

# Problematic Physicians: A Comparison of Personality Profiles by Offence Type

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**Objective:** This exploratory study compares objective personality test findings among physicians exhibiting different forms of misconduct. The importance of delineating distinctive personality characteristics by type of offence is that such characterizations can direct therapy and prognosis for remediation.

**Method:** Eighty-eight physicians referred to the Vanderbilt Comprehensive Assessment Program for Professionals (V-CAP) completed the Minnesota Multiphasic Personality Inventory-2, the Personality Assessment Inventory, or both, as part of their evaluation. On the basis of referral information, physicians were partitioned into 3 groups of offenders: "sexual boundary violators," "behaviourally disruptive," and "other misconduct."

**Results:** On both personality measures, the sexual boundary violators generated the greatest percentage of profiles indicative of character pathology.

**Conclusions:** Although all 3 groups exhibited unacceptable behaviours, the pervasive personality features of the sexual boundary violators are associated with greater therapeutic challenge, and these individuals likely pose the greater risk of reoffending.

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## Clinical Implications

- Objective personality data are lacking on problematic physicians.
- This is the first study to compare problematic physicians according to offense type.
- This article presents a scholarly discussion integrating current research findings with clinical-observational data from the literature.
- The findings suggest the importance of seeking collateral information, of using objective personality testing, and of considering polygraph testing as part of a comprehensive workup.

## Limitations

- There was no matched control group of nonproblematic physicians.
- Findings from V-CAP referrals may not generalize to problematic physicians referred elsewhere.
- The "other misconduct" (that is, mixed) group of problematic physicians may be too heterogeneous for meaningful comparisons with the other 2 groups in the study.

**Key Words:** physician health, sexual boundaries, psychological testing

Doctors are primarily talented, responsible, and compassionate healers. However, there are problematic physicians whose professional misconduct threatens care quality and risk minimization.<sup>1</sup> In 1981, Dorr<sup>2</sup> noted that the literature on problematic physicians is "rich in clinical observations, but lacking in quantitative data."<sup>2, p451</sup> Twenty-five years later, the paucity of empirical studies (for example, those using objective measures of personality such as the MMPI) of troubled physicians persists. Nevertheless, it is important to delineate personality characteristics of physician-offenders so that such characterizations can direct therapy and prognosis for remediation. Garfinkel et al<sup>3</sup> compared MMPI findings for 2 male psychiatrists whose licenses were revoked for sexual misconduct with findings for 38 male psychiatrists without similar allegations. The MMPIs had been administered during residency training. The preoffence MMPI profiles of the 2 sexual offenders were characteristic of individuals with antisocial and often narcissistic personality traits, and also of individuals exhibiting high levels of defensiveness. Langevin et al<sup>4</sup> compared 19 male physician sexual offenders (whose offense was primarily sexual assault on adult women) with a closely matched control group of unusually well-educated nonphysicians (almost all had at least a college degree) with similar sexual-offence histories. The MMPI results did not differ significantly between the 2 groups. The findings suggested that both offender groups suffered from depression and anxiety, which the investigators interpreted as a likely result of legal charges. Further, as did the sexual boundary offenders in the Garfinkel et al study,<sup>3</sup> the respondents slanted their MMPI responses in a socially desirable direction. They either had inaccurate self-knowledge or were deliberately attempting to fake test results in a positive direction. We found no study comparing psychological test profiles of physician sexual boundary violators to physician peers with other problematic behaviours. Such a comparison could shed light on whether or not there are differences in the dysfunctional personality patterns and psychopathology of physicians exhibiting different forms of misconduct. If there are such contrasts, these differences might have implications for treatment and

prognosis. Therefore, in the current study, we compare 3 groups of physicians referred to the V-CAP for fitness-for-duty evaluations related to problematic behaviour(s). These groups are "sexual boundary violators," "behaviourally disruptive," and "other misconduct" offenders.

## Method

### *Patient Referral*

The V-CAP is a multidisciplinary program that provides fitness-for-duty evaluations for complex problems relating to mental health, addictions, burnout, compulsive sexual behaviour, and disruptive behaviour(s).<sup>5</sup> Referrals are made by state PHPs and medical boards, by hospital physician wellness committees or medical executive committees, or by the physician's practice administration.

*Subjects.* This retrospective study was conducted with the approval of the Vanderbilt University Medical Center Institutional Review Board. The subjects were 88 physicians who had been referred to V-CAP for evaluations. Of these 88 physician referrals, 82 were men (mean age 46.8 years, SD 9.5), and 6 were women (mean age 47.5 years, SD 12.2); 80% were married, 13% were divorced, and 7% were single. Additionally, 89% were white, 5% were African American, 4% were Hispanic, and 1% were Asian.

*Subject Placement Into Offender Group.* The coordinator of VCAP, a social worker and substance abuse specialist, has almost 30 years of professional experience working in the areas of mental health and substance abuse. After speaking with the referral source, the coordinator clarified and then classified the primary areas of inappropriate professional behaviour that led to the referral. Although the initial classification of offenders occurred prior to the study, independent verification of the assignment was conducted by a VCAP psychologist familiar with placement criteria (see categories below). There was interrater agreement on 86 of the initial 88 assignments ( $\kappa = 0.98$ ).

Two subjects initially assigned to the disruptive behaviour group were switched to the other misconduct group owing to primary substance abuse.

*Offender Categories.* Three categories of offences were derived, based on referent behaviour (accusation). Each category was operationalized as follows:

- Behaviourally disruptive subjects ( $n = 39$ ) had exhibited repeated inappropriate behaviours such as uncontrolled anger or other conduct demeaning to others in the medical workplace.<sup>6-8</sup>
- Sexual boundary violators ( $n = 25$ ) had engaged in alleged impropriety or misconduct of a sexual nature, such as physician-patient sex or physician-staff sex, or

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### Abbreviations used in this article

ANOVA	analysis of variance
MMPI	Minnesota Multiphasic Personality Inventory
PAI	Personality Assessment Inventory
PHP	physician health program
SD	standard deviation
V-CAP	Vanderbilt Comprehensive Assessment Program

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had been allegedly sexually provocative or exploitive with patients or staff.<sup>9-12</sup>

- Other misconduct offenders ( $n = 24$ ) included a more heterogeneous group and involved substance use, emotional instability that interfered with work performance, or a pattern of professional irresponsibility.<sup>1,2</sup>

On demographics, the 3 offender groups did not differ significantly in age, ethnic distribution, or marital status (all  $P$ s > 0.05).

*Personality Test Measures Administered.* The MMPI-2<sup>13,14</sup> and the PAI<sup>15</sup> are valid, reliable, broadband personality inventories designed to define and classify an individual's personality and psychopathology. They are also important assessment devices for treatment planning. These multiscale personality inventories were selected because of their wide use and extensive empirical support.<sup>13-16</sup>

### *Minnesota Multiphasic Personality Inventory-2*

The empirically based 567-item MMPI-2 is the 1989 restandardization of the original MMPI. Interpretation of the MMPI-2 is based primarily on a profile analysis of the 4 validity scales that essentially measure the respondent's test-taking attitude (for example, attempts to misrepresent results, such as positive or negative impression management) and the 2 or 3 most highly elevated of the following 10 clinical scales: Hypochondriasis, Depression, Hysteria, Psychopathic Deviate, Masculinity-Femininity, Paranoia, Psychasthenia (that is, personality features such as anxious obsessiveness, fearfulness, and unreasonable guilt feelings), Schizophrenia, Mania, and Social Introversion. Raw scores on these scales are translated into  $T$  scores (standardized scores with a mean of 50, SD 10). Typically, these scores can range from  $T$  of 30 to  $T$  of 120.  $T$  scores above 65 (1.5 SDs above the mean) are considered clinically significant.  $T$  scores at this level of elevation represent an occurrence by less than 7% of the standardization samples because a  $T$  score of 65 represents a percentile score of 93.3. In the present study, we administered the 370-item short form of the MMPI-2. Although not the standard 567-item MMPI-2 administration, Graham<sup>14</sup> notes that this specific abbreviated version of the test enables the scoring of 3 of the 4 validity scales and all 10 of the clinical scales.<sup>14</sup> It does not allow for the scoring of the MMPI-2 supplemental scales.

*Categorizations by MMPI-2 Clinical Scales.* As mentioned previously, clinical scales were considered significantly elevated at  $T$  scores of 65 or higher (1.5 SDs above the mean, that is, exceeding a percentile score of 93.3). We assigned code types based on each subject's single (or rarely, 2) most elevated MMPI-2 clinical scale(s) (that is, reaching a  $T$  score of at least 65, with no other requirement). A highly experienced MMPI-2 researcher then placed participants with similar code

types (for example, an elevated scale or scales indicative of subjective distress) into 1 of 4 rationally derived groups. A second rater, provided with a description of the assignment rules, independently assigned each physician to an MMPI group. The raters agreed on 100% of the physician MMPI-2 group placements. The MMPI-2 groups were as follows:

- Subjective distress ( $n = 14$ ). These clinical scale code types were characterized by depression as determined by significant scores on the Depression and (or) Psychasthenia (that is, anxiety) and (or) Hypochondriasis (that is, somatic expressions of psychological distress) and (or) Hysteria Scales.
- Characterological features ( $n = 17$ ). These code types were grouped because of their association with problematic characterological features, including antisocial attitudes and (or) behaviour, impulsivity, and poor judgment, according to the Psychopathic Deviation Scale; and suspiciousness, cynicism, anger, and hypersensitivity to criticism, according to the Paranoia Scale.
- Normal profiles ( $n = 42$ ). This group included all physicians whose MMPI-2 results yielded no significant elevations, that is, no clinical scale  $T$  score greater than 64, and for the validity scales, an L ("lie") Scale score less than  $T = 66$  and a K ("subtle defensiveness") Scale score less than  $T = 70$ .
- Invalid profiles ( $n = 11$ ). This group included those physicians whose MMPI-2 performance yielded no clinical scale greater than  $T = 64$  and either an L Scale greater than  $T = 65$  or a K Scale greater than  $T = 69$ . Although the clinical implications of elevated L and K Scales can differ, we chose to treat them equivalently, with the exception of having a higher cut-off for the K Scale because, in a well-educated population (as was studied here), scores on the K Scale are usually higher than scores on the L Scale.

For 2 physicians, the MMPI-2 performance suggested a thought disorder (the Schizophrenia Scale score was greater than  $T = 75$  and was the highest clinical scale score). Because there were only 2 of these MMPI-2 profiles, they were simply excluded from the analyses.

We evaluated the success of this strategy for dividing physicians into MMPI-2 groups by using ANOVAs to compare the groups across the identified scales on which they would be expected to differ. As can be seen in Table 1, the subjective distress group scored higher than the other groups on the Depression, Psychasthenia, Hypochondriasis, and Hysteria Scales; the characterological features group scored highest of all groups on the Psychopathic Deviate and Paranoia Scales; and the normal profile group scored lowest of all groups on all the clinical scales designated above.

**Table 1 MMPI-2 Clinical Scales (T scores) by MMPI-2 group type**

MMPI-2 Scale	Subjective distress	Characterological features	Normal profile
Depression (Scale 2)	61.9 <sup>a</sup>	60.1 <sup>a</sup>	49.5 <sup>b</sup>
Psychasthenia (Scale 7)	58.1 <sup>a</sup>	60.7 <sup>a</sup>	47.7 <sup>b</sup>
Hypochondriasis (Scale 1)	65.2 <sup>a</sup>	56.8 <sup>b</sup>	48.2 <sup>c</sup>
Hysteria (Scale 3)	65.2 <sup>a</sup>	59.5 <sup>a</sup>	51.0 <sup>b</sup>
Psychopathic deviation (Scale 4)	58.9 <sup>a</sup>	67.2 <sup>b</sup>	50.8 <sup>c</sup>
Paranoia (Scale 6)	55.4 <sup>a</sup>	68.6 <sup>b</sup>	52.3 <sup>a</sup>

Note: T-Scores within a row that do not share a common superscript are significantly different ( $P < 0.05$ ) from each other. For example, on the MMPI-2 Depression Scale, the normal profile group (with the superscript "b") had a score that differed significantly from the subjective distress and characterological features groups (neither of which has a superscript "b").

**Table 2 MMPI-2 profile type by physician offence type**

Offence type		MMPI-2 profile type				Total
		Subjective distress	Characterological features	Normal profile	Invalid	
Disruptive behaviour	Count, <i>n</i>	6	7	24	1	38
	Within offence, %	15.8	18.4	63.2	2.5	100.0
Sexual boundary violator	Count, <i>n</i>	1	8	7	7	23
	Within offence, %	4.3	34.8	30.4	30.4	100.0
Other misconduct	Count, <i>n</i>	5	4	11	3	23
	Within offence, %	26.2	13.0	47.8	13.0	100.0
Total	Count, <i>n</i>	12	19	42	11	84

### MMPI-2 Results

Chi-square analysis of the distribution of the 4 MMPI-2 profile types across the 3 problem behaviour groups yielded a significant effect ( $\chi^2 = 15.51$ ,  $df 6$ ;  $P < 0.02$ ). As can be seen in Table 2, compared with the other 2 groups combined, sexual boundary violators were:

- Over twice as likely (43.8%, compared with 17.5%) to have valid MMPI-2 profiles indicative of character deficits such as impulsiveness or anger ( $\chi^2 = 4.80$ ,  $df 1$ ;  $P < 0.03$ ).
- Several times more likely (30.4%, compared with 6.6%) to have produced invalid MMPI-2 profiles indicative of extreme defensiveness ( $\chi^2 = 8.37$ ,  $df 1$ ;  $P < 0.005$ ).
- Nearly one-half as likely (30.4%, compared with 57.4%) to have normal MMPI-2 profiles indicative of no significant psychopathology ( $\chi^2 = 4.85$ ,  $df 1$ ;  $P < 0.03$ ).

### Personality Assessment Inventory

The 344-item PAI was constructed in 1991 and comprises 11 clinical scales (psychopathology–diagnosis), 5 treatment consideration scales (prognosis), 2 interpersonal scales (social support), and 4 validity scales (assessing response biases, such as minimization or exaggeration of response, as well as random responding and careless responding). The clinical scales are Somatic Complaints, Anxiety, Anxiety-Related Disorders, Depression, Mania, Paranoia, Schizophrenia, Borderline Features, Antisocial Features, Alcohol Problems, and Drug Problems. An important aspect of the PAI scales is that they are further divided into 1 to 3 subscales that reflect specific components of their respective disorders. These subscales allow for greater diagnostic accuracy and personality differentiation. For example, the Depression Scale includes Cognitive (measuring thoughts of worthlessness or hopelessness), Affective (measuring feelings of sadness or

**Table 3 PAI scales (T scores) by PAI group type**

PAI Scale	Subjective distress	Interpersonal difficulties	Antisocial	Normal profile
Somatic Complaints: Health Concerns	59.2 <sup>a</sup>	53.9 <sup>ab</sup>	55.4 <sup>ab</sup>	49.3 <sup>b</sup>
Anxiety-Related Disorders: Traumatic Stress	65.8 <sup>a</sup>	50.5 <sup>bc</sup>	54.5 <sup>c</sup>	45.5 <sup>b</sup>
Depression: Cognitive	54.9 <sup>b</sup>	50.2 <sup>b</sup>	50.5 <sup>b</sup>	44.1 <sup>a</sup>
Paranoia: Persecution	51.2 <sup>b</sup>	61.6 <sup>a</sup>	47.9 <sup>b</sup>	46.5 <sup>b</sup>
Schizophrenia: Social Detachment	53.4 <sup>ac</sup>	59.3 <sup>a</sup>	50.8 <sup>bc</sup>	46.1 <sup>b</sup>
Borderline Features: Negative Relationships	58.1 <sup>ac</sup>	59.7 <sup>a</sup>	52.1 <sup>c</sup>	46.0 <sup>b</sup>
Aggression: Aggressive Attitudes	46.4 <sup>b</sup>	60.3 <sup>a</sup>	50.9 <sup>b</sup>	46.4 <sup>b</sup>
Antisocial Features: Antisocial behaviours	47.1 <sup>b</sup>	47.4 <sup>b</sup>	59.1 <sup>a</sup>	46.2 <sup>b</sup>
Mania: Grandiose	47.6 <sup>b</sup>	52.6 <sup>ab</sup>	54.8 <sup>a</sup>	48.2 <sup>b</sup>
Alcohol Problems	52.6 <sup>ab</sup>	45.8 <sup>bc</sup>	59.1 <sup>a</sup>	44.9 <sup>c</sup>
Drug Problems	49.6 <sup>b</sup>	45.8 <sup>b</sup>	60.0 <sup>a</sup>	46.1 <sup>b</sup>

Note: T scores within a row that do not share a common superscript are significantly different ( $P =$  or  $\leq 0.05$ ) from each other.

loss of sense of pleasure), and Physiologic (measuring decrease in energy and appetite) subscales. As with the MMPI-2, performance on the PAI is expressed in terms of T scores.

**Categorizations by PAI Clinical Subscales.** We identified the specific subscales for each global clinical scale on which the most physicians earned a T score of at least 65 to maximize identification of clinically meaningful PAI differences among the 3 offence groups. Three individuals with T scores of 70 or greater on the Positive Impression validity scale were excluded because scores in this range are commonly seen as indicative of defensiveness sufficient to render the rest of the scores invalid. The small number of these invalid profiles made comparison with the other PAI groups inappropriate. We excluded the Anxiety and Suicidal Ideation Scales because no physician had a T score over 65 on these scales. We then grouped the profiles on the basis of the subscale on which they scored highest (that is, we combined subscales with related symptom correlates, as was done with the MMPI-2), as follows:

- Subjective distress ( $n = 10$ ). Physicians in this category were those scoring highest on subscales characterized primarily by anxiety or depression (specifically, the Anxiety-Related Disorders, Traumatic Stress Subscale; or the Depression, Cognitive Subscale) or on subscales assessing somatization characteristic of psychological distress (specifically, the Somatic Complaints, Health Concerns Subscale).

- Interpersonal Difficulties ( $n = 16$ ). This category comprised those scoring highest on subscales characterized by disturbed interpersonal relationships (specifically, the Paranoia, Persecution Subscale; the Schizophrenia, Social Detachment Subscale; the Borderline Features, Negative Relationships Subscale; or the Aggression, Aggressive Attitude Subscale).
- Antisocial ( $n = 13$ ). This group comprised physicians scoring highest on the subscales assessing antisocial features (the Antisocial Features, Antisocial Behaviours Subscale) and related features (the Mania, Grandiose Subscale; and the Alcohol Problems or Drug Problems Scales; there are no subscales for the latter 2 scales).
- Normal Profiles ( $n = 41$ ). This group obtained no T score of at least 65 on any of the 11 PAI clinical scales.

We evaluated the success of this placement strategy for dividing physicians into PAI groups by comparing the groups (via ANOVAs) across the identified scales on which they would be expected to differ. Table 3 illustrates the following findings:

- The subjective distress group scored higher than the other groups on the Anxiety-Related Disorders, Traumatic Stress Subscale; the Depression, Cognitive Subscale; and the Somatic Complaints, Health Concerns Subscale.
- The interpersonal difficulties group scored highest on the Paranoia, Persecution Subscale; the Schizophrenia, Social Detachment Subscale; the Borderline Features, Negative Relationships Subscale; and the Aggression, Aggressive Attitude Subscale.

**Table 4 PAI Category type by physician offence type**

Offence type		PAI Category				Total
		Subjective Distress	Interpersonal Difficulties	Antisocial	Normal Profile	
Disruptive behaviour	Count, <i>n</i>	3	10	2	22	37
	Within offence, %	8.1	27.0	5.4	59.5	100.0
Sexual boundary violator	Count, <i>n</i>	3	4	8	5	20
	Within offence, %	15.0	20.0	40.0	25.0	100.0
Other misconduct	Count, <i>n</i>	4	2	3	14	23
	Within offence, %	17.4	8.7	13.0	60.9	100.0
Total	Count, <i>n</i>	10	16	13	41	80

- The antisocial group scored highest on the Antisocial Features, Antisocial Behaviours Subscale; the Mania, Grandiose Subscale; and the Alcohol Problems and Drug Problems Scales.
- The normal profiles group scored lowest on nearly every scale and subscale just mentioned.

It should be noted that not all physicians who took the MMPI-2 ( $n = 86$ ) also took the PAI ( $n = 83$ ), owing to time constraints resulting from the need to incorporate other tests (for example, screening for attention-deficit hyperactivity disorder) in specific cases.

#### PAI Results

The distributions of the 4 PAI categories across the 3 offender groups (see Table 4) were significantly different from each other ( $\chi^2 = 16.85$ ,  $df 6$ ;  $P < 0.01$ ).

As with the MMPI-2, the sexual boundary violators group had, by more than one-half, the fewest physicians producing normal PAI scores (that is, scoring within normal limits on all scales) ( $\chi^2 = 7.4$ ,  $df 1$ ;  $P < 0.01$ ). Percentages were as follows: 25%, sexual boundary violators group; 59.5%, behaviourally disruptive group; and 60.9%, other misconduct offenders group.

The PAI category (excluding the normal profiles group) that included the most physicians differed substantially by offence. Behaviourally disruptive physicians most frequently produced PAI elevations associated with interpersonal difficulties ( $\chi^2 = 6.6$ ,  $df 1$ ;  $P < 0.01$ ), and sexual boundary violators most frequently produced PAI elevations associated with antisocial features ( $\chi^2 = 4.4$ ,  $df 1$ ,  $P < 0.05$ ).

#### Discussion

This exploratory study examined the personality profiles of problematic physicians exhibiting different forms of offences (categorized as sexual boundary violators, behaviourally

disruptive individuals, and other misconduct offenders). Physicians who were referred because of sexual boundary violations generated the fewest normal profiles on both personality inventories employed in this study and, as in the Garfinkel et al<sup>3</sup> study, produced the highest percentage of MMPI-2 and PAI profiles indicating character disorder. Personality traits associated with the specific MMPI-2 and PAI elevations of the sexual boundary violators also suggested that, as a group, they tend to experience greater problems with impulse regulation and to be more self-centred, less empathetic, less likely to take responsibility for their offences (and more likely to blame others or circumstances), and less likely to be influenced by societal norms.<sup>14,15</sup> Similar to findings by both Garfinkel<sup>3</sup> and Langevin,<sup>4</sup> they also produced the most MMPI-2 protocols suggesting exaggerated attempts to present themselves in an unrealistically positive light. These particular personality attributes suggest significant therapeutic challenge and a generally more guarded prognosis than that for physicians engaging in the other misbehaviours.<sup>17</sup> The empirical findings noted above are consistent with clinical findings. Abel and Osborn<sup>18</sup> observed that "Physicians involved in sexual misconduct usually show minimal appreciation of the plight of their victims"<sup>18, p 232</sup> and that

When individuals carry out behaviours inconsistent with their image of themselves . . . they will attempt to neutralize such negative feelings by developing cognitive distortions, justifications, and rationalizations to legitimize [their] misconduct.<sup>18, p 230</sup>

For example, one member of the sexual boundary violators group attempted to justify his inappropriate behaviour with a female patient by stating that the complainant "wanted to perform oral sex on me." It is not necessarily the sexual offence that led this physician to ascribe blame to his patient: individuals with this personality profile have a strong tendency to blame others for any troubles they encounter. The marked

guardedness of our alleged sexual offender sample may be a reflection of society's zero tolerance for sexual boundary infractions, fear of punishment (for example, incarceration, loss of license, and stigmatization), and shame.<sup>19</sup>

The small percentage of invalid profiles observed in the behaviourally disruptive group suggests more openness to the assessment process and greater willingness to admit to personal shortcomings than are found in the sexual boundary violators group (which had the highest percentage of invalid profiles). The behaviourally disruptive physicians also scored high on scales measuring interpersonal dysfunction. Although many of the behaviourally disruptive physicians we evaluated freely admitted to their angry outbursts or other misconduct, they tended to rationalize their responses as stemming from their being passionate healers who would not tolerate problems (for example, substandard performance by a staff member) that could negatively affect their patients. There are clearly times when a situation justifies a physician's frustration and (or) anger, but excessive emotionality leading to abusive language and (or) disparaging remarks to a coworker is not defensible.

Our study had several limitations. First, we had no matched control group of nonproblematic physicians. Notably, however, the only MMPI study that included a "normal" (that is, nonclinical) sample of physicians found no clinically significant group elevation on either MMPI validity or clinical scales.<sup>2</sup> This finding adds confidence to our assumption that the elevations in our study are not characteristic of physicians as a group. Further, agreement between the MMPI-2 and PAI findings adds support to the validity of our results. A second limitation of the current study is that referrals for V-CAP assessment may not generalize to problematic physicians assessed elsewhere. For example, Langevin's<sup>4</sup> group of sexual offenders (who sexually assaulted adult women) displayed more violent behaviour than our group of sexual boundary violators. Further, Katsadvakis et al.<sup>20</sup> reported that participants' therapists were the largest source for 334 referrals for assessment and (or) treatment at the Menninger Clinic (1975 to 2000). The most commonly cited problems leading to referral in their study were "marital and emotional difficulties rather than substance abuse, boundary violations, or prescribing information."<sup>20, p60</sup> Our referrals primarily came from state licensing boards and other organizations, including practice groups, hospital boards, and physician wellness programs, and involved boundary violations or other professional misconduct. These various contextual factors involving physician offences and (or) problems, sites of study, and referral sources must be carefully considered before generalizing about problematic physicians from individual studies. Finally, our group of other misconduct offenders may be too heterogeneous for meaningful comparisons to

the other groups. Unfortunately, there was no single subgroup within this diverse cohort that was sufficiently large enough for meaningful comparisons with the other 2 groups. Even with its limitations, however, our research should stimulate prospective studies that corroborate or challenge our findings. In particular, our finding that, relative to other problematic physicians, physicians referred for sexual boundary violations demonstrate objective evidence of greater character pathology could have important implications for treatment interventions and prognosis.<sup>18,21</sup>

Specific directions for future research are suggested by our current findings and by Roback and Crowder's findings<sup>22</sup> in a national survey of psychiatric resident dismissal from training programs. It is important to identify factors that predict the emergence of impairment during medical school and residency training rather than later in the professional's career. Future research might also be directed at empirically determining specific subgroups within each offence category. Another important area of study will be the determination of the specific therapies and (or) other clinical management strategies that are most successful with different offender groups.

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### **Résumé : Les médecins problématiques : une comparaison des profils de personnalité selon le type d'infraction**

**Objectif :** Cette étude exploratoire compare les résultats de tests de personnalité objectifs chez les médecins qui démontrent différentes formes d'inconduite. Il importe de discerner les caractéristiques de personnalité distinctes selon le type d'infraction parce que cette caractérisation peut orienter la thérapie et le pronostic de mesures correctives.

**Méthode :** Quarante-huit médecins adressés au programme d'évaluation complet Vanderbilt pour professionnels (V-CAP) ont répondu à l'inventaire de personnalité multiphasique du Minnesota-2, à l'inventaire d'évaluation de la personnalité, ou aux deux dans le cadre de leur évaluation. D'après les renseignements sur la personne adressée, les médecins ont été répartis en 3 groupes de délinquants : « transgresseurs des limites sexuelles », « perturbateurs comportementaux » et « autre inconduite ».

**Résultats :** Aux 2 mesures de la personnalité, les transgresseurs des limites sexuelles produisaient le pourcentage le plus élevé de profils indicateurs de pathologie caractérielle.

**Conclusions :** Bien que les 3 groupes affichent des comportements inacceptables, les traits de personnalité prépondérants des transgresseurs des limites sexuelles sont associés avec un problème thérapeutique plus grave, et ces personnes posent probablement de plus grand risque de récidive.

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