
4 whatever it is. But anything that will make our bureau
5 more accessible to the public, I am certainly in favor of
6 it. If that is disseminating forms to other places, we
7 will be glad to do that.
8 Q I have been here only 12 years and I don't
9 recall in the 12 years in the three administrations ever
10 receiving any type of a form from the bureau on any type
11 of complaint. I would appreciate it personally. I am
12 Representative Caltagirone from Berks. I would like to have
13 some complaint forms so I could keep them in the district
14 office. You got to make the public aware what their rights
15 are. And that if the professionals out there are
16 mistreating them, I think we should provide that as easily
17 as possible to them. So that they can in fact present
18 complaints. Talking about complaints, what percentage,
19 you have been in 18 months now.
20 A That is correct.
21 Q Are the frivolous type would you say?
22 A That varies with the individual boards.
23 Historically, something in the area of about 85 percent
24 of the complaints in the past have been dismissed without
25 disciplinary action. Now that doesn't necessarily mean

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1 they are frivolous. It may mean that. It may mean we
2 simply are not able to obtain the evidence that we would
3 need to prosecute even though something serious is alleged.
4 I also suspect that that total figure is dropping, but
5 not substantially. Again, it depends on the board. I
6 would suggest with the Medical Board, the number of
7 serious complaints is substantially higher. With the
8 Real Estate Commission, for example, and I don't mean to
9 impugn realtors, but real estate transactions just seem
10 to generate heartburn. The number of frivolous complaints
11 is substantially higher. So it tends to vary.
12 Q How about due process, thumbnail sketch,
13 both for a complainant and for a defendant? What really
14 happens? How are they notified? What are the time
15 restraints in notification and the process as you go
16 through?
17 A I am glad you asked that because we have just
18 undertaken a change that will, hopefully, both expedite
19 the proceedings to a certain extent and allow us to deal
20 with more cases, disciplinary cases, than we have in the
21 past. In the past, the process takes about five steps.
22 The complaint's office reviews it to ensure it is something
23 that we should even be dealing with in the first place.
24 They then either direct the law enforcement personnel to
25 conduct the investigation or if they can obtain the

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1 information more expeditiously themselves, they pursue that.
2 Once the file is, hopefully, complete, it goes to the
3 prosecuting attorney for review to determine is there a
4 violation of the law alleged here and should we prosecute.
5 That is taken to the board who then reviews that in a
6 semi-probable cause determination and issue the marching
7 orders to prosecute or don't prosecute. If the determination
8 is made to prosecute an individual, we prepare an order
9 to show cause which is served on the individual and he or
10 she has 30 days to respond to that. They can respond in
11 writing simply giving their answers to the allegations.
12 They can request a formal hearing.
13 In the past, our practice was a little different
14 in that area. We sent out what we called an administrative
15 complaint in order to show cause and set a hearing for
16 every case. A substantial number of our cases throughout
17 the bureau involved individuals who never showed up. Yet
18 we nonetheless went ahead and had a full hearing and
19 waited for a transcript, etc., to take action. In my
20 opinion that is ludicrous. We are not going to do that
21 anymore. I want to make it clear, we are not going to
22 deny anyone an opportunity for a hearing. But if someone
23 has no interest in maintaining their license, they make
24 that statement very clear and we can proceed at that point.
25 But they have 30 days to answer that. If they want a

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1 hearing, we will schedule one. After the hearing is held,
2 my folks are really out of it at that point. The
3 adjudication order is prepared and served on the individual.
4 At that point any disciplinary action becomes effective.
5 Then, of course, the individual has the right to appeal.
6 First they can ask the board to reconsider the action
7 and then they have the right to appeal to Commonwealth
8 Court.
9 REPRESENTATIVE CALTAGIRONE: Thank you. Thank
10 you, Mr. Chairman.
11 CHAIRMAN DEWEESE: Yes, sir. Mr. Lashinger.
12 We do need to move along if we can.
13 BY REPRESENTATIVE LASHINGER:
14 Q I do have a number of questions. So I will
15 ask you to be brief also. Who is the trier of facts,
16 the administrative law judge in all these cases?
17 A No, that varies by board. The three boards,
18 the Medical, the Osteopathic and Podiatry Boards have
19 statutory authority for hearing examiners. Only the
20 Medical Board avails themselves of that. Those medical
21 examiners are attorneys who have a loose contractual
22 relationship with the bureau.
23 Q With the bureau or with the individual board?
24 A It's probably a question of semantics. It is
25 with the board.

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1 Q Does the Medical Licensure Board pick its
2 triers, its ALJs?
3 A I am not really sure. The ones that we have,
4 we have had apparently ever since the legislation was
5 passed. I am not sure who picked them or how, but we
6 have maintained the same list for many years.
7 Q Do they prepare an adjudication and order?
8 A Yes, they do.
9 Q And then it is presented to the board?
10 A Well the Medical Board, that adjudication and
11 order is a final order unless the individual appeals it
12 to the board. If the hearing examiners act for other
13 cases as they do from time to time, it is then a proposed
14 order which is presented to the board for its approval
15 or modification.
16 Q So delays in the preparation of adjudication
17 and final orders are really the blame of some ALJs who
18 might be delayed in --
19 A In some cases, that is true.
20 Q What about a specific case that I believe you
21 handled the prosecution personally in Montgomery County?
22 There is an already visible case in Montgomery County
23 where testimony has been closed for a substantial period
24 of time. We are still waiting for a board decision.
25 A I didn't do that one. If I am thinking about

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1 the correct case, let me just ask to make sure I am not
2 speaking of the wrong one, the case of all the neuro-
3 surgeons and patients?
4 Q Sure.
5 A Yes. The adjudication and order was prepared
6 and was issued. It was appealed by both the physician
7 and my staff. He wanted something better and we wanted
8 something worse. The Medical Board is now in the process
9 of determining that.
10 Q That is what I am getting to. That is why
11 I asked the question about that board. Why doesn't the
12 board, does the board wait for its routine monthly meeting
13 to make a decision on that appeal or is there a procedure
14 for emergency meetings of the full board to pass on what
15 is, obviously in this case, a most sensitive problem.
16 MR. ALCORN: Normally the board waits for
17 their monthly meeting to take action of this nature.
18 Although they could, they do have the power to call a
19 special meeting. One time they could do that by a telephone
20 conference. With the Medical Practice Act of 1985 they
21 no longer have that ability due to an amendment that
22 requires that they physically be present. Part of the
23 problem, and I am really not at liberty to speak at all
24 to this case because the case is currently on appeal,
25 cases of this nature are of tremendous magnitude. Not

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1 something easily decided upon, reviewed and decided in
2 a short period of time.
3 BY REPRESENTATIVE LASHINGER: (To Mr. Alcorn)
4 Q Is that why the recommendation from Dr. Perper
5 that the avenue for appeal be elsewhere than the board?
6 A I don't want to speak for Dr. Perper. He
7 will speak to that.
8 DR. PERPER: I just want to make sure that
9 this is my personal view. This is not a view which I
10 express on behalf of the board or on behalf of the bureau.
11 I really don't have a great deal of experience but I am
12 a few months on the board and I can see this problem.
13 I don't see how the layman in the law can deal with this
14 tremendous amount of legal material and really pass
15 an informed judgment. I don't think they have the time
16 and the expertise to do it fairly.
17 BY REPRESENTATIVE LASHINGER: (To Mr. Alcorn)
18 Q In this specific case, I don't want to
19 prejudice -- let's not talk about that specific case.
20 But where there is great controversy over whether a person
21 should continue to practice, given the level of charges
22 against the practitioner, I think it requires more than
23 a normal monthly meeting of the board. It requires the
24 immediate attention of the Licensure Board and deliberations
25 on a full-time basis to arrive at a decision. I understand

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1 these people are volunteers and aren't reimbursed for
2 anything but their expenses. But you've got people in the
3 community who continue to be treated, in some cases,
4 by these practitioners and a decision has to be made
5 one way or the other. I'm not suggesting that it probably
6 won't be made, but I think it requires more immediate
7 attention.

8 A My answer to that would be the decision was
9 made by the hearing examiner. That decision was issued
10 and does get issued. Following that, if it is in fact
11 a revocation or a suspension, in order to -- that board
12 sanction becomes effective. And that is stayed either
13 by the board or the Commonwealth Court. So there is a
14 determination early on, while pending appeal before the
15 board, whether that practitioner should continue to
16 practice if in fact the sanction was to take him out of
17 practice. That is a concern that does get covered early.
18 Mr. Barrett.

19 MR. BARRETT: Just briefly, I would like to
20 point out, one of the additional things in our budget
21 request for next fiscal year is the creation of two full-
22 time hearing examiner positions for the bureau which I
23 believe are absolutely necessary to allow for the expeditious
24 prosecution of these cases. Because although I do think
25 the boards are doing a wonderful job, but as you pointed

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1 out, they are only here once a month or less frequently.
2 And the ability to have someone here full time on our
3 staff, whose schedule we are not working around, will
4 help us at least to do the initial trial level hearing a
5 lot faster. It would take some type of legislative change
6 to impact on the appellate type hearings that you are
7 addressing in this particular case.
8 BY REPRESENTATIVE LASHINGER: (To Mr. Barrett)
9 Q What is the procedure of temporary suspension
10 of a license pending hearing?
11 A Assuming that an individual's conduct rises
12 to the clear and immediate danger standard, a petition is
13 prepared by the prosecuting attorney, presented to the
14 board and they issue an order suspending immediately the
15 individual's license.
16 Q You gave Representative McHale statistics
17 on how many prosecutions, how many revocations. About
18 how many temporary suspensions pending hearing in the
19 last year for the Medical Licensure Board?
20 A Three or four. The only cases we have had
21 in the last year, three. We have had one dentist, three
22 physicians, two psychologists.
23 Q All I -- again, it is not being directed at
24 you. That figure is equally alarming as the other figure
25 on the temporary suspensions. You know, when you are

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1 balancing, I know it is a difficult balance. But my
2 suspicions would be that people, especially those people
3 who receive care, would rather the balance be in the other
4 direction.
5 A I agree with that and that is the posture
6 that we are attempting to take. We are taking a more
7 assertive view. As to that standard, we have one case that
8 I am aware of where we have attempted to obtain such and the
9 board determined that what we alleged didn't constitue a clear and
10 immediate danger. I agree that six or seven cases is a
11 very small figure. It is probably two or three times the
12 number from the previous year. It is a step in the right
13 direction. We have a long way to go.
14 REPRESENTATIVE McHALE: Mr. Chairman, Mr.
15 Lashinger indicated to me he would yield to me for one
16 question.
17 CHAIRMAN DEWEESE: You are recognized.
18 REPRESENTATIVE McHALE: Thank you, Mr. Chairman.
19 BY REPRESENTATIVE McHALE: (To Mr. Barrett)
20 Q Mr. Barrett, in talking about the temporary
21 emergency suspension and the clear and immediate danger
22 and the standard that is applied to invoke that provision,
23 isn't it in fact true that even if you have a death case
24 where the physician negligently kills someone, if it appears
25 that that medical malpractice was aberrational conduct on

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1 his part, never killed anyone before but he committed
2 in this case, in a case, a serious misjudgment that
3 resulted in death, you probably will not be able to
4 suspend his license on an emergency basis. Thereby
5 resulting in a situation that a physician, who negligently
6 or even perhaps through gross negligence kills someone,
7 may remain in practice for another two or three years
8 while the investigation continues.
9 A That is correct.
10 Q I think that is a serious flaw in our system.
11 A physician who has killed someone should not be allowed
12 to continue in practice simply because he did not habitually
13 kill people. I think where you have a situation involving
14 a death where serious misjudgment can easily be shown in
15 that case, that ought to be a prime example where a
16 temporary emergency suspension should be able to be invoked
17 under the law.
18 A I can't argue with you on that. That clear
19 and immediate standard is a high threhold for us to meet.
20 I am aware that other states, and of course, the very name
21 emergency temporary suspension implies something serious.
22 But other states do have provisions for temporary
23 suspension with a lesser standard pending formal
24 disciplinary action. If that could be worked out, I
25 wouldn't be adverse to that. But until then I am stuck

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1 with what we live with.

2 REPRESENTATIVE McHALE: Let me say, and I

3 will close in about five seconds, I recognize how important

4 a medical license is to a physician and I don't want to

5 see that physician deprived of his or her license without

6 due process of law. But conversely, because of the

7 length of time involved in the administrative process,

8 particularly when you are talking about a death case,

9 I do not want an incompetent physician to continue to

10 practice for two or three years simply because it takes

11 that long to administratively adjudicate the matter. And

12 it is my understanding that that in fact is happening today.

13 CHAIRMAN DEWEESE: Quickly, gentlemen.

14 MR. ALCORN: I just wanted to add, the

15 emergency temporary suspension is/an extraordinary order

16 in fact. It does occur, the suspension does occur

17 absent any hearing, any notice. And for that reason I

18 suppose the board looks at these cases carefully. And

19 if the physician is in fact incompetent, the board has

20 those facts, they are going to issue that emergency

21 suspension because then I think the physician is an

22 immediate and clear danger.

23 REPRESENTATIVE McHALE: I suggest you review

24 your caseload. Perhaps there ought to be something in

25 between temporary emergency ex parte suspension and the

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ultimate, normal administrative process where there is notice, there is a hearing but it is on an expedited basis so it doesn't take two or three years to determine whether or not there ought to be a temporary suspension. We have the extremes covered here. But it seems to me that we don't have a proper process to deal with a case where the facts may not be totally clear, where because of the seriousness of the allegation, there ought to be an expedited procedure for reviewing the evidence. We don't have that kind of procedure. As a result of that physicians who have killed people have been able to remain in practice for two or three years after that original act of malpractice and I am concerned about that. Thank you, Mr. Chairman.

CHAIRMAN DEWEESE: You are very welcome. Mr. Lashinger, and then we will go to the next set of witnesses.

BY REPRESENTATIVE LASHINGER: (To Mr. Barrett)

Q On that same note, if you have got a case of sexual conduct between a doctor and a patient, per se ethical violation, Dr. Perper would agree with that, does that rise to a clear and present danger standard?

A In my opinion it does, but there is one problem we often face. That is my opinion. That is not necessarily the board's opinion. Based on the fact that

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1 one incident, which may be all that we have initially,
2 indicate one thing wrong done by the practitioner. In
3 my opinion, too, is at least a good indication of the
4 course of conduct, and if we can show a course of conduct,
5 I think the board is not going to have any problem with
6 imposing an emergency temporary suspension. So what has
7 been our practice in the past is to, if we get a single
8 complaint of sexual misconduct by an individual and we
9 have a screening process to identify these potential
10 emergency cases, hopefully as quickly as possible, and
11 expedite the investigation. We look for enough information
12 to indicate a course of conduct so that we can impose that
13 emergency order. If not, if we have occasion where we have
14 only once complaintant, and we are afraid that it won't
15 reach the level for the board to grant the emergency order,
16 we will still expedite that hearing as much as we can
17 within the typical administrative process.
18 Q I don't mean to be rhetorical. I think the
19 answer was no if it doesn't rise to the level here in
20 Pennsylvania unless there is a course of conduct. But
21 if you can establish a course of conduct. I would echo
22 Representative McHale. We were here at hearings talking
23 of sexual abuse, the doctor-patient relationship, I
24 think it would be, I don't want to say the opinion of the
25 Committee, surely it is my opinion that that rises if it

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1 is a per se ethical violation. Then I would say that that
2 doctor presents a clear and present danger as evidenced
3 by the fact that he or she conducted themselves in that way.
4 I am surprised to hear that.
5 One other real quick question. Why don't
6 the investigators work for the prosecutor? Wouldn't that
7 make sense that the investigators work with you? Wouldn't
8 that help expedite matters? Wouldn't you have a better
9 handle on your prosecutions that way?
10 A Yes.
11 Q Who do they work for? Who do the investigators
12 work for, the respective boards?
13 A No, they work for the bureau as a whole. But
14 they are a separate division. Their chief reports to
15 someone who I guess is, roughly, my counterpart on the
16 administrative half. And I don't want to imply there is
17 a bad relationship between my office and the investigators
18 that existed in the past. It has gotten a lot better.
19 It could be better still.
20 REPRESENTATIVE LASHINGER: Thank you, Mr.
21 Chairman.
22 BY CHAIRMAN DEWEESE:
23 Q In other words, the Committee would probably
24 benefit by having a dialogue with Jim Haggerty some time
25 in the future about a different schematic over at your shop

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1 and have the investigators at least possibly or potentially
2 work for you rather than the individual boards? Would that
3 be worth our while to discuss that? That would probably
4 be under a different committee's purview. We could
5 suggest that to some of our colleagues?
6 A Probably. There is another change that is
7 hopefully going to happen imminently that may be a halfway
8 step but will achieve the same thing. The complaint's office
9 that I referred to earlier, one of the functions of the
10 individuals down there is to direct law enforcement
11 investigative efforts. Up to now that complaint's unit
12 was part of the law enforcement division and responsible
13 to the chief of the law enforcement. In the near future
14 that office's functions are going to shift to my
15 responsibility. So my people will be directing law
16 enforcement efforts in investigations. Although the
17 investigators won't work directly for me or my staff.
18 Q Two real quick ones. Why aren't the DAs,
19 most of the cases you are getting are not coming from the
20 DAs. Where are the DAs?
21 A I would like to know. I know the Commissioner
22 intends to send a letter out this week to all district
23 attorneys to kind of nudge them.
24 Q I would like for the Commissioner to make it
25 known that the Judiciary Chairman at least and some other

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1 members of the Committee were quite vexed at their lack
2 of participation in this arena. And also simultaneously
3 disconcerted by the fact that they are not more aggressively
4 involved. I would like, naturally I cannot write the
5 letter, but I would stress that you share that with some
6 of your contacts within the DA's Association since they
7 weren't polite enough to return our calls and come here
8 and visit with us today.
9 A I will be very happy to do that.
10 Q The final thing, folks say you support this
11 legislative initiative. Respectfully, why hasn't someone
12 from your eschelon come forward in the past? Not
13 necessarily you gentlemen at the table, but for the past
14 three years, four years, five years, eight years. If this
15 problem is as piquant and keen as it seems to be, why
16 haven't people from the Bureau of Professional and
17 Occupational Affairs come forward and help draft some
18 legislation? I am just curious.
19 DR. PERPER: I think it is almost impossible,
20 I think as it is for me to ask why someone else didn't
21 make a certain decision.
22 CHAIRMAN DEWEESE: Okay, you are right.
23 DR. PERPER: But I believe that there is a
24 certain, certainly a great deal of credit to the public
25 organization which bring those problems before us and they

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1 nudge us to do something in matters which deserve action
2 and I think this is one of the things that happen in this
3 particular case. That is the way which our system works.
4 CHAIRMAN DEWEESE: Gentlemen, thank you very
5 much for being with us this morning.
6 MR. BARRETT: Thank you.
7 DR. PERPER: Thank you.
8 CHAIRMAN DEWEESE: Sam Knapp, Doctor of
9 Education and representing Pennsylvania Psychological
10 Association. I don't know whether it was Jimmy Carter or
11 someone said life is not fair. Life is not fair. You
12 have been very polite, you have waited, you have gotten
13 bumped up, bumped down and now I'm going to ask you to
14 summarize and keep it comparatively brief.
15 DR. KNAPP: I anticipated that.
16 CHAIRMAN DEWEESE: Well you don't have to.
17 I mean, I'll stick around for a while. My assistant is
18 coming back. He is going to help. I do have, for the
19 audience and for the record, I have a commitment to speak
20 at a Rape Crisis Center in Indiana County tonight. So
21 I am not going to be here all that much longer. But the
22 hearing can go on at its normal pace. I don't want to
23 rush this thing. Mr. Kosinski, Subcommittee Chairman,
24 will be back down here in a little bit to take over.
25 But please feel welcome and thank you very much

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1 for enduring a comparatively long morning.

2 DR. KNAPP: Thank you. My name is Dr. Samuel

3 Knapp and I represent the Pennsylvania Psychological

4 Association, which is a professional society, representing

5 over 2,000 psychologists in Pennsylvania. And I welcome

6 the opportunity to comment on these bills and I commend

7 the coalition, the Committee Against Abuse by Professionals

8 for bringing public attention to this problem. I also

9 commend the courage of the victims who have testified this

10 morning. I hope that the testimony presented today will

11 further the legislative and non-legislative remedies to

12 this problem.

13 I am going to abbreviate certain portions of

14 the written testimony that you have before you. This has

15 been stated by other speakers. Certainly there is a

16 problem. This has been verified by surveys done with

17 psychologists and with psychiatrists. To my knowledge

18 other mental health professionals such as social work,

19 nursing, professional counselors and so on that have

20 not been surveyed to their members, certainly it is a

21 problem with them, but the extent of the problem is unknown.

22 Also, sexual activity with psychotherapy patients is

23 not limited to psychotherapy patients but occurs with

24 other medical patients as well. This has been documented

25 by other speakers this morning. Of course, pointing the

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1 finger at other professionals is no excuse to minimize
2 the shortcomings of psychologists.
3 Certainly the sexual contact with psycho-
4 therapists is harmful and this is a conclusion which has
5 been reached by surveys of patients who were under treatment
6 and have had sex with the psychotherapists, an analysis
7 of published accounts, volunteers in research study and
8 certainly by some of the witnesses this morning.
9 The overall conclusion is clear. Sexual
10 contact harms most patients. In addition to the harm of
11 the patients, sexual contact harms the public image of
12 psychotherapists in general. It probably deters some
13 people from seeking the treatment that they need. Patients
14 receiving psychotherapy may become distrustful of their
15 psychotherapists and misinterpret innocent signs of support
16 as sexual advances. And persons contemplating receiving
17 psychotherapy may be deterred by rumors of sexual
18 exploitation.
19 Currently, the exploited patient may seek
20 redress through ethics committees, licensing boards, or
21 malpractice suits. Each of these avenues has unique powers
22 and procedures.
23 Ethics committees without legal power can only
24 reprimand offenders or drop them from their membership
25 rolls.

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1 Licensing boards appear to be a stronger avenue.
2 The Pennsylvania State Board of Psychology can suspend or
3 revoke the licenses of an offending psychologist. A survey
4 of disciplinary actions in Ohio found that one-half of the
5 complaints resulted in some kind of disciplinary action,
6 reprimands, temporary suspensions, supervision of practice
7 or revocation of licenses.
8 Pennsylvania's recently enacted Professional
9 Psychologists Practice Act also has special provisions for
10 psychologists who are impaired by mental disorders or
11 substance abuse. These professionals may be rehabilitated
12 and resume full practice if they agree to treatment to
13 remedy their mental disability. Although engaging in the
14 sexual exploitation of patients does not necessarily
15 indicate psychological impairment, some authorities
16 believe that impaired psychologists may account for
17 a higher than average portion of ethical violations.
18 The regulations for the implementation of this portion
19 of the law is not in place so I can give you no more
20 details about it. Perhaps in the future this may be an
21 additional avenue to address some of the problems of
22 sexual exploitation.
23 Finally, of course, injured patients have
24 redress through a malpractice suit which was commented on
25 earlier today.

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1 The two proposed bills provide criminal and
2 civil penalties against offending psychotherapists.
3 Although the Pennsylvania Psychological Association
4 supports the general concept behind these bills, it does
5 not support them as they are presently written.
6 PPA has four major concerns with those bills.
7 One of the major problems is the qualified mandated
8 reporting provision which holds that any psychotherapists
9 who, in the course of their employment, occupation or prac-
10 tice of their profession, come into contact with a patient
11 who has allegedly been sexually assaulted by a psycho-
12 therapist shall, with the consent of the patient, report
13 or cause a report to be made.
14 We are opposed to this qualified mandated
15 reporting provision because we believe it is unnecessary
16 in most situations and is potentially harmful. The most
17 common mandated reporting laws are for abused children.
18 The major rationale behind the mandated reporting laws
19 for children is that children are helpless in an abusive
20 situation. The qualified mandated reporting provision
21 in House Bill 1465 has a similar underlying assumption
22 that adults are emotionally dependent and helpless. The
23 analogy of adult patients to abused children does not
24 hold up very well, however. The shortcoming of this
25 analogy is highlighted by the requirement to report if

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1 consent of the patient is obtained. If the patient is
2 independent enough to give consent, then mandated reporting
3 is probably not required.

4 Furthermore, the qualified mandated reporting
5 does not allow for the ambivalence of many patients towards
6 making a report of sexual exploitation. The decision
7 making process should take time and be made with careful
8 deliberation with a competent psychotherapist. We would
9 not want to see a competent psychotherapist charged with
10 a failure to report when they are acting in an ethical
11 and responsible manner by giving their patient enough time
12 to make an informed and well thought-out decision.

13 Finally, House Bill 1465 reads that the report
14 should be made when the psychotherapist has reason to
15 believe, on the basis of their medical, professional or
16 other training and experience, that the patient coming
17 before them in their professional or official capacity
18 is or has been sexually assaulted by a psychotherapist.

19 There could be a problem of determining whether
20 the professional was using reasonable judgment to ascertain
21 if the patient was exploited. We would not want to see
22 psychotherapists who are using their best judgment later
23 be accused of failure to report something which they did not
24 believed actually occurred.

25 PPA's second concern deals with the definition

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1 of former patient. These bills define a former patient
2 as "a person who was given psychotherapy within two years
3 prior to sexual assault by the psychotherapist, whether
4 or not that person was charged for the service" 3129 (n).
5 The rationale appears to be that the patients could still
6 have emotional dependency upon the psychotherapists
7 for two years after termination. This does not appear
8 realistic, however. Although adult psychotherapy patients
9 may often have some dependency, it is rare that the
10 dependency would be so extreme that it would last two
11 years beyond termination.
12 Also, PPA has concerns about the ten-year
13 statute of limitations. Statute of limitation laws were
14 enacted for a purpose. That is, the difficulty in
15 presenting accurate evidence to a court increases over
16 time and the likelihood of making an accurate verdict
17 decreases over time. Statutes of limitations should
18 correspond to other judicial actions of a similar nature.
19 Finally, PPA is also concerned that the
20 legislation addresses problems only with psychotherapists
21 or counselors. Exploitation by other health-care
22 professionals does occur and is probably more frequent
23 than with psychotherapists (see study by Kardiner et al.).
24 Legislation should address this problem as well.
25 CHAIRMAN DEWEESE: Thank you. Mr. Caltagirone.

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1 REPRESENTATIVE CALTAGIRONE: No questions.
2 CHAIRMAN DEWEESE: Staff. Ms. Germanio.
3 BY MS. GERMANIO:
4 Q You say in your testimony that the mandating
5 reporting provision of House Bill 1465 has underlying
6 assumptions that adults are emotionally dependent and
7 helpless. The analogy of adult patients to abused
8 children does not hold up very well, however.
9 I think when you go to a psychologist for
10 help, you are having some kind of an emotional problem
11 be it dependency or otherwise. Could you explain what
12 you are trying to get at here?
13 A Our concern is that the decision about what
14 to do about, the crime should rest with the patient and
15 not be influenced by legislation. I was also concerned
16 about the suggestion by a previous speaker that this should
17 be strengthened. I am concerned that the patients might
18 be twice victimized, that is victimized first by the
19 offending psychotherapist and victimized by the mandated
20 reporting law which requires their private lives be
21 exposed to the public. I think this could have some
22 adverse consequences to the patient. It may deter them
23 from seeking additional treatment which they need because
24 of the fear of the mandated reporting law. Does that
25 answer your question?

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1 Q Well, it is only mandated if the patient
2 in fact gives her consent. I think a patient who is strong
3 enough to give her consent would probably be doing it for
4 the purpose of having the psychotherapist that abused her
5 brought under some kind of a disciplinary action or a criminal
6 sanction to save other prospective patients from having to
7 suffer from the same kind of turmoil all their lives.
8 So I think there may be a purpose in this reporting
9 section. We are not forcing anyone to report it. We
10 are just saying if they consent to report it, that the
11 person they report it to should follow through with that.
12 A Another concern I have with this qualified
13 mandated reporting provision is it requires reporting
14 in 15 days. I think this does not address the difficult
15 decision that people go through when they make this
16 decision. It is very common to have ambivalence. I could
17 see a lot of difficulty requiring a report be made within
18 15 days when a person has not had adequate time to think
19 through whether they want to report it or not.
20 Q I think that's a technical problem that could
21 probably be worked out quite easily.
22 BY CHAIRMAN DEWEESE:
23 Q Former patients, run that one by me one more
24 time.
25 A Well, this is a complicated area. It deals

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1 with something Dr. Perper, I think he addressed this
2 issue, too. The problem of defining emotional dependency.
3 He had substituted the phrase substantial relationship.
4 And here there is no empirical evidence to guide us. So
5 we are really in a no man's land. I have no idea how
6 a court would define emotional dependence. Certainly
7 sometimes sex with a former patient is obviously ethically
8 wrong. The extreme case would be when a psychotherapist
9 discontinues therapy with the intent of assuming a sexual
10 relationship and then starts it up immediately.
11 On the other hand, there could have been a
12 patient where brief therapy, terminated successfully by
13 mutual consent. People can meet by chance a year and a
14 half later. Under this bill it would be illegal for them
15 to start a social relationship. The majority of
16 psychotherapists believe, about 75 percent, the only survey
17 that I have on this, believe that any relationship with
18 a former patient is unethical. Twenty-five percent don't
19 agree. They see mitigating circumstances. I hate to see
20 the high penalty of a criminal charge be made when the
21 situation is ambiguous like this.
22 Q Real fast, statute of limitations. What do
23 you think it should be?
24 A I think it should be the same for comparable
25 offenses. I am not sure if it is two or five years for

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1 these crimes under the Criminal Code.

2 Q And final question, you talk if there were

3 other people involved under the umbrella, other counselors,

4 you wouldn't feel the antipathy that maybe you do now;

5 preachers, social workers. How many people would you

6 consider being put in this bill that you are more pleased

7 with?

8 A Well, it is more of an issue with health-care

9 professionals in general as documented by some of the

10 testimony this morning. There was an optometrist, a

11 general practitioner who was involved. I don't know about other

12 health professionals. Certainly exploitation does occur

13 with podiatrists, dentists, and other health professionals.

14 Q Doctor, it seems to me that possibly you are

15 not completely disparate from the thrust of this morning's

16 events?

17 A That is right.

18 Q With a couple more health-care professionals

19 put in, at least the Committee looking at some of the

20 statute of limitations language, consent of a former patient,

21 you do have significant areas of disagreement, but I

22 don't think they are overwhelming?

23 A That is right. We support the general intent

24 of the legislation. We support it with certain modifica-

25 tions.

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1 CHAIRMAN DEWEESE: Thank you very much for
2 appearing. I'm sorry, Representative Caltagirone.
3 BY REPRESENTATIVE CALTAGIRONE:
4 Q One quick area, a psychologist or psychiatrist
5 that goes to a psychologist or psychiatrist for treatment
6 because of this very problem, how is it handled? Is it
7 reported because of the confidentiality between client
8 and patient?
9 A The competent psychotherapist should provide
10 options to the patient. These are things you can do;
11 malpractice suit, ethics committee, licensing board,
12 whatever. Provide information to the patient and allow
13 the patient to decide.
14 Q Is there a high incidence of people in that
15 particular field seeking help that you have a record of?
16 A You mean the offending psychotherapist seek
17 treatment on their own?
18 Q Yes. I mean from others in their own
19 profession.
20 A I was looking at a survey this morning which
21 found 40 percent of one-time offenders did seek treatment
22 for doing that. Did seek professional help because they
23 had done that. It is much higher, people seeking treatment
24 on their own are much higher first-time offenders. Much
25 lower with repeat offenders. This goes back to the testimony

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1 of Dr. Pedigo when he was mentioning that there is some
2 offenders who do this out of personal problems. Mostly
3 first-time offenders who can be rehabilitated. Repeat
4 offenders, there is a lot who cannot be and should be
5 suspended and prohibited from ever practicing again.
6 Q Within the profession though do they in fact
7 report them?
8 A The reporting has to be done with the consent
9 of the client. I regret to say it is not done as often
10 as I would like it to be.
11 Q So there is a high incidence that is going
12 unreported?
13 A That is right.
14 REPRESENTATIVE CALTAGIRONE: Thank you, Mr.
15 Chairman.
16 CHAIRMAN DEWEESE: You are very welcome. Thank
17 you, sir. Dr. Pedigo, just in a sentence or two, you
18 don't even have to take the mike. Could you respond to
19 Mr. Caltagirone's question? Just for my own enlightenment.
20 Would you repeat the question? Could you rephrase it
21 please?
22 BY REPRESENTATIVE CALTAGIRONE:
23 Q The number of psychiatrists, psychologists
24 that are being treated by their own peers for the very
25 problems we are discussing here today, how often is it

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1 reported because of the confidentiality of the situation?
2 What is being done to ferrét out their own problems within
3 their own and are they really facing up to the problem?
4 Is it being reported and how is it being handled?
5 A For psychiatry there are answers to those
6 questions. There was recently a survey of every fifth
7 psychiatrist in the U.S. And in that survey the question
8 was asked do you know of situations in which patients
9 have told you that they have been sexually involved with
10 former therapists. And of those who answered, yes, I
11 do know of such situations, about 40 percent did. The question
12 was asked did you report this. About eight percent said,
13 yes, I reported it.
14 Q Isn't that kind of high? When you look at
15 the total professionals by licensure, licensure of the
16 state, the Commonwealth, is that high compared to other
17 professionals that treat people such as medical doctors?
18 A The only two fields that have really been
19 very well surveyed are psychiatry and psychology and the
20 statistics are about the same for both of those two.
21 Q Is that because of the intimate relationship
22 and personal diálogue that has to be established in order to perform
23 a true test as opposed to a meidical doctor who may provide some mino
24 medication and a quick examination and out you go?
25 A Some information is known there, too. When

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1 MDs are surveyed about have you had sexual contact with
2 your patients, generally, those who answer anonymous surveys,
3 generally anesthesiologists come out in the highest percent,
4 obstetricians next and psychiatrists third.
5 CHAIRMAN DEWEESE: Thank you, sir. Don McCoy,
6 Pennsylvania Psychiatric Society and Dr. John Bulette, also
7 an M.D. I did say doctor. So I don't have to say M.D.
8 of course. I want you to know I knew better. Just as
9 far as format is concerned, how do you gentlemen want to
10 do this?
11 MR. McCOY: Basically, I'm here to respond
12 to questions. I can also respond to some of Representative
13 Caltagirone's questions about the State Board of Medicine.
14 Dr. Bulette will read our prepared statement and then
15 respond to some of the clinical issues as far as the
16 problems presented.
17 CHAIRMAN DEWEESE: And that prepared statement
18 is comparatively brief I have heard.
19 DR. BULETTE: I will abbreviate it further.
20 CHAIRMAN DEWEESE: No that is, I think it is
21 sort of short.
22 DR. BULETTE: I think I can usefully do that.
23 CHAIRMAN DEWEESE: Welcome to our hearing
24 and thank you very much for your patience. Please
25 proceed.

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1 DR. BULETTE: I might just mention I am
2 substituting for Dr. Lansford, who is the Chairman of
3 the Pennsylvania Psychiatric Society, Government Relations
4 Committee. I co-chair that committee with him.
5 I am testifying on behalf of the Pennsylvania
6 Psychiatric Society, a district branch of the American
7 Psychiatric Association.
8 Sexual relationships between patients and
9 helping professionals - physicians, psychologists, teachers,
10 ministers, social workers, can never be tolerated. The
11 Principles of Medical Ethics With Annotations Especially
12 Applicable to Psychiatry specifically forbids sexual contact
13 with patients.
14 In my statement I have several quotes for that
15 which I am not going to read at this point but are certainly
16 very relevant to the intent of this legislation which we
17 certainly support.
18 The APA and PPS Ethics Committees have developed
19 specific procedures for handling ethical complaints which
20 assure prompt examination of these allegations. Member
21 psychiatrists found guilty of an ethical violation may be
22 suspended or expelled from membership and/or recommended
23 for further treatment or disciplinary action. Complaints
24 regarding non-member physicians and other professionals
25 are referred to the appropriate association or state

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1 licensing boards.

2 My purpose today is to express the concerns of

3 the Pennsylvania Psychiatric Society over the language and

4 intent of House Bills 1465 and 1466 which deal with civil

5 and criminal action against a group of treating professionals

6 identified as psychotherapists.

7 In preparation for this testimony, the Society's

8 legal counsel was asked to review current criminal and civil

9 statutes. The following comments relate to that review:

10 "We believe that criminal penalties are already

11 available in the existing Crimes Code. The sexual offenses

12 dealt with in HB 1465 include sexual assault by a

13 psychotherapist, deviate sexual intercourse by a psycho-

14 therapist and indecent assault by a psychotherapist. The

15 definition of sexual assault contained in the bill makes

16 this crime the equivalent of rape which is a crime under

17 18 Pa. C.S.A. Section 3121. The remaining offenses

18 contained in the proposed legislation are crimes under

19 18 Pa. C.S.A. Sections 3123 and 3126 respectively."

20 These provisions of the Crimes Code provide

21 penalties which are as severe, if not more severe than

22 those specified in HB 1465. "A major problem in criminal

23 prosecutions involving professionals, and the use by them

24 of their position to commit these acts, is that often the

25 patient has given assent and has participated in these acts

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1 willingly rather than as a result of fear of physical harm.
2 We suggest that the Committee focus upon this very real
3 problem and approach the solution in a manner which is
4 simple and direct, and which uses existing law to the
5 maximum extent possible."
6 "We suggest that, for criminal prosecutions,
7 an amendment be made to 18 Pa. C.S.A. Section 311(c) by
8 adding the following:
9 (5) it is induced as a result of the use by
10 the actor of superior force or duress, including force
11 or duress which is physical, moral, or psychological
12 in nature.
13 "The section of the Crimes Code which we
14 propose to amend deals with the subject of consents.
15 Subsection (c) contains a number of situations under which
16 any consent is to be considered ineffective. Our proposed
17 section would be another example of ineffective consent."
18 "This change would eliminate the defense of
19 consent in criminal cases without encountering the problems
20 with the proposed legislation which have been suggested
21 both in our testimony and that of the Pennsylvania
22 Psychological Association which you have heard this morning."
23 "With respect to civil actions which are the
24 subject of HB 1466 we believe that the problem also is one
25 of consent. In civil actions which already exist under

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common law we have an action for assault and battery. These are unpermitted touching or threat of touching which result in damage. Again, the issue is one of permission or consent. We do not believe that the common law would recognize permission or consent in the situation which is the subject of this legislation. We, therefore, do not believe that the legislation is required."

There are a number of technical problems in the legislation which I will address later. Our most immediate concern is the focus of the legislation on the practice of "psychotherapy" and the requirement that the individual must practice or purport to practice psychotherapy.

As you are aware, there have been instances reported where licensed professionals, including accountants, attorneys, dentists, nurses, etc. have been accused of sexual involvement with their patient/client and it has been determined that the involvement is the result of their professional relationship and the power or influence exerted over the patient/client by the licensed professional. The scope of such practices have never adequately or accurately been investigated. The American Psychiatric Association is one of the only professional organizations, to my knowledge and I think I would add our colleagues in psychology, to actually attempt to gain, by a survey of

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its membership, information which could help to determine the prevalence of such practice in psychiatry. The results indicated that the percentage of APA members who engage in sexual contact with patients is small, probably under seven percent. Despite the low percentage of incidence, this unethical practice standard has caused the Psychiatric Association to change its Principles of Medical Ethics to focus specifically on these practices. The APA has also attempted, through publication of the survey findings to its own members to educate psychiatrists to the problems and situations which could lead to such conduct and how to avoid it. The APA disseminated to the public information calling attention to these practices and providing assistance to the patient/former patient to seek corrective action.

I am not aware of efforts by the other professional organizations in identifying unethical sexual practices within their membership since to me this might be an opportunity to address that. The Society believes that it may be premature for the General Assembly to legislate disciplinary action against a portion of the licensed professionals who may be involved in varying degrees in such practices.

It would therefore be the recommendation of the Pennsylvania Psychiatric Society that the General Assembly request information from the associations

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representing licensed professionals who may engage in sexual relations with their patients/clients on the possible incidence of such practices and what, if any, steps have been taken by those associations to address the problem, to educate its membership and the public, and to correct the problem.

It is further recommended that at such time as the General Assembly determines to consider this legislation (HB 1465/1466) that the language of the bills be amended to include all licensed professionals and that appropriate language changes be made to refer to the individual as a client/patient. Definitions will also have to be included defining professional services beyond psychotherapy and the relationship between the client/ patient and the licensed professional beyond the therapeutic relationship.

The Society's second concern relates to the difficulties surrounding the requirements to report suspected sexual relations. The potential for misreporting or for damage caused by reporting to the patient, the patient's family, the former therapist, or the reporting party is great and cannot be minimized by the current legislative wording.

For a treating therapist to consider reporting an alleged case of sexual abuse or involvement, he/she

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1 must evaluate the truth of the situation. Obviously, some
2 question of the patient's accuracy of statement is needed
3 on the basis of the condition for which treatment is
4 sought, the impression of the patient's feelings toward
5 the previous therapist, and the success of previous therapy.
6 What may be real to the patient may be related to their
7 condition or their feelings toward the therapist.
8 The sections of the legislation requiring
9 informed consent and suggesting that the reporting be done
10 in the best interest of the patient address some of the
11 dilemma facing the therapist. These sections should be
12 strengthened so that it is possible to fully inform the
13 patient of the ramifications and the options available.
14 Those options should also include forms of redress short
15 of reporting for the purpose of civil and/or criminal action.
16 Most professional organizations, including the APA and
17 the Pennsylvania Psychiatric Society, have formal processes
18 for investigation of complaints toward members. For
19 incidents involving non-members there is also the grievance
20 process of the Commonwealth's licensing boards. Information
21 on these organizations and their procedures, both formal
22 and informal, for handling such complaints should be
23 available to the patient and the therapist.
24 The section dealing with privileged communica-
25 tions seems to contradict the sections dealing with consent

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1 and patient interest in that if the patient refused consent
2 or if reporting is determined not to be in the best interest
3 of the patient, the therapist may still be at risk if
4 claiming that the allegation is part of privileged
5 communication.
6 That section should be clarified to indicate
7 that privileged communication may only be used as
8 justification for failure to report where informed consent
9 was given or where it is obviously in the best interest
10 of the patient to report.
11 The most destructive aspect of the reporting
12 problem is the destruction of the therapeutic relationship
13 by the act of reporting. One possible situation which
14 could occur is that if the second therapist identifies
15 that a sexual relationship has occurred and discusses
16 reporting with the patient, the patient may not believe
17 the accusation and therefore, the current therapeutic
18 relationship is damaged and the patient is driven back
19 to the first therapist or to another therapist leaving the
20 matter unresolved and potential destruction.
21 The statute of limitations presents a
22 considerable problem. A ten-year limitation takes the
23 reporting requirement beyond any such requirement for any
24 other reportable condition or event. It limits the
25 opportunity for the professional to obtain verifiable

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1 readily retrievable evidence to support the claims of the
2 patient and it would have a tendency to cloud the patient's
3 perspective of the events, not to mention the circumstances
4 surrounding those events. A statute two years from the
5 date of discovery, which is more in keeping with other
6 reporting requirements would be more appropriate.
7 Finally, the length of time needed for the
8 therapeutic relationship to be developed should be
9 addressed. The proposed legislation would not permit a
10 defense on the basis of lack of establishment of a
11 therapeutic relationship or dependence.
12 Clearly, as with any relationship, it is
13 unlikely for a therapeutic relationship or dependence to
14 be developed as the result of one or two diagnostic and
15 evaluative encounters. Meaningful transference develops
16 only over a period of time. However, since the point
17 at which such a relationship does develop will be different
18 in each situation, a restriction to prevent evidence of
19 its effect as mitigating information or as part of an
20 overall defense removes one of the accused professional's
21 rights to the presumption of being innocent until proven
22 guilty and being able to mount the most effective defense.
23 Further, it shifts the burden of proof to the defendant
24 rather than the plaintiff.
25 The Society's concerns represent problems with

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1 the language of the bill and its implementation. It
2 doesn't indicate that the Society is unsympathetic with
3 the problem of inappropriate sexual relations between
4 treating professionals with their patients. We applaud
5 the efforts and courage of individuals and the Committee
6 Against Abuse by Professionals to bring this issue to
7 public focus and attention. We do feel that the current
8 legislation may hinder the existing efforts to correct
9 the problem and substitute a legal system solution for
10 what first and foremost is a moral and ethical obligation
11 of all persons who have power or authority over another.
12 On behalf of the Pennsylvania Psychiatric
13 Society, I would like to thank you for permitting the
14 Society to present testimony. The Society offers its
15 assistance to the General Assembly as you consider this
16 issue.
17 CHAIRMAN DEWEESE: Mr. McCoy, do you have
18 any comments or anything --
19 MR. McCOY: Basically to respond to some of
20 Representative Caltagirone's --
21 CHAIRMAN DEWEESE: Before we get to that,
22 anything in general?
23 MR. McCOY: No.
24 BY CHAIRMAN DEWEESE: (To Dr. Bulette)
25 Q Bottom line, I want a bill that says it is a

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1 crime for a psychotherapist to commit these acts, and
2 with all due respect in your early remarks you threw in
3 a chain of different professions and even accountants
4 as one of them. My CPA or my psychotherapist are two
5 different kinds of folks. And bottom line, if we can
6 work out some language, what's going to happen when we
7 bring up in the Committee or on the floor, you folks don't
8 think it should be a crime for a psychotherapist,
9 psychologist or psychiatrist to have sexual relations
10 under the circumstances that have been described this
11 morning.
12 A I thought we made it very clear that we do.
13 Q You do?
14 A Absolutely. I think the American Psychiatric
15 Association has been very unambiguous with that. In fact,
16 have really led certainly the national effort to clarify
17 that. There is no problem with that at all.
18 Q Do you have any reason for optimism vis-a-vis
19 the proposals before us after radical amendment?
20 A Yes, indeed. That is why we are here. We
21 would like to further the cause.
22 CHAIRMAN DEWEESE: Tom. I'm sorry, you and
23 Mr. McCoy can have brief colloquy.
24 MR. McCOY: I wish I could share some of the
25 optimism as far as the actual implementation. Unfortunately,

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1 we have suffered from some of the same frustrations that
2 you have expressed this morning about the operation of the
3 State Professional Licensing Boards. Part in terms of
4 funding, part in terms of staffing, part in terms of the
5 way they are structured.

6 As you know, we went through a major legislative
7 effort this past legislative session. The sunset of
8 the majority of the health-care licensing bills. Hopefully,
9 they have been strengthened in that sunset process.

10 I think it is also important to respond to
11 some of your specific questions as to how the State Board
12 of Medicine, which is the one I am most familiar with
13 functions in the investigation of complaints such as this.
14 First of all, you should be aware that in addition to
15 the basic funding that is permitted under state budget,
16 that the Professional Licensure Board of the State Board
17 of Medicine has the authority to establish almost any
18 funding level it requires through its biannual registration
19 of physicians. As you also know, the last few years that
20 has been a registration fee of less than $25 when you
21 take it over the several years. That money was put in
22 purposely and at the request of the medical society for
23 the purposes that we have been trying to address here today.

24 I think the other thing that is very important
25 is the fact that unless this is very publicly advertised

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1 as far as the availability of such efforts, that we are
2 not going to get to public education whether we have a
3 strong bill or not. I think one of the things you have
4 hit on, the deficiency of the current law with reporting,
5 is the fact that conviction of felony, until recently,
6 had not found its way into a report to the state licensing board
7 In other words, there was no requirement for courts or
8 any other parties to make that report to the licensing
9 board. I think until such language is in there to require
10 those people that have been convicted of felonies such as
11 rape, of getting that information to the respective licensing
12 board, that you are not going to see a correction. And I
13 think that the legislative bodies, whether it be this
14 Committee or whether it be Professional Licensure, has
15 the authority over those licensing boards puts pressure
16 on those boards to react, I don't think you are going to
17 see a resolution of the problem.
18 BY REPRESENTATIVE CALTAGIRONE: (To Mr. McCoy)
19 Q Getting down to the psychologists and psychiatrists
20 in the Commonwealth, several people who have testified
21 here today have indicated that in fact there is not good
22 reporting of incidents or swift and certain action that is
23 being taken. What is the total figure that your organization
24 in this Commonwealth and how many, of course, in total do
25 not participate? Do you have a figure?

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1 A We have 1900 members in the Pennsylvania
2 Psychiatric Society. It is the second largest branch in
3 the American Psychiatric Association.
4 Q Forty thousand doctors and 1900 of them are
5 psychiatrists?
6 A Nineteen hundred members. We estimate that
7 there are probably 2200 psychiatrists in the state.
8 Q Out of 40,000?
9 A The 40,000 would also, is essentially licenses
10 indicated. They do not necessarily represent practicing
11 physicians in the state. The estimate is probably around
12 30 to 32,000 people that practice in some form. Either,
13 the Veterans Administration does not require licensure
14 or one of the other forms that would not be in active
15 practice, academic perhaps.
16 DR. BULETTE: Five or six and a half percent
17 of people go into psychiatry.
18 CHAIRMAN DEWEESE: It is just a lot higher
19 level than I ever thought.
20 MR. McCOY: You also have to know we have a
21 large state hospital population which also deals with a
22 number of psychiatrists.
23 BY REPRESENTATIVE CALTAGIRONE: (To Mr. McCoy)
24 Q With the number of incidents that we have had,
25 evidently there is quite a backlog of cases that have not

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been handled yet. They are going through the adjudication process with the licensing boards. What do you in fact do if you see these problems within your own? How do you remedy that situation?

A Basically through the ethics process of the American Psychiatric Association when an ethical complaint is investigated. As an example, this morning I had a call on our toll-free line of a request for how to initiate a complaint against a physician for sexual abuse. Essentially I explained the process to the individual. I also explained the alternative of pursuing the complaint through the State Board of Medicine. That basically once the ethics process is begun in the Psychiatric Society, we take the ethics investigation to its continuation, make recommendations to our board of directors. Upon approval it goes to the American Psychiatric Association. They approve the process that we have followed to make sure that due process was followed. And then the final opinion is rendered and all parties are notified, both the complainant and the defendant. At that point it is published in the American Psychiatric News which goes not only to member psychiatrists but probably is disseminated around the country. The Pennsylvania delegation to the APA has requested and will be formally requesting at the annual meeting this May of the APA that that

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1 newsletter also be sent to the state boards of licensure
2 in all states. So that any disciplinary action that is
3 reported, just as any changes in the member status, go to
4 the appropriate state licensure boards.
5 Q Where do people get the complaint forms?
6 A The complaint forms can be gotten by calling
7 our toll-free number 1-800-422-2900. They can also contact
8 the Medical Society which will refer them to us. They can
9 contact the American Psychiatric Association or in the
10 case of the state board, they can contact the state board.
11 I was interested this morning, I was not aware that the
12 state board had an 800 toll-free number. But I will
13 certainly give it out in the future.
14 Q I would also suggest if you want to make
15 public awareness, do it through your elected representatives.
16 You have 253 members of the General Assembly that deal
17 with people every single day. I think a packet as to
18 almost all the other agencies that is sent to us, whether
19 it is PHEAA, Real Estate, whatever --
20 CHAIRMAN DEWEESE: Ten, 15, 20, 25 contacts
21 a day counting phone and dropping by the home office.
22 That is an average.
23 REPRESENTATIVE CALTAGIRONE: That is an average
24 for just about every member of the General Assembly. If
25 they get a complaint or two complaints in a year's time

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1 per member, at least they would have access ability to
2 a standardized complaint form that constituents can fill
3 out to start the process if they feel that is what is needed.
4 So that we have a handle on helping people that come to us
5 with complaints about this nature.
6 BY REPRESENTATIVE CALTAGIRONE: (To Mr. McCoy)
7 Q Getting back to the total number, you said
8 2200 licensed and operating in the state?
9 A That is correct.
10 Q In the last year, five years, how many have
11 been brought up on charges and how many have lost their
12 licenses to practice in the state?
13 A We do not have licensing powers as far as
14 removal of license. As far as termination, we have
15 recommended three for termination out of approximately
16 12 investigated complaints in the past year and a half.
17 Q Do you think it is under reporting of those
18 situations?
19 A I think it is certainly under reporting of
20 the situation based on lack of information to the public on where t
21 report and who to report to.
22 Q What percentage of the total?
23 A I would have to agree probably with the
24 national statistic that Dr. Bulette has mentioned of
25 approximately seven percent.

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1 Q Approximately seven percent?

2 A I would say that would probably hold with all

3 licensed professionals, not just psychiatrists. Whether i

4 be OB-GYN, whether it be anesthesiologists if you would

5 level it out.

6 Q I don't know if it was implied in your statement

7 or the previous speaker's, that there could be some

8 therapeutic value from a situation involving a patient

9 and a psychiatrist or a psychologist.

10 CHAIRMAN DEWEESE: That was not in his statement.

11 Do you agree with that?

12 DR. BULETTE: Absolutely not. I think that

13 both the American Psychiatric Association and I believe

14 the Psychological Association are really very unambivalent

15 about that kind of behavior. I think they have been very,

16 very clear in saying that it is unethical and there is

17 no mitigating circumstances.

18 REPRESENTATIVE CALTAGIRONE: Thank you. Thank

19 you, Mr. Chairman.

20 CHAIRMAN DEWEESE: You are very welcome. Thank

21 you, gentlemen, for sharing your testimony. The final

22 scheduled witnesses, Ms. Sandra Walton, Constance Brunt

23 and Kathleen Shuey will please come to the table. And

24 then the Chair will recognize the conclusion of our formal

25 hearing, Ms. Sharon Baron of Havertown, Pennsylvania for

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1 She is not scheduled to testify. It is the Chair's decision
2 to allow two minutes' testimony by Ms. Baron of Havertown,
3 who is the President of Association Against Client
4 Exploitation by Professionals.
5 Ms. Walton, Counselor Brunt, Ms. Shuey.
6 Welcome to our hearing. At this time I'm going to turn
7 the gavel over to our Subcommittee Chairman on the courts,
8 my friend and one of my legal advisors, Gerry Kosinski
9 from Philadelphia. Thank you very much for being here
10 with us. As I said earlier, for the record, I am on my
11 way to Indiana County for another event.
12 ACTING CHAIRMAN KOSINSKI: Thank you, Mr.
13 Chairman.
14 MS. WALTON: Thank you. My name is Sandra
15 Walton and I am from Philadelphia. I have been sexually
16 exploited by a licensed psychologist from the Bucks County
17 area.
18 I was in therapy with this psychologist from
19 February to October 1986. I was very depressed and
20 vulnerable when I first started therapy and therefore was
21 an easy target for exploitation. The very first session,
22 he asked for oral sex in exchange for payment, I refused
23 and left his office. The second session he asked me again
24 for oral sex in exchange for payment. I just said, "You
25 as a professional would not permit such a thing would you?"

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1 He just smiled. I refused again and left his office. I
2 thought he was playing heavy head games with me--but now
3 when I look back I truly believe with all my heart that
4 he was setting me up from day one and that every session
5 was sexually oriented. The hugs and kisses started and
6 I was buying him gifts almost every other session. When
7 he told me that he loved me, I believed him, as I had
8 trusted him and I had him on such a high pedestal. However,
9 when the inappropriate touching started, I questioned him
10 and he said that he saw nothing wrong with what we were
11 doing. I was so confused by his suggestions and innuendos,
12 yet he apparently didn't care about how he was harming me.
13 Unfortunately, under HMO insurance I was locked in with
14 this psychologist. Even though I told my primary doctor
15 of what this psychologist was doing, HMO and my primary
16 completely ignored my concerns. I was very fortunate that
17 I left therapy with this psychologist before sexual
18 intercourse occurred, or before I did what he actually
19 wanted, which was oral sex.
20 The psychologist neglected to set boundaries
21 in his office and took advantage of my weakness and
22 vulnerability. His unethical and unprofessional manner
23 drove me to near suicide. I was placed on three different
24 kinds of medication by a psychiatrist, for anxiety,
25 depression and sleeplessness. I had been on this medication

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for one year. It has now been 17 months since I left therapy with this psychologist and to this day I have very deep psychological and emotional scars of how he mistreated me. I will never forget what he did to me and I question every day, Why??? I saw him in November, 1987 (he did not see me) and I ended up in a hospital with hypertension and angina. The sheer sight of this man again puts me into such stress, as I then relive what had happened to me when I was his patient.

In November, 1986 I filed formal complaints against this psychologist with the American Psychological Association, the Bureau of Professional and Occupational Affairs (State Board of Psychology), and HMO insurance. I also had contacted a total of 11 attorneys. Each and every attorney said that the psychologist was wrong, but to prove it would cost more than they felt recovery would be. I have now lost my statute of limitations and yet this psychologist continues to go on his merry way.

Upon my allegations, APA did a second investigation on the psychologist's credentials. His Ph.D. proved to be a misrepresentation, as his diploma indicated attendance at a school that does not exist; he was charged by APA for misrepresentation of credentials. I am now awaiting the final decision regarding my allegations and what action has been taken against this

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psychologist.

When I was informed by APA that there was misrepresentation on the psychologist's part, I immediately notified the prosecuting attorney for the State Licensing Board. However, that issue was never reviewed and apparently the State Board overlooked my concern regarding the issue of misrepresentation. The state, after 13 months dismissed and closed the case due to the fact that it was one of my word against the psychologist's word. I am very frustrated by the state's system of handling a complaint.

I asked the state for an appeal and I was refused. I also had been informed that this psychologist had received a copy of my 19-page complaint. When I asked for a copy of the psychologist's response, again I was refused, stating "this is not the procedure." Also, the state never called this psychologist before the Board to question him.

I finally wrote to the Commissioner regarding my concern of how the state handled my case and I asked how does a victim acquire proof. I was informed by the Commissioner that taking pictures would be an "entrapment" and of course a tape recording is nonpermissible. So, I ask you, what proof does a victim have? It is quite obvious that the professional is very well protected and

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the victim suffers as the professional knows he can continue to get away with such actions. Lastly, I asked the Commissioner why the issue of the psychologist's credentials was not investigated and why did the state do nothing? I was informed by the Commissioner that "such representation was not discovered in this course of the Board's investigation." How can that be, when I personally told the prosecuting attorney of the APA's findings? Also, the Commissioner said "APA's actions has resulted in the psychologist's discontinuance of his misleading practice. Therefore, formal action by the Board was deemed unnecessary." I truly believe that the state should have taken action against the psychologist for his misrepresentation also, as his signs still have Ph.D. on them and that is misleading.

Is there no protection for the client, as these sick professionals continue to exploit their patients while no real action is taken against them?

To protect the people who are truly hurt (psychologically and emotionally) I sincerely support House Bills 1465 and 1466. To mandate such reporting of sexual exploitation would only aid in acquiring the appropriate help for these sick professionals. Also, the victims will be able to prosecute on criminal charges instead of being told the case is not strong enough as it's one of his word against yours. I firmly believe that

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1 if tougher laws are passed these misguided professionals
2 will then realize that they cannot continue to get away
3 with exploiting their patients. As long as there is no
4 real discipling of these professionals, the exploitation
5 will continue and innocent people like myself will continue
6 to get hurt.
7 After I left therapy with this psychologist
8 in October, 1986, I immediately went into therapy with a
9 woman therapist. It has been a long tough road; however,
10 I believe the worst is behind me. However, there is not a
11 day that goes by that I don't think to myself, Why? Why
12 did he want to hurt me so much--so much that I wanted to
13 kill myself? This man is suppose to help people and
14 instead he exploits and abuses for his own sick mind.
15 In the spring of 1987 I contacted several
16 organizations in the Philadelphia area to see if there
17 were any peer support groups concerning sexual exploitation
18 by a professional. To my amazement, there was not one
19 such group to help people like myself. So, I researched
20 and contacted a lot of professional people and have now
21 formed the first peer support group serving the Philadelphia
22 and Lower Bucks County areas. The group is called
23 Victims of Professionals.
24 It is most difficult for anyone to admit that
25 they were a victim by a professional who they trusted. The

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1 shame one feels is so strong, along with guilt and
2 numerous other feelings. However, victims must step
3 forward and get the appropriate help and then try to report
4 the professional. I believe that this is part of the
5 healing process.
6 My personal feelings at this time are: I am
7 quite angry at my previous psychologist for allowing
8 certain things to happen in his office. He misused his
9 control of the boundaries between therapist and patient.
10 I am also angry that when a person does step forward to
11 file a complaint, especially to the state, the experience
12 is usually one of frustration.
13 I appreciate your time in letting me express
14 to all of you what had happened to me and of my personal
15 feelings. Thank you for allowing me to share this ordeal
16 with you.
17 I have attached my written testimony for the
18 Committee's consideration in this matter. Thank you.
19 ACTING CHAIRMAN KOSINSKI: We're going to
20 come back to a few questions. I have a few myself about
21 this situation.
22 MRS. BRUNT: Good afternoon. My name is
23 Constance Brunt. And accompanying me today is my client,
24 Kathleen Shuey. I am an attorney in private practice here
25 in Harrisburg. As an attorney in private practice, I have

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1 recently become sensitive to the issues inherent in this
2 proposed legislation. I was retained by Kathleen Shuey
3 to represent her in the pursuit of a claim against a
4 local clergyman, who engaged her in a sexual relationship
5 while ostensibly providing counseling services to her.
6 Mrs. Shuey had attended her church for many
7 years and was well-known to the pastor, who had been the
8 pastor for this church for over 20 years. Because she
9 was experiencing some personal problems and marital
10 difficulties, Mrs. Shuey sought counseling from her pastor.
11 After some time, the pastor engaged in a sexual relation-
12 ship with Mrs. Shuey, a relationship that persisted for
13 approximately five months. Only when he was informed
14 that Mrs. Shuey feared that she had become pregnant, did
15 the pastor abruptly terminate his contact with her. By
16 that time, Mrs. Shuey had come to believe that she was
17 in love with him and that her feelings were reciprocated.
18 The termination of this relationship had a devastating
19 effect on her. The pastor took Mrs. Shuey to a church-
20 related psychotherapist, who counseled her that it would
21 be disastrous for her and for the pastor if she were to
22 disclose their relationship to anyone, including her
23 husband.
24 Mrs. Shuey did ultimately reveal this
25 relationship to her husband, and together they sought

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1 redress through the church hierarchy. The pastor defended
2 his actions by initially claiming that his sexual encounter
3 was an isolated incident, initiated by Mrs. Shuey, who
4 he claimed had seduced him. When the church's governing
5 body and the area Conference of Churches of this
6 denomination took no action to censure the pastor or to
7 remedy the wrong done to her, Mrs. Shuey sought legal
8 counsel.

9 An action was instituted in the Court of
10 Common Pleas of Dauphin County, but was later transferred
11 to Lebanon County. Named as defendants were the pastor,
12 his church and the Area Conference. The complaint set
13 forth causes of action based on negligence or clergy
14 malpractice, the intentional infliction of mental distress,
15 assault and slander. Liability against the church and
16 the Conference was claimed on the basis of respondent
17 superior (or the vicarious liability of an employer for
18 the acts of an employee), negligence in hiring, training
19 and supervising the pastor, and the intentional conduct
20 of church and conference officials in slandering Mrs. Shuey
21 and assisting the pastor to cover the truth about his
22 involvement with her.

23 The defendants responded by claiming that
24 there was simply no cause of action available to Mrs. Shuey
25 as a result of this relationship, characterizing her suit

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1 as being a claim for seduction. Further, the defendants
2 asserted that any cause of action against the pastor,
3 the church and the Conference was barred by the religion
4 clauses of the First and Fourteenth Amendments to the
5 United States Constitution and by Article I, Section 3
6 of the Pennsylvania Constitution. Certain other procedural
7 defenses were raised, but were not addressed by the court
8 in disposing of the case.
9 On preliminary motions, prior to any extensive
10 discovery and without testimony, the Court of Common Pleas
11 of Lebanon County dismissed all of the claims made in
12 Mrs. Shuey's complaint, with the exception of the allegations
13 of slander. The court characterized Mrs. Shuey's claim
14 as being based on the pastor's mishandling and manipulation
15 of the psychological phenomenon of transference as was
16 claimed in the complaint. The court then determined that
17 "...no duty is recognized by the laws of Pennsylvania..."
18 that would obligate the pastor to perceive and correctly
19 handle this psychological phenomenon. The thrust of the
20 decision was that the clergy cannot be held to the same
21 standard as psychologists or psychiatrists who are, in the
22 court's estimation, trained and/or licensed to practice
23 psychological, psychoanalytic or psychiatric technique.
24 Mrs. Shuey was also held by the court to have exhibited
25 apparent consent, making it reasonable for the pastor to

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1 believe that she consented to an affair, in the court's
2 terminology. Finally, in dismissing the claim for
3 intentional infliction of mental distress, the court
4 found that the pastor's conduct could not reasonably
5 be regarded as extreme and outrageous, instead describing
6 it as merely "unsavory." The court did not address the
7 constitutional issues.
8 Mrs. Shuey has chosen not to pursue her claim
9 further. This decision was based on the significant
10 financial and emotional cost to her in pursuing the case
11 through preliminary motions and the great expense involved
12 in and limited chances for success on appeal. Although
13 there is some common law authority for this cause of
14 action, the law is by no means clear. Consequently,
15 victims of sexual exploitation must spend substantial
16 amounts of time and money just trying to convince a court
17 of their right to bring a civil action for damages and
18 to proceed to trial. This burden obviously dissuades
19 many claimants from seeking redress. I personally was
20 consulted by another woman concerning a similar claim
21 against a priest. My candid description of the difficulties
22 she could expect, based on my experience with the Shuey
23 case, and estimate of the cost involved have apparently
24 led her to forego pursuit of the claim.
25 I support passage of this legislation. I also

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strongly endorse the inclusion of clergy in the definition of psychotherapist. In my opinion, it is unrealistic to allow clergy who are performing the same services as other counselors to hide behind their clerical garb to escape civil liability or prosecution for their exploitative conduct. If members of the clergy undertake to provide similar services, they should be held to the same standards. This legislation will not help Kathleen Shuey now, but the outcome of her case would, I believe, have been vastly different had it been enacted several years ago. I know that Mrs. Shuey urges passage of this legislation too, hoping that it will prevent some experiences similar to those she has suffered and that it will allow other victims protection and redress.

ACTING CHAIRMAN KOSINSKI: Mrs. Shuey.

MRS. BRUNT: Mrs. Shuey is not prepared to give a statement, however, she is available to answer questions.

BY ACTING CHAIRMAN KOSINSKI: (To Ms. Walton)

Q Can we get back to Ms. Walton? What I am mainly concerned about is the action of the State Board in this matter. In your meeting with other members of victims groups has this psychologist ever been brought up on charges before or after to your knowledge?

A No, he has not.

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1 Q The one thing that really bothers me, apart
2 from your story, is the fact that the evidence is there
3 that he is practicing without proper credentials. Since
4 I am an attorney and I know what is on my forms when I
5 fill out an application, that the least they could do is
6 prosecute for perjury when he filled out his application
7 stating he had a doctorate. If that is not true, the
8 minimum criminal charges should be brought against him
9 for that.
10 In the course of your pursuing the case did
11 you ever contact any elected official?
12 A I had gone to State Representative Denny O'Brien.
13 He tried to get me a legal attorney who would not accept
14 the case. The case was not strong enough.
15 Q I know what some of the problems are with
16 recovery, especially on a contingent fee basis when you
17 do have a case like that and the recovery would be quite
18 small and a lot of times financially it is not worth the
19 attorney's efforts to pursue the case. And if you do
20 charge on an hourly basis, it precludes further discussion
21 or further appeals of cases. So that is a situation.
22 But unfortunately, your story is not unusual in dealing
23 with state boards and it is a shame. It is one of our
24 problems that members do have. Representative McHale
25 I know has had a number of problems in his area dealing

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1 with state boards.

2 A I would like to say I never had any contact

3 from the Board. I always had to initiate it and ask,

4 what is going on, what is going on. I never had any

5 contact from the prosecuting attorney unless I initiated

6 it. When a person goes through this, they are not up

7 to all this to begin with. They shouldn't have to do that.

8 I am not saying he had to get in touch with me every single

9 time, but I think to leave me know what is going on I think

10 was not asking too much.

11 But when I questioned about the Ph.D. to the

12 prosecuting attorney, I got one story and then a different

13 story completely from the Commissioner. It was just like

14 a big runaround. I am very frustrated. And I am not

15 surprised victims don't step forward.

16 ACTING CHAIRMAN KOSINSKI: You have a right

17 to be frustrated.

18 BY ACTING CHAIRMAN KOSINSKI: (To Mrs. Brunt)

19 Q Counselor, in your research on your case,

20 I would imagine Pennsylvania case law has practically

21 nothing on your situation. Other states, do they have

22 similar, either statutory or a decision by precedent?

23 A In my research, because I was, of course,

24 dealing with a common law cause of action, I frankly did

25 not do a great deal of research into statutory provisions

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1 in other states. I found some cases in other states
2 dealing primarily with psychologists, psychiatrists.
3 There were two cases dealing with social workers who had
4 been determined by the courts in those cases to have
5 held themselves out in much the same way as psychologists
6 or psychiatrists.
7 Q Were they California cases?
8 A No, surprisingly they were not all California
9 cases. I don't have my brief here with me right now.
10 But there were cases from states that you would not, as
11 an attorney, assume would be on the cutting edge of the law.
12 The problem was that there was just a dearth of cases
13 involving the clergy at all. I did find one case, which
14 was a California case, relating to a counseling relationship
15 with a clergyman. It did not involve sexual exploitation.
16 It was primarily a malpractice case and an intentional
17 infliction of mental distress case based on improper
18 counseling to a young man who was suicidal and then later
19 did commit suicide. But the principles were very much
20 the same in that the clergyman in that instance was held
21 to be a counselor and was held to the same standards as
22 psychologists and psychiatrists in terms of a proper method
23 of counseling. It also was a very important case because
24 it addressed the constitutional issues raised in my case
25 but not addressed by the court.

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1 BY ACTING CHAIRMAN KOSINSKI: (To Mrs. Shuey)

2 Q Mrs. Shuey, would you like to add anything?

3 A I would like to see justice be done. It just
4 gives you a very devastating feeling that you cannot turn
5 to anyone.

6 ACTING CHAIRMAN KOSINSKI: That is one of the
7 reasons the bill is in there. Further questions?

8 (No response.)

9 Thank you very much for your time today.

10 Our final witness, scheduled witness is Sharon
11 Y. Baron, President of the Association Against Client
12 Exploitation by Professionals. She is from Havertown,
13 Pennsylvania.

14 MS. BARON: Do I have to talk fast?

15 ACTING CHAIRMAN KOSINSKI: Take your time.
16 I have my soup so I'm happy.

17 MS. BARON: I really do want to know, am I
18 operating under a two-minute time limit or do I actually
19 have more time?

20 MS. GERMANIO: Now that Bill is gone, we
21 can extend the two minutes.

22 MS. BARON: Thank you. I need one second to
23 get my papers in order. Thank you for providing me with
24 this time to speak. I am President of the Association
25 Against Client Exploitation by Professionals, which is a

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1 multi-disciplinary professional organization in the
2 Philadelphia area. Although our membership has now
3 expanded across Pennsylvania and we are now receiving
4 memberships from across the country.
5 I became involved with the issue of
6 professional exploitation, because as a psychotherapist
7 in private practice, I had several referrals of clients
8 who had been previously involved sexually with a therapist.
9 At that time I was advised by my attorney that I could not,
10 under current Pennsylvania law, report the offending
11 therapist based on hearsay without risking a liable suit
12 on my own part. My clients gave me permission to report
13 it. They were not willing to come forward themselves and
14 report it. Because of that that is why I became involved
15 in forming the organization.
16 The purposes of our organization are to increase
17 public and professional awareness, offer education and
18 training and to provide support for victims and professionals
19 Our members have appeared on radio and TV talk shows and
20 spoken at professional conferences and inservices. In
21 less than two years of operation we've received over 200
22 telephone calls from victims and their significant others
23 (spouses, boyfriends,etc.). Several of our members are
24 providing follow-up counseling to victims. One of our
25 board members, Jim Pedigo, works with offenders. We have

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been networking nationally with others who are working on this issue and are planning a national conference in Philadelphia in May.

The experience of exploitation by a psychotherapist is similar to incest. What takes place is a misuse of power and a breach of trust. The psychotherapy relationship, by its very nature, is one of unequal power as has been discussed by previous speakers. That is why I believe that although a relationship between a therapist and a patient may appear to be one of two consenting adults, in reality such a relationship may be better described as being incestuous. In fact, many victims of such exploitation were previously victimes of some other form of abuse in childhood. In formal research has now demonstrated that. And this is information which the offending therapists knew and used in deciding to become involved with that patient.

Even when therapy sessions are terminated, I believe that the unequal relationship frequently remains with the former client remaining emotionally dependent on the therapist for an extended period of time. This addresses the section in the bill about post-therapy relationships.

Consequently, a sexual relationship which develops between a therapist and a <u>former</u> client/patient

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may be just as imbalanced and emotionally damaging as such a relationship during the active period of therapy. Thus the necessity for an extension of the liability period to include the "former patient" for two years.

Often it takes a victim several years to realize what has happened to her. She may have been left with not only the unresolved issues that initially brought her into therapy, but a whole new set of problems resulting from her exploitive relationship with her therapist. Frequently her fear, distrust of her own judgment and the professional community and the denial of how she has been exploited delay her seeking help from another therapist or an attorney. In most of the cases I have seen, it was well beyond the current two-year statute of limitations on civil actions before the victim even began to seek the support she needed to file a claim. It is for this reason that the proposed ten-year statute of limitations is a necessary component of these bills.

I recognize the previous speakers have addressed the issue of five years, ten years, etc. I am particularly addressing the fact that two years isn't enough. It takes too long to come to terms with what has happened.

Working with victims of exploitation by trusted professionals, particularly therapists, is challenging work which requires sensitivity and honesty. The victims

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1 reveal three primary issues: 1) Distrust - they feel
2 betrayed by the professional, the state licensing board,
3 significant others in their lives and by themselves. It
4 is particularly because of the distrust issue that I
5 believe that it is essential for the patient's consent
6 for filing a complaint about the therapist. Second, there
7 is a damaged self-concept - they experience low self-esteem,
8 increased dependency, a desire for specialness, and fears
9 about their own sexuality; and 3) Difficulties in the
10 expression of anger - they fear their own anger, they feel
11 fragile as well as fearing overwhelming others.
12 I feel for any professional to exploit the
13 unique relationship with his or her client is a betrayal
14 of trust and of the professional contract. Sexual or
15 erotic contact and other forms of psychological or
16 physical exploitation by a professional towards a client
17 are never okay; they are always unethical and beyond the
18 bounds of professional treatment. For these reasons
19 I believe the Committee should consider expanding the
20 scope of this bill to include such offenses by other
21 health-care professionals and attorneys.
22 The Association Against Client Exploitation
23 by Professionals supports the need for these bills and
24 encourage this Committee to recommend their passage.
25 ACTING CHAIRMAN KOSINSKI: Questions, Susan.

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1 BY MS. GERMANIO:

2 Q Sharon, you say that your association is made

3 up of practicing professionals. Have you had any feedback

4 from non-psychotherapist type professionals such as

5 osteopaths, optometrists like we have heard about today?

6 A I am not clear what you mean by feedback.

7 Q Have any one of them become aware of your

8 association or wanted to join or to participate or be

9 interested?

10 A Yes. When I say that we are an organization

11 of professionals, let me define that. I am a nurse.

12 We include on our board, we have psychiatrists, psychologists,

13 we have nurse midwives. We have an attorney. On our

14 advisory committee we include a gynecologist, other

15 physicians and social workers and our membership has

16 included people of varying professional groups. And they

17 have expressed interest in our organization.

18 Q You don't see that if we were to amend this

19 bill to include all health-care professionals, there would

20 be a mass move to block its passage?

21 A Well, I think that there may be some professionals

22 that will attempt to block its passage. I can't speak for

23 other professional groups. I do believe that there are

24 professionals that are in each discipline that are equally

25 concerned about this problem and have expressed interest

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1 in the issue here. I cannot speak for whether their
2 professional organizations would or would not support it.
3 Q I had one question by mail, the Pennsylvania
4 Coalition Against Rape wanted to include a provision in
5 the bill which would allow simultaneous filing of the
6 complaint with the board as well as pursuing this at the
7 criminal or civil level. Do you agree that needs to be
8 spelled out?
9 A I think it needs to be clarified. I am not
10 an attorney so I'm not exactly sure how this would work.
11 I know that one of our attorneys has worked with victims
12 of these experiences and expressed the frustration that
13 they feel because they either have to decide to file
14 a civil suit or decide to file a complaint with the
15 licensing board. Sometimes it is a toss up about which
16 one they want to do more. So there is a lot of frustration.
17 If they want to obtain damages for themselves in terms of
18 financial remuneration, they can't file a complaint with
19 the licensing board and then that person is still out there
20 practicing while the civil suit goes on.
21 Q The licensing board then may lose their
22 statute of limitations.
23 A That is right.
24 ACTING CHAIRMAN KOSINSKI: Any further questions?
25 MS. GERMANIO: Thank you.

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1 ACTING CHAIRMAN KC NSKI: Thank you. Before
2 I close the hearing, is there any other party interested
3 who would like to testify?
4 (No response.)
5 Let the record reflect that no party wanted
6 to testify. So I hereby declare this hearing closed.
7 Thank you, everybody for coming and for your insightful
8 comments on the bills.
9 (Whereupon at 2:45 p.m. the hearing was
10 adjourned.)
11
12 I hereby certify that the proceedings and
13 evidence taken by me in the within matter are fully and
14 accurately indicated in my notes and that this is a true
15 and correct transcript of the same.
16 Dorothy M. Malone
17 Dorothy M. Malone
Registered Professional Reporter
135 S. Landis Street
18 Hummelstown, Pennsylvania 17036
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