WHO MINDS THE MINDERS?

Steve Vinay Gunther

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ABSTRACT

Professional regulatory bodies - including ethics committee, association boards, and government licensing authorities - oversee the ethical behaviour of professionals, specifically monitoring their use of power. However there is relatively less scrutiny regarding the use of power by such regulatory bodies in the consideration of grievances against professionals. The quasi-legal nature of their administration of justice is questioned here, and significant limitations in the implementation of administrative law are addressed. The use of adversarial models of investigation is called into question, and other possibilities are outlined The shortcomings of the 'crime and punishment' model are outlined, and a number of alternatives are examined. The foundation of professional ethical codes are addressed and critiqued.

KEYWORDS

Professional codes of ethics, regulation, regulatory bodies, sanctions, rule-based alternatives, boundaries, sexual misconduct, victims, power differential, natural justice, due process, administrative law, alternatives to adversarial, impairment.

Ironically they overlook the fundamental bedrock of all ethical considerations that are based on a human understanding of love. Instead they use whatever mistake a colleague may (or may not) have made as justification to impose a primitive, punitive and harsh system of justice. (Welch, 1998)

THE EFFICACY OF PROFESSIONAL CODES OF ETHICS, AND THEIR ENFORCEMENT

Prelude

I ran a psychotherapy training school for several decades. In its early days I had occasion to deal with a serious complaint from a student regarding one of the supervisors on my referral list. This was in relation to a rumour she had heard about another of his supervisees, a third party who was not one of my students. At this time there was no professional association to refer the matter to, so I became both investigator and judge. Although the action of this practitioner appeared to be clearly out of order, I found on investigation that the situation was more complex, the circumstances required more and more investigation, and involved more and more people. It became a very time consuming process for me, which I could scarce afford. I drew limits, came to my conclusion and imposed certain consequences on the supervisor.

I found that no one was happy. The student complained I had not taken the matter seriously enough, and that the consequences were not strong enough. The supervisor felt I had acted without a sufficient investigation and had not taken into account a number of important mitigating factors. The third party was not interested at all in the investigation and refused to provide any evidence. I felt that I did my best, but could see that in dealing with such matters, things were not straightforward at all.

In the intervening years, I have witnessed the mostly problematic attempts of properly organised professional associations to deal with ethical matters. Most of the time the results appear to be unsatisfactory for at least one party, the proceedings questionable, and process of the administration of justice contains glaring lapses. I am both sympathetic to the difficulties faced by those conducting such investigations, and disturbed at times by the results.

This essay is an attempt to delve into the complexities and ground of the construction, operation, and monitoring of professional ethics.

Introduction

One of the tenets of a profession is that it operates for the public good, and not only for the benefit of members of that profession. This is a major reason for the generation of codes of ethics: to keep the profession in good repute, and specifically, to keep professionals honest and competent.

These are noble aims, and all professions have adopted guiding codes. However, codes means little unless they is promoted amongst the members through education there is some way to enforce them. There are several corollories to implementation of enforcement.

The first is that the collection of broad principles which generally make up such codes can be seen to become a set of laws when it comes to hearing a complaint and determining whether a breach has occurred. There is a shift from statements of philosophical orientation to measures by which behaviour can be evaluated.

Where the rules are spelled out in explicit detail, this process is more straightforward. When principles alone are referred to there is a great deal more interpretation involved, and thus room for dispute.

Secondly, mechanisms to hear grievances, and evaluate professional breaches have to be established. These mechanisms have some of the trappings of legal processes - and often use legalistic type of language - although they may not take place in the context of a court system. Infractions which are deemed as lesser may be dealt with in other ways, but complaints are generally heard in an adversarial context which includes initial charges, an investigation, a prosecution process or hearing, and a judgement. This involves the exercise of significant power on the part of the responsible body, including ultimate decisions about a professional's career.

Society grants both status and a certain freedom of practice to members of a profession; the social contract involves an expectation that the resultant privilege and power will not be abused. The issue fundamentally at stake in ethics investigations is the exercise of power by the professional under examination: are they using their power in a way which upholds the standards of the profession, and is in service of the client? In recent years courts, tribunals, boards and committees have attempted to demonstrate that they are not there only to protect the members of the profession, but even more so to protect the general public.

In the professional sphere there is debate as to what constitutes ethical conduct, and there is much research and writing about the topic. Complaints generally focus on the use of power by individual professionals. Less attention is paid to the power wielded by regulatory bodies in relation to the enforcement of ethics and standards of professional behaviour. This may be due to assumptions that that such bodies are doing a good-enough job. This is however not always the case. There are many documented instances where professionals were not treated fairly during investigations, and there are numerous anecdotal instances of unjust procedures and out of proportion consequences.

Without systematic research, the actual extent and detail of these problems cannot be accurately assessed. However, such research is made difficult by the fact that professionals may be subject to a range of bodies such as civil courts, criminal courts, administrative courts, ethics committees of professional associations, licensing boards, professional review committees aligned with institutions or employers and health care tribunals.

Each of these bodies has its rules and procedures, and is constituted by different populations. Court roles include judges, public prosecutors and sometimes juries. Professional regulatory bodies are generally made up of professional peers, private investigators, appointed lawyers, or members of the general public. Problems that arise from such a makeup can include conflicts of interest, personal bias, limited knowledge of the administration of justice or the exercise of institutional power, limited understanding of ethics, and lack of skill involving investigations or the interpretation of codes.

These deficiencies then can show up in a range of procedural issues, including flaws in the investigation process, methods of prosecution and presentation of evidence, and passing judgement. As a result, procedural fairness may be compromised, and the principles of natural justice bypassed.

Final judgements also need to be considered in this picture. There are a range of consequences which may be imposed as a result of a finding against a professional, including reprimand, penalties, rehabilitation, through to suspension or expulsion. At one end such consequences can be seen as relatively benign. At the other end they can have major impact on the professional concerned.

However, the process of enquiry itself, even if resulting in exoneration, can be highly stressful, leading to anxiety, depression, relationship breakdown, and even suicide. If the process is poorly or unfairly conducted, this can have an additional destructive impact.

One of the results of the increasing scrutiny of professionals, and the concomitant rise in complaints and hearings is a reactive policy of risk management. This self defensive response can be useful in terms of a heightened self monitoring in relation to ethical behaviour. It can however lead to certain types of minimalist professional practices which are based more on fear than concern for clients, leading to negative consequences for the quality of practice.

There are some professions such as medicine where the exercise of technical expertise is more marked in the relationship with patients. In this domain, ethical practice can utilise ethics consultations, which can include patients and family members.

In other professions such as psychology or teaching, there is often emphasis is less on the technical side and more on relationship; decision making does not generally involve the life and death issues of medicine. In this more subjective climate the administration of accountability can be more fraught.

We will examine each of these areas in some detail, and consider alternative viewpoints and structures in each case. The subject of this investigation are the regulatory bodies which monitor professional behaviour, especially in the health care industries. Although they are different in form, scope and jurisdiction, they share the common feature of holding power over a professional's ability to practice, and their standing in the community. These shall collectively be referred to here as 'regulatory bodies', with the understanding that this refers to entities which are responsible for monitoring professionals.

CODES - REASON AND CONSTRUCTION

Professional codes of ethics perform multiple functions: enhancing the publics' trust in the profession, providing a source of social accountability, defining professional practice, distilling collective experience, a source of support in the face of unreasonable claims on professionals, and a deterrent to unethical behaviour (Pritchard, 2006). They are integral to the claim of a profession to legitimacy (Anderson & Swanson, 1994; Mabe & Rollins, 1986) and reflect social agreement on standards or principles of behaviour (Rouseau, 1762/1979).

Institutions and professional bodies express their particular values through their codes of ethics (Hadjistavropoulos & Malloy, 1999; Malloy & Hadjistavropoulos, 1998) which represent the social conscience of a profession (Camenisch, 1983). The codes provide members with guidelines for what is understood by the organisation as ethical conduct, in professional and legal terms. It is important that these formal values are matched by the values of members (Liedtka, 1989; Trevino, 1986); the degree of congruence determines the health of an organisation's culture (Sinclair, 1993).

A range of concepts and values underpinning current definitions of professionalism are incorporated into codes of ethics; many of these values are assumed, and are not always subject to critical examination. Codes can reflect certain social, class and professional bias, and may not sufficiently address areas such as minority or rural values and concerns (Pope & Vetter, 1992). Unquestioned tenets concerning professionalism include *contractual relationships*, *the professional as expert*, *fee for service* and the perception of the client role as *relatively vulnerable and passive* (Koehn, 1994). There are however other perspectives in relation to client involvement and accountability, based on the notion of a covenant between the professional and society (May, 1983) and predicated on a 'pledge-based', service-oriented professional ethic (Koehn, 1994 p.44). Rogers (1973) suggests that certification and professionalism tend towards conservatism and stagnancy, as compared with the ethics of creativity and diversity which is more likely to create responsible and responsive practitioners.

Critics of the regulatory approach to ethics variously describe the effect of a legalistic monoculture; a defensive managerial orientation which creates an ethics under duress, and produces false compliance (Gladstone, 2008; Postle, 2007; Tudor, 2011b). The 20th Century saw a burgeoning of licensing of range of professions, with aims including improving the quality of professional services and restraining incompetent practitioners; cogent analyses show that the demonstrable benefits have in actual fact been limited, and there have been a range of negative side effects including increases in costs of services, problems in supply, and limited effectiveness of discilpline (Hogan, 1983). The mooted benefits of monitoring, regulation and accompanying standards of competency have not necessarily been borne out in practice (Gross, 1978; Postle, 2007).

This raises a much larger question regarding the appropriateness of regulation of the health field. Whilst in contemporary terms this seems a foregone conclusion, there are challenges to the fundamental beliefs which underly the momentum for regulation and accreditation (Postle & House, 2009). This paper explores some of the issues related to the process of discipinary findings. Tudor (2011a) provides a thorough critique of a range of contemporary problems of relguation, pointing out that legislation such as that of the New Zealand Ministry of Health (2010) aims to protect the public from harm but may not achieve this in any kind of substantial way, and can even work against public benefit by producing a misguided complacency. The codes which arise from such acts of government do not necessarily provide increased protection of clients, as they change neither character, not prevent human error.

Without ongoing input and critical evaluation, a code can steer towards inflexibility or dogma, and become overly self referential (Frankel, 1989). Codes need to evolve so that they remain a living framework which is relevant to members and interpreted in a way that is sensitive to context. However, in the process of isomorphism, professional codes tend to echo each other, striving for a demonstration of legitimacy rather than questioning fundamental assumptions (Holder-Webb & Cohen, 2012). This represents a fundamental tension inherent in ethical frameworks, between the need to codify - with the accompanying dangers of ossification (Smith, 2005), and the need for the 'vital traditions' (MacIntyre, 1984) and 'disclosive space' (Spinosa, Flores, & Dreyfus, 1997) where responsive dialogues are conducted that engage tensions across difference (Strong, 2010)

Professional codes of ethics generally have three dimensions - they are aspirational, educational and regulatory (Sawicki, 2010; Strahlendorf, 2013). The aspirational dimension is oriented towards best practice, rather than specifically identifying right and wrong. The educational dimension assists professionals with decision making and coping with complex situations. The regulatory component functions as a basis for evaluating grievances and is enforceable. Such enforcement may also perform the function of censoring ideas which stray too far from the norms of the group (Frankel, 1989).

Constraining unethical behaviour in the professions occurs through the threat of sanctions, the monitoring of colleagues, and the public nature of the code, which allows for complaint when standards have not been met. By self-declaring accountability - and demonstrating the willingness to take the implementation seriously - codes provide the basis for demonstrating a profession's claim to a measure of autonomy (Frankel, 1989).

The professional association creates a significant sense of belonging and underpins a professional identity; this provides a sense of a place in the community, and the capacity to make a quality contribution (Rizzardi, 2005). The fear of losing membership operates to keep professionals within the bounds of normative ethical behaviour. The danger of a loss of membership or license is not only a financial and vocational fear, but also strikes at the core need for belonging. Given that shame and belonging are at two opposite poles (Lee & Wheeler, 1996), the enforcement of ethical codes raises issues of isolation and alienation (Warren, 2013).

Codes need to be broad enough to allow professionals to exercise judgement (Austin, Moline, & Williams, 1990), but this can also create problems, as a set of general principles can interpreted in multiple ways (Adams, 2001). On the other hand, if codes are too specific and rule based they lose the flexibility required for different circumstances (Eriksson et al., 2008), and may become so complex that it becomes unrealistic to adhere to all the standards (Shapiro et al., 2008). This inherent tension is reflected in problems with the administration of codes, especially through ethics and licensing hearings: the interpretive dimension requires subjectivity, though it may appear as though the committees and boards represent an objective position.

Another source of ethics frameworks comes from regulatory bodies themselves. For instance, the Health Care Profession's Council (HCP) in the UK defines its entire ethical reference in several core phrases: *'[having] the health and character…the necessary skills and knowledge… to do their job safely and effectively… to act legally…maintaining public confidence in the professions and professionals…'*(HPC, 2014 p2).

The phrases cover 16 professions, from Dentistry to Psychotherapy - arguably entirely different realms of practice, each with its own variables. Each of these broad phrases is highly open to interpretation, yet they form the basis on which professionals are tried, and may lose their ability to practice. Certain requirements such as 'must meet the needs of the client' (HPC, 2012) reference a consumer-supplier model which does not fit the expectations of professions such a psychotherapy, where the relationship is 'based less on harmony than on discord' (Samuels, 2014 p.9). Thus an ethic from one domain is applied to another in ways which are questionable. Similarly, the term 'informed consent' is not particularly meaningful for someone who has not experienced therapy before; such expectations set up unrealistic requirements which place practitioners in the danger of 'acting unethically'.

Ethical codes, being compilations of general principles, are not written with their 'most dangerous uses in mind' (Williams, 1999). Clinical decisions are specific but codes are made up of generic statements (Clark, 2012b); when these codes are used in a litigious context each word can become a weapon (Adams, 2001). For instance, the APA code specifically states that General Principles are aspirational in nature and should not be used in as a basis for sanctions (APA, 2003), but in the end such codes are used in the quasi-legal processes of enforcement by regulatory bodies.

In contrast, a relational approach to ethics differs from the more common rules-based framework, viewing core ethical concerns as involving an attitude which is rooted in mutuality, relational engagement and the value of uncertainty and openness (Birrell, 2011). This is at odds with the climate of caution which tends to be induced by risk management approaches (Annas, 1991). The adoption of adversarial dynamics in the hearing of complaints tends to abandon collaborative or humanistic values, often treating the professional concerned in a pathologising and hostile manner (Shapiro et al., 2008).

Critchley points out that ethical codes emerge out of specific and personal disappointments which are subsequently articulated in terms of meaning (a philosophic or religious orientation), or justice (a political orientation). This is clearly the case with the genesis of the APA code of ethics, which drew from case examples of problematic conflicts, provided by members (APA, 1951); these were then distilled into a specified and enforceable framework. Once such a framework is created, it attains a life of its own, assuming authority by the nature of its existence, and achieving a kind of moral status that is reminiscent of religious codes. Bakhtin (1984) has described this type of process as centripetal, the converging on prescriptive meanings.

This is contrasted with centrifugal processes, an example of which is the dialogue which has been involved in the development of the *Universal Declaration of Ethical Principles for Psychologists* (Gauthier, 2006); this endeavour represents the search for a larger, cross-cultural platforms as the basis for the articulation of professional codes.

Decision making and alternatives to rule based ethics

Most professionals are familiar with what they *should* do, but actual action will reflect their own values (Wilkins et al., 1990) and often departs from the identified ideal (Bernard, Murphy, & Little, 1987). This discrepancy is reduced in situations where professional rules are clearly stated; but many circumstances require increased judgement and in these cases professionals are influenced not only by the codes, but also by personal values and practical issues. Decisions have to be made in situations where a number of principles may conflict (Smith et al., 1991). Especially during crisis conditions, the general principles of an ethical code may not help to deal with complex decision-making under pressure (Hanson, Kerkhoff, & Bush, 2005); practitioners need both internal and external support at those times (Koocher & Keith−Spiegel, 2013), but may not have immediate access to such support.

The implementation of a code by a practitioner involves a decision making process, whether explicit or implicit. Hence, one of the roles of professional codes is to provide a guide to decision making and a framework for evaluating choices (Austin et al., 1990); however professionals may be subject to a number of codes and guidelines which do not always completely overlap and may at times pull in different directions (Holder-Webb & Cohen, 2012).

Alongside the construction and promulgation of ethical codes are a range of models of decision making which are proffered as mechanisms for determining ethical action (Hadjistavropoulos & Malloy, 2000). Many of these models present a linear process, sometimes represented as a flow chart, and are generally based on classical decision theory. They depend on explicit reasoning processes that follow somewhat predetermined routes (Williams, 2004). The steps are clearly defined in rational terms (McAuliffe & Chenoweth, 2008), usually in the form of a decision-making algorithm comprising specified steps (Clark, 2012b).

These guides focus on the application of relevant principles, address dilemmas of how to balance competing claims (Beauchamp & Childress, 2013; Callahan, 1988), and show how to arrive at a rational position (Eyde & Quaintance, 1988; Kitchener, 1984). There is an assumption, both in the field and by the regulatory bodies, that there are objective and universally correct interpretations of any particular dilemma (see for instance Kohlberg, 1971). Case studies are used as a demonstration of how to apply clear thinking, and they are analysed according to specific rules.

However, naturalistic investigations of decision-making show that people do not necessarily operate in this way. Many professional situations present problems that are unformulated, contain limited information, may be poorly defined, and to which there may be multiple correct answers (Williams, 2004). At the same time, the response of an individual professional is often subject to bias, personal needs, external pressures and influences which are out of awareness (Sternberg & Ben-Zeev, 2001).

Thus rational judgement is a contested term; even in cases in which rules seem to fit a classical model of rationality, their application requires what Brown (1988) describes as 'non-classical' rationality. He argues that non-rule based decisions are necessary in scenarios where new rules need to be developed, it is necessary to choose between competing rules, or where familiar rules fail.

Critics of a rule-based ethic hold that it narrows too much the definition of ethical discourse (Dykstra, 1981; Kilpatrick, 1986; Pincoffs, 1971). Focusing on problem solving and reasoning addresses only the cognitive side of human problems, thus distancing from the affective, value and intuitive dimensions of human experience and functioning (Clark, 2012b; Meilaender, 1984).

Despite the predominance of models centred around rational, conscious and legal reasoning, personal and interpersonal factors clearly have a significant bearing (Haidt, 2001). Rational cognition fails to address the breadth of human behaviour (Kahneman & Klein, 2009), and people tend to miss their own bias (Chugh, Bazerman, & Banaji, 2005; Ehrlinger, Gilovich, & Ross, 2005; Pronin & Kugler, 2007). This leads to suggestions that dispassionate, conflict-of-interest-free judgements are an unrealistic and unattainable ideal (Bazerman, Morgan, & Loewenstein, 1997).

In contrast, the view generally held by investigative bodies is that non-rational influences corrupt the critical-evaluative reasoning process, and are therefore a weakness to be overcome (Ford, 2006). However, Haidt (2001, 2007) found that moral reasoning tends to be constructed ex-post-facto in order to justify decisions that are based more on intuitions, and that cultural and social factors significantly influence moral judgements. While the emphasis contained in ethical decision making instructions for professionals is on reflective practice (Fouad et al., 2009), the stories people tell themselves tend to be highly compelling and result in a variety of distortions (Baron, 2000).

Educating people about their non-rational processes and blind spots has been found to help reduce bias (Pronin & Kugler, 2007), and professional guidelines which incorporate intuitive and affective responses are more likely to ensure better decisions (Bechara et al., 1997). Both intuition and emotions can be honed and used in service of personal and professional values (Anderson & Handelsman, 2010; Handelsman, Knapp, & Gottlieb, 2009; Kahneman & Klein, 2009; Knapp & VandeCreek, 2006), resulting in a more complex and inclusive type of decision making (Rogerson et al., 2011). The development of professional ethics over the last half century has increased the capacity and willingness of practitioners to recognise and self monitor their behaviour (Hedges et al., 1997); it is argued here that it is time for professional associations to be more willing to undergo a parallel level of ethical self examination.

Although clearly necessary, ethical codes vary in their capacity to influence behaviour (Badaracco & Webb, 1995). This stems in part from the capacity for self deception, and a process known as 'ethical fading' whereby 'individuals can behave in a self-interested manner and still hold the conviction that they are ethical persons' (Tenbrunsel & Messick, 2004 p.225). This results in professionals diminishing the ethical significance and impact of behaviour, distancing from ethical issues and personal responsibility. Recognising such self deception is difficult (Bok, 1989), and requires sophisticated levels of self awareness. A rule based ethics does not necessarily equip professionals to operate at this depth, and this suggests an argument for more advanced forms of education for members.

As mentioned above, codes tend to emphasise the question 'what should I do'; on the other hand, virtues based approaches propose a different query: 'who should I be?'. Instead of separating out personal from

professional, a virtues based view understands that who a person is drives what they do, and thus emphasise the importance of attending to context, community and the shaping of the person (Jordan & Meara, 1990). This can also be described in terms of traits, which have also been referred to as 'self-management' skills (Bolles, 2012). So for instance, a professional who holds the character quality of *integrity* will be more likely to act in ethical ways, without the dependence on a legalistic type of code (Strahlendorf, 2013). May (1984) suggests that this can take the professional beyond rules, principles, and the current over-focus on the virtue of *conscientiousness*, which is emphasised as a dominant virtue in the context of a litigious climate.

This virtues orientation is also reflected in the existential view, which focuses on the way we are in the world as the starting point to understanding behaviour (Spinelli, 2003). Interpersonal mutuality is seen as the best basis for ethical behaviour (Buber, 1987; Farber, 1967) rather than the current orthodoxy which defines ethical probity in terms of rule-adherence and formally derived informed consent (Jordan & Meara, 1990).

The existential approach is underpinned by authentic decision making. Guignon (1986 p.88) suggests 'the authentic agent might be better equipped to evaluate different ethical standpoints and their applicability to specific contexts of action than the slavish rule-follower [i.e., deontologist] or the cool cost/benefit calculator [i.e., utilitarian]'.

The deontological - an emphasis on the duty to abide by certain principles - is useful in helping professionals determine how morally laden an issue is, but tends to bypass attention to the question as to what constitutes a good end. It is the approached favoured by organisations as it lends itself to the formation of policy, and thus the capacity to monitor and regulate (Maitrepierre, 2010). Consideration of consequences - a teleological approach - attends to the actual efffect, but misses attention to the means, and lacks authenticity. The existential approach focuses on one's own values, but can disregard the means or ends of an action. Hadjistavropoulos *et al (2002)* advocate an approach which uses all three orientations to identify the 'moral intensity' (p.108) of an issue in a decision making process.

Dawson (1994) contrasts self-directed following of one's own conscience, and adhering to the rules and codes that emanate from an external source such as a professional association. At times, to abide by a code simply in order to 'do the right thing', may represent a contradiction with personal values (Ayer, 1990). In this sense codes provide a false sense of security or protection as the ethical choices which are made each moment are in some ways fresh, and require an ongoing engagement with the ethical decision making process (Nowell-Smith, 1969).

Fromm made the distinction between an authoritarian ethic and a humanistic ethic (1967, p. p.54), and this philosophical distinction becomes significant in the face of the regulation of professional practice. From an organisational and social view what matters is adherence to the codes, and this is what is tested in the hearing of complaints. But this focus in some ways usurps an autonomous ethics, replacing it with an emphasis on compliance (Schwartz, 2000).

Research on the actual attitudes (and therefore likely behaviours) of psychologists regarding core issues reveals, naturally, a range of views (Pope, Tabachnick, & Keith-Spiegel, 1987). Pressures to conform to the codes via regulation may be at odds with the authentic stance of individual members, and without ongoing and robust debate, the gap between actual beliefs and prescribed principles and practices can result in a code which is not completely embraced. Berry & Sam (1997) examine the interface of personal and professional values, and outline a spectrum including integration (more likely to lead to actions defined as professionally ethical), assimilation (rigid adherence without true integration), and marginalisation (disparity, and therefore potential problems). Whilst they focus on the training context, the implications are wider in terms of self awareness of the meshing of personal and professional values. However the legalistic ethos, which is characteristic of many regulatory bodies, tends to focus on the end result rather than the complexities of personal integration.

Hermeneutics offers another approach to professional ethics, involving attention to different perspectives in a situation, the process of enquiry, and engagement in dialogue (Boyd, 2005). The ethics of professional relationships are at times dichotomised in terms of patient autonomy vs the professional's exercise of power; however a hermeneutic perspective emphasises the interpersonal and mutual components of the relationship (A´rnason, 2000). This challenges the idea that there is a 'right' way of doing things or that ethical behaviour is matter of knowing and correctly applying rules (Clark, 2012b), suggesting instead that what is required is attention to one's own prejudices and a willingness to 'fuse horizons' in coming to an expanded understanding (Gadamer, 2004).

A proactive and preventative approach to ethical behaviour transgressions is proposed by Tjeltveit & Gottlieb (2010), who suggest that a focus on ethical resilience and awareness of ethical vulnerabilities is more likely to result in behavioural change than the current quasi-legal treatment of professional transgressions. Other proactive approaches include *positive (aspirational) ethics* (Handelsman, Knapp, & Gottlieb, 2002), *self care* (Baker, 2003; Norcross & Guy, 2007) and *emotional competence* (Pope & Vasques, 2007). These have similarities to virtues based approaches, addressing emotions and personal values of practitioners in advance of problematic ethical behaviour (Albee & Ryan, 1998; Peterson & Seligman, 2004).

Strahlendorf (2013 p.4) proposes the development of 'strong moral explanations' in dealing with moral dilemmas. This entails considering all persons affected, utilising a range of values, and considering different

moral perspectives. Brincat & Wike (2000) suggest a framework to achieve this moral explanation which includes addressing rightness or wrongness (applying a rule), using a moral theory (the more the better), while applying a value.

The Canadian Psychological Association has provided within the structure of their code a direction to assist in ethical decision making, ranking the principles in order of importance, and thereby providing a guide for clinicians which has both empirical and theoretical support (Hodgkinson, 1996; Sinclair et al., 1987). This fits with the concept of 'moral intensity', which Jones (1991) describes as 1) mediating the way in which a moral imperative is recognised, 2) assisting the establishment of a moral intent, and 3) influencing resultant behaviour. A dilemma is more likely to be recognised as having ethical implications if its is associated with a higher level of moral intensity.

This code also provides a seven step decision making model which Hadjistavropoulos & Malloy (1999) have elaborated on, introducing a multidimensional ethical approach into each step in order to yield a more informed ethical decision making process.

In recent years however, the hierarchy of values which have been embedded in the code as an assistance to professional decision making, have been questioned. Clark (2012a) points out that the rank ordering of principles contains a cultural bias which is hidden. Haidt and Kesebir (2010) describe a number of fundamental moral foundations: Harm/Care, Fairness/Reciprocity, In-group/Loyalty, Authority/Respect and Purity/Sanctity. In individualistally-leaning Western academic and professional frames, the first two principles are privileged, but its can be argued that this imposes a narrow idea of morality which other groups and peoples may not share.

Ethical decision models for professionals, as exampled by the Canadian code, generally invoke rational thought and the ranking of priorities; but Haidt (2001) shows that 'moral intuition' (an affective response, and thus one embedded in culture) occurs before 'moral reasoning' takes place.

Underpinning decision-making frameworks is the question of the moral development of practitioners. Ultimately this will be the basis for the quality of ethical action. An over-focus on externalities such as the requirements of codes leads to a reliance on sanctions to reduce 'bad actiing', whereas ethics is characterised by the idea of 'to make well' (Maitrepierre, 2010 p.1). There are resource allocation decisions that all professional organisations have to make about how much to invest in the facilitation of this moral development, and how much to operate an effective regulatory process. These decisions are themselves underpinned by value questions which are akin to debates in wider society regarding 'law and order' issues. It is argued here that in order to support the moral development of member-practitioners, organisations themselves need to have a sufficiently developed capacity for relfection and discussion of these issues.

ETHICAL ISSUES

Boundaries - crossing or violation

Much of the literature on professional ethics points to the dangers that arise from a lack of awareness around boundaries; ethical codes are particularly concerned about the issue of boundary violations. Most complaints relate to some kind of boundary issue (Smith, 1995).

COTO (2009 p.3) describes a boundary as 'the implicit or explicit demarcation separating the professional relationship with a client from one that is personal'. At issue is the distinction between boundary crossing and boundary violation; a topic discussed extensively in the literature (Gutheil & Gabbard, 1998; Gutheil & Gabbard, 1993; Pope & Keith-Spiegel, 2008; Sonne, 2007b; Zur, 2007). Crossing a boundary refers to the act of stepping out of the professional/clinical mode; what is ultimately of concern is where this is harmful in some way to the client (Zur, 2007). Concerns include conflict of interests which may occur, and the exploitation of the power differential by the practitioner. However the same act could be a harmful or harmless boundary crossing, depending on the context; this is not always taken into account in judgements by regulatory bodies (Gutheil & Simon, 2002).

In fact other than the sexual arena, there is a lack of consensus regarding what consitutes a boundary violation (Brooks et al., 2012). A recent survey of counsellors revealed areas of close agreement about problematic boundary dynamics (e.g. regarding sexual and romantic relationships), but also showed 40% of areas where there were significant disagreements between respondents, as well as with official organisational policies (Neukrug & Milliken, 2011).

However, the decision-making axe of regulatory bodies tends to fall on a more conservative interpretation of the line between crossing and violation: for instance a boundary crossing in and of itself may be taken as presumptive evidence of sexual misconduct (Gutheil & Gabbard, 1993). At times, the future of a professional may rest on perceptions that an action 'may' lead to transgression, an arguably tenuous basis for the imposition of serious consequences.

Regulatory bodies regularly adopt this 'slippery slope' concept - implying that once a boundary is crossed the situation will become unmanageable (Gutheil & Gabbard, 1993; Pope & Vasques, 2007). This idea operates within a rule-based orientation to ethical decision making, which has been challenged in its orientation

towards the self protection of professionals, its emphasis on neutrality, and a consequent lack of support for dealing with ambiguity (Coale, 1998a). The effect of the current risk management ethos can lead to a rigid approach to boundaries which can be unhelpful and at times damaging to clients; healthy interactions are more likely to lie somewhere in the middle between the dangers of entanglement at one extreme, and over-scrupulousness at the other (Davidson, 2005).

Graded-risk models give a more attenuated framework than the generic slippery slope concept, providing guidance to boundary crossing in ways which address the complexity of clinical situations. By fosuing on specific client, therapist and relationship factors better decision making can be achieved in the context of multiple relationships (Sonne, 2007a). These factors include a consideration of potential harm or potential benefit to the client, the presence or abscence of coercive or exploitative elements, and the nature of professional motives (Martinez, 1998). In such a framework certain boundary crossings may not only be helpful, they may be highly appropriate.

Whilst the clinical role can buffer against such violations by providing professional distance, clarity, and safety, it can also be impersonal and sometimes maintained at the cost of human relationship (Zur, 2007). As relationship develops, a range of 'crossings' can naturally occur. Sometimes these can blur the awareness of a practitioner regarding the operation of their self interest, at other times they can be beneficial to the client (Martinez, 2000).

Although the principles of beneficence are universal in ethical codes, the strict enactment of boundaries by helping professionals may not always be in the best interests of the patient. For example, Frank (2002) suggests that doctors may maintain a boundary between themselves and their patients (and their pain), in order preserve themselves. This could be necessary out of self preservation, but it is not always what a patient needs. Barstow (2014) provides the example of a therapist who refused to give the client a hand up when they fall out of the chair in the office. The ethics of such self protective behaviours can be questioned, even though professional boundaries have been maintained.

There are also criques of the use of the term 'boundaries', proposing that implicit in the languaging there is a communication of ideological positions. Coale (1998b) suggests that the focus on boundaries by rule-based ethics actually stifles ethical thinking. The notion of boundaries can serve to separate, define individuals, rigidify power differentials, and evidence the western focus on individual experience. An alternative proposal is to focus on relationships instead (Ragsdale, 1996); rather than observe and enforce boundaries, the language of relationship can be used to assess the impact of behaviours, with greater capacity for attention to complexity and context (Greenspan, 1996).

However, in rule based ethical frameworks the focus is often narrowed and investigations may leave aside complex and contextual relational questions in order to make a determination of 'guilty or not guity' (Adams, 2001).

Transference

The concept of transference is used throughout the health professions, although it originates from the domain of psychotherapy. It is widely used in describing the power a therapist holds, and is frequently invoked in the context of ethics complaints. Its use is so common that it appears to be an uncontested construct. Courts have accepted the term without question, and adopted the position that the inevitable corollary of transference is client vulnerability (Strasburger, Jorgenson, & Sutherland, 1992). This is extrapolated into terms such as 'transference abuse', which is used to claim therapist exploitation and boundary violations in malpractice litigation and administrative hearings (Williams, 1997). Such terms are not likely to be questioned in the course of a hearing.

However there are writers who challenge the construct; for instance Zur (2007) points out that the meaning of the term transference has morphed from the original psychoanalytic context, and does not now have a universally agreed interpretation; he and others also question its contemporary relevance.

Binswanger sees the term devaluing the actual encounter (Brice, 1978); Schlein (1984) and May (1967), point to the fallacy that a response resonant with a previous experience is simply a repetition of it; Smith (1991) outlines the difference between transference as a hypothesis, and the clinical phenomena which it seeks to explain; Winnicott (1965) sees it as a self-serving way for therapists to maintain their distance from difficult encounters; Boss (1963) highlights the Cartesian view which transference is based on, and challenges the representation of affects as reified mental objects which can be detached from their original context; Szasz (1963) critiques the way it allows therapists to use their power to proclaim unfalsifiable interpretations.

Reviews of the concept have been undertaken by Handley (1995), Spinelli (1995), and White (2008). They contest the term as being simply unnecessary, no longer useful in dealing with complexity of human experience, and a red herring when used in the legal and pseudo legal deliberations of regulatory bodies. It is perhaps time that this particular basis for determinations about what is ethical is eschewed for a more explicit description of phenomena and actual experience. Otherwise the notion of transference can lend itself to unquestioned and abstract framing of experience, moving away from immediate and demonstrable facts, and thus endangering the robustness of ethical investigations.

A case in point is the determination of what constitutes a 'boundary violation'; this has been extended in the courts to include verbal behaviours which a patient may interpret as 'seductive or sexually demeaning' (Minnesota State Laws, 2012). Whilst sexual harassment is clearly unacceptable, the wording of this type of statute creates uncertainty for a practitioner undertaking basic professional activities such as taking a sexual history or exploring a client's sexual fantasy life. In jurisdictions where a civil cause of action for 'sexual contact' includes 'viewing the inner thigh' (Rhode Island Senate Bill, 1998), the professional is placed in a fraught position in relation to a client wearing shorts; the effect may be to push out of bounds therapeutic discussion with a client around erotic tension.

Gutheil (1998 p.414) points out that this type of regulation is based on a perception of transference which becomes 'reified into a fact for legal purposes'. Other critical voices suggest that the term is no longer relevant or useful in terms of a contemporary understanding of relationship - that it is a 'dissipated and confused' concept which is not actually a clinical phenomenon (White, 2008 p15), and has ceased to be useful as it fails to help in differentiating transferential and non-transferential responses (Chertok, 1968).

Questioning such a major and taken for granted concept is a signficant undertaking. What is being suggested here is that one of the central planks in analyses of power in professional relationships requires deeper examination; otherwise it can become a shorthand term which does not serve a more complex understanding of the operation of professional ethics, and can at times be counter productive when it is used in the process of making findings in the context of comlaint hearings.

Multiple relationships

Another corollory of the notion of transference is the priviledging of the professional relationships which have only a singular role. This fits into a much wider social process which has been described using the concepts of Gemeinschaft and Gesellschaft (Tönnies, 1963); the movement of society from community characterised by multiple connections, to the professionalised world of more formal and contractual relationships.

This is syntonic with the professional distancing that Freud propsed as necessary for the therapeutic relationship; proposing the need for an analyst to be entirely unknown to the client on a personal level - *opaque* as he termed it (Handley, 1995); this was seen as necessary in order that the transference could be properly analysed.

In contemporary terms it is the notion of the 'boundary' that is invoked when addressing the issue of dual (or multiple) relationships, due to issues seen to arise from the power differential between practitioner and client (Zur, 2007). At issue is the risk of exploitation which may occur as a result of entering into additional relationships (Gottlieb, 1993). These concerns have led to dual relationships often being viewed as unethical, in and of themselves, by regulatory bodies examining complaints (Gutheil & Gabbard, 1998).

However, for those operating in subcultures or rural communities, the urban model of health service creates standards - subsequently imposed by regulatory bodies - that have been criticised as incongruent, unhelpful and out of touch, especially in the area of dual relationships (Helbok, Marinelli, & Walls, 2006; Murray & Keller, 1991; Reed, 1992; Roberts, Battaglia, & Epstein, 1999). Consequentially, the APA has removed the term 'dual relationships' due to its ambiguity (Kaplan et al., 2009), instead outlining three areas in which boundary issues may be important: sexual and romantic relationships, the addition of a non-professional relationship, and change in professional role relationships (Neukrug & Milliken, 2011). Not all reglatory bodies have taken this step, leaving those in small communities in a potentially compromised position with their professional associations, in regards to the practical realities they face of multiple relationship situations.

Critics point out that not all dual relationships are exploitative, and may at times even be helpful (Gottlieb, 1993; Younggren & Gottlieb, 2004; Zur, 2011; Zur, 2007); rather than trying to avoid dual relationships, proponents suggest the use of ethical decision making models for nonsexual dual relationships (Anderson & Swanson, 1994; Younggren & Gottlieb, 2004; Zur, 2011, 2013a).

The evaluation of multiple relationships is also contexutalised by the modality of the practitioner. There are a range of philosophies, theories and practices which offer diverse views on what constitutes appropriate clinical boundaries. Feminist codes of ethics address complex relationships by framing them as *overlapping relationships* (Feminist Therapy Institute, 2000), and reference concepts such as 'the personal is political' (Tessman, 2009 p.xiv) to allow for more of the personal to enter into professional conduct. Humanistic modalities tend to operate from a value system and methodology where techniques such as self disclosure are seen as central to definitions of good practice.

However, such alternative viewpoints may not be recognised or given much value in the process of investigating a complaint (Lazarus, 1994), where practitioners are generaly expected to evidence 'prudent decision making' by demonstrating that there is no loss of objectivity (Younggren & Gottlieb, 2004), and expert witnesses may not take into account the operating model of the practitioner concerned (Helbok, 2003).

Sexual misconduct

One of the most important areas of boundary violation that comes before regulatory bodies is that of practitioner-client sexual contact. Over the last 40 years there has been a significant shift in how this is viewed, from an ethos which did not take it so seriously, to the current status which has seen it criminalised in many jurisdictions (Gabbard, 1994; Pope, 1990; Sarkar, 2004). This is an important and progressive response to a phenomenon which is evidently abusive.

Yet one side effect is a reduced willingness amongst practitioners to talk about the issue. The experience of attraction to clients has been found to be widely prevalent (80 - 100%) (Bernsen, Tabachnick, & Pope, 1994; Giovazolias & Davis, 2001b; Nickell et al., 1995; Paxton, Lovett, & Riggs, 2001; Pope, 1987; Pope & Tabachnick, 1993; Rodolfa et al., 1994; Stake & Oliver, 1991). Yet Pope *et al* (2006b) found most practitioners (63%) felt guilty, anxious or confused when attracted to a client; only 9% felt they had sufficient suport to deal with the issue. Practitioners who speak of sexual attraction in order to get support may get shamed or isolated (Folman, 1991b). This may explain why only 45 - 60% of practitioners seek supervision when dealing with this issue (Bernsen et al., 1994; Giovazolias & Davis, 2001a; Nickell et al., 1995; Paxton et al., 2001; Pope, Keith-Spiegel, & Tabachnick, 1986; Rodolfa et al., 1994; Stake & Oliver, 1991).

For a practitioner to disclose attraction to clients they need to feel very confident about getting a supportive response from their supervisor (Bridges, 1998); this is made harder by many supervisors glossing over the topic as a result of their own discomfort (Celenza, 2007). In the moral tone that the topic has acquired ('just don't do it, its wrong'), it is hard for therapists to explore and understand the importance and place of the erotic in the professional relationship (Casement, 1990; Celenza, 2010). For this reason Norris *et al* (2003) suggest lowering the threshold for non-judgmental consultation, but this requires firstly that peers or supervisors are actually comfortable themselves with the topic.

The picture of intentional and premeditated grooming by the psychopathic predator - the 'bad apple' model (Gutheil, 1989) - creates an easy distinction from the ordinary practitioner; but this creates a false sense of security as there are many other types of personality profiles who engage in sexual intimacies with clients. In fact the majority (75%) are 'one-time transgressors' whose misconduct, although a serious ethical violation, can occur in a practitioner who is otherwise ethically sound and professionally competent (Celenza & Gabbard, 2003 p.484). There is a strong tendency on the part of such professionals to rationalise the abuse as being well intentioned, benign, and ethically justifiable (Pilgrim & Guinan, 1999). In fact, most perpetrators are senior professionals who could be expected to know better (Garrett & Davis, 1994). In most cases there is are a combination of psychological, situational and relational factors involved (Martin et al., 2011). For instance, there is a link between trainees who were sexually victimised, and those who go onto abuse patients later in their career (Folman, 1991a; Garrett, 1998).

Clearly, the dynamics of power are a key element in the abusive nature of sexual contact with clients. There is a correlation between sexual contact between therapists and clients, and the therapist's attempts to neutralise the power differential, by minimising the client's mental health issues and emphasising the conventionality of the relationship (McNulty, Ogden, & Warren, 2013). This highlights the significance of the conscious meaning making process, whereas it is often the unconscious processes ('transference') which are focused on in investigations. Support is needed both in dealing with the stress of the verticality of the relationship, and in understanding how to treat the client with an attitude of mutuality without endangering the boundary (Brooks et al., 2012; Spinelli, 2003).

Those practitioners who transgress the sexual boundary may feel victimised by the regulatory investigation process, seeing it as an attack. This is especially the case for those who remain attached to the patient, or believe that having terminated the therapy relationship they had dealt with boundary issues. As a result, extreme stress reactions can occur which are not necessarily characteristic of the professional. Unfortunately this is the time when decisions are made about the possibility of a rehabilitation process. It may be in fact some time later - following an acceptance and ownership of the problematic component of their actions - that they may become amendable to rehabilitation .

In a study of female complainants (Vinson, 1987), some reported negative experiences with administrative staff of the regulatory agency, either putting them off the process, or adding shame to their vulnerable states. Some had angry husbands who had 'taken over' their issue, and reported the abuse on their behalf, the effect of which was disempowering and contrary to the healing experience they needed. When other therapists or boards themselves register a complaint against a therapist without the involvement or agreement of the harmed person, this can be experienced as a further violation (Folman, 1991b). In some jurisdictions there is a mandated reporting issue for practitioners whose clients report to them experiences of sexual contact with another professional (McMahon, 1997). This has been termed 'intrusive advocacy' (Sonne & Pope, 1991), and can feel like an additional boundary infringement on the client.

Employer, legal, and professional responses are based on differing assumptions about moral agency, consequently evaluating wrongdoing in different ways (Allsop & Mulcahy, 1998). When professional bodies adopt an empathic approach to offending practitioners it can allow for slippage from explanation to excuse (Tedeschi & Reiss, 1981), thus attracting accusations of collegial leniency. On the other end, disciplinary or risk management processes emphasise the protection of clients but often display a lack of interest in the

person or circumstances of the professional, focusing exclusively on behaviours and the provision of hard line consequences - expulsion or criminal charges (Pilgrim & Guinan, 1999).

Given the seriousness of these type of charges, it is problematic that investigations and hearings are often conducted by organisation or board members whose background includes no training at all in investigative techniques or judicial style procedures. Investigations tend to be limited by funds, and investigators are often left out of pocket for their activities (Vinson, 1987). This does not breed thoroughness or professionalism in the performance of such duties, and can lead to premature conclusions. The length of time taken to process cases (2 - 3 years) is also problematic, both for the complainant and for the accused professional; the limiting factors are generally budgetary constraints and a lack of personnel .

There is widespread agreement regarding the seriousness of the prohibition against sex with clients (McMahon, 1997; Neukrug & Milliken, 2011), but interventions have not appeared to make an appreciable difference over time. Despite improvements in professional knowledge about the topic and significantly increased regulation, the incidence (2-10%) does not appear to have significantly changed over four decades (Schoener, 2013). The topic of sexual misconduct has stimulated an evolution of codes of ethics, research, discussion, and the handling of complaints; however, the problem continues without much change. The discipline and punish approach may provide the public with a demonstration that the issue is taken seriously, but given the lack of effective prevention, it can be argued that it is time for some new initiatives (Schoener, 2013).

We will examine this question, but first the controversial issue of the victim position will be addressed.

VICTIMS AND THE POWER DIFFERENTIAL

The power differential: a skewed view

One of the fundamental assumptions in professional ethics is that there is a power differential between practitioner and client. Professionals by their training, expert knowledge, experience, and position, hold a great deal of bestowed power, both from society and clients (Savan, 1989). The nature of codes is to see that power is used well, and to guard against it being used harmfully (Barstow, 2008). The central issue at stake in an ethics complaint or malpractice suit is that the professional did not use their power properly and the client was harmed in some way as a result.

Despite these principles being widely accepted, there are voices which challenge certain assumptions about power differentials. Any such critiques need to be treated with caution, being alert to where they may be used to discount victim experience or rationalise destructive abuses of power.

There are dangers at either end of the spectrum of attitudes towards the power differential. One the one hand, any argument which diminishes the responsibility of the professional can potentially leave them without sufficient accountability for misuses of power. On the other hand, if the client's victim status is overplayed the result can be to strip them of agency and result in a paternalistic position which also diminishes any responsibility at all on their part. Some writers (e.g. Anderson, 1992) portray clients using the metaphor of infants, emphasising their inability to make autonomous decisions in the therapy context; this is questionable, produces an arguably flawed ethic, and would likely be contested by the clients themselves.

Due to the way that ethics complaint investigations generally utilise an adversarial mode, the presentation of cases tends to emphasise the vulnerable or victim status of clients, and underscore the power of the professional (Rutter, 1989). Such assumptions are not generally open to question in grievance procedures, though they tend to underlie both investigation and decision making processes in relation to a complaint (Williams, 2000). Even to question some of these assumptions can be seen as tantamount to siding with exploitative practitioners, creating loopholes whereby they can escape the weight of their responsibility. Yet, without a real debate, there may be danger of the issues being ossified into unquestionable beliefs.

There is widespread agreement that professionals carry a range of types of power (Pope & Vasques, 2007; Younggren & Gottlieb, 2004), but the literature rarely discusses the client's power (Zur, 2013c). While it is important to identify issues at stake in the use and misuse of power by professionals, it is also relevant to deconstruct the dynamics of power usage by those who are identified in the 'disempowered', or lesser-powered position. By understanding the choices and responsibility of the client, a deeper analysis can be arrived at regarding the problems that lead to complaints (Zur, 2013b).

This is fraught territory, as the very nature of an ethics complaint is related to the position of lesser power on the part of the client. Yet to unravel such a gordian knot it is necessary that there not be an undue bias in either direction. It is difficult to even raise the idea that a client may have some responsibility as historically this has been used to discount the abuse experienced by clients and to justify and protect professionals; hence any such discussion can appear to play into 'victim blaming' (Sykes, 1992). However, to be able to fully explore ethical issues and the nature of ethical transgressions, it is important to move beyond an either-or stance, and examine the ways that client-practitioner power exists along a continuum (Lazarus, 1994).

Following Zur (2013c), we can examine the ways that clients hold power. There is very little written about this - the primary focus is generally on the power that practitioners hold. French and Raven (1959) offer a typology of power which will be used here as lenses to identify some facets of the client side of the equation.

Clients may have their own *expert power* in areas which the practitioner may know little or nothing; they may have *positional power* if they have some kind of social or role based authority (such as a judge or police officer); they have *coercive power* in terms of the capacity to intimidate, stalk, or vexatiously litigate; *reward power* comes firstly through the bestowal (or withdrawal) of 'the job' (as their provider) to the treating professional - though there are other ways clients can reward on a relational level for instance by approval, or conversely they may punish by venting; *referent power* describes personal charisma, which some clients may possess and use in the context of the relationship to try to get what they want; *manipulative power* refers to certain ploys that clients can use to get their way - from engaging the professional in order to procure a court or insurance report, to the kind of deceit that social workers and drug and alcohol staff experience with addicts whose intentions and behaviours are contrary to their presentation.

Outlining these sources of client power in no way obviates the duties of the practitioner. Barstow & Feldman (2013) characterise clients as being 100% responsible for their actions, and practitioners being 150% responsible. The point of this exploration is that power involves dynamics, relationship, and complexity. Following Giddens (2003), there is always both an agency and a structural component to any power dynamic. This means that there are choices being exercised by both parties which should be accounted for, as well as wider contexts including the nature of the role transaction, the governing institution and broader influences such as the particular profession, its history and values.

The deliberations of disciplinary bodies tend to focus on one aspect only of this - the power exercised by the professional in the context of their role. Whilst investigations need to draw pragmatic boundaries around scope and complexity, focusing too narrowly can undermine the robustness of findings and produce overly simplistic conclusions.

The power of complaint

We will examine here the domain of psychotherapy in order to explore issues relating to power in the professional relationship, though much of this is also relevant to other healthcare and helping professions.

Therapy uncovers trauma, with the intent to bring about healing. However, part of the mindset connected with trauma is often an ongoing identification with the experience of the victim role, resulting in a type of concrete thinking which pre-emptively identifies aggressors and boundary violators (Saperstein, 2006); this constitutes part of an interactive system (Berne, 1964) which may get co-opted in an ethics investigation process. Put another way, analyses based on linear notions of causality attribute aggression to the behaviour of individuals - and specifically the professional who is on trial; but systemically, aggression can be understood to be 'in the system', and this perspective suggests a very different type of interpretation and response which utilises multiple causality and a different way of understanding the distribution of responsibility (Robine, Yontef, & Spagnuolo-Lobb, 2001). This stepped back view can then recognise a multiplicity of forms that aggression can take, including for instance the combativeness that is often involved in a complaint process (Sandler, 2004).

In fact, a shift in the power dynamic occurs when an investigation is initiated. The client puts forward a complaint and the practitioner becomes a defendant. Unless the professional body holds a bias against the client (less usual these days, though it did occur in the past more frequently), the weight of doubt is on the professional (Schoenfeld, Hatch, & Gonzalez, 2001). This is literally the case, as in administrative law there is not a presumption of innocence, and the benchmark for evidence is not 'beyond reasonable doubt'. Lesser rules are used, for instance 'preponderance of the evidence'. This is aimed at balancing the power of the professional, and strengthening the capacity of the client to challenge it.

The practitioner - by virtue of their additional knowledge, status and responsibility for the fiduciary relationship - is put in the position of needing to demonstrate that they properly used the power that accompanies those responsibilities. This throws the burden of proof of innocence onto the practitioner. While there are arguments for the onus to demonstrate that one has done the right thing, the danger is that the operation of administrative law (which generally frames these hearings) essentially adopts a 'guilty until proven innocent' orientation. This flies in the face of the traditions of natural justice, and also changes the power dynamic radically: at the word of a client, a professional career can be entirely jeaopordised, with only minimal rules of evidence in play.

Thus power of the client is significantly increased in this process and the result can be a finding against the practitioner, even if there is no other evidence. Despite this altered power dynamic, the status of the client in such investigations is the 'aggrieved party', which provides them with the *identity* of vulnerability.

Whilst this vulnerability is generally very real, at least in a subjective sense, there is also the fact of the vulnerability of the practitioner in this situation. Ethics complaints or malpractice suits often take several years to get to court, during which time the professional has been isolated, alienated and investigated; the emotional impact on the practitioner is usually devastating (Neukrug & Milliken, 2011; Saunders et al., 2007). In the face of this, professionals often make errors of judgement throughout the process, from the

provision of evidence to accounting for their actions before a panel; such errors can jeapordise a case, show them in their worst light, and negatively impact on jury or judge decisions (Belk, 2013).

The issue fundamentally at stake is the question of the misuse of the practitioner's power at some point of the professional relationship. In order to examine this, an institution takes over the relationship, so that the professional is no longer in the power-up position. This may be necessary in order to give sufficient weight to the complaint, but one of the questions being raised here is the nature of the use of power by the investigating body itself through the proceedings, and consequent issues of empowerment or disempowerment of both parties in the process. For in championing the client in their lesser-power role, the institutional process may overlook the facets of the dynamic where the client exercises power. This is a problem that is at times evident when social workers attempt to help someone in the 'underdog' role, only to find that there is a great deal more complexity involved with the interlocking dynamics of power; at times the 'vulnerable client' may turn their hostility onto the worker, often resulting in distress and ultimately burnout (Enosh, Tzafrir, & Gur, 2013; Savaya, Gardner, & Stange, 2011).

Unethical use of power by clients and peers

In exploring this topic, it must be stated that under no circumstances does questioning of the nature of the power dynamic in a therapeutic relationship exonerate the therapist from their responsibilities. Nor does it in any way diminish the harm which is done by a therapist acting out of either lack of sufficient skill or lack of care, especially in cases where a client is used for the sexual needs of the therapist. There is some danger that by questioning the way power shifts in the professional relationship, an argument may be created which can be misused to discount client experiences, or avoid full responsibility on the part of the practitioner. With this caution in mind, we will now explore the ways that clients may misuse their power.

There are examples of clients who do indeed use the power of the complaint in unethical ways, whereby a therapist is falsely accused for some kind of gain (Wright, 1985b). Williams describes this as being 'Victimised by Victims' (2000). Ironically, it has been proposed that therapy itself tends to sell a victim story to clients as a way of defining their experience (Dineen, 1996); this can produce a polarity of hidden aggression which may at times play itself out through a complaint process.

Pope & Vetter (1991) found that 50% of psychologists reported encountering at least one client who had been sexually involved with a former therapist. This is of course a disturbing figure. But they also found that 5% reported clients who had falsely accused their previous therapists of sexual assault. Whilst this is clearly a minority, any level of miscarriage of justice is of concern, and needs to be understood and responded to by regulatory bodies who have a responsibility to see that this is minimised.

It may be argued that any system of justice is not perfect, and that there will always be some people who will abuse it; the cost of supporting those on the lesser side of a power differential is that occasionally a person in the power-up role may suffer to an unwarranted degree. This does not however preclude discussion about the phenomena of false accusations, or consideration of the context in which they may arise. Malingering and fraud play a significant role in complaints (Rogers, 1997), arising from the fact that they occur in a system which awards monetary compensation. In fact sometimes insurance companies will settle out of court even if there is insufficient evidence, just to head off further costs (Wright, 1985a).

A major difficulty in cases where there has been a false allegation is that the accused essentially has to prove a negative - that it didn't happen. A fair investigation will attempt at least to engage in a thorough fact finding process, identifying if the alleged action occurred, and if so, its significance. However there are certain subjects, such as hearings in relation to practitioner-patient sex complaints, which tend to be highly emotionally charged and lend themselves to prejudgement of either accusations or denials. It is hard for persons' hearing such cases to maintain an unbiased and careful evaluation of each situation; there are strong tendencies to want to either protect colleagues, or the patients (Pope, 1990). For this reason sexual harassment type cases are not always conducted using sufficient thoroughness, with terrible consequences for the professional if there is a false finding (Burr, 2011).

Psychopathology itself is one of the origins of false allegations. There are a disproportionate number of litigants who fall in the Borderline Personality Disorder class (Raffle, 2013). People with Borderline characteristics can make use of complaints processes to 'act out lifelong issues involving their good and bad internalised parental images' Williams (2013 p.1). Obviously the person bringing the grievance is not on trial, nor in most instances can they be psychologically tested. But it would be appropriate for regulatory bodies in the health care industry to be on guard against court processes being used as a part of a pattern of manipulation; such patterns can be recognisable in the distorted ways of viewing the world characterised by this personality type (Forward, 1997). The phrase 'you are one borderline away from losing your license' suggests the nature of this issue is not simply about practitioner shortcomings, but is an outcome of a difficult relationship that is often a feature of treatment with this type of client (Zur, 2008 p.1).

Another source of false allegations can be the result of the influence exerted by subsequent therapists. There have been instances where a client 'memory' of abuse from a therapist was implanted as a result of a suggestion or line of leading questions by another therapist (Williams, 2000). Comments therapists make in a disapproving tone about the treatment provided by the previous therapist can be taken out of context by

patients, who can come to see the treatment they received as being unethical. The patient becomes a kind of battleground for differing theoretical persuasions (Williams, 1997); ethics investigations can become an unwitting instrument for this to play out, and clients may exercise their power of complaint in a way which is destructive rather than self protective.

Codes can also be manipulated by professionals who are competitors or by angry family members for the purpose of revenge (Adams, 2001; Shapiro et al., 2008). An instance of the former is the case of the psychologist who was accused by a colleague of holding an 'unethical point of view' regarding a marital therapy case; this actually came before the APA as a full complaint (Adams, 2001). Revenge can be a factor in the filing of grievances against professionals, especially in child custody cases where the losing party takes their frustration out on the associated practitioner. The lack of filing fees and ease of registering a complaint with a board means that an action can be easily instigated, causing many problems to the professional - the object may not be related to financial gain, but rather seeking vengeance (Williams, 2000).

In a study by Montgomery et al (1999), the number of psychologists being threatened with complaints was 14%, and with malpractice lawsuits was 7%. The second highest source of complaints were child custody cases, and they represented the third highest basis for malpractice suits.

Whilst psychologists do make mistakes, these type of complaints are more likely to result from stresses which a parent may be experiencing in relation to a custody issue, and which ends up being displaced onto the professional concerned. This suggests the need for some kind of counterbalancing mechanism in regulatory processes, giving due weight to the consideration of complaints, but not allowing the process to become an avenue for inappropriate venting or secondary blaming. Whilst regulatory authorities would always claim probity in such matters, there are legitimate critiques which have been raised about the way the power of the regulatory system can be co-opted for inappropriate purposes by clients (Adams, 2001).

All complaints need to be taken seriously, and there are instances where practitioners act in ways which create significant and identifiable harm. There are degrees of magnitude though, and where lesser therapeutic mistakes are labelled 'abusive' in a manner which assumes they are highly damaging, the complexity and difficult shifts which occur in a therapeutic relationship can get inappropriately reduced to summary charges (Samuels, 2014). It is a well known phenomena that intensive therapy will often contain phases of idealisation, and then so-called 'negative transference' Whilst the negative phase can contain useful material for the therapy (and valid 'grains of truth' in terms of a critique of the therapist), if a complaint emerges from this stage of the work, it may be coloured with a high degree of reactiveness in which small actions of the therapist - even ones requested by the client - can come to be seen as some type of violation (Levenson, Butler, & Powers 2008).

Though investigating bodies have the brief to discern what is overreaction, and whether in fact professional misconduct has occurred, it appears that there are instances where findings are made in ways that unduly echo into the complainant's sense of rage and betrayal (Welch, 2000).

For instance, the case of the therapist who faced changes in insurance coverage which resulted in the client being unable to afford continuing treatment; the client felt 'abandoned', even though the therapist had taken proper steps to refer them on. The investigating board impugned that the therapist had a need to create an overly close relationship with the client, and that therefore the client's distress was their responsibility (Williams, 2013). In another complaint, a 2 year investigation ensued after a client charged that a group leader was fingering his tie in a way she felt to be sexually suggestive (Adams, 2001). In cases such as these, the adversarial approach taken by the investigative authority can become aligned with - and arguably hijacked by - disproportionate client reactions. The investigative body takes the client complaints seriously - which they must do in the first place, but then the weight of power can be arraigned against the practitioner in ways which do not appear to be balanced, or even reflect common sense.

Risk management is predicated on the notion that practitioners can control their exposure to complaints and lawsuits of this type, but the factors described here may be relatively independent of a practitioners acts, such that risk management may not in fact provide complete protection (Bennett et al., 1990; Goisman & Gutheil, 1992). The focus on managing risks in relation to clients misses the fact that some of the risk derives from the way that investigatory bodies deal with complaints - a larger structural issue.

The description of patients as 'consumers' or 'customers' represents a shift in the way that relationships with health professionals are conceptualised. Health care becomes a commodity, and the relationship is seen in of consumer-merchant terms. Within this frame the consumer is the ultimate arbiter - the employer of the professional - and this represents a shift in the way the power dynamic operates when a complaint arises. The result is a bias in favour of the 'customer', which subsequently influences the way complaints are seen and processed; the issue is reduced to a baseline question - was the customer getting what they paid for, or contracted for (Adams, 2001; Peterson, 2001; Williams, 2001; Woody, 2009).

The professional relationship has a fiduciary basis involving trust that the practitioner will act in the best interests of the client. The trouble with the emphasis on client as consumer is that the focus of the relationship narrows into a commercial transaction, and evaluated on this basis. The role of the consumer is not questioned in this context; in a commodified world, a financially based relationship draws almost no comment and is simply seen as part of the equation of exchange. Ironically however, it gives lie to the

'Singular relationship', which is only optimally true in settings where a professional is employed by an institution, and does not rely on the direct exchange of time for money involved in a private practice.

Whilst some professions may position the client as a "*passive recipient of a procedure instigated and implemented by an active practitioner who applies their 'skills' and 'professional expertise' to the problem*", this is not the case with therapy or social work (Samuels, 2014 p.7). In these professions, the relationship is the main ingredient (Duncan & Miller, 2000); it is not predictable or controllable in the way a 'product' might be, and problems which arise may to some degree be co-created. In fact, in the case of therapy, the practitioner may not necessarily attempt to meet the clients presenting need, which can be seen as covering more fundamental needs of which they have less awareness. Thus the simplistic model of consumer rights is not a fair or relevant measuring stick when a complaint arises.

Part of the problem here is the evaluation of therapist professional behaviour using frameworks which are not syntonic with actual models being followed by the therapists themselves. In this respect it could be seen that a meta-power struggle is going on between competing views on the nature of the professional relationship, with a particular model (client-passive) being imposed on therapists, and used as an evaluatory tool in hearing complaints by regulatory bodies.

Therapy, social work, and a variety of other helping professions require a level of 'therapeutic alliance', which underpins all technical and skill based interventions (Duncan & Miller, 2000). When this goes wrong, the meta question is whether it gets dealt with as a relational fracture, or as an offence against a code. To take a case in point: when therapists take on clients with a history of childhood trauma, they can find themselves in a kind of rescuer role. However, this can take a dark turn whereby the therapist can be subsequently find themselves in the position of repeating the original injury in a variety of ways, echoing the original trauma (Gabbard, Shengold, & Grotstein, 1992).

To use the language of Karpman (2007), we see here cycles of therapists who were rescuers turning into persecutors; but in the transactional nature of such systems, clients who start as victims also then take a turn in the role of persecutor. Whilst it is the right of clients to bring a grievance, it is also important to understand the systemic patterns which may be present, and the ways in which the complaints process can in some way become subsumed in these transactions. From this point of view, grievance processes would be better structured so as to step out of such dysfunctional dynamics as far as possible, and orient themselves instead towards healing and a better quality of resolution between complainant and professional.

The adversarial system by which ethics complaints are heard, generally constructs a story of the complainant as innocent, powerless and dependent (Mitchell, 1999). Whilst there are elements of this which are often true, in the end it may not be respectful to accept or promote this view as it does not address some of the complexities of professional relationship, nor the shifts of powers that occur in a complaints process. The challenge is to engage in a more complex analysis of the power dynamics, and move away from unquestioned assumptions in regards to the power differential (Zur, 2008).

Ultimately the goal must be to find healing, learning, and a capacity to resolve relational fractures. The model of identification of guilt and consequent punishment may not best serve either client in the notifier position, or the practitioner who may have erred in some way.

The subjectivity of harm

Accusations that harm has been effected by a professional can be problematic when the alleged violation is highly subjective, as the perceptions and reactions of a client may be afforded an almost objective status by a regulatory hearing.

Boundaries, apart from physical ones, are after all perceptual affairs. This does not diminish the importance of a complainant's subjective experience, but it does point to the need for caution when making serious judgments about a professional during a hearing process. When boundaries are reified, a 'boundary violation' can be an actual charge which constitutes the subject of investigation. This is problematic as it lends an objective status to something which is entirely relational and intersubjective (Kirsher, 2013). Mental or emotional injuries are hard to define, and causation is a complex question which cannot always be clearly established (Deardorff, Cross, & Hupprich, 1984).

Phillips (2003 p.317) points out that 'in some situations, a boundary violation can be defined as virtually anything the patient experiences as intrusive or harmful no matter how innocent or "therapeutic" the intent of the professional'. Phillips evidences a range of cases in which actions which were later characterised as 'boundary violations' were originally instigated by the client, sometimes through relentless demands; (excluding here anything which would be sexually related) - the patient requested something, then later sued the therapist for providing what was requested.

Obviously, it behooves therapists to act with caution, care, and professionalism. But there are also limits to what can reasonably be foreseen, and the very nature of therapy requires that boundaries - 'the conjunction of safety and spontaneity' (Gabbard & Lester, 1995 p.41) - are flexible. After analysing a number of problematic cases, Williams (2013) questions whether a therapist who is perhaps naive and does not successfully manage the complexity of a sensitive client's rage, should not necessarily be subject to an extended inquisition-like process where they may be portrayed as acting abusively.

Malpractice cases require proof of 'demonstrable harm'; there are instances where the mere presence of a negative state of mind subsequent to the therapy is claimed as harm. However, proof of causality is fraught when it comes to subjective states, and the claim 'I feel that I have been harmed' is impossible to contest (Adams, 2001). At its worst this can lead to trials where an accusation based on a feeling becomes a 'fact', without the need for substantive evidence. In a court of law this category error would not pass the rules of evidence, but in the much lower requirement for evidence that is used in professional grievances cases, this type of accusation can become the basis for an adverse finding.

It it to the question of the dispensation of justice that we now turn.

Regulatory processes

Limitations - financial and conflict of interests

The regulation of ethical codes and licensing systems for professionals requires significant resources - time, energy and generally financial expenditure (Frankel, 1989). This is one of the places that regulatory bodies run into problems, as resources are generally limited. Positions in professional organisations are often filled primarily by volunteers and perhaps a small staff. Membership on ethics committees and licensing boards is commonly on a volunteer basis.

This is one of the ethical issues that arises in relation to the operation of regulatory bodies. When people are not paid for their work there are often other undeclared exchanges, expectations and costs which underpin the gift of their time. They may want to limit the amount of time that deliberations take; they may want gratification from their own views being incorporated; or they may want to influence the field in ways which suit their interests (Willmore, 2003). One of the compensations for the lack of monetary compensation can be the power which can be gained by membership of a regulatory board or committee. As with all matters of the exercise of power, a lack of awareness of these dynamics can lead to its misuse (Barstow & Feldman, 2013). Whilst some of this may be true for paid staff, the exchange of time for money is more explicit and more open to the imposition of standards. Ironically, this is one of the reasons that it is often seen as unethical to barter professional services - the boundaries are not always clear as compared to a financial exchange (Gutheil & Gabbard, 1993).

Operating regulatory boards or committees with limited resources can and does result in a low quality standard of operation (Van Horne, 2004). This is a major issue when it comes to the application of due process. Brief investigations, lack of fact checking, limited times for hearings, gaps between meetings; all this can add to significant delays and poor decisions. When someone's career is at stake, this is clearly unacceptable. Frankel (1989) asserts that 'a system of self-regulation should not be undertaken without realistic assessment of what can be achieved', yet the very existence and legitimacy of a professional organization in this era requires a code, and therefore a means of enforcement. The very smallest professional group must have its code of ethics, its complaint process, and a mechanism for processing those complaints; but there is no benchmark or performance standards in place. Larger bodies also have problems bearing the costs of regulation when their sole source of fees may be from memberships, and which have to cover many other aspects of organisational operation.

Even in larger bodies - including state licensing boards - there are inherent concerns about a range of conflicts of interest which can be seen to arise from peers sitting in judgement over each other. Such concerns tend to be overlooked or minimised, yet constitute important issues about the ethics of the oversight of ethical behaviour on the part of other professionals (Cohen, 1980; Sandrick, 2003).

Limitations - ethical expertise

The level of knowledge and skill held by board or committee members in regulatory positions is an important consideration. Without some kind of minimum standards of ethical and legal knowledge, members rely on either life and professional experience, or a base of ethical understanding which may be very limited or overly simplistic. For such committees and boards to function properly members need to have core knowledge in moral reasoning, ethical theory, bio-ethical issues, professional contexts, clinical standards, relevant codes, laws, and organisational guidelines (Hoffman, Tarzian, & O'Neil, 2000). They should understand the major strands of approaches to ethical analysis, as well as being able to hold critical understandings of such views (Dienhart, 1995). The education of board or committee members would need to include training in an epistemological framework to identify legitimate points of view, a methodological framework to understand how ethical problems are analysed, and a historical understanding of case law (Loewy, 1993). Practically, there can be problems getting sufficient people to volunteer for boards, and so minimum standards are sometimes done away with (Hoffman et al., 2000).

Additionally, we argue that it is important to understand the problems inherent with the exercise of power. When members of such bodies are examing the ethical behaviour of other professionals and can hold a person's career in the balance, it behooves them to have sufficient knowledge of the ethical use of power in

their role position in much the same way as they are evaluating the mis/use of power by the professional coming under their jurasdiction.

There is discussion as to the difference between virtue and duty based ethics for practitioners (Doukas, 2003). In this respect it may be relevant to consider what kind of character traits are necessary for a person who sits in a position of power over another professional's career. This is difficult to assess or measure, but that does not mean that it can't be named or expected. Respect, kindness and compassion are arguably essentials (Sheehan, 1994); this contrasts with less admirable qualities which are evidenced at times in regulatory bodies such as hostility or high-handedness (Pope & Vetter, 1992).

Larcher et al (2010) suggest an intake process for ethics committee members which includes assessment of ethical reasoning, abilities, interpersonal skills, knowledge of ethical theory and personal characteristics. The latter, also known as 'self management skills' (Bolles, 2012) may include honesty, courage, prudence, and integrity. The idea is that those judging other's probity need to demonstrate a measure of self understanding and ethical skill, not assumed simply by virtue of being a practicing professional for a number of years. Larcher also proposes minimum requirements of continuing education for the duration of the post.

The role nature of membership of such bodies can obscure the personal dynamics which underly the formal procedures. It requires some training for people to be able to distinguish their own bias, and ensure that it does not influence decision making (Casey et al., 2012).

Limitations - legal expertise

Given that hearings resemble the court system in a number of ways, many of the processes are more legal in character than ethical. Annas (1991 p.21) points out that 'encouraging a group of lay people to attempt to practice law makes no more sense than encouraging a group of lawyers to attempt to perform surgery'. As regulatory bodies exercise significant power, this can be seen as tantamount to a type of unprofessional practice. Those who play the role of investigator, prosecutor or judge do not necessarily come with the necessary skills, nor are they given training in the exercise of those duties; there an assumption that they have sufficient knowledge of what constitutes due process, without any evalution of this at all (Adams, 2001).

Significant concerns have been expressed about the operation of ethics committees such as the presumption of guilt, the use of police methods, the redundancy of local, state and national committees, and conflicts of interest when members of regulatory boards or committees are competitive with those they are investigating (Pope & Vetter, 1992). This paper returns repeatedly to the question of where the oversight is in the excesses of power which can and do manifest in the operation of regulatory bodies. The legal profession has the attention of the media, the scrutiny of civil rights advocates, and internal processes such as the law reform commission. There is is a relative dearth of these checks and balances in the health regulation field.

Highly provocative areas such as the investigation of allegations of sexual intimacy between practitioner and client tend to produce strong personal reactions in those conducting the hearings. Without appropriate knowledge and training it is hard to maintain the type of detachment necessary to go beyond reactive bias (Dasgupta, 2009). It is a difficult task to balance the desire to protect colleagues who may be seen as innocent, and protect patients from what may be seen as the further victimisation of not being believed; even seasoned prosecutors do not always wield their power with complete ethical integrity. This can be due to institutional distortions which allow for or even support abuses of power, or else internal difficlties in remaining objective (O'Brien, 2009).

Those serving as expert witnesses face the same challenge. There is a hard line to walk and the stakes are high: great harm will be done to a practitioner if there a false accusation judged to be true, and great harm will be done to a patient whose claim is unfairly dismissed or discounted (Pope, 1990).

The idea of 'discovering' the 'truth' in a trial process is disputed by writers in the legal field who point out that achievement of objectivity and neutrality can only ever be aspirational (Delgado, 1989), and that the story that is represented at a hearing is a construction, a 'work of fiction' (White, 1985 p.186), to be evaluated by those sitting in judgement via their own stock of stories, scripts and schemata (Mitchell, 1999). While debate about these issues is a part of the legal profession (Coleman & Letter, 1993), it is not necessarily a level of sophsitication that is likely to be achieved by 'lay' people (in legal terms) who play significant power roles such as prosecutor or judge in ethics complaint processes.

Due process and natural justice

Due process

Administrative law is used to regulate business and public processes, and operates under a different set of operational principles than civil or criminal law (Gonsiorek, 1997). The reason for this limiting of due process rights is ostensibly to protect the public, essentially holding that the rights of an accused professional are less important than the need to protect the rights of the consumer (Williams, 2001). However, when a regulatory body adopts the protection of the public as its sole mission, the subsequent investigation and prosecution process cannot be seen to be balanced or impartial. A case in point is where the measurement

of effectiveness of a regulatory body is solely in terms of the number and success of prosecutions, rather than the quality of justice administered (Adams, 2001).

Rights

Criminal and civil law offer the following rights:

- Right of discovery: the accused receives notice of witnesses that will be brought forward, allowing proper preparation
- Statute of limitations: as key witnesses and records may become unavailable over time, limits are set on periods for claiming
- Enjoy the fruits of a successful defence: after a hearing has been conducted, the accused should be able to enjoy the fruits of a successful defence (boards can ignore such rulings)
- Protection against 'fishing expeditions': the prosecution can only collect evidence relevant to the complaint

None of these rights are guaranteed in administrative hearings (Williams, 2001).

The United Nations (1995) defines fair trials as including the following rights:

- be tried by a competent, independent and impartial tribunal established by law
- have a fair hearing
- be heard in person
- be defended by a lawyer
- be present at one's trial
- not to be compelled to testify against oneself or to confess guilt
- prohibition of evidence obtained through unlawful means
- able to call and examine witnesses
- have the Right of Appeal

Many of these basic rights are not available in trials of professionals for ethical misconduct (Bricklin, Bennett, & Carroll, 2003). Without these in place, the likelihood of a fair trial is reduced.

Investigations

Because Miranda warnings are not given (i.e.. that evidence provided may be used against the accused) in administrative law, investigators can (and do) draw out incriminating evidence from the accused, who may believe that explaining themselves fully will lead to an early resolution; this belief may also arise from assurances and promises provided to them by the investigators at the time, but which are not honoured at the trial (Williams, 2001). A practitioner in a stressed state may make serious mistakes, prematurely agreeing to a charge, admitting violations that did not actually occur, or undermining their own defence in a variety of ways such as revealing too much information (Thomas, 2005). Out of anxiety practitioners sometimes sabotage their cases by acting rashly or with insufficient support and preparation (Hedges, 2000). Reactions can also include writing over-long responses, trying to provide investigators with explanations, or revealing other errors not part of the investigation (Thatcher, 2000). Depression - a common effect of such investigations - can also produce other knock-on effects such as missing deadlines, not returning phone calls, or incomplete submissions , all of which will be held against them (Schoenfeld et al., 2001).

Adams (2001) extensively documents a range of serious issues in the conduct of disciplinary investigations. Some investigations proceed without revealing to the accused what the charges actually are. The collection of depositions occurs with no moderation of a judge to limit intrusive irrelevancies, while on the other hand, there is no opportunity to cross examine the complainant; the accused may only learn about the facts as they are actually presented at a hearing. Enforcement officers can collect any evidence they can find, place the professional under surveillance, and even using wired operatives. But if they find any exculpatory evidence, they are under no obligation to mention this. Because there is no statute of limitations, a complaint may trigger an investigation which can involve a hostile examination of every aspect of a professional's practice, from its inception up to the present; minor infractions or mistakes can result in being treated with criminal suspicion.

Investigators in such cases often receive limited training, may be careless and insufficiently thorough, and are not taught to maintain objectivity (Shapiro et al., 2008). They sometimes work in a way which is intimidating, persecutory and dismissive (Freckelton, 2007b; Kandle, 2006).

Normal conventions relating to the investigation of alleged wrongdoing are often entirely absent in hearings, allowing miscarriages of justice to occur. For instance, Schlafy (2002) provides the example of a New York physician who lost his license when a patient made a charge of improper behaviour in the examining room. In fact there was a chaperone present at the time, but the Board claimed the chaperone was biased because she was in the employment of the doctor. Schlafy points out, in regards to this and many other cases, 'It is likewise irrational that a physician enjoys greater rights in contesting a simple speeding ticket than in a disciplinary proceeding threatening his livelihood' (2002 p.2).

Expert witnesses

Decisions are often oriented around key evidence from expert witnesses. They are not however in a neutral position, and it can be argued that their potential for objectivity is compromised if they are retained on a paid basis by regulatory bodies. Volunteer expert witnesses are not necessarily a solution either, as they may not represent the wider body (Williams, 2001). Cases often depend on expert definitions of 'standard of care' in determining negligence or wrongdoing; in an adversarial setting, each side can employ expert witnesses who will make opposite claims, highlighting the lack of agreement of the standard by which professionals should be tried (Adams, 2001).

Expert witnesses can be used in a variety of inappropriate ways to strategically support the prosecution's theory with the aim to secure a conviction, rather than to tell the truth (Giannelli & McMunigal, 2007); there are generally few mechanisms in place to guard against this occurring. In fact the employment of expert witnesses is potentially fraught with conflict of interests, as in the case where an expert witness found a practitioner to be operating outside of her standard of care; the sanction imposed by the board was for her to spend 4 hours (at $300 per hour) with the same expert, for an 'educational review' (Shapiro et al., 2008 p. 134).

Double or triple jeopardy

A significant proportion of cases opened by the APA (25%) were found guilty solely on the basis of punishment elsewhere (Grenier & Golub, 2009 p. 193). Thus an ethics committee finding can trigger a licensing hearing, and possibly also a civil case.

A case in point was a psychologist who was subject to a barrage of allegations from a patient diagnosed with borderline personality disorder. The state psychological association investigated with a 6 month process which concluded in a requirement for 1 year supervision. After this was completed the psychologist received a positive report. However, the state licensing board then commenced an action on the basis of the fact of the first action, going through the same charges, and resulting in a requirement to take an ethics course and resit the licensing exam. The psychologist fulfilled all the requirements. However, after this was complete, the ethics committee of the national association opened an investigation, again solely on the basis of the original matter. One year later, they recommended expulsion, which she appealed, and then lost. The entire process took 9 years, and completely drained her of money; she left the field (Adams, 2001).

Timeliness

One of the consistent concerns about the operation of regulatory bodies is the time taken to process complaints (McCabe, 1998). This can be onerous for both notifier and the professional concerned (Freckelton, 2007b). One of the conditions of justice is the right to be tried 'without undue delay', or 'within a reasonable time' (United Nations, 2003). The degree of complexity of the cases does not always warrant the amount of time taken, it is more often related to limited resources. This is not a legitimate reason, as it is a universal statute that 'the difficult economic situation' of an entity is not an excuse for non-compliance with the right to a timely trial (United Nations, 1995 p. 267). When a case continues over a period of several years the distress involved for both sides is unduly drawn out, and this can be seen as a form of secondary harm (Freckelton, 2007b).

The excessive time taken can create an undue negative impact on practitioners and their careers, which is of particular concern when they may subsequently be found innocent - for instance the HPC in the UK took more than 2 years to process cases, 23% of which concluded that the case was unfounded (Samuels, 2014)

Burden of proof

Of the various rights which are not currently recognised or enacted in administrative law, of most significance is the presumption of innocence - a bedrock of the notion of due process in civil and criminal law (Quintard-Morenas, 2010). The reason for removing this fundamental right is related to the notion of *the privilege of licensure*, as a result of which civil rights are abridged (Adams, 2001).

The taxonomy of proof in the administration of justice ranges through a spectrum of measures. These start at the minimum with *suspicion*, proceed through the following grades - *reason to believe, credible evidence, substantial evidence, preponderance of the evidence,* with *beyond reasonable doubt* being the most exacting (James, 1961).

Herbsleb *et al* (1985) argue that, as in a court of law, the burden of proof should lie with a regulatory body to produce evidence that the practitioner is no longer qualified or has engaged in unethical conduct; this is not generally the case. There are some codes which specifically declare that professionals coming before a committee are considered innocent until proven guilty (for instance see AAMFT, 2013), but these are the exception. Most boards use lesser thresholds such as *preponderance of the evidence* or *clear and convincing evidence*; the standard of proof chosen has a direct correlation to the nature of final decisions (Schlafy, 2002; Van Horne, 2004).

These minimal standards provide little protection from false accusations, which do occur in complaint hearings (Williams, 2001). Relatively low standards of evidence can and do lead to inappropriate investigations. Even

if the complaint is eventually dismissed and the practitioner exonerated, they are still left with a significant financial, emotional and professional price to pay (Woody, 1988).

Furthermore, in some jurisdictions there is even more at stake; the consequence for ethical violations can result in criminal sanctions including jail terms, simply on the preponderance of the evidence. In such hearings, where there is conflicting evidence, credibility assessment is generally not admitted; boards are allowed to rely on their own expertise rather than having to call in experts, and the degree of their evaluative power makes their findings virtually unreviewable (Jorgenson, Randles, & Strasburger, 1991).

In many hearings there is limited (or even no) allowance for robust cross-examination, presentation of counter proof or other measures which are considered basic in the criminal justice system for ensuring the quality of evidence (Giannelli & McMunigal, 2007). This increases the likelihood of miscarriages of justice.

Problems with the application of administrative law

Unlike criminal trials, inflammatory and prejudicial language is allowed in administrative hearings. Another contrast is that information about prior crimes is not admissible in criminal cases, but in administrative trials information from prior complaints is admitted, even if it is unsubstantiated (Shapiro et al., 2008).

It would seem reasonable that the accused should have the right to be heard by an unbiased decision maker; this is not the case when a board member can act firstly as investigator - gathering evidence, interviewing witnesses - and then pronounce judgement in the next turn (Herbsleb et al., 1985). Administrative law allows a board to operate as complainant, prosecutor, judge and appeals court; without any checks and balances this does not produce confidence that justice will be done (Adams, 2001; Welch, 2001). Board members sometimes have conflicts of interests, which are not always declared (Shaw, 2011). Normal protections - such as the exclusion of hearsay, or the right to challenge a judge or jury on the basis of a conflict of interest - are not available to defendants, diminishing the likelihood of a fair trial (Adams, 2001; Schlafy, 2002).

Without adequate notice of intended actions against a practitioner (including specified grounds for the action, and the nature of the unfavourable evidence), it can be difficult to prepare fully for a hearing. During a hearing, without the right to cross examine key witnesses, it can be difficult to challenge or disprove false or distorted evidence (Schlafy, 2002).

Members of regulatory boards are often political appointees, resulting in a situation where impartiality becomes less likely. This is further exacerbated in jurisdictions where the board meets in secret, hearing a summary of the prosecution case but not the defence case (Adams, 2001), or searches records in order to generate new complaints based on their findings, thereby increasing the danger of a witch hunt occurring (Chauvin & Remley, 1996).

Because agencies often identify themselves as existing for the protection of the public, complainants can register their grievance and see the full resources of the regulatory body brought to bear in the prosecution process, while the defendant must bear all costs themselves; there is no system of access to a public defender.

The measure described as ‘the standards of one peers’ is often used as a reference point in trials. But this begs the question of what standards are being evaluated; some of the categories used have been challenged as secondary to the question of the capacity to practice. For instance, a majority of medical board actions are character related, rather than centring directly around the question of competency (Sawicki, 2010). Some of the arguments used in these cases can easily be shown as specious, e.g. predictive projection of future possible harm on the basis of inputed character features; yet in the hands of a disciplinary body, they become a substantive basis for prosecution and negative findings (Rhode, 1985).

A common term used in the prosecution of professionals is ‘a reasonable standard of care’. There is however a skew in the determination of this standard as it is based on ‘hindsight bias’: after the fact of an outcome, the contributing steps become apparent, though they were less clear at the time (Shapiro et al., 2008).

Some regulatory entities give themselves powers that are beyond the scope of normal criminal investigations; a case in point is the New Zealand Act in reference to health care professionals, which allows for the ability to search a premises solely based on the perception that a practitioner may *intend* to so something which contravenes the Act. The same act acknowledges natural justice, but then allows as evidence ‘any statement, document, information, or matter, whether or not it would be admissible in a court of law’, thereby allowing hearsay to be accepted as evidence (Ministry of Health, 2010 §72(1)). Such powers can easily be subject to abuse, reduce the likelihood of a fair hearing, and contribute to a climate for practitioners.

Appeals

The capacity to appeal is an important part of the provision of justice (Edelman, 1990; Haraway, 2005). This is an uneven matter in professional hearings, and varies in terms of organisation, jurisdiction, state, country and profession. Small organisations do not always have proper appeal channels. Some state licensing board decisions have been appealed in an administrative court, won, and yet the board would not accept the decision (Peterson, 2001). In other instances, courts simply rubber stamp decisions made by licensing boards on the basis that the professionals sitting on the case knew best (Thomas, 2005). The assumption is that the appellant has benefited from full due process, when that is often not the case (Schlafy, 2002).

This highlights the situation whereby the problems arising from the decision making processes of regulatory bodies are wider than simply intra-organisational issues. The larger system they are a part of must also be held accountable for minimum standards of fair and just treatment. However, just as there is little oversight for the regulatory bodies regarding the issues raised in this paper, there is even less for the larger system dynamics where regulatory bodies interact with each other.

Emotional and personal costs

Although complaint hearings are likely to be stressful for both parties, the possible outcomes have a very different trajectory. The hoped-for outcome by the complainant is for their case to be vindicated and some kind of consequence imposed for the practitioner; there may also be a possible financial gain for the complainant as well.

However for the practitioner, the best that could happen is exoneration; and even with that, there may still be a great deal of negative fallout. Worst case outcomes may include loss of license, public shaming, and a range of other major impacts on their life and work.

The impartial view is that this is simply the cost of regulation, that it produces a social good, and that individuals must bear these costs (even if found innocent in the end) for the sake of the standing of the profession and the protection of the public.

However, in the context of the health care field, such detachment seems at odds with a valuing of people, and a concern for any unnecessary imposition of suffering. In fact, it is a primary premise of the necessity and operation of ethical codes and regulatory bodies, that the duty of the practitioner is to commit to reducing suffering rather than increasing it; this is the very responsibility which is generally at the heart of what is being tested in complaints. So it would seem a reasonable extension that these same values would apply to the governing institutions, and specifically their regulatory bodies, in terms of concern about the suffering that occurs as a byproduct of the complaints process (Freckelton, 2007b).

In fact both practitioners and notifiers suffer, experience themselves as powerless in the process, and generally find little lasting benefit from the trial ordeal (Freckelton, 2007b). The effect on practitioners of hearing processes is well documented and can include loss of self confidence, isolation, shock, anger, terror, disbelief, guilt, shame, anxiety, anguish, somatic symptoms and physical illness (Adams, 2001; Celenza & Gabbard, 2003; Freckelton, 2007b; Greenburg & Greenburg, 1988; Miller, 1992; Nash, Tennant, & Walton, 2004), high incidences of depression (45%) (Montgomery et al., 1999), and suicide (Peterson, 2001). Even if exonerated the experience can leave lasting scars both personally and professionally (Williams, 2000). Health care delivery is also impacted because sued practitioners are likely to stop seeing high risk clients, practice defensively or retire early (Charles, Wilbert, & Franke, 1985).

The experience of being accused is personally and professionally devastating (Sommers-Flanagan & Sommers-Flanagan, 2007). The web of supportive relationships that professionals have is impacted, the identity that comes with professional practice is undermined, and the limbic system is flooded with stress. Under these difficult circumstances there is no professional ritual to support healing processes or develop a shared meaning (Neimeyer, Prigerson, & Davies, 2002). Even in cases where the outcome is exoneration, the fact of having been accused results in a 'spoiled identity' (Goffman, 1986), with consequent shunning by the professional community (Adams, 2001 p.191).

The costs in time and money can be significant and draining (Adams, 2001; Peterson, 2001; Schoenfeld et al., 2001; Williams, 2000). A case requires significant preparation, and where this stretches on for years, it can be a large drain on time and emotional energy. The average financial costs for a psychologist to come before a licensing board are $10,000 for legal fees and $18,500 for personal therapy, but many cases costs blow out to $100,000 or even more (Montgomery et al., 1999); cases have been known to escalate up to $400,000 (Saeman, 1997). In addition the result may be a fine, payment for extra treatment for the complainant, and there are often circumstances where insurance may not cover all of the damages awarded (Peterson, 2001). If the finding is against the practitioner the result is generally a loss of job, income and earning potential. Even if the case turns out in their favour, they may still have lost their job (Thomas, 2005).

A compounding factor to this stress is the response of colleagues, which is often to shun the person (Adams, 2001). When a professional's reputation is at risk they may withdraw from social or professional contact, further isolating themselves; often they are instructed by legal counsel to talk to no one at all about the matter (Belk, 2013). This in turn can put undue pressure on existing family and friends, often more than the system can cope with. Further pressure and exposure arises if reports are published in the media, and

especially if the reporting is not accurate or balanced (Thomas, 2005). Clients, not bound to confidentiality, may discuss the case publicly with the consequence that rumours may spread, and this can be especially significant in small communities; at the same time, the professional is effectively gagged and cannot respond or quell distorted rumours (Helbok, 2003).

Clinical work can be adversely affected, producing over-vigilance, anxiety in relation to clients with similar characteristics or issues, premature termination, under or over-playing pathology, or being too accommodating. In turn this can lead to mistrust on the part of patients, or at times, a response of sympathy. These responses obviously compound problems the professional is experiencing (Montgomery et al., 1999).

Malpractice cases usually take several years to get to court, during which time the professional has been isolated, alienated and investigated. However, any show of hostility on the stand is likely to negatively influence juries in their decision, who are often take into account how likeable they find the defendant (Belk, 2013).

The sum of these effects alone should be enough to step back and reconsider the current approaches to regulatory investigations. A blithe response may be to say that all traumatic experiences can be a source of learning, but this ignores the duty of care that institutions have towards members, going beyond the cold 'letter of the law', and attending to the impact of the process (Freckelton & List, 2004).

A sanctioned professional needs to be respectfully heard, both personally and professionally; whilst this can occur through personal therapy, it can be argued that it is not solely a private issue. Such individuals need support, not scorn from their profession (Chauvin & Remley, 1996), and the philosophy of the 'helping professions' must surely extend to compassion for those members who may have erred. The resultant learning can benefit not only the individual practitioner, but also the community of professionals; 'their stories may be our guide and lifeline at some point in our own professional career' (Warren, 2013 p.14).

New Directions

The enforcement of profession ethics has been oriented around the protection of the client, and the demonstration of this to society at large. However, the practitioner has not always received fair treatment in the process. Getting the balance right requires a range of factors to be in place.

On an organisational level this includes feedback channels, regular reviews of the process, and mechanisms for reform. Organisations must be held accountable; however attitudes need also to change. There are many instances where boards have been found to have acted wrongly by superior courts, but with little real impact on how they continue to operate. This suggests that there need to be interventions which bring about change in the culture of such organisation.

On a structural level, this involves increased attention to ensuring that due process and natural justice are served; this also requires a willingness to address areas where they are not sufficiently present. To the degree that investigations mimic legal processes, there must be a commitment to minimum standards of procedural quality, including also the reduction of processing time frames. All of this may necessitate increased resources, or exploring alternatives the the adversarial system.

Members of regulatory bodies need to have sufficient training and knowledge of the field they are regulating, and sufficient knowledge of ethical theories and their application. They also need training in the issues related to the wielding of power, and some degree of awareness of where and how this can be distorted.

It is time that the high ethical standards that individual practitioners are being asked to conform to, are also applied to the bodies that oversee the regulation of those practitioners.

Alternatives to the adversarial system

Problems with adversarial process

A grievance or complaint about a practitioner performs a number of functions. It indicates that something went wrong - something that the professional clearly needs to learn from. It can be empowering for someone in a client role to speak up, articulate their boundaries and needs, and identify what they need in response (Jurkiewicz, Giacalone, & Bittick, 2004).

Professions have a number of priorities in addressing complaints. Firstly, to ensure that perceived wrongs are seen to be addressed - the public is sent the message that infractions are taken seriously; secondly, that there is a corrective mechanism for any errors which have occurred; thirdly, that the professional would be less at risk of creating harm in the future; and overarchingly, that the integrity of the profession is maintained (Pope et al., 1987).

Regulatory bodies have adopted - however imperfectly - a process to achieve these aims which derives from the adversarial system that most western courts are based on. The focus is on determining if the practitioner is guilty or innocent - a limiting reduction of the complexity of the professional relationship into one of two discrete categories (Menkel-Meadow, 1996). The two versions have been described as 'stories' of what went wrong (Mitchell, 1999). In these type of investigations, it is seen as necessary to simplify such stories in order to arrive at a clear finding, but much is lost in the endeavour to squeeze a range of facts into narrow categories (White, 1985).

In the process, a number of needs of the complainant may be bypassed by this system. Barstow & Feldman (2013) argue that the needs of the person bringing a grievance are fundamentally relational ones. This includes some of the following: an acknowledgment of their experience; they often want to understand what was going on for the professional in the process; they generally want an apology or expression of regret; they want assurance that the professional has learned from this, and will act differently in their future practice; and they may want some kind of repair in the relationship, or the ability to cleanly let it go.

Menkel-Meadow (1996) raises fundamental questions about the relevance and effectiveness of using the adversarial method of getting to 'the truth'. She points out that our contemporary understanding interrogates the notion of a singular truth which is stable and discoverable (see also Rosenau (1992)); suggesting instead that all such endeavours are contextualised by the interests and bias of the investigators. She suggests the existence of alternatives, where empathic enquiry is valued as much as rational and forensic processes, and ambiguity is accepted as part of the nature of stories of truth. In fact, truths can be seen to be missed and distorted by the exaggerated and selective representation of competing stories and the manipulation of information which is often part of the adversarial methodology. The notion of 'neutral' judges is challenged, as are unspoken cultural bias; for instance the quest for 'truth' may be replaced in cultures which are Confucian based, by a striving for 'harmony'.

Samuels (2014) presents two critiques of the adversarial process. The first problem with the attack-defence mode is that it tends to provoke survival behaviours which consequently reduce the likelihood of hearing, repair or resolution. In protecting the 'public good', the complainant themselves may not be well served. In fact, they can be more traumatised by the process of investigation itself if it becomes escalated in a way they cannot stop, and may even be compelled to give evidence against their wishes.

Secondly, practitioners are placed in an ethically untenable position as a result of the adversarial process. They are entitled to defend themselves, but in order to do so they may need to attack the evidence produced by the complainant, or reveal exculpatory information which would break confidentiality. This sets up a conflict between their ethics around confidentiality and the right for self defence, and may further damage the relationship with the complainant.

The following case demonstrates the this concern:

> Trevor was a psychotherapy trainer. One his students was consistently disruptive in class, often picking fights with other students. The student brought an ethics complaint against the Trevor, claiming that he was 'wounded' by the way that Trevor had handled a conflict between himself and another student. The ethics committee upheld that the student had been harmed, and found against Trevor.
>
> When it was appealed, the appeal committee chastised Trevor for challenging the evidence, stating 'Harm and risk are subjective experiences, not a matter of debate especially between a psychologist/ trainer and a patient/consumer, and further demonstrates the lack of adequate understanding of the issues and ethical and professional responsibilities'. The same committee went on to state that the process was 'communitarian, not adversarial', and therefore the trainer should have accepted the findings rather than appealed.

In this evidently convoluted logic the disciplinary process is characterised as if it is not really an adversarial system, and therefore there is no place for practitioners to defend themselves or make any appeal. This is reminiscent of double bind theory (Gibney, 2006; Weakland, 1974) in which an authority provides two contradictory injunctions, both of which end in negative consequences.

This exposes some of the internal contradictions which can flow from using the adversarial system as a way to protect clients from harm. Menkel-Meadow (1996) suggests that rather than a one size fits all approach, there needs to be a range of ways to process client concerns, appropriate to each situation.

We now turn to an exploration of some of the alternative approaches available.

Malpractice alternatives

The malpractice system is one way that client complaints are addressed. Although it is predominantly used in relation to medical cases, other healthcare practitioners are also subject to claims (USDHH, 2014). It is of note because it is a particularly lengthy, inefficient and expensive system of addressing disputes, particularly in the US. The statistics speak for themselves: most lawsuits (60%) are dismissed, yet still cost up to $80,000 to defend, and the total system costs (US) are estimated at around $100 billion a year; the cost of resulting defensive medicine is estimated at $83 to $151 billion. Cases average 5 years and have less than 10% success rates for plaintiffs, and even then most of the awards go to attorneys (Sohn & Sonny Bal, 2012). The process is demonstrably stressful for both plaintiff, and defendant (Klebanow, 2013).

A variety of other countries also use the tort system (e.g. Japan, Israel, Australia and the UK), though in different ways; for instance the UK system has an emphasis on local resolution (Wada, Saegusa, & Nakanishi, 2012). One of the mooted benefits of the tort system is the deterrence of negligence; in actuality, relatively few (2%) who are injured file a claim (Localio et al., 1991), and when they do, the prolonged length of the process is also a deterrent to complainants (Hyman, 2002). However, rather than improving practices, the result is a decrease in the willingness of professionals to admit errors (Gawande, 2005), fueling a climate of mistrust and defensive practice (Bishop, Federman, & Keyhani, 2010). As a consequence, 92% of physicians reported

practicing defensively (Jackson Healthcare, 2009). Compounding these problems are the marked number of medical malpractice cases (25%) where the court had erred significantly in its findings (Studdert et al., 2006). The general legislative response has been to impose caps on payouts, but the standards vary widely (Loughlin, 2009), and this approach has not been generally successful in terms of any of the above mentioned problems (Burkle, 2011).

There are other aspects of the malpractice system which are questionable. Non economic losses are subjective, and putting a price on pain, suffering and trauma is often determined by the perceived personality of the accused and the theatrics of a hearing in front of a jury (Belk, 2013). The problematic effects of the whole system is indicated by the response of those doctors who forego malpractice insurance and consequently limit their practice, refusing to take certain patients (e.g. trauma) or perform high risk procedures (AAP, 2004).

One alternative - for medical malpractice at least - is a no-fault administrative model whereby compensation is offered for injuries that are either avoidable or preventable, pre-calculated by standardised accounting methods (Bovbjerg, Tancredi, & Gaylin, 1991; Mathews, 2010; Studdert et al., 2006). In addition to economic equity and reigning in of costs, the result is improvement of patient safety (Kachalia et al., 2008). Unlike the negligence based model, which shuts down communication due to fear of guilt and blame, this approach encourages communication and provides incentives for best practice (Mello et al., 2006). Another no-fault approach allows for automatic compensation for harm resulting from practices falling outside preset guidelines (Stimson, Dmochowsk, & Penson, 2010).

There are other national models. Scandinavian countries use a well established administrative system which separates client complaints from compensation, therefore containing costs; however it is weak at resolving issues at a local level (Wada et al., 2012). New Zealand also uses an administrative system. Although the tort system is used in Japan, the matter is dealt with by a panel of judges; in France special commissions are used to provide a uniform response; in Denmark there are specific health courts used to hear these matters. These systems reduce both costs and time delays, providing more responsive and effective means of complaint processing (Klebanow, 2013).

A more contextual solution is enterprise liability, which involves shifting legal responsibility from the individual practitioner to the health care organisation, devolving the onus onto the institution to monitor appropriate care (Studdert et al., 2006). This reduces stress on individual practitioners, and creates an environment where best practice is a collective issue.

Alternative dispute resolution

The adversarial approach to addressing grievances is generally adopted by regulatory bodies without much consideration of the alternatives. However, it places the complainant and the professional in combative positions, each struggling to prove their own case, and disprove the other; complex relational dynamics are often reduced to black and white assertions (Williams, 2013). A cycle of attack and defense can ensue, magnifying the original harm in the process. This competitive orientation is more likely to lead to destructive than constructive outcomes in grievances hearings (Deutsch, 2000), and research consistently shows that cooperative processes are more likely to lead to better psychological health (Johnson & Johnson, 1994). If a case is managed as a mediated conversation rather than an investigation and trial, the fuel for denial or defensiveness is significantly reduced.

There are well proven alternatives to the legalistic model of complaint processing; many of these frame the complaint as a problem in the relationship between practitioner and client; responses can include negotiation, mediation, facilitation and alternative dispute resolution (Freckelton, 2007b; Sohn & Sonny Bal, 2012). These processes help identify the interests and needs underneath positions, support people to feel heard and understood, explore issues with a view to finding resolution, and encompass listening and communication techniques. This is concluded by an agreement which is written, and then followed up. A significant difference is that those conducting such processes are not the deciders, but supporters who empower the parties to come to a mutual understanding (West & Gibson, 1992).

In this alternative approach to justice, power is not imposed from above in terms of authoritative decisions, but the position of the facilitator is used to create the ground whereby any differential in power between the two parties is managed so both needs are fairly considered (John Howard Society, 1997). The emphasis is on problem solving rather than simply dispute resolution, and the development of a cooperative dialogue rather than conflictual engagement (Wexler, 2011). There is a focus on process - the way people are treated and dealt with by the system - emphasising voice, validation and respect (Tyler, 1990). The orientation is towards a comprehensive and holistic approach to all aspects of the enquiry process, and a focus on creative problem solving framed by a multi disciplinary scope (Freiberg, 2011).

This can be critiqued as a naive view of power differentials; it can be argued that clients need the power of an institution to take on the status of a professional when a serious allegation is raised (Osborne, 1992). The notion of a negotiation implies a level of power equity which may not be perceived, or may not be the case. A structural view suggests that institutions, professions and professionals hold status, position and collective power (Johnson, 2005); despite the presence of a mediator, the dialogue is not likely to be balanced because

of these background factors, increasing the risk that the complainant would not be able to hold their ground. Pyke (1996) is critical of mediation, claiming it can legitimise the interests of the professional while 'forcing the victim to bargain for her rights' (p.5).

Countering these concerns Young (2006) suggests that by putting two people together with a mediator, problems which originate in the context of a professional relationships can come down to 'human size' and be dealt with person to person. From this perspective, it is the personal empowerment of both parties which can lead to genuine dialogue and the possibility of resolution. The complainant retains some control over the process, unlike in formal hearings; even where the rupture in relationship has been devastating for the client, mediation has been found to be successful in its outcomes (TMI, 1999). However this involves the complainant foregoing - at least within the mediation process - their ability to harness the power of the regulatory body to investigate, interrogate, expose, find guilty, and punish the practitioner (Bazemore, 1995).

In cases of serious allegations such as sexual misconduct, the objection to mediation is that it may let an offender off with insufficient consequences. There are concerns that facing the complainant with their abuser could contribute further to their distress - especially if the professional denies what occurred (Pyke, 1996). This remains an open question however, as a significant motivation for denial derives from the adversarial setting. In a context in which there is real dialogue the motivation for denial is reduced, especially if the professional is faced directly with the experience of the complainant and is able to hear them non-defensively. Changing the ethos to one of communication is more likely to support this non defensive stance, ultimately benefiting the complainant (Rabinovich-Einy, 2011).

Mediation is not generally undertaken in criminal cases, where the state brings the case and the goals are retribution and deterrence, or other situations where it is desired to send a public message, as mediation is generally a private process (Neiman, 2014). To be successful, mediation requires certain attitudes such as good faith, patience, preparation, a willingness to listen and be transparent; the skill of the mediator in facilitating the process is also an important variable (Young, 2006). If these factors are not present, it is less likely to be a successful option.

One of the consequences of the adversarial means of addressing disputes is a consequent practice of defensive communication. When a dispute escalates, the professional hunkers down into a self protective position, and communication becomes limited; this is driven both by fear of litigation or formal complaint as well as advice by legal counsel (Hetzler et al., 2004). Unfortunately and ironically, this in itself can become the trigger for an escalation into a formal complaint.

Alternative dispute resolution (ADR) processes have been used successfully in institutional settings to increase communication skill and usage, thereby reducing the likelihood of complaints escalating in this way; it was found however that having a neutral party available to support the process increased the chances of success (Rabinovich-Einy, 2011). This suggests a different role for either courts or regulatory bodies, in assisting ADR, rather than being a vehicle for a battle being played out in the hearings process.

Another approach is to use mediation as part of a rehabilitation plan, after a clients concerns have been heard by a regulatory body. An experienced therapist meets with the transgressing professional and the client for several sessions, providing an opportunity for the client to talk about how they experienced the betrayal and an opportunity for the practitioner to offer an apology (Celenza & Gabbard, 2003).

Mediation has a 75-90% success rate in avoiding subsequent litigation, while achieving significance cost savings and high (90%) satisfaction rates for both plaintiffs and defendants (Sohn & Sonny Bal, 2012). It creates a more informal atmosphere and allows space for a variety of outcomes other than monetary compensation or punitive outcomes. In fact in one survey of plaintiffs, money was not the primary thing they were seeking - more important was an apology and information about how the adverse event occurred (Szmania, Johnson, & Mulligan, 2008).

Conversational models

The emphasis in professional ethics is often on what to avoid (Geraghty, 2005), and in these days of risk management, ethics discussions tend to defer to the question of what is legal (Geraghty, 2012). The focus of both the education and administration of professional ethics can be oriented around ideas of right and wrong as referenced by a code, regulators being the ultimate guardians and evaluators of the achievement or failure to meet those standards (O'Donohue & Ferguson, 2003).

An alternative to this is the approach offered by the constructivist perspective (Freedman & Combs, 1996) (Chambon, 1999), where truth is understood as being 'illusive, partial, interpretable, dependent on the characteristics of the knowers, as well as the known, and most importantly, complex' (Menkel-Meadow, 1996 p.49). By reframing the process from an investigation into truth and 'relevant' information, to creating the opportunity for stories to be authentically told, the orientation changes to empowerment and a version of truth that is explicitly personal (Mitchell, 1999).

White and Epston (1990) pioneered a narrative approach to both therapy and wider social issues. They proposed the creation of a conversational space for people to come forward in new ways, sidestepping defensiveness and engaging in multiple descriptions of the problem situation (White, 2005).

This idea of multiple meanings is a core part of a social constructivist thesis, and incorporates terms such the 'decentred position' (Geraghty, 2012 p56) and 'not knowing' (Anderson & Goolishian, 1992). If these approaches were applied to ethics investigations, the outcome would be one deepening understanding and transforming meaning around the grievance, as well as a much greater capacity on the part of the professional to take full responsibility and be empathic with the complainant (see for instance Jenkins, 1990).

Constructivists challenge the idea that there are objective facts to be discovered, or that there is an objectivity that can be impaired or lost (See the American Psychological Association, 2010, code of ethics (p.5): '...that would likely lead to ... loss of objectivity'). Claims to objectivity are seen as containing unquestioned cultural views (Martin & Sugarman, 1999) that lack critical evaluation (Kaye, 1999) and ignore 'positionality' (Bartlett, 1990). Instead, what really matters in professional practice - and by extension, in dealing with complaints - are conversations which develop a shared meaning about events (Strong, 2005).

Heinz von Foerster (2002; 2010) points out that as soon as ethics are codified, they come to serve a variety of agendas, often diverging from the stated aims that they were originally intended for. He proposes a radically different way of languaging ethics, one that is oriented towards enquiry, discovery, and focusing on what allows ethics to 'flow implicitly, without becoming explicit' (2010 p17). Foerster's proposed ethic can be summarised in his direction to 'act at all times so as to increase the number of choices' (2010 p15). This is clearly in contrast to normative or deontological approaches which judge ethical probity in relation to a set of ethical rules.

In fact, constructivist ethics tends to be agnostic about what morals and ethics should be (Hoffmann, 2009), focusing instead on the question of interpretation and the construction of meaning (Strong, 2005). These appear to be abstract questions, far from the practical realities of behaviour in professional relationships, and the processing of grievances. However, constructivism allows us to see the frame though which we view the world (Bem, 1993), and helps us to examine assumptions which are embedded in standards of practice and ethical codes (Foster & Lasser, 2011).

One of the bedrocks being questioned in this critique is a focus on the psychology of the individual - proposing instead a social and biological conception of ethics (Cottone, 2004). Bateson (1972) points to the mind as being a social matrix, while Gergen (1985) sees thought as arising from the sharing of language, and a manifestation of social interaction.

In this sense, the individual decision-making of a professional is shaped by and emerges from a social context, including biological and social forces. Ethical decisions arise out of a 'consensualizing' process, which is an interpersonal dynamic which takes place in a professional context (Cottone, 2004 p8). Ethical conflicts such as occur in a grievance - where the client comes to hold a different view than the practitioner - can therefore involve the negotiation of different truths, rather than a search for 'the' truth.

Codes of ethics themselves are simply expressions of negotiation and consensual agreement amongst organisational representatives or committees (much as DSM categories are, in the final instance, the result of a vote). In this way, codes represent 'a conduit for communicating the rich history and professional culture of the profession…a message of tradition…an excellent example of a social construction of ethical and unethical professional behaviour' (Cottone, 2004 p12). The quality of the ethical culture of the profession is seen here as an essential ingredient in the ethical behaviour of individuals, and may be just as appropriate a place of intervention as the behaviour of a specific professional.

A large body of literature now exists detailing the nature of ethical practice, the dangers and remedies in relation to practitioners in the therapeutic and health fields. But the focus is almost exclusively on the responsibility of the individual practitioner; White (1993 p.122) suggests that professional ethics is situated in a professional monoculture in which thin descriptions (Geertz, 1978) lead to thin conclusions. An alternative perspective is provided by a 'multiply contextualised' ethics (White, 1993 p.123), which utilises a multifaceted approach to fostering responsible professional behaviour as well as dealing with lapses in the use of power. There are a range of possible systemic responses including detection of impairment, educational programs, opportunities for collaboration and mentoring, reducing isolation, increasing dialogue and awareness, improving standards of supervision and training, and encouraging self assessment and consultation.

Some of the post-modern perspectives explored here - and specifically, radical constructivist propositions - are vulnerable to charges of ethical relativism and a type of groundless morality (Koppelman, 2009). Thomson (2000) answers this critique by suggesting that through questioning apparent certainties and epistemic assumptions, a greater degree of self reflection is encouraged and alternatives perspectives are considered; however he also acknowledges that there are times when it is appropriate to act with certainty. These are important considerations when using a constructivist approach to professional ethics, as the need for standards must be accounted for alongside considerations of the multiplicity of truth and the questioning of underlying certainties.

Restorative justice

Restorative justice (Braithwaite, 2002) is another approach which can be applied in constructing a dialogue between complainant and professional. Legal type processes are usually framed in terms of State (or professional association) vs the accused (practitioner), and continue even if the complainant drops the case (Adams, 2001). An alternative approach is to increase involvement of the complainant at all stages - pre-trial, trial, sentencing and post sentencing. This is framed by the proposition that harm is something that occurs between persons, rather than a violation against an organisation or the state (Umbreit & Carey, 1995).

This is a contrast to the usual modus of the legal system which purports to represent the complainant, but at the same time puts them in a neglected and peripheral position in the whole process (Christie, 1982). Therefore alternative solutions to complaints involve direct dialogue (Austin & Krisberg, 1982), with a focus on rehabilitation and restoration of status of the professional. Adversarial processes tend to be more oriented towards sanctions, punishment, retribution and 'harm in response to harms done' (John Howard Society, 1997 p.5). Restorative justice proponents view this as expressing a spirit of revenge rather than resolution, and propose a focus on the broader relationship of complainant, accused, and society (Bazemore, 1995). This provides a different way to consider 'the public good', a phrase which is heavily emphasised in the activity of regulatory bodies

In contrast to deterrence, the restorative justice approach is the goal of reparation, allowing the accused to make amends (Austin & Krisberg, 1982). The current system actually interferes with this process: when money is awarded to the complainant, it does not come directly from the accused, but from their insurance provider. The sums have become so large that they are generally beyond the means of an individual practitioner; the idea of reparation has arguably become distorted and inflated, losing its potentially healing aspects. Where reparation occurs via a pre-emptive out of court settlement by the insurance company in order to ward off a full trial, there is even less opportunity for any kind of acknowledgement or amends process; it bypasses the professional, the complainant, and the actual content of the issue at stake.

A comparison of the adversarial and restorative approaches is displayed in the following table, adapted from the John Howard Society (1997).

	Adversarial	**Restorative**
Central issue	Breaking of rules	Harm done to a person
Aims	Sanctions and deterrence	Restore complainant, accused and community to a pre-offence status
Offender's role	Guilt or innocence determined, sanctioned	Make amends, 'right the wrong'
Complainant's role	To report the offence and give evidence; otherwise peripheral	To reconcile with the offender; central
Complainant's rights	Background; possibly receive monetary compensation	To confront the offender and receive restitution
Focus	Backwards looking: determination of guilt, administration of pain	Forwards looking: search for solutions and promotion of reconciliation
Concept of justice	'Right-rules', tested by process and intent	'Right-relationships', tested by outcomes

It can be seen from these comparisons that restorative justice is based on a significantly different value set as compared to the current system. Unfortunately there is little consideration of this approach within the field of professional ethics and licensure, and there are few examples of where this has actually been attempted. Saperstein (2006) describes a relatively unique attempt at 'psychoanalytic justice', which centring on a process of 'ethical inquiry'. This focuses on providing the support necessary for the aggression and anger which generated the complaint to be fully heard and held, rather than allowing a splitting into 'good' and 'bad' which usually characterises adversarial hearings.

A salient feature of this difference is that the focus is on justice-within-relationship. The professional relationship is the setting where things have gone wrong, and this approach sees that the solutions also lie within the relationship. The adversarial system is more likely to produce exclusion; even when the outcome is 'exoneration', the process of going through a disciplinary hearing is alienating for the professional, and often leads to the demise of collegial relationships (Adams, 2001).

Another example of this relational ethos is contained in the stated aims of the grievance procedure of the Eastern Mennonite University (2014 p23), which is based on constructivist ideas and notions of critical reflection: 'The main concern in any grievance is to bring reconciliation and growth in ways that enhance community'.

A comprehensive review by Strang et al (2012) demonstrates the efficacy of restorative justice in terms of both recidivism and victim satisfaction. While the most common application of this is in the field of juvenile justice, it is worth considering how it may be piloted within the management of professional ethics violations. The field of psychology in particular is ostensibly about relationship, so 'ruptures' as they are known (for instance, see Safran & Muran, 1996), generally need the kind of support that is offered by restorative justice, rather than the attack mode inherent in the adversarial model.

Therapeutic jurisprudence

The central dangers for tribunals are in being either overly sympathetic with the practitioner, leading to a diminishment of faith from the community, or being over-censorious, going beyond the scope of the enquiry to critique the practitioner's clinical work. There is an additional danger of being too legalistic, out of a fear of being appealed.

Therapeutic jurisprudence provides an alternative approach which focuses on the impact of the law on the well-being of all participants in a hearing, including their emotional states (Wexler & Winick, 1996). This views the investigation process as a clinical intervention, potentially having positive effects on the individuals concerned (Freckelton, 2007b). This represents a complete turnaround from the adversarial mindset which is focused entirely on winning, and in which being heard or validated is of little importance (Shapiro et al., 2008).

Disciplinary proceedings have tended to draw on a traditional model of criminal investigation (Wexler, 1993); the result is a significant potential of traumatisation of the participants. Therapeutic jurisprudence involves balancing fact-finding accuracy and fairness with processes and results that are therapeutic for the practitioners, notifiers, witnesses, community members and the investigating authorities of the regulatory body (Winick & Wexler, 2003). The emphasis is on minimising adverse outcomes, and attending to social relationships and emotional issues arising from legal processes (Freckelton, 2008).

This innovative approach takes a caring attitude towards both parties. It sits alongside other pioneering approaches to the law which include preventive law, restorative justice, procedural justice, facilitative mediation, alternative dispute resolution, holistic law, collaborative divorce, law in society, law in context, and ethics of care approaches (Freckelton, 2008).

The following outline is derived from the extensive work of Freckleton (2006; 2007a, 2007b, 2008; 2004) in this field. We recount some of the detail because it provides an exceptional example of a well thought through alternative approach, incorporating a variety of the concerns raised in this paper.

Notifiers are generally emotionally vulnerable and need sensitivity and assistance. They are likely to need support throughout the process so they do not undergo further suffering in the process of disclosures. They are therefore offered sessions with a health practitioner during and after the hearing if they are suffering significant distress, and to help them come to terms, one way or the other, with the findings.

A respectful investigation process is seen to involve transparency at each step, providing the notifier with as much information as possible, including the thinking of the hearing body. If a decision is made to drop the case, they are provided with documentation including a summary of the whole process and the thinking of the regulatory body which caused it to close the file.

Respect also includes notifiers are being pushed by investigators, so that they can reveal what and when they are ready to, with support. What they generally need is empowerment and validation, but what often happens in adversarial proceedings is that their story is taken from them and twisted into an altered narrative that suits the purposes of the case.

The stressors on a practitioner in the course of a case are multiple. Their professional identity is challenged, they are likely to experience shame, and they may feel guilty simply because a client is angry enough to make an allegation. Investigators are cognizant of this, and so are careful in drawing inferences from the professional's behaviour over the course of the hearing.

It is seen as a responsibility of the regulatory body to also provide support to the practitioner during the process, and to help them cope with any adverse decision which is likely to have a major ongoing impact on their lives.

Increased scope is given for ventilation by both parties to the hearing - more so than would be normally tolerated in court proceedings. This is consistent with a broader emphasis - not only on achieving justice, but also on a therapeutic and healing outcome.

The exposing nature of a hearing can be embarrassing and distressing for both parties, and can lead to further trauma and the possibility of stigmatisation (Coverdale, Nairn, & Clausen, 2000). However for the practitioner, public shaming and exposure may be part of the necessary and powerful sources of motivation to change future behaviour. In order to leverage this effect in a way which is positive rather than traumatic, the process is made more personal - judgments are delivered with the accused practitioner standing, and

able to interact with the panel during the decision delivery process. The aim is not humiliation, but to communicate powerfully about the conduct in question, provide a perspective on the causal factors, and direct the practitioner towards reparative steps. This can be a sobering but revelatory experience for a practitioner, coming to terms with what they have done; at the same time they are given a signal indicating the start of a journey towards new learning. Judgements include a focus on mentoring, and communication to the practitioner about how they can move forwards in their career, take steps to make improvements, and avoid future problems.

The notifier is also present at this ritual, and the panel may speak to them directly as well. This can include an acknowledgment of the difficulties they have experienced in bringing the case forward, their personal disclosures, and the beneficial result for others of their actions.

These type of processes take time (and are therefore more costly), and require a higher degree of skill from tribunal members. This pioneering direction has yet to become more widely known, let alone gain acceptance from the regulators or the community.

New directions

Whilst adversarial processes are an established means to conduct enquiries into wrongdoing, they are not necessarily the best way to go about this, and tend generate additional problems for the complainant, the accused, and also including the wider context of the health professions.

It is only by questioning the taken for granted assumptions that this is the best response, that alternatives can be considered. There is some track record of such alternatives being proven successful in the legal arena, but the health professions have been slower to experiment, despite many positive indications.

In the realm of psychotherapy, where the focus is on care, healing and healthy growth, it seems somewhat of a contradiction that when something goes wrong, the same ethos is not utilised as a part of addressing the concerns that arise.

There is a need for the development of new versions of disciplinary hearings, which involve care for both sides, an orientation towards healing, and support for the growth and empowerment of both complainant and practitioner.

Discipline and consequences - punishment or remediation?

Complaint mechanisms are seen as a central means by which to hold a profession and its members accountable (Nash et al., 2004). One sign of effectiveness is seen to be the administration of appropriate sanctions for violations of the code (Ferrell & Gresham:, 1995; Nitsch, Baetz, & Hughes, 2005; Schwartz & Cragg, 2000). Providing penalties fulfils several functions: sending a signal to professionals about the consequence of unethical behaviour; trying to effect a change in the person found guilty of misconduct; and giving an indicating to society that unethical behaviour is taken seriously and efforts are being made to protect the public (Freckelton, 2006; Freckelton, 2007b; Higgs-Kleyn & Kapelianis, 1999; Sawicki, 2010). If violations are not punished, the organisation loses its authority, the code is not treated as seriously, and cynicism and disrespect can breed when behaviours which do not correlate with the code are left unchecked (Adams, 2001).

No professional career is free of ethical mistakes (Welfel, 2005); a majority of mental health professionals admit to having committed an ethical violation during the course of their career (Sherry & et al., 1991). Given that the definition of a profession includes the notion of self regulation and acting in the interests of the community (Pryzwansky & Wendt, 1999), a more effective system of dealing with ethical issues could arguably include support for self evaluation on the part of professionals, as part of a formal process when a complaint arises.

However, externally imposed sanctions are seen as necessary, as a professional is unlikely to self-sanction to the extent that may be imposed on them. The very issue of self versus other interest is what is at stake in a complaint about professional practice, so it is seen as unlikely that the person under review would suddenly set aside their own interest. The premise of sanctions and enforcement is that in the face of dishonest, selfish or harmful behaviour it is necessary for a higher authority to step in, take control, and issue consequences (APA, 1951).

Criminal law is focused on punishing wrongdoers, civil law at compensation; professional discipline is primarily concerned with protecting the public welfare by dealing effectively with the question of competent practice. However the matter of professional discipline is related to the scope of attention, and the beset way to achieve competent practice is a debated question. Higgs-Kleyn & Kapelianis (1999) found no relationship between perceived penalties for the contravention of a professional code and the frequency of contravention; others challenge the value and effectiveness of exclusion as a punishment, both practically and philosophically (Hellinger, Weber, & Beaumont, 1998)(Ulsamer, 2003)(Franke, 2003).

Whilst there needs to be consequences for unethical behaviour, the demonising of those with violations is clearly unhelpful (Zur, 2008). The public has to be protected from damaging or incompetent actions on the part of professionals, but the question is whether an emphasis on enforcement and punishment is the most

effective way to achieve this (O'Connor, 2001). The type of strategies which derive from dealing with criminal behaviour are not always appropriate for the variety and complexity of professional misconduct, or the type of clients involved (Hedges, 1999; Welch, 2000).

There are a range of consequences which can be imposed by professional regulatory bodies depending on the nature of the infraction. These include education, various forms of support, specified oversight (such as supervision), mandated therapy or other treatments, as well as range of punitive responses including reprimand, censure, fines, demotion, practice restrictions, suspension, stipulated resignation, expulsion, or loss of license (Corey, Corey, & Callanan, 2007; Higgs-Kleyn & Kapelianis, 1999; Layman & McNamara, 1997; Reid, 2005; Sawicki, 2010). Alternatives to more punitive disciplinary measure - such informal consent agreements, educational advisories, or other mediated conclusions to a complaint - are not always considered or provided by regulatory bodies (Van Horne, 2004).

There are significant tensions between the need to 'stick together', which dissuades colleagues from reporting on each other regarding unethical behaviour, and a basic sense of duty to the collective to expose problematic behaviour, thus strengthening the group's integrity. The willingness to report transgressions is somewhat dependent on how colleagues are treated during the complaints process, as well as whether the end result is a focus on rehabilitation or punishment (Frankel, 1989). This reinforces the importance of considering alternatives to the imposition of punitive consequences.

It is in the nature of being human to have life crises, and to experience vulnerabilities and lapses. Many health professionals work under intense pressure, and those in public systems often face insufficient resources. Those in private practice may work in isolated environments, and clients can act out in frightening ways; 20% of psychologists have been physically attacked by a client, and 97% have experienced fear of a client committing suicide (Pope, Sonne, & Greene, 2006). In addition, the work of professional practice tends to be competitive, so public discussion of mistakes is unlikely. This contributes to a climate which reduces the likelihood of personal disclosure or self examination.

Stress is also exacerbated by role complexity, which can include 'teacher, administrator, researcher, therapist, mediator, entrepreneur, crisis counsellor, and referral source all in the course of a day, sometimes changing roles by the hour' (O'Connor, 2001 p.346). This can produce various forms of compassion fatigue and burnout (Collins & Long, 2003). The underbelly of the 'helping profession' includes affective responses to the challenges of working with clients; 80% report experiences of fear, anger, and sexual attraction to clients (Pope & Tabachnick, 1993).

It is therefore no surprise that the impairment prevalence for for psychologists has been estimated at between 5-15% (Laliotis & Grayson, 1985). Those with substance abuse problems are in the 6-15% range (Elliot & Guy, 1993; Thoreson & Skorina, 1986), and 61% report experiencing depression at some point in their career (Pope, 1994); the rates of suicide for physicians are higher than the rest of the population (Gold, Sen, & Schwenk, 2013). In the light of these figures there is clearly necessary to balance attribution of responsibility and castigation, with compassion and support.

Impairment

There is debate over the question of impairment, and to what degree consequences should be remediatory or punitive. Particularly when it comes to damaging behaviour such as sexual relations with clients, some argue that there should be no 'second chances', and the lapse is of an order of magnitude that it should preclude practice entirely (Pope, 1990). Others propose that disciplinary programs need to have a rehabilitative orientation and that this is a viable alternative (Frankel, 1989).

Codes tend to be silent on personal behaviour, and direct attention towards role-defined professional behaviour, although the question of whether to apply sanctions or remediation evidences a lack of agreement about exactly where and how the boundaries lie between the two arenas (Pipes, Holstein, & Aguirre, 2005). While some behaviours are both personal and professional, impairment can be understood as 'a debilitating intrusion of personal variables into the professional realm' (p.327).

Welfel (2005) proposes the metaphor of recovery, involving healing for both the professional and the client affected. This references the work of Rest (1994) and involves four stages: recognition of error, regret and remorse, restitution, and rehabilitation to prevent recurrence. The focus here is on the empowerment of the professional to take responsibility in the face of errors, moving away from the blame inherent in adversarial approaches, providing support instead to bring such vulnerabilities 'from the shadows and into the light of rational and compassionate examination' (p.130).

One contemporary move is away from a concentration on unacceptable conduct, and towards an evaluation of competency deficits - insufficient knowledge or skill (Reid, 2005). This focus on impairment is positively oriented, seeking to address the deficiency and thus prevent harm on further occasions - an approach known as 'performance pathways' (Freckelton, 2007b p.152). The emphasis is a collaborative one, but can be provocative for notifiers, who may see it as going soft on the professional.

Ethics violations can result from a wide range of personal and professional variables, making it difficult to arrive at a uniform response (Keith-Spiegel, 1977), so effective remediation requires an individually oriented approach that takes into account contextual and individual factors (Schoener & Gonsiorek, 1988). Successful

interventions with ethical violators have been found to depend on the type of deficit displayed by the practitioner - in the case of sexually exploitative therapists, the group most potentially remediable are described as neurotic, dealing with situational stress, and recognising the impact of their behaviour (Gonsiorek, 1995). Greater degrees of denial and rationalisations reduce the effectiveness of such programs, and they are contraindicated for people with serious pathologies (Gabbard & Lester, 1995; Gonsiorek, 1995; Schoener, 1994; Schoener & Gonsiorek, 1988).

Brown (1997) provides a larger critique, not only of punitive approaches but also rehabilitative ones which focus only only on the practitioner. Presenting a contextual view, she points out that there are many levels of relationship which are involved in a violation. In light of this, rehabilitation of the professional alone is not a sufficient response; instead she proposes a 'making amends' process for the immediate and secondary victims of a boundary violation. This is supported by research which shows that much of the complainant's motivation for suing can be successfully addressed by apology (Sohn & Sonny Bal, 2012; Vincent, Phillips, & Young, 1994); apology laws have been found to significantly reduce legal action by 19-20%, and time to settlement by 16-18% (Ho & Liu, 2011).

Without an apology the victim is left out of the equation, perhaps receiving a refund of therapy fees or an insurance payout, but little else in the way of their own distress being attended to. A systemic response recognises the needs and wishes of the person initiating the complaint which includes being heard and acknowledged directly by the professional, not just taken seriously by the regulatory body. From this point of view, fines or punishments may be secondary considerations for the complainant.

The forensics of proof that are a part of the adversarial process may distract from other types of truth telling. Rather than 'forensic truth' (Minow, 1998 p.85), the truth value in a complainant's story may be addressed by the offering of sympathetic listening, acknowledgment and documentation by an audience. *Reparative truth-seeking* is about the acknowledgment and understanding of someone's painful truth as a step towards becoming whole, both for that person, and for the fragmented relationships that have resulted from their experience (Lourde, 1984; Taylor, Gilligan, & Sullivan, 1995). From this perspective the hearing process provides a type of public ritual that can offer a context and a degree of focused intensity which assists in the healing of harm created (Douglas, 2002). This has otherwise been described as 'lustration' (Patterson, 2011 p.81), a collective process which seeks to address traumas in order to gain a fresh start.

The black and white attributions of good and evil and the operations of moral justice are a part of our sociocultural ground, whether in the embedded values of the Judaeo-Christian tradition or the enduring themes of the Hollywood message. Ethical investigation, which emerges out of this context and is enacted in the process of professional regulation, stands in contrast to what Sapperstein (2006 p.755) terms 'ethical enquiry'. This involves a relational approach, adopting a receptive attitude towards - controversially perhaps - the 'co-created unconscious process'. A complaint is seen as the result of a failure in the relationship between practitioner and client, and support is needed for the rupture to be attended to within this relationship. Punishment may be appropriate, but at best only obliquely addresses this rupture, and does nothing to directly support dialogue and resolution. A focus on the relational dynamic is consistent with contemporary styles of therapeutic explanation and exploration which arise from an understanding of the intersubjectivity of experience (Stolorow, 1994)(Mills, 2012).

Applying this to ethics complaints involves adopting such an intersubjective view, consequently understanding harm and rupture in that context. This should not be equated with a simplistic 'everyone is equal' concept, but rather involves a critical reflection regarding accountability. The emphasis is on containment - in the sense of finding ways to hold pain, distress and rage - in order to produce relief and a sense of being understood. This view is consistent with a psychodynamic understanding, and it can be argued that it is representative of the deeper yearnings that a complainant brings to the process.

These type of processes, in common with those described by Patterson (2011), do not centre around the alleged 'facts' of the complainant, or the 'selected facts' of the therapist (Saperstein, 2006 p.755). Instead, the method is oriented towards support for the therapist to be able to reflect and become accountable for their conscious and unconscious participation in the breach, on the thesis that humiliation and guilt create obstacles to the goals of such an enquiry. This is consistent with trauma theory, which points to the fact that people do not function well under high stress (Levine & Frederick, 1997); certainly a case involving a complainant and a regulatory body creates significant duress for the practitioner.

The emphasis on *inquiry* offers a different premise from a focus on innocence versus guilt, or finding a punishment to fit the crime; it involves an acknowledgment of the inevitability of error in human life, and an analysis of the failures or errors of the professional which have now become a community responsibility. The phenomena of professionals taking ethics investigations 'personally' is understood through the premise that one's individuality shows up in one's work, which is experienced as an expression of self. Hence the inquiry process looks not only at the way a role was performed and subsequent misconduct in those terms, but also at the person occupying that role. This type of personal but non-defensive exploration would be very difficult in the atmosphere of righteous indignation which is often evident on both sides of an ethical complaint, and fuelled by adversarial processes (Saperstein, 2006).

The virtue of obedience, which involves the mastery of codes and law-like principles, has been referred to as the 'engineering model' of ethics (Caplan, 1982). What is left out is both social context and the individual particularities and circumstances (Clarke & Simpson, 1989). A narrative approach seeks to explore these specific histories of relationship, responsibility, and moral or immoral action in a way which enriches complex understanding. From this view the moral application of codes and associated principles creates a proverbial procrustean bed, paring down the story to determine guilt or innocence. Walker (1993 p.35) argues for a holistic type of ethics, invoking the concept of *moral competence*:

> *General moral maxims or principles can often be connected to particular instances only by a thick tissue of perceptions and interpretations; these are fed by diverse skills and rooted in varied habits of thought and feeling. Moral competence is thus not reducible to a code-like decision instrument (much less an algorithmic one) any more than carpentry is reducible to a saw.*

This offers a different approach to the regulation of unethical behaviour, one that is more akin to a conversational therapeutic model than the dominant legal one.

Consequences for practitioner-client sex

While there is widespread agreement that practitioner-client sexual contact is unethical and damaging, there are no clear best options in terms of appropriate and effective consequences. Current remedies include complaint to either a registration board, professional organisation, health complaints authority, undertaking civil action, criminal action, or submitting a sexual harassment grievance. While some actions may be initiated concurrently, this could be considered as unfair to the accused.

There are limitations in all the above approaches. It has been suggested that some registration boards do not follow through with serious enough consequences, such as deregistration (Borruso, 1991). Not all practitioners are members of a relevant association, and even then, the strongest action available may be that of expulsion. Health complaints authorities have not always been seen to be effective in dealing with such matters (McMahon et al., 1994), and civil actions can be costly and time consuming.

In fact, it has been found that holding strong values about a patient's welfare, and the particular nature of one's personal ethics are more significant in refraining from sex with clients than fear of negative consequences (Pope, Keith-Spiegel, & Tabachnick, 2006a).

Despite this type of data, there has been a move to criminalisation of practitioner-patient sexual contact in a number of jurisdictions; it has not however proved to be an effective measure. Few people file criminal charges under these provisions, and the voiding of malpractice coverage often means there is little financial compensation available (Strasburger, Jorgenson, & Randles, 1991). The proceedings are stressful, higher levels of proof are required, and unlike the administrative law, there is allowance for the question of consent.

The issue of consent is a complex one; many board jurisdictions have determined that consent is ruled out (McMahon, 1997), yet there is a debate regarding whether denying consent erodes patient autonomy and conflicts with related ethical principles (Miller, 2011). The concept of transference is used as a justification for disallowing the notion of consent (Benetin & Wilder, 1989), but there are many different understandings possible of what exactly transference is and what it means (Wiener, 2009), and there are those who contest it all together (Serban, 1981; Simon, 1989; Stone, 1984)(Shlien, 1984)(White, 2008)(Spinelli, 1995)(Yalom, 1980).

The question of the extension of prohibition of sexual contact to former patients is not a settled matter either, with a range of responses from regulatory bodies, resulting in inconsistency in approach and consequences (McMahon, 1997).

How should a regulatory body determine whether to take a punitive or a non-disciplinary approach? Reid (2005) outlines the procedure the Australian Medical board has developed. This involves a parsing system, based on an initial assessment of whether the behaviour in question falls into any of the following four categories: *unethical, reckless, criminal*, or *wilful*; these terms parallel categories used by Wheeler and Bertram (2008 p.2)*: intentional disregard and careless disregard*. If one or more of these markers are present, the board will investigate with a view to disciplinary action; this occurs rarely. If not, a performance program is developed using non-disciplinary, non-adversarial and educative interventions.

In these cases, rather than making a finding in relation to the notification, a rigorous assessment of performance is undertaken in the practitioner's own environment. If it is determined that impairment is the issue, a special panel works with the case. Otherwise, the focus is on effective intervention, with the full cooperation of the practitioner; this also includes monitoring and possible reassessment. It has been found that despite the lack of investigation of the triggering notification, the tailor-made remediation-focused outcome tends to satisfy complainants, to see that 'the same thing doesn't happen to anyone else' (Reid, 2005 p.18).

Another successful remediation-based approach has been applied over a period of 40 years at the Walk-In counselling centre in Minnesota, with a documented and consistent track record. The process requires the agreement of all parties that a violation has occurred, and then involves a systematic procedure of evaluation and assessment, monitoring and feedback, and final determination of reentry into practice (Gonsiorek, 1995; Gonsiorek, 1997; Schoener & Gonsiorek, 1988). Remedies can include substance abuse

treatment, family therapy, repeat internship, or even retraining. A range of other remediation approaches have also proved successful, with success rates over a several decades as high as 88% (Brooks et al., 2012).

The effectiveness of rehabilitation has been found to be related to the type of impairment of the practitioner (Halter, Brown, & Stone, 2007; Schoener, 1994). These are characterised in a range from *Naive* and *Situational offenders,* to *Sociopaths, Manic* and *Psychotic disorders* (Halter et al., 2007; p.96). This approach requires assessment, and then a rehabilitation plan which is constructed accordingly. Rehabilitation is seen as complete when the associated problems have been remedied.

Empathy training is a key element in many rehabilitation programs (Abel, Barrett, & Gardos, 1992; Gonsiorek, 1987). There is some controversy over whether empathy can actually be taught as a skill, or whether people simply parrot what they have been taught and exhibit behaviours which simulate empathy (Zucker, Worthington, & Forsyth, 1985). However, programs that teach empathy have proved to be effective with professionals who engaged in sex with clients: Regehr & Glancy (2001) reported nil remissions over an eight year period.

Empathy is also something that needs to be modelled in order for it to be taken up as a core value. The training of doctors starts with an emphasis on science and detachment, tends to develop pride, and emphasises isolation and hard work through treating medical students harshly and putting them under high stress. Hence the importance of working with physicians who are guilty of sexual misconduct in a way which models empathy and compassion (Spiro et al., 1993); this provides another argument for finding alternatives to punitive consequences.

With programs such as these available, the issue becomes whether a regulatory body will incorporate this option into the way they deal with ethical violations. Many do not, and simply stop at punitive consequences (Adams, 2001); it has however been argued that discipline and rehabilitation are not mutually exclusive (Schoener, 1994).

THE MISUSE OF POWER: CASE EXAMPLES

The following small sample of cases provide an illustration of some of the issues covered in this paper. They are troubling, and point to the urgency for the need for reform; unfortunately there are many more examples. What is even more concerning is that there are relatively few places in any of the regulatory bodies where actual systemic learning takes place in order that glaring problems are addressed and rectified. The result is that the same problems continue to be repeated, with damaging consequences for both individuals and the professions.

Case #1: Jason and the tribunal.

Jason practiced as an osteopath. Over the course of his career he developed an interest and expertise in a wider range of 'alternative' treatments. At times he would incorporate these into his practice; at other times he would refer patients to other practitioners who he saw as complementary to the work he did. He was successful and highly regarded.

However, one of these referrals went sour. The practitioner who he sent a female patient to was skilled, but rigid, and with insufficient interpersonal skills. The patient was highly offended and the treatment subsequently did not improve things.

She brought a complaint to a health care tribunal, not about the problematic practitioner, because he was unlicensed, but against Jason, as a registered professional.

The tribunal considered that there was a case to answer, and thence ensued 2 years of stress for Jason.

An investigator came to see him without warning, saying he just wanted to talk with him, and that it would be off the record. At the conclusion of the interview he asked Jason to sign an agreement to release the conversation to the hearing. Jason asked to see a copy before he did so. When the copy came, he found that many of the things he said had been left out, and other statements he made were altered so much that meaning was completely changed. So he made corrections and then sent it back, signed. During the hearing, the prosecutor claimed that because Jason had made corrections, he had in fact changed his testimony, and therefore was clearly lying, and a person of poor moral character.

One of the two expert witnesses the prosecution called had only casually perused Jason's (significant) list of qualifications, and had done no checking at all as to what some of the initials signified. When he was cross examined, he concluded that Jason was insufficiently qualified and did not meet the minimum standards of training for the profession. Jason was not permitted to directly challenge this erroneous finding.

Through the course of the investigation the number of charges were increased from three to eleven. The tribunal would write a letter, demanding a timely response, but then there were long periods of silence from them, with no indication as to what was going on.

The second expert witness had gone to college with Jason, knew of his work, and provided a positive report which countered many of the damaging accusations. Jason was exonerated, but for many years afterwards he was still getting over the stress the process had brought him.

Commentary

The conduct of the trial made it clear that Jason was under suspicion for his use of alternative treatments, and the consequently hostile attitude of the committee was evident throughout the proceedings. This hostility itself reduced the likelihood of fair treatment, and is a far cry from the image of justice, blindfolded. The members of the committee had a clear bias, which showed through their line of questioning and their selective picking up of the facts of the case.

The investigator evidenced dishonesty and disingenuousness in his communication and his report, which carried through into the prosecutor's twisting of Jason's legitimate corrections to impute character flaws.

The sloppiness of the first expert witness could have spelled a final blow to Jason's career.

Finally, the conduct of the hearings evidenced lack of respect for Jason, as there were extended periods of no communication from the committee, interspersed with urgent demands from him for more information. This is an intimidating and opaque use of power, and produces a high degree of stress in the person under review.

Case #2: David and the medical registration board

David was a well respected doctor, and a member of a medical registration board for over a decade. During this period he became increasingly concerned with the way the board operated. The board members were all government appointed, and there were strong political pressures on it to make decisions in line with government policy. When it did not do so, the board was threatened by the minister with being dissolved.

Historically it had a low number of disciplinary actions, which would seem to be a good thing. But a public consumer ranking, comparing it to other boards, made it appear as if the low number was in fact a sign it wasn't doing it job. This ranking had the effect of a kind of pressure on the board to 'get tougher' and increase the rate of denial of licenses.

In this context, the board started being more 'activist' about cases that came before it. There were many highly competent and very experienced doctors whose licenses were revoked for relatively spurious reasons. For instance one had numerous malpractice cases against him, but he had won every single case. In fact all the cases were from a single religious group who had sued him 25 years earlier Nevertheless, he was struck off.

This kind of action was connected with the use of phrases such as 'tip of the iceberg' and the necessity of 'reading between the lines'. It also stemmed from a doctor who became chair of the board in a secret (and illegal) ballot. He managed board deliberations by asking for a summary of the case, stating his opinion, and then immediately asking for a vote. He actively discouraged discussion.

Case after case was treated in a high handed and cowboy type of manner. A doctor had obtained a prescription on one occasion for a colleague with back pain 10 years previously. The hospital had terminated his employment as a result, as it was very strict about such things. Since then he had worked with no black marks against him. He had no problems with drug use, or complaints of any sort.

The board deliberations consisted of propositions that he was obviously a drug addict, this was the tip of the iceberg, and he was clearly a danger to his patients. The chair instructed the board to read between the lines, as he must have been terminated for more than just this occasion. His license was revoked, and he lost two appeals, as the same accusations were repeated each time, taking on the mantle of 'facts' as they were now in the documentation file of the case.

David became know as the 'soft touch' on the board for his opposition to this way of doing things, and board members stopped listening to him. He even began questioning his own sense of reality. He also became exhausted and demoralised by the process as he saw decision after decision being made in ways where were unfair and unjust.

Commentary

This provides an insight into the operations of a registration board. The larger political pressures are apparent - attempts at interference and intimidation by politicians, contributing to a climate of tension and instability.

Another larger context - the measures which compared boards with each other - changed the meaning of the low number of prosecutions, making it appear as if this was a failing, resulting in pressure to 'get the numbers up'.

This contributed to a climate of suspicion and even paranoia in the examination of practitioner's faults, and led to the dangerous practice of ignoring or distorting facts in order to fit an assumption of guilt. The result was that many solid practitioners lost their licences.

An exacerbating factor was the conduct of the chair, who had attained his seat in an evident grab for power. By truncating discussion, he was able to manipulate proceedings in order to achieve the maximum number of negative findings.

These factors add up to an abusive and destructive use of power by the board, impacting negatively not only on the doctors concerned, but the state of the profession, and a consequent reduction in the services available to patients.

Case #3: Martha and the university complaints committee

Martha had been teaching counselling for over 30 years. She had written extensively in the area, and was considered a respected professional.

In the course of one teaching year, she and another staff member were informed that complaints had lodged against them by two different students. The substance of the complaints were that the students were upset because people talked about personal matters in some of the counselling groups, whereas the complaining students felt that it should have consisted only of role plays. The students complained that they were affected by hearing other people's actual stories, and they were not adequately prepared for this (although it had been made clear in both the course descriptions, as well as at the start of the course, that this would in fact be the case).

The complaints were not tagged with names. Martha received a copy of two of the complaints, but was told there was a third complaint, which she could not view because the student was 'terrified' of repercussions, and was deemed to have a 'right to confidentiality'. At no stage in any of the proceedings was she informed of the content of the third complaint.

She made a written submission in response to the two complaints.

She heard nothing further, until 4 months later when she was informed by an administrative staff member that the matter was finalised, and that the experiential part of the course was to be immediately halted. She was not provided with any formal written decision, nor provided with any reasoning, or process by which the decision had been arrived at. She had no idea of the exact nature of the committee making the decision, its composition, nor its process.

She was also told by the staff member that there had been other complaints in the past, though she had never been informed of them. When she asked as to when they had been made and the content, she was told that they were not able to divulge the details.

Martha asked how she could protest the decision, but was told there was no avenue for appeal. When a new dean came into the school, she made a complaint to him about the process. The dean said he would have conversations with the complaints committee, and get back to her. She heard nothing further, and when she pressed the dean, she was told that the matter would not go any further.

The next year Martha's teaching contract was not renewed.

Commentary

This case demonstrates the consequences of a poorly structured and badly run grievance system. At every stage of dealing with the complaints there was lack of due process. The consistent opaqueness of the investigation meant that Martha was subject to the power of an authority which was not identified, did not divulge its deliberations, and which she could not challenge. The story is Kafkaesque, but true. The final consequence was the loss of employment, occurring again in a completely hidden manner.

Case #4: Janet and the psychology board

Janet was a psychologist in private practice. Some of her clients complained to her about the behaviour of another psychologist ('B.T.') in the area, who had sex with his clients and had suggested to quite a few of them that they had multiple personalities as the result of childhood abuse.

Janet assisted the clients to put in a formal complaint to the psychology board.

Meanwhile, BT made some allegations against Janet to the Attorney General's department. BT was friendly with a reporter from the local paper, and gave a copy of his allegations to the reporter, who called Janet to enquire about this. She denied everything.

The reporter then went ahead and published the article which suggested that Janet was using untested techniques, and that she had 'lured' some clients to her home on several occasions; it also stated that the psychology board had been investigating her for a year, a fact which had been confirmed to the reporter by the director of the board.

Janet confronted the newspaper, who published an apology and retracted the article. She also contacted the psychology board, who had not informed her that she was being investigated.

The board did not respond to Janet's letter for 3 months. She then received an email stating that they had attempted to call her some time previously, but could not reach her. She organised to discuss the matter on the phone, and a month later was informed that the case against her was dropped.

Commentary

It was patently inappropriate for the board to indicate to the newspaper that it was conducting an investigation when it had not informed Janet of the situation. The time period was also clearly unacceptable, as was the lack of responsiveness to her communication and the feeble attempts to contact her.

She was cleared, but there were no consequences to the board for their unprofessionalism, lack of boundaries, inefficiencies, and poor communication.

MINDING THE MINDERS

But none of us is infallible…Questioning someone's ethical decisions and behavior must be a two-way street, and it is crucial to question our own decisions and behavior -- and to open ourselves to questioning by others -- at least as much as we question others. (Pope & Keith-Spiegel, 2007 p.2)

Professions prefer to self regulate, and this includes in the arena of complaint processing; but the question of the administration of justice is a larger issue of social and government concern (Gonsiorek, 1997). There are unfortunately, more than an acceptable number of instances where regulatory bodies themselves have acted in ways which could be judged as unethical (Williams, 2001). The literature on this is relatively small, but there are clear and substantial instances which are significant enough to warrant a call for a review of the way such bodies operate.

Gonsiorek (1997) describes instances where licensing board members operate in a self serving way to settle feuds, deal with political scores, or protect important people. Adams (2001) has documented and explored the misuses of power on the part of various professional regulatory bodies. It is hard to empirically ascertain the degree of the misuse of power across these agencies without perhaps some kind of journalistic type of investigation.

We have provided some examples in this paper; Peterson (2001) documents a number of issues and cases relating to psychologists which are highly alarming. These include:

1. A psychologist won an appeal in administrative court against a licensing board decision; the board nevertheless revoked his license, and continued to refuse to recognise the court decision although he subsequently won two more appeals.
2. A board charged a psychologist based on new ethical standards, and refused to revise the report on the basis of the difference to the original standards; his license was revoked.
3. A lapse in record keeping by a practitioner led to a charge (and finding) of unethical behaviour, although no one had complained or reported any harm.
4. Chairs of licensing boards admit in private that they start with an assumption of guilt
5. Selective use of experts for prosecution - when one expert gave an opinion that a psychologist had done nothing wrong in a case, his services were terminated.
6. An unreviewed deposition by the complainant was used in proceedings, but the board would not use a deposition from the psychologist who had been charged.
7. A psychologist was threatened not to criticise actions of the board, or new charges would be brought against him.

These instances speak of the importance of a review of current practices of professional regulatory bodies. Of course, no justice system is perfect, and there will always be some level of miscarriage of justice. But it is the responsibly of society and of the professions concerned to see that there is an ongoing system of auditing any body which wields power over its constituents. This type of oversight is rare.

Schoenfeld *et al* (2001) found that 66% of psychologists who had been through a complaints procedure, regardless of the outcome, characterised their treatment to be discourteous, describing the handling of the process as being punitive, unfair and even abusive. They found themselves presumed guilty and consequently being treated as criminals. Schoenfeld *et al* point out that, 'the APA ethics code emphasizes the psychologist's potential to do harm to the public, but generally, little is done to protect psychologists from peers, clients, or boards' (p.495). Regulatory bodies are vigilant to a degree which may victimise professionals in the attempt to maintain discipline (Van Horne, 2004), and produce an uneven playing field in terms of the treatment of complaints (Woody, 1993).

Regulatory boards investigate professionals for unethical uses of power in relation to their role; but like the proverbial 'mote in the eye', there appears to be a dearth of awareness of the unethical use of the power by the regulatory bodies themselves. With the burgeoning of professional ethics in the last 40 years in the health professions there is an increased willingness of practitioners to examine the shadow of their own power (Hedges et al., 1997), but the same cannot be said for the bodies overseeing them. A case in point is the furore over the APA's weak response on the involvement of psychologists in torture at Guantanamo Bay (Welch, 2014). Professional ethics involves a focus on practitioners' behaviour with clients, but this becomes myopic and lacks integrity if organisational values and dynamics are themselves ethically unsound.

Kelman & Hamilton (1989) point out that being in a position of authority can lead to a submergence of awareness of ones own personhood and an over identification with the role, seeing oneself as a 'servant of the system'. This is one of the contributors to unethical behaviour on the part of those in authority (Blumenthal, 1999). The stronger the role orientation, the more the effect (Tsang, 2002). Thus, in the same way that it is at hard times for professionals to admit to an abuse of their power, it is difficult for those in power in regulatory bodies - chairs, investigators, board members - to recognise flaws in their own behaviour, or that of the system they are a part of.

Ehrlinger *et al* (2005 p681) describe a 'bias blind spot', which refers to the belief that one's own judgements are less prone to bias than those of others. Research on this topic points to the ubiquity of such perceptions

(Pronin, Gilovich, & Ross, 2004)(Pronin, Lin, & Ross, 2002)(Friedrich, 1996). People believe they have less self-interest than others (Miller & Ratner, 1998) and are more ethical (Epley & Dunning, 2000). The tendency is to view one's own understanding of the world as a direct perception, while others are seen as uninformed or biased (Pronin et al., 2002)(Ross & Ward, 1996). This is related to the differing ways people assess themselves, as compared to the way they assess how others make judgements (Pronin et al., 2002)(Pronin et al., 2004).

This has implications for the ethical practice of professionals, pointing both to the difficulty in being truly objective in clinical interactions, as well as the dangers in self-distortions when it comes to ethical decision making. In fact, one of the measures that is assessed - implicitly or explicitly - in trials of professionals is the degree of 'insight' into errors in their thinking and perception which led to the particular grievance.

On the other hand though, the question of bias on the part of members of an investigatory body is rendered opaque, as is not generally subject to question. Judges in the criminal system only attain their position after a complete legal education and extensive experience in the practice of law. It could be said they have at least a technical understanding of the question of bias in the investigation and trial process.

This is not the case with most of the bodies which are regulating professionals, and so the issue of the lack of awareness of bias is highly relevant. Given that people tend to feel their own judgements to be untainted by bias (Ehrlinger et al., 2005), it is less likely that those in positions of judgement and power in regulatory bodies are able to truly step out of their bias.

Hence the necessity to provide those in judgement with performance feedback from peer reviews regarding their decision making process and possible bias (Son Hing, Li, & Zanna, 2002).

Reform

There are a number of possible solutions to the issues raised in this paper.

Adams (2001) provides an extensive list of recommendations for reform, some of which stem from APA reviews. These proposals include:

Malpractice reforms

- ensure false accusations do not pay
- defendants get prompt affordable help
- stop damaging media coverage of malpractice cases
- legally guarantee due process
- insurance lawyers represent defendants
- disallow contingency fees of lawyers for complainants

Association reforms

- enshrine protection and advocacy for professional members
- survey people affected by regulatory board hearings
- eliminate ethics adjudication
- restrict complaint based cases
- redirect resources from processing complaints to education
- licenses are not suspended without clear signs of danger

Investigations

- proper response time frames
- professional training of investigators
- protocols for investigators, such as identify themselves, and informing the accused of their rights
- education and guidelines for the role of expert witness
- making public the names of expert witnesses used in a case
- evidence collected not be made available for use in civil suits
- disallow the use of entrapment by undercover investigators
- statutes of limitation

We would add the following areas which need reform

Whilst it is clearly necessary to have explicit ethical frameworks, where these are used in adversarial processes, they become used as defacto laws. This process is fraught, and needs a great deal of scrutiny, and debate. One alternative is to institute non-adversarial processes where possible. But for those cases where an adversarial process is retained, better ways to address this issue need to be found.

A major problem is the lack of expertise in the administration of justice on the part of those serving on regulatory bodies. This indicates the need for extensive training, both in an understanding of ethics, as well as the fundamentals of natural justice and due process.

The investigation phase requires higher standards of professionalism and improved, more transparent guidelines for the conduct of investigators.

Procedural issues need to be significantly improved so there are opportunities for proper cross examination, fact checking and the challenging of evidence. Standards regarding the burden of proof need to be reassessed in order to ensure that a person is treated as innocent unless proved guilty.

The use of expert witnesses needs to be reviewed for a range of possible problems, and systems put in place which ensure that they cannot be used selectively, in a way which exhibits bias.

Those in positions of adjudication need to have proper training in how to avoid bias, and systems of peer review should be implemented to provide feedback on their decision making.

The whole model of adversarial investigation needs to be reviewed and alternative approaches implemented where possible. If processes which involved more dialogue and less adjudication were utilised, the potential for the misuse of power by regulatory bodies would decrease.

Quality mechanisms need to be implemented for monitoring, supervision and feedback regarding the operation of regulatory bodies and their administrators.

The use of punitive measures needs an extensive review; wherever possible, remediation should be used, and successful models of dealing with impairment should be more widely considered.

Williams (2001) proposes a standing committee, which could investigate allegations of licensing board misconduct. This idea could be widely applied to regulatory bodies, facilitating the recognition of systemic problems including the identification of either laxness, or overzealousness.

Conclusion

The ethical spotlight is being increasingly placed on professionals. This can be seen as a positive direction, requiring greater accountability, ensuring that standards of practice are maintained, and harmful or destructive behaviour is minimised.

However, there has not been a comparable degree of attention paid to the bodies which regulate professional practice. Despite many sincere efforts on the part of these bodies, at times the processes and outcomes fall below a acceptable standard of fairness.

In this sense issues of power - which are at the core of problems in professional practice - remain substantially unexamined on the part of the bodies which wield power over professionals. Without the willingness and structures to provide feedback, and the use of checks and balances to allow for ongoing reform, regulatory bodies are in danger of operating as entities without real scrutiny.

Reform is urgently needed, not only at organisational level with many of these bodies, but also at a larger social level - the institutionalisation of values-in-action regarding the principles of natural justice.

Additionally, a rethink is called for regarding the mechanisms for dealing with ethical infractions. The use of punitive measures by regulatory bodies is up for question, as much as it is within the wider criminal justice system. There is enough evidence of the superiority and effectiveness of alternative approaches such as restorative justice, to warrant a more widespread investigation of how these approaches could be used in dealing with problems in the ethical practice of professionals.

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