

**STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH ¹**

IN RE: Department of Public Health
vs.

Petition No. 930408-58-001

George Gorton, CISW²

TO: Mr. George Gorton
8 Forest Lane
P.O. Box 504
Gales Ferry, Connecticut 06335

FINAL MEMORANDUM OF DECISION

Procedural Background

On June 8, 1994 the Department of Public Health and Addiction Services ("Department") issued a Statement of Charges against George Gorton, CISW ("Respondent"). The Statement of Charges alleged that the Respondent provided treatment that was below an acceptable standard of care.

Prior to the initiation of the Statement of Charges, the Department offered the Respondent the opportunity to attend a compliance conference scheduled on December 28, 1993, to demonstrate his compliance with §20-195p of the Connecticut General Statutes.

The Department served the Notice of Hearing and the Statement of Charges on the Respondent by certified mail, return receipt requested. An Answer to the Statement of Charges, dated June 24, 1994, was filed on behalf of the Respondent by his counsel as of that date, Mathew H. Greene, Esq., of New Haven, Connecticut.

¹ Effective July 1, 1995, the Department of Public Health and Addiction Services became the Department of Public Health. 1995 Connecticut Public Acts No. 95-257.

² Effective October 1, 1995, Connecticut ceased certifying independent social workers and began licensing clinical social workers. All persons certified as independent social workers before October 1, 1990 were deemed eligible to be licensed as clinical social workers. 1995 Connecticut Public Act No. 95-116.

On October 11, 1994, the Commissioner of Public Health and Addiction Services ("Commissioner") appointed Irene DiPace as Hearing Officer to hear this case and to recommend findings of fact, conclusions of law, and a proposed order upon the conclusion of the hearing.

The administrative hearing was held on November 8 and 22, 1994, in accordance with Chapter 54; Section 19a-2a; and Section 19a-14 of the Connecticut General Statutes and Section 19-2a-1, et seq., of the Regulations of Connecticut State Agencies ("Regulations"). The Respondent appeared with his attorney, Robert Walzer, Esq., of New Canaan, Connecticut. Judith Lederer, Esq., represented the Department. Both the Department and the Respondent presented evidence and conducted cross-examination of witnesses.

On July 27, 1995, Hearing Officer DiPace noticed the Respondent, the Respondent's attorney, and the Staff Attorney for the Department, that she was including into the record the following documents from the National Association of Social Workers ("NASW"):

1. Code of Ethics of the National Association of Social Workers effective July 1, 1994 ("NASW Code of Ethics"); and
2. NASW Standards for the Practice of Clinical Social Work revised ("NASW Standards") April 1989.

The Proposed Final Decision by Hearing Officer DiPace was rendered on January 8, 1996 and sent to the Respondent, through his attorney Mr. Walzer, and to Ms. Lederer, the advocate on behalf of the staff of the Department, on January 12, 1996. Both the Respondent and Ms. Lederer were informed of their right, pursuant to Connecticut General Statutes §4-179, to file briefs and exceptions and to present oral arguments concerning the Proposed Decision to the Commissioner. In a letter dated January 24, 1996, the Respondent requested an "oral discussion" with the Commissioner. On February 20, 1996, the Department received a letter from Mr. Walzer stating he no longer

represented the Respondent. On March 27, 1996, the Commissioner designated this Hearing Officer to hear the oral arguments and to render a final decision in this matter. The Respondent and Ms. Lederer presented oral argument before this Hearing Officer on April 29, 1996.

After oral argument the Respondent submitted a letter dated May 1, 1996, with a three page attachment. On May 7, 1996, the Department responded to this letter with an Objection To Post-Argument Submission. By the time this Hearing Officer reviewed these two documents, the entire record of this case had been read, the oral arguments had been heard, and the final decision had been made.

This Final Decision is based entirely on the record and the oral arguments heard on April 29, 1996. This Final Decision sets forth the facts as found in this case, the conclusions of law, and an order.

ALLEGATIONS

In paragraphs 1 and 2 of the Statement of Charges, the Department alleged that the Respondent, holder of Connecticut certification number 001953, provided marital counseling to Wanda Kerr and her former husband, between approximately July 21, 1992 and approximately September 11, 1992.

In sub-paragraphs 3a-3d of the Statement of Charges, the Department further alleged that the treatment the Respondent provided to Ms. Kerr was below an acceptable standard of care in one or more of the following ways:

- a. the Respondent failed to maintain appropriate boundaries between familial and individual therapy; and/or
- b. the Respondent failed to maintain proper records on this patient; and/or
- c. the Respondent failed to develop a preliminary diagnosis and treatment plan in a timely fashion; and/or

ANSWER

The Respondent admitted the allegations in paragraphs 1 and 2 and denied all the allegations in sub-paragraphs 3a-3d.

FINDINGS OF FACT

1. Dr. Gorton was a Certified Independent Social Worker holding Connecticut certificate number 001953, at all times referenced in the Statement of Charges and during the hearing of this case. As of the date of this Final Decision, Dr. Gorton is licensed by Connecticut as a clinical social worker, with license number 001953.

Findings of Fact 2, 4-11, 13-34, and 38, that were recommended by the Hearing Officer, Irene DiPace, in her Proposed Final Decision dated January 8, 1996, are hereby adopted. A copy of these findings of fact are attached hereto and incorporated herein.

DISCUSSION AND CONCLUSIONS OF LAW

Connecticut General Statutes §20-195p provides in pertinent part:

The commissioner may take any action set forth in section 19a-17 [Disciplinary action by department, boards and commissions] if the license holder fails to conform to the accepted standards of the social work profession, including, but not limited to, the following: ... negligent, incompetent or wrongful conduct in professional activities

In the absence of any state regulation with regard to the conduct and practice of social workers, the prevailing standard may be found in the NASW Code of Ethics and the NASW Standards. These standards are designed to guide clinical social work practice; guide state regulatory agencies; provide information to insurance carriers and others; and inform consumer groups. The NASW Standards has defined clinical social work as follows:

Clinical social work shares with all social work practice the goal of enhancement and maintenance of psychosocial functioning of individuals,

families, and small groups. Clinical social work practice is the professional application of social work theory and methods to the treatment and prevention of psychosocial dysfunction, disability, or impairment, including emotional and mental disorders. It is based on knowledge of one or more theories of human development within a psychosocial context.

The perspective of person-in-situation is central to clinical social work practice. Clinical social work includes interventions directed to interpersonal interactions, intrapsychic dynamics, and life-support and management issues. Clinical social work services consist of assessment; diagnosis; treatment, including psychotherapy and counseling; client-centered advocacy; consultation; and evaluation. The process of clinical social work is undertaken within the objectives of social work and the principles and values contained in the NASW Code of Ethics.

Prior to October 1, 1995, and pursuant to Chapter 383b, the Department certified independent social workers. Effective October 1, 1995, Chapter 383b was amended by Connecticut Public Act Number 95-116 to delete the certification category and add a license category for clinical social workers. All persons who were certified as independent social workers before October 1, 1990 were deemed automatically eligible to be licensed as clinical social workers. The Respondent now holds a license as a clinical social worker.

The Department bears the burden of proof by a preponderance of the evidence. The Department sustained that burden with regard to paragraphs 1, and 2, and sub-paragraphs 3a, 3b, and 3c of the Statement of Charges. The Department did not sustain the burden of proof with regard to sub-paragraph 3d of the Statement of Charges.

With Regard to Sub-paragraph 3a

The Department sustained its burden of proof that the treatment provided to Ms. Kerr by the Respondent was below an acceptable standard of care with regard to sub-paragraph 3a of the Statement of Charges, which alleged that the Respondent failed to maintain appropriate boundaries between familial and individual therapy.

Ms. Diane Edell, the social worker who evaluated the case for the Department, testified that Mr. and Ms. Kerr articulated different goals to the Respondent: Mr. Kerr wanted to leave the marriage and Ms. Kerr wanted to try to save the marriage. There is no evidence that this inherent conflict between the husband and wife was ever addressed with them by the Respondent.

The Respondent saw Mr. Kerr separately (and sometimes with his young son) for several months after Ms. Kerr terminated counseling with the Respondent, yet the Respondent insisted, at the hearing, that he always viewed his "patient" to be the family. In fact, as both Ms. Edell and Ms. Mary Lou Costanzo, the Respondent's witness, testified, although this therapy began as a couples therapy, it shifted to therapy of an individual, Mr. Kerr. There is no evidence that the Respondent was aware of the shift.

Neither Ms. Edell nor Ms. Costanzo believed there was anything inherently wrong with shifting from a couples therapy to individual therapy of either party. The problem in this case was that the alteration of the relationship of the parties was not addressed and the new arrangement, the therapy of Mr. Kerr as an individual, was never fully clarified and understood by the husband, wife and therapist.

Ms. Edell testified, and it has been found, that the necessary boundaries between familial, individual and possible marital therapy were not maintained in an appropriate fashion in this case. This failure to maintain appropriate boundaries between familial and individual therapy is below an acceptable standard of care.

The Respondent's conduct in providing treatment below an acceptable standard of care subjects the Respondent to disciplinary action under §20-195p for "negligent, incompetent or wrongful conduct in professional activities."

With Regard to Sub-paragraph 3b

The Department sustained its burden of proof that the treatment provided to Mrs. Kerr by the Respondent was below an acceptable standard of care with regard to sub-paragraph 3b of the Statement of Charges, which alleged that the Respondent failed to maintain proper records on Ms. Kerr.

Section 19a-14-40 of the Regulations defines the purpose of a medical records to be “a vehicle for: documenting actions taken in patient management; documenting patient progress; providing meaningful medical information to other practitioners” Section 19a-14-42 of the Regulations provides in part: “Each person licensed or certified pursuant to [chapter 383b] shall maintain appropriate medical records of the assessment, diagnosis, and course of treatment provided each patient”

Standard 8 of the NASW Standards provides in part, “The clinical social worker keeps records of clients that substantiate service in a secure place. He or she maintains the records accurately and in a manner that is free from bias or prejudicial content. The social worker makes these records available to clients at their request.”

The records maintained by the Respondent on Ms. Kerr contained no clear clinical assessment, diagnosis, nor a course of treatment. They lacked documentation of the specifics of therapy and clinical interpretation of patient responses to the counseling sessions. The records lacked clarity, were in some instances misleading to the reader, and contained unprofessional language. The Respondent failed to maintain proper records on Ms. Kerr and this conduct is below an acceptable standard of care.

The Respondent’s conduct in providing treatment below an acceptable standard of care subjects the Respondent to disciplinary action under §20-195p for “negligent, incompetent or wrongful conduct in his professional activities.”

With Regard to Sub-paragraph 3c

The Department sustained its burden of proof that the treatment provided to Ms. Kerr by the Respondent was below an acceptable standard of care with regard to sub-paragraph 3c of the Statement of Charges, which alleged that the Respondent failed to develop a preliminary diagnosis and treatment plan in a timely fashion.

The MMPI test taken by Ms. Kerr on August 7, 1992, produced "Diagnostic Considerations," not a diagnosis. Noted at the bottom of the same page is the following caveat:

This MMPI-2 interpretation can serve as a useful source of hypotheses about clients. This report is based on objectively derived scale indexes and scale interpretations that have been developed in diverse groups of patients. The personality descriptions, inferences and recommendations contained herein need to be verified by other sources of clinical information since individual clients may not fully match the prototype....

Thus, merely having the client take the MMPI does not satisfy the Respondent's responsibility to make, at least, a preliminary diagnosis.

Although the Respondent testified that the development of a plan was an "ongoing thing" there were no established goals or objectives. There was no demonstrated plan of therapy for this patient even after the MMPI results indicated the need for a focus on the patient's negative family feelings if there was to be a therapeutic effect for this person. Finally, the Respondent himself admitted that he had not formulated a treatment program for Ms. Kerr and had not set in motion a treatment program.

There had been sufficient opportunity to establish a diagnosis and subsequent treatment plan, even though either could have changed as therapy progressed. It is not necessary that a diagnosis stay with a patient forever, however, the establishment of one is critical to therapy. The diagnosis, even if preliminary and subject to change, aids the therapist in formulating a plan to help the patient. In this case there was no noted diagnosis out of

which the Respondent developed a therapeutic treatment plan. The Respondent failed to develop a preliminary diagnosis and treatment plan in a timely fashion and this conduct is below an acceptable standard of care.

The Respondent's conduct in providing treatment below an acceptable standard of care subjects the Respondent to disciplinary action under §20-195p for "negligent, incompetent or wrongful conduct in his professional activities."

With Regard to Sub-paragraph 3d

The Department did not sustain its burden of proof that the treatment provided to Ms. Kerr by the Respondent was below an acceptable standard of care with regard to sub-paragraph 3d of the Statement of Charges, which alleged that he breached client confidentiality.

On August 10, 1992, Ms. Kerr had signed a release form authorizing the Respondent to reveal information relative to her diagnosis and treatment, specifically including records, written communication, and psycho/social testing.

The Respondent did not breach Ms. Kerr's confidentiality and thus is not subject to disciplinary action under Section 20-195p for conduct alleged in sub-paragraph 3d of the Statement of Charges.

ORDER

Pursuant to authority in §20-195p and §19a-17 of the Connecticut General Statutes the following Order is issued in this case against George Gorton, Licensed Clinical Social Worker, License Number 001953, Petition Number 930408-58-001:

1. The Respondent shall be assessed a civil penalty of three hundred dollars (\$300.00). This penalty shall be paid by certified check or money order made payable to "Treasurer, State of Connecticut," and shall include the Department petition number on its

face for identification purposes. This penalty shall be paid no later than forty-five (45) days from the receipt of this Order and shall be sent to the attention of Bonnie Pinkerton at the address set forth in paragraph 5, below.

2. The Respondent's license as a clinical social worker shall be suspended for two (2) years, effective the date of this Order. The suspension of his license shall be stayed.

3. The Respondent shall be on probation for a period of two (2) years. The Respondent shall have forty-five (45) days from receipt of this Order in which to implement the probation plan. The terms and conditions of the probation are as follows:

- a. The Respondent shall obtain, at his own expense, the services of a licensed clinical social worker to supervise his clinical social work practice. Said clinical social worker shall be licensed in the State of Connecticut, shall practice clinical social work in the State of Connecticut, and shall be pre-approved by the Department;
- b. The Respondent shall provide a copy of this Final Decision to the supervisor;
- c. The Respondent's supervisor shall meet with him not less than once every month for the entirety of the probation. This supervisor shall conduct a random review of ten percent (10%) or fifteen (15) of the Respondent's patient/client records, whichever is the larger number. In the event the Respondent has fifteen (15) or fewer patients/clients, the supervisor shall review all of the Respondent's patient/client records on a monthly basis;
- d. The supervisor shall have the right to monitor the Respondent's practice by any other reasonable means which he or she deems appropriate. The Respondent shall fully cooperate with the supervisor during such monitoring;

- e. The Respondent shall be responsible for the supervisor providing written reports directly to the Department monthly for the first year of probation, and quarterly thereafter. Such supervisor's reports shall include documentation of the date and duration of each meeting with the Respondent; additional monitoring techniques utilized; and a statement that the Respondent is observing proper boundaries between familial and individual therapy, is adhering to proper record keeping, is developing timely diagnoses and therapeutic treatment plans for his patients/clients, and is practicing with reasonable skill and safety;

- f. The Respondent shall attend and successfully complete a minimum of fifty (50) hours of continuing professional education courses each year. The courses shall be primarily focused on the Respondent's failures as found in this case, i.e., a lack of maintenance of appropriate boundaries between familial and individual therapy, failure to maintain proper records on a patient, and failure to develop a preliminary diagnosis and treatment plan in a timely fashion. All courses must be pre-approved by the Department;

- g. The Respondent shall be responsible for any and all expenses which are a consequence of his fulfillment of the terms of probation;

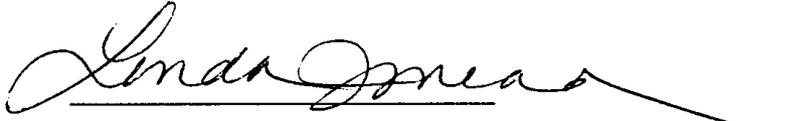
- h. Any revisions to the terms of the probation plan must be pre-approved by the Department in writing;

- i. The Respondent shall notify the Department in writing of any change of employment, his business address or his home address within fifteen (15) business days of such change;

4. Any deviation by the Respondent from the terms and conditions of probation in paragraph 3, above, shall result in the following procedure:
 - a. The Respondent will be notified in writing that the terms and conditions of the probation have been violated, provided no prior written consent for deviation from the terms and conditions had been granted by the Department;
 - b. Such notification shall state the act(s) or omission(s) which violated those terms and conditions;
 - c. The Respondent will be allowed fifteen (15) business days to demonstrate to the Department that he was in compliance with the terms and conditions and/or to cure the violation(s);
 - d. If the Respondent does not demonstrate compliance and/or cure the violation(s) to the satisfaction of the Department by the fifteen (15) day date certain contained in the notification of violation, the Department may bring an action based on the violation(s);
 - e. The Respondent shall be entitled to a hearing on the issue of whether he violated the terms and conditions of the probation. The case shall be heard by the Commissioner or his duly designated representative;
 - f. Evidence presented at the hearing, by either the Department or the Respondent, shall be limited to the alleged violation(s) of the terms and conditions of this probation.

5. All correspondence and reports are to be addressed to:

Bonnie Pinkerton, Nurse Consultant
Department of Public Health
410 Capitol Avenue, MS# 12INV
Hartford, Connecticut 06134-0308



Linda J. Mead, Hearing Officer
Department of Public Health

4 June 1996

Date