
Professional Sexual Misconduct: The Role Of The Polygraph In Independent Comprehensive Evaluation

A. J. Reid Finlayson, MD; Kimberly P. Brown, PhD; Richard J. Iannelli, PhD; Ron Neufeld, BSW; Kendall Shull, MSc; Danielle P. Marganoff, MEd; Peter R. Martin, MD

ABSTRACT: This study examines the use of Psychophysiological Detection of Deception (Polygraphy) as part of an independent, comprehensive, fitness-for-practice evaluation. It compares the findings for 18 non-randomized polygraph subjects selected from 60 medical professionals referred for assessment between 2007 and 2014 for violating sexual boundaries. Information derived from polygraph examination of fitness-for-practice evaluation subjects was independently rated for seven variables and retrospectively compared with that from subjects who were not polygraphed. Consensus values were used as final ratings associated with each case. In 56% of the 18 polygraphed cases, important new information was uncovered about sexual boundary problems that had not been elicited beforehand by repeated interviews and other standard clinical methods. This rose to 73% among those cases determined to be unfit for practice. Various recommendations were made in each case to improve patient safety and to enhance professionalism through specific education, treatment, support, supervision, monitoring and practice restrictions. Results suggest that the polygraph appears to be a useful component of an independent, comprehensive evaluation for sexual misconduct, as it may provide additional information to better understand what happened and more accurately determine a strategy for possible rehabilitation of the physician.

Introduction

Rules that govern the conduct of health care practitioners exist to prevent harm to patients, deliver quality care, enhance the effectiveness of healing relationships, and preserve the reputation of the profession. Physicians are governed by their profession's ethical standards and regulated by state licensing boards. While general ethical standards¹ for physician behavior² have varied little over time, recently those standards have been more clearly specified and more uniformly enforced for chemical dependency (FSMB policy 1995, 2011) and sexual boundary issues (FSMB policy guidelines 2006). As sanctions for failing to adhere to regulations governing medical practice^{3,4} were increasingly enforced, programs were developed in most states to support physician health. Effective strategies have evolved through these physician health programs to identify, monitor, and support physicians with substance use disorders.⁵

Additionally, the 2008 Joint Commission on Accreditation of Healthcare Organizations (JCAHO) publication⁶ titled "Behaviors that undermine a culture of safety or that are disruptive to the optimal functioning of healthcare teams" raised concern about actions or speech that interferes with

the ability of a clinical team to achieve its intended outcomes. Behavior that demeans, disrespects or upsets other health care workers may be active (e.g., angrily throwing a scalpel), passive-aggressive (e.g., comments in patient records that are critical of other professionals) or passive (e.g., chronic lateness, failure to complete records or recurrent failure to respond to pager).^{7,8} The JCAHO guidelines^{9,10} also assigned considerable responsibility for the

WHILE GENERAL ETHICAL STANDARDS FOR PHYSICIAN BEHAVIOR HAVE VARIED LITTLE OVER TIME, RECENTLY THOSE STANDARDS HAVE BEEN MORE CLEARLY SPECIFIED AND MORE UNIFORMLY ENFORCED FOR CHEMICAL DEPENDENCY AND SEXUAL BOUNDARY ISSUES.

oversight of professional conduct to the institutions in which physicians work.¹¹ Holding physicians more widely accountable is a significant change from the traditional oversight of doctors by their own profession: it demands that medical practitioners be held to a standard based upon evolving societal attitudes about bullying and harassment.

It is the province of state licensing bodies to safeguard health, safety and welfare by interpreting the laws, rules and regulations that determine appropriate standards of practice and ensure the highest degree of professional conduct. State medical boards are responsible for the investigation of alleged violations of these rules and for the discipline of licensees who are found guilty of such violations.

Sexual boundary violations are among the most egregious transgressions that raise fitness-for-practice concerns about physicians. A clear dictate about the inappropriateness of sexual relationships with patients has existed since the time of Hippocrates: *“Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and, further, from the seduction of females or males, of freemen and slaves.”*

Concern about sexual exploitation of patients and employees resurfaced during the 1970s, as medical boards increasingly recognized the deleterious effects of sexual victimization upon patients by some physicians¹² and enforced behavioral standards for professional relationships.¹³ The Federation of State Medical Board (FSMB) guidelines¹⁴ for addressing sexual boundary violations emphasize the need to thoroughly assess the nature and scope of the sexual misconduct. An evaluation for sexual boundary violation aims to determine both what is required to prevent future risk to patients

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and evaluate the possibility for rehabilitating the offending physician. Research on the treatment of physician perpetrators and the potential for return to practice remains controversial. Proponents of “zero tolerance”¹⁵ would prohibit any physician who engaged in sexual behavior with a patient from returning to practice.¹⁶ Others posit that some who transgress sexual boundaries with patients may have the potential for rehabilitation^{17, 18} and eventual return to a modified or restricted form of practice.^{19, 20} Each case and circumstance presents unique challenges to resolve conflicting accounts of events

and determine the most accurate approximation of what is credible:²¹ the truth (of the victim’s experience) the whole truth (leaving nothing out) and nothing but the truth (no lies)*.

This paper reports on the use of the polygraph as part of independent comprehensive fitness-for-practice assessments in cases of alleged physician sexual misconduct following the 2006 FSMB guidelines. The study was retrospective and does not address the decision to offer polygraph examination, or whether and why any subjects refused.

Case Examples**

Case #1

A female psychiatry resident complained to her state medical board that the psychiatry professor who supervised her and also treated her with psychotherapy for depressed mood had sexual intercourse with her repeatedly during sessions. The professor denied any sexual activity, describing the resident’s allegations as symptomatic of her borderline personality organization. Although the professor had entered psychotherapeutic treatment with a colleague, the medical board ordered him to submit to an independent, comprehensive professional evaluation. Conflicting accounts of the sexual allegations remained unresolved by the evaluation, which recommended more intensive inpatient evaluation or polygraph testing. The professor’s psychiatrist was highly critical of the independent report, and his lawyer advised against a polygraph. Eventually the medical board sought and obtained the records of his treatment. The notes revealed discussion about sexual activity occurring between the professor and the patient/supervisee/female resident. The medical board revoked the professor’s license. The psychiatrist treating him was formally reprimanded.

Case #2

A 41 year-old, recently divorced physician was referred for evaluation by his state medical board after a female patient complained that he had demanded sex in exchange for prescriptions. The

* The oath, ‘I swear to tell the truth, the whole truth and nothing but the truth’ evolved from medieval British law. Reporting only a part of the facts can distort the truth, while misleading indications and innuendos alter the interpretation of facts and sometimes the truth can be used to substantiate lies.

** Case details have been altered to preserve confidentiality.

investigative report, provided at the time of the evaluation, revealed that he first met the woman in an exotic dance club, where she worked. Initially the doctor wrote prescriptions for the dancer, plus two of her friends, for amphetamines and benzodiazepines, and failed to keep patient records. He continued dating the woman, while he was writing prescriptions of controlled substances for her. The physician tried to end the relationship sometime later when he learned that she was obtaining additional prescriptions from another physician and giving medication to her friends. However, the woman threatened to report him to the Medical Board unless he continued to write prescriptions. A year later, when he did stop, she contacted the medical board and complained.

Extensive collateral contacts revealed no other history of sexual violation with either staff or patients and no other complaints filed regarding this physician. His polygraph test revealed no further information and indicated no deception. After the physician responded to treatment for depression and completed clinical education programs on maintaining professional boundaries and proper prescribing practices, the medical board permitted him to return to supervised practice that was initially limited to male patients.

Case #3

A 47 year-old Obstetrician-Gynecologist was referred for evaluation following a patient complaint that he had engaged in a sexual relationship with her several years previously. The doctor admitted the behavior but emphasized its consensual aspects and asserted that it had been an isolated incident. Polygraph evaluation determined that there had been additional victims of professional sexual misconduct, including several occurrences in his practice office.

Psychophysiological Detection of Deception (PDD) — Polygraphy

The case examples above demonstrate the complexity of ferreting out the truth. We previously reported that professionals referred to the Vanderbilt Comprehensive Assessment program (VCAP) for evaluation of sexual boundary violations (who well know that their license and livelihood may be at risk) are motivated to present themselves as better adjusted and more virtuous than may actually be the case.²² Our study suggested that professionals who violate sexual boundaries tended to distort or

conceal information, and more resembled criminal sexual offenders than their colleagues whose behavior disrupts clinical teams. Thus, we began including polygraph examination, as suggested in FSMB guidelines (2006 op. cit.), to further evaluate deception and to improve diagnosis for more accurate treatment planning.

A polygraph is a multichannel recorder that displays respiration, the pressure in a partially inflated arm cuff, and change in skin resistance through the measurement of respiratory movements, pulse wave, relative blood pressure, and electrodermal activity.²³ These mechanical or electrical impulses reveal emotional responses that are useful in detecting deception. Geddes²⁴ describes three principal

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forensic benefits of polygraph testing: 1) eliminating a subject as a suspect, 2) providing direction regarding what further information is needed, and 3) providing evidence that a suspect has nothing to conceal due to willingness to participate.

Opinion is divided on the utility of the polygraph and there is little agreement on its accuracy or how it works. Meijer et al²⁵ attributed the polygraph effect simply to intimidation by the polygraph procedure itself, rather than any inherent diagnostic capability the technique may have. Greenberg²⁶ (2002) quotes President Richard Nixon (who ordered polygraphs to investigate White House leaks in 1971) as stating, "I don't know anything about lie detectors other than they scare the hell out of people." The public mystique persists that the polygraph is infallible.

Greenberg²⁶ (2002) assessed the National Academy of Sciences report,²⁷ which addressed the difficulties of measuring polygraph accuracy, the usefulness of the technique for aiding interrogation and for deterrence, opining, "The polygraph can snare the innocent and allow the guilty to escape." Grubin²⁸ (2002) criticized the validity and reliability of polygraphy including having undefined inter-rater and test-retest reliability, varying accuracy rates from 70 to 95%, insufficient standardization, and incomplete understanding of individual differences.

He concluded, "One can see why there should be unease about reaching conclusions of guilt or innocence, or in deeming someone an employment or security risk, when essential information about the technique is lacking."

The strength of impulses may vary with the emotional sensitivity of a subject, and there is insufficient proof that each subject's physical response correlates with his/her mental state. Additionally, error is possible within the machine itself²⁹, and Iacono³⁰ has clarified that demonstrating deception on polygraphy (outcome) and confession (criterion) are not independent variables. Grubin (2010) suggests that the psychological set created during the pre-test polygraph interview may facilitate the physiological arousal that results in deceptive responses to specific questions during the actual polygraph test.³¹

Criticism of testing credibility by polygraph ranges from the absence of reliable science as proposed by Brett³² et al (1986) to doubtful outcomes according to Steinbrook³³ and discrepancy with other indices like "hard evidence" (such as medical findings, witness accounts, additional victims and police evidence beyond victim statements) that more accurately predict successful criminal prosecution in child sexual abuse (Faller, 1997).³⁴

Three over-simplified conclusions can be reached from a polygraph examination: *No Deception Indicated* (no specific, consistent, and significant responses were observed to the relevant questions and the examinee essentially passed); *Deception Indicated* (specific, consistent, and significant

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responses were observed to the relevant questions and the examinee essentially failed); and *No Opinion* (for some reason adequate data could not be collected or a conclusive opinion could not be reached by the examiner). However, all examinees react to relevant questions to some degree. Simply reacting to relevant questions is not the basis for decision-making. For a decision of Deception Indicated the examinee must react more consistently and intensely on physiological measurements in response to questions that are relevant (e.g., "did you shoot your wife?") than to a category of

technical questions that are added to the test as benchmarks. Conversely, if changes in physiologic measures in response to relevant questions are similar to or smaller than those to the benchmark questions, a decision of No Deception Indicated may be made. But it is not the mere presence or absence of reactions that determine test results, as is commonly misunderstood by the

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lay public. No Deception Indicated is an inference of truthfulness when scores from the physiological data fall below a set threshold. Likewise, results of Deception Indicated apply when scores from the data exceed another generally accepted threshold of benchmarks.

This Control Question (polygraph) Technique (CQT) measures autonomic reactivity to neutral questions compared to the response associated with more specific questions. The CQT compares quantifiable autonomic responses to "relevant" questions (e.g., "did you shoot your wife?"), to those of "control" questions³⁵ designed to contrast the effect of the generally threatening nature of relevant questions. Control questions concern events vaguely similar to those being investigated, but refer to the subject's past and are usually broader in scope; for example, "Have you ever betrayed anyone who trusted you?" Evidence derived from CQT has been discredited and is usually ruled inadmissible³⁶ in criminal trials; however, the evidentiary standard of administrative law (preponderance of evidence) applies to medical board hearings, which are not required to adhere to the criminal law standard (beyond reasonable doubt).

The Guilty Knowledge Technique (GKT), also known as the Concealed Information Test (CIT), if carefully administered, has been ruled admissible as criminal evidence. The CIT is based upon the premise that innocent examinees are not aware of the central details of a crime that the guilty suspect knows. When presenting a series of neutral items to an examinee that seem plausibly related to the crime, but including an item that really is a crime detail, guilty suspects tend to physiologically respond most strongly to the true crime detail, whereas an innocent person will respond randomly.

Conducting a CIT presupposes that information has been protected from public disclosure, therefore the only reasonable explanation for physiologically responding consistently to details about the crime is that one is aware of those details.

The information derived during the questioning before the polygraph test is often more important than the result (deception indicated, no deception indicated, or inconclusive) of the test itself. The polygraph may also provide a face-saving way to disclose information that has previously been withheld when a deceptive response occurs, because the subject feels a need to explain the deceptive result. This “truth facilitation” polygraph function was studied prospectively in monitoring sex offenders on community probation and shown to reduce recidivism by preventing a number of offences that otherwise would have been committed. Offenders who were motivated by the expectation of polygraph testing reportedly did not reoffend.³⁷ Polygraph use was associated with more complete disclosure of offenses and high-risk behaviors, better identification of prospective targets, and improved cooperation with treatment in a large study of post-conviction sex offenders.³⁸

Polygraph evidence is generally not admissible as evidence in state and federal criminal courts because the subjective interpretation of results depends on many factors, including the skill of the operator. Only 20 states and nine of 12 federal circuit courts have ruled that polygraph evidence met the 1993 standards of the Daubert*** case, in which the Supreme Court decision articulated a flexible standard for admissibility of scientific opinion evidence in federal cases to ensure that expert scientific opinions are grounded in a reliable methodology.³⁹ Ford⁴⁰ summarizes the judicial rulings explaining how the polygraph test has met Daubert evidentiary standards, in spite of a lack of scientific consensus. Finally, given the administrative/rehabilitative focus of medical board hearings, and given the use of PPD in a comprehensive evaluation primarily to enhance diagnosis and treatment rather than detect deception, the Supreme Court ruling in *Parham v. J.R.* (1979)⁴¹ suggests that the polygraph test should be allowed, and perhaps even the CQT should be permitted.

*** The Daubert standard identifies a number of factors for trial judges to consider when evaluating the admissibility of expert testimony. As the “gatekeeper” of scientific evidence, the judge may choose to exclude such testimony on the ground that it (1) is unreliable, (2) is legally irrelevant, or (3) does not fit the facts of the case. (American Bar Association)

To assess the utility of the polygraph we compared the characteristics of 18 subjects who received polygraphy with 42 of 60 fitness-for-practice sexual boundary referrals who did not.

Methods

We report here on the use of polygraph evaluation among physicians referred for fitness-for-practice evaluations due to sexual boundary violations since 2007 at the Vanderbilt Comprehensive Assessment Program (VCAP). The selection of physicians for polygraph assessment was not random, but occurred in response to requests by the referring agency, usually the state medical board. In a few cases, polygraph testing was recommended by the VCAP evaluating team to resolve discrepancies or after repeated inconclusive interviews.

VCAP has evaluated more than 500 physicians from 39 of the United States and four Canadian provinces since 2001, using the previously described assessment protocol⁴² that follows the American Psychiatric Association⁴³ guidelines and FSMB⁴⁴

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(Addressing Sexual Boundaries) guidelines for state medical boards. PDD is specified in the FSMB Elements of Comprehensive Evaluation: “8. Forensic polygraph examination if indicated (questions need to be clearly focused on past behavior and not intent).”

Between 2007 and 2014, 60 cases (physicians and doctoral-level professionals) were referred for fitness-for-duty evaluations due to sexual boundary violations. Of these 60 cases, 18 (30%) underwent polygraph examination as part of the evaluation. Polygraph examination was not offered systematically but was often suggested for egregious sexual violations, when dishonesty was suspected or for investigation when stipulated by a state medical board or physician health program. The sample comprised only men; most of who were in their 40s and Caucasian (see Table 1). The physician’s state medical board and/or physician health program most often initiated referral for comprehensive evaluation.

Two raters independently rated the evaluation findings from each of the 18 cases across seven variables related to contribution of the polygraph results to the fitness-for-duty conclusions (see Table 2). An operational method was devised to clarify information to be considered for each

IN 56% OF 18 POLYGRAPH CASES WE REVIEWED, THE PROCEDURE ADDED IMPORTANT NEW INFORMATION ABOUT SEXUAL BEHAVIOR PROBLEMS THAT WAS NOT ELICITED BEFOREHAND.

variable as well as directions on how to score each item (see Appendix A). Initial inter-rater reliability between the two raters for the seven variables ranged from .48 (moderate agreement) for Variable 4 to 1.00 (perfect agreement) for Variables 2 and 6. Raters reviewed discrepancies jointly. After discussion and further review of the reports and ratings, consensus was attained on all variables in which there were initially discrepant scores. The consensus values were used as final ratings if disagreement occurred.

One experienced Certified Forensic Polygraph Examiner conducted the polygraph examinations utilizing a CQT format that meets United States Government standards, as well as standards set forth by the American Polygraph Association. The data were collected using the standard field Lafayette LX-4000 computerized polygraph system. The polygraph charts were evaluated numerically and globally using scoring techniques adopted and taught by the United States Government and generally accepted throughout the polygraph community. The polygraph examiner's conclusions were based on the examinee's performance on the polygraph examination using questions relevant to their situation and which were derived with the team of VCAP evaluators. Concealed information testing was utilized when appropriate information was available.

Prior to polygraph examination, the examinees were advised that the examination was voluntary and could be terminated at any time if requested. All examinees signed a *Consent to Polygraph* form, after explanation of the polygraph process and discussion of the questions that would be reviewed. A pre-polygraph interview was conducted with the examinee by the polygraph examiner prior to assessment of markers of deception.

Results

The demographic, practice and outcome of evaluations are shown in Table 1.

The majority of the overall sample (58.3%) was found fit to practice following evaluation, whereas 41.7% were found unfit to practice.

In the polygraph group of 18, nearly 78% had some type of physical sexual-boundary violation with a patient. About half involved physical boundary violations with staff. Whereas about 61% of the overall sample had verbal sexual boundary violations with patients, 39% had verbal sexual boundary violations with staff. Many individuals had multiple types of violations and were coded for each type.

In 56% of 18 polygraph cases we reviewed, the procedure added important new information about sexual behavior problems that was not elicited beforehand by repeated interviews and other standard clinical methods (see Table 2).

This occurred most frequently in those cases in which the person was found unfit to practice, for which the polygraph added new information about sexual problems in 73% of the cases.

In two of those 18 cases, the determination of deception was not tested because one examinee refused the polygraph test and the other disclosed sufficient additional information during the interview portion of the polygraph procedure that it was unnecessary to administer the test phase. Of the

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16 cases in which polygraph testing was conducted, polygraph detected deception in five of the cases (31%), among the group found unfit deception occurred more frequently (50%). All five cases in which deception was indicated were assessed to be unfit for practice by the assessment team. The polygraph results did influence the fitness-for-practice decisions.

The polygraph examination added details about sexual activity with additional staff or patients not previously known from other information (e.g., referral source,

Table 1**Demographic and evaluation characteristics of 60 male physicians evaluated for sexual behavior violations, by polygraph**

Variable	Total n = 60		Polygraph			
			Yes n = 18		No n = 42	
	N	%	N	%	N	%
Age						
20 - 29	1	1.7%	0	0.0%	1	2.4%
30 - 39	9	15.0%	3	16.7%	6	14.3%
40 - 49	24	40.0%	6	33.3%	18	42.9%
50 - 59	17	28.3%	7	38.9%	10	23.8%
60 or >	9	15.0%	2	11.1%	7	16.7%
Race						
African American	7	11.9%	3	16.7%	4	9.8%
Asian American	8	13.6%	2	11.1%	6	14.6%
Hispanic	1	1.7%	0	0.0%	1	2.4%
White	43	72.9%	13	72.2%	30	73.2%
Degree						
MD	54	90.0%	15	83.3%	39	92.9%
DO	1	1.7%	0	0.0%	1	2.4%
PhD	4	6.7%	2	11.1%	2	4.8%
DC	1	1.7%	1	5.6%	0	0.0%
Primary Specialty						
Anesthesiology	2	3.4%	1	6.3%	1	2.4%
Emergency Medicine	3	5.2%	2	12.5%	1	2.4%
Family Practice	11	19.0%	3	18.8%	8	19.0%
Internal Medicine	8	13.8%	2	12.5%	6	14.3%
OB/GYN	4	6.9%	1	6.3%	3	7.1%
Psychiatry	5	8.6%	2	12.5%	3	7.1%
Surgery	9	15.5%	1	6.3%	8	19.0%
Other	16	27.6%	4	25.0%	12	28.6%
Referral Source						
Attorney	9	15.0%	1	5.6%	8	19.0%
Hospital	11	18.3%	3	16.7%	8	19.0%
Self	5	8.3%	0	0.0%	5	11.9%
State Medical Board	15	25.0%	5	27.8%	10	23.8%
State PHP	12	20.0%	6	33.3%	6	14.3%
Therapist	2	3.3%	0	0.0%	2	4.8%
Other	6	10.0%	3	16.7%	3	7.1%
Recommended Fit to Practice						
Yes	35	58.3%	7	38.9%	28	66.7%
No	25	41.7%	11	61.1%	14	33.3%
Recommended Outcome						
Monitoring	11	26.2%	7	38.9%	18	30.0%
Psychiatric Treatment	11	26.2%	4	22.2%	15	25.0%
Psychotherapy	21	50.0%	4	22.2%	25	41.7%
Residential/Intensive Treatment	29	69.0%	10	55.6%	39	65.0%
Targeted Continuing Education	20	47.6%	8	44.4%	28	46.7%

Note: Multiple outcomes may be recommended following assessment; thus, percentages do not sum to 100.

Table 2
Additional information from polygraph procedure by fitness-for-practice

Coding Item	Total n = 18	Fit to Practice Rating	
		Fit n = 7	Unfit n = 11
	(N, %)	(N, %)	(N, %)
Variable 1 Polygraph Added New Information Regarding Sexual Problems	10 (55.6%)	2 (28.6%)	8 (72.7%)
Variable 2 Deception was Indicated on the Polygraph Results* (total n = 16, 6 Fit & 10 Unfit)	5 (31.3%)	0 (0.0%)	5 (50.0%)
Variable 3 Depth of the Offense			
More Details Included Learning About Sex with Additional Staff or Patients	7 (38.9%)	1 (14.3%)	6 (54.5%)
More Details Included Learning About Additional Compulsive Sexual Behavior	3 (16.7%)	1 (14.3%)	2 (18.2%)
Variable 4 Physical Sexual Boundary Violation with Staff	9 (50.0%)	4 (57.1%)	5 (45.5%)
Variable 5 Physical Sexual Boundary Violation with Patient(s)	14 (77.8%)	5 (71.4%)	9 (81.8%)
Variable 6 Verbal Sexual Boundary Violation with Staff	7 (38.9%)	4 (57.1%)	3 (27.3%)
Variable 7 Verbal Sexual Boundary Violation with Patient(s)	11 (61.1%)	3 (42.9%)	8 (72.7%)

*Note: Two individual polygraph procedures were terminated prior to being able to ascertain deception.

records, interviews) in about 39% of the cases. It added additional information about other important sexual behavior in about 17% of the cases. Again this additional information was more likely uncovered in the unfit than fit subjects (see Table 3).

VCAP provided independent evaluation and made specific treatment recommendations for each physician's inappropriate sexual behaviors aimed at restoring fitness-for-practice. These included seven referrals for residential rehabilitation, two to brief intensive treatment experiences, one for further evaluation in a residential rehabilitation facility and one to complete a continuing medical education program on maintaining professional boundaries. If appropriate, specific practice restrictions (e.g., same sex patients only), stipulations for ongoing treatment, support and supervision were suggested.

Table 3
Deception findings from polygraph examination

Outcome	Total n = 18		Completed Examination n = 16	
	N	%	N	%
No Deception Indicated	11	61.1%	11	68.8%
Deception Indicated	5	27.8%	5	31.3%
No opinion*	2	11.1%	—	—

*Note: Two polygraph procedures were terminated prior to being able to ascertain deception.

Occasionally, and only if appropriate following successful rehabilitation, follow up polygraphy testing may be suggested to monitor patient safety and response to treatment.

Discussion

Professional integrity and rigorous honesty are essential factors in determining questions of patient safety and the potential for rehabilitation of an offending physician. Other important factors, beyond the scope of this paper, that influence suitability for rehabilitation and eventual return to practice (or modified practice), include the egregious nature of the exploitation, the prescription or use of drugs that potentially alter the victim's judgment, whether the perpetrator takes full responsibility for his behavior and finally, the degree to which the perpetrator is aware of the impact (shows remorse) and potential sequelae resulting from sexual victimization of a patient by a professional (victim empathy). The reputation of the profession is enhanced by appropriate intervention in cases of professional sexual misconduct.

Factors affecting subject selection for polygraph were not considered for this study and the sample size is small. More systemized research and larger study population is needed to confirm our findings. However, the polygraph does appear to be an additional useful technique for detecting deception and uncovering previously undisclosed information relevant to the fitness-for-duty determination of professionals who allegedly violate sexual boundary violations. In the

context of comprehensive evaluation (FSMB guidelines), polygraph examination cannot be the sole determinate of fitness-for-duty. Nevertheless, when polygraph examination uncovers more information relevant to misconduct than the physician chose to reveal during investigation or could be elicited by experienced clinical interviewers conducting fitness-for-duty evaluation, questions arise about integrity and whether the subject is sufficiently honest to practice medicine safely. In many cases, it was not the formal polygraph determination of 'Deception Indicated' that influenced the evaluation outcome.

Sometimes the additional information obtained from the polygraph was elicited during the pre-polygraph interview and not from the actual polygraph determination of Deception Indicated. On these occasions, the examinee "passed" the polygraph, but only after they had already revealed additional relevant information during the interview portion of the polygraph examination. Thus, the final fitness for duty opinion was often influenced by additional information the polygraph examiner obtained (with the presence of the polygraph machine), rather than whether or not deception was actually indicated on the actual polygraph test. The polygraph examiner's experience testing criminals may provide a valuable independent perspective to balance the collegial bias of clinically trained assessors.

In the first case example, a polygraph examination was suggested to assess the credibility of the professor, who allegedly violated his patient/supervisee/female trainee but it was declined. Arguably, conducting a polygraph may have reduced the financial and emotional cost of protracted medical board deliberations and the suffering of the victim. In addition, timely diagnosis and accurate treatment might have increased the possibility for rehabilitation of the professor and restoration of his medical licensure. The protective bias of his treating psychiatrist underscores the importance of independent comprehensive evaluation. In case #2 the absence of either deception or any additional information derived from polygraph examination facilitated accurate diagnosis, specific treatment and re-education, in support of the physician's timely return to practice. In the third case example polygraph examination uncovered that what seemed to be an isolated lapse in professional judgment appeared to be a more predatory practice.

Conclusion

"Indeed, given what we know about the efficacy of polygraph testing with sex offenders, one might argue

that it is no longer a question of why we should use it in forensic psychiatry, but why we don't." (Grubin, 2010)

Routine use of the polygraph may be helpful in the independent, comprehensive evaluation of professional sexual boundary violations when discrepant accounts of sexual violations must be resolved to prevent further occurrences. Timely and credible resolution of these difficult situations can potentially diminish further traumatization of the victim, support restorative justice, facilitate rehabilitation of offending colleagues and restore the reputation of the profession.

The goal of comprehensive fitness-for-duty evaluation in professional sexual misconduct is to understand and diagnose the physician offender, and where possible suggest remediation that may allow the safe return to safe practice. When polygraph testing adds information that is not otherwise accessible in a comprehensive assessment, it can improve diagnostic accuracy and enhance patient safety. Our findings suggest support for the inclusion of polygraph evaluation in the FSMB guidelines for state medical boards, for example; a significantly higher percent of our polygraph subjects were judged unfit to practice (67% vs. 39%). However, determining whether the polygraph significantly improves the accuracy of these assessments would require random selection or mandatory testing. Professionals may violate sexual boundaries infrequently, but the consequences for victims and the profession can be devastating, hence accurate assessment is vitally important. The quest for more accurate diagnosis and better treatment for professional sexual misconduct presents another leadership opportunity for our healing profession. ■

About the Authors

A. J. Reid Finlayson, MD, is an Associate Professor of Clinical Psychiatry at the Vanderbilt Comprehensive Assessment Program, Vanderbilt University.

Kimberly P. Brown, PhD, is an Assistant Professor of Psychiatry at the Vanderbilt Comprehensive Assessment Program, Vanderbilt University.

Richard J. Iannelli, PhD, is the Senior Associate Director of the Vanderbilt Institutional Research Group.

Ron Neufeld, BSW, is Program Director at the Vanderbilt Comprehensive Assessment Program.

Kendall Shull, MSc, is Principal of Kendall Investigations & Polygraph Services, Knoxville, Tennessee.

Danielle P. Marganoff, MEd, is an Analyst at the Vanderbilt Institutional Research Group.

Peter R. Martin, MD, is a Professor of Psychiatry and Pharmacology at the Vanderbilt Comprehensive Assessment Program, Vanderbilt University.

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Appendix A

Variables Coded

The following coding guidelines were used in reviewing the reports of the 18 individuals referred for sexual boundary violations who also received polygraph examinations. The raters coded each case across seven variables:

Variable 1: Yes or No — Polygraph Added New Information Regarding Sexual Problems

Variable 2: Yes or No — Deception Indicated on Polygraph

Variable 3: Depth of Offense:

Polygraph (or threat of polygraph) resulted in:

1. More details that included learning of more occurrences or greater severity of behavior with the same patient(s) and/or staff than was previously known
2. More details that included learning about sexually inappropriate behavior with additional patients and or staff than was previously known
3. More details that included learning about sexually compulsive behavior that was not previously known but did not pertain to patients/staff (e.g., frequenting strip clubs, paying for prostitutes, affairs, excessive masturbation, etc...)

Variable 4: Yes or No — Physical Sexual Boundary Violation with Staff

Variable 5: Yes or No — Physical Sexual Boundary Violation with Patient(s)

Variable 6: Yes or No — Verbal Sexual Boundary Violation with Staff

Variable 7: Yes or No — Verbal Sexual Boundary Violation with Patient(s)

Coding Sheet

Variable 1: Yes or No — Polygraph Added New Information Regarding Sexual Problems

The rater indicates whether the polygraph examination yielded new or more information regarding sexual problems than was obtained from the evaluation otherwise. The rater should consider any information obtained in the evaluation when deciding if the polygraph added additional information. For example, if the polygraph matched information obtained in records reviewed (e.g., investigation by a medical board) but was more than the person being evaluated reported, the polygraph still did not add additional information and the rater should rate “No.” Only if the polygraph revealed information not known up until that point from any source is the variable coded as “Yes.” In addition, consider information presented to the polygrapher before, during, and after the polygraph. It need not necessarily come about only during the formal portion of the polygraph. New information regarding sexual problems includes more occurrences with the same patient (s) and/or staff, verbal or physical sexual interactions with new patients and/or staff, greater severity of behavior, or more sexually compulsive behavior than was previously known (e.g., visiting of strip clubs, prostitutes, etc... with greater frequency than was known prior to polygraph).

Variable 2: Yes or No — Deception Indicated on Polygraph

Variable 3: Depth of Offense

Polygraph (or threat of polygraph) resulted in:

1. More details that included learning of more occurrences or greater severity of behavior with the same patient(s) and/or staff than was previously known
2. More details that included learning about sexually inappropriate behavior with additional patients and or staff than was previously known
3. More details that included learning about sexually compulsive behavior that was not previously known but did not pertain to patients/staff (e.g., frequenting strip clubs, paying for prostitutes, affairs, excessive masturbation, etc...)

Variable 4: Yes or No — Physical Sexual Boundary Violation with Staff

The rater indicates whether any source of information from the evaluation (including the polygraph) reveals a physical sexual boundary violation with staff. Staff includes employees, hospital administrators, nurses, physicians employed in the practice or hospital, or other individuals with whom the examinee works or has work related contact. Sexual relationships with professionals who are employed by

the health care system but with whom the examinee has no professional relationship (e.g., no direct contact in the workplace, do not work in same practice, do not jointly treat the same patients, etc...) does not count. Only if the staff member has professional contact with the examinee are they considered to be staff. Examples could include touching a medical assistant on the behind, rubbing up against a nurse at the hospital, having sex with a tech with whom they work, etc... Physical contact includes kissing, rubbing, touching, licking, massaging, sexual activity, etc. ... Physical boundary violations could also include invasion of personal space (e.g., standing very close to or breathing upon the neck of a staff member).

Variable 5: Yes or No—Physical Sexual Boundary Violation with Patient(s)

The rater indicates whether any source of information from the evaluation (including the polygraph) reveals a physical sexual boundary violation with patients. A patient is an individual whom the examinee treats or has provided professional health related services. Physical contact includes kissing, rubbing, touching, licking, massaging, sexual activity, etc. ... Physical boundary violations could also include invasion of personal space (e.g., standing very close to or breathing upon the neck of a patient). Examples could include inappropriately examining a patient during an exam (e.g., touching breasts), engaging in sexual activity with a patient outside of the office, or rubbing up against patients as they leave the office.

Variable 6: Yes or No—Verbal Sexual Boundary Violation with Staff

The rater indicates whether any source of information from the evaluation (including the polygraph) reveals a verbal sexual boundary violation with staff. Staff includes employees, hospital administrators, nurses, physicians employed in practice or hospital, or other individuals with whom the examinee works or has work related contact. Sexual comments to professionals who are employed by the health care system but with whom the examinee has no professional relationship (e.g., no direct contact in the workplace, do not work in same practice, etc...) does not count. For example, if an examinee makes a sexual comment at a private party to a nurse with whom he does not work, this does not count. Only if the staff member has professional contact with the examinee are they considered to be staff. Examples could include using sexually inappropriate language, inquiring about the staff member's sex

life, discussing personal sexual matters with the staff member, commenting on the staff member's appearance/attractiveness, commenting on the staff member's sexual parts, etc... Verbal sexual boundary violations are verbal comments, asides, names, etc... made to or in the presence of staff.

Variable 7: Yes or No—Verbal Sexual Boundary Violation with Patient(s)

The rater indicates whether any source of information from the evaluation (including the polygraph) reveals a verbal sexual boundary violation with patients. A patient is an individual for whom the examinee treats or has provided professional health related services. Examples could include using sexually inappropriate language, inquiring about the patient's sex life inappropriately, discussing personal sexual matters with the patient, commenting on the patient's appearance/attractiveness, commenting on the patient's sexual parts, etc... Verbal sexual boundary violations are verbal comments, asides, names, etc... made to or in the presence of patients.

Note: If an individual had more than one boundary violations type, all were coded. For example, an examinee who makes sexually harassing comments to his nurse and also has touched her inappropriately, was coded yes for both verbal and physical boundary violations with staff. An examinee could conceivably be coded yes for all four sexual boundary violation variables or coded yes for only one.

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