

DR. SMITH GOES TO SEXUAL-REHAB SCHOOL

John E. Smith was accused of sexual misconduct by patients.

He claimed he was just being thorough. A jury found him not guilty, but the Minnesota medical board decided he needed a 90's-style lesson in boundaries. **By Laurie Abraham**

'NO," DR. JOHN E. SMITH ANSWERS IMMEDIATELY, "I NEVER had a sexual thought while I was examining a patient." Beneath drooping eyebrows, his pale hazel eyes are unblinking.

The 63-year-old family practitioner is sitting beside his wife, Peggy, who has just cleared the dinner table of leftover breaded perch, bowls of peas and buttered noodles. Through the kitchen windows, a sheet of ice hard enough for skating glimmers in the front yard. When the moon is full, the frozen lawn becomes a spotlight on the Smiths' spacious 1950's beige-brick rambler in suburban Minneapolis. But on this March night not even a crescent creases the sky, and the ice remains dark, unrevealing.

At the kitchen table, the light is neither bright nor dim, the middling wattage of a man and a woman who dwell, above all, in moderation. For the past two years, however, the Smiths' lives have been dominated by charges that the doctor indulged in behavior of the most intemperate sort; that in the privacy of his medical office, he touched women's breasts in a sexual manner during respiratory and breast exams.

Every morning this week, Smith dons a sports jacket, tie and freshly pressed shirt, courtesy of Peggy, and drives his immaculate white Honda five miles into Minneapolis to the Professional Assessment Program, a couple of offices and a conference room on the fifth floor of the old nurses' quarters at Abbott Northwestern Hospital. He puts in eight-hour days, shuttling from one bland office to another, as if on rounds. But Smith the doctor is the patient here, paying \$5,000 to undergo an intensive evaluation by experts who take the mental temperatures of doctors and other professionals accused of sexual misconduct.

Three days into the assessment, Smith has had a medical workup and

is undergoing a dozen psychological and neurological tests. The team — two psychiatrists, two psychologists and a pastoral counselor (a former nun) — inquires into his childhood, his marriage, his religious beliefs and the encounters that led to the complaints against him.

In a trial last year, a jury found Smith not guilty of 10 counts of fourth-degree felony sexual misconduct, each carrying a penalty of up to 10 years in jail. Though the charges he was acquitted of require a finding of intent, medical boards don't have to find intent. Many, like the Minnesota board, can discipline doctors for behavior a "reasonable" patient might interpret as sexual. In January 1995, the board forbade him to treat women — about two-thirds of his practice — prompting him to "retire" temporarily. The board agreed to reconsider providing he complete a course in "professional boundaries" and submit to the psychiatric evaluation, which, as one board member put it, can distinguish "the sexual predator from the clueless guy who might be able to get a clue."

To be clueless may be the best Smith can hope for. The son of a family practitioner and the father of another, he considers himself a medical man, with all the qualities the old-fashioned term implies: proud, specially skilled, diligently bestowing his gifts of healing on the sick and asking that they honor him in return. ("The golden age of medicine is gone," Smith reminisced in a 1987 medical journal essay. The 1960's and 70's "seemed golden to me not for the harvested coin . . . but rather for the golden glow of approval that a good doctor-patient relationship radiated for us to bask in.")

But the 6-foot-1 doctor, whose narrow gray beard and sideburns can't hide slightly sunken cheeks, has been reduced to a dirty old man by the 6 o'clock news. So although Smith, a past president of the Minnesota Academy of Family Physicians, would hate to be summed up as a doddering doctor out of step with new standards of care, at this point he would probably be lucky to come away with that assessment.

Are you angry about what's happened to you? It is one of the first

Laurie Abraham is the author of "Mama Might Be Better Off Dead: The Failure of Health Care in Urban America."

experienced clinicians tend to select the few that correspond to a particular patient's complaint, and often through thin garments.

"No one wants to criticize a doctor for doing too much," says Dr. Patricia Cole, an assistant professor of family practice at the University of Minnesota and one of two doctors who testified on Smith's behalf. "But if patients don't expect that kind of exam, and he comes from the back, and he unhooks their bras, and he doesn't explain what he's doing, the situation is ripe for misunderstanding."

Cole seems an unlikely defender. Smith graduated from medical school in 1956, she in 1973 — a 17-year gap that not only saw growing numbers of women training as doctors, but also the advent of modern feminism and the women's health movement. So while Smith says he didn't think twice in medical school when he and his classmates performed their first pelvic exam on a prostitute, Cole remembers protests against a professor who invited a bikini-clad model to demonstrate proper human gait. Today she talks of "women finding their voices and challenging the medical model's patriarchal assumptions" and of feeling "anguish for the pain" suffered by Smith's accusers. Nevertheless she adds, "It was too simplistic to look at the case only from the victim's perspective."

Cole is convinced that Smith is not a pervert or a criminal. Rather, she describes him as an "inept communicator," stuck in a doctor-knows-best style of practice. She thinks the respiratory patients who said he cupped their breasts without the stethoscope in his hand (perhaps the most damning charge) were simply mistaken: "He uses a small stethoscope, as opposed to one with a large, obvious head — it's warm. He's smooth because he's done this exam thousands of times, and the patient thinks all she's feeling is his hand."

evaluating and rehabilitating doctor sex offenders, founded the Minneapolis P.A.P. He had written and lectured extensively about his work there before being lured to Atlanta to replicate the program at the Talbott-Marsh Recovery Center. Kent Neff, P.A.P.'s current director, had agreed to meet me and discuss the program, but later refused. Irons, who is joining the staff at Menninger, is willing to talk. He dips into the poetic language of psychoanalytic archetypes to help classify the doctors he sees: the Dark King, for example, possesses "charm and skill in manipulating others" and "engages in sexual exploitation as an expression of power."

But what about doctors accused of sexually touching breasts during examination? I ask Irons. Someone who fits Smith's profile?

The unwelcome toucher may be a *frotteur*, Irons offers, the equivalent of the "dirty man in the elevator" who grabs women to satisfy sexual urges. But the doctors he sees rarely suffer from such a dramatic, distinct illness. To describe the others, the balding, round-faced internist, who has until this point spoken deliberately and cautiously, jumps up and walks to his desk, a make-believe examining table where a make-believe female patient sits facing him.

"I've had doctors who would be examining the shoulder, and they're so intent on what they're doing they don't realize their groins are against the woman's knees." He grinds into the desk. "And she thinks he's got an erection, but he's really got a hammer in his pocket, or a beeper that's right here." His own innocuous beeper transmogrifies before my eyes. "I've had doctors who've forgotten the patient was a woman. They're thinking tendons and joints, or lymph nodes, and then this breast gets in the way, and they just push it to the side." He swats at an imaginary breast.

'The advantages of being a friend to your patients don't make up for the problems of being a friend,' says John Hung, a psychologist who schooled Smith in patient-doctor boundaries. It was part sensitivity training, part defensive medicine.

There are also innocent explanations for Smith's breast examination techniques. To help detect the dimpling and masses that suggest cancer, doctors routinely inspect breasts as women put their hands on their hips, or over their heads — an aspect of the examination that disturbed Leila White. More troubling to White was that Smith held both breasts at the same time. He contends that he was checking for symmetry and texture — differences could indicate cancer. Cole says that while most doctors palpate one breast at a time, "you could make the case that the simultaneous approach yields the same information."

But Gary Schoener, a Minneapolis psychologist who has counseled or testified on behalf of thousands of women who have accused doctors and ministers of sexual misconduct, fairly snorts when he hears the explanations of Smith's behavior: "You can tease out each of his actions, and alone they may not be a problem. But together? Why would you unsnap a woman's bra, unless both her arms were broken? If you've got even two women who say, 'The doctor touched me sexually,' the likelihood that he touched them sexually is very great. Where there's smoke, there's usually fire."

WITH ONE DAY LEFT TO GO IN HIS WEEK AT P.A.P., SMITH IS hoping to be declared innocent. That's the word he uses, sitting at his kitchen table, wearing the "innocent" clear glasses his lawyer suggested he wear at the trial instead of his more sinister dark ones. But P.A.P. probably can't grant Smith's wish to return to medicine's Garden of Eden. Although the doctor understandably regards his psychiatric evaluation as a second trial, the question the psychiatric team will try to answer is not whether he is innocent or guilty, but whether he is sick or well.

Dr. Richard Irons, 46, a leader in the small but growing field of

Doctors like this obviously need serious work on their bedside manner, but Irons goes further, giving the vast majority a medical diagnosis. Granted, some of them have a serious underlying disorder, like manic depression. But others may get slapped with a diagnosis out of the Diagnostic and Statistical Manual of Mental Disorders like "work-related problem" — tautologically defined as an "occupational problem" not due to a mental illness — or the all-encompassing "adjustment disorder," which could include a doctor so preoccupied with his divorce he forgets where his hands are.

Irons dismisses the possibility that some charges grow out of P.C. hypervigilance or that some offenders are merely compassless in a sea of shifting sexual norms. "It doesn't matter what norms are," he says. "It's a case of nontherapeutic touch if the patient didn't feel it was therapeutic."

This is almost a restatement of sexual misconduct as defined by licensing boards that P.A.P. and similar programs sprang up to serve. The bottom line for Irons is that when complaints make it as far as his front door, the doctor (or his sickness) is somehow to blame. But could the incidence of illness he encounters illustrate the bromide "To a man with a hammer everything looks like a nail"? No way, he says. Because of his experience — Irons says he has assessed professionals from 36 states and 4 provinces of Canada — state boards tend to refer the most disturbed, defensive doctors to him.

Indeed, programs like P.A.P. draw criticism from the other direction, from a public worried that sexual predators are being sent back into hospitals and examination rooms. Irons says many doctors accused of misconduct are able to resume their practice, but may need up to two years' treatment beforehand and close monitoring after

they are back on the job. As yet there are no data on how well such scrutiny works, or how many doctors "relapse" into sexual misconduct.

IT'S FRIDAY AFTERNOON, THE END OF A LONG WEEK IN THE HOT SEAT at the Minneapolis P.A.P. Now Smith is folding his lanky frame into a chair, fulfilling the second condition set by the medical board, the boundaries course. Taught by a clinical psychologist, John Hung, the lessons are part sensitivity training and part defensive medicine. After Hung asks Smith to carefully consider whether he wants me to observe today's session — and the doctor agrees to sign a consent form laying out in excruciating detail the dangers of opening one's life to a reporter — Smith allows me to stay. Hung, an assistant professor of family practice at the University of Minnesota, devotes most of the rest of the two-hour tutorial to teaching his pupil to read and respond to a patient's indirect signals of unease: "Maybe you've got a guy who thinks he needs a wrist brace for carpal tunnel syndrome, but he won't protest when the doctor prescribes aspirin. He'll just say: 'Well, if you think that's what I need. You're the doc.'"

Smith fixes Hung with his steady gaze. "As a rule," he stolidly replies, "that kind of thing wouldn't have been communicated to me." Hung laughs. "That's why you didn't become a psychiatrist," he says, as if he recognizes how psychologically astute he is asking this rigid medical man to become.

While it is not clear that Smith has digested all of Hung's advice, he gets the risk-management message loud and clear. Had I noticed, Smith asks me when Hung leaves the room to answer a page, that the psychologist works alone, without even a secretary in the office? I'm puzzled by what he is getting at.

"I would think there would be times that he would want someone close by," Smith continues, "someone who could say, 'Hey, I was there — he didn't do anything wrong.'"

Doctors nationwide, not just on the litigious East and West Coasts, are turning increasingly to chaperons for cover. The shift is part of a larger boundaries movement within a medical profession seeking a bulwark against what regular-guy doctors perceive as legions of prickly women whose new sexual sensitivities are bewilderingly obscure and thus dangerous. Times *have* changed. It used to be, for example, that a doctor wouldn't examine a patient unless she was nearly naked; now the doctor is expected to methodically cover each body part as he finishes examining it. But many of the changes seem so easy to grasp that women are often amazed that doctors need special articles and lectures to figure this stuff out.

Talk to women, doctors are told. Tell them what you're doing when you're poking around their bodies. Knock before you enter the examination room. Don't "sensually rub a patient's back while discussing findings of her pelvic exam" or gush about the "nice set of breasts" a 16-year-old is developing — examples of sexual-boundary violations cited in a recent issue of the *Journal of the American Medical Association*.

"Women are demanding that doctors not treat them like pieces of meat," Dr. Alison Coulter-Knoff, a family practitioner, tells hundreds of doctors at seminars throughout Minnesota, largely in response to fears that they could end up like Smith. Fair enough, but some of what she and her fellow boundaries coach, John Hung, teach doctors might make women doubt whether boundaries are what they want.

"Hug a patient, hire a lawyer," Coulter-Knoff continues. The doctor who drops off groceries for a sick patient, even an elderly shut-in, is also asking for trouble, Hung warns. "What are you going to do when the patient dies, leaves you all her money in her will and the family brings a lawsuit against you for unduly influencing her?" His advice? Get on the phone and ask a social worker to help. "The advantages of being a friend to your patients don't make up for the problems of being a friend."

The price of mutual mistrust between women and doctors may be

higher than we think. University of Minnesota researchers recently found that women who visit female family practitioners and internists are up to twice as likely to receive mammograms and Pap smears as those who go to male doctors. One explanation may be that male doctors worry about allegations of sexual impropriety. Such fears may inhibit preventive care in quite subtle ways, suggests Dr. Karen Margolis, an author of the study. Although many techniques may be used to examine breasts, the one factor that has been most consistently shown to increase detection of abnormal lumps is the length of the examination.

"I'd estimate that doctors usually take less than a minute to examine both breasts, but some of the latest recommendations say we should spend up to five minutes on each breast," Margolis says. "Can you imagine a male doctor trying to explain *that* to his patients?"

DURING HIS WEEK AT P.A.P., SMITH MENTIONS THAT ONE OF THE evaluators, the former nun, suggested that he needed to grieve about leaving medicine. "I told her it was the proper action — why should I grieve about a proper thing?" Smith tersely repeats what he told her. But when I later come upon his medical journal essay, it tells me a different story, the story of a man who to this day answers his home phone with a lilting, "Dr. Smith." For an epitaph, he wrote: "I'm thinking that my choice would be 'Doctor, father, husband, storyteller' — in that order. I can even imagine carrying on as a widower, but I cannot conceive of myself as no longer being a physician."

Finally, in mid-April, P.A.P. issues the report. It's almost total vindication for Smith: "The assessment team did not find any evidence that his behavior with patients had sexual overtones. ... He did not explain thoroughly what he was about to do or was in the process of doing. While this was not a problem for patients of long standing, it is likely that younger, new patients with no familiarity with his style perceived him as strange, odd and or cold."

The report recommends that the medical board remove restrictions from Smith's license and that he update his examination technique, enlisting a doctor to accompany him until both feel "comfortable" with his new approach. Then Smith should examine women in the presence of a female chaperone — "as we recommend for all physicians."

"No one really listened to the ladies," says Leila White, who stretched her sales

clerk's budget to buy a rueful reminder of Smith, a hand-shaped piece of crystal. "Why would so many women come forward if nothing happened?" Susan Field expresses anger but not surprise: "You think the truth is good enough, and you find out it's a game. I feel like I have to stand outside Dr. Smith's office with a little sign, 'Perverts Practice Here.'"

Pickets probably won't be necessary. The board has not lifted the condition forbidding Smith to treat women, for reasons a board lawyer says cannot be disclosed by law. But even if Smith gets an unrestricted license, he doesn't plan to examine patients anymore. "I'd be too suspicious of them," says Smith, who is also fighting malpractice suits based on the complaints. He can't afford to permanently retire, so the man who once compared medicine to a religious calling now just wants an administrative job. In a way, that forced conversion may put Smith into the ranks of modern medical men, if his son Tony is any measure. "For people of my generation, medicine is a job," Tony says. "I'm happiest coming home at the end of the day and spending time with my family."

As for the elder Smith's own doctor-father, Archie, it's probably fortunate that he isn't alive to see what medicine has become for his only son. If Smith gets the kind of job he hopes for, he will end up as a medical director at a nursing home — pushing papers in an institution where medicine is often more irrelevant than exalted. ■



John Hung taught Smith about patients' indirect signs of unease.