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Commentary An Ethical Paradigm for Sex Offender Treatment: A Response to Levenson and D'Amora

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ABSTRACT

Levenson and D'Amora in their response to my article, correctly emphasize that the continued use of certain interventions by mental health professionals in sex offender treatment programs is necessary for their success. Yet the mere fact that such interventions are successful does not mean that they are ethically justified. Furthermore, sex offenders are not going to learn virtues of honesty and congruence from therapists who struggle to maintain loyalty to the often conflicting interests of the offender and wider society. Therapeutic jurisprudence offers an alternative ethical paradigm that restores good faith in dealings with sex offenders. It makes explicit the therapist's obligation to punish (albeit only to the minimum degree necessary) rather than promote the offender's well-being.

KEYWORDS: therapeutic jurisprudence; sex offender treatment; mental health.

In their response to my paper (Glaser 2003), Jill Levenson and David D'Amora have performed a useful service in clarifying many of the subtle and perplexing ethical issues which make the treatment of sex offenders such a challenging task. They argue that, in contrast to my own thesis, traditional codes of ethical practice in the mental health field (and they specifically cite those formulated by the APA and the NASW) can provide a relevant and practical framework for ethical decision-making by therapists dealing with sex offenders. In particular, they provide a very detailed and thoughtful refutation of six examples provided in my paper of where treatment programs for such offenders might breach traditional ethical codes of mental health practice.

When asked to provide a commentary on their response, my initial reaction was to think of further examples to rebut their views. While this might have been of some value, there is a risk that it could degenerate into a series of "yes-it-is-no-it-isn't" declarations on both sides. Rather, what I would like to do is to discuss in broader terms the reasons that a new ethical basis for sex offender programs is required and to provide further clarification of the approach to the problem suggested by therapeutic jurisprudence.

WHAT IS ETHICAL MENTAL HEALTH PRACTICE?

When mental health clinicians treat sexual offenders, a fundamental ethical issue is that of whether there is a code of ethics which distinguishes their practice from codes which might be followed by other professionals involved with such offenders (e.g. law

enforcement officers, legal practitioners, correctional Indeed, much recent debate has been officers etc.). focused on whether there is a "unique" ethics for psychiatrists (and, by implication, other mental health professionals; see Radden 2002, 2004; also see Crowden 2003, 2004). There seems to be considerable agreement that mental health ethics emphasizes three issues which are probably not as prominent in other professional work (and indeed not as salient for nonmental health helping professionals). These include the features of the therapeutic relationship (which is the "key ingredient in therapeutic effectiveness"), the vulnerabilities of the psychiatric patient (including not only their diminished judgment and autonomy but also the stigma and exploitation to which they are often exposed), and the "therapeutic project" (which, at the very least, "seeks to restore some earlier level of functioning and to relieve debilitating signs and symptoms." See particularly Radden 2002).

In dealing with these professional challenges, the mental health clinician has a distinctive (some would say unique) role, which binds them to certain ethical courses of action more strongly than the general moral precepts applying to the rest of the community. Health practice in forensic settings (of which, of course, the treatment of sex offenders is one example) provides numerous instances of the dilemmas involved and one of these is set out by Radden herself, even though she muddies the waters somewhat by talking about the obligation to treat a patient's physical, rather than psychological, difficulties:

[A] doctor is bound to treat the wounds of a fleeing convict before, or even instead of,

assisting in the convict's capture. Broad-based morality would dictate that the convict must be caught; professional-role morality would dictate that he must be treated. (Radden 2004).

In other words, the health practitioner has special moral responsibilities which extend beyond those of the average citizen. She has to take into account the "therapeutic" significance of her therapeutic relationship with the convict, has to give primary consideration to his vulnerability when treating his wounds, and must do her utmost to provide the best treatment that she can, even though this may mean that he could successfully escape lawful arrest.

Moreover, this specific role conferring moral obligations on mental health clinicians cannot be simply feigned or played out like a soap opera. They cannot manipulate or deceive clients, particularly clients who, by the nature of their condition, may have difficulty in distinguishing the genuine from the fake. Rather, the therapist has to possess certain specific virtues which enable them to perform their role successfully (to "inhabit", rather than act, their role). Such virtues include, apart from the traditional "health care virtues" (such as trustworthiness, honesty, kindness etc), specifically important virtues in mental health work such as compassion, humility, fidelity, respect for confidentiality, veracity, prudence, warmth and sensitivity, and perseverance (Radden 2002).

Herein lies the problem for therapists attempting to provide contemporary and evidence-based treatment for sex offenders. As I attempted to demonstrate in my previous paper, the practices followed by these therapists, by their very nature, cannot conform to these specialized and sometimes very rigorous ethical rules which appear to be so necessary for mental practitioners to fulfill their traditional roles. This is, of course, the fundamental area of disagreement between Levenson and D'Amora and myself, but before elaborating further, I need to comment on two important points kindly raised by them.

Firstly, in contrast to the implication in their paper, I am in no way advocating the abandonment by mental health clinicians of sex offender treatment programs. As I made very clear in my own paper, there is ample evidence that mental health clinicians have contributed enormously to making sex offender treatment programs both more efficacious and more humane.

A second issue concerns the detailed empirical and clinical data presented by Levenson and D'Amora to justify, in practical terms, practices such as the limiting of confidentiality and the preference for involuntary treatment highlighted in my own paper. I have no quibble with these justifications and indeed would agree completely with the authors that these practices are nearly always necessary to achieve a successful

outcome, particularly the reduction of risk to potential However, the point which must be victims. emphasized here is that the mere fact that an intervention works does not mean that it can be ethically To take a rather extreme example, some cultures might deal with stealing behaviors by cutting off an offender's arms. Objectively, such an intervention could successfully produce a major reduction in recidivism rates for the normally high-risk Yet, there would be group of property offenders. obvious ethical concerns associated with its use. While I am in no way suggesting that the contemporary practice of sex offender therapists is as draconian as this example, the point must be made that a clinical intervention cannot be ethically justified by the fact that it works or even by its widespread use by various practitioners in the area.

HOW DO SEX OFFENDER PROGRAMMES ETHICALLY BREACH THIS?

To return to the major thesis of this paper: What is it that sex offender therapists do which so obviously breaches traditional codes of mental health ethics? A broad answer to this question may be found in the documents kindly referred to by Levenson and D'Amora (and I apologize for not referring to them in my own previous paper). These are the *Professional Code of Ethics* of the Association for the Treatment of Sexual Abusers (2001a) and the same Association's "Practice Standards and Guidelines for Members of the Association for the Treatment of Sexual Abusers" (2001b).

Interestingly enough, the *Code of Ethics* makes no mention of issues such as the primary obligation of therapists. However, the "Standards and Guidelines" state unequivocally as their first "guiding principle" that:

Community safety takes precedence over other considerations and ultimately is in the best interests of sexual abusers and their families.

Other important guiding principles include:

- Many sexual abusers will not comply with treatment or supervision requirements without external motivation. Internal motivation improves the prognosis for completing a treatment program, but in and of itself may not be sufficient for treatment engagement and compliance.
- Criminal investigation, prosecution and a court order requiring specialized sexual abuser treatment are important components of effective intervention and management ...

• members should work co-operatively with probation/parole officers, child welfare workers, clients' support persons and therapists working with victims. (ATSA 2001b).

All of these principles clearly state that:

- A. "Community Safety" always trumps any other therapeutic considerations, including respect for an offender's autonomy or personal opinions. Indeed, with the justification of "community safety", the therapists can choose to completely ignore these.
- B. The therapist is justified in using force ("external motivation") to make an offender complete a program.
- C. The therapist will follow and, if necessary, enforce, the views of community agencies who may often have no interest in an offender's welfare (e.g. the police, courts, corrections officers, victims' advocates and supporters etc.) in order to promote "effective intervention and management".

Most importantly of all, this disregard for the offender's autonomy and welfare is not an occasional exception to ethical rules prompted by unusual or extreme circumstances (such as a dire risk of serious harm to the offender or someone associated with them) but rather a routine requirement which is deemed necessary for good treatment practice.

It is obvious that standards and guidelines such as these cannot in any way be consistent with the ethical mandates for a good mental health clinician discussed above. The therapeutic relationship is given, at best, a secondary role in the therapeutic enterprise: coercion and the enforcement of the therapist's own values are seen as much more important influences. Very little account is taken of the vulnerability of the "patient" and indeed there is a requirement for the therapist to administer state-ordered coercive measures, no matter how oppressive these might be for the individual Finally, the therapeutic enterprise itself, offender. although admittedly aiming at restoring some type of "normal" functioning for the offender, deals with problems that the offender may find neither debilitating nor maladaptive (even though their behaviors certainly represent a major risk to vulnerable people in our community).

It is hypocritical to suggest that the ATSA "Standards and Guidelines" will ultimately promote treatment "in the best interests of sexual abusers and their families". Cynics could easily argue that if this is

their true aim, then a therapist would also be morally obliged to teach sex offenders and those associated with them, techniques for avoiding detection and prosecution of their crimes. Of course, I in no way endorse such a view but it highlights the mental gymnastics that one has to perform in order to reach the conclusion that therapists coercively acting as agents of social control can still see themselves as being primarily interested in their clients' welfare.

WHAT CAN THERAPISTS DO?

I have already emphasized that the absence of appropriate ethical justifications for clinical interventions with sex offenders does not mean that they have to be abandoned. Indeed, as also highlighted in my previous paper, there are good reasons for mental health clinicians to stay involved in the field. But any professional group serving the community needs an ethical code to define standards of conduct for its members and to make those public, as a demonstration of the commitment it has made to serve the community in a particular fashion.

The challenge is therefore that of devising ethical precepts which best apply to the specific (and, some would say, unique) role which sex offender therapists serve in our community. For the reasons explained above, these precepts cannot be derived from the elements which are specific or unique to general mental health practice, precisely because treatment with sex offenders requires therapists to continuously and actively breach the guidelines of these more traditional mental health ethical codes.

In my own paper, I proposed a therapeutic jurisprudence approach as an initial step in formulating guidelines for ethical practice in this area. The response of Levenson and D'Amora to this suggestion was a quite understandable: "so what?" and they pointed out that the therapeutic jurisprudence model is "remarkably similar to existing 'best practice' standards and ethical guidelines promulgated by ATSA". (In a sense, I take this as a back-handed compliment because it supports, at least in part, the point that I have been trying to make, i.e. that therapeutic jurisprudence offers a more consistent approach than more traditional mental health ethical codes).

It has to be acknowledged, however, that there has been a gap in my reasoning here. In particular, I did not specify the broader ethical issues which therapeutic jurisprudence was more successful, than other approaches, in addressing.

To do this, we need to refer to our earlier discussion of Radden's thoughts regarding the virtues characterizing mental health professionals and the importance of demonstrating those virtues in a sincere and genuine fashion. As we have seen, Radden warns that feigning traits such as honesty, compassion, etc.

ultimately results in manipulation and deception of the patient and corruption of the therapist's own character because the patient, due to their vulnerability in a therapeutic relationship, has less chance of recognizing the therapist's pretences.

This virtue, i.e. of possessing congruence between one's behaviors and one's inner thoughts and feelings, of being "true to oneself", have been labeled as "good faith". Some regard it as being the "philosophical virtue par excellence" because it characterizes its possessor as someone who

sets truth above all things, above honor or power, happiness or systems, and even virtue or love. He would rather know that he is evil than pretend that he is good; he would rather stare love's absence in the face when it occurs or his own egoism when it prevails (which is almost always) than persuade himself falsely that his is loving or generous. (Comte-Sponville 2003:209).

A desire to carry out treatment in good faith underlies most therapeutic endeavors. Sex offender therapists are no exception and most ethical therapists will clearly explain to their offender clients such issues as the limits on confidentiality, the non-voluntary nature of the treatment, the links between the therapist and corrections authorities etc. But the problem which remains is that of expectation: despite what the therapist says, and because they are a mental health clinician or, at the very least, present themselves as a therapist, it is understandable that the offender/client will expect them ultimately to give ethical priority to issues such as the therapeutic relationship, the vulnerability of the client, and the benefit of therapy for the client as an individual.

Often, of course, there will be little or no conflict between these matters of ethical concern and other matters for which the therapist is responsible such as the protection of society and the need to cooperate with agencies who may have no interest in the client's welfare. However, where there is such conflict, the therapist has the potential to become as devious and deceptive (of both self and others) as the client. This deviousness and deception can take many forms. At a relatively harmless level (for example), enhancing an offender's self-esteem not only is for his own benefit but also follows the "hidden agenda" of improving his ability to deal effectively with high-risk precursors to relapse. More sinisterly, encouraging an offender to be open and honest about prior offences (particularly undetected ones) may improve the offender's ability to trust the therapist, but also promotes self-incrimination which may ultimately be severely detrimental to him.

In other words, for therapists in sex offender programs, there is frequently another agenda behind

even the most obviously benevolent intervention, because of the very nature of the conflicting interests which the therapist has to follow. For even the most congruent and "up-front" therapist, it may become increasingly difficult to be completely honest with clients (and indeed with themselves) as to what their true motives are for initiating particular interventions.

Astute readers will by now have noted that the context of this ethical discussion is that of virtue ethics, originally formulated by Aristotle as a response to the perennial question of how people are to lead flourishing and happy lives. Aristotle proposed that since human beings function best (and are most characteristically human) when they lead virtuous lives, then living according to these virtues (some of which Aristotle goes on to describe in detail) will lead to enjoyment of the "good life". (Aristotle, Nichomachean Ethics, book 2, chapter 7; Hughes 2001: chapters 3 & 4).

Interestingly enough, this context of virtue ethics has recently been adopted by Tony Ward when discussing his "good lives" approach to the rehabilitation of sex offenders. Ward points out that

[when] offenders agree to enter a rehabilitation program, they are implicitly asking therapists "how can I live my life differently?" and "how can I be a different kind of person?" This requires a clinician to offer concrete possibilities for living good or worthwhile lives, to take into account each individual's abilities, circumstances, interests and opportunities. (Ward and Stewart 2003).

Ward's approach to rehabilitation interventions, rather than (for example) emphasizing the situations or things which an offender needs to avoid or abandon, focuses on alternative ways which they can use to achieve the "goods" which they are so desperately seeking through their offending, e.g. intimacy, feelings of power etc.

I personally have some reservations regarding Ward's approach. After all, even Aristotle, at the end of his huge treatise on ethics, was forced to admit that many (probably most) people would be too ignorant or unwilling to recognize the advantages of living a virtuous life and thus would have to have virtue forced upon them, if necessary by the authority of the State (Aristotle, Nichomachean Ethics, book X, chapter 9; Glaser 2004.) Nevertheless, any therapist who is assisting an offender to acquire the skills which will help them achieve the "good life" without resorting to criminal activity must offer "concrete possibilities" (as Ward emphasizes) for them to do so. Importantly therapists must, as far as possible offer demonstrations in their own interactions with offenders as to how these possibilities can be realized. Clearly, an offender is unlikely to abandon the deviousness and self-deception at which so many sex offenders become so adept, if the

therapist, even inadvertently, repeatedly shows ulterior motives and a lack of congruence in their dealings with them.

FROM GOOD FAITH TO THERAPEUTIC JURISPRUDENCE

A therapeutic jurisprudence approach, as discussed in my previous paper, is one answer to the lack of consistency between traditional mental health codes of practice and the practicalities of treating sex offenders. It is, as noted there, the "study of the role of the law as a therapeutic agent" and, in particular, of the influence of the law on emotions and on psychological well-being (Wexler and Winick 1996: xvii). It does not mean that a "therapeutic" outcome becomes the law's primary aim: the perspective of therapeutic jurisprudence on sex offenders, for example, emphasizes the continuing importance of preserving the civil and legal rights of individual offenders and, particularly, the avoidance of unjust outcomes such as overly harsh punishments, even if justified in the name of "treatment" (Glaser, 2003). therapeutic jurisprudence explicitly Furthermore, encourages the application of ethics of punishment rather than those of treatment to the treatment of sex offenders, i.e. treatment programs, while having their primary aim as the protection of society, are obliged to cause only the minimum of suffering to the sex offender necessary to achieve this.

The focus therefore moves away from the ethical areas highlighted in traditional mental health practice. That is not to say that the issues discussed above such as the therapeutic relationship, the vulnerability of the client and the beneficial aims of therapy are not important. However, they are only *conditionally* important in so far as consideration of them may reduce unnecessary suffering and make punishment of the offender both more efficient and more humane. If, however, society is at risk, then these concerns will be over-ridden every time.

Therapeutic jurisprudence, therefore, uses its awareness of the law's effects on an offender's psychological and social functioning in a purely instrumental fashion. It recognizes that, generally, the protection of society can be better guaranteed if the offender does not have to sacrifice too much in their lives to lead a law-abiding lifestyle and, in particular, that the offender retains, as far as possible, the normal legal rights and privileges of any other citizen.

But the therapeutic jurisprudence approach is more than just a utilitarian or instrumental one. As we have already noted, an inviolable principle espoused by it is that "therapeutic" considerations can never trump the rule of law. That means that it more closely conforms to the aim of maintaining good faith in one's dealings with the offender: whatever happens to an offender, he must be made aware of the nature and consequences of

the decisions being made about him by those making the decisions, e.g. the police at the time of his arrest, the prosecution when he is brought to trial, the courts when he is being sentenced, etc. Therapeutic jurisprudence might advocate that such decisions and such awareness may be rendered less painful in certain circumstances (through its understanding of the psychological and social impact of the law). However, it would never condone the abandonment of such legal safeguards, no matter how "therapeutic" this might be.

Often, for sex offenders participating in treatment these requirements for programs, openness, accountability, fairness etc. (i.e. "good faith") in those making decisions regarding them, present no problems. There are many cases where the aims of protecting society and ensuring the well-being of the offender closely coincide. However, there are a number of contentious or ambiguous cases where the requirement for good faith is hard to fulfill and these have been discussed above, e.g. the requirement for an offender to be as honest as possible about previous offending behaviors, which may result in self-incrimination.

Recent work has demonstrated the value of a therapeutic jurisprudence approach in making explicit the role of sex offender treatment programs and, in particular, the loyalties and priorities of the therapists. La Fond and Winick (2003) have developed a detailed proposal for "sex offender re-entry courts" as a response to current sentencing practices for sex offenders such as harsh sentences, indeterminate civil commitment, or sex offender registration and notification laws, all of which rely heavily on predictions on future behavior made at a single point in time which may or may not be accurate. They suggest instead the establishment of courts which use a risk management approach to determine graduated release into the community and subsequent long-term supervision and treatment, using repeatedly up-dated evaluations of risk and the offender's responses to treatment and supervision measures.

The reader will immediately see that the aim is not primarily that of more humane treatment of the offender (although this is certainly a welcome "side-effect"). Rather, it involves a community protection initiative that

[is] both smart and tough. It strikes an appropriate balance between enhancing community safety by aggressively monitoring more sex offenders in the community, while also creating and managing powerful incentives for sex offenders to invest in rehabilitation, thereby reducing sexual recidivism and increasing community protection. (La Fond and Winick 2003:320).

The ethical implications of this development are Treatment programs will be specifically important. linked to a "problem-solving court" which applies "principles of therapeutic jurisprudence to motivate sex offenders to deal with their underlying problems and to monitor their compliance with, and progress in treatment ...". The judge becomes effectively "a member of an interdisciplinary team, in this case serving as a 're-entry manager' for sex offenders" (La Fond and Winick 2003:314). The offender knows exactly where he stands: Non-compliance with treatment, inappropriate behaviors and refusal to answer appropriate questions regarding their activities (for example, during a polygraph examination) would result inevitably in the use of sanctions by the court. On the other hand, compliance with treatment, appropriate behaviors and truthful answering of questions (with the proviso that such answers could not be used in subsequent probation or parole revocation hearings) would result in rewards such as increased liberty of movement and more favorable assessments of risk on offender registration data-bases.

The offender thus has no illusions as to what he is being offered. He is being given punishment which, to be sure, is hopefully just, humane and aimed at minimizing the suffering he must undergo. But it is punishment nevertheless and it is in this light that he is able to see more clearly the context of "treatment" offered as part of that punishment regime and the implications of this.

CONCLUSION

I introduced my previous paper with a discussion of the difficulty in distinguishing "treatment" from punishment. Treatment is aimed primarily at benefiting an offender, the object of punishment is primarily to protect society. For many sex offenders, participation in treatment programs will be mainly a benign experience and, because the avowed aims of treatment and punishment in their individual cases are very similar, they will not be too fussed by the ethical commitments of the practitioners who treat them. Yet in other cases these practitioners will be torn between their traditional obligations to the offender and their mandated responsibility to protect society.

Mental health clinicians must continue to be involved in sex offender treatment programs, because techniques developed by them have been shown to substantially reduce the risks posed by such offenders to future potential victims and society in general. However, ethically, the use of such techniques is no longer treatment, it is punishment, and to confuse the two is both unethical and dangerous. The mere fact that a treatment technique which works in treatment settings also works for the purposes of punishment does not ethically justify its being labeled as "therapeutic"

when it is applied in the process of punishment. Furthermore, sex offenders who have spent so much of their lives deceiving themselves and others as to the true nature of, and motives for, their actions, will certainly derive no inspiration to reform from a therapist who, however inadvertently, disguises the true reason for the various interventions which they require sex offenders to undertake.

A therapeutic jurisprudence approach restores the virtue of good faith to dealings with an offender. The insistence of therapeutic jurisprudence on the primacy of the rule of law, despite its own emphasis on mitigating wherever possible, the psychological and social impact of the law on individual offenders, promotes good faith in our "therapeutic" interactions with sex offenders. It may well be distressing for an offender to realize that he will always be required by his therapist to make a sacrifice (often considerable) of his own well-being for the good of society. However, he will also be comforted by a recognition that the law will attempt to ensure that his therapist's demands on him are neither harsh nor disproportionate and that his therapist's support and assistance arise from a genuine desire to minimize his suffering to the least extent necessary. For the sex offender that is better than an erratic and inconsistent trust which can be breached at any time because of the therapist's conflicting and often-disguised loyalties.

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