Reducing Recidivism Potential: Experiences from an Education Provider

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Introduction

Board-ordered sanctions for healthcare professional offenses often include a remediation course to address ethics, boundary, or professionalism lapses.However, little is known about the effectiveness of remedial courses, particularly in preventing recidivism.

Methods

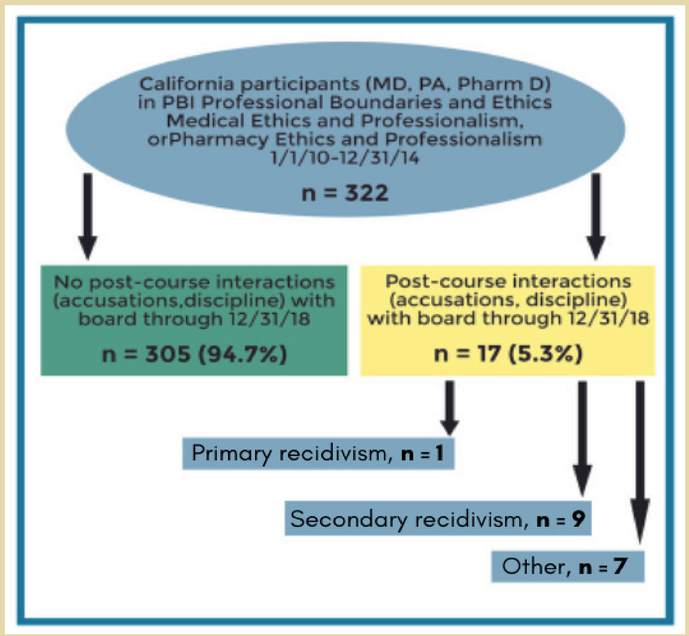
Prong 1: Retrospective cohort analysis. California licensees who graduated from PBI Education's (PBI's) Professional Boundaries and Ethics, Medical Ethics and Professionalism, or Pharmacy Ethics and Professionalism courses between 1/1/10, and 12/31/14 were tracked for subsequent interactions with their California regulator through 12/31/18. All participants with a post-course interaction with their regulator were examined independently on a case-by-case basis by three PBI staff members. Uncertainties or disagreements were resolved by consensus agreement.

Prong 2: Development of a Recidivism Formula© (RF) to understand why some disciplined licensees might reoffend. The RF is based on the premise that every disciplined licensee has the potential to reoffend and adapts PBI's Boundary/Ethics Formula© (BF), a conceptual framework for understanding the elements that cause an individual to commit a professional violation. We applied the RF to one of the participants in our cohort.

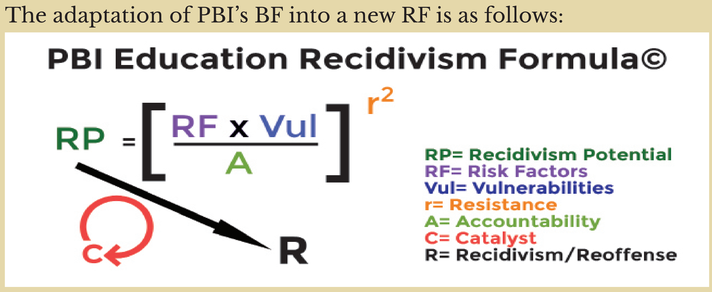
Prong 3: Recidivism literature review to compare our work to that of other investigators.

Results

322 clinicians met inclusion criteria (Figure). Of those, 17 (5.3%) had post-course interactions with their regulator. These individuals' douments were subjected to sub-group analysis. Reasons for these post-course interactions are summarized in Tables 1-3.



The adaptation of PBI's BF into a new RF is as follows:



RP = One's recidivism potential. Not an arithmetic equation, but a "formula" that depicts the interrelationships of multiple elements that, taken together, elevate an individual's potential to commit a violation. In the context of a catalyst (defined as c) and without appropriate safeguards, a violation will almost certainly occur.

RF = Risk factors, such as elements of one's professional life or practice

Vul = Personal vulnerabilities, such as physical, emotional or mental health, or stressors in one's personal life

r = resistance to self-assessment, such as denial, rationalization, justification, other-blaming. Resistance is so powerful a force in increasing the potential for recidivism that it is depicted as an exponent. Some individuals are so resistant to recognizing their resistance that their resistance is further increased exponentially.

Results (cont'd)

A = Accountability measures offset risk factors, vulnerabilities, and resistance and serve to reduce one's recidivism potential.

c = A catalyst can be a crisis, transition, trauma, or loss, or an individual who prompts a re-enactment of a previous emotional issue in the clinician, or the development of a physical or mental illness.

We applied the RF to the 2012 participant with primary recidivism. Although we do not know this physician's specific risk factors, vulnerabilities, and degree of resistance that contributed to the initial misconduct, it is known that previous board sanction is a strong risk factor for subsequent board sanction. (1, 2). Given the breadth and depth of the accusations, a more impactful disciplinary decision likely would have been more effective in getting this physician's attention and prompting positive change. The subsequent action against this physician's license included terms and conditions all aimed at addressing aspects of their clinical practice or personal situation that may have put them at risk for the negligence, incompetence, and shoddy record keeping. The clinical competence evaluation, course work, and monitoring all bolster accountability which, in turn, serves to reduce this physician's recidivism potential.

Our review of the literature did not yield any controlled outcome studies. Anecdotal reports of relapses of professional misconduct do not provide details of the nature of the discipline meted out, leaving open to speculation whether it is characteristics of the offending professional or characteristics of the sanction, or both, that determine whether or not recidivism will occur.

Our observed recidivism of < 1% is the of the same order of magnitude as the observed recidivism in participants in the Behavioral Medicine Institute of Atlanta treatment program who were followed for seven years. (3) None of the other articles attached a numerical value to recidivism with certainty. Multiple articles aimed to provide regulators with frameworks for assessing an individual licensee's risk for relapse, such as

- Demonstrated empathy and self-awareness
- Compliance with a personalized plan of safeguards to improve self-regulation, such as:
  - Elective or board-ordered course work
  - Avoidance of professional isolation
  - Development of mentoring relationships
  - Participation in an extended follow-up program (4, 5)

Those recommendations are consistent with the elements of our RF. For example, professional isolation and lack of mentoring relationships are risk factors that elevate one's recidivism potential. Lack of empathy, insight, and self-awareness are examples of resistance that powerfully elevate one's recidivism potential. And course work and participation in an extended follow-up program are examples of accountability that would decrease one's recidivism potential. This point is underscored by a study that suggested that greater monitoring or extended follow-up may reduce the number of repeat offenders. (1)

Number of Participants (year of course)	Reason for post-course board interaction
Table 1: Primary Recidivism, n = 1 (0.33% of total; 5.9% of the sub-group)	
1 (2012)	Accusations: repeated acts of gross negligence, incompetence, poor records. Action: Public letter of reprimand for documentation only; ethics course. Reoffended with same accusations. Subsequent action: revocation (stayed), probation x 3 years, clinical competence evaluation, courses, practice monitoring.
Table 2: Secondary Recidivism, n = 9 (2.8% of total cohort; 53% of the sub-group)	
2 (2012) 6 (2013) 1 (2014)	Violations of probation terms and conditions after course (e.g., lab testing, abstinence, etc.), all different from initial violation. Three surrendered licenses voluntarily. All have chemical addictions.
Table 3: Other, n = 7 (2.2% of total; 41.2% of the sub-group)	
4 (2012) 2 (2013) 1 (2014)	Five voluntarily surrendered licenses (e.g., late career, in lieu of discipline, 2° mental illness); one license was revoked. The second set of accusations for one occurred prior to taking the PBI course

Discussion

For nearly 20 years, we have observed that education can bring about remediation, as long as it is impactful education offered as part of a omprehensive, impactful disciplinary action. Education is necessary, but not sufficient.

It is striking that all of those individuals in the secondary recidivism category had addiction as the underlying reason for their professional misconduct, raising questions about whether addiction might confer its own unique resistance.

Limitations:

- Our analysis provides a snapshot of the participants over a limited time; it is possible that additional participants in this cohort might relapse in the future.
- We looked only at the participants in California
- Some of our participants may have relapsed without our knowing
- The size of our sample dictated that participants with a range of infractions be considered together as a single cohort. In a much larger sample, it may be illuminating to analyze the outcomes of participants according to their infraction (e.g., sexual boundary violation, addiction-related violations, clinical negligence, etc.).

Conclusions and Recommendations

Our work contributes to the conversation among regulators and the public:

- Recidivism can be prevented when one understands the elements that contribute to it
- Obstacles to the accurate tracking of recidivism are clarified
- Consideration of the RF elements may contribute to more impactful disciplinary dispositions

This report can assist regulators, educators, and researchers in generating additional research questions and avenues for exploration:

- Uniform standards for timely and accessible reporting of board actions across all states
- The role of victim empathy training within the context of a remedial course and/or as part of an extended remediation plan
- Clear language in board orders in all states describing the exact infraction (rather than, for example, "unprofessional conduct" or "other"), to enable accurate categorization and tracking.
- Exploration into whether individuals with chemical addictions—or even other conditions or behaviors—may represent a special group that should be handled differently from others
- Long-term monitoring of clinicians with a disciplinary history for evidence of recidivism: how should this be done, by whom, and for how long?
- Support for remediated clinicians from professional societies, a peer group of other remediated clinicians, workplaces, and elsewhere to decrease their isolation and assist in maintaining their accountability

Acknowledgments

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References

1. Grant D, Alfred K. Sanctions and Recidivism: An Evaluation of Physcian Discipline by State Medical Boards. *J Health Polit Policy Law* 2007; 32(5):867-885
2. DuBois JM et al. Sexual Violation of Patients by Physicians: A Mixed-Methods,
Exploratory Analysis of 101 Cases. *Sex Abuse* 2017; Jun 1: 1079063217712217
3. Abel GG, Osborn CA, Warberg BW. *"Professionals." Sourcebook of Treament*
Programs for Sexual Offenders. Ed. William L Marshall et al. New York: Plenum Press, 1998. pp 331-334.
4. Regehr C, Glancy G. *Empathy and Its Influence on Sexual Misconduct*. Trauma,
Violence, & Abuse 2001; April 1: 1524838001002002003
5. Tillinghast E, Cournos F. *Assessing the Risk of Recidivism in Physicians with Histories of Sexual Misconduct.* J Forensic Sci 2000; 45(6): 1184-1189