When the Pediatrician Is a Pedophile

Sexual Exploitation of Patients By Health Professionals, A.W. Burgess & C.R. Hartman, editors, New York: Praeger, 1986, 99-106.

Carolyn Moore Newberger and Eli H. Newberger

As recently as the late 70's, child sexual abuse was considered extremely rare. Recent retrospective surveys, however, suggest that from 3 to 6 percent of males and from 12 to 38 percent of females are sexually victimized during their childhoods (Finkelhor 1979; Russell 1983). Although there is variation from study to study in estimates of incidence, the magnitude of the problem is clear. During the past few years, cases of child sexual abuse have involved day care centers, prominent families, and respected institutions (Trainor 1984).

Little is known about adults who commit sexual acts with children. Available data suggest that 95 percent of the sexual abuse of girls and about 85 percent of the abuse of boys is committed by men, most of whom are known to the child. The offenders come from all ethnic and income groups and may be community leaders who exploit their positions of prestige to gain access to children. They are more likely than the general population to be outwardly religious and rigid about sexual mores (Finkelhor 1984).

Most child sexual abusers appear normal to the rest of the world, and their deviancy is frequently not recognized by their wives, friends or colleagues. They may be homosexual, heterosexual, or bisexual; they may have sexual relations with adults as well as children or only with children. Some individuals prefer sustained relations with one child, while others favor brief sexual encounters with many. They may rape infants or "initiate" adolescents. Some sexual abusers operate "sex rings" in which groups of children become involved with one or more adults, usually through some neighborhood or recreational activity (Finkelhor 1984; Burgess et al. 1984).

Pedophiles, individuals whose sexual preference is for children, may select professional contexts in which access to children is assured. Within the medical profession, pediatrics offers such access. The pediatrician, usually a beloved and trusted member of the community, has intimate and often private contact with children's bodies. When the pediatrician is a pedophile, the interests and needs of many parties are compromised: the children's needs to be free of abuse and exploitation and to trust adult caregivers, the medical profession's needs to maintain its standards for care and its status within the community, and the community's needs to maintain social order and to trust those on whom it relies for the care of children.

Such multiple needs and interests are reflected in our society's confusion over what to do about the sexual abuse of children. This confusion reflects a fundamental set of moral

conflicts: (1) the conflict between personal and institutional needs and the assumption of responsibility for others, and (2) the conflict between responding with standard rules of justice and responding with individualized prescriptions for care. In this chapter, we present a case that illustrates these central moral conflicts and discuss how we might resolve them in ways that achieve an enlightened, moral response.

WHOSE INTERESTS ARE SERVED? THE CASE OF THE PEDIATRICIAN PEDOPHILE

When we are confronted with sexual abuse, especially abuse by a powerful professional, all too often every interest but the child's seems to take priority. This appears to be true in the case of a pediatrician we call Dr. Smith.

Dr. Smith was the subject of a disciplinary proceeding before a state board of registration in medicine. The pediatrician is a respected, prestigious, and powerful member of his community. He is married and an active member of a local church.

During the routine physical examination of a 14-year-old boy, Dr. Smith removed the child's undershorts while the boy lay on the examining table and began stroking his genitals and asking questions about injury to the penis, sperm color, and problems with ejaculation. After masturbating the child to ejaculation, the doctor hugged the boy, saying "I'm a pretty cute guy," and then kissed him on the neck. By this time, the child became very nervous and confused. He was subjected to several more hugs before leaving the examination room. After the boy and his mother left the doctor's office, he told her what had happened.

Shortly after, the boy's family called police. Although an initial contact was made, the police inquiry apparently then stopped. No criminal charges were filed, and there was never any public disclosure of the incident. Rather, the matter was addressed six months later in a closed hearing of the state board of registration in medicine. The board retained a private attorney to conduct its own investigation and to serve as the prosecutor in a closed meeting in which the complainant, other witnesses, and the doctor would appear.

During the closed inquiry, the doctor claimed that boys often had ejaculations during physical examinations and revealed the names of two other boys. His records showed a private shorthand for the events and lavish descriptions of the boys' bodies. He also said that he served often and without compensation as a lecturer on teen-age sexuality, that he worked as both a school and a camp physician, and that his examinations of boys' genitals often lasted more than five minutes. He steadfastly maintained that there was no harm in what he did.

The doctor's license was suspended for 30 days and he was placed on probation for ten years, during which time he was to seek psychiatric help until discharged by the psychiatrist. Dr. Smith was instructed to have a third person present during the examinations of his patients throughout the probationary period. Responsibility for arranging for that third person was left with the doctor.

The parents of Dr. Smith's patients were not notified of the hearing or its findings, and public communication was limited to a small notice in the local newspaper. The self-monitoring and limited public communication, especially in light of the doctor's failure to acknowledge any wrong doing, made the effectiveness of controls over Dr. Smith's practice questionable. Dr. Smith discontinued psychiatric treatment following an evaluation period.

In the meantime, two other cases of past abuse were revealed. The victims were boys who had approached Dr. Smith with problems after a sex education class during which he invited children concerned about sexuality to consult with him. One boy had worries about homosexuality; the other was worried about venereal disease and about whether he had impregnated his girlfriend. These disclosures prompted a reopening of Dr. Smith's case by the state board of registration.

The deliberations of the second hearing, 18 months after the initial disclosure, resulted in Dr. Smith's permanently losing his license to practice medicine. Dr. Smith again refused to admit wrongdoing. During at least part of this time, he had continuing opportunity to molest his young patients.

Dr. Smith demonstrates some of the classic characteristics of pedophilia (Lanning 1984):

- The perpetrators are male.
- They select a particular age and gender of victim.
- They choose professions (medicine) and specialties (adolescent pediatrics) that provide legitimate reasons for sustained (and in the doctor's case, intimate) contact with the children they prefer.
- The perpetrators keep a personal record that permits prompt retrieval of material about their victims.
- They protect themselves.

Several aspects of this case are particularly interesting. First, after being contacted by the parents of the child who first reported the abuse, police contacted the boy's school before even contacting the doctor. The school secretary was asked to check the boy's records, and she found four minor disciplinary infractions. No mention is made in the police records of whether this was done with the permission of the child or family. The implicit statement in the police action is that the child's behavior in school will have something to do with how the police will respond to the accusation. This means that the victim, rather than the act, is the first line of investigation, at least when the accused is a powerful member of the professional community.

Second, according to Dr. Smith's testimony, he was informed by the state and national offices of the American Academy of Pediatrics and by the American Medical Association that there are no guidelines for dealing with this offense. In light of new estimates of the prevalence of the sexual abuse of children, of the likelihood that the abuser is known and trusted, and of the probability that pedophiles choose positions where they have access to

the victims, these organizations have an obligation to establish clearly articulated values and procedures.

Third, following a brief period, the discreet police inquiry stopped. There were no criminal charges or public disclosures. The doctor continued in his practice, while the board of registration in medicine conducted an investigation that resulted in a closed hearing six months later. These procedures served to protect the physician and his profession, but failed to protect the public.

A final highlight of these cases is that Dr. Smith's conduct was found by the board to be improper, inappropriate, and unprofessional. This is tantamount to saying he was a "bad boy" and does no justice to the seriousness of the charges and to the effects of the abuse on the victims. Because there was no public disclosure, Dr. Smith could take a month-long vacation and thus camouflage the suspension. He arranged for his own chaperoning. When the case was reopened after the two previous patients came forward, he stated on deposition that he did not believe that he needed treatment, that what he had done was not wrong, and that his actions had no effects on the children.

A MORAL ANALYSIS OF THE CASE OF DR. SMITH

The issue of morality is not an issue simply for the sexual victimizer, but also for the systems and individuals that respond to the victimization. How do we articulate a framework for moral choice to guide public and private behavior, especially when the interests of powerful adults threaten to obscure the rights and needs of children?

When we examine professional practice and policy in relation to child sexual abuse, moral tensions and conflicts between self-interest and responsibility and between justice and care are present. Some of the confusion and conflict around the sexual victimization of children centers on the extent to which we feel we should take public responsibility, and when we do, whether a morality of justice or a morality of care is the appropriate response.

The Conflict between Self-Interest and Responsibility

The conflict between self-interest and responsibility is generated in this case in at least three ways.

1. Dr. Smith's sexual desires for his patients versus his responsibility to these children as a pediatrician.
2. The inferred need on the part of the police to stay in favor with the powerful medical community versus their responsibility to investigate openly a case considered a crime by community standards.
3. The desire on the part of the medical community to protect its reputation by secrecy versus its responsibility to the public to protect children from sexual exploitation and to allow parents informed choice about whether they want their children to be treated by a man who molested other children in his care.

Clearly each of these were resolved on the side of self-interest.

The first step in applying moral choice is interpersonal awareness, or being aware of the effects of actions on others. Dr. Smith appears not able to make that first step, insisting that what he is doing is not wrong and does not effect his patients. That he acted out his own needs, rather than his patients', is clear. Less clear is how self-interest and responsibility are defined by his professional peers, who suspended his license to practice for a brief period but did not take steps to ensure that additional children would not be victimized. Is it self-interested not to inform people that their pediatrician is a pedophile? Does it protect the image of the profession that has the task of judging him? Or does it protect people from the knowledge that caregivers might be capable of hurting them, knowledge that might cause harm if people then fail to seek medical care?

The Conflict between a Morality of Justice and a Morality of Care

The justice versus care dilemma in child sexual victimization might be articulated as follows: How can we maintain social order and justice, while at the same time respond to individual needs for healing and care? As a society, we are confused whether to treat adult sex with children as a crime to be punished or as a symptom of pathology to be cured. This confusion has led to a continuing conflict, with some people arguing for universal criminalization of child sexual abuse and other people advocating a more family and treatment-oriented approach.

The conflict between a morality of justice and a morality of care is evident in several aspects of this case:

1. On the part of the police, the conflict was between whether to treat this case as any case of sexual molestation would be treated (i.e., to apply a standard of equal justice with the consequent exposure of a member of the medical community), or whether to respond to the needs of the medical community by turning the case over to its own governing body.
2. On the part of the board of registration, the conflict was whether to treat this case as a violation of medical conduct, which requires loss of the privileges of the profession, or to approach it as a case of a sick physician who needs to be cured.

The issues of justice or care in relation to the victims appear not to have been considered.

Resolving the Moral Conflicts of Sex with Children

For everyone who must respond to the sexual victimization of children (families of victims, clinical providers, protective workers, members of the criminal justice and judicial systems, and architects of social policy), there is' a need to recognize the moral conflicts the victimization presents. Can we face the problem when it conflicts with our own needs and interests? Can we provide justice while not neglecting individual needs for healing and care?

Three orientations toward persons and problems can be viewed as characterizing how individuals and institutions have responded to sex with children. We suggest that these orientations define a developmental progression of response to child sexual victimization.

An egocentric orientation. The problems of child sexual victimization are avoided, denied, or responded to out of individual need. In the case of Dr. Smith, the response was in terms of protecting a powerful profession and a colleague rather than the children.

A conventional orientation. Criminal or clinical rules and procedures bind and constrain action on child sexual victimization. Individual differences are not understood or acknowledged. For example, a conventional interpretation of sexual victimization as a criminal act leads to the universal prescription of prosecution and punishment. A conventional interpretation of sexual victimization as psychopathology leads to a universal prescription of psychotherapy. Although responsibility for responding to sex with children is assumed, response tends to be rigid and ideological. In this case, psychotherapy was ordered without considering the doctor's motivation to change. His steadfast belief in the normalcy of his behavior and his consequent failure to follow through with treatment means that unless other options can be considered and applied, children with whom he has contact will continue to be at risk.

An individualized orientation. Evaluation of each situation in terms of its own particular needs and realities guides response, which considers the needs of the child for emotional support and protection, the offender's need for corrective intervention, and our institutions' needs to do their jobs. A variety of options are available to be applied in the service of both justice and care.

TOWARD RESPONSIBILITY IN THE CASE OF DR. SMITH

Can we define a response to Dr. Smith's victimization of his patients that will protect children from further abuse and will permit intervention to be both fair and individualized? As a first step, we identify goals of intervention for the four primary constituencies in this case: the community, the medical profession, the victims, and Dr. Smith.

Constituency	*Goals*
Community	To maintain laws that deter others and provide equitable redress for crimes
	To apply the law without favoritism
	To protect its population from harm
Medical profession	To uphold the ethical imperative to do no harm
	To maintain public trust and confidence
Victims (past and future)	To have an opportunity to recover from the abuse and to know the abuse was not their fault
	To be protected from sexual exploitation
Dr. Smith	To be removed from situations where he can sexually abuse others
	To be rehabilitated to assure that he assumes responsibility for his

acts and will not sexually abuse others

The task of the responding institutions is to identify flexible and realistic options that would satisfy as fully as possible all these goals. Our preference is for a system of interdisciplinary practice, with members from the mental health, law enforcement, legal, and medical communities, to evaluate $such cases. The protection of children must be the primary concern, with the protection of the needs of offenders and institutions secondary.

In our opinion, justice was not served by the doctor's treatment as a special case, and the care of children was violated by the failure to inform parents of the risk of child sexual abuse by Dr. Smith. In addition, the goal of rehabilitation was not served by the prescription of mental health treatment in the face of Dr. Smith's denial of a need for change. In this case, criminal action may have been warranted in order to impress upon Dr. Smith the seriousness of his behavior. Strong external controls may be necessary, at least initially, in the face of minimal internal acknowledgement.

Although the ultimate removal of Dr. Smith's license to practice medicine may be a removal from opportunities to abuse children sexually, this action may protect the medical profession more than it protects children from Dr. Smith. He will no longer have access to children as a pediatrician, but it does not prevent access to children in other ways. The power of sexual desires and preferences in pedophiles is extremely strong, and pedophiles often form rings and networks that enable them to have contact with children. In this context, Dr. Smith is a pedophile first and a pediatrician second. He should be treated not as an errant pediatrician, but as a pedophile who remains a threat to children.

REFERENCES

Burgess, A., C. Hartman. M. McCausland, and P. Powers. 1984. "Impact of Child Pornography and Sex Rings on Child Victims and Their Families." In *Child Pornography and Sex Rings*, edited by A. Burgess. pp. 111-26. Lexington. Mass.: Lexington Books.

Finkelhor, D. 1984. *Child Sexual Abuse*. New York: The Free Press.

_______.1979. *Sexually Victimized Children*. New York: The Free Press.

Lanning. K. 1984. "Child Pornography and Sex Rings." Paper presented at the annual meeting of the American Orthopsychiatric Association. Toronto.

Russell, D. 1983. "The Incidence and Prevalence of Intrafamilial and Extrafamilial Sexual Abuse of Female Children." *Child Abuse and Neglect* 7:133-46.

Trainor, C. 1984. "Sexual Maltreatment in the United States: A Seven-Year Perspective. " Paper presented at the Fifth International Congress on Child Abuse and Neglect, Montreal.