Oregon
Kate Brown, Governor

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PHYSICIAN SEXUAL MISCONDUCT WORKGROUP

Meeting Agenda
Videoconference

February 8, 2021, 10:00AM

The mission of the Oregon Medical Board is to protect the health, safety, and wellbeing of Oregon citizens by regulating the practice of medicine in a manner that promotes access to quality care.

Committee Members:
Patti Louie, PhD, Chair
Erin Cramer, PA-C
Ali Mageehon, PhD
Chere Pereira
Jill Shaw, DO
David Farris, MD, Medical Director

OMB Staff:
Nicole Krishnaswami, JD, Executive Director
Elizabeth Ross, JD, Legislative & Policy Analyst
Gretchen Kingham, Executive Assistant

10:00AM

1	**Welcome and Introductions**	**Louie**

2	**Review of Workgroup Charter**	**Mageehon**

3	**Overview of Complaint and Investigative Process** *Informational Only*	**Pereira**

4	**Statutes: ORS 677.188 and 677.190 – Grounds for Discipline** *Statutes are laws adopted by the Oregon State Legislature. The legislative process requires approximately 18-24 months before a bill becomes a law.*	**Cramer**

5	**Rules: OAR 847-010-0073(3)(b)(G) – Sexual Misconduct** *Oregon Administrative Rules are regulations adopted by the Medical Board. The rulemaking process requires approximately 6-9 months before becoming effective.*	**Pereira**

6	**Statement of Philosophy: Sexual Misconduct** *Statements of Philosophy are not enforceable regulations; instead, they communicate the Medical Board's perspective on a particular issue. The drafting and adoption process requires approximately 3-6 months.*	**Mageehon**

7	**Educational Outreach and Publications** *Educational materials are not enforceable regulations; instead, they inform the public about the practice of medicine and Medical Board processes. Publication timelines depend on the content and format for the information.*	**Shaw**

8	**Planning for Future Discussion Topics and Next Meeting Date**	**Louie**

9	**Public Comment** *Written comments and inquiries may be sent to Elizabeth Ross, Legislative and Policy Analyst, Elizabeth.Ross@omb.oregon.gov or 971-673-2700.*	**Louie**

ADJOURN

WORKGROUP CHARTER

Purpose

The Workgroup on Provider Sexual Misconduct will review current information and regulations related to provider sexual misconduct, determine needed changes, and recommend future action.

Members

A Chair will be selected from among the following members:

- Three public members of the Board
- Two licensed professional members of the Board
- Board Medical Director

Administrative support will be provided by OMB staff.

Scope

The Workgroup will review regulations, statements of philosophy, and public educational materials, such as printed informational brochures and information at www.oregon.gov/OMB.

Currently out of scope:

- Review of internal policies and procedures
- Review of individual investigative cases

Meetings

Monthly public meetings will be held January through March. Meetings will be subject to public meetings law, including public notice, public records, public access, and public comment period. The meetings will be held via teleconference or videoconference.

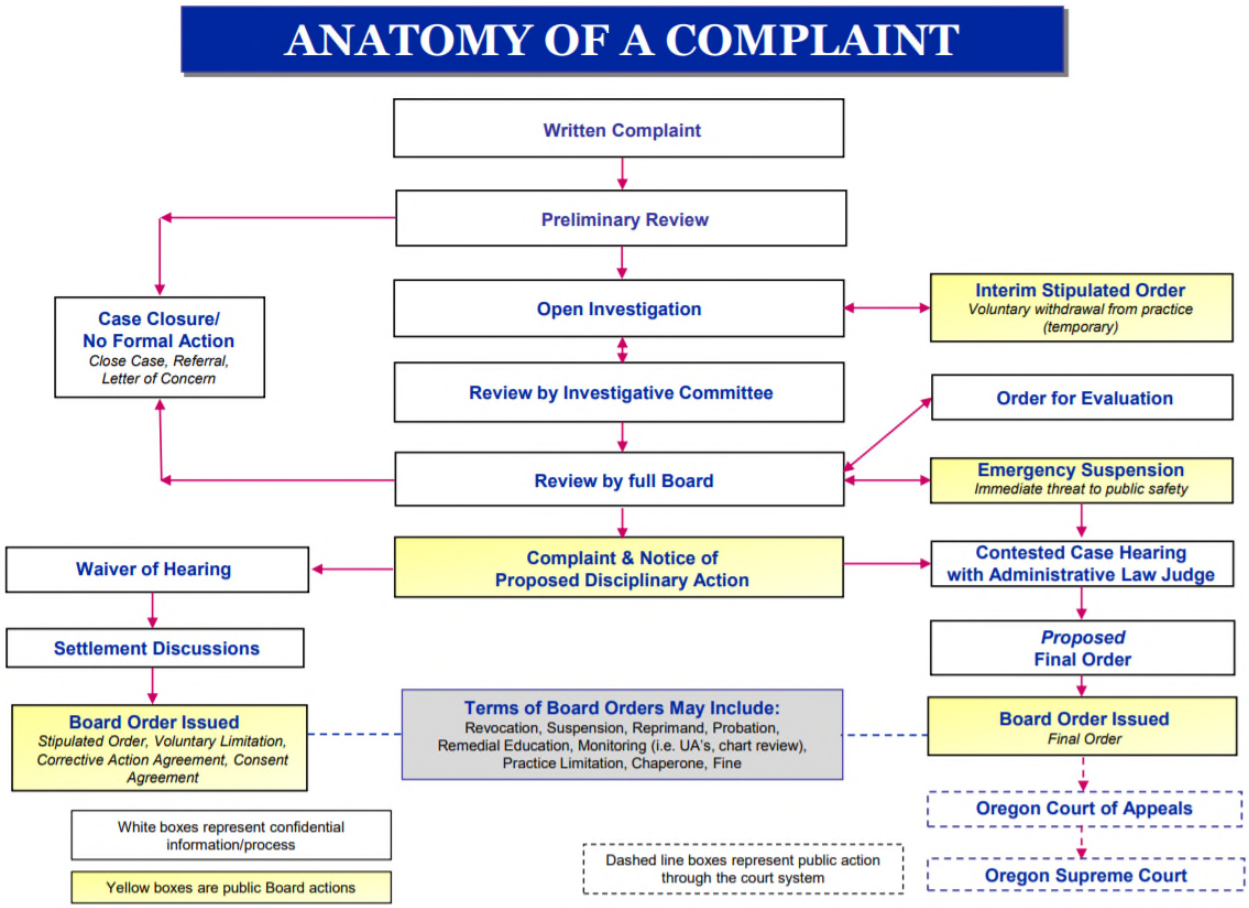
Exact dates and times are TBD based on workgroup member availability.

Objective

The workgroup may recommend creating educational materials, possible edits to the Board's Statement of Philosophy, potential rulemakings, and suggested 2023 legislative concept(s).

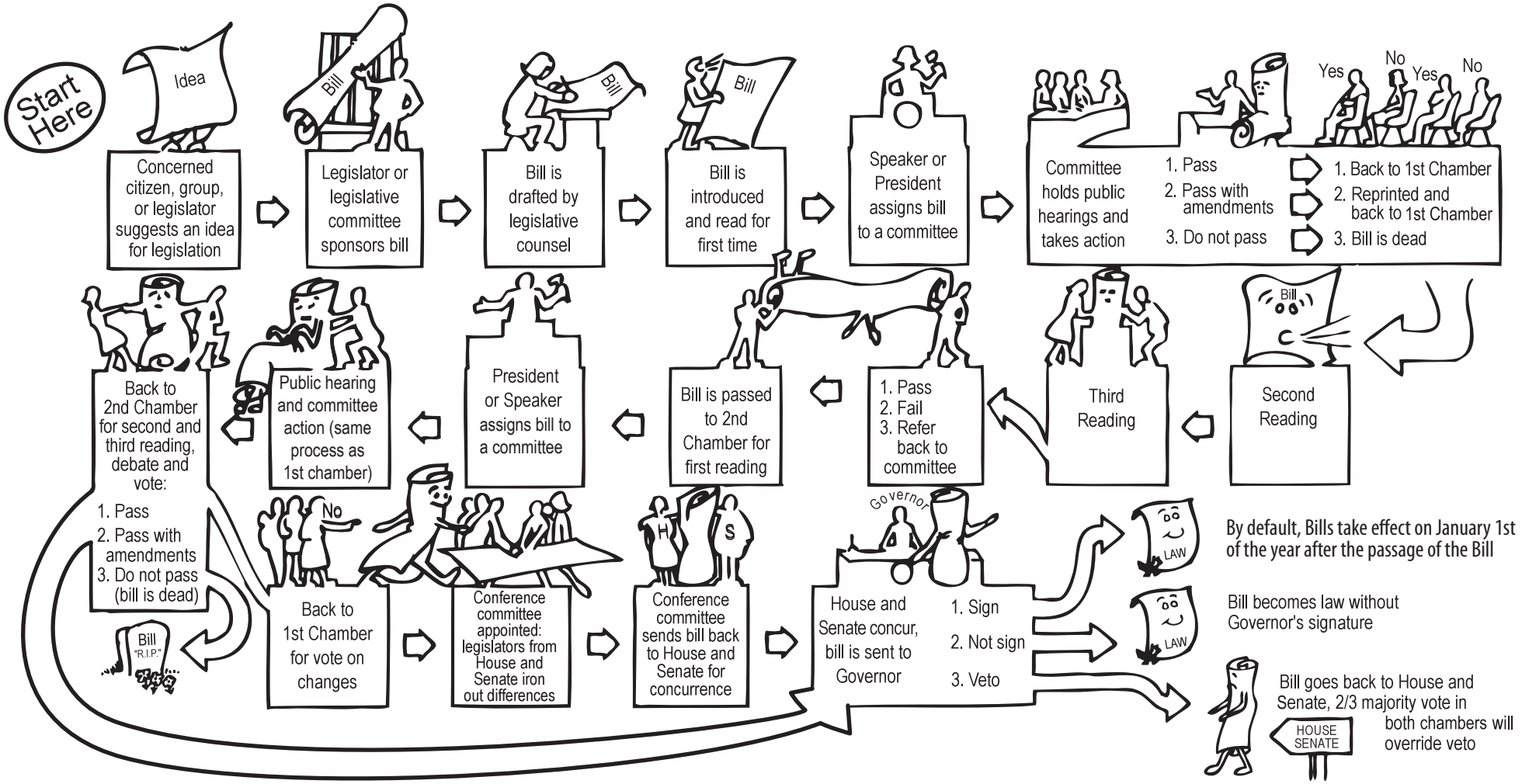
Workgroup recommendations will be reviewed by the Administrative Affairs Committee on March 10, 2021, and the full Board on April 2, 2021.

ANATOMY OF A COMPLAINT



How an Idea Becomes Law

A simple view of the Oregon Legislative Process



The Oregon Legislative Assembly

The Oregon Legislative Assembly is state government's "board of directors." It is responsible for making laws dealing with Oregon's well-being, adopting the state's budget, and for setting public policy. The Legislative Assembly is made up of two bodies: the Senate and the House of Representatives. The Senate consists of 30 members elected for four-year terms. The House consists of 60 representatives elected for two-year terms. Each member of the legislature represents a district (an area determined by population). Every Oregonian is represented by one state Senator and one state Representative.

The legislature convenes annually in February at the State Capitol in Salem, but sessions may not exceed 160 days in odd-numbered years and 35 days in even-numbered years, unless extended by a two-thirds vote in each chamber. About 3,000 bills are considered in each odd-year session. Relying largely upon work done in committees, the legislature enacts about one-third of these bills into Law

Oregon Revised Statute (ORS), Chapter 677
Regulation of Medicine, Podiatry and Acupuncture

ORS 677.188 and 677.190 - Grounds for Discipline

677.188 Definitions for ORS 677.190. As used in ORS 677.190, unless the context requires otherwise:

(1) "Fraud or misrepresentation" means the intentional misrepresentation or misstatement of a material fact, concealment of or failure to make known any material fact, or any other means by which misinformation or a false impression knowingly is given.

(2) "Fraudulent claim" means a claim submitted to any patient, insurance or indemnity association, company or individual for the purpose of gaining compensation, which the person making the claim knows to be false.

(3) "Manifestly incurable condition, sickness, disease or injury" means one that is declared to be incurable by competent physicians or by other recognized authority.

(4) "Unprofessional or dishonorable conduct" means conduct unbecoming a person licensed to practice medicine or podiatry, or detrimental to the best interests of the public, and includes:

(a) Any conduct or practice contrary to recognized standards of ethics of the medical or podiatric profession or any conduct or practice which does or might constitute a danger to the health or safety of a patient or the public or any conduct, practice or condition which does or might adversely affect a physician's ability safely and skillfully to practice medicine or podiatry;

(b) Willful performance of any surgical or medical treatment which is contrary to acceptable medical standards; and

(c) Willful and repeated ordering or performance of unnecessary laboratory tests or radiologic studies; administration of unnecessary treatment; employment of outmoded, unproved or unscientific treatments; failure to obtain consultations when failing to do so is not consistent with the standard of care; or otherwise utilizing medical service for diagnosis or treatment which is or may be considered inappropriate or unnecessary. [1967 c.470 §29; 1969 c.684 §14; 1975 c.796 §1; 1983 c.486 §21; 1987 c.377 §3; 2009 c.756 §22; 2013 c.129 §11]

677.190 Grounds for suspending, revoking or refusing to grant license, registration or certification; alternative medicine not unprofessional conduct. The Oregon Medical Board may refuse to grant, or may suspend or revoke a license to practice for any of the following reasons:

(1)(a) Unprofessional or dishonorable conduct.

(b) For purposes of this subsection, the use of an alternative medical treatment shall not by itself constitute unprofessional conduct. For purposes of this paragraph:

(A) "Alternative medical treatment" means:

(i) A treatment that the treating physician, based on the physician's professional experience, has an objective basis to believe has a reasonable probability for effectiveness in its intended use even if the treatment is outside recognized scientific guidelines, is unproven, is no longer used as a generally recognized or standard treatment or lacks the approval of the United States Food and Drug Administration;

(ii) A treatment that is supported for specific usages or outcomes by at least one other physician licensed by the Oregon Medical Board; and

(iii) A treatment that poses no greater risk to a patient than the generally recognized or standard treatment.

(B) “Alternative medical treatment” does not include use by a physician of controlled substances in the treatment of a person for chemical dependency resulting from the use of controlled substances.

(2) Employing any person to solicit patients for the licensee. However, a managed care organization, independent practice association, preferred provider organization or other medical service provider organization may contract for patients on behalf of physicians.

(3) Representing to a patient that a manifestly incurable condition of sickness, disease or injury can be cured.

(4) Obtaining any fee by fraud or misrepresentation.

(5) Willfully or negligently divulging a professional secret without the written consent of the patient.

(6) Conviction of any offense punishable by incarceration in a Department of Corrections institution or in a federal prison, subject to ORS 670.280. A copy of the record of conviction, certified to by the clerk of the court entering the conviction, shall be conclusive evidence of the conviction.

(7) Impairment as defined in ORS 676.303.

(8) Fraud or misrepresentation in applying for or procuring a license to practice in this state, or in connection with applying for or procuring registration.

(9) Making statements that the licensee knows, or with the exercise of reasonable care should know, are false or misleading, regarding skill or the efficacy or value of the medicine, treatment or remedy prescribed or administered by the licensee or at the direction of the licensee in the treatment of any disease or other condition of the human body or mind.

(10) Impersonating another licensee licensed under this chapter or permitting or allowing any person to use the license.

(11) Aiding or abetting the practice of medicine or podiatry by a person not licensed by the board, when the licensee knows, or with the exercise of reasonable care should know, that the person is not licensed.

(12) Using the name of the licensee under the designation “doctor,” “Dr.,” “D.O.” or “M.D.,” “D.P.M.,” “Acupuncturist,” “P.A.” or any similar designation in any form of advertising that is untruthful or is intended to deceive or mislead the public.

(13) Gross negligence or repeated negligence in the practice of medicine or podiatry.

(14) Incapacity to practice medicine or podiatry. If the board has evidence indicating incapacity, the board may order a licensee to submit to a standardized competency examination. The licensee shall have access to the result of the examination and to the criteria used for grading and evaluating the examination. If the examination is given orally, the licensee shall have the right to have the examination recorded.

(15) Disciplinary action by another state of a license to practice, based upon acts by the licensee similar to acts described in this section. A certified copy of the record of the disciplinary action of the state is conclusive evidence thereof.

(16) Failing to designate the degree appearing on the license under circumstances described in ORS 677.184 (3).

(17) Willfully violating any provision of this chapter or any rule adopted by the board, board order, or failing to comply with a board request pursuant to ORS 677.320.

(18) Failing to report the change of the location of practice of the licensee as required by ORS 677.172.

(19) Imprisonment as provided in ORS 677.225.

(20) Making a fraudulent claim.

(21)(a) Performing psychosurgery.

(b) For purposes of this subsection and ORS 426.385, “psychosurgery” means any operation designed to produce an irreversible lesion or destroy brain tissue for the primary purpose of altering the thoughts, emotions or behavior of a human being. “Psychosurgery” does not include procedures which may produce an irreversible lesion or destroy brain tissues when undertaken to cure well-defined disease states such as brain tumor, epileptic foci and certain chronic pain syndromes.

(22) Refusing an invitation for an informal interview with the board requested under ORS 677.415.

(23) Violation of the federal Controlled Substances Act.

(24) Prescribing controlled substances without a legitimate medical purpose, or prescribing controlled substances without following accepted procedures for examination of patients, or prescribing controlled substances without following accepted procedures for record keeping.

(25) Providing written documentation for purposes of ORS 475B.797 without having legitimately diagnosed a debilitating medical condition, as defined in ORS 475B.791, or without having followed accepted procedures for the examination of patients or for keeping records.

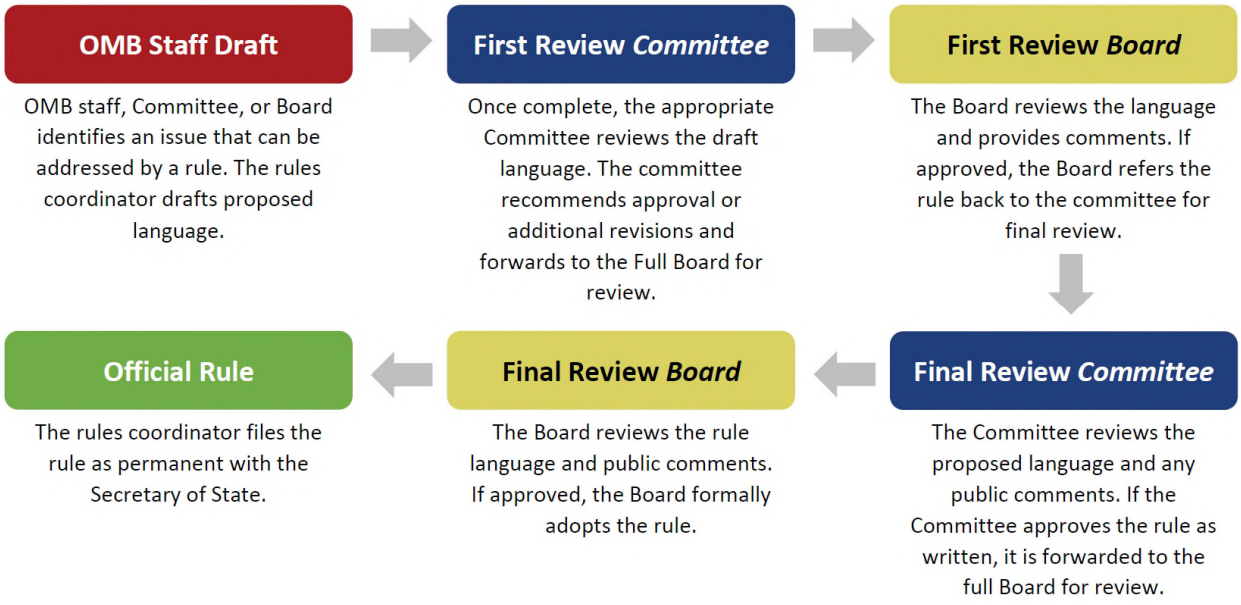
(26) Failure by the licensee to report to the board any adverse action taken against the licensee by another licensing jurisdiction or any peer review body, health care institution, professional or medical society or association, governmental agency, law enforcement agency or court for acts or conduct similar to acts or conduct that would constitute grounds for disciplinary action as described in this section.

(27) Failure by the licensee to notify the board of the licensee’s voluntary resignation from the staff of a health care institution or voluntary limitation of a licensee’s staff privileges at the institution if that action occurs while the licensee is under investigation by the institution or a committee thereof for any reason related to medical incompetence, unprofessional conduct, physical incapacity or impairment.

RULE MAKING PROCESS

The Oregon Medical Board and other state agencies operate under a system of administrative rules to ensure fairness and consistency in procedures and decisions. Periodically, these Oregon Administrative Rules (OARs) must be amended in response to evolving standards and circumstances. OARs are written and amended within the agency's statutory authority granted by the Legislature.

Rules go through a First and Final Review before being permanently adopted. Temporary rules are effective after First Review, but they expire in 180 days unless permanently adopted after a Final Review. Official notice of rulemaking is provided in the Secretary of State Bulletin.



Oregon Administrative Rules (OARs), Chapter 847

847-010-0073, Reporting Requirements

847-010-0073(3)(b)(G)

(G) Sexual misconduct: Licensee sexual misconduct is behavior that exploits the licensee-patient relationship in a sexual way. The behavior is non-diagnostic and non-therapeutic, may be verbal, physical or other behavior, and may include expressions of thoughts and feelings or gestures that are sexual or that reasonably may be construed by a patient as sexual. Sexual misconduct includes but is not limited to:

(i) Sexual violation: Licensee-patient sex, whether or not initiated by the patient, and engaging in any conduct with a patient or the patient's immediate family that is sexual or may be reasonably interpreted as sexual, including but not limited to:

(I) Sexual intercourse;

(II) Genital to genital contact;

(III) Oral to genital contact;

(IV) Oral to anal contact;

(V) Genital to anal contact;

(VI) Kissing in a romantic or sexual manner;

(VII) Touching breasts, genitals, or any sexualized body part for any purpose other than appropriate examination or treatment, or where the patient has refused or has withdrawn consent;

(VIII) Encouraging the patient to masturbate in the presence of the licensee or masturbation by the licensee while the patient is present; or

(IX) Offering to provide practice-related services, such as medications, in exchange for sexual favors.

(ii) Sexual impropriety: Behavior, gestures, or expressions that are seductive, sexually suggestive, or sexually demeaning to a patient or the patient's immediate family, to include:

(I) Sexually exploitative behavior, to include taking, transmitting, viewing, or in any way using photos or any other image of a patient, their family or associates for the prurient interest of others.

(II) Intentional viewing in the health care setting of any sexually explicit conduct for prurient interests.

(III) Having any involvement with child pornography, which is defined as any visual depiction of a minor (a child younger than 18) engaged in sexually explicit conduct.

(IV) Sexually explicit communication in person, by mail, by telephone, or by other electronic means, including but not limited to text message, e-mail, video or social media.

Statement of Philosophy: Sexual Misconduct

The Oregon Medical Board recognizes that the practice of medicine entails a unique relationship between the medical professional and the patient. The patient's trust and confidence in a provider's professional status grants power and influence to the physician, physician assistant, or acupuncturist.

Licensees are expected to maintain a professional manner and to avoid behaviors that may be misunderstood by or considered offensive by the patient. Licensees should take proactive steps to eliminate misunderstandings through clear, appropriate, and professional communication.

Recommended proactive practices:

1. Provide a professional explanation about each component of examinations, procedures, tests, and other aspects of patient care.
2. Communicate actions in advance, such as physical touch during an exam.
3. Have a chaperone present during sensitive examinations and procedures and anytime when requested by the patient.
4. Be cognizant of sexual or romantic feelings toward a patient or patient representative, and transfer the patient to another health care provider.
5. Be alert to a patient's or patient representative's sexual or romantic feelings; the licensee is responsible for ensuring that the boundaries of the professional relationship are maintained.
6. Exercise extreme caution in electronic communications due to the high potential for misunderstanding. The Oregon Medical Board's Statement of Philosophy on Social Media provides additional guidelines.

Sexual or romantic contact or a suggestion of any sort within a professional relationship, or any such contact outside of the provider-patient relationship is unethical and constitutes unprofessional conduct. "Contact" includes any interaction, whether verbal, physical, or over electronic means.

- Adopted 1995
- Amended October 3, 2019

"'Sexual misconduct' is behavior that exploits the licensee-patient relationship in a sexual way. The behavior is non-diagnostic and non-therapeutic, may be verbal, physical or other behavior, and may include expressions of thoughts and feelings or gestures that are sexual or that reasonably may be construed by a patient as sexual."

- Oregon Administrative Rule 847-010-0073(3)(b)(G)

Sexual Trauma Support

The Oregon Medical Board takes accusations of sexual misconduct extremely seriously. If you have filed a sexual misconduct complaint with the Board and would like additional resources, please visit the Oregon Attorney General's Sexual Assault Task Force webpage. There, you will find contact information for nonprofit organizations in your area. Please note that the Sexual Assault Task Force does not operate a shelter or crisis hotline.

Educational Outreach and Publications:

Oregon Attorney General's Sexual Assault Task Force

North Carolina Brochure

New North Carolina Medical Board Podcast: 'What to expect during a physical exam'

KNOW THE SIGNS OF **SEXUAL MISCONDUCT**

NORTH CAROLINA MEDICAL BOARD

SEX AND MEDICAL CARE NEVER GO TOGETHER

It is inappropriate and unethical for a medical professional to initiate sexual contact under the pretext of providing medical care.

THIS INCLUDES:

- Suggesting to the patient that sexual contact is necessary or will benefit the patient's health
- Sexual contact that occurs while a patient is incapacitated

PATIENTS CANNOT "CONSENT"

Sexual activity with a medical professional is never appropriate. This is true even if the patient suggests starting a sexual relationship or accepts a provider's invitation to begin one.

A medical professional is always in a position of power when interacting with a patient. As a result, a patient cannot give true consent.

RECOGNIZING MISCONDUCT

It is not always easy to tell if a medical professional is behaving inappropriately. He or she may start by crossing over relatively minor boundaries to test how a patient might respond to sexual advances.

SOME EXAMPLES OF "RED FLAG" BEHAVIORS BY A MEDICAL PROFESSIONAL INCLUDE:

- Telling sexual jokes to patients
- Leering at patients' breasts or other sexual body parts
- Invading patients' personal space or "accidentally" brushing against patients' bodies
- Telling patients about the provider's own love life or sexual preferences
- Offering patients gifts or personal favors
- Contacting patients for non-medical reasons
- Suggesting that medical appointments be scheduled outside of typical office hours, or away from the practice
- Inviting patients to lunch, dinner or other "date-like" activities

MORE SERIOUS EXAMPLES INCLUDE:

- Asking for details of patients' sexual experiences and preferences when there is no valid medical reason
- Performing a genital examination without the use of gloves
- Performing an intimate examination (genitals, breasts) when there is no medical need
- Touching a patient in a way that seems sexual. This includes:
  - Groping and touching of the breasts, buttocks or genitals
  - Kissing
  - Oral to genital contact
  - Penetrative sexual contact

NCMB provides assistance to victims of sexual assault. Learn more at:

ncmedboard.org/victimservices

PROTECTING PATIENTS FROM SEXUAL MISCONDUCT

Under state law the North Carolina Medical Board has the authority to:

- Deny licensure to any physician, physician assistant or other provider licensed by NCMB if that individual has been convicted of a felony sex crime or revoke the license of any currently licensed professional who is convicted of one.
- Investigate allegations of sexual misconduct and, provided sufficient evidence is obtained, suspend or restrict the provider's authority to practice.

DUTY TO REPORT

North Carolina's "Duty to Report" law requires physicians and PAs to notify NCMB if they are aware that another licensed medical professional has engaged in sexual activities with patients.

- Professionals making a report are not required to have absolute proof of the sexual misconduct.
- A report should be made if a medical professional "reasonably believes" that misconduct has occurred.
- Belief that misconduct has occurred may be based on the medical professional's own observations, or on reports from office staff or others.

REPORTING **MISCONDUCT**

Patients are strongly encouraged to report sexual misconduct by a medical provider. Filing a complaint with NCMB gives the medical board the opportunity to hold the provider accountable.

Some of the behaviors described in the brochure may be unlawful as well as unethical. Patients should also consider reporting to local law enforcement.

Submit a complaint to NCMB at:

ncmedboard.org/complaints

NORTH CAROLINA MEDICAL BOARD

Physician Sexual Misconduct

Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct

Adopted as policy by the Federation of State Medical Boards
May 2020

Section 1: Introduction and Workgroup Charge

The relationship between a physician and patient is inherently imbalanced. The knowledge, skills and training statutorily required of all physicians puts them in a position of power in relation to the patient. The patient, in turn, often enters the therapeutic relationship from a position of vulnerability due to illness, suffering, and a need to divulge deeply personal information and subject themselves to intimate physical examination. This vulnerability is further heightened in light of the patient's trust in their physician, who has been granted the power to deliver care, prescribe needed treatment and refer for appropriate specialty consultation.

It is critical that physicians act in a manner that promotes mutual trust with patients to enable the delivery of quality health care. When there is a violation of that relationship through sexual misconduct, such behavior and actions can have a profound, enduring and traumatic impact on the individual being exploited, their family, the public at large, and the medical profession as a whole. Properly and effectively addressing sexual misconduct by physicians through sensible standards and expectations of professionalism, including preventive education, as well as through meaningful disciplinary action and law enforcement when required, is therefore a paradigmatic expression of self-regulation and its more modern iteration, shared regulation.

In May of 2017, Patricia King, M.D., PhD., Chair at the time of the Federation of State Medical Boards (FSMB), created and led a Workgroup on Physician Sexual Misconduct (hereafter referred to as "the Workgroup"), and charged its members with 1) collecting and reviewing available disciplinary data, including incidence and spectrum of severity of behaviors and sanctions, related to sexual misconduct; 2) identifying and evaluating barriers to reporting sexual misconduct to state medical boards, including, but not limited to, the impact of state confidentiality laws, state administrative codes and procedures, investigative procedures, and cooperation with law enforcement on the reporting and prosecution/adjudication of sexual misconduct; 3) evaluating the impact of state medical board public outreach on reporting; 4) reviewing the FSMB's 2006 policy statement, *Addressing Sexual Boundaries: Guidelines for State Medical Boards,* and revising, amending or replacing it, as appropriate; and 5) assessing the prevalence of sexual boundary/harassment training in undergraduate and graduate medical education and developing recommendations and/or resources to address gaps.

In carrying out its charge, the Workgroup adopted a broad lens with which to scrutinize not only the current practices of state medical boards and other professional regulatory authorities in the United States and abroad, but also elements of professional culture within American medicine, including notions of professionalism, expectations related to reporting instances of misconduct or

impropriety, evolving public expectations of the medical profession, and the impact of trauma on survivors of sexual misconduct. In analyzing these issues, the Workgroup benefited tremendously from discussions with several of the FSMB's partner organizations and stakeholders that also have a role in addressing the issue of physician sexual misconduct. The Workgroup extends its thanks, in particular, to the American Association of Colleges of Osteopathic Medicine (AACOM), Association of American Medical Colleges (AAMC), Student Osteopathic Medical Association (SOMA), Australian Health Practitioner Regulation Agency (AHPRA), American Medical Association (AMA), American Medical Women's Association (AMWA), American Osteopathic Association (AOA), Council of Medical Specialty Societies (CMSS), Federation of Medical Regulatory Authorities of Canada (FMRAC), Federation of State Physician Health Programs (FSPHP), several provincial medical regulatory colleges from Canada, subject matter experts from Justice3D, PBI Education, and additional physician experts, and especially the victim and survivor advocates who bravely shared their experiences with Workgroup members. This report has been enriched by these partners' valuable contributions.

A call for cultural change

The Workgroup acknowledged the importance of the environment and culture, from medical school to practice, for the development of and commitment to positive professional values and behaviors in medicine. In this regard, the Workgroup also acknowledged the existence of several highly problematic aspects of sexual misconduct in medical education and practice, many of which permeate the prevailing culture of medicine and self-regulation. The National Academies of Sciences report that organizational culture plays a primary role in enabling harassment and that sexually harassing behaviors are not typically isolated incidents.[1] Medical students and trainees who are subjected to environments in which harassment is accepted suffer not only as victims, but may also be undermined in their educational and professional attainment, resulting in loss of talent for the profession. To the extent that a culture that is permissive of sexual harassment results in perceived license to engage in such conduct oneself, patients are ultimately put at risk of dire consequences. Permissive environments could also reduce the likelihood that bystanders will feel responsibility to report misconduct.

Beyond the many instances, both reported and unreported, of sexual assault and boundary violations, concerns about sexual misconduct in medicine include various aspects of the investigative and adjudicatory processes designed to address them; the professional responsibility of health care practitioners to report suspected instances of sexual misconduct and patient harm; variation in state medical board policies and processes, as well as in state laws; transparency of state medical board processes and actions; a widespread need for education and training among medical regulators, board investigators, attorneys, and law enforcement personnel about trauma and how it might impact complainant accounts and the investigative process; and challenges posed for decisions about re-entry to practice and remediation.

This report summarizes these problematic elements so that they may be more widely appreciated, while offering potential solutions and strategies for state medical boards to consider for their

[1] National Academies of Sciences, Engineering, and Medicine. 2018. *Sexual Harassment of Women: Climate, Culture, and Consequences in Academic Sciences, Engineering, and Medicine*. Washington, DC: The National Academies Press. doi: https://doi.org/10.17226/24994.

jurisdictions. It aspires to provide best practice recommendations and highlight existing strategies and available tools to allow boards, including board members, executive directors, staff, and attorneys, to best protect the public while working within their established frameworks and resources. The report also advocates for an educational focus to change and improve culture, awareness, and behaviors across the continuum of medical education and practice, so as to improve care for and protection of patients.

Section 2: Principles

The analysis in this report is informed by the following principles:

- **Trust**: The physician-patient relationship is built upon trust, understood as a confident belief on the part of the patient in the moral character and competence of their physician.[2] In order to safeguard this trust, the physician must act and make treatment decisions that are in the best interests of the patient at all times.
- **Professionalism**: The avoidance of sexual relationships with patients has been a principle of professionalism since at least the time of Hippocrates. Professional expectations still dictate today that sexual contact or harassment of any sort between a physician and patient is unacceptable.
- **Fairness**: The principle of fairness applies to victims (also sometimes described as survivors) of sexual misconduct, who must be granted fair treatment throughout the regulatory process and be afforded opportunities to seek justice for wrongful conduct committed against them. Fairness also applies to physicians who are subjects of complaints in that they must be granted due process in investigative and adjudicatory processes; proportionality should be considered in disciplinary actions.
- **Transparency**: The actions and processes of state medical boards are designed in the public interest to regulate the medical profession and protect patients from harm. As such, the public has a right to information about these processes and the bases of regulatory decisions.

Section 3: Terminology:

Sexual Misconduct:

For the purposes of this report, physician sexual misconduct is understood as behavior that exploits the physician-patient relationship in a sexual way. Sexual behavior between a physician and a patient is never diagnostic or therapeutic. This behavior may be verbal or physical, can occur in person or virtually,[3] and may include expressions of thoughts and feelings or gestures that are of a sexual nature or that a patient or surrogate[4] may reasonably construe as sexual. Hereinafter, the term "patient" includes the patient and/or patient surrogate.

[2] Beauchamp T and Childress J., (2001) *Principles of Biomedical Ethics*, 5th ed., 34.
[3] Federation of State Medical Boards, *Social Media and Electronic Communication*, 2019.
[4] Surrogates are those individuals closely involved in patients' medical decision-making and care and include spouses or partners, parents, guardians, and/or other individuals involved in the care of and/or decision-making for the patient.

Physician sexual misconduct often takes place along a continuum of escalating severity. This continuum comprises a variety of behaviors, sometimes beginning with "grooming" behaviors which may not necessarily constitute misconduct on their own, but are precursors to other, more severe violations. Grooming behaviors may include gift-giving, special treatment, sharing of personal information or other acts or expressions that are meant to gain a patient's trust and acquiescence to subsequent abuse.[5] When the patient is a child, adolescent or teenager, the patient's parents may also be groomed to gauge whether an opportunity for sexual abuse exists.

More severe forms of misconduct include sexually inappropriate or improper gestures or language that are seductive, sexually suggestive, disrespectful of patient privacy, or sexually demeaning to a patient. These may not necessarily involve physical contact, but can have the effect of embarrassing, shaming, humiliating or demeaning the patient. Instances of such sexual impropriety can take place in person, online, by mail, by phone, and through texting.

Additional examples of sexual misconduct involve physical contact, such as performing an intimate examination on a patient with or without gloves and without clinical justification or explanation of its necessity, and without obtaining informed consent.

The severity of sexual misconduct increases when physical contact takes place between a physician and patient and is explicitly sexual or may be reasonably interpreted as sexual, even if initiated by the patient. So-called "romantic" behavior between a physician and a patient is never appropriate, regardless of the appearance of consent on the part of the patient. Such behavior would at least constitute grooming, depending on the nature of the behavior, if not actual sexual misconduct, and should be labeled as such.

The term "sexual assault" refers to any type of sexual activity or contact without consent (such as through physical force, threats of force, coercion, manipulation, imposition of power, etc., or circumstances where a person lacks the capacity to provide consent due to age or other circumstances) and may be used in investigations where there is a need to emphasize the severity of the misconduct and related trauma. Sexual assault is a criminal or civil violation and should typically be handled in concert with law enforcement. Sexual assault should be reported to law enforcement immediately, except in cases where reporting would contravene the wishes of an adult complainant and non-reporting in such an instance is permitted by applicable state law.

While the legal term "sexual boundary violation" is a way of denoting the breach of an imaginary line that exists between the doctor and patient or surrogate, and is commonly used in medical regulatory discussions, the members of the Workgroup felt that it was an overly broad term that may encompass everything from isolated instances of inappropriate communication to sexual misconduct and outright sexual assault. Thus, this report avoids the term in favor of more specific terms.

[5] American Academy of Pediatrics "Protecting Children from Sexual Abuse by Health Care Providers," Committee on Child Abuse and Neglect, 2010-2011, Published in *Pediatrics*, August 2011, Vol. 128, Issue 2.

Trauma:

For the purposes of this report, the definition of trauma provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) is used:

"Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."[6]

According to SAMHSA, "a program, organization, or system that is *trauma-informed* realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization."[7]

Patient:

A patient is understood as an individual with whom a physician is involved in a care and treatment capacity within a legally defined and professional physician-patient relationship.

Physician:

While this report primarily addresses physician licensees, the content and recommendations should be viewed as applying to all health professionals licensed by member boards of the FSMB, as well as other members of the health care team, including medical students.

Section 4: Patient Rights and Expectations for Professional Conduct in the Physician-Patient Encounter

Communication and Patient Education

Communication between a physician and patient should occur throughout any examination or procedure (provided the patient is not under general anesthetic during the procedure), including conveying the medical necessity, what the examination or procedure will involve, any discomfort the patient might experience, the benefits and risks, and any findings. This is especially important during the performance of an intimate examination. This not only lays out the parameters of the interaction for both parties; it may also help minimize the possibility that the patient will misinterpret the physician's actions.

[6] Substance Abuse and Mental Health Services Administration. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
[7] *Id*. Emphasis added.

The use of educational resources to educate patients about what is normal and expected during medical examinations and procedures is encouraged and should be provided by both physicians and state medical boards.

Informed Consent and Shared Decision-Making

The informed consent process can be a useful way of helping a patient understand the intimate nature of a proposed examination, as well as its medical necessity. The informed consent process should include, at a minimum, an explanation, discussion, and comparison of treatment options with the patient, including a discussion of any risks involved with proposed procedures; an assessment of the patient's values and preferences; arrival at a decision in partnership with the patient; and an evaluation of the patient's decision in partnership with the patient. This process must be documented in the patient's medical record.

Where possible, the consent process should take place well in advance of any procedure so that the patient has an opportunity to consider the proposed procedure in the absence of competing considerations about cancellation or rescheduling. Requiring decisions at the point of care puts patients at a disadvantage because they may not have time to consider what is being proposed and what it means for themselves and their values. However, it is recognized that obtaining consent well in advance is not always possible for urgent, emergency, or same-day procedures. The consent process should also include information about the effects of anaesthesia, including the possibility of amnesia, because these can be particularly problematic with respect to sexual misconduct. Use of understandable (lay, or common) language during the consent process is essential.

In instances where a patient is unable to provide consent to a pelvic or otherwise intimate examination due to the presence of anesthesia or for any other reason, an intimate examination should only be performed when it is medically necessary. Intimate examinations must never be performed for purely educational purposes when consent cannot be obtained.

Section 5: Complaints and the Duty to Report

In order for state medical boards to effectively address instances of sexual misconduct, they must have access to relevant information about licensees that have harmed or pose a significant risk of harming patients. The complaints process and physicians' professional duty to report instances of sexual misconduct are therefore central to a regulatory board's ability to protect patients.[8]

Complaints and Barriers to Complaints

It is essential for patients or their surrogates to be able to file complaints about their physicians to state medical boards in order that licensees who pose a threat to patients may be investigated and appropriate action taken. However, studies have estimated that sexual misconduct by physicians

[8] Additional reporting to entities other than state medical boards may also be warranted for purposes of patient protection, including law enforcement, hospital or medical staff administration, and medical school or residency program directors and supervisors.

is significantly under reported, and several challenges which may dissuade patients from filing complaints must be overcome.[9] These include distrust in the ability or willingness of institutions such as state medical boards, hospitals and other health care organizations to take action in instances of sexual misconduct; fear of abandonment or retaliation by the physician; societal or personal factors related to stigma, shame, embarrassment and not wanting to relive a traumatic event; a lack of awareness about the role of state medical boards and how to file complaints; or uncertainty that what has transpired is, indeed, unprofessional and unethical.

State medical boards can play an important role in providing clarity about the complaints process by providing information to the public about the process itself and how, why, and when to file a complaint. Recommended methods for optimizing the complaints process include:

- Providing the option to file complaints via multiple channels, including in writing, by telephone, email, or through online forms
- Making the process accessible to patients with information about filing complaints that is clearly posted on state medical board websites
- Ensuring that information about the complaints process is made available via translation for complainants who do not speak English

State medical boards, the FSMB and its partner organizations representing medical specialties whose members perform intimate examinations and procedures may also wish to provide education for patients on topics such as:

- The types of behavior that should be expected of physicians
- Types of behavior that might warrant a complaint
- What to do in the event that a physician's actions make a patient uncomfortable
- Circumstances that would warrant a report directly to law enforcement

State medical boards can also restore public trust and confidence in the complaints process by demonstrating swift and appropriate action on verified complaints.

The ability to file a complaint anonymously may be especially important in instances of sexual misconduct. The trauma and fear associated with sexual misconduct can pose barriers to legitimate complaints, especially when anonymity is not granted. While the ability of complainants to remain anonymous to the general public is recommended, complainant anonymity to the state medical board may not be possible.

State medical boards should address complaints related to sexual misconduct as quickly as possible for the benefit and protection of the complainant and other patients. Initial stages of investigations should be expedited to determine whether there is a high likelihood of imminent risk to the public, meriting steps to modify or cease practice while the investigation is completed.

[9] Dubois J, et al. Sexual Violation of Patients by Physicians: A Mixed-Methods, Exploratory Analysis of 101 Cases. *Sexual Abuse* 2019, Vol. 31(5) 503–523

State medical board staff and board investigators of administrative complaints are encouraged to communicate frequently with complainants throughout the complaint and investigative processes and to ask complainants about their preferred mode and frequency of communication, as well as their expectations from the process. Where possible, boards should consider having a patient liaison or navigator on staff who would be specially trained to provide one-on-one support to complainants and their families.

Duty to Report

In a complaint-based medical regulatory system, it is imperative that state medical boards have access to the information they require to effectively protect patients.[10] In addition to a robust complaints process, it is therefore essential that patients, physicians and everyone involved in healthcare speak up whenever something unusual, unsafe or inappropriate occurs. All members of the healthcare team, as well as institutions, including state medical boards, hospitals and private medical clinics also have a legal as well as an ethical duty to report instances of sexual misconduct and other serious patient safety issues and events. This duty extends beyond physician-patient encounters to reporting inappropriate behavior in interactions with other members of the healthcare team, and in the learning environment.

Early reporting of sexual misconduct is critical. This includes reporting of those forms of misconduct at the less egregious end of the spectrum that fall under potential grooming behaviors. Evidence indicates that less egregious violations that go unreported frequently lead to more egregious ones. Less egregious acts and grooming behaviors are almost always committed in private or after hours where they cannot be witnessed by parties external to the physician-patient encounter and therefore go unreported. Early reporting is therefore one of the only ways in which sexual misconduct with patients can be prevented from impacting more patients.

The ethical duty to report has proven insufficient in recent years, however, to provide the information state medical boards must have to stop or prevent licensees from engaging in sexual misconduct. There are likely several factors that inhibit reporting, including the corporatization of medical practice, which has led many institutions to deal with instances of misconduct internally. While corporatization increases accountability for many physicians and internal processes may be effective in addressing some types of sexual misconduct, it can also cause some institutions to neglect required reporting and the need for transparency. Physicians may also avoid reporting because of the moral distress and discomfort some physicians feel when asked to report their colleagues, and the impracticality of reporting where power dynamics exist and where stakes are high for reporters.

Thus, rather than relying on professional or ethical duties alone, alternative strategies and approaches should be considered. State medical boards should have the ability to levy fines against institutions for failing to report instances of egregious conduct. While many boards already have statutory ability to do so, they are reluctant to engage in legal proceedings with hospitals or other institutions with far greater resources at their disposal. An ability to publicize reasons for levying fines may also be helpful as the reputational risk to an institution could provide added incentives to report.

[10] Federation of State Medical Boards, *Position Statement on Duty to Report*, 2016.

Results of hospital and health system peer review processes should also be shared with state medical boards when sexual misconduct is involved. This type of conduct is fundamentally different from other types of peer review data related to performance and aimed at quality improvement and, while still relevant to medical practice, should be subject to different rules regarding reporting. Hospitals should also be required to report to state medical boards instances where employed physicians have been dismissed or are forced to resign due to concerns related to sexual misconduct.

Boards should have the authority to impose disciplinary action on licensees for failure to report. Where such authority does not currently exist, legislative change may be sought.[11] Language used in state laws describing when reporting is mandatory varies and can include "actual knowledge" of an event, "reasonable cause" to believe that an event occurred, "reasonable belief," "first-hand knowledge," and "reasonable probability" (as distinguished from "mere probability").[12] Despite the variance in language, the theme of reasonability runs throughout. If it is reasonable to believe that misconduct occurred, this should be reported to the state medical board and, in most instances, to law enforcement.

Reporting to Law Enforcement

There is variability in state laws that address when state medical boards are required to report instances of sexual misconduct to law enforcement. Despite this variability, best practices dictate that boards have a duty to report to law enforcement anytime they become aware of sexual misconduct or instances of criminal behavior. When reporting requirements are unclear, consultation with a board attorney is recommended, but boards are encouraged to err on the side of reporting. Protocols and consensus can also be established in collaboration with law enforcement to help clarify reporting requirements. This can also help to clarify circumstances where law enforcement should report instances of physician sexual misconduct to state medical boards.

In limited circumstances, boards may choose not to report to law enforcement. These may involve less egregious forms of sexual misconduct such as inappropriate speech or include circumstances where a complainant requests that law enforcement not be notified, as long as there is no law establishing a mandatory reporting requirement. Wishes of complainants should be respected in such circumstances, as victims may be at different stages of coming to terms with the trauma they've experienced. However, reporting to law enforcement must occur for any instance of child abuse, abuse of a minor, and abuse of a dependent adult, regardless of whether the complainant wants reporting to occur. In any instance where reporting sexual misconduct to law enforcement is considered, especially in instances where a decision is made *not* to report, a clear rationale for the board's decision should be documented. Boards can also facilitate the reporting process for patients by offering assistance or educational resources about the reporting process and relevant contact information.

[11] See, e.g., N.C. Gen. Stat. § 90-5.4

[12] Starr, Kristopher T Reporting a Physician Colleague for Unsafe Practice: What's the Law? *Nursing2019*: February 2016 - Volume 46 - Issue 2 - p 14

Cultivating Professionalism

Empowering physicians and physicians in training to report violations of professional standards is essential given the barriers posed by the hierarchical structure of most health care institutions.[13] Those in a position to observe and report sexual misconduct should be protected from retaliation and adverse consequences for medical school matriculation, training positions, careers or promotions. Cultivating positive behavior through role modelling and establishing clear guidance based on the values of the profession is the responsibility of multiple parties, not the state medical board alone. A broader notion of professionalism should be adopted that goes beyond expectations for acceptable conduct to include a duty to identify instances of risk or harm to patients, thereby making non-reporting professionally unacceptable. Physicians who fail to report known instances of sexual misconduct should be liable for sanction by their state medical board for the breach of their professional duty to report.

Unscrupulous, frivolous or vexatious reporting motivated by competition or personal animus is counterproductive to fulfilling this notion of professionalism and protecting the public, so should be met with disciplinary action. Processes for reporting and complaints should be normalized by making them a core component of medical professionalism, rather than a burdensome responsibility that befalls particular unfortunate individuals. This may help physicians feel less like investigators and more like responsible stewards of professional values. Those physicians and other individuals who do report in good faith should be protected from retaliation through whistleblower legislation and given the option to remain anonymous.

Section 6: Investigations

State Medical Board Authority

It is imperative that state medical boards have sufficient statutory authority to investigate complaints and any reported allegations of sexual misconduct. State medical boards should place a high priority on the investigation of complaints of sexual misconduct due to patient vulnerability unique to such cases. The purpose of the investigation is to determine whether the report can be substantiated in order to collect sufficient facts and information for the board to make an informed decision as to how to proceed. If the state medical board's investigation indicates a reasonable probability that the physician has engaged in sexual misconduct, the state medical board should exercise its authority to intervene and take appropriate action to ensure the protection of the patient and the public at large.

Each complaint should be investigated and judged on its own merits. Where permitted by state law, the investigation should include a review of previous complaints to identify any such patterns of behavior, including malpractice claims and settlements. In the event that such patterns are identified early in the investigation, or the physician has been the subject of sufficient previous complaints to suggest a high likelihood that the physician presents a risk to future

[13] Dubois J. et al. Preventing Egregious Ethical Violations in Medical Practice, Evidence-Informed Recommendations from a Multidisciplinary Working Group. *Journal of Medical Regulation* 2018, Vol.104(4), 23-31.

patients, or in the event of evidence supporting a single egregious misconduct event, the state medical board should have the authority to impose terms or limitations, including suspension, on the physician's license prior to the completion of the investigation.

The investigation of all complaints involving sexual misconduct should include interviews with the physician, complainant(s) and/or patient and/or patient surrogate. The investigation may include an interview with a current or subsequent treating practitioner of the patient and/or patient surrogate; colleagues, staff and other persons at the physician's office or worksite; and persons that the patient may have told of the misconduct. Physical evidence and police reports can also be valuable in providing a more complete understanding of events.

In many states, a complaint may not be filed against a physician for an activity that occurred beyond a certain time threshold in the past. There is a growing trend among state legislatures in recent years to extend or remove the statute of limitations in cases of rape, sexual assault and other forms of sexual misconduct. Given the impact that trauma can have on a victim of sexual misconduct, the length of time that it may take to understand that a violation has occurred, to come to terms with it, or be willing to relive the circumstances as part of the complaints process, the members of the Workgroup feel that no limit should be placed on the amount of time that can elapse between when an act of misconduct occurred and when a complaint can be filed.

Trauma-Informed Investigations

Because of the delicate nature of complaints of sexual misconduct and the potential trauma associated with it, state medical boards should have special procedures in place for interviewing and interacting with such complainants and adjudicating their cases. In cases involving trauma, emotions may not appear to match the circumstances of the complaint, seemingly salient details may be unreported or unknown to the complainant, and the description of events may not be recounted in linear fashion. Symptoms of trauma may therefore be falsely interpreted as signs of deception by board investigators or those adjudicating cases.

Professionals who are appropriately trained and certified in the area of sexual misconduct and victim trauma should conduct the state medical board's investigation and subsequent intervention whenever possible. Best practices in this area suggest that board members and staff should undergo specialized training in victim trauma. It is further recommended that all board staff who work with complainants in cases involving sexual misconduct undergo this training to develop an understanding of how complainants' accounts in cases involving trauma can differ from other types of cases. This can inform reasonable expectations on behalf of those investigating and adjudicating these cases and help eliminate biases. The FSMB and state medical boards should work to identify and ensure the availability of high-quality training in trauma and a trauma-informed approach to investigations. While a greater understanding of victim trauma is a priority, additional training in implicit bias related to gender, gender identity, race, and ethnicity would also help ensure fair and comfortable processes for victims.

Where state medical boards have access to investigators of different genders, boards should seek the complainant's preference regarding the gender of investigators and assign them accordingly. State medical boards should also allow inclusion of patient advocates in the interview process

and treat potential victims (survivors) with empathy, humanity, and in a manner that encourages healing. Questioning of both complainants and physicians should take the form of an information-gathering activity, not an aggressive cross-examination.

Section 7: Comprehensive Evaluation

State medical boards regularly use diagnostic evaluations for health professionals who may have a physical or mental impairment. Similarly, the use of diagnostic evaluations when handling a complaint regarding sexual misconduct provides significant information that may not otherwise be revealed during the initial phase of the investigation. A comprehensive evaluation may be valuable to the board's ability to assess future risk to patient safety.

A comprehensive evaluation is not meant to determine findings of fact. Rather, its purpose is to:

- assess and define the nature and scope of the physician's behavior,
- identify any contributing illness, impairment, or underlying conditions that may have predisposed the physician to engage in sexual misconduct or that might put future patients at risk,
- assist in determining whether a longstanding maladaptive pattern of inappropriate behavior exists, and
- make treatment recommendations if rehabilitative potential is established.

If its investigation reveals a high probability that sexual misconduct has occurred, the state medical board should have the authority to order an evaluation of the physician and the physician must be required to consent to the release to the board all information gathered as a result of the evaluation. The evaluation of the physician follows the investigation/intervention process but precedes a formal hearing.

The evaluation of a physician for sexual misconduct is complex and may require a multidisciplinary approach. Where appropriate, it should also include conclusions about fitness to practice.

Section 8: Hearings

Following investigation and evaluation (if appropriate), the state medical board should determine whether sufficient evidence exists to proceed with formal charges against the physician. In most jurisdictions, initiation of formal charges is public and will result in an administrative hearing unless the matter is settled.

Initiation of Charges

In assessing whether sufficient evidence exists to support a finding that sexual misconduct has occurred, corroboration of a patient's testimony should not be required. Although establishing a pattern of sexual misconduct may be significant, a single case is sufficient to proceed with a

formal hearing. State medical boards should have the authority to amend formal charges to include additional complainants identified prior to the conclusion of the hearing process.

Open vs Closed Hearings

If state medical boards are required, by statute, to conduct all hearings in public, including cases of sexual misconduct, many patients may be hesitant to come forward in a public forum and relate the factual details of what occurred. State medical boards should have the statutory authority to close the hearing during testimony which may reveal the identity of the patient. Where closing a hearing is not possible, great care should be taken to deidentify any personally identifying or sensitive information in transcripts and medical records. The decision to close the hearing, in part or in full, should be at the discretion of the board. Neither the physician nor the witness should control this decision. Boards should allow the patient the option of having support persons available during both open and closed hearings.

Patient Confidentiality

Complaints regarding sexual misconduct are highly sensitive. Therefore, enhanced attention must be given to protecting a patient's identity, including during board discussion, so that patients are not discouraged from coming forward with legitimate complaints against physicians. State medical boards should have statutory authority to ensure nondisclosure of the patient's identity to the public. This authority should include the ability to delete from final public orders any patient identifiable information.

Testimony

Sexual misconduct cases involve complex issues; therefore, state medical boards may consider the use of one or more expert witnesses to fully develop the issues in question and to define professional standards of care for the record. Additionally, the evaluating/treating physician or mental health care practitioners providing assessment and/or treatment to the respondent physician may be called as witnesses. The evaluating clinician may provide details of treatment, diagnosis and prognosis, especially the level of insight and change by the practitioner. Also, a current or subsequent treating practitioner of the patient, especially a mental health provider, may be called as a witness. All these witnesses may provide insight into factors that led to the alleged sexual misconduct, an opinion regarding the level of harm incurred by the patient, and describe the physician's rehabilitative potential and risk for recidivism.

Implicit Bias

In any case that comes before a state medical board, it is important for those responsible for adjudicating the case to be mindful of any personal bias that may impact their review and adjudication. Bias can be particularly strong where board members themselves have been victims of sexual assault or have been subject to previous accusations regarding sexual misconduct. Bias may even influence the decisions of state medical board members by virtue of their being

physicians themselves. Training about implicit bias is recommended for board members and staff in order to help identify implicit bias and mitigate the impact it may have on their work.[14]

Diverse representation on state medical boards in terms of gender, age, and ethnicity is important for ensuring balanced discussion and decisions. The inclusion of public members on state medical boards can also contribute to the reduction of bias in adjudication, while also amplifying the patient perspective through commitment to the priorities and interests of the public.[15] In order to ensure effective and meaningful participation from public members, appropriate orientation and education about their role should occur.

Section 9: Discipline

State medical boards have a broad range of disciplinary responses available to them that are designed to protect the public. Upon a finding of sexual misconduct, the board should take appropriate action and impose one or more sanctions reflecting the severity of the conduct and potential risk to patients. Essential elements of any board action include a list of mitigating and aggravating factors, an explanation of the violation in plain language, clear and understandable terms of the sanction, and an explanation of the consequences associated with non-compliance.

Findings of even a single case of sexual misconduct are often sufficiently egregious as to warrant revocation of a physician's medical license. Certain serious forms of unprofessional conduct should presumptively provide the basis for revocation of a license in order to protect the public. Misconduct in this class would include sexual assault, conduct amounting to crimes related to sex, regardless of whether charged or convicted, or egregious acts of a sexual nature. State medical boards should also consider revocation in instances where a physician has repeatedly committed lesser acts, especially following remedial efforts.

In a limited set of instances, state medical boards may find that mitigating circumstances do exist and, therefore, stay the revocation and institute terms and conditions of probation or other practice limitations. If a physician is permitted to remain in practice and gender- or age-based restrictions are used by state medical boards, consideration may also be given to coupling these restrictions with additional regulatory interventions such as education, monitoring or other forms of probation.

In determining an appropriate disciplinary response, the board should consider the factors listed in **Table 1**.

[14] Project Implicit, accessed November 13, 2019 at https://implicit harvard edu/implicit/
[15] Johnson DA, Arnhart KL, Chaudhry HJ, Johnson DH, McMahon GT, The Role and Value of Public Members in Health Care Regulatory Governance *Acad Med*, Vol. 94, No. 2 / February 2019

Table 1: Considerations in determining appropriate disciplinary response	
• Patient Harm[16] • Severity of impropriety or inappropriate behavior • Context within which impropriety occurred • Culpability of licensee • Psychotherapeutic relationship • Existence of a physician-patient relationship • Scope and depth of the physician-patient relationship • Inappropriate termination of physician-patient relationship	• Age and competence of patient • Vulnerability of patient • Number of times behavior occurred • Number of patients involved • Period of time relationship existed • Evaluation/assessment results • Prior professional misconduct/disciplinary history/malpractice • Recommendations of assessing/treating professional(s) and/or state physician health program • Risk of reoffending

Boards should not routinely consider romantic involvement, patient initiation or patient consent to be a legal defense. Sexual misconduct may still occur following the termination of a physician-patient relationship, especially in long-standing relationships or ones that involve a high degree of emotional dependence. Time elapsed between termination of the relationship is insufficient in many contexts to determine that sexual contact is permissible. Other factors that should be considered in assessing the permissibility of consensual sexual contact between consenting adults following the termination of a physician-patient relationship can include documentation of formal termination; transfer of the patient's care to another health care provider; the length of time of the professional relationship; the extent to which the patient has confided personal or private information to the physician; the nature of the patient's health problem; and the degree of emotional dependence and vulnerability.[17] Termination of a physician-patient relationship for the purposes of allowing sexual contact to occur is unacceptable and would still constitute sexual misconduct because of the trust, inherent power imbalance between a physician and patient, and patient vulnerability that exist leading up to, during and following the decision to terminate the relationship. Any consent to sexual or

[16] Broadly understood as inclusive of physical and emotional harm, resulting distrust in the medical system and avoidance of future medical treatment, and other related effects of trauma.
[17] Washington Medical Commission, *Guideline on Sexual Misconduct and Abuse*, 2017.

romantic activity provided by a patient within the context of a physician-patient relationship or immediately after its termination should be considered invalid.

Society's values and beliefs evolve, and some individuals may be slower to abandon long-held beliefs, even where these may be sexist or prejudiced in other ways. However, adherence to an outdated set of generational values that has since been found to be unacceptable is not a reason to overlook or excuse sexual misconduct.

The potential existence of a physician workforce shortage or maldistribution, or arguments related to particular restrictions being tantamount to taking a physician "out of work" should also not be used as reasons for leniency or for allowing patients to remain in harm's way. In cases involving sexual misconduct, it is simply not true that unsafe or high-risk care is better than no care at all. A single instance, let alone many instances, can cause an extremely high degree of damage to individuals and the communities in which they reside. However, staying true to the principle of proportionality also means considering the fact that some forms of discipline, including public notifications, generate significant shame upon the disciplined physician. This can compound the degree of severity of a disciplinary action and may be taken into consideration by state medical boards where less egregious forms of sexual impropriety are involved.

Temporary or Interim Measures:

In the event that a state medical board decides to remove a licensee from practice or limit the practice of a licensee as a temporary measure in order to reduce the risk of patient harm while an investigation takes place, there are several different interim measures that can be used. Common measures include an interim or summary suspension/cessation of practice, restrictions from seeing patients of a certain age or gender, restrictions from seeing patients altogether, or the mandatory use of a practice monitor (to be understood as distinct from a chaperone, as explained below) for all patient encounters.

The appropriateness of age and gender-based interim restrictions should be considered carefully before being imposed by state medical boards. Sexual misconduct often occurs for reasons related to power, rather than because of a sexual attraction to a particular gender or age group, thereby making these restrictions ineffective to protect patients in many cases.

Remediation

As discussed above, many forms of sexual misconduct and harmful actions that run against the core values of medicine should appropriately result in revocation of licensure. However, there may be some less egregious forms of sexual impropriety with mitigating circumstances for which a physician may be provided the option of participating in a program of remediation to be able to re-enter practice or have license limitations lifted following a review and elapse of an appropriate period of time.

The decision to allow a physician who has committed an act of sexual misconduct the opportunity to undergo a program of remediation with an end goal of potential license reinstatement is difficult for boards to make. Boards are therefore encouraged to draw from the

professional resources that already exist in making determinations about remediation potential and license reinstatement.

State medical boards should be mindful that not all physicians who have committed sexual misconduct are capable of remediation. Reinstatement and monitoring in such a context would therefore be inappropriate. For those who are considered for remediation, if at any point it becomes clear that the physician presents a risk of reoffending or otherwise harming patients, the remediation process should be abandoned, and reinstatement should not occur.

In determining whether remediation is feasible for a particular physician, state medical boards may wish to make use of a risk stratification methodology that considers the severity of actions committed, the mitigating and aggravating factors listed in section 9 above (Discipline), the character of the physician, including insight and remorse demonstrated, as well as an understanding of how their actions violated standards of professional ethics and state medical practice acts, and the perceived likelihood that they may reoffend. The consequences to patients and the general public of allowing a physician to engage in remediation and re-enter practice after a finding of sexual misconduct should be considered, including any erosion of the public trust in the medical profession and the role of state medical boards.

The goals of the remediation process should be clearly outlined, including expectations for acceptable performance on the part of the physician. The process of remediation should take place in-person (online or other forms of distance learning would not be sufficient), require full disclosure of and relate to the physician's offense(s) and be targeted to identified gaps in understanding of their particular vulnerabilities and other risks for committing sexual misconduct. As a condition of successful completion of a program of remediation, participants should be required to articulate not only *why* their actions were wrong, but also *how* they arrived at the point at which they were willing to commit them, and *how* they will guard against arriving at such a point again. For this to occur, assessment and remediation partners must be provided access to investigative information in order to properly tailor remedial education to the particular context in which the misconduct occurred. Finally, state medical boards should be mindful that remediation cannot typically be said to have "occurred" following successful completion of an educational course. Rather, a longitudinal mechanism must be established for maintaining the physician's engagement in a process of coming to terms with their misconduct and avoiding the circumstances that led to it. The longitudinal mechanism both demonstrates the physician's commitment to accountability and the effectiveness of a board's monitoring reach.

The members of the Workgroup acknowledge that shortcomings exist in the current evidence base regarding the effectiveness of remediation in instances of sexual misconduct. As noted elsewhere in this report, recidivism is exceedingly difficult to study well. Recommendations about the use of consistent terminology and improving the tracking of disciplined physicians will contribute to understanding what kinds of remedial interventions are most appropriate and effective in the context of sexual misconduct. Moreover, the Workgroup feels that further research is needed in several other areas, such as group learning experiences, instruction in victim empathy, remedial instruction with or without additional interventions, and identification of subgroups of offenders who may be at higher risk of reoffending.

License Reinstatement/Removal of License Restriction(s)

In the event of license revocation, suspension, or license restriction, any petition for reinstatement or removal of restriction should include the stipulation that a current assessment, and if recommended, successful completion of treatment, be required prior to the medical board's consideration to assure the physician is competent to practice safely. Such assessment may be obtained from the physician's treating professionals, state physician health program (PHP),[18] or from an approved evaluation team as necessary to provide the board with adequate information upon which to make a sound decision.

Transparency of board actions:

As state medical boards regulate the profession in the interest of the public, it is essential that evolving public values and needs are factored into decisions about what information is made publicly available. It has been made clear in academic publications and popular media, as well as through the #MeToo and TimesUp movements that the public increasingly values transparency regarding disciplinary actions imposed on physicians. It is likely that any action short of a complete revocation of licensure will draw scrutiny from the public and popular media. Such scrutiny can also be expected regarding decisions to reinstate a license or remove restrictions. The public availability of sufficient facts to justify a regulatory decision and link it to a licensee's behavior and the context in which it occurred can help state medical boards to explain and justify their decision.

The ability to disclose particular details of investigative findings and disciplinary actions is limited by state statute in many jurisdictions. State medical boards are encouraged to convey this fact to the public in order to protect the trust that patients have in boards, but also make efforts to achieve legislative change, allowing them to publicize information that is in the public interest. Where disclosure is possible, boards should select means for conveying information that will optimally reach patients. This should include making information available on state medical board websites and reporting to the FSMB Physician Data Center, thereby allowing for disciplinary alerts to be sent to other jurisdictions in which the physician holds a license and making information about disciplinary actions publicly available through FSMB's docinfo.org website, and the National Practitioner Data Bank. The use of private agreements or letters of warning in cases involving sexual misconduct is inappropriate because of the importance of disclosure for public protection and data sharing with other state medical boards or medical regulatory authorities from other jurisdictions.

Boards should also consider additional means of communicating, such as through mobile phone applications,[19] notices in newspapers and other publications. California[20] and Washington[21] both

[18] "A Physician Health Program (PHP) is a confidential resource for physicians, other licensed healthcare professionals, or those in training suffering from addictive, psychiatric, medical, behavioral or other potentially impairing conditions. PHPs coordinate effective detection, evaluation, treatment, and continuing care monitoring of physicians with these conditions." Source: Federation of State Physician Health Programs.
[19] The Medical Board of California has launched a new mobile application allowing patients to receive updates about their physician, including licensure status and practice location.
[20] CA Bus and Prof Code §1007 (2018)
[21] RCW 18.130.063

require that patients be notified of sexual misconduct license stipulations/restrictions at the time of making an appointment and that the patient verify this notification. Other boards have required licensees to obtain signatures from all patients in their care acknowledging their awareness of an adjudication for professional sexual misconduct. Boards may wish to consider whether these could be viable options in their states.

State medical boards are also encouraged to implement clear coding processes for board actions that provide accurate descriptions of cases, and clearly link licensee behaviors to disciplinary actions. Where sexual misconduct has occurred, the case should be labeled as such. A label of "disruptive physician behavior" or even "boundary violation" is less helpful than the more specific label of "sexual misconduct." State medical boards and the FSMB should work together to develop consistent terminology that allows a violation and the underlying causes of discipline to be stated explicitly, thereby promoting greater understanding for the public and the state medical boards, while also enabling the tracking of trends, frequencies, recidivism and the impact of remedial measures.

Where particular actions on the part of the physician may not meet a threshold for disciplinary action, but might nonetheless constitute grooming or other concerning behaviors, state medical boards should consider ways in which to allow previously dismissed cases to be revisited during subsequent cases, such as through non-disciplinary letters of education or concern which remain on a licensee's record. The ability to revisit previous cases involving seemingly minor events can help identify patterns of behavior in a licensee and provide additional insight into whether a licensee poses a risk to future patients.

Section 10: Monitoring

Following a finding of sexual misconduct, if a license is not revoked or suspended, it is essential that a state medical board establish appropriate monitoring of the physician and their continued practice. Monitoring in the context of sexual misconduct occurs differently from monitoring substance use disorders and the resources available to boards differ from state to state. Many PHPs do not offer monitoring services for physicians who have faced disciplinary action because of sexual misconduct and even where such monitoring by a PHP is possible, it is typically only part of a way forward, rather than a solution on its own.[22]

For the purposes of this report, the members of the Workgroup understand the use of a *chaperone* as an informal arrangement of impartial observation, typically initiated by physicians themselves. A chaperone in this context is meant to protect the doctor in the event of a complaint, although their presence may also offer comfort to the patient.[23] The patient may request that the chaperone not be present for any portion of the clinical encounter. The American College of Obstetricians and Gynecologists (ACOG) has recently recommended that a chaperone be present for all breast, genital, and rectal examinations because of the profoundly negative

[22] Federation of State Physician Health Program Statement on Sexual Misconduct in the Medical Profession, May 2019.

[23] Paterson, R. Independent review of the use of chaperones to protect patients in Australia, Commissioned by the Medical Board of Australia and the Australian Health Practitioner Regulation Agency, February 2017.

effect of sexual misconduct on patients and the medical profession and the association between misconduct and the absence of a chaperone.[24]

The Workgroup supports ACOG's recommendation because of the potential added layer of protection that an impartial third party brings, while acknowledging that the use of board-mandated chaperones has been discontinued in some international jurisdictions and by particular state medical boards, because of a belief that they merely provide the illusion of safety and may therefore allow harmful behaviors to go unnoticed. There is risk of this occurring in instances where a chaperone is untrained or uninformed about their role, is an employee or colleague of the physician being monitored or does not adequately attend to their responsibilities. In order to distinguish a chaperone in a less formal arrangement with a physician from one mandated by a state medical board with established reporting requirements and formal training, the Workgroup recommends referring to the latter individual as a "practice monitor."

A *practice monitor* differs from a chaperone. We define a practice monitor as part of a formal monitoring arrangement mandated by a state medical board, required at all patient encounters, or all encounters with patients of a particular gender or age. The practice monitor's primary responsibility is to the state medical board and their presence in the clinical encounter is meant to provide protection to the patient through observation and reporting. Costs associated with employing a practice monitor are typically borne by the monitored physician, but practices may vary across states. The patient must be informed that the practice monitor's presence is required as part of a practice restriction. As the practice monitor is mandated for all clinical encounters, the patient may not request that the practice monitor not be present for any portion of the encounter. If a patient is uncomfortable with the presence of a practice monitor, they will need to seek care from a different physician. Patient supports (parents, family members, friends) may be present during examinations but do not replace, nor can they be used in lieu of a board mandated practice monitor.

While even this formal arrangement with a clearly defined role, training and direct reporting may have limitations, the practice monitor may be a useful option for boards in certain specific circumstances. In particular, in instances where there is insufficient evidence to remove a physician from practice altogether, but significant risk is believed to be present, the opportunity to mandate practice monitoring provides boards with an additional option, short of allowing a potentially risky physician to return to independent practice. As such, when practice monitors are implemented judiciously, the Workgroup believes that their use can enhance patient safety and should therefore be considered by state medical boards.

Practice monitors should only be used if the following conditions have been met:

- The practice monitor has undergone formal training about their role, including their primary responsibility and direct reporting relationship to the state medical board (as opposed to the physician being monitored).

[24] Sexual misconduct. ACOG Committee Opinion No. 796. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2020;135:e43–50.

- It is highly recommended that all practice monitors have clinical backgrounds. If they do not, their training must include sufficient content about clinical encounters so they can be knowledgeable about what is and is not appropriate as part of the monitored physician's clinical encounters with patients.
- The practice monitor should be approved by the state medical board and cannot be an employee or colleague of the monitored physician that may introduce bias or otherwise influence their abilities to serve as a practice monitor and report to the board or intervene when necessary. Pre-existing contacts of any sort are discouraged, but where a previously unknown contact is not available, the existing relationship should be disclosed. In some states, practice monitors are required to be active licensees of another health profession as it is felt that this reinforces their professional duty to report. When health professionals serve as practice monitors, they should not have any past disciplinary history.
- The practice monitor has been trained in safe and appropriate ways of intervening during a clinical encounter at any point where there is confidence of inappropriate behavior on the part of the physician, the terms of the monitoring agreement are not being followed, or a patient has been put at risk of harm.
- The practice monitor submits regular reports to the state medical board regarding the monitored physician's compliance with monitoring requirements and any additional stipulations made in a board order.
- Where possible, state medical boards should consider establishing a panel of different practice monitors that will rotate periodically among monitored physicians to ensure monitor availability and that a collegial relationship does not develop between a practice monitor and a monitored physician, unduly influencing the nature of the monitoring relationship.

Monitoring should be individualized and based on the findings of the multidisciplinary evaluation, and, as appropriate, subsequent treatment recommendations. If a diagnosis of contributory mental/emotional illness, addiction, or sexual disorder has been established, the monitoring of that physician should be the same as for any other mental impairment and state medical boards are encouraged to work closely with their state physician health program as a resource and support in monitoring. Conditions, which may also be used for other violations of the medical practice act, may be imposed upon the physician. Examples are listed in **Table 2**.

Table 2: Possible Conditions of Practice Following a Finding of Sexual Misconduct
• Supervision of the physician in the workplace by a supervisory physician • Requirement that practice monitors are always in attendance and sign the medical record attesting to their attendance during examination or other patient interactions as appropriate.[25] • Periodic on-site review by board investigator or physician health program staff if indicated. • Practice limitations as may be recommended by evaluator(s) and/or the state physicians health program. • Regular interviews with the board and/or state physician health program as required to assess status of probation. • Regular reports from a qualified and approved licensed practitioner, approved in advance by the board, conducting any recommended counseling or treatment. • Completion of a program in maintaining appropriate professional boundaries, which shall be approved in advance of registration by the board.

Section 11: Education

Education and training about professional boundaries in general and physician sexual misconduct in particular should be provided during medical school and residency, as well as throughout practice as part of a physician's efforts to remain current in their knowledge of professional expectations.

State Medical Board Members and Staff

State medical boards and the FSMB should take a proactive stance to educate physicians, board members and board staff about sexual misconduct and the effects of trauma. Members of state medical boards and those responsible for adjudicating cases involving sexual misconduct can also experience trauma. Education for dealing appropriately with traumatic elements of cases and finding appropriate help and resources would also be valuable for board members.

[25] Where a practice monitor does not have authority to make entries in a medical record, alternatives such as handwriting and scanning the attestation should be considered.

Medical Education and Training

Education and training should include information about professionalism and the core values of medicine; the nature of the physician-patient relationship, including the inherent power imbalance and the foundational role of trust; acceptable behavior in clinical encounters; and methods of reporting instances of sexual misconduct. For both medical schools and residency programs, this education and training should also include tracking assessment across the curriculum, identification of deficiencies in groups and individuals, remediation, and reassessment for correction, appropriate self-care, and the potential for developing psychiatric illness or addictive behaviors. Early identification of risk for sexual misconduct and unprofessionalism is central to public protection and maintaining public trust.

Physicians

For practicing physicians, because of lack of education or awareness, physicians may encounter situations in which they have unknowingly violated the medical practice act through boundary transgressions and violations. A reduction in the frequency of physician sexual misconduct may be achieved through education of physicians and the health care team. Engagement in accredited continuing medical education that addresses professionalism, appropriate and acceptable behavior, and methods for reporting sexual misconduct should be encouraged among physician licensees and other members of the healthcare team.

Resources should also be made available to physicians to help them develop better insight into their own behavior and its impact on others. These could include multi-source feedback and 360-degree assessments, and self-inventories with follow-up education based on the results. As with apology legislation, the use of these resources and the results from self-assessment or other forms of assistance should not be used against physicians. Such resources would likely be used more broadly if they came from specialty and professional societies, rather than from state medical boards alone.

Cooperation and Collaboration

State medical boards should develop cooperative relationships with state physician health programs, state medical associations, hospital medical staffs, other organized physician groups, and medical schools and training programs to provide physicians and medical students with educational information that promotes awareness of physician sexual misconduct. This information should include a definition of physician sexual misconduct, what constitutes appropriate physician-patient boundaries, how to identify and avoid common “grooming” behaviors such as adjusting appointment timing to facilitate time alone with a particular patient, contacting patients outside of clinical hours, or divulging personal information to a patient, and the potential consequences to both the patient and the physician when professional boundaries are not maintained. Physicians should be educated regarding the degree of harm patients experience as a result of sexual misconduct.

Patients

Education for patients is also essential so that they may be better informed about what to expect during a clinical encounter, what would constitute inappropriate behavior, and how to file a complaint with their state medical board. Information about boundary issues, including physician sexual misconduct, should be published in medical board newsletters and pamphlets. Media contacts should be developed to provide information to the public. Efforts should also be made by state medical boards and the FSMB to better educate the public about the existence and role of state medical boards.

Section 12: Summary of Recommendations

The goal of this report is to provide state medical boards with best practice recommendations for effectively addressing and preventing sexual misconduct with patients, surrogates and others by physicians, while highlighting key issues and existing approaches.

The recommendations in this section include specific requests of individual entities, as well as general ones that apply to multiple parties, including state medical boards, the FSMB and other relevant stakeholders. The Workgroup felt strongly that effectively addressing physician sexual misconduct requires widespread cultural and systemic changes that can only be accomplished through shared efforts across the medical education and practice continuum.

Culture:

1. Across the continuum from medical education to practice, continue to eliminate harassment and build culture that is supportive of professional behavior and does not tolerate harassment of any type.

Transparency:

2. State medical boards should ensure that sufficient information is publicly available (without breaching the privacy of complaints) to justify regulatory decisions and provide sufficient rationale to support them.

3. State medical boards should implement clear coding processes for board actions that provide accurate descriptions of behaviors underlying board disciplinary actions and clearly link licensee behaviors to disciplinary actions.

4. State medical boards and the FSMB should work together to develop consistent terminology for use in board actions that allows greater understanding for the public and the state medical boards, while also enabling the tracking of trends, frequencies, recidivism and the impact of remedial measures. These should support research and the early identification of risk to patients.

5. The means of conveying information to the public about medical regulatory processes, including professional expectations, reporting and complaints processes, and available resources should be carefully examined to ensure maximal reach and impact. Multiple communication modalities should be considered.

Complaints:

6. State medical boards are encouraged to provide easily accessible information, education and clear guidance about how to file a complaint to the state medical board, and why complaints are necessary for supporting effective regulation and safe patient care. The FSMB and its partner organizations representing medical specialties whose members perform intimate examinations and procedures should provide education to patients about the types of behavior that can be expected of physicians, what types of behavior might warrant a complaint, what to do in the event that actions on the part of a physician make a patient uncomfortable, and circumstances that would warrant a report to law enforcement.

7. State medical boards and board investigators of administrative complaints are encouraged to communicate frequently with complainants throughout the complaint and investigative process, according to the preferred mode and frequency of communication of the complainant.

8. Complaints related to sexual misconduct should be addressed as quickly as possible given their traumatic nature and to protect potential future victims.

9. State medical boards should have a specially trained patient liaison or navigator on staff who is capable of providing one-on-one support to complainants and their families.

Reporting:

10. Institutions should be required by statute to report instances of egregious conduct to state medical boards and be subject to fines levied by the state medical board, another appropriate regulatory agency or the state attorney general for failing to report.

11. Results of hospital and health system peer review processes should be shared with state medical boards when sexual misconduct is involved.

12. Hospitals should be required to report to state medical boards instances where employed physicians have been dismissed or are forced to resign due to concerns related to sexual misconduct.

13. Physicians who fail to report known instances of sexual misconduct should be liable for sanction by their state medical board for the breach of their professional duty to report.

14. Unscrupulous, frivolous or vexatious reporting motivated by competition should be met with disciplinary action.

15. Physicians and other individuals who report in good faith should be protected from retaliation and given the option to remain anonymous.

Investigations:

16. If the state medical board's investigation indicates a reasonable probability that the physician has engaged in sexual misconduct, the state medical board should exercise its authority to intervene and take appropriate action to ensure the protection of the patient and the public at large.

17. Where permitted by state law, investigations should include a review of previous complaints to identify any patterns of behavior, including malpractice claims and settlements.

18. State medical boards should have the authority to impose interim terms or limitations, including suspension, on a physician's license prior to the completion of an investigation.

19. Limits should not be placed on the length of time that can elapse between when an act of alleged physician sexual misconduct occurred and when a complaint can be filed.

20. Investigators should use trauma-informed procedures when interviewing and interacting with complainants alleging instances of sexual misconduct and adjudicating these cases.

21. State medical board members involved in sexual misconduct cases (either in investigation or adjudication) and all board staff who work with complainants in cases involving sexual misconduct should undergo training in the area of sexual misconduct, victim trauma, and implicit bias.

22. Where possible, boards should seek the complainant's preference regarding the gender of investigators and assign them accordingly.

23. State medical boards should also allow inclusion of patient advocates in the interview process.

24. The FSMB and state medical boards should work to identify and ensure the availability of high-quality training in sexual trauma and a trauma-informed approach to investigations.

Comprehensive Evaluation:

25. State medical boards should have the authority to order a comprehensive evaluation of physicians where investigation reveals a high probability that sexual misconduct has occurred.

Hearings:

26. State medical boards should have statutory authority to ensure nondisclosure of the patient's identity to the public, including by closing hearings in part or in full, and deleting any identifiable patient information from final public orders. Patient identity must also be protected during board discussion.

Discipline:

27. Certain serious forms of unprofessional conduct should presumptively provide the basis for revocation of a license in order to protect the public. Misconduct in this class would include sexual assault, conduct amounting to crimes related to sex, regardless of whether charged or convicted, or egregious acts of a sexual nature. State medical boards should also consider revocation in instances where a physician has repeatedly committed lesser acts, especially following remedial efforts.

28. Gender and age-based restrictions should only be used by boards where there is a high degree of confidence that the physician is not at risk of reoffending.

29. Practice monitors should only be used as a means of protecting patients if the conditions outlined in this report have been met, including appropriate training, reporting relationship to the state medical board and lack of pre-existing relationship with the monitored physician.

30. When considering remedial action after sexual misconduct, state medical boards should employ a risk stratification model that also factors in risk of erosion of public trust in the medical profession and medical regulation.

31. As part of remedial efforts, any partners in the assessment and remediation of physicians should be provided access to investigative information in order to properly tailor remedial education to the context in which the sexual misconduct occurred.

32. Following remedial activities, state medical boards should monitor physicians to ensure that they avoid being in circumstances similar to those in which they engaged in sexual misconduct.

33. State medical boards should consider ways in which to allow pertinent information from previously dismissed cases to be revisited during subsequent cases, such as through non-disciplinary letters of concern or education which remain on a licensee's record.

Education:

34. Education and training about professional boundaries and physician sexual misconduct should be provided during medical school and residency, as well as throughout practice as part of a physician's efforts to remain current in their knowledge of professional expectations. This should include education about how to proceed with basic as well as sensitive/intimate exams and the communication with the patients that is required as a component of these exams. This education should be informed by members of the public, as best possible.

35. State medical boards and the FSMB should provide education to physicians, board members and board staff about sexual misconduct and the effects of trauma. This should include resources to help physicians develop better insight into their own behavior and its impacts on others. Resources and materials should be developed in collaboration with state physician health programs, state medical associations, hospital medical staffs, other organized physician groups, and medical schools and training programs.

36. As stated in Recommendation #6 regarding complaints, state medical boards are encouraged to provide easily accessible information, education and clear guidance about how to file a complaint to the state medical board, and why complaints are necessary for supporting effective regulation and safe patient care. The FSMB and its partner organizations representing medical specialties whose members perform intimate examinations and procedures should provide education to patients about the types of behavior that can be expected of physicians, what types of behavior might warrant a complaint, what to do in the event that actions on the part of a physician make a patient uncomfortable, and circumstances that would warrant a report to law enforcement.

37. The FSMB, state medical boards, medical schools, residency programs, and medical specialty and professional societies should provide renewed education on professionalism and the promotion of professional culture. A coordinated approach facilitated by ongoing communication is recommended to ensure consistency of educational messaging and content.

38. The FSMB should facilitate the adoption and operationalization of the recommendations in this report by providing state medical boards with an abridged version of the report which highlights key points and associates them with resources, model legislation, and educational offerings.

Appendix A: Sample Resources

The following is a sample list of resources available to support greater understanding of sexual misconduct, sexual boundaries, the impacts of trauma, and implicit bias. The FSMB has not conducted an in-depth evaluation of individual resources, and inclusion herein does not indicate, nor is it to be interpreted as, an endorsement or guarantee of quality. Further, while some resources listed below are available free of charge, others are only accessible through purchase.

1. Sexual misconduct, sexual/personal/professional boundaries:
    - AMA: Code of Medical Ethics: Sexual Boundaries
        - Romantic or Sexual Relationships with Patients
        - Romantic or Sexual Relationships with Key Third Parties
        - Sexual Harassment in the Practice of Medicine
    - AMA: CME course: Boundaries for physicians
    - AAOS: Sexual Misconduct in the Physician-Patient Relationship
    - FSMB Directory of Physician Assessment and Remedial Education Programs
    - North Carolina Medical Board: Guidelines for Avoiding Misunderstandings During Patient Encounters and Physical Examinations
    - University of Vermont: Mandatory Reporters and CSAs (Sample Reporting Guidelines)
    - Vanderbilt University Medical Center: Online CME Course: Hazardous Affairs – Maintaining Professional Boundaries
    - Vanderbilt University Medical Center: Boundary Violations Index

2. Trauma-related resources:
    - SAMHSA: Concept of Trauma and Guidance for a Trauma-Informed Approach
    - National Institute for the Clinical Application of Behavioral Medicine: How Trauma Impacts Four Different Types of Memory
    - Frontiers in Psychiatry: Memory distortion for traumatic events: the role of mental imagery
    - Government of Canada, Department of Justice: The Impact of Trauma on Adult Sexual Assault Victims
    - National Institutes of Health: Trauma-Informed Medical Care: A CME Communication Training for Primary Care Providers
    - Western Massachusetts Training Consortium: Trauma Survivors in Medical and Dental Settings
    - American Academy of Pediatrics: Adverse Childhood Experiences and the Lifelong Consequences of Trauma
    - American Academy of Pediatrics: Protecting Physician Wellness: Working With Children Affected by Traumatic Events
    - Public Health Agency of Canada: Handbook on Sensitive Practice for Health Care Practitioners
    - Psychiatric Times: CME: Treating Complex Trauma Survivors
    - NHS Lanarkshire (Scotland): Trauma and the Brain (Video)
    - London Trauma Specialists: Brain Model of PTSD - Psychoeducation Video

3. Implicit bias:
    - AAMC: Online Seminar: The Science of Unconscious Bias and What To Do About it in the Search and Recruitment Process
    - AAMC: Proceedings of the Diversity and Inclusion Innovation Forum: Unconscious Bias in Academic Medicine
    - AAMC: Exploring Unconscious Bias in Academic Medicine (Video)
    - ASME Medical Education: Non-conscious bias in medical decision making: what can be done to reduce it?
    - APHA: Patient Race/Ethnicity and Quality of Patient–Physician Communication During Medical Visits
    - Institute for Healthcare Improvement: Achieving Health Equity: A Guide for Health Care Organizations
    - BMC Medical Education: Training to reduce LGBTQ-related bias among medical, nursing, and dental students and providers: a systematic review
    - American Psychological Association: CE - How does implicit bias by physicians affect patients' health care?
    - Joint Commission: Implicit bias in health care
    - Oregon Medical Board: Cultural Competency – A Practical Guide for Medical Professionals
    - StratisHealth: Implicit Bias in Health Care (Quiz)

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ACOG | Clinical
The American College of Obstetricians and Gynecologists

Sexual Misconduct

Committee Opinion
Number 796
January 2020

Number 796 *(Replaces Committee Opinion No. 373, August 2007)*

Committee on Ethics

This Committee Opinion was developed by the American College of Obstetrician and Gynecologists' Committee on Ethics in collaboration with committee member David I. Shalowitz, MD, MSHP.

ABSTRACT: The practice of obstetrics and gynecology includes interaction in times of intense emotion and vulnerability for patients and involves sensitive physical examinations and medically necessary disclosure of private information about symptoms and experiences. The patient–physician relationship is damaged when there is either confusion regarding professional roles and behavior or clear lack of integrity that allows sexual exploitation and harm. Sexual misconduct by physicians is an abuse of professional power and a violation of patient trust. Although sexual misconduct is uncommon in clinical care, even one episode is unacceptable. Routine use of chaperones, in addition to the other best practices outlined in this Committee Opinion, will help assure patients and the public that obstetrician–gynecologists are maximizing efforts to create a safe environment for all patients.

Recommendations and Conclusions

On the basis of the principles outlined in this Committee Opinion, the American College of Obstetricians

and Gynecologists (ACOG) makes the following recommendations and conclusions:

- Sexual misconduct by an obstetrician–gynecologist is an abuse of power and a violation of patients' trust. Sexual or romantic interaction between an obstetrician–gynecologist and a current patient is always unethical, is grounds for investigation and sanction, and in some cases should be considered for criminal prosecution.

- It is unethical for obstetrician–gynecologists to misuse the trust, knowledge, or influence from a professional relationship in pursuing a sexual or romantic relationship with a former patient.

- Physical examinations should be explained appropriately, undertaken only with the patient's consent, and performed with the minimum amount of physical contact required to obtain data for diagnosis and treatment. Draping should be used to minimize patients' exposure during examinations. Patients should be offered the opportunity to ask questions or raise concerns about any element of the examination.

- It is recommended that a chaperone be present for all breast, genital, and rectal examinations. The need for a chaperone is irrespective of the sex or gender of the person performing the examination and applies to examinations performed in the outpatient and inpatient settings, including labor and delivery, as well as during diagnostic studies such as transvaginal ultrasonography and urodynamic testing.

- Obstetrician–gynecologists are obligated ethically and professionally to report sexual misconduct or suspected sexual misconduct by any health care professional to appropriate authorities, such as supervisors, department chairs or other institutional officials, peer review organizations, and professional licensing boards. Law enforcement should be involved in cases of sexual or physical assault.

- Institutions should have clear guidelines that allow clinical staff to report sexual misconduct or suspected sexual misconduct without concern for retaliation. Patients, family members, and loved ones should have the opportunity to express concerns about interactions with clinical staff without fear of adversely affecting clinical care.

- Medical students and trainees in obstetrics and gynecology should be educated about the inherent power imbalance in the patient–physician relationship, avoidance of sexually offensive or denigrating language, risk factors for sexual misconduct, and procedures for reporting suspected misconduct.

Introduction

The practice of obstetrics and gynecology includes interaction in times of intense emotion and vulnerability for patients and involves sensitive physical examinations and medically necessary disclosure of private information about symptoms and experiences. The relationship between obstetrician–gynecologists and their patients therefore requires a high level of trust and professional responsibility. The patient–physician relationship is damaged when there is either confusion regarding professional roles and behavior or clear lack of integrity that allows sexual exploitation and harm. Sexual misconduct by an obstetrician–gynecologist is an abuse of power and a violation of patients' trust **1** .

Although sexual misconduct is uncommon in clinical care, even one episode is unacceptable. The ethical prohibition of sexual misconduct is forceful, and its application in medical practice is essential **2** . This Committee Opinion has been revised to incorporate current data on the prevalence of physician sexual misconduct, to delineate ACOG's expectations for obstetrician–gynecologists' interactions with their patients to ensure that all patients are cared for safely and professionally **2** , and to provide clinical best practice recommendations to support obstetrician–gynecologists' mission to provide the highest quality health care to their patients.

Background

Definition

The Federation of State Medical Boards categorizes the range of behaviors that constitute sexual misconduct into "sexual impropriety" (behavior, gestures, or expressions that are seductive, sexually suggestive, disrespectful of patient privacy, or sexually demeaning to a patient) and "sexual violation" (physical sexual contact between a physician and patient, whether or not initiated or consented to by the patient, and engaging in any conduct with a patient that is sexual or may be reasonably interpreted as sexual) **Box 1** **3** . Examination of the breast or genitals without appropriate consent from a patient or surrogate decision maker qualifies as sexual misconduct under both of these categories. Sexual misconduct may be grounds for disciplinary action, and sexual misconduct that falls under the category of sexual violation also may meet the criteria for criminal prosecution (eg, sexual assault). The U.S. Department of Justice defines s*exual assault* as "any nonconsensual sexual act proscribed by Federal, tribal, or State law, including when the victim lacks capacity to consent" **4** . Sexual assault

encompasses a continuum of sexual activity that ranges from sexual coercion to contact abuse (unwanted kissing, touching, or fondling) to rape [5] [6].

Box 1.

Examples of Physician Sexual Misconduct From the Federation of State Medical Boards

Sexual Impropriety

Sexual impropriety may comprise behavior, gestures, or expressions that are seductive, sexually suggestive, disrespectful of patient privacy, or sexually demeaning to a patient that may include, but are not limited to, the following:

- Neglecting to employ disrobing or draping practices respecting the patient's privacy, or deliberately watching a patient dress or undress
- Performing an intimate examination or consultation without clinical justification or appropriate consent
- Subjecting a patient to an intimate examination in the presence of medical students or other parties without the patient's informed consent or in the event such informed consent has been withdrawn
- Examination or touching of genital mucosal areas without the use of gloves
- Inappropriate comments about or to the patient, including but not limited to, making sexual comments about a patient's body or underclothing, making sexualized or sexually demeaning comments to a patient, criticizing the patient's sexual orientation, making nonclinically relevant comments about potential sexual performance during an examination
- Using the patient–physician relationship to solicit a date or romantic relationship
- Initiation by the physician of conversation regarding the sexual problems, preferences, or fantasies of the physician
- Requesting details of sexual history or sexual likes or dislikes when not clinically indicated for the type of examination or consultation

Sexual Violation

Sexual violation may include physical sexual contact between a physician and patient, whether

or not initiated by the patient, and engaging in any conduct with a patient that is sexual or may be reasonably interpreted as sexual, including but not limited to the following:

- Sexual intercourse, genital-to-genital contact
- Oral-to-genital contact
- Oral-to-anal contact, genital-to-anal contact
- Kissing in a romantic or sexual manner
- Touching breasts, genitals, or any sexualized body part for any purpose other than appropriate examination or treatment, or when the patient has refused or has withdrawn consent
- Encouraging the patient to masturbate in the presence of the physician*
- Masturbation by the physician while the patient is present
- Offering to provide practice-related services, such as drugs, in exchange for sexual favors

*ACOG recognizes the value of physician-guided sexual health counseling in the proper clinical context by an appropriately trained provider.

Modified from Federation of State Medical Boards. Federation of State Medical Boards. Addressing sexual boundaries: guidelines for state medical boards. Adopted as policy by the House of Delegates of the Federation of State Medical Boards. May 2006. Euless (TX): FSMB; 2006. Available at: https://www.fsmb.org/siteassets/advocacy/policies/grpol_sexual-boundaries.pdf.

Scope of the Problem

It is difficult to estimate accurately the incidence of sexual misconduct. Available data rely heavily on patient reporting, and it is estimated that less than 10% of patients subjected to sexual misconduct report their experience [7]. One prominent report by *The Atlanta Journal-Constitution* identified 3,100 individual physicians named in sexual misconduct reports brought to state medical boards between 1999 and 2016. *The Atlanta Journal-Constitution* identified an additional 450 physicians from allegations during 2016 and 2017 [8]. Additionally, between 2003 and 2013, 1,039 physicians had at least one sexual misconduct-related report filed with the National Practitioner Data Bank by hospitals, state medical boards, or other eligible entities [9]. A review of cases brought to the American Medical Association (AMA) Council on Ethical and Judicial Affairs between 2004 and 2008 found that 32 of 298 cases were related to possible sexual misconduct [10]. However, this number may be an underestimate because

related to possible sexual misconduct [10]. However, this number may be an underestimate because sanctions related to sexual misconduct may not be identified as such [11].

Limited data suggest that the greatest number of reported allegations of sexual misconduct involves physicians who practice family medicine, psychiatry, internal medicine, and obstetrics and gynecology [12] [13]. An analysis of 101 cases of sexual abuse of patients by physicians revealed a strong, consistent association with male physician gender (100% of cases), age more than 39 years (92%), lack of board certification (72% of cases involving "nonconsensual sex"), consistent examination of patients without a chaperone (85%), and practice in nonacademic medical settings (94%) [14].

Sexual misconduct by clinicians during labor and delivery may be more prevalent than previously thought. A large survey of U.S. and Canadian obstetric support personnel raised concern that clinicians may at times use sexually degrading language with laboring women or perform genital examinations or procedures without appropriate consent or despite the patient's refusal [15]. Again, although sexual misconduct during obstetric care likely is uncommon, the experience of sexual violation during childbirth may be associated with long-lasting consequences for patients' mental health. Intimate examinations and procedures performed without consent or under circumstances perceived by the patient to be coercive are associated with psychological trauma during childbirth [16] [17]. Likewise, patients may find being physically exposed to more personnel than necessary for their clinical care during childbirth to be a dehumanizing and traumatic experience [16]. Patients who experience childbirth as a traumatic event are at high risk of developing depression and posttraumatic stress disorder in the postpartum period [18]. Although the interpretation and generalizability of these data are limited by the studies' methods, patients' vulnerability to perceived sexual violation during childbirth deserves special consideration, especially given the sometimes intensive and acute nature of intrapartum care.

Ethical and Professional Guidelines

Romantic or Sexual Relationships With Current Patients

Sexual or romantic interaction between an obstetrician–gynecologist and a current patient is always unethical, is grounds for investigation and sanction, and in some cases should be considered for criminal prosecution. Such interactions may exploit patients' vulnerability, compromise physicians' ability to make objective judgments about patients' health care, and ultimately be detrimental to patients' long-term health [19] [20]. Furthermore, an uncomfortable or traumatic experience in a physician's office may become a major barrier to seeking needed health care in the future.

Sexual or romantic behavior by a physician toward a current patient constitutes misconduct regardless of whether a patient appears to initiate or consent to such behavior. Physicians' professional codes of ethics have historically precluded the initiation of romantic or sexual contact with a patient because such a relationship is likely to compromise the physician's objectivity regarding treatment decision making and may exploit a power differential for personal gain **1** **21** . The inherent imbalance of power in the patient–physician relationship makes coercion or its appearance more likely; for example, there may be an explicit or implicit suggestion that continued care is contingent on the patient's willingness to accept sexual contact. Additionally, obstetrician–gynecologists should be aware of the possibility that a patient's apparent desire for a romantic or sexual relationship with a treating physician may be a manifestation of a transference reaction related to gratitude for clinical care **22** **23** . For these reasons, a patient's apparent consent to enter into a romantic or sexual relationship with a treating physician does not make the relationship permissible.

Romantic or Sexual Relationships With Former Patients

Consensual romantic or sexual relationships between physicians and former patients are ethically challenging because of the potential for these relationships to be unduly influenced by the power dynamic accompanying the former patient–physician relationship. The Committee on Ethics agrees with the AMA that it is unethical for obstetrician–gynecologists to misuse the trust, knowledge, or influence from a professional relationship in pursuing a sexual or romantic relationship with a former patient **21** . For example, it would be unethical for an obstetrician–gynecologist to coerce a former patient into a romantic or sexual relationship under the threat of disclosing private information obtained during treatment. Treating a person who is not a current patient, but with whom the obstetrician–gynecologist has a current romantic or sexual relationship, may not be sexual misconduct but instead may violate ethical proscriptions against treating family members **24** .

Obligation to Report Misconduct

In addition to involving harm to the victim, an episode of sexual misconduct may not be isolated and could indicate a history of misconduct toward other patients or a risk of future misconduct. Furthermore, physician misconduct damages public trust in medical professionals. The ACOG Code of Professional Ethics states that "obstetrician–gynecologists should strive to address through the appropriate procedures the status of those physicians who demonstrate questionable competence, impairment, or unethical or illegal behavior. In addition, the obstetrician–gynecologist should cooperate with appropriate authorities to prevent the continuation of such behavior" **1** . Therefore, to protect patients and colleagues, obstetrician–gynecologists are obligated ethically and professionally to report sexual misconduct or suspected sexual misconduct by any health care professional to appropriate authorities, such as supervisors, department chairs or other institutional officials, peer review organizations, and professional licensing boards. Law enforcement should be involved in cases of sexual or physical assault (see the "Definition" section earlier in this document). Additional guidance on reporting unethical behavior by colleagues is available from the AMA and the Federation of State Medical Boards **25** **26** **27** .

Best Practices for Clinical Care

The American College of Obstetricians and Gynecologists is invested in ensuring that the standards for an obstetrician–gynecologist's behavior in a clinical encounter are transparent. In some situations, patients may have experienced sexual misconduct as part of an obstetric or gynecologic encounter but not recognized or reported it as such. Conversely, patients may perceive an interaction as sexual or romantic when in fact there was no such intent on the part of the obstetrician–gynecologist. The following clinical best practices are recommended to decrease the risk of misunderstandings related to the provision of appropriate clinical care and to increase patients' ability to recognize and report inappropriate interactions in the clinical setting.

Maintaining Appropriate Boundaries

Regardless of intent, any clinical or nonclinical contact with a patient that may be perceived as a romantic or sexual overture should be avoided. For example, clinical evaluation of a patient outside of a usual clinical setting may blur the boundaries between professional and non-professional interactions and, therefore, is discouraged; however, exceptions may include emergency care or a medically indicated home visit. Likewise, obstetrician–gynecologists should strictly avoid sexual innuendo, sexually suggestive humor, and sexually provocative remarks in professional settings. Nonclinical communication

suggestive humor, and sexually provocative remarks in professional settings. Nonclinical communication with current patients, including interactions by telephone, e-mail, text-messaging, or social media, should be approached with caution, and professional boundaries should be maintained at all times **28** .

Under some circumstances, limited physical contact between physician and patient (eg, hugging or holding a patient's hand) may be a valuable, therapeutic expression of support. However, obstetrician–gynecologists should be careful to ensure that patients are open to such contact and that its duration is appropriately limited. If inappropriate contact is initiated by a patient, obstetrician–gynecologists should feel empowered to separate themselves from the patient, reinforce professional boundaries, and request assistance if needed.

Physical Examinations

Physical examinations should be explained appropriately, undertaken only with the patient's consent, and performed with the minimum amount of physical contact required to obtain data for diagnosis and treatment. Draping should be used to minimize patients' exposure during examinations. Patients should be offered the opportunity to ask questions or raise concerns about any element of the examination. The Committee on Ethics re-emphasizes that patients capable of decision making must provide consent for all procedures, and that patients have the right to refuse any and all examinations and procedures **29** . Best practices for physical examination also apply to diagnostic tests involving instrumentation of the genital, urinary, or lower gastrointestinal tracts, such as transvaginal ultrasonography or urodynamics.

Photography and Video Recordings

Patients must consent to any photograph or video taken of them, and consent should be documented in the medical record. Photographs of pathology and unclothed or internal anatomy must be de-identified to the extent possible and used only for clinical documentation or academic purposes, including education of colleagues and trainees and publication in peer-reviewed medical literature. Identifiable images should be stored and sent (if necessary) in a secure manner, and images no longer being used for the above purposes should be destroyed securely.

Trauma-Informed Care

For some patients with a history of sexual trauma, even commonly used gestures and language may trigger memories of past physical or sexual abuse and may cause discomfort or fear during a clinical encounter. Because trauma often involves an experience of powerlessness, it is important to refrain from behaviors that a patient may perceive as overpowering or threatening **30** **31** **32** **33** . Common triggers include leaning over a patient during a discussion or pelvic examination, using commands such as "try to relax" before an internal examination, and exposing or touching parts of a patient's body during a physical examination without adequate warning **32** **33** . All obstetrician–gynecologists should become familiar with the principles of trauma-informed care and seek to integrate them into general practice **34** . Issues related to the care of survivors of sexual abuse, intimate partner violence, and reproductive and sexual coercion are detailed in other ACOG documents **35** **36** **37** .

Chaperones

The presence of a third party, or "chaperone," in the examination room can provide reassurance to the patient about the professional context and content of the examination and the intent of the obstetrician–gynecologist. The chaperone also serves as a witness to the events taking place should there be any misunderstanding or concern for misconduct. In the obstetric setting, chaperones may decrease the risk of patient-perceived trauma during childbirth by advocating for patients and serving as a deterrent to potentially inappropriate behavior. The American College of Obstetricians and Gynecologists previously recommended an "opt-in" approach regarding the presence of chaperones, in which a chaperone was required if mandated by a clinical practice's policy or if requested by the patient or obstetrician–gynecologist. Given the profoundly negative effect of sexual misconduct on patients and the medical profession and the association between misconduct and the absence of a chaperone, ACOG now believes that the routine use of chaperones is needed for the protection of patients and obstetrician–gynecologists. Therefore, it is recommended that a chaperone be present for all breast, genital, and rectal examinations. The need for a chaperone is irrespective of the sex or gender of the person performing the examination and applies to examinations performed in the outpatient and inpatient settings, including labor and delivery, as well as during diagnostic studies such as transvaginal ultrasonography and urodynamic testing. Chaperones currently are required by the U.S. Veterans Health Administration health care system, and routine use of chaperones is considered essential by the Royal College of Obstetricians and Gynaecologists **38** **39** .

Exceptions should be made in circumstances in which it is likely that failure to examine the patient would result in significant and imminent harm to the patient, such as during a medical emergency. If a patient declines a chaperone, it should be explained that the chaperone is an integral part of the clinical team whose role includes assisting with the examination and protecting the patient and the physician. Any concerns the patient has regarding the presence of a chaperone should be elicited and addressed if feasible. If, after counseling, the patient refuses the chaperone, this decision should be respected and documented in the medical record. Under such circumstances, obstetrician–gynecologists may defer breast, genital, or rectal examinations for the protection of the patient and the physician. If an unchaperoned examination is performed, the rationale for proceeding should be documented. This approach allows patients to opt out of a chaperoned examination if they feel strongly but does not compel physicians to examine the patient without the protection of a chaperone, except in the case of a medical emergency, as discussed previously.

Chaperones should clearly understand their responsibilities to protect patients' privacy and the confidentiality of health information. Obstetrician–gynecologists also should ensure that an opportunity exists for private conversation with patients so that the presence of a chaperone does not inhibit the communication of information important to the clinical encounter. Although chaperones may deter or discourage sexual misconduct by physicians **14** , sexual misconduct still can occur in their presence. Chaperones should, therefore, be trained in the requirements of best clinical practices as stated previously and empowered to report concerning behavior through a process independent of the health care provider being chaperoned. Family members should not be used as chaperones and should be present for physical examination only if requested by the patient **40** . Use of trainees (eg, medical students or residents) as chaperones generally is discouraged unless they are trained in appropriate clinical practices and empowered to report concerns about the health care provider's behavior during an examination.

Implementation of Routine Chaperoning

The Committee on Ethics recognizes that recommending the routine use of chaperones for obstetric, gynecologic, and diagnostic examinations may require some practices to adjust staffing procedures. There also may be concern about the time and resources needed to implement changes and their potential effect on patient care. Although these concerns merit study, there is robust evidence of the detrimental effects of sexual misconduct on patients' well-being, the patient–physician relationship, and public perception of the medical profession. Therefore, there is a need for obstetrician–gynecologists and clinical practices to institute routine chaperoning as an ethical best practice measure to reduce the risk of sexual misconduct **41** . Steps taken to prioritize patients' safety and comfort likely will improve public trust in obstetric and gynecologic care and may thereby improve patients' willingness to seek care when indicated.

Institutional Responsibilities

Examination areas should protect patients' privacy, and staffing should be adequate to permit routine use of chaperones for physical examination and procedures. Institutions and clinical practices also should consider providing patients with a "what to expect" guide before obstetric or gynecologic appointments so that patients are prepared for their clinical encounters and better able to recognize deviations from proper medical practice. For example, see ACOG's related patient education resource, *Your First Gynecologic Visit* **42** .

Institutions should have clear guidelines that allow clinical staff to report sexual misconduct or suspected sexual misconduct without concern for retaliation. Patients, family members, and loved ones should have the opportunity to express concerns about interactions with clinical staff without fear of adversely affecting clinical care. All such reports should be promptly and thoroughly investigated, and appropriate disciplinary or remedial action, or both, should be taken.

Medical Education

Teaching physicians are expected to be exemplars of appropriate behavior for trainees; likewise, residents and fellows-in-training should model best practices for medical students and other trainees. Relevant elements of the clinical examination should be highlighted specifically when appropriate (eg, draping methods, explanation of examination to patient, use of trauma-sensitive language, appropriate use of chaperones, and solicitation of questions and permission to proceed with an examination). Trainees taking part in patient care should be introduced, and the patient should be given the opportunity to agree to their participation. Breast, genital, and rectal examinations (including examinations under anesthesia) that are for educational purposes only may not be performed without patients' specific informed consent **43** .

Medical students and trainees in obstetrics and gynecology should be educated about the inherent power imbalance in the patient–physician relationship, avoidance of sexually offensive or denigrating language, risk factors for sexual misconduct, and procedures for reporting suspected misconduct **44** **45** **46** **47** . Although education may not eliminate the possibility of misconduct, formalized clinical and didactic training will help to make best clinical practices routine and may assist obstetrician–gynecologists in managing the boundaries between clinical care and inappropriate behavior and in identifying and reporting when these boundaries have been crossed by others.

Conclusion

Sexual misconduct by physicians is an abuse of professional power and a violation of patient trust. Such behavior jeopardizes the well-being of patients and carries immense potential for harm. Obstetrician–gynecologists should implement best clinical practices to ensure that patients are afforded a safe environment for their health care. Routine use of chaperones, in addition to the other best practices outlined in this Committee Opinion, will help assure patients and the public that obstetrician–gynecologists are maximizing efforts to create a safe environment for all patients. Obstetrician–gynecologists are ethically obligated to model responsible clinical practices and to report sexual misconduct or suspected sexual misconduct. Health care institutions, likewise, should provide resources to support best clinical practices and to ensure that patients are protected to the greatest extent possible.

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15-Year Summary of Sexual Misconduct by U.S. Physicians Reported to the National Practitioner Data Bank, 2003 — 2017

In-Depth, Updated Evidence on White Coat Betrayal

Acknowledgments

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Executive Summary

"I will come for the benefit of the sick, remaining free of . . . sexual relations with both female and male persons." — The Hippocratic oath, fourth century B.C.[1]

Background

Sexual relations between physicians and their patients are unequivocally unethical and cause lasting harm for these patient victims. Yet, some physicians cross this bright line: hardly a week goes by without a shocking media story exposing new cases of physicians who sexually abused multiple patients, often over the course of years or even decades.

Due to several factors — including underreporting by victims and bystander health care professionals and the largely secretive, self-regulated nature of the medical profession — very little is known about the full extent and context of this problem in the U.S.

Purposes

Public Citizen's Health Research Group sought to examine quantitative and qualitative data for physicians who have been reported to the National Practitioner Data Bank (NPDB) — a national repository for reports containing information on medical malpractice payments (malpractice payments) and certain adverse actions related to physicians and other health care practitioners — due to sexual misconduct. This analysis updates the results of our 2016 study[2] on this issue and benefits from illuminating nonpublic information that provides a more comprehensive account about the characteristics of physicians with NPDB reports involving sexual misconduct, the forms and details of the sexual misconduct that they inflicted on their victims, the characteristics of these victims, and various other contextual factors that may explain the persistence of this problem in the U.S.

Methodology

We analyzed retrospective data from the NPDB from January 1, 2003, to December 31, 2017, for three types of physician reports in which sexual misconduct was specified as the basis (reason) for disciplinary action or malpractice payment: (1) reports of licensing actions taken by state medical boards (hereafter referred to as "licensing reports"); (2) reports of clinical-privileges actions taken by peer-review committees at hospitals, other health care organizations, or health plans (hereafter referred to as "clinical-privileges reports"); and (3) reports of malpractice payments by malpractice insurers or institutional payers (hereafter referred to as "malpractice-payment reports"). The analysis used a report-level data file that contained the deidentified data for all variables included in the NPDB Public Use Data File and for a number of nonpublic NPDB report-level restricted variables (including physician specialty and gender, month and year

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versions of all report date variables, and narrative descriptions) for those physicians with sexual-misconduct–related reports in our study.

Main Results

A total of 1,354 unique physicians had sexual-misconduct–related reports during our study period. Ninety-three percent of these physicians had only one type of these reports: 76.6% had only licensing reports, 8.4% had only clinical-privileges reports, and 7.7% had only malpractice-payment reports. The remaining 7.3% physicians had more than one type of these reports.

These 1,354 physicians accounted for 0.2% of the U.S. general physician population and 1.1% of all physicians with NPDB reports that met our study criteria. These proportions are much lower than the proportion of physicians who self-reported sexual contact with patients in anonymous surveys.

Ninety percent of the physicians with sexual-misconduct–related reports identified in our study were aged 40 years or older. There were significantly more physicians aged 50 years or older and fewer physicians younger than 40 years with sexual-misconduct–related reports than their respective representations in the U.S. general physician population. Ninety-four percent of the physicians with these reports were men, although male physicians accounted for only 66.9% of the U.S. general physician population ($P < .0001$). Three specialties (family medicine/general practice, psychiatry, and obstetrics and gynecology) collectively accounted for 51.1% of the physicians with sexual-misconduct–related reports and each was significantly over-represented among physicians with these reports relative to their representation in the U.S general physician population.

The mix of victim types (patients or non-patients) reported in the narrative descriptions varied across the three types of physician sexual-misconduct–related reports. Sixty-two percent of the 1,133 physicians with licensing reports for these offenses had only patient victims identified (32.5% had only unspecified victim types). Forty-seven percent of the 163 physicians with clinical-privileges reports for these offenses had only patient victims identified, and 27.0% had only nonpatient-employee victims identified (19.6% had only unspecified victim types). Most (93.2%) of the 161 physicians with malpractice-payment reports for these offenses had only patient victims identified. Although information about victim vulnerability was not consistently reported, 16.9%, 14.1%, and 50.3% of the physicians with sexual-misconduct–related licensing, clinical-privileges, and malpractice-payment reports, respectively, had patient victims who had certain vulnerability factors, such as mental illness or being a minor.

We found that 18.5% and 36.8% of the physicians with sexual-misconduct–related licensing and clinical-privileges reports, respectively, had multiple victims. Additionally, 3.0% and 19.6% of the physicians with sexual-misconduct–related licensing and clinical-privileges reports, respectively, had a history or pattern sexual misconduct. We also found that 17.4% of the physicians with sexual-misconduct–related malpractice-payment reports had multiple victims (as evidenced mostly by having multiple reports involving different victims).

Physical sexual contact or relations was the primary form of sexual misconduct for 41.0% of the physicians with licensing reports, 47.2% of those with clinical-privileges reports, and 60.9% of those with malpractice-payment reports that involved sexual-misconduct–related offenses. Additionally, nonspecific sexual misconduct (including "boundary violation," "sexual act," "sexual harassment," and "trading drugs/prescriptions/treatment for sexual favor") was the

primary form of sexual misconduct for 31.2% of the physicians with licensing reports, 39.9% of those with clinical-privileges reports, and 32.9% of those with malpractice payment reports that involved sexual-misconduct–related offenses. Inappropriate comments or communication was the primary form of sexual misconduct for 1.2%, 4.3%, and 0.6% of the physicians with licensing, clinical-privileges, and malpractice-payments reports that involved sexual-misconduct–related offenses, respectively. Other forms of sexual misconduct, such as "indecent exposure," "ejaculation in presence of others/masturbation in presence of others," and "possession of pornography," accounted for less than 1% of the primary forms of sexual misconduct perpetrated by the physicians with each of these three report types. No details were available to determine the form of sexual misconduct for the remaining 26.0%, 8.0%, and 5.6% of physicians with licensing, clinical-privileges, and malpractice-payments reports that involved sexual-misconduct–related offenses, respectively.

Fifty-two percent and 41.1% of the physician sexual-misconduct–related licensing and clinical-privileges reports, respectively, included at least one other basis for actions in addition to sexual misconduct. These additional bases included criminal convictions, violations of laws, unprofessional conduct, negligence or substandard care, patient abuse, and being an immediate threat to health or safety. For the physician sexual-misconduct–related malpractice-payment reports, 21.4% had additional malpractice allegations other than sexual misconduct listed in the reports, including improper management and assault and battery.

Our analysis of physician sexual-misconduct–related licensing and clinical-privileges reports showed that when medical boards and peer-review committees at hospitals, health care organizations, or health plans took disciplinary actions against physicians for sexual misconduct, their actions tended to be more serious than those taken against physicians with other offenses. However, 510 (37.7%) of the physicians with sexual-misconduct–related NPDB reports continued to have active licenses and clinical privileges in the states where they were disciplined, or had malpractice payments due to their sexual-misconduct offenses. Because some physicians may have had active licenses and clinical privileges in states other than the ones in which they were disciplined, an even higher proportion of physicians may have been able to continue practicing medicine because medical boards and health care organizations in these other states may not have taken disciplinary actions against these physicians that resulted in revocation or suspension of their licenses and clinical privileges.

Of the 317 physicians with at least one sexual-misconduct–related clinical-privileges or malpractice-payment report, 221 (69.7%) had not been disciplined by any state medical board for such misconduct during our study period. Importantly, 151 (68.3%) of these 221 physicians committed sexual misconduct involving patient victims and 61 (27.6%) committed sexual misconduct involving multiple victims. Physical sexual contact or relations and nonspecific sexual misconduct were the primary reported forms of sexual misconduct perpetrated by 116 (52.5%) and 85 (38.5%) of these 221 physicians, respectively.

Our report presents powerful case examples that illustrate several ways in which largely self-regulated state medical boards and medical peer-review committees in health care organizations deal leniently with sexually abusive physicians, failing to prioritize patients' protection over the interest of these physicians. Examples include the following:

(1) Sexual abuse is regarded as a knowledge gap (that can be bridged by boundary or ethics classes) or an illness that can be cured by psychiatric evaluation and "rehabilitation;"
(2) Private nonreportable agreements, consent decrees, or suspended disciplinary actions often are employed as the first line of action against these physicians;
(3) A chaperone requirement or limitation/restriction of clinical practice or license are often the second line of action against these physicians until they are "rehabbed" and returned to practice;
(4) Sexually abusive physicians can be permitted to resign, surrender their licenses or clinical privileges, or retire to avoid revocation actions — allowing them to move to other health care organizations or obtain licenses in other states; and
(5) Reporting entities may conceal sexual misconduct in the NPDB by using nonspecific Basis for Action Codes, such as "unprofessional conduct," in lieu of the "sexual misconduct" code.

We also discuss other factors that we identified from the literature that perpetuate the problem of sexual abuse by physicians.

Conclusions

The number of physicians who have been reported to the NPDB due to sexual misconduct remains low. Therefore, our report only scratches the surface of the full extent of physician sexual misconduct in the U.S. Unfortunately, this problem has not received the attention it deserves from the medical community. It is incumbent on the medical community to adopt an explicit zero-tolerance standard against sexual abuse of patients or others by physicians in all its forms. Such physicians must not be allowed to practice medicine. We also call on the medical community to make tangible systemic and cultural changes to attain this goal. We provide more than a dozen actionable recommendations to begin the quest for that zero-tolerance standard.

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List of Abbreviations

ACOG	American College of Obstetricians and Gynecologists
AMA	American Medical Association
APA	American Psychiatric Association
CME	Continuing Medical Education
DEA	Drug Enforcement Administration
D.O.	Doctor of osteopathic medicine
DPDB	Division of Practitioner Data Bank
FSMB	Federation of State Medical Boards
HCQIA	Health Care Quality Improvement Act
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
IHPP	Impaired health professional program
M.D.	Doctor of allopathic medicine
MEC	Medical executive committee
NPDB	National Practitioner Data Bank
PTSD	Posttraumatic stress disorder

1. Introduction

1.1 Background

> *"'He's a miracle worker. He can fix anyone or anything.' Thinking back to these words filling my naïve mind, all I can think of is how this man, someone who held oh-so-many high credentials, was the monster who left me with more pain and scars than I came to his office with."*[3] *— Jade Capua, gymnast, in her testimony against the disgraced physician, Lawrence (Larry) Nassar of Michigan State University*

The proscriptions against sexual relations between physicians and their patients have existed since the earliest professional guidelines in medicine: The Hippocratic oath in the fourth century B.C., required physicians to abstain from all intentional wrongdoing and harm and especially from abusing the bodies of both female and male persons.[4] Medical guidelines, including those from the Council on Ethical and Judicial Affairs for the American Medical Association (AMA), also stipulate that it is unethical for a physician to have a romantic relationship or sexual contact with a current patient and that a sexual relationship with a former patient is also unethical if the physician "uses or exploits trust, knowledge, emotions, or influence" derived from the prior physician-patient relationship.[5] Similar positions are taken by state legislatures and other professional medical organizations, including the American College of Obstetricians and Gynecologists (ACOG)[6] and the American Psychiatric Association (APA).[7] Notably, the APA prohibits sexual relations between physicians and both current and past patients.

Most Americans were stunned to find out about the vicious sexual abuses involving hundreds of minor girls and young adult women at the hands of the sports medicine physician Larry Nassar. Nassar, who established a comprehensive system of abuse and committed almost all of his sexual crimes, from the early 1990s until mid-2016, under the guise of providing medical care.[8] An independent investigation of the factors underlying Nassar's abuses of female athletes concluded that although he bears the primary responsibility for his crimes, numerous individuals and institutions, including medical professionals and administrators, enabled his abuses by ignoring red flags and neglecting clear calls for help from his patient victims. The investigation also found that multiple law enforcement agencies neglected to intervene when they were presented with opportunities to do so. In addition, apparently none of the individuals who worked

[3] Correa C, Louttit M. More than 160 women say Larry Nassar sexually abused them. Here are his accusers in their own words. *The New York Times*. January 24, 2018. https://www.nytimes.com/interactive/2018/01/24/sports/larry-nassar-victims.html. Accessed May 6, 2020.

[4] Edelstein L. The Hippocratic Oath: Text, translation and interpretation. In: Veatch R, ed. *Cross Cultural Perspectives in Medical Ethics: Readings*. Boston: Jones and Bartlett; 1989:6-24.

[5] Council on Ethical and Judicial Affairs, American Medical Association. Sexual misconduct in the practice of medicine. *JAMA*. 1991;266(19):2741-2745

[6] Committee on Ethics, American College of Obstetricians and Gynecologists. ACOG Committee opinion no. 373: Sexual misconduct. *Obstet Gynecol*. 2007;110(2 Pt 1):441-444.

[7] American Psychiatric Association. The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry, 2013 edition.

[8] McPhee J, Dowden JP. Report of the independent investigation. The constellation of factors underlying Larry Nassar's abuse of athletes. December 10, 2018. https://www.nassarinvestigation.com/en. Accessed May 6, 2020.

with or supervised Nassar reported him to the Michigan Board of Osteopathic Medicine and Surgery, despite the complaints of his patient victims.[9] This board did not suspend Nassar's medical license until April 2017 and permanently revoke it until April 2018.[10]

However, what is more appalling is that Nassar's case is not a rarity. Recently, investigative reporters have uncovered numerous physicians — many of whom were serial abusers like Nassar — who betrayed the ethics of their profession and engaged in sexual abuse of their patients, thereby doing lasting harm to them.

1.2 Study Rationale

Scholarly national-level analyses of physician sexual abuses are scarce. In 2016, we published results from the first analysis of physician sexual-misconduct–related reports in the National Practitioner Data Bank (NPDB), — a national repository for reports containing information on medical malpractice payments (malpractice payments) and certain adverse actions related to physicians and other health care practitioners.[11] That study, which was based on a limited number of quantitative variables, showed that only 1,039 physicians had sexual-misconduct–related reports over more than a decade (from January 1, 2003, to September 30, 2013).

The present study spans NPDB reports from January 1, 2003, to December 31, 2017, and benefits from illuminating nonpublic information that provides a more comprehensive account about the characteristics of physicians with NPDB reports involving sexual misconduct, the forms and details of the sexual misconduct that they inflicted on their victims, the characteristics of these victims, and the various other contextual factors that may explain the persistence of this problem. We relate our findings to prior evidence and conclude with recommendations to address this problem.

1.3 Definitions: Sexual Misconduct/Abuse

Sexual misconduct is an umbrella term used by the medical community to denote sexualized behavior that is perpetrated by a physician against a patient, a patient's family member, or some other individual in the health care setting, including employees.

The AMA's Council on Ethical and Judicial Affairs indicates that physicians may perpetrate sexual misconduct against their patients in a variety of ways including: (1) becoming involved in personal relationships with patients that are concurrent with but independent of treatment, (2) using their position to gain sexual access to their patients by representing sexual contact as part of care or treatment, and (3) assaulting patients by engaging in sexual contact with incompetent or unconscious patients.[12] The AMA's council further indicates that for some

[9] PBI Education. The duty to report misconduct. August 2018. https://pbieducation.com/the-duty-to-report-misconduct/. Accessed May 6, 2020.

[10] Department of Licensing and Regulatory Affairs' (LARA) Michigan Board of Osteopathic Medicine and Surgery. LARA permanently revokes Nassar's medical license, issues largest fine in department history. April 6, 2018. https://www.michigan.gov/lara/0,4601,7-154-11472-465774--y_2018,00.html. Accessed May 6, 2020.

[11] AbuDagga A, Wolfe SM, Carome M, Oshel RE. Cross-sectional analysis of the 1039 U.S. physicians reported to the National Practitioner Data Bank for sexual misconduct, 2003–2013. *PLoS One*. 2016;11(2):e0147800.

[12] Council on Ethical and Judicial Affairs, American Medical Association. Sexual misconduct in the practice of medicine. *JAMA*. 1991;266(19):2741-2745.

physicians, sexual misconduct against patients is "the conscious (and usually repeated) use of [physicians'] professional positions to manipulate or exploit their patients' vulnerabilities for their own gratification … [and that] self-gratification is the only basis for the behavior of physicians who engage in sexual contact with incompetent or unconscious patients."[13]

The AMA extends its definition of sexual misconduct to also include sexual or romantic relationships between physicians and key third parties who play an integral role in the patient-physician relationship, such as patients' spouses, partners, parents, guardians, and proxies.[14] The AMA advises that physicians "should refrain from sexual or romantic interactions with key third parties when it is based on the use or exploitation of trust, knowledge, influence, or emotions derived from a professional relationship."[15]

Consistent with the Regulated Health Professions Act of Ontario, Canada,[16] we propose that the term "sexual abuse" should be used in lieu of term "sexual misconduct" when referring to any sexual contact between a physician and a patient or any behavior or remarks of a sexual nature by a physician toward a patient because of the breach of trust and exploitative nature of such actions.[17] We believe any characterization that does not involve the term "abuse" fails to connote the profound unethical nature of physical sexual contact or relations and sexual interactions between physicians and their patients.

The Ontario act defines sexual abuse as: "(a) sexual intercourse or other forms of physical sexual relations between the [physician] and the patient, (b) touching, of a sexual nature, of the patient by the [physician], or (c) behavior or remarks of a sexual nature by the [physician] towards the patient."[18] According to this definition, "sexual nature" does not include touching, behavior or remarks of a clinical nature appropriate to the service provided. One explicit purpose of the Ontario law is "to eradicate the sexual abuse of patients by [physicians]."

Notably, the forms of sexual abuse identified in the Ontario act overlap largely with sexual misconduct as defined by the U.S. professional and regulatory medical organizations, including the Federation of State Medical Boards (FSMB),[19] a national organization that represents state medical and osteopathic boards (hereafter referred to as medical boards) in the U.S. However, such U.S. definitions of sexual misconduct do not explicitly characterize these behaviors as "sexual abuse."

[13] *Ibid*.
[14] American Medical Association. The AMA code of medical ethics' opinions on observing professional boundaries and meeting professional responsibilities. *AMA J Ethics*. 2015;17(5):432-434.
[15] *Ibid*.
[16] Government of Ontario. Regulated Health Professions Act, 1991, S.O. 1991, c. 18. (Currency date: January 1, 2020). https://www.ontario.ca/laws/statute/91r18/v6. Accessed May 6, 2020.
[17] AbuDagga A, Carome M, Wolfe SM. Time to end physician sexual abuse of patients: Calling the U.S. medical community to action. *J Gen Intern Med*. 2019;34(7):1330-1333.
[18] Government of Ontario. Regulated Health Professions Act, 1991, S.O. 1991, c. 18. (Currency date: January 1, 2020). https://www.ontario.ca/laws/statute/91r18/v6. Accessed May 6, 2020.
[19] Federation of State Medical Boards. Physician sexual misconduct: Report and recommendations of the FSMB Workgroup on Physician Sexual Misconduct. May 2020. http://www.fsmb.org/siteassets/advocacy/policies/report-of-workgroup-on-sexual-misconduct-adopted-version.pdf. Accessed May 7, 2020.

1.4 Ethical Problems With Physician Sexual Abuse

> *"Professional sexual seduction is wrong because it is motivated by the needs of the doctor… We [physicians] are there to serve our patients, not for them to serve us."— Mary V. Seeman, M.D., Psychiatrist-in-Chief, Mount Sinai Hospital, Toronto, Ontario, 1987*[20]

> *"There is no profession where the patient passes so completely within the power and control of the operator as does the medical patient." — California Court of Appeal in Fuller v. Board of Medical Examiners, 1936*[21]

There are two primary reasons that physicians' physical sexual contact or relations with their patients is unethical. The first reason relates to the principle of trust which is central to the physician-patient relationship: Patients trust that their physicians will act in the best interests of their patients.[22] Therefore, it is a breach of trust for a physician to have physical sexual contact or relations with a patient. The second reason relates to the significant power imbalance inherent in the physician-patient relationship: A patient is, by definition, someone who is dealing with an illness or a trauma, which make him or her dependent on the physician for health care. In contrast, a physician is not dependent on his or her patient. This asymmetrical relationship not only makes patients vulnerable for exploitation by their physicians, but also means that such exploitation is an abuse of power on the part of the physician.

The asymmetry in the physician-patient relationship explains why there can never be such a thing as a "consensual sexual relationship" between a physician and his or her patients. Patient may have low self-esteem, believing that they will experience increased self-worth by establishing a relationship with a physician because of the status of the latter.[23] Patients may feel grateful to the physician or feel dependent and needy and therefore fear that the physician will stop helping them if they were to resist. In addition, patients may be willing to trade sexual favors for drugs, care, or other forms of support from the physician.

The lack of true consent on the part of the patient makes physician-patient sexual contact analogous to incest or sexual abuse of a child by a family member: In both of these exploitative situations there is a vulnerability, weakened self-protective instincts, and diminished capacity for patient victims to make decisions in their best interest.[24] Other parallels between incest or sexual abuse of a child by a family member and sexual abuse of patients by their physicians include secrecy and fear of explosive disruptions in the relationship with the perpetrator.

[20] Seeman MV. Sexual misconduct. *CMAJ*. 1987;137(8):699.
[21] Justia US Law. Fuller v. Board of Medical Examiners. 1936;14 Cal.(App.2d):741. http://law.justia.com/cases/california/court-of-appeal/2d/14/734.html. Accessed May 6, 2020.
[22] Walton M. Sex and the practitioner: The predator. *Aust J Forensic Sci*. 2002;34(1):7-15.
[23] McPhedran M, Macdonald S. To Zero: Independent Report of the Minister's Task Force on the Prevention of Sexual Abuse of Patients and the Regulated Health Professions Act, 1991. 2016. http://www.health.gov.on.ca/en/common/ministry/publications/reports/sexual_health/taskforce_prevention_of_sexual_abuse_independent_report.pdf. Accessed May 6, 2020.
[24] Walton M. Sex and the practitioner: The predator. *Aust J Forensic Sci*. 2002;34(1):7-15.

1.5 Harmful Effects of Physician Abuse on Patients

> *"The wounds inflicted by sexual abuse are not surface wounds. They cut deeply. They threaten to destroy your sense of safety, your faith and your sense of self. Your world was changed by the abuse you suffered. Your world no longer felt secure. If the abuse was repetitive, then any illusion of security or hope of safety was shattered. Whatever you did to try to stop the abuse proved to be useless." — Diane M. Langberg, Ph.D., practicing psychologist*[25]

Most of the studies on the consequences of sexual abuse in therapeutic relationships, including those involving physicians and their patients, demonstrate that this abuse is almost always harmful to patients, resulting in devastating, often long-lasting harms.[26] A survey of victims of sexual abuse by physicians showed that most of them reported a serious decline in their overall wellbeing following these incidents.[27] There also is evidence that these abuses can shatter patients' trust in the medical profession, thus compromising their future health care.[28] For example, female patients subjected to sexually abusive pelvic examinations (characterized by the absence of a chaperone, inappropriate touching by the hands of the physician, excessive use of lubricant and unusually lengthy exam) tend to develop an aversion to gynecological health care after these incidents.[29] Similarly, women who experienced sexual contact with male psychotherapists showed an increased distrust of men and of the psychotherapy profession.[30]

Generally, research shows that many survivors of physical sexual assault develop physical illnesses, such as chronic pelvic pain or functional gastrointestinal disorders.[31] These patients frequently experience chronic pain for years and eventually completely dissociate the assault from their physical symptoms.[32] For many, healing cannot commence until the connection between the patient's emotional experience and ongoing physical illness is recognized.[33]

In terms of the psychological impact of sexual abuse by health care professionals, the research evidence consistently shows numerous additional harms, including blaming oneself for the abuse, damaged self-esteem, anger, depression, shame, guilt, posttraumatic stress disorder (PTSD), suicidal thoughts, trust issues, break-up of relationships, loss of employment, and drug or

[25] Langberg DM. *On the Threshold of Hope*. Carol Stream, IL: Tyndale House Publishers, Inc.; 2012.
[26] Fahy T, Fisher N. Sexual contact between doctors and patients. *BMJ*. 1992;304(6841):1519-1520.
[27] Eichenberg C, Becker-Fischer M, Fischer G. Sexual assaults in therapeutic relationships: prevalence, risk factors and consequences. *Health*. 2010;2(9):1018-1026.
[28] Galletly CA. Crossing professional boundaries in medicine: the slippery slope to patient sexual exploitation. *Med J Aust*. 2004;181(7):380-383.
[29] Burgess AW. Physician sexual misconduct and patients' responses. *Am J Psychiatry*. 1981;138(10):1335-1342.
[30] Council on Ethical and Judicial Affairs, American Medical Association. Sexual misconduct in the practice of medicine. *JAMA*. 1991;266(19):2741-2745.
[31] Volkmann ER. Silent survivors. *Ann Fam Med*. 2017;15(1):77-79.
[32] *Ibid*.
[33] *Ibid*.

alcohol abuse.[34,35,36] A recent study of cases of sexual abuse, including sexual abuse of patients by health care professionals, argued that even sexual offenses that are legally classified as "minor" can have serious damaging effects on victims.[37]

Sexual misconduct by health care professionals also harms people close to the victims, particularly partners and children. Common problems for partners include symptoms of major depression, PTSD, anger, and confusion.[38] Most children of the victims of sexual misconduct by health care professionals suffer confusion about the parent's behavior and anxious mood and worry about the marriage problems of their parents and that their parents might separate or divorce.[39]

Additionally, there are societal impacts for physician sexual misconduct. Members of the public may lose trust and respect for the entire medical profession after learning about cases of physician sexual abuse of patients. These effects are more pronounced when it is revealed that members of the medical community knew of such abuse cases but did not take actions to stop the physician perpetrators from abusing more patients.

1.6 Study Purposes

This study aimed to address the following research purposes:

(1) Determine the number and characteristics of physicians with sexual-misconduct–related licensing, clinical-privileges, or malpractice-payment NPDB reports (hereafter referred to as "sexual-misconduct–related reports");

(2) Compare the characteristics of physicians with sexual-misconduct–related reports with those of the U.S. general physician population;

(3) Examine the number, type and characteristics of victims in physician sexual-misconduct–related reports;

(4) Characterize the primary forms of sexual misconduct perpetrated by physicians against victims in physician sexual-misconduct–related reports;

(5) Describe additional bases for action or alleged medical malpractice in physician sexual-misconduct–related reports;

(6) Describe the disciplinary actions taken against physicians with sexual-misconduct–related licensing or clinical-privileges reports for all such reports and by each form of sexual misconduct;

[34] Muldoon SD, Taylor SC, Norma C. The survivor master narrative in sexual assault. *Violence Against Women*. 2015;22(5):565-587.
[35] Galletly CA. Crossing professional boundaries in medicine: the slippery slope to patient sexual exploitation. *Med J Aust*. 2004;181(7):380-383.
[36] Luepker E. Effects of practitioners' sexual misconduct: A follow-up study. *J Am Acad Psychiatry Law*. 1999;27(1):51-63.
[37] Muldoon SD, Taylor SC, Norma C. The survivor master narrative in sexual assault. *Violence Against Women*. 2015;22(5):565-587.
[38] Luepker E. Effects of practitioners' sexual misconduct: A follow-up study. *J Am Acad Psychiatry Law*. 1999;27(1):51-63.
[39] *Ibid*.

(7) Compare the disciplinary actions taken against physicians with sexual-misconduct–related licensing or clinical-privileges reports with those taken against physicians with other-offenses–related licensing or clinical-privileges reports;

(8) Compare the characteristics of victims and severity of their alleged malpractice-related injuries and the setting of injury for physician sexual-misconduct–related malpractice-payment reports with those variables in physician malpractice-payment reports for other allegations;

(9) Determine the size of malpractice payments for physicians with sexual-misconduct–related malpractice-payment reports for all such reports and by each form of sexual misconduct;

(10) Determine the proportion of physicians with clinical-privileges or malpractice-payment reports related to sexual misconduct who were not disciplined by any state medical board for this misconduct;

(11) Determine the proportion of physicians who faced cessation of license or clinical privileges due to sexual misconduct; and

(12) Identify various practices in physician discipline processes that may explain the persistence of physician sexual abuse of patients in the U.S.

2. Methodology

We used de-identified physician data for U.S. physicians who were reported to the NPDB from January 1, 2003, through December 31, 2017. Our study was retrospective in nature: it employed mixed (quantitative and qualitative) methods pursuant to our research purposes.

2.1 Data Sources

The NPDB — a national centralized clearinghouse established by Congress under the Health Care Quality Improvement Act (HCQIA) of 1986[40] that is administered by the Health Resources and Services Administration (HRSA) — was our primary data source. The goal of the NPDB is to improve health care quality, protect the public, and reduce health care fraud and abuse in the U.S. by restricting the ability of incompetent physicians and other health care professionals to move from one state to another without disclosure or discovery of their previous damaging or incompetent performance.[41]

By law, certain entities are required (or authorized) to submit reports about physicians and other health care professionals to the NPDB, query the NPDB about physicians or other health care professionals, or both. These entities include state medical boards, medical malpractice insurers, hospitals, other health care organizations, professional societies, health plans, peer review organizations, private accreditation organizations, and certain federal and state agencies. Reports submitted to the NPDB are permanently maintained unless corrected or voided by the reporting entity or by the NPDB through a dispute-resolution process. The NPDB is self-supported though user fees from queriers.

HRSA makes available on its website for use by researchers, journalists, and others a Public Use Data File that contains de-identified data with selected variables from reports submitted to the NPDB. The file is update four times per years.

Through a data-use agreement between the Division of Practitioner Data Bank (DPDB), which is part of HRSA, and Public Citizen's Health Research Group, we obtained a report-level NPDB data file that contained the de-identified data for all variables included in the Public Use Data File and for a number of nonpublic NPDB report-level restricted variables (including physician specialty and gender, month and year versions of all report date variables, and narrative descriptions) for those physicians with sexual-misconduct–related reports in our study.

The research staff at the DPDB determined the physician specialties by linking each NPDB physician report with the physician's respective specialty in the AMA's Physician Masterfile. For physicians practicing in more than one specialty, the DPDB staff used the AMA's definition of primary specialty, which is the specialty in which the physicians practiced most of the time. We used FSMB counts of the U.S. general physician population in 2010,[42] the median year in our

[40] Department of Health and Human Services. Title IV of Public Law 99-660. The Health Care Quality Improvement Act of 1986, as amended 42 USC Sec. 11101 01/26/98. https://www.npdb.hrsa.gov/resources/titleIv.jsp. Accessed May 6, 2020.

[41] Department of Health and Human Services, Health Resources and Services Administration. NPDB Guidebook. October 2018. https://www.npdb.hrsa.gov/resources/NPDBGuidebook.pdf. Accessed May 6, 2020.

[42] Young A, Chaudhry HJ, Thomas JV, Dugan M. A census of actively licensed physicians in the United States, 2012. *J Med Regul*. 2013;99(2):11-24.

study period, to compare the age groups and types of physicians who had sexual-misconduct–related reports with those of the U.S. general physician population.

2.2 Selection Criteria

We identified NPDB reports for doctors of allopathic medicine (M.D.), doctors of osteopathic medicine (D.O.), physician residents, and osteopathic physician residents, using related codes in the Practitioner's field-of-license variable. The following sections describe how we selected and classified the reports that we included in our final study population.

2.2.1 Physician Report Types

We limited our analysis to the following three types of NPDB reports for physicians (see Appendix A for the codes that we used to identify these reports):

(1) Licensing actions taken against physicians by state medical boards. We refer to these reports hereafter as "licensing reports."

(2) Professional review actions taken by peer-review committees at hospitals, other health care organizations, or health plans against a physician's clinical privileges for a period of more than 30 days, or acceptance of a physician's surrender or restriction of clinical privileges while under investigation for possible professional incompetence or improper professional conduct or in return for not conducting such an investigation or not taking a professional review action that otherwise would be required to be reported to the NPDB.[43] Clinical privileges include privileges, medical staff membership, and other circumstances (such as network participation and panel membership) in which a physician is permitted to provide medical care. We refer to these reports hereafter as "clinical-privileges reports"

(3) Malpractice payments resulting from physician malpractice that are paid by malpractice insurers or other entities. We refer to these reports hereafter as "malpractice-payment reports."

2.2.2 Classifications of Physician Reports as Sexual-Misconduct–Related Versus Other (Nonsexual-Misconduct–Related)

We classified each of the three types of physician reports included in our study as either "sexual-misconduct–related" or "other" (nonsexual-misconduct–related) as follows (see Appendix A for the related codes):

(1) For physician licensing and clinical-privileges reports, sexual-misconduct–related reports were those in which sexual misconduct was reported in any of the five basis-for-action (i.e., reason-for-action) variables in these reports. The rest of these reports were classified as "other" reports if they had any other valid basis-for-action values.

[43] Department of Health and Human Services, Health Resources and Services Administration. National Practitioner Data Bank Guidebook. October 2018. https://www.npdb.hrsa.gov/resources/NPDBGuidebook.pdf. Accessed May 6, 2020.

(2) For physician malpractice-payment reports, sexual-misconduct–related reports were those in which sexual misconduct was reported in any of the two specific malpractice-acts-or-omissions allegations variables in these reports. We classified the rest of these physician reports as "other" reports if they had any other valid specific malpractice-act-or-omission allegations values.

2.2.3 Excluded Reports

We excluded from our analysis licensing and clinical privileges reports that did not include a basis for action. Virtually all such reports are Revision-to-Action reports rather than reports of new actions. We also excluded reports that only had Revision-to-Action licensing or clinical-privileges codes (Appendix B). Revision-to-Action reports are submitted to the NPDB by the entities that send the initial versions of these reports and represent a change in penalty rather than a new action. Because Revision-to-Action reports are not permitted for malpractice-payment reports, we did not exclude any malpractice-payment reports that met our study criteria.

2.2.4 Study Period

Explicit sexual-misconduct basis-for-action variable codes (Appendix A) were introduced for licensing and clinical-privileges reports in September 2002 and for malpractice-payment reports in January 2004. The restricted data for physicians with sexual-misconduct–related reports that we obtained from the DPDB included data through December 31, 2017. Therefore, our study period for licensing and clinical-privileges reports was from January 1, 2003, through December 31, 2017, and for malpractice-payment reports the period was from January 1, 2004, through December 31, 2017.

2.2.5 Narrative Descriptions

The DPDB requires various entities that submit NPDB reports to respond to a limited number of standardized variables and to provide qualitative narrative description for each report. This narrative description can be up to 4,000 characters including spaces and punctuation.[44] It can provide future queriers of the NPDB with additional important information. For licensing and clinical-privileges reports, the narrative description is supposed to include details about the type of disciplinary actions taken against the physician who was named in the report, the specific acts or omissions upon which these actions were based, and the circumstances that led to the actions. For malpractice-payment reports, the narrative description is supposed to include a description of the alleged acts or omissions and injuries upon which the malpractice payment was based and any conditions (including the terms of payment). As part of our data-use agreement with the DPDB, we obtained the narrative descriptions that were available for all physician sexual-misconduct–related reports during our study period. The research staff at the DPDB redacted from these narrative descriptions all names and other identifying information for the physicians and reporting entities.

[44] *Ibid*.

We reviewed these narrative descriptions for each physician sexual-misconduct–related report during our study period and extracted information from them regarding several variables that we could not have determined in our 2016 analysis[45] because we did not have access to such information then. Specifically, we extracted variables pertaining to the reported characteristics of the victims of physician sexual misconduct, the nature of the physician sexual misconduct, and any practices in physician discipline by state medical boards and health care organizations that can explain the persistence of physician sexual misconduct in the U.S.

2.3 Data Elements

The three types of physician reports included in our study had a few standardized variables in common, such as physician age groups. Additionally, the list of basis-for-action codes for licensing and clinical-privileges reports is the same. However, the reports differed with respect to other variables. For example, only malpractice-payment reports included a few variables about the victims (age group, gender, severity of injury), setting of malpractice, and amounts of malpractice payments. We describe these variables in the following sections and how we used them to address our study purposes.

2.3.1 Physician Characteristics

We examined four physician characteristics for all physicians with one or more sexual-misconduct–related report of any type that met our study criteria: (1) age group (under 40, 40 to 49, 50 to 59, 60 years or older, or unspecified), (2) gender (female, male, or unspecified), (3) license type (M.D. or D.O), and (4) specialty or specialty group (anesthesiology; emergency medicine; family medicine/general practice; internal medicine, allergy and immunology, pulmonary medicine, and gastroenterology [hereafter referred to as "internal medicine"]; obstetrics and gynecology; pediatrics and pediatric cardiology [hereafter referred to as "pediatrics"]; psychiatry; surgery; other; or unspecified). We presented these characteristics at the physician level. For physicians with multiple sexual-misconduct–related reports, we selected their respective characteristics from the earliest applicable report during our study period.

2.3.2 Number and Characteristics of Victims of Physician Sexual Misconduct

We extracted information from the narrative descriptions of each of the three types of physician sexual-misconduct reports included in our study regarding the number of victims (one, multiple [two or more], or unspecified). We also extracted information about three victim characteristics: (1) type (patient,[46] patient's family member, nonpatient employee [employee was defined as any individual employed by the health care organization where the offending physician practiced], nonpatient other, or unspecified), (2) gender (female, male, or unspecified), and (3) age (adult, minor, or unspecified).

[45] AbuDagga A, Wolfe SM, Carome M, Oshel RE. Cross-sectional analysis of the 1039 U.S. physicians reported to the National Practitioner Data Bank for sexual misconduct, 2003–2013. *PLoS One*. 2016;11(2):e0147800.

[46] A small proportion of victims categorized as "patient" were also employees of the health care organization where the offending physician practiced.

Additionally, we extracted information regarding any specific vulnerabilities of the victims of physician sexual misconduct, including minor age, being under anesthesia or undergoing surgery, incarceration, or having psychiatric illness at the time of sexual misconduct by a physician. However, this vulnerability information was reported in the narrative descriptions of fewer reports than was information about other characteristics of the victims.

To minimize missing values for victim variables, we imputed information from other parts of the same report type for each physician, where applicable. For example, we considered reports involving obstetrics and gynecology physicians to involve "female" victims, if the victim was reported to be a "patient" but no gender information was provided in the narrative description of the report. Similarly, if the age of the victim was not reported but the physician's specialty was pediatrics, we imputed the age of the victim as "minor" if the victim was reported to be a "patient" in the narrative description. We considered all nonpatient employee victims to be adults, unless indicated otherwise in the narrative descriptions. We also considered all patient sexual-misconduct victims in reports for psychiatric physicians to be vulnerable. We reported results about the victim characteristics that we extracted from the narrative descriptions at the physician level for each of the three types of reports separately.

2.3.3 Malpractice Victim Variables and Setting in Sexual-Misconduct–Related Versus Other-Offenses–Related Reports

We compared sexual-misconduct–related and other-offenses–related malpractice-payment reports for the physicians during our study period with respect to four standardized variables that were not included in licensing and clinical-privileges reports. These variables were (1) victim's age group (under 20, 20 to 39, 40 to 59, or 60 to 79 years, or unknown), (2) victim's sex (female, male, or unknown), (3) setting where the malpractice occurred (inpatient, outpatient, both inpatient and outpatient, or unknown), and (4) severity of alleged malpractice injury ("emotional injury only"; "insignificant injury"; "minor temporary injury"; "major temporary injury"; "minor permanent injury"; "significant permanent injury"; "major permanent injury"; "quadriplegic, brain damage, or lifelong care"; "death"; or "cannot be determined from available records").

2.3.4 Primary Forms of Sexual Misconduct

For each of the three types of physician sexual-misconduct reports, we extracted information from the narrative descriptions about the forms of sexual misconduct. This yielded a long list of sexual behavior and actions. We reviewed this list and classified each behavior or action into one of the following hierarchical categories: (1) physical sexual contact or relations (including "inappropriate touching during an examination or procedure" and "sexual act"), (2) nonspecific (including "boundary violation," "sexual act," "sexual harassment," and "trading drugs/prescriptions/treatment for sexual favors"), (3) inappropriate comments or communication (including "flirting," "inappropriate comments," and "sexting"), (4) other (including "indecent exposure," "ejaculation in presence of others/masturbation in presence of others," and "possession of pornography"), and (5) undescribed sexual offenses (Appendix C). We categorized the primary form of sexual misconduct at the physician level for each of the three types of reports. If a physician had committed multiple forms of sexual offenses, we reported the most serious form.

Our approach to categorization of the primary form of sexual misconduct for each physician was conservative. In particular, for some of the physicians whose primary form of sexual misconduct was categorized as "nonspecific" based on information identified from the narrative

descriptions, the sexual misconduct likely involved behaviors or actions that would have otherwise been categorized as physical sexual contact or relations had complete details been provided in those reports.

2.3.5 Licensing Actions

For each physician with sexual-misconduct–related licensing reports, we identified and counted the types of unique actions taken against him or her that were listed in these reports. If a physician had the same action listed more than once, we counted this action only once. We further counted the number of physicians who had one or more serious licensing actions and those who had one or more nonserious licensing actions. We defined a serious licensing action based on the presence of any of the following 11 actions: "revocation of license," "probation of license," "suspension of license," "summary/emergency limitation/restriction on license," "summary or emergency suspension of license," "voluntary surrender of license," "limitation or restriction on license/practice," "denial of license (renewal only)," "voluntary agreement to refrain from practicing or suspension of license pending completion of an investigation," "denial of initial license," and "voluntary limitation/restriction of license." We defined a nonserious licensing action based on the absence of any serious action in the report and the presence of at least one of the following four actions: "reprimand or censure of license," "publicly available fine/money penalty (licensing)," "publicly available negative action/finding," and "other licensing action (not classified)." We also counted the number of physicians who had these individual licensing actions in their sexual-misconduct–related licensing reports. We replicated the above calculations at the report level for physician sexual-misconduct–related and other-offenses–related licensing reports during our study period to determine whether the frequency of these various actions differed between these two types of reports.

To assess whether a physician was able to continue practicing without interruption in the state that submitted one or more sexual-misconduct–related licensing reports for that physician, we determined whether that physician had any of the following licensing actions listed in any of his or her sexual-misconduct–related licensing reports: "denial of initial license," "denial of license (renewal only)," "summary or emergency suspension," "suspension," "revocation," "voluntary surrender," or "voluntary agreement to refrain from practicing or suspension of license pending." We considered a physician with any of these licensing actions to have lost their license at least temporarily in that state. In contrast, we considered those without these actions to have been able to continue to practice in that state without interruption.

2.3.6 Clinical-Privileges Actions

For each physician with sexual-misconduct–related clinical-privileges reports, we identified and counted the types of unique actions taken against him or her that were listed in these reports. If a physician had the same action listed more than once (in the same or in another clinical-privileges report), we counted this action only once. There were nine types of unique actions in physician sexual-misconduct–related clinical-privileges reports: "revocation of clinical privileges/panel membership," "professional review employment or panel membership firing," "voluntary surrender of clinical privileges/panel membership under investigation," "involuntary resignation/panel membership," "denial of clinical privileges," "suspension of clinical privileges/panel membership," "summary or emergency suspension of clinical privileges/panel membership," "limitation/restriction of procedures/practice area," and "other restriction/limitation

of clinical privileges." We considered all clinical-privileges actions to be serious because nonserious clinical-privileges actions — those limiting the ability of a physician to practice at the reporting entity to 30 days or less — are not reported to the NPDB.

We replicated the above calculations at the report level for physician sexual-misconduct–related and other-offenses–related clinical-privileges reports during our study period to determine whether the frequency of these various actions differed between these two types of reports. In doing so, we encountered additional clinical-privileges actions listed in a small number of other-offenses–related reports for physicians that were not listed in their sexual-misconduct–related counterpart reports. These additional actions were "voluntary limitation," "restriction," or "reduction of clinical privileges"; "concurring consultation required before procedures action"; "proctoring or monitoring required during procedures action"; "withdrawal of renewal application while under investigation"; and "privileges expired while under investigation."

To assess whether a physician retained clinical privileges allowing continued medical practice without interruption at the hospital or other health care organization that submitted one or more sexual-misconduct–related clinical-privileges reports for that physician, we determined whether that physician had any of the following actions listed in any of his or her sexual-misconduct–related clinical-privileges reports: "denial," "involuntary resignation/panel membership," "professional review employment or panel membership firing," "revocation," "summary or emergency suspension," "suspension," or "voluntary surrender" of clinical privileges. We considered a physician with any of these clinical-privileges actions to have lost their clinical privileges at least temporarily at the respective hospital or health care organization that submitted the report(s). In contrast, we considered those physicians without these actions to have retained their clinical privileges and been able to continue practicing.

2.3.7 Size of Sexual-Misconduct–Related Malpractice Payments

For sexual-misconduct–related malpractice-payment reports, we examined the "payment" variable, which represents the payment awarded to the plaintiffs and can serve as a proxy for the seriousness of alleged malpractice. This variable was coded in the NPDB's Public Use Data File as the midpoint of specified ranges of the actual payments. For example, payments between $100,001 and $1,000,000 were reported as the midpoint of $10,000 increments; thus, payments between $100,001 and 110,000 were coded as $105,000.[47] A detailed account of how these midpoint amounts were calculated is presented in Appendix D.

We adjusted these payments for inflation to the 2017-dollar values using the Consumer Price Index (CPI)[48] inflation factors. As recommended in the NPDB codebook, we used the CPI for all urban consumers using the U.S. city average for all items (1982-8=100). We did not use the CPI for medical care because malpractice payments are based on many factors, not just the cost of medical care. We reported the adjusted sexual-misconduct–related payment amounts at the physician level. That is, if a physician had more than one sexual-misconduct–related report during our study period, we reported the total payments from all applicable reports.

[47] National Practitioner Data Bank Public Use Data File. December 31, 2019. https://www.npdb.hrsa.gov/resources/PublicUseDataFile-Format.pdf. Accessed May 6, 2020.

[48] U.S. Department of Labor, Bureau of Labor Statistics. CPI for all urban consumers (CPI-U). U.S. city average, all items - CUUR0000SA0. https://data.bls.gov/cgi-bin/surveymost?cu. Accessed May 6, 2020.

2.3.8 Other Bases for Action/Malpractice Allegations in Sexual-Misconduct–Related Reports

As discussed earlier, entities that submit licensing or clinical-privileges reports to the NPDB must include at least one and may include up to five bases for action for the disciplinary actions they take against physicians. Additionally, entities that submit malpractice-payment reports must include at least one and may include a second specific malpractice-act-or-omission allegation. Reporting entities can choose these bases for action or malpractice-act-or-omission allegations from standardized lists; each item on these lists has a specific assigned code. We reviewed the additional bases for action or allegations in physician sexual-misconduct–related reports and described their distributions.

2.3.9 Contextual Sexual-Misconduct–Related Information

For physician sexual-misconduct–related reports, we extracted information from the descriptive narratives pertaining to the following items, when relevant details were reported: (1) whether the physician had a history or exhibited a pattern of engaging in sexual misconduct (as identified by either the explicit use of terms such as "history," "past, "pattern," or "repeated" when referring to sexual offenses in the narrative descriptions of individual reports, or based on our determination from synthesizing information from the narrative descriptions of one of more reports of these physicians, as applicable), (2) how the sexual-misconduct–related report was triggered (e.g., through a complaint by a patient, family member, colleague, or other individual; legal action [including arrest or conviction]; or reported action by another entity), (3) whether a licensing action was part of a consent decree or a similar negotiated agreement between the physician and the state medical board, and (4) whether a serious licensing action was stayed for a lesser action. We also reviewed the narrative descriptions of these reports to learn about the various factors and practices in the current physician disciplinary system that may explain the persistence of physician sexual abuse and included brief excerpts from selected illustrative cases.

2.4 Analytic Approach

2.4.1 Units of Analysis

We conducted most of our analyses at the physician level, pursuant with our research purposes. We conducted two types of analyses at the report level: (1) comparison of disciplinary actions in physician sexual-misconduct–related with those in other-offenses–related licensing and clinical-privileges reports and (2) comparison of victim variables and the severity of alleged malpractice injury in physician sexual-misconduct–related with those in other-offenses–related malpractice-payment reports.

2.4.2 Content Analysis

We transposed the data file that we obtained — which included the standard deidentified data for all variables included in the Public Use Data File and for the additional data for a number of nonpublic restricted variables described in the data elements section above — for the physicians with sexual-misconduct–related reports from the report level to the physician level. Thus, if a physician had multiple reports, these reports were arranged in additional columns as opposed to rows. We saved this data file as an Excel spreadsheet to facilitate the necessary manual content analysis and extraction of information from the narrative descriptions. One researcher (AA) reviewed the narrative descriptions for each physician and extracted information (e.g., the number

and characteristics of victims, primary forms of sexual misconduct) for each report type separately. We reviewed the results of this initial step as a team and decided to categorize the forms of sexual misconduct into five hierarchical groups as described above. AA then reviewed the narrative descriptions again, recategorized the primary form of sexual misconduct for each report type separately using the five hierarchical groups and rechecked the accuracy of the other extracted information. Therefore, AA analyzed content from the narrative descriptions twice: the first time during the initial extraction of the different forms of sexual misconduct and the second time after we determined the hierarchical groups of sexual misconduct types. During the content analysis, we also identified numerous examples of physicians with sexual-misconduct–related reports that highlight certain problematic practices that became apparent during our review, which may explain why this serious problem persists in the U.S. These examples are presented in the results section.

2.4.3 Statistical Analysis

We analyzed the variables that we derived from the report-level NPDB data file that we obtained for the DPDB (and most of the variables that we derived through the content analysis) using SAS version 9.4. We calculated frequencies and proportions for categorical variables. We calculated medians, means, and ranges for sexual-misconduct–related malpractice payments. We used the Pearson's chi-square or Fisher's exact tests to examine bivariate associations between the survey variables. The 0.05 significance level was used for all bivariate comparisons.

3. Results

3.1 Categorization and Characteristics of All Physicians With Sexual-Misconduct–Related Reports

Of 128,368 unique physicians with licensing, clinical-privileges, or malpractice-payment reports in the NPDB that met our study criteria, 1,354 had one or more sexual-misconduct–related reports — with the number of such reports totaling 1,675 — accounting for 0.2% of the U.S. general physician population and 1.1% of all physicians with any NPDB reports that met our study criteria. Ninety-three percent of these 1,354 physicians had only one of the three types of sexual-misconduct–related reports: 76.6% had such licensing reports, 8.4% had such clinical-privileges reports, and 7.7% had such malpractice-payment reports (Figure 1). As shown in Table 1 and Figure 1, 7.3% of these 1,354 physicians had multiple types of sexual-misconduct–related reports. Overall, 13.4% of these 1,354 physicians had multiple reports of the same type, with licensing reports being the most common report type among these physicians.

Figure 1: Categorization of the 1,354 Physicians With Sexual-Misconduct–Related Reports by Report Type

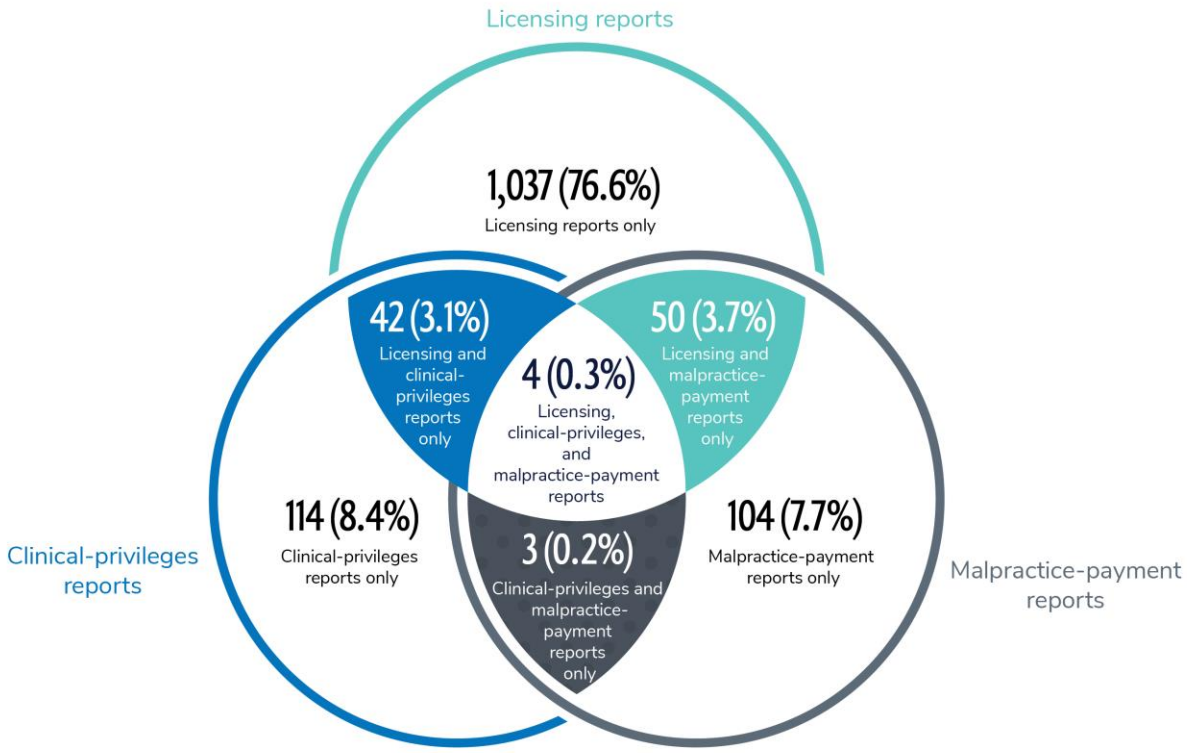


Table 1. Categories of Physicians With Sexual-Misconduct–Related NPDB Reports by Report Type, 2003–2017 (Physician-Level Results)

Category	No. (%)
Physicians with ≥ 1 sexual-misconduct–related report of any type	1,354 (100.0)
Physicians with only one type of sexual-misconduct–related report	1,255 (92.7)
Physicians with ≥ 2 types of sexual-misconduct–related reports	99 (7.3)
Physicians with ≥ 2 sexual-misconduct–related reports of the same type	181 (13.4)
≥ 2 licensing reports	139 (10.3)
≥ 2 clinical-privileges reports	15 (1.1)
≥ 2 malpractice-payment reports	29 (2.1)
Physicians with ≥ 1 sexual-misconduct–related clinical-privileges and/or malpractice-payment report	317 (23.4)
Physicians with ≥ 1 sexual-misconduct–related clinical-privileges or malpractice-payment report but no sexual-misconduct–related licensing reports[*]	221 (69.7)
Physicians with ≥ 1 sexual-misconduct–related licensing report	1,133 (83.7)
Physicians with ≥ 1 sexual-misconduct–related clinical-privileges report	163 (12.0)
Physicians with ≥ 1 sexual-misconduct–related malpractice-payment report	161 (11.9)

[*] Percentage for this count is based on the counts in the preceding row.

3.1.1 Demographic Characteristics of Physicians With Sexual-Misconduct–Related Reports

Ninety percent of the physicians with sexual-misconduct–related reports were aged 40 or older. There were statistically significant differences in the proportions of physicians with sexual-misconduct–related reports who were aged 20 to 39, 50 to 59, and 60 or older compared with the proportions for the U.S. general physician population in these age groups during the median year of our study: 10.0% of physicians with sexual-misconduct–related reports vs 23.3% for the U.S. general physician population were aged 20 to 39 ($P < .0001$); 33.8% vs 24.8% were aged 50 to 59 ($P < .0001$); and 28.9% vs 24.4% were aged 60 or older ($P = .0001$) (Table 2). Therefore, there were significantly more physicians aged 50 or older and significantly fewer physicians under 40 with sexual-misconduct–related reports than their respective representations in the U.S. general physician population.

Notably, 94.4% of the physicians with sexual-misconduct–related reports were male, whereas male physicians accounted for only 66.9% of the U.S. general physician population ($P < .0001$) during the median year of our study period.

Table 2. Characteristics of Physicians With Sexual-Misconduct–Related Reports Versus Those of the U.S. General Physician Population (Physician-Level Results)

Physician characteristics	Physicians with sexual-misconduct–related reports	U.S. general physician population	Expected physicians with sexual-misconduct–related reports	
	No. (%)[a]	No. (%)[a,b]	No.[c]	*P* value
All	1,354 (100.0)	850,085[b] (100.0)		
Physician age group				
Under 40	135 (10.0)	198,174 (23.3)	316	< .0001
40–49	367 (27.1)	211,668 (24.9)	337	.0614
50–59	458 (33.8)	210,797 (24.8)	336	< .0001
60 or older	391 (28.9)	207,515 (24.4)	331	.0001
Unspecified	3 (.2)	21,931 (2.6)	35	< .0001
Physician sex				
Male	1,278 (94.4)	568,501 (66.9)	905	< .0001
Female	44 (3.3)	246,314 (29.0)	392	< .0001
Unspecified	32 (2.4)	35,270 (4.1)	56	.0016
Physician license type				
Allopathic physicians	1,208 (89.2)	789,788 (92.9)	1,258	< .0001
Osteopathic physicians	146 (10.8)	58,329 (6.9)	93	< .0001
Unspecified	0 (0)	1,968 (.2)	3	NA

[a] Percentages may not add up to 100 due to rounding.
[b] Source: Young A, Chaudhry HJ, Rhyne J, Dugan M. A census of actively licensed physicians in the United States, 2010. *J Med Regul*. 2011;96(4):10-20.
[c] Expected counts assume the same percentage distribution for the characteristics of physicians with sexual-misconduct–related reports as in the U.S. general physician population.

3.1.2 Types and Specialties of Physicians With Sexual-Misconduct–Related Reports

As shown in Table 2, a slightly larger proportion of osteopathic physicians had sexual-misconduct–related reports (10.8%) than their proportion in the U.S. general physician population in 2010 (6.9%) ($P < .0001$). In contrast, a slightly smaller proportion of allopathic physicians (89.2%) had sexual-misconduct–related reports than their proportion in the U.S. general physician population (92.9%) ($P < .0001$).

There were sexual-misconduct–related reports for almost every physician specialty. However, the proportions of physicians with sexual-misconduct–related reports who were in three specialties (family medicine/general practice, psychiatry, and obstetrics and gynecology) were significantly greater than the proportions of physicians in each of those specialties in the U.S. general physician population (Table 3). Physicians in family medicine/general practice comprised the highest proportion of physicians with sexual-misconduct–related reports and also were overrepresented among physicians with these reports. Of all U.S. physicians in 2010, 11.4% were in family medicine/general practice, whereas 27.3% of the physicians with sexual-misconduct–related reports belonged to this specialty ($P < .0001$), a 2.4-fold overrepresentation. Likewise, 4.7% of U.S. physicians in 2010 were psychiatrists, whereas 17.4% of the physicians with sexual-misconduct–related reports belonged to this specialty ($P < .0001$), a 3.7-fold overrepresentation. Lastly, obstetrics and gynecology physicians comprised 5.1% of U.S. physicians, yet 6.4% of the

physicians with sexual-misconduct–related reports belonged to this specialty during our study period (*P* = .0298), a 1.25-fold overrepresentation. The remaining specialties (anesthesiology, emergency medicine, internal medicine, pediatrics, surgery, and other) were all significantly underrepresented among physicians with sexual-misconduct–related reports. Of note, physicians in pediatrics accounted for only 3.8% of the physicians with sexual-misconduct–related reports even though they comprised 9.3% of the U.S. general physician population (*P* <.0001).

Table 3. Specialty Distribution of Physicians With Sexual-Misconduct–Related Reports Versus Those in the U.S. General Physician Population (Physician-Level Results)

Physician specialty	Physicians with sexual-misconduct–related reports	U.S. general physician population	Expected physicians with sexual-misconduct–related reports	
	No. (%)[a]	No. (%)[a,b]	No.[c]	*P* value
All	1,354 (100.0)	844,894 (100.0)		
Family medicine/general practice	370 (27.3)	96,209 (11.4)	154	< .0001
Internal medicine, allergy and immunology, pulmonary medicine, and gastroenterology	261(19.3)	189,924 (22.5)	304	.0048
Psychiatry	236 (17.4)	39,738 (4.7)	64	< .0001
Surgery	121 (8.9)	121,120 (14.3)	194	< .0001
Obstetrics and gynecology	87 (6.4)	42,797 (5.1)	69	.0298
Pediatrics and pediatric cardiology	51 (3.8)	78,502 (9.3)	126	< .0001
Anesthesiology	33 (2.4)	43,359 (5.1)	69	< .0001
Emergency medicine	33 (2.4)	33,278 (3.9)	53	.0044
Other[d]	129 (9.5)	135,814 (16.1)	218	< .0001
Unspecified	33 (2.4)	64,153 (7.6)	103	< .0001

[a] Percentages may not add up to 100 due to rounding.
[b] Obtained by the NPDB's staff from the American Medical Association's Physician Masterfile.
[c] Expected counts assume the same percentage distribution for the characteristics of physicians with sexual-misconduct–related reports as in the U.S. general physician population.
[d] The following various specialties were included in the "other" category: anatomic/clinical pathology, cardiovascular diseases, dermatology, diagnostic radiology, forensic pathology, general preventive medicine, hospitalist, neurology, nuclear medicine, occupational medicine, osteopathic manipulative medicine, pain management, pain medicine, phlebology, physical medicine and rehabilitation, public health and general preventive medicine, radiation oncology, radiology, and other/unspecified.

3.1.3 Examples of Physician Sexual Misconduct

Content analysis of the narrative descriptions of physician sexual-misconduct–related reports generally provided informative details about the sexual misconduct by physicians. The following excerpts from report narrative descriptions show examples of these cases:[49]

> Case 1: *"[The female psychiatrist's] clinical privileges were revoked in response to initiating and [maintaining] a longstanding covert sexual and emotional relationship with her mental health patient. [This psychiatrist] placed her own needs above the clinical needs of her patient, despite full knowledge of the unethical nature of her behavior. [H]er judgment resulted in obvious failures in clinical care, including the failure to appropriately refer her patient for comprehensive substance use treatment when indicated."*
>
> Case 2: *"[T]he board found that [the male surgeon] sexually assaulted [a female patient] by inappropriately touching her breasts and buttocks on multiple occasions and asking her if he could have sex with her in the context of the provision of injections that would make her incoherent. [T]he board further found that his acts constituted professional misconduct, sexual misconduct, acts constituting a crime or offense involving moral turpitude, repeated failures to comply with the provisions of an act or regulation administered by the board, and demonstrated a lack of good moral character which is a requisite to maintaining a license to practice medicine in the state…"*
>
> Case 3: *"[The male obstetrics and gynecology physician] … was found guilty [of a crime that the board determined involved sexual misconduct]… a sentence of five years [was imposed]. [T]he charges filed against the [physician] make reference to the events in the indictment when the [physician] was working as a physician in [the state]… took advantage of the trust of the [female] patient … where she placed him in a relationship of superiority due to being under medical treatment."*
>
> Case 4: *"[The male physician] approached the [female technician] from behind and put his arms underneath [her] arms and grasped [her] breasts and squeezed them. [B]y grasping the [female technician's] breasts, [the male physician] engaged in an unwelcome sexual advance which constitutes sexual harassment under … the bylaws [of the hospital]… [B]oth actions by [the physician] … constitute a sexual assault upon an associate of the hospital; violate [multiple] sections of the bylaws and the medical staff code of conduct policy; constitute unprofessional behavior; violate the bounds of decent and respectful human behavior; violate the bounds of appropriate workplace behavior; and constitute egregious and outrageous behaviors that violated an associate of the hospital. [A]fter considering all of the evidence presented, including the hearing panel's recommendations regarding the disciplinary action for the sexual harassment, the board determined that the action to be taken against [the physician] was termination of his medical staff privileges."*

[49] Quoted information presented in all case examples throughout this report was excerpted from the narratives of physician sexual-misconduct–related licensing, clinical-privileges, or malpractice reports, as noted in each section.

Case 5: *"[D]ue to [a female] patient's lack of health insurance [and] transportation, [the male emergency medicine physician] offered to provide a home-based subsequent dressing change. After treatment for the burn ended, an adult sexual relationship developed [and] ended mutually after… four months. During the relationship an [additional] prescription of 20 [V]icodin tablets was provided for dental pain without a formal exam or office note. An [additional] prescription of 20 [V]icodin tablets was made 3 months after relationship ended, again, without a formal exam or office note. [B]ased upon these facts, [the female patient] alleged she had participated in the relationship with practitioner for the purpose of securing prescription pain medication. She also alleged she was incapable of consenting to the sexual relationship [and] that she sustained emotional [and] psychological injuries."*

The patient was awarded a malpractice payment of more than $40,000.

Case 6: *"[T]he patient, a … mother of three, her husband and their three minor children, allege the [male psychiatrist] became obsessed with his patient while treating her for depression and suicidal ideation. [T]hey allege the [psychiatrist] committed malpractice by mishandling transference, committing sexual and non-sexual boundary violations, prescribing medication without sufficient controls and abandoning the patient. [T]he patient alleges emotional and financial damages. [I]n addition, her husband alleges damages for loss of consortium and the children allege damages for 'loss of the love, care companionship and guidance as well as damage to the normal parent-child [relationship] with their mother.'"*

The patient and her family were awarded a malpractice payment of more than $1 million.

Case 7: *"[T]he [male patient] alleged that he was overprescribed controlled substances [by the male family medicine/general practice physician] causing a physical and psychological addiction used in exchange for sexual favors."*

The patient was awarded malpractice payments totaling more than $1.5 million.

Case 8: *"[T]he [male] patient killed his wife and committed suicide," according to the malpractice-payment report for which the malpractice-acts-or-omissions allegations were improper conduct and sexual misconduct by a male family medicine/general practice physician.*

The plaintiffs were awarded a malpractice payment of more than $1.3 million.

3.2 Physicians With Sexual-Misconduct–Related Licensing Reports

There were 49,194 physician licensing reports that met our study criteria. Of these reports, 1,289 (2.6%) were sexual-misconduct–related, involving 1,133 unique physicians.

In the next sections we summarize our findings regarding what triggered these reports, the number and characteristics of the victims of physicians with these reports, the primary forms of sexual misconduct experienced by the victims, and the types of licensing actions taken against the physicians with these reports. We also compare the licensing actions listed in the sexual-misconduct–related physician licensing reports with those listed in other-offenses–related physician licensing reports.

3.2.1 Triggers of Licensing Actions Due to Physician Sexual Misconduct

Of the 1,133 physicians with sexual-misconduct–related licensing reports, only 198 (17.5%) had at least one such report with narrative information that described how the state medical boards became aware of the physician's sexual misconduct. Specifically, 116 (10.2%) of the 1,133 physicians had a report with a narrative describing sexual-misconduct–related legal actions against them (including charges, indictments, convictions, imprisonment, police reports, and court actions) that predicated the reported licensing actions. Complaints by victims or their proxies were cited in report narratives for only 42 (3.7%) of the 1,133 physicians. Twenty-four physicians (2.1%) had prior state board actions (whether by the same or another state) that predicated the reported licensing actions for sexual misconduct. Twelve physicians (1.1%) had prior clinical-privileges actions that led to the reported licensing actions for sexual misconduct. Only four (0.4%) of the 1,133 physicians self-reported their sexual misconduct to the medical boards.

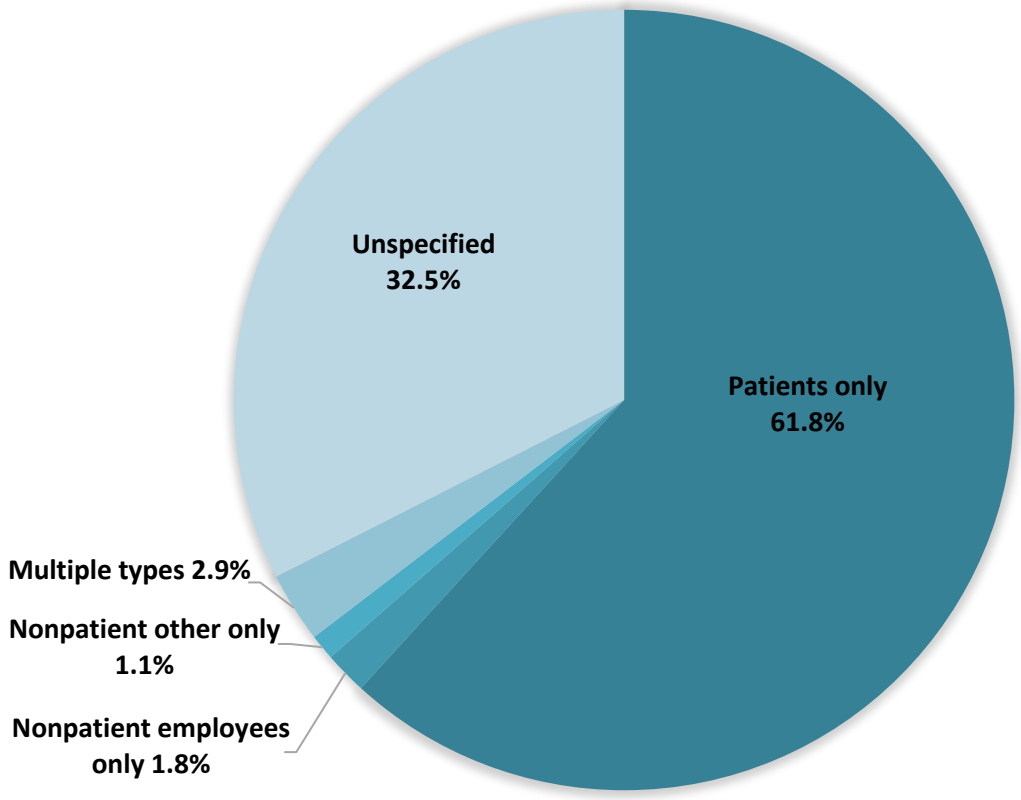
3.2.2 Victims of Physicians With Sexual-Misconduct–Related Licensing Reports

Content analysis of the narrative descriptions of physician sexual-misconduct–related licensing reports showed that 209 (18.5%) of the 1,133 physicians with these reports had multiple sexual-misconduct victims each, whereas 497 (43.9%) had one victim each. It is, of course, possible that the latter groups of physicians had other victims unknown to the medical boards. No information was available in the pertinent licensing reports for the remaining 427 physicians (37.7%) with these reports to determine the number of their sexual-misconduct victims.

Victim Characteristics and Vulnerability Factors

For 700 (61.8%) of the 1,133 physicians with sexual-misconduct–related licensing reports, only patient victims were identified (Figure 2). Of note, one or more patient victims for 11 of those 700 physicians also were employees of the health care organization where the offending physician practiced. For 20 (1.8%) of the 1,133 physicians, only nonpatient-employee victims were identified; and for 12 (1.1%), only other types of nonpatient victims (including members of patients' families, such as mothers of pediatric patients, and members of the physicians' own families) were identified. Thirty-three physicians (2.9%) had multiple types of victims identified (including patients, patient family members, nonpatient employees, or nonpatient others). Notably, no details were reported to determine the types of victims for the remaining 368 (32.5%) of the 1,133 physicians.

Figure 2. Identified Victim Types for the 1,133 Physicians With Sexual-Misconduct–Related Licensing Reports



For 837 (73.9%) of the 1,133 physicians with sexual-misconduct–related licensing reports, there was no information regarding the gender of any victims; 282 physicians (24.9%) with these reports had only female victims identified, 11 (1.0%) had only male victims identified, and three (0.3%) had both female and male victims identified.

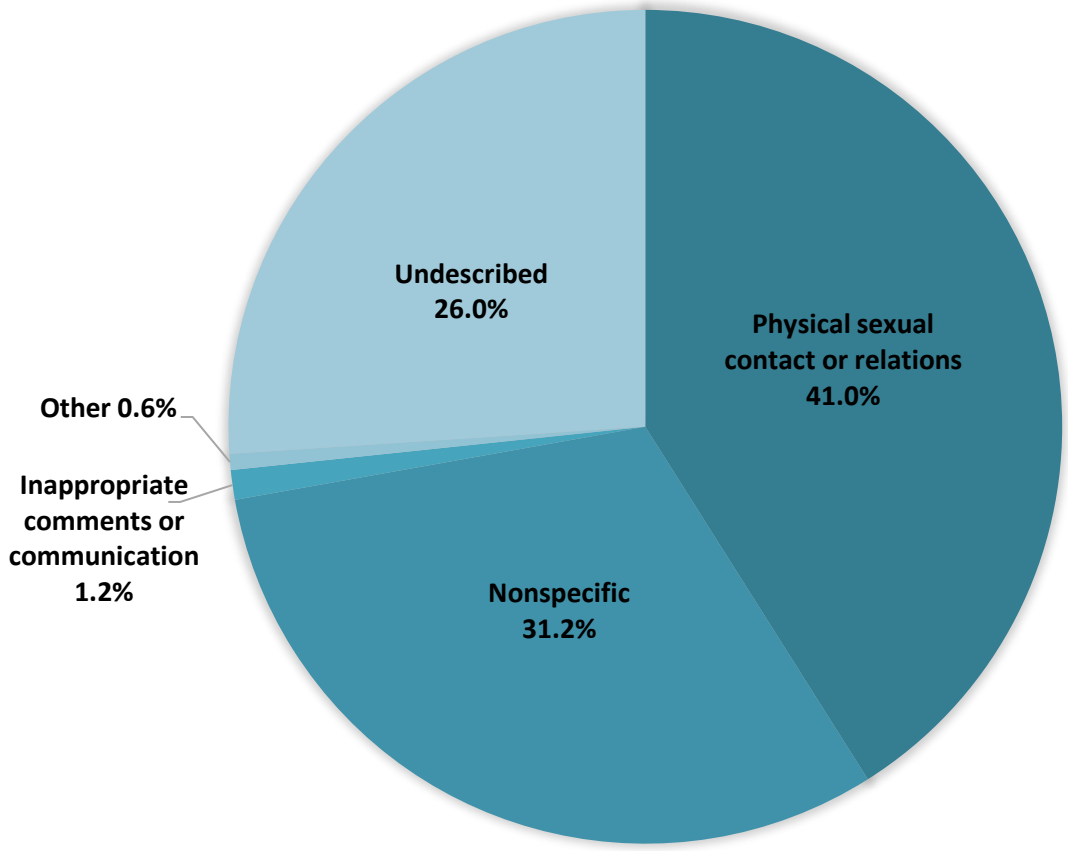
For 965 (85.2%) of the 1,133 physicians with sexual-misconduct–related licensing reports, there was no information regarding the ages of any victims. For 46 physicians (4.1%), only victims who were minors were identified, whereas 112 (9.9%) had only adult victims identified. Ten physicians (0.9%) had both minor and adult victims identified.

Victims with characteristics that made them vulnerable were identified in narrative descriptions pertaining to 192 (16.9%) of the 1,133 physicians with sexual-misconduct–related licensing reports. In addition to the 56 physicians (4.9%) who had minor victims identified, 131 physicians (11.6%) had victims with mental illnesses, including four physicians who had minor victims with mental illnesses; three (0.3%) had victims who were under anesthesia at the time of sexual misconduct; three (0.3%) had incarcerated victims; one (0.1%) had a patient with a history of sexual abuse; and two (0.2%) had victims who were described as “vulnerable” without specifying the basis for this designation.

3.2.3 Primary Forms of Sexual Misconduct Committed by Physicians With Sexual-Misconduct–Related Licensing Reports

Physical sexual contact or relations was the primary reported form of sexual misconduct for 465 (41.0%) of the 1,133 physician with sexual-misconduct–related licensing reports, whereas nonspecific forms of sexual misconduct (including "boundary violation," "sexual act," "sexual harassment," and "trading drugs/prescriptions/treatment for sexual favor") were the primary reported form for 353 (31.2%) of these physicians (Figure 3). Inappropriate comments or communication and other forms of sexual misconduct were the primary reported forms of sexual misconduct for 13 (1.2%) and seven (0.6%) of the 1,133 physicians with these reports, respectively. Licensing reports for the remaining 295 (26.0%) of the physicians did not include information about the forms of sexual misconduct. Notably, three physicians had sexual-misconduct–related licensing reports indicating that they were either registered or ordered to register as sex offenders.

Figure 3. Primary Forms of Sexual Misconduct Committed by the 1,133 Physicians With Sexual-Misconduct–Related Licensing Reports



3.2.4. History or Pattern of Sexual Misconduct Among Physicians With Sexual-Misconduct–Related Licensing Reports

The narrative descriptions for 34 (3.0%) of the 1,133 physicians with these licensing reports indicated that the physicians had a history or pattern of sexual misconduct. Specifically, the narrative descriptions in the reports of most of these physicians explicitly referenced or clearly described such a history or pattern. Of the 34 physicians with a history or pattern of sexual misconduct, the licensing reports for 29 physicians documented multiple victims, most of whom were patients.

Examples of Physicians With a History or Pattern of Sexual Misconduct in Sexual-Misconduct–Related Licensing Reports

> Case 9*: The male anesthesiologist in his fifties had two sexual-misconduct–related licensing reports originating in the same state that were submitted four years apart. The first report noted that the anesthesiologist had "engaged in unprofessional conduct by making inappropriate sexual comments to employees… [He] was ordered [by the board] to complete three hours of continuing education on sexual harassment issues and pay [a] fine. [He] was further ordered to permanently refrain from making inappropriate sexual comments to employees." The second report noted that he had "engaged in inappropriate sexual touching of a patient, sexually inappropriate behavior toward patients and staff, discussing sexual acts, his own genitalia, and making sexually charged comments in the office." This report also noted that this physician had "performed invasive medical procedures in his clinic without having registered the clinic with the [state] division of public health as required" and cited other treatment-related offenses by this physicians including failing "to conduct complete patient evaluations" and "to address 'red flags' for medication abuse." Only at this point did the board revoke the license of this physician.*
>
> *Before his first sexual-misconduct–related licensing report, this physician had four reports originating in three states (other than the state of the sexual-misconduct–related licensing report): three were licensing reports (one was for "unprofessional conduct" and the other two for a licensing action by a federal, state, or local authority, and they entailed permanent actions). These three reports documented either reprimand or censure licensing actions or an administrative fine/money penalty action. The fourth report was a treatment-related malpractice-payment report with a payment of approximately $171,000.*
>
> Case 10: *The state medical board "has found that there is probable cause to believe that [the male obstetrics and gynecology physician in his fifties] has engaged in unprofessional and unethical conduct. [T]he board has issued a statement of charges alleging repeated acts of an unethical exercise of influence within a doctor-patient relationship for the purpose of engaging a patient in sexual activity. [T]he board finds that [the physician] is likely to continue his practices of unethical and inappropriate behavior unless the board takes immediate action. [T]herefore, the board has issued a summary suspension of [the physician's] license and hearing has been set."*
>
> *Importantly, before the submission of his sexual-misconduct–related licensing report to the NPDB, seven other reports for this physician had been submitted to the NPDB 10 to 16 years earlier. Three of these reports originated in a different state than that of the sexual-misconduct–related licensing report: (a) The first entailed a permanent voluntary surrender of clinical privileges/panel membership under investigation due to other (not*

classified) reasons and (b) the other two reports were malpractice-payment reports with a combined payment of approximately $85,000 (both for improper conduct and one also for failure to obtain informed consent or lack of informed consent and being surgery-related). The other four reports originated in the same state as the sexual-misconduct–related licensing report: (a) two licensing reports with other licensing actions (the first had an indefinite probation of license and the second had an indefinite other not classified licensing action), (b) a clinical privileges/panel membership report (with permanent voluntary surrender of clinical privileges/panel membership under investigation) due to alcohol and/or other substance abuse, and (c) a surgery-related malpractice-payment report with a payment of approximately $266,000 for an allegation that was not otherwise classified.

The physician had 27 reports originating in the same state as the sexual-misconduct–related licensing report submitted to the NPDB within four to five years after submission of his sexual-misconduct–related licensing report: (a) one permanent revocation of his license (no basis for action was provided) and (b) 26 malpractice-payment reports for "improper conduct" involving female victims (whose ages ranged from twenties to sixties), with malpractice payments totaling approximately $1,235,000.

Case 11: *"[T]he board concluded that the public health, safety, or welfare imperatively required emergency action based on investigative facts regarding sexual contact [the male family medicine/general practice physician in his fifties had] with [X] female patients, engaging in this kind of behavior for over [X] years, and…[was] being criminally charged with second-degree assault and fourth-degree sexual offense of two of the patients." The action taken by the board in this sexual-misconduct–related licensing report was an indefinite summary/emergency suspension of license.*

Case 12: *The male family medicine/general practice physician in his fifties "agreed not to treat patients until the pending disciplinary charges are resolved… [T]he board charged [the physician] with engaging in a pattern of sexual misconduct, unprofessional conduct and disruptive behavior in the practice of medicine. [T]he board alleged that [the physician] engaged in an inappropriate sexual relationship with a former patient…, and the patient stole his prescription pad and illegally obtained prescription drugs. [T]he board also alleged that [the physician] made inappropriate sexual advances toward a female co-worker… [H]e was the subject of a number of complaints from female patients who alleged that he engaged in inappropriate touching and unprofessional comments[,] and he viewed and stored pornographic images on a computer at his workplace… [T]he board ordered [the physician] to complete a comprehensive physical, neuropsychological, mental health, sexual misconduct and substance abuse evaluation[,] and he completed the evaluation... [T]he board determined that [the physician] is not safe to treat patients at this time."*

The physician had a licensing report one year later originating in the same state as the sexual-misconduct–related licensing report. The subsequent report entailed a permanent voluntary surrender of license and a reprimand or censure of license due to other (not classified) basis for action.

Case 13: *The male psychiatrist in his fifties had three sexual-misconduct–related licensing reports originating in the same state over three years. The first report indicated that "a disciplinary panel of the [state] medical board temporarily suspended, without notice, the medical license of [the psychiatrist] after determining that [his] continuation in the practice of medicine constitutes a continuing threat to the public welfare. [T]he panel found that [the psychiatrist]…has demonstrated a pattern of sexually abusing teenage boys in his care for inpatient psychiatric treatment over a period of nearly 20 years." The second report stated that "the board and [the psychiatrist] entered into an agreed order of suspension, suspending [the psychiatrist's] license and barring him from the practice of medicine until final disposition of the criminal charges pending against him… [The psychiatrist] was indicted by a…grand jury on charges involving sexual assault of a child." The third report indicated that "the board found [that the psychiatrist]…was arrested in a public park for public lewdness after officers witnessed him engaging in sex acts with another person in a wooded area. [I]n addition, [he] remains involved in another criminal proceeding related to sexual misconduct with a minor." All three reports entailed suspension or summary/emergency suspension licensing actions.*

3.2.5 Additional Bases for Action in Physician Sexual-Misconduct–Related Licensing Reports

Of the 1,289 physician sexual-misconduct–related licensing reports submitted for 1,133 physicians, 673 (52.2%) included at least one other basis for the licensing actions in addition to sexual misconduct.

Table 4 enumerates the reports that listed each of the most commonly cited additional bases for action. Of note, 165 (12.8%) of the 1,289 reports listed violations of federal or state statutes, regulations, or rules; 120 (9.3%) listed unprofessional conduct; and 89 (6.9%) listed negligence as an additional basis for the licensing action. Eighty-eight (6.8%) of the reports listed other (not classified) basis as an additional basis for the licensing actions.

Table 4. Additional Bases for Action in Physician Sexual-Misconduct–Related Licensing Reports (n = 1,289)

Report category by type of additional basis for action[a]	No. (%)[b]
Physician sexual-misconduct–related licensing reports with at least one other basis for action	673 (52.2)
Reports with the most commonly cited additional bases for licensing actions	
Reports with violation of federal or state statutes, regulations, or rules basis	165 (12.8)
Reports with unprofessional conduct basis	120 (9.3)
Reports with negligence basis	89 (6.9)
Reports with criminal conviction basis	83 (6.4)
Reports with license action by federal, state, or local licensing authority basis	77 (6.0)
Reports with narcotics violation or other violation of drug statute basis	66 (5.1)
Reports with failure to maintain adequate or accurate records basis	40 (3.1)
Reports with substandard or inadequate care basis	39 (3.0)
Reports with failure to maintain records or provide medical, financial, or other required information basis	34 (2.6)
Reports with immediate threat to health of safety basis	33 (2.6)
Reports with unable to practice safely by reason of alcohol or other substance abuse basis	24 (1.9)
Reports with patient abuse basis	21 (1.6)
Reports with unable to practice safely by reason of psychological impairment or mental disorder basis	17 (1.3)
Reports with other (not classified) basis	88 (6.8)

[a] Reports are for 1,133 unique physicians with sexual-misconduct–related licensing reports.

[b] All percentages were calculated using 1,289 as the denominator.

3.2.6 Types of Actions Taken by State Medical Boards Against Physicians With Sexual-Misconduct–Related Licensing Reports

As shown in Table 5, of the 1,133 physicians with sexual-misconduct–related licensing reports, 1,007 (88.9%) had one or more serious licensing actions taken by state medical boards in response to their sexual misconduct. Suspension, probation, summary or emergency suspension, and revocation actions were the most common types of these serious licensing actions, reported for 267 (23.6%), 195 (17.2%), 165 (14.6%) and 158 (14.0%) of these physicians, respectively. Voluntary surrender and voluntary limitation or restriction of license occurred in sexual-misconduct–related licensing reports for 125 (11.0%) and 121 (10.7%) of these physicians, respectively.

Most of the 1,007 physicians with serious sexual-misconduct–related licensing actions had either physical sexual contact or relations, nonspecific, or undescribed forms of sexual-misconduct violations: 415 (41.2%), 303 (30.1%), and 274 (27.2%), respectively. Most of the 158 physicians with sexual-misconduct–related revocation licensing actions had either physical sexual contact or relations (38.6%), nonspecific (32.9%), or undescribed (25.9%) forms of sexual misconduct. Most of the 267 physicians with sexual-misconduct–related suspension licensing actions had either physical sexual contact or relations (41.6%), nonspecific (32.2%), or undescribed (25.1%) forms of sexual misconduct.

Most of the 195 physicians with sexual-misconduct–related probation licensing actions had either physical sexual contact or relations (41.5%), undescribed (32.3%), or nonspecific (25.1%) forms of sexual misconduct.

Most of the 165 physicians with sexual-misconduct–related summary or emergency suspension licensing actions had either physical sexual contact or relations (54.5%), nonspecific (30.9%), or undescribed (12.7%) forms of sexual misconduct. Most of the 125 physicians with sexual-misconduct–related voluntary-surrender licensing actions had either physical sexual contact or relations (35.2%), undescribed (32.0%) or nonspecific (31.2%) forms of sexual misconduct. Most of the 121 physicians with sexual-misconduct–related voluntary limitation or restriction of license actions had either physical sexual contact or relations (36.4%), undescribed (34.7%), or nonspecific (27.3%), forms of sexual misconduct.

As shown in Figure 4, 720 (63.6%) of the physicians who were disciplined by state medical boards for sexual misconduct were forced (through licensing suspension or revocation actions) or had volunteered to stop practicing medicine, at least temporarily. The remaining 413 (36.4%) of these physicians were subjected to lesser licensing actions that permitted them to continue practicing in their respective states without interruption, sometimes with certain conditions (e.g., probation or voluntary limitation or restriction of license [such as seeing male patients only if the sexual misconduct involved female patients]). Additional requirements against some of these physicians included undergoing psychiatric evaluation and treatment, enrolling in an impaired-physician health program, or completing a professional boundaries course or taking a few hours of continuous medical education in ethics and passing a medical jurisprudence exam (test of state laws and rules governing medical practice). We provide case examples in Section 3.6.2 to demonstrate how state medical boards can be unacceptably lenient in handling physician sexual misconduct, as shown in sexual-misconduct–related licensing reports.

Figure 4. Effect of Sexual-Misconduct–Related Licensing Actions on Physicians' Ability to Practice in Their Respective States (n = 1,133)

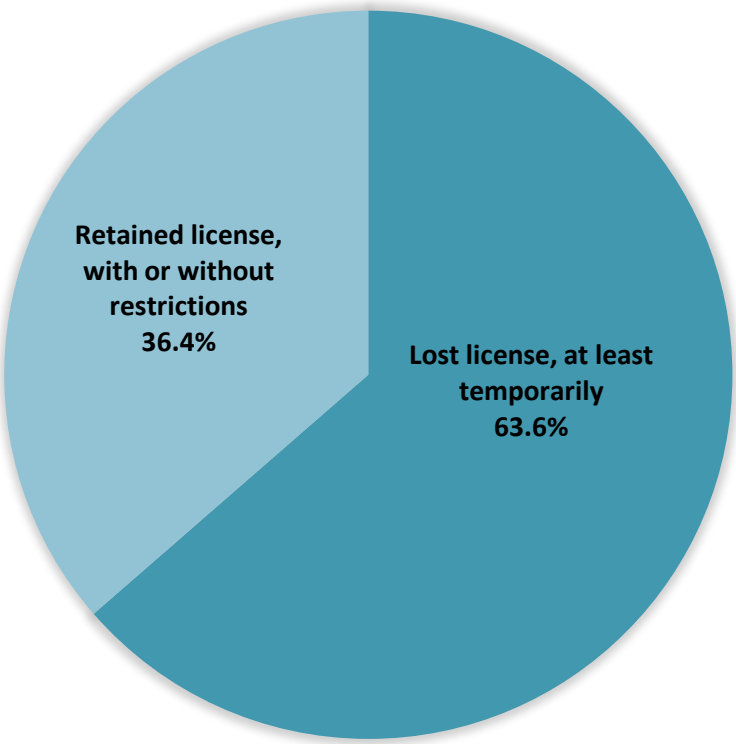


Table 5. Actions Taken by State Medical Boards Against Physicians With Sexual-Misconduct–Related Licensing Reports, by Primary Forms of Sexual Misconduct (Physician-Level Results)

	Primary forms of sexual misconduct					
	All	**Physical sexual contact or relations**	**Non-specific**	**Inappropriate comments or communication**	**Other**	**Undescribed**
Category of physicians with sexual-misconduct–related licensing actions*	**No. (% of all 1,133)**	**No. (% of row total)**	**No. (% of row total)**	**No. (% of row total)**	**No. (% of row total)**	**No. (% of row total)**
Physicians with any sexual-misconduct–related licensing action	1,133 (100.0)	465 (41.0)	353 (31.2)	13 (1.2)	7 (0.6)	295 (26.0)
Physicians with ≥ 1 serious licensing actions	1,007 (88.9)	415 (41.2)	303 (30.1)	8 (0.8)	7 (0.7)	274 (27.2)
Physicians with no serious licensing actions	126 (11.1)	50 (39.7)	50 (39.7)	5 (4.0)	0 (0.0)	21 (16.7)
Physicians with specific types of serious sexual-misconduct–related licensing actions						
Physicians with revocation of license action	158 (14.0)	61 (38.6)	52 (32.9)	3 (1.9)	1 (0.6)	41 (25.9)
Physicians with probation of license action	195 (17.2)	81 (41.5)	49 (25.1)	2 (1.0)	0 (0)	63 (32.3)
Physicians with suspension of license action	267 (23.6)	111 (41.6)	86 (32.2)	1 (0.4)	2 (0.7)	67 (25.1)
Physicians with summary/emergency limitation/restriction on license action	13 (1.2)	9 (69.2)	3 (23.1)	0 (0.0)	0 (0)	1 (7.7)
Physicians with summary or emergency suspension of license action	165 (14.6)	90 (54.5)	51 (30.9)	1 (0.6)	2 (1.2)	21 (12.7)
Physicians with voluntary surrender of license action	125 (11.0)	44 (35.2)	39 (31.2)	0 (0.0)	2 (1.6)	40 (32.0)
Physicians with limitation or restriction on license/practice action	21 (1.9)	4 (19.0)	4 (19.0)	0 (0.0)	0 (0)	13 (61.9)
Physicians with voluntary limitation/restriction of license action	121 (10.7)	44 (36.4)	33 (27.3)	2 (1.7)	0 (0)	42 (34.7)

Table 5. Actions Taken by State Medical Boards Against Physicians With Sexual-Misconduct–Related Licensing Reports, by Primary Forms of Sexual Misconduct (Physician-Level Results) (Continued)

Category of physicians with sexual-misconduct–related licensing actions*	Primary forms of sexual misconduct					
	All	Physical sexual contact or relations	Non-specific	Inappropriate comments or communication	Other	Undescribed
Physicians with denial of initial or renewal of license action or voluntary agreement to refrain from practicing/suspension of license PCI action	21 (1.9)	14 (66.7)	4 (19.0)	0 (0)	0 (0)	3 (14.3)
Physicians with specific types of nonserious sexual-misconduct–related licensing actions						
Physicians with reprimand or censure licensing action	181 (16.0)	73 (40.3)	70 (38.7)	6 (3.3)	0 (0)	32 (17.7)
Physicians with publicly available fine/money penalty licensing action	124 (10.9)	50 (40.3)	49 (39.5)	1 (0.8)	0 (0)	24 (19.4)
Physicians with publicly available negative licensing action/finding	2 (0.2)	0 (0.0)	1 (50.0)	0 (0.0)	0 (0)	1 (50.0)
Physicians with other licensing (not classified) action	109 (9.6)	53 (48.6)	33 (30.3)	5 (4.6)	0 (0)	18 (16.5)

Abbreviation: PCI, pending completion of an investigation.

* Each report can have up to five actions; actions aggregated across multiple reports if applicable.

3.2.7 Actions Taken by State Medical Boards for Sexual-Misconduct–Related Versus Other-Offenses–Related Licensing Reports

Report-level analysis showed that serious licensing actions comprised a greater proportion of the actions taken by state medical boards for sexual-misconduct–related licensing reports compared with licensing reports related to other offenses (88.4% vs 65.4%, $P < .0001$) (Table 6). Of all major types of serious licensing actions, license suspension was the most frequently noted in sexual-misconduct–related reports at 22.9%, compared with 14.5% of reports related to other offenses ($P < .0001$). License revocation was the second-most-frequent serious licensing action for sexual-misconduct–related reports, representing a significantly greater proportion compared with reports related to other offenses (15.0% vs 7.0%, $P < .0001$). Additionally, summary/emergency license suspension and voluntary limitation or restriction of license were noted in higher proportions of sexual-misconduct–related reports than reports related to other offenses (14.3% vs 5.4%, $P < .0001$; and 9.9% vs 7.0%, $P < .0001$, respectively). Probation of license and voluntary surrender of license were noted in comparable proportions in sexual-misconduct–related licensing and other-offenses–related licensing reports (16.2% vs 17.9%, $P = .1224$; 12.0% vs 11.0%, $P = .2419$, respectively).

Conversely, nonserious licensing actions of reprimand or censure of license and publicly available fine/money penalty licensing action were noted in lower proportions of sexual-misconduct–related reports than in physician reports related to other offenses (14.2% vs 26.2%, $P < .0001$; and 9.7% vs 12.6%, $P = .0021$, respectively).

Table 6. Actions Taken by State Medical Boards for Sexual-Misconduct–Related Versus Other-Offenses–Related Physician Licensing Reports (Report-Level Results)

Category of physician licensing reports by action taken[a]	Sexual-misconduct–related reports (n = 1,289)[b]	Other-offenses–related reports (n = 47,905)[c]	
	No. (%)	No. (%)	*P* value
Reports with one or more serious licensing actions	1140 (88.4)	31,317 (65.4)	< .0001
Reports with no serious licensing actions	149 (11.6)	16,588 (34.6)	< .0001
Specific types of serious licensing actions			
Reports with revocation of license action	193 (15.0)	3,342 (7.0)	< .0001
Reports with probation of license action	209 (16.2)	8,567 (17.9)	.1224
Reports with suspension of license action	295 (22.9)	6,936 (14.5)	< .0001
Reports with summary or emergency limitation/restriction on license action	13 (1.0)	153 (.3)	.0005
Reports with summary or emergency suspension of license action	184 (14.3)	2,566 (5.4)	< .0001
Reports with voluntary surrender of license action	155 (12.0)	5,265 (11.0)	.2419
Reports with limitation or restriction on license/practice action	23 (1.8)	806 (1.7)	.7793
Reports with voluntary limitation/restriction of license action	128 (9.9)	3,357 (7.0)	< .0001
Reports with denial of license (renewal only) action	5 (.4)	1,064 (2.2)	< .0001

Table 6. Actions Taken by State Medical Boards for Sexual-Misconduct–Related Versus Other-Offenses–Related Physician Licensing Reports (Report-Level Results) (Continued)

Category of physician licensing reports by action taken[a]	Sexual-misconduct–related reports (n = 1,289)[b]	Other-offenses–related reports (n = 47,905)[c]	
	No. (%)	No. (%)	*P* value
Reports with denial of initial license action	12 (0.9)	773 (1.6)	.0536
Reports with voluntary agreement to refrain from practicing or suspension of license pending PCI action	8 (0.6)	374 (0.8)	.5182
Specific types of nonserious licensing actions			
Reports with reprimand or censure licensing action	183 (14.2)	12,527 (26.2)	< .0001
Reports with cease and desist licensing action	0 (0)	238 (0.5)	NA
Reports with publicly available fine/money penalty licensing action	125 (9.7)	6,024 (12.6)	.0021
Reports with prescriptive authority action	0 (0)	114 (0.2)	.0790
Reports with publicly available negative licensing action/finding	2 (0.2)	413 (0.9)	NA
Reports with other licensing (not classified) action	111 (8.6)	6,917 (14.4)	< .0001

Abbreviation: PCI, pending completion of an investigation.
[a] Each report can have up to five actions.
[b] Reports are for 1,133 unique physicians with sexual-misconduct–related licensing reports.
[c] Reports are for 29,883 unique physicians with other-offenses–related licensing reports.

3.3 Physicians With Sexual-Misconduct–Related Clinical-Privileges Reports

Of the 8,859 clinical-privileges reports for physicians that met our study criteria, 180 (2.0%) were sexual-misconduct–related. These 180 reports involved 163 unique physicians. In the next sections we summarize our findings regarding what triggered these reports, the number and characteristics of the victims of physicians with these reports, the primary forms of sexual misconduct experienced by the victims, and the types of clinical-privileges actions taken against the physicians with these reports. We also compare the clinical-privileges actions listed in the sexual-misconduct–related physician clinical-privileges reports with those listed in other-offenses–related physician clinical-privileges reports.

3.3.1 Triggers of Clinical-Privileges Actions Due to Physician Sexual Misconduct

Of the 163 physicians with sexual-misconduct–related clinical-privileges reports, 94 (57.7%) had at least one such report that had narrative information that described how the sanctioning institutions became aware of the physician's sexual misconduct. Complaints by the victims or their proxies were cited in report narratives for 58 (35.6%) of the physicians with sexual-misconduct–related clinical-privileges reports. Sexual-misconduct–related legal actions (including charges, indictments, convictions, imprisonments, police reports, and court actions) were cited in report narratives for 20 (12.3%) of these physicians. Six (3.7%) of the 163 physicians had a report

narrative describing actions taken by a state medical board that predicated the reported clinical-privileges actions for sexual misconduct. Complaints by colleagues of the offending physicians or by other unspecified witnesses were cited in report narratives for five (3.1%) of these physicians. Only three (1.8%) of the 163 physicians with these reports self-reported their sexual misconduct to the sanctioning health care institutions. Finally, two (1.2%) of these physicians had a report narrative indicating that the sanctioning institutions found out about the sexual misconduct from the media or other public reports.

3.3.2 Victims of Physicians With Sexual-Misconduct–Related Clinical-Privileges Reports

Content analysis of the narrative descriptions of physician sexual-misconduct–related clinical-privileges reports showed that 60 (36.8%) of the 163 physicians with these reports had multiple sexual-misconduct victims each, whereas 75 (46.0%) had one victim each. It is possible, of course, that there were other victims for the latter group of physicians not known to the peer reviewers. No information was available in the pertinent clinical-privileges reports for the remaining 28 physicians (17.2%) with these reports to determine the number of sexual-misconduct victims.

Victim Characteristics and Vulnerability Factors

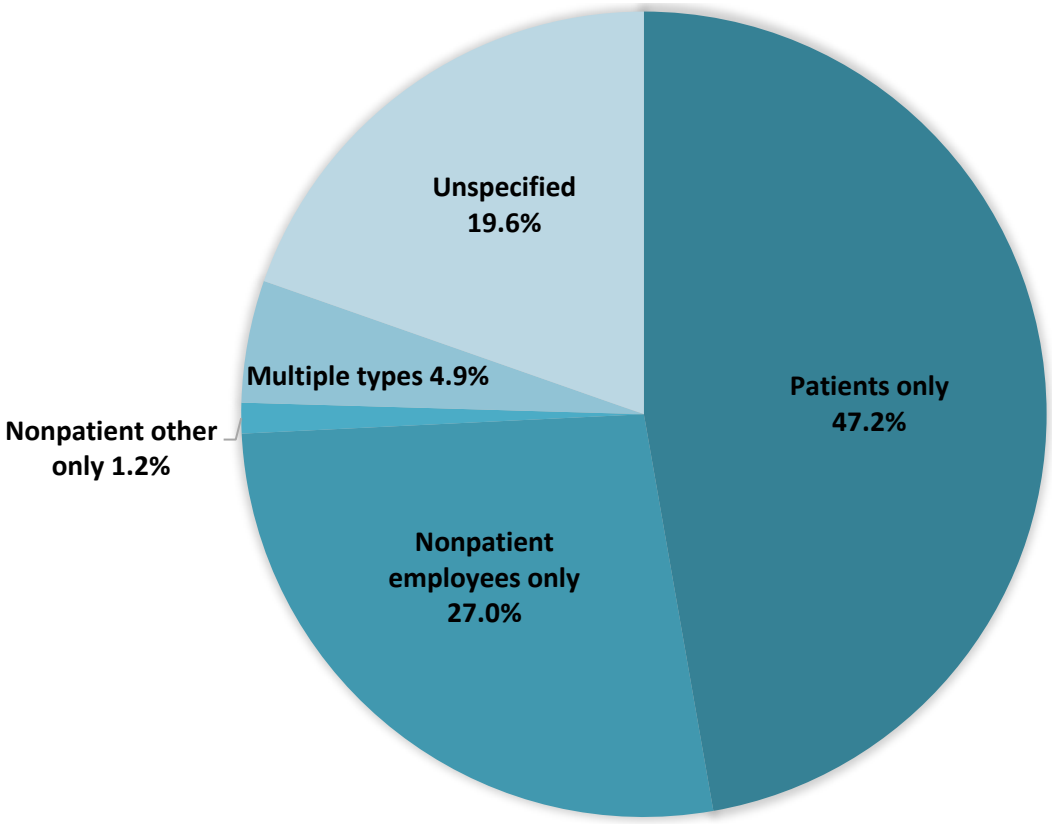
For 77 (47.2%) of the 163 physicians with sexual-misconduct–related clinical-privileges reports, only patient victims were identified (Figure 5). Of note, the patient victims for three of these 77 physicians also were employees of the health care organization where the offending physician worked. For 44 (27.0%) of these 163 physicians, only nonpatient-employee victims were identified, and for eight (4.9%) physicians, multiple victim types were identified (including patients [all eight physicians], patient family members [one physician], and employees [seven physicians]). For two (1.2%) of these 163 physicians, only other types of nonpatient victims were identified (one was a member of the physician's own family, and the other was another type of individual). Notably, no details were reported about the types of victims for the remaining 32 (19.6%) of these 163 physicians.

For 113 (69.3%) of the 163 physicians with sexual-misconduct–related clinical-privileges reports, there was no information about the gender of any victims. Forty-eight (29.4%) of these 163 physicians had only female victims identified, and two (1.2%) had only male victims identified.

For 87 (53.4%) of the 163 physicians with sexual-misconduct–related clinical-privileges reports, there was no information regarding the ages of any victims. For 63 physicians (38.7%), only adult victims were identified, whereas for six (3.7%), only minor victims were identified. One physician (0.6%) had both minor and adult victims identified.

Victims with characteristics that made them vulnerable were identified in narrative descriptions pertaining to only 23 (14.1%) of the 163 physicians with sexual-misconduct–related clinical-privileges reports. In addition to the seven physicians (4.3%) who had minor victims identified, 10 (6.1%) of these physicians had victims with mental illness, four (2.5%) had victims who were under anesthesia or in the operating room, and two (1.2%) had victims who were incarcerated.

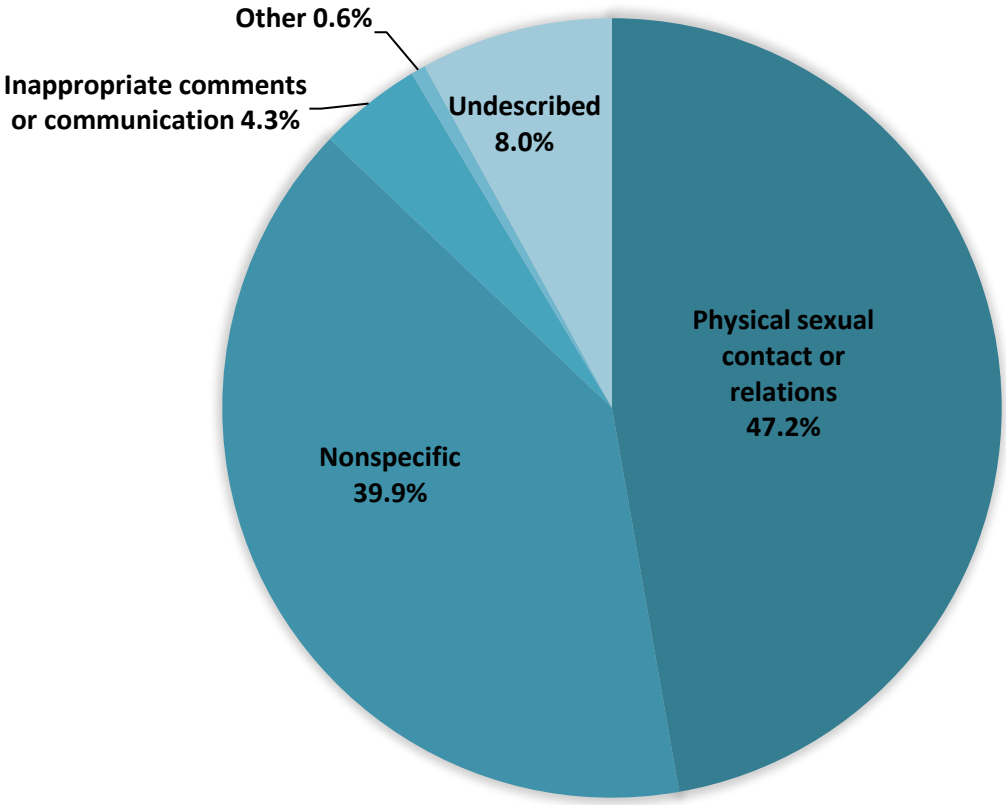
Figure 5. Identified Victim Types for the 163 Physicians With Sexual-Misconduct–Related Clinical-Privileges Reports



3.3.3 Primary Forms of Sexual Misconduct Committed by Physicians With Sexual-Misconduct–Related Clinical-Privileges Reports

Physical sexual contact or relations were the primary reported form of sexual misconduct for 77 (47.2%) of the 163 physicians with sexual-misconduct–related clinical-privileges reports (Figure 6). Nonspecific sexual misconduct was the primary reported form of sexual misconduct for 65 (39.9%) of the physicians with these reports. Inappropriate comments or communication was the primary reported form of sexual misconduct for seven (4.3%) of these 163 physicians. "Other" forms of sexual offenses were reported for one physician (0.6%). No information was available to determine the forms of sexual misconduct for the remaining 13 (8.0%) of the physicians with these reports.

Figure 6. Primary Forms of Sexual Misconduct Committed by the 163 Physicians With Sexual-Misconduct–Related Clinical-Privileges Reports



3.3.4 History or Pattern of Sexual Misconduct Among Physicians With Sexual-Misconduct–Related Clinical-Privileges Reports

The narrative descriptions for 32 (19.6%) of the 163 physicians with these clinical-privileges reports indicated that the physicians had a history or pattern of sexual misconduct. Specifically, narrative descriptions in the reports explicitly referenced or clearly described such a history or pattern.

Notably, the narrative descriptions of clinical-privileges reports for 26 of these 32 physicians documented that they had multiple victims (46.2% of these 26 physicians had only nonpatient-employee victims, 26.9% had only patient victims, and 11.5% had both employee and patient victims). One of these physicians was found to have failed to disclose being listed in a child abuse/neglect and central registry because he had sexually abused his own minor daughter.

Examples of Physicians With a History or Pattern of Sexual Misconduct in Sexual-Misconduct–Related Clinical-Privileges Reports

Case 14: *The health care institution "received an anonymous complaint from a patient who was examined by [the male family medicine/general practice physician in his fifties] for complaints of nausea. [T]he anonymous patient complained that [the physician] made her feel uncomfortable in the appointment by hugging her inappropriately and giving her unsolicited compliments… [The institution] opened an investigation of this complaint immediately and placed [the physician] on administrative leave pending the outcome of the investigation. [The] investigation was unable to identify the anonymous caller or otherwise confirm or corroborate the patient's complaints… [The physician's] employment was terminated by [the health care institution]. [F]ollowing his termination, [the institution] received two additional complaints of a similar nature by identifiable patients. [B]oth complaints were thoroughly investigated[,] and in each case, [the institution was] able to confirm or corroborate the complaints. [The institution was and is] concerned[,] particularly [] now when it [has been] brought to [the institution's] attention that [the physician] was arrested …, on a charge of [continuous sexual abuse of a child]."*

Eight to 11 years before the sexual-misconduct–related clinical-privileges report, this physician had four reports in the same state as the sexual-misconduct–related clinical-privileges report: (a) Three licensing reports; the first documented an indefinite license suspension for a criminal conviction, the second documented an indefinite reduction of a previous licensure action (basis code was not required), and the third documented a complete restoration or reinstatement of the license; and (b) An indefinite suspension of clinical privileges/panel membership for other (not classified) reasons.

Two years after the sexual-misconduct–related clinical-privileges report, the physician had two reports in the same state as where the sexual-misconduct–related clinical-privileges report originated: (a) a licensing report that entailed an indefinite revocation for criminal conviction and (b) an indefinite [HHS Office of Inspector General] exclusion report for conviction due to patient abuse or neglect.

Case 15: *"[A] patient made a complaint to a staff provider that [the male family medicine/general practice physician in his sixties] made inappropriate sexual jokes and unsolicited advances towards the patient. [T]he governing board placed the physician on administrative duties while an investigation was conducted. [T]he physician was informed of the board's intent to terminate employment in 30 days. [T]he physician immediately resigned his position. [A] medical staff investigation was on-going at the time of the physician's resignation. [T]he resignation resulted in termination of the physician's medical staff appointment and revocation of all clinical privileges. [The physician] was previously suspended for 7 days… because he crossed sexual and social boundaries with patients and staff. [A]t that time he was given letters of expectation regarding appropriate interaction with patients and staff and he was required to take ethics training."*

Case 16: *"[T]he clinical privileges of [the male anesthesiologist in his forties] were suspended based upon information concerning the physician's conduct in touching an anesthetized patient's breasts without medical justification in one recent case, one previous case recently reported by a hospital employee, and by the doctor's admission, three or four prior cases." As a result, the clinical privileges of this anesthesiologist were suspended indefinitely. The narrative description added that during the suspension, the anesthesiologist was required to undertake a psychiatric evaluation and complete any and all recommended counseling or therapy, and to complete a course on sexual harassment or sensitivity training.*

Three years later, the physician had a sexual-misconduct–related malpractice-payment report submitted to the NPDB reporting a payment amount of approximately $76,000. All of the reports involving this physician originated in the same state.

Case 17: *The male family medicine/general practice physician in his fifties had "engaged in a pattern of behavior with primarily female patients that demonstrated: [1] a failure to communicate his intentions to conduct breast and genital area examinations[, 2] a failure to obtain appropriate consent for such examinations[, and 3] conducting unwarranted breast and genital area examinations." As a result, his clinical privileges were permanently suspended.*

3.3.5 Additional Bases for Action in Physician Sexual-Misconduct–Related Clinical-Privileges Reports

Of the 180 sexual-misconduct–related clinical-privileges reports submitted for 163 physicians, 74 (41.1%) included at least one other basis for the clinical-privileges actions in addition to sexual misconduct. Table 7 enumerates the number of reports that listed each of the most commonly cited additional bases for action. Of note, 32 (17.8%) of the 180 reports listed unprofessional conduct; 11 (6.1%) listed licensing action by federal, state, or local authorities; and seven (3.9%) listed immediate threat to health or safety as an additional basis for the clinical-privileges action.

Table 7. Additional Bases for Action in Physician Sexual-Misconduct–Related Clinical-Privileges Reports (n = 180)

Report category by type of additional basis for action[a]	No. (%)[b]
Physician sexual-misconduct–related clinical-privileges reports with at least one other basis for action	74 (41.1)
Reports with most commonly cited additional bases for clinical-privileges actions	
Reports with unprofessional conduct basis	32 (17.8)
Reports with licensing action by federal, state, or local authorities basis	11 (6.1)
Reports with immediate threat to health or safety basis	7 (3.9)
Reports with surrendered clinical privileges basis	7 (3.9)
Reports with criminal conviction basis	5 (2.8)
Reports with patient abuse basis	4 (2.2)
Reports with narcotics violation or other violation of drug statutes basis	3 (1.7)
Reports with other (not classified) bases	3 (1.7)

[a] These reports pertain to 163 unique physicians with sexual-misconduct–related clinical-privileges reports.
[b] All percentages were calculated using 180 as the denominator.

3.3.6 Types of Actions Taken by Peer-Review Committees at Hospitals, Other Health Care Organizations, or Health Plans Against Physicians With Sexual-Misconduct–Related Clinical-Privileges Reports

Voluntary surrenders and revocations of clinical privileges were the most common types of actions taken against the 163 physicians with sexual-misconduct–related clinical-privileges reports, occurring for 48 (29.5%) and 47 (28.8%) of the physicians with these reports, respectively (Table 8). Summary or emergency suspensions and standard suspensions of clinical privileges were cited in reports for 35 (21.5%) and 34 (20.9%) of these physicians, respectively.

Of the 48 physicians with voluntary surrenders of clinical privileges under investigation related to sexual misconduct, 21 (43.8%) had physical sexual contact or relations, 17 (35.4%) had nonspecific forms of sexual misconduct, five (10.4%) had inappropriate comments or communication, and five (10.4%) had undescribed forms of sexual misconduct.

Of the 47 physicians with revocations of clinical privileges due to sexual misconduct, 27 (57.4%) had physical sexual contact or relations, and 18 (38.3%) had nonspecific forms of sexual misconduct. One physician (2.1%) had inappropriate comments or communication, and another physician (2.1%) had an undescribed form of sexual misconduct.

Of the 35 physicians with summary or emergency suspensions of clinical privileges related to sexual misconduct, 16 (45.7%) had physical sexual contact or relations, 12 (34.3%) had nonspecific forms of sexual misconduct, one (2.9%) had inappropriate comments or communication, one (2.9%) had other forms of sexual misconduct, and five (14.3%) had undescribed forms of sexual misconduct.

Of the 34 physicians with other suspensions of clinical privileges related to sexual misconduct, 15 (44.1%) had physical sexual contact or relations, 14 (41.2%) had nonspecific forms of sexual misconduct, two (5.9%) had inappropriate comments or communication, one (2.9%) had other forms of sexual misconduct, and two (5.9%) had undescribed forms of sexual misconduct.

Table 8. Actions Taken by Peer-Review Committees at Hospitals, Other Health Care Organizations, or Health Plans Against Physicians With Sexual-Misconduct–Related Clinical-Privileges Reports, by Primary Forms of Sexual Misconduct (Physician-Level Results)

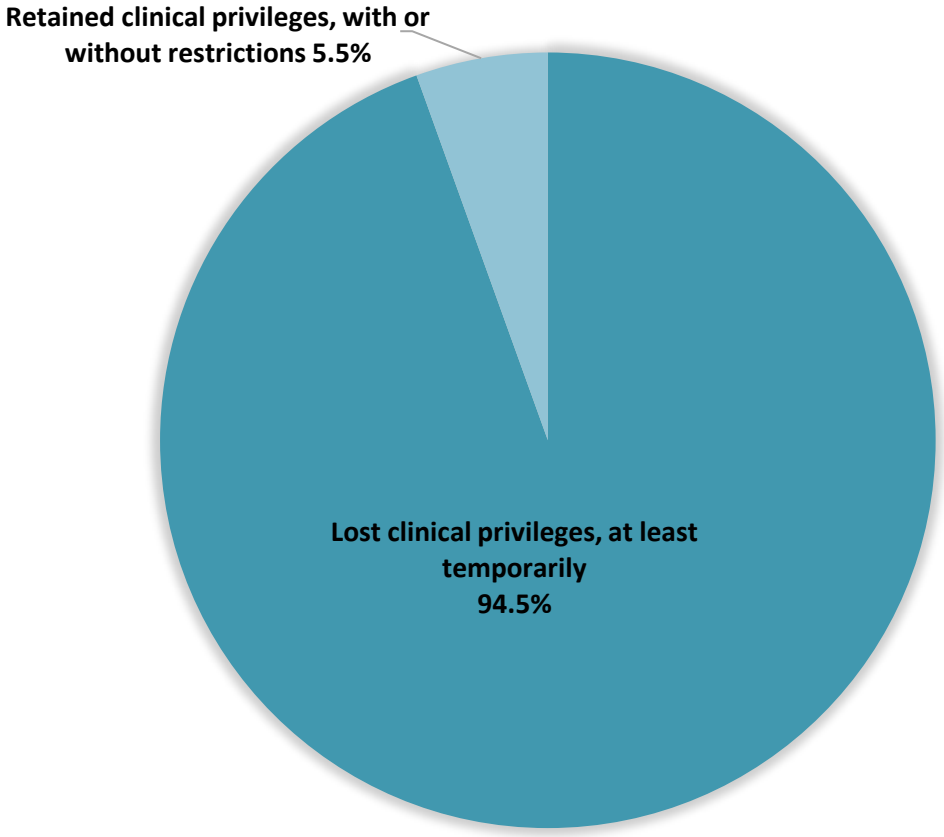
	Primary forms of sexual misconduct					
	All	Physical sexual contact or relations	Non-specific	Inappropriate comments or communication	Other	Undescribed
Category of physicians with sexual-misconduct–related clinical-privileges actions*	**No. (% of all 163 physicians)**	**No. (% of row total)**	**No. (% of row total)**	**No. (% of row total)**	**No. (% of row total)**	**No. (% of row total)**
Physicians with any sexual-misconduct–related clinical-privileges action	163 (100.0)	77 (47.2)	65 (39.9)	7 (4.3)	1 (0.6)	13 (8.0)
Physicians with revocation of clinical privileges action	47 (28.8)	27 (57.4)	18 (38.3)	1 (2.1)	0 (0)	1 (2.1)
Physicians with professionally reviewed firing action	8 (4.9)	4 (50.0)	2 (25.0)	1 (12.5)	0 (0)	1 (12.5)
Physicians with suspension of clinical privileges action	34 (20.9)	15 (44.1)	14 (41.2)	2 (5.9)	1 (2.9)	2 (5.9)
Physicians with summary or emergency suspension of clinical privileges action	35 (21.5)	16 (45.7)	12 (34.3)	1 (2.9)	1 (2.9)	5 (14.3)
Physicians with voluntary surrender of clinical privileges under investigation	48 (29.5)	21 (43.8)	17 (35.4)	5 (10.4)	0 (0)	5 (10.4)
Physicians with involuntary resignation; voluntary leave of absence while under/to avoid investigation; summary/emergency limitation/restriction/reduction, reduction, or denial of clinical privileges; and limitation/ restriction of procedures/practice area action	13 (8.0)	5 (38.5)	7 (53.8)	0 (0)	0 (0)	1 (7.7)
Physicians with other unspecified restriction/limitation of clinical privilege action(s)	15 (9.2)	7 (46.7)	7 (46.7)	0 (0)	0 (0)	1 (6.7)

* Each report can have up to five actions; actions aggregated across multiple reports if applicable.

As shown in Figure 7, 154 (94.5%) of the 163 physicians with sexual-misconduct–related clinical-privileges actions were forced or had volunteered (through revocation, suspension, or surrender of clinical privileges or involuntary resignation) to stop practicing medicine — at least temporarily — at their respective hospitals or health care organizations. The remaining nine (5.5%) of these physicians were subjected to lesser actions that permitted them to retain their clinical privileges and continue practicing at their respective hospitals or health care organizations after their sexual misconduct.

We provide case examples in Section 3.6.3 to demonstrate how health care organizations can be unwarrantedly lenient in handling physician sexual misconduct as shown in sexual-misconduct–related clinical-privileges reports.

Figure 7. Effect of Sexual-Misconduct–Related Clinical-Privileges Actions on Physicians' Ability to Practice at Their Respective Hospitals or Health Care Organizations



3.3.7 Clinical-Privileges Actions Taken by Hospitals, Other Health Care Organizations or Health Plans for Sexual-Misconduct–Related Versus Other-Offenses–Related Reports

As shown in Table 9, report-level analysis demonstrated that the overall proportions of physician sexual-misconduct–related clinical-privileges reports that cited revocations and summary or emergency suspension were significantly higher than those for reports related to other offenses (27.8% vs 18.6%, *P* = .0019; and 21.7% vs 15.9%, *P* = .0368, respectively).

Table 9. Actions Taken by Peer-Review Committees at Hospitals, Other Health Care Organizations, or Health Plans for Sexual-Misconduct–Related Versus Other-Offenses–Related Physician Reports (Report-Level Results)

Category of physician clinical-privileges reports by action taken[a]	Sexual-misconduct–related reports (n = 180)[b]	Other-offenses–related reports (n = 8,679)[c]	
	No. (%)	No. (%)	*P* value
Reports with revocation of clinical privileges action	50 (27.8)	1,618 (18.6)	.0019
Reports with professionally reviewed firing action	9 (5.0)	182 (2.1)	.0158
Reports with suspension of clinical privileges action	34 (18.9)	1,423 (16.4)	.3718
Reports with summary or emergency suspension of clinical privileges action	39 (21.7)	1,380 (15.9)	.0368
Reports with voluntary limitation/restriction/reduction of clinical privileges	0 (0)	221 (2.6)	NA
Reports with voluntary surrender of clinical privileges under investigation	52 (28.9)	2,133 (24.6)	.1840
Reports with involuntary resignation/panel membership	2 (1.1)	47 (0.5)	.2626
Reports with voluntary leave of absence while under/to avoid investigation	1 (0.6)	75 (0.9)	1.0
Reports with summary/emergency limitation/restriction/reduction of clinical-privileges action	1 (0.6)	143 (1.7)	.3741
Reports with reduction of clinical privileges action	1 (0.6)	295 (3.4)	.0356
Reports with limitation/restriction of procedures/practice area action	2 (1.1)	145 (1.7)	.7717
Reports with concurring consultation required before procedures action	0 (0)	78 (0.9)	NA
Reports with proctoring/monitoring required during procedures action	0 (0)	120 (1.4)	NA
Reports with denial of clinical privileges action	6 (3.3)	658 (7.6)	.0322
Reports with withdrawal of renewal application while under investigation	0 (0)	78 (0.9)	NA
Reports with privileges expired while under investigation	0 (0)	82 (0.9)	NA
Reports with other unspecified restriction/limitation of clinical privileges action(s)	15 (8.3)	839 (9.7)	.5485

[a] Each report can have up to five actions.
[b] Reports are for 163 unique physicians with sexual-misconduct–related clinical-privileges reports.
[c] Reports are for 6,992 unique physicians with other-offenses–related clinical-privileges reports.

Voluntary surrender of clinical privileges under investigation and suspension of clinical privileges were two common actions cited in similar proportions of sexual-misconduct–related and other-offenses–related clinical-privileges reports (28.9% vs 24.6%, $P = .1840$; 18.9% vs 16.4%, $P = .3718$, respectively). Denial of clinical privileges was noted in a lower proportion of sexual-misconduct–related reports than in reports for other offenses (3.3% vs 7.6%, $P = .0322$).

3.4 Physicians With Sexual-Misconduct–Related Malpractice-Payment Reports

Of the 148,776 malpractice-payment reports for physicians that met our study criteria, 206 (0.14%) were sexual-misconduct–related. These 206 reports involved 161 unique physicians.

The next sections summarize our findings regarding the number and characteristics of the victims of physicians with these reports and the primary forms of sexual misconduct that they experienced. We also compare victim characteristics and severity of alleged malpractice injuries identified in malpractice-payment reports for these physicians with victim characteristics and severity of alleged malpractice injuries identified in physician malpractice-payment reports involving other allegations.

3.4.1 Victims of Physicians With Sexual-Misconduct–Related Malpractice-Payment Reports

Content analysis of the narrative descriptions of physician sexual-misconduct–related malpractice-payment reports showed that 126 (78.3%) of the 161 physicians with sexual-misconduct–related malpractice-payment reports had one victim each. It is possible, of course, that these physicians had other victims who did not file a claim or who filed a claim but did not obtain a payment. Twenty-eight (17.4%) of these 161 physicians had multiple victims (as evidenced in most cases by having multiple reports involving different victims). No information was available in the malpractice-payment reports pertaining to the remaining seven physicians (4.4%) to determine the number of their sexual-misconduct victims.

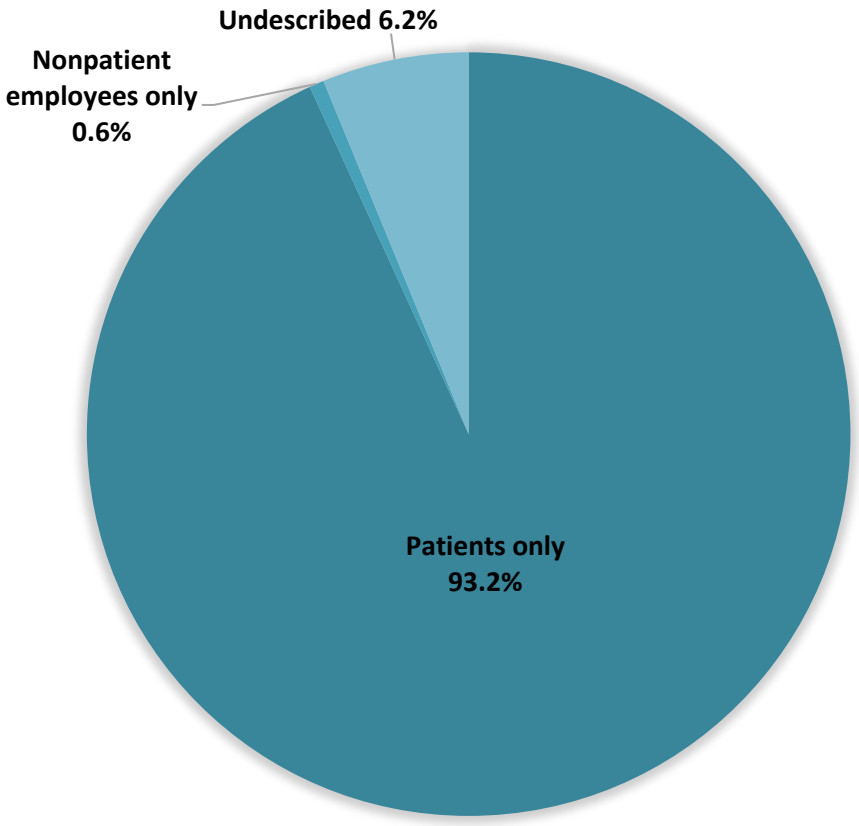
Victim Characteristics and Vulnerability Factors

For 150 (93.2%) of the 161 physicians with sexual-misconduct–related malpractice-payment reports, only patient victims were identified (Figure 8); the identified patient victim of one of these 150 physicians also was an employee of the health care organization where the offending physician practiced. For one (0.6%) of the161 physicians with sexual-misconduct–related malpractice-payment reports, only one nonpatient-employee victim was identified. No details about victim type were reported for the remaining 10 physicians (6.2%) with these reports.

Seventy-six (47.2%) of the 161 physicians with sexual-misconduct–related malpractice-payment reports had only female victims identified, and eight (5.0%) had only male victims identified. No information about the gender of any victims was reported for the victims of the remaining 77 physicians (47.8%) with these reports.

Victims with characteristics that made them vulnerable were identified in narrative descriptions pertaining to 81 (50.3%) of the 161 physicians with sexual-misconduct–related malpractice-payment reports. Specifically, 67 (41.6%) of these physicians had victims with mental illness; eight (5.0%) had minor victims (one physician had a minor victim who also was disabled, a second physician had a minor victim who also had a psychiatric condition, and a third physician had a minor victim who also was sedated); two (1.2%) physicians had victims who were under anesthesia at the time of sexual misconduct; and four (2.5%) physicians had victims who had addiction problems. Victim information was missing for the remaining 80 physicians (49.7%) with these reports.

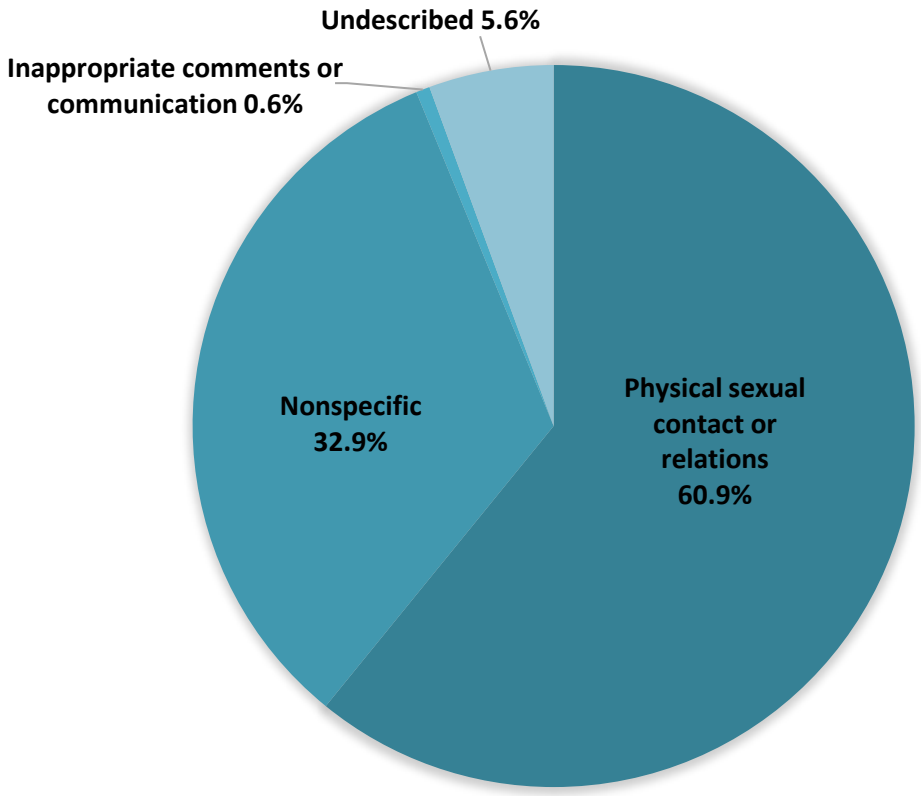
Figure 8. Identified Victim Types for the 161 Physicians With Sexual-Misconduct–Related Malpractice-Payment Reports



3.4.2 Primary Forms of Sexual Misconduct Committed by Physicians With Sexual-Misconduct–Related Malpractice-Payment Reports

Physical sexual contact or relations was the primary reported form of sexual misconduct for 98 (60.9%) of the 161 physicians with sexual-misconduct–related malpractice-payment reports (Figure 9). Nonspecific sexual misconduct and inappropriate comments or communication were the primary reported forms of sexual misconduct for 53 (32.9%) and one (0.6%) of the physicians with these types of reports, respectively. Forms of sexual misconduct were undescribed for the remaining nine (5.6%) of the physicians with these reports.

Figure 9. Primary Forms of Sexual Misconduct Committed by the 161 Physicians With Sexual-Misconduct–Related Malpractice-Payment Reports



3.4.3 Additional Malpractice Allegations in Physician Sexual-Misconduct–Related Malpractice-Payment Reports

Of the 206 sexual-misconduct–related malpractice-payment reports submitted for 161 physicians, 44 (21.4%) included a second specific malpractice allegation from a category other than sexual misconduct.

Table 10 enumerates the number of these reports that listed each specific type of additional malpractice allegation. Notably, improper conduct was the most frequently listed additional specific malpractice allegation, appearing in 13 (6.3%) of the 206 reports.

Table 10. Additional Malpractice Allegations in Physician Sexual-Misconduct–Related Malpractice-Payment Reports (n = 206)

Report category by type of additional malpractice allegations[a]	No. (%)[b]
Physician sexual-misconduct–related malpractice-payment reports with any additional malpractice allegation	44 (21.4)
Reports with improper conduct allegations	13 (6.3)
Reports with improper management allegations	4 (1.9)
Reports with failure/delay in referral or consultation allegations	3 (1.5)
Reports with assault and battery allegations	3 (1.5)
Reports with failure to diagnose allegations	2 (1.0)
Reports with failure to order appropriate medication allegations	2 (1.0)
Reports with improper performance allegations	2 (1.0)
Reports with improper technique allegations	2 (1.0)
Reports with wrong dosage dispensed allegations	2 (1.0)
Reports with wrong medication dispensed allegations	2 (1.0)
Reports with failure to monitor allegations	1 (0.5)
Reports with failure to treat allegations	1 (0.5)
Reports with wrong medication administered allegations	1 (0.5)
Reports with wrong procedure or treatment allegations	1 (0.5)
Reports with abandonment allegations	1 (0.5)
Reports with allegation, not otherwise classified	4 (1.9)

[a] These reports pertain to 161 unique physicians with sexual-misconduct–related clinical-privileges reports.
[b] All percentages were calculated using 206 as the denominator.

3.4.4 Sexual-Misconduct–Related Malpractice Payment Amounts

After adjustment for inflation to 2017 dollars, the median malpractice payment for the 161 physicians with sexual-misconduct–related malpractice-payment reports was approximately $61,637 (approximate range: $750 – $4,217,264).

Table 11 provides the median inflation-adjusted malpractice payments for the physicians for whom the primary forms of sexual misconduct identified in the report narratives were physical sexual contact or relations (98 physicians), nonspecific sexual misconduct (53 physicians), inappropriate comments or communication (one physician), and undescribed (nine physicians).

Table 11. Malpractice Payment Amounts for Physicians With Sexual-Misconduct–Related Malpractice-Payment Reports, by Primary Forms of Sexual Misconduct (Physician-Level Results)

Category of physicians with sexual-misconduct–related malpractice payment reports by primary form of sexual misconduct	Malpractice-payment amounts (inflation adjusted to 2017 dollars)					
	n (%)	Mean	Median	Standard deviation	Minimum	Maximum
Physicians with any primary form of sexual misconduct	161 (100)	$223,706	$61,637	$447,060	$750	$4,217,264
Physicians with physical sexual contact or relations	98 (60.9)	$163,522	$62,856	$217,354	$2,669	$1,070,546
Physicians with nonspecific sexual misconduct	53 (32.9)	$340,266	$49,124	$697,172	$750	$4,217,264
Physicians with inappropriate comments or communication	1 (0.6)	$10,982	$10,982	NA	$10,982	$10,982
Physicians with undescribed forms of sexual misconduct	9 (5.6)	$216,268	$62,066	$353,575	$19,924	$1,136,837

Abbreviation: NA, not applicable.

3.4.5 Victim Characteristics in Physician Sexual-Misconduct–Related Versus Other-Allegations–Related Malpractice-Payment Reports

As shown in Table 12, the proportion of victims under 20 years of age identified in physician sexual-misconduct–related malpractice-payment reports was slightly lower than that for the same-aged victims identified in physician malpractice-payment reports related to other types of allegations (8.7% vs 13.9%, $P = .0330$). The proportion of victims who were between 20 and 39 years of age identified in sexual-misconduct–related reports was more than double that for the same-aged victims identified in other-allegations–related reports (46.1% vs 22.1%, $P < .0001$). Conversely, the proportion of victims aged 60 and older identified in sexual-misconduct–related reports was approximately one-seventh as high as that for the same-aged victims identified in reports related to other allegations (3.4% vs 23.7%, $P < .0001$). Finally, the proportion of victims between 40 and 59 years of age identified in sexual-misconduct–related reports was not significantly different from that for the same-aged victims identified in other-allegations–related reports (32.0% vs 35.8%, $P = .2593$).

The proportion of females identified as victims in physician sexual-misconduct–related malpractice-payment reports was significantly higher than that for other-allegations–related malpractice-payment reports (86.9% vs 54.7%, $P < .0001$).

A large majority of sexual-misconduct–related physician malpractice-payment reports concerned incidents in the outpatient setting; this proportion was significantly higher than that for physician malpractice-payment reports related to other allegations (84.5% vs 40.2%, $P < .0001$) (Table 12). In contrast, far fewer sexual-misconduct–related malpractice-payment reports concerned incidents in the inpatient setting than did malpractice-payment reports related to other allegations (8.7% vs 44.5%, $P < .0001$). A smaller proportion of sexual-misconduct–related reports concerned incidents in both the inpatient and outpatient settings than that for other-allegations–related malpractice-payment reports (2.4% vs 9.2%, $P = .0007$).

3.4.6 Severity of Victim Injury in Physician Sexual-Misconduct–Related Versus Other-Allegation–Related Malpractice-Payment Reports

"Emotional injury only" accounted for a significantly higher proportion of victim injuries identified in sexual-misconduct–related malpractice-payment reports than that for reports related to other allegations (82.5% vs 1.5%, $P < .0001$) (Table 12). In contrast, the proportions of victims reported to have died or sustained a major temporary, minor permanent, significant permanent, or major permanent injury in sexual-misconduct–related reports were significantly lower than those in malpractice-payment reports related to other allegations.

Table 12. Victim Characteristics and Type of Victim Injury in Physician Sexual-Misconduct–Related Versus Other-Allegations–Related Malpractice-Payment Reports (Report-Level Results)

Victim characteristics	Sexual-misconduct–related reports (n = 206)[a]	Other-allegations–related reports (n = 148,570)[b]	
	No. (%)[c]	No. (%)[c]	*P* value
Age group			
Under 20 years	18 (8.7)	20,613 (13.9)	.0330
20–39 years	95 (46.1)	32,760 (22.1)	< .0001
40–59 years	66 (32.0)	53,202 (35.8)	.2593
60–79 years	7 (3.4)	35,193 (23.7)	< .0001
Unknown	20 (9.7)	6,802 (4.6)	.0004
Sex			
Female	179 (86.9)	81,195 (54.7)	< .0001
Male	27 (13.1)	65,179 (43.9)	< .0001
Unknown	0 (0)	2,196 (1.5)	NA
Setting			
Inpatient	18 (8.7)	66,098 (44.5)	< .0001
Outpatient	174 (84.5)	59,722 (40.2)	< .0001
Both inpatient and outpatient	5 (2.4)	13,712 (9.2)	.0007
Unknown	9 (4.4)	9,038 (6.1)	.3035
Severity of alleged malpractice injury[d]			
Emotional injury only	170 (82.5)	2,178 (1.5)	< .0001
Insignificant injury	4 (1.9)	2,387 (1.6)	.5775
Minor temporary injury	15 (7.3)	14,212 (9.6)	.2652
Major temporary injury	4 (1.9)	15,505 (10.4)	< .0001
Minor permanent injury	3 (1.5)	17,543 (11.8)	< .0001
Significant permanent injury	1 (0.5)	22,647 (15.2)	< .0001
Major permanent injury	1 (0.5)	15,953 (10.7)	< .0001
Quadriplegic, brain damage, or lifelong care	0 (0)	7,522 (5.1)	NA
Death	2 (1.0)	47,349 (31.9)	< .0001
Cannot be determined from available records	6 (2.9)	3,274 (2.2)	.4689

Abbreviation: NA, not applicable.

[a] Reports are for 161 unique physicians with sexual-misconduct–related malpractice-payment reports.

[b] Reports are for 103,695 unique physicians with malpractice-payment reports related to other allegations.

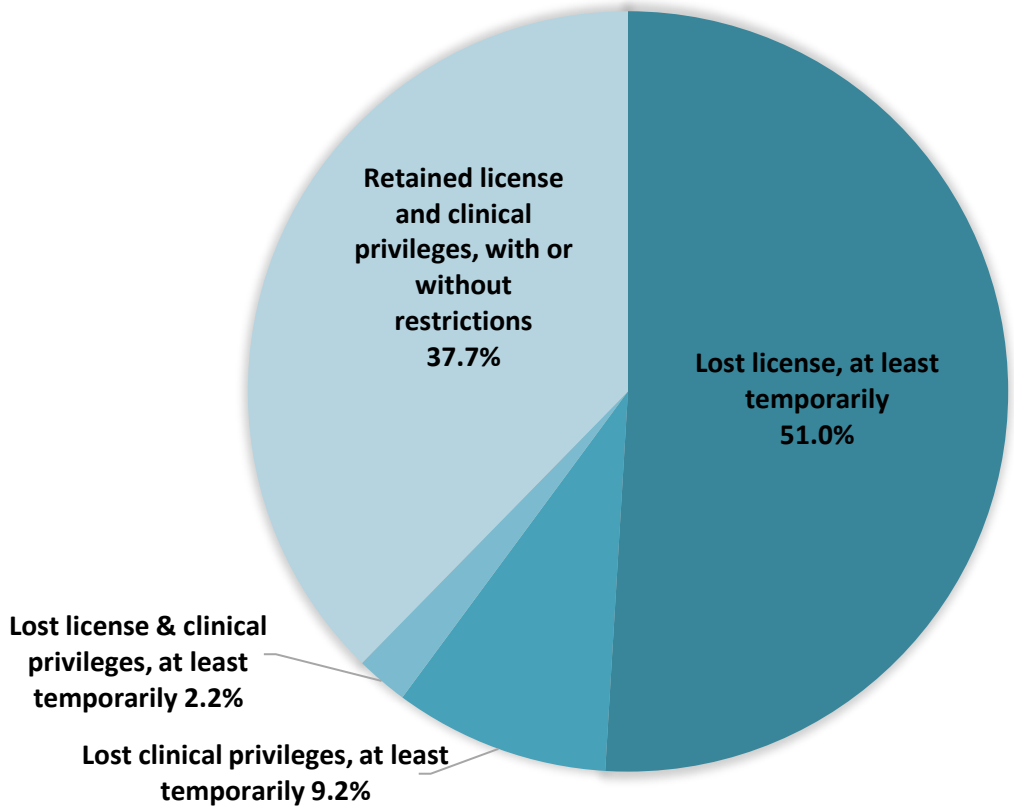
[c] Percentages may not add up to 100 due to rounding.

[d] Only one severity type of injury code is permitted in malpractice-payment reports.

3.5 Overall Impact of Sexual-Misconduct–Related Reports on Licenses and Clinical Privileges of Offending Physicians

As shown in Figure 10, 690 (51.0%) and 124 (9.2%) of the 1,354 physicians with sexual-misconduct–related reports lost their licenses or clinical privileges, respectively, at least temporarily, as a result of their sexual offenses. Only 30 (2.2%) of these physicians lost both their licenses and clinical privileges as a result of their sexual misconduct. However, the remaining 510 (37.7%) of these physicians continued to have active licenses and clinical privileges in the states where they were disciplined or had malpractice payment reports after their sexual misconduct offenses, although some of them faced certain restrictions or limitations as shown in Table 5 and Table 8.

Figure 10. Disposition of Licensing and Clinical Privileges Among All 1,354 Physicians With Sexual-Misconduct–Related Reports



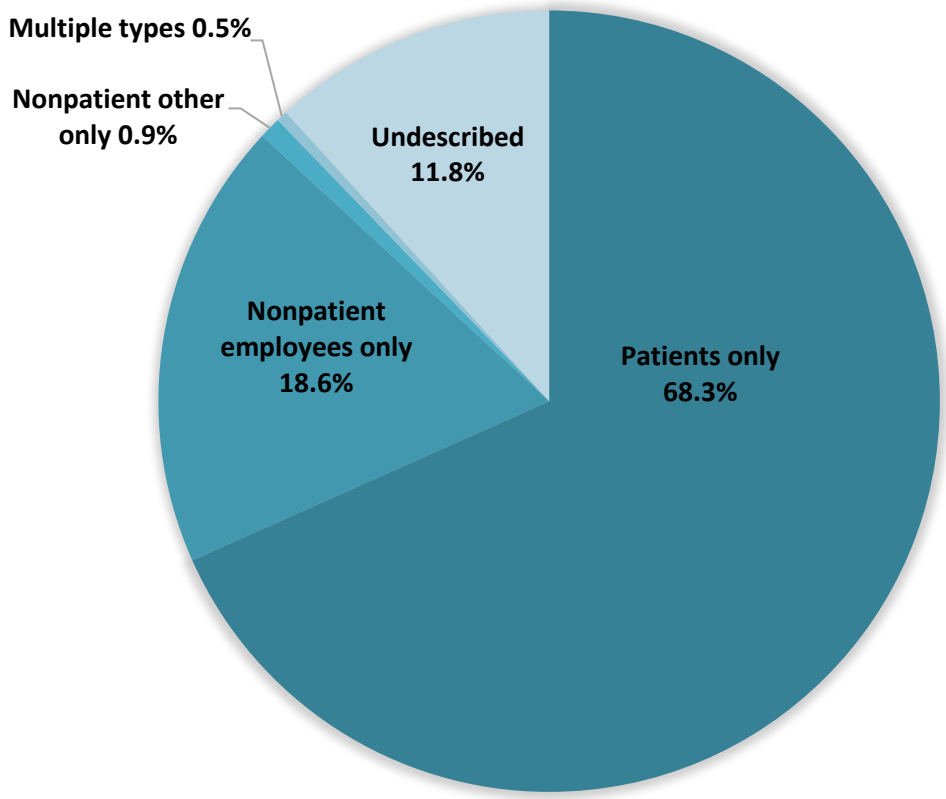
3.6 Evidence of Unwarranted State Medical Board and Health Care Organization Leniency With Physicians Who Engaged in Sexual Misconduct

3.6.1 Physicians With No Licensing Reports for Sexual Misconduct Despite Evidence of These Offenses From Clinical-Privileges or Malpractice-Payment Reports

There were 317 physicians with one or more sexual-misconduct–related clinical-privileges or malpractice-payment reports. Of these, 221 (69.7%) had no sexual-misconduct–related licensing reports (Table 1). Content analysis of the narrative descriptions of the sexual-misconduct–related clinical-privileges and malpractice-payment reports for these 221 physicians showed that 139 (62.9%) had one victim each, whereas 61 (27.6%) had multiple victims each. No information was available in the pertinent clinical-privileges or malpractice-payment reports for the remaining 21 (9.5%) of these 221 physicians to determine the number of their sexual-misconduct victims.

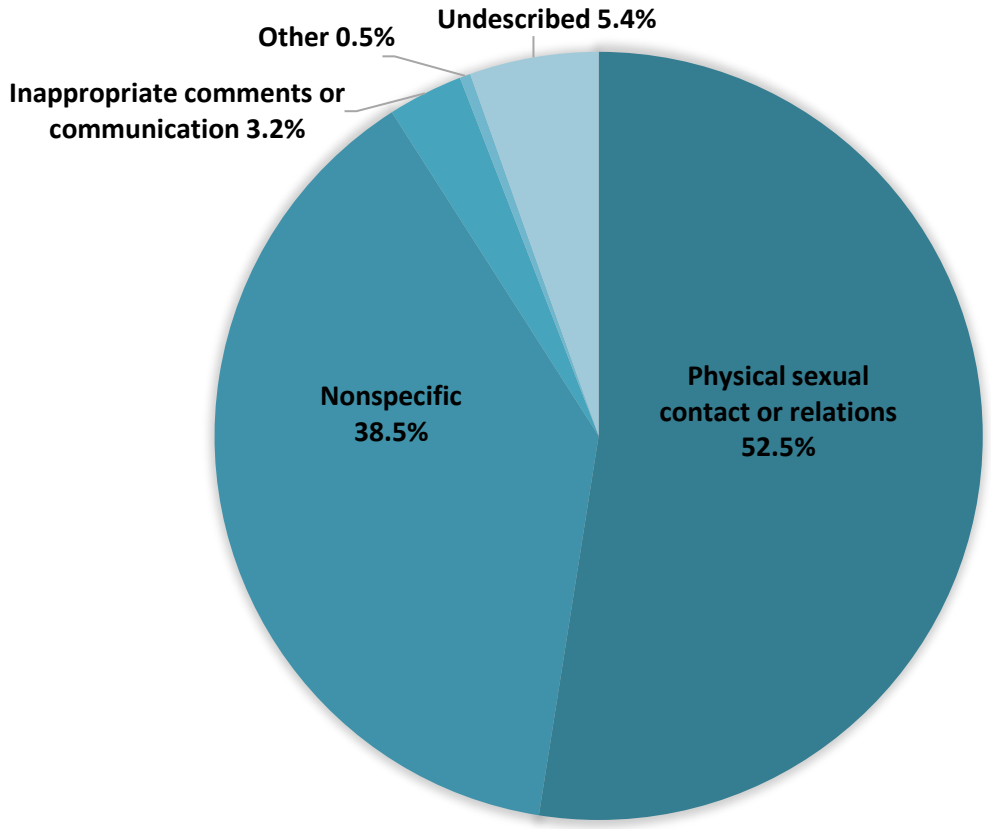
For 151 (68.3%) of the 221 physicians with one or more sexual-misconduct–related clinical-privileges or malpractice-payment reports but no sexual-misconduct–related licensing reports, only patient victims were identified, whereas for 41 (18.6%) of these physicians, only nonpatient-employee victims were identified (Figure 11).

Figure 11. Identified Victim Types for the 221 Physicians With Sexual-Misconduct–Related Clinical-Privileges or Malpractice-Payment Reports but No Sexual-Misconduct–Related Licensing Reports



Physical sexual contact or relations and nonspecific sexual misconduct were the primary reported forms of sexual misconduct for 116 (52.5%) and 85 (38.5%) of these 221 physicians, respectively (Figure 12). Inappropriate comments or communications was the primary reported form of sexual misconduct for seven (3.2%) of these 221 physicians. One physician (0.5%) had a form of sexual misconduct categorized as other. Insufficient information was reported to determine the primary forms of sexual misconduct for the remaining 12 (5.4%) of these 221 physicians.

Figure 12. Primary Forms of Sexual Misconduct Committed by the 221 Physicians With Sexual-Misconduct–Related Clinical-Privileges or Malpractice-Payment Reports But No Sexual-Misconduct–Related Licensing Reports



There were three physicians with both sexual-misconduct–related clinical-privileges reports and sexual-misconduct–related malpractice-payment reports but no sexual-misconduct-related licensing reports: One of them had multiple victims, and each of the other two had one victim. Physical sexual contact or relations was the primary reported form of sexual misconduct for all three of these physicians.

Of the 221 physicians with sexual-misconduct–related clinical-privileges or malpractice-payment reports but no sexual-misconduct–related licensing actions, 107 (48.4%) had sexual-misconduct–related malpractice-payment reports; the inflation-adjusted median malpractice payment amount for these physicians was approximately $79,005 (approximate range: $750 – $4,217,265).

Examples of Physicians With No Licensing Reports for Sexual Misconduct Despite Evidence of These Offenses Documented in Clinical-Privileges or Malpractice-Payment Reports

> Case 18: *The malpractice-payment report indicates that "although [the female patient] requested a female doctor in advance of the appointment, she was told this was not possible and (was) reassured that it would not be necessary to disrobe. [H]owever, [the male internal medicine physician in his sixties] did require [the patient] to remove all her clothing, in his presence and under his observation, and conducted an examination in a negligent, excessively obtrusive manner. [The physician] examined and touched [the] patient (unclothed) more extensively than required for the purpose of [an] exam, and failed to provide a female chaperone. [The physician] conducted the examination in a manner which was inconsistent with reasonable measures to protect the dignity and privacy of his patient, and which he should have known would embarrass, humiliate and inflict great emotional distress." The patient victim was awarded a malpractice payment of approximately $300,000.*
>
> Case 19: "*[The allegation is] that [the] special needs minor [male] patient was repeatedly sexually molested over four months" by the male psychiatrist in his thirties. The victim was awarded a malpractice payment of approximately $256,000.*
>
> Case 20: *"[The victim] alleged [an] improper sexual relationship [by the male family medicine/general practice physician in his sixties] with patient a, despite knowledge of patient a's psychiatric vulnerability, and improper treatment of anxiety and depression of patient a, leading to worsening psychiatric condition, and falsely advising patient b that his health concerns were so severe that he should refrain from sexual relations with [his] wife, patient a, which allegedly lead to panic attacks." The victim was awarded a malpractice payment of approximately $223,000.*
>
> Case 21: *"[The male anesthesiologist in his thirties] was summarily suspended…at…[three hospitals…based on an allegation that he…[had] engaged in sexual misconduct with one (1) or more patients during course(s) of treatment. On [date], at…hospital [X], circulating…'nurse a' notified supervisor of an incident on [date]…wherein, during the surgical prep of a patient[,] had witnessed [the physician] touching the patient's penis without an apparent medical purpose. [T]here was also a report made by 'nurse c' of prior suspicious, but unconfirmed behaviors on approximately four (4) other occasions. [Hospital X's] medical staff leadership [was] notified accordingly, and contacted [the physician] immediately[.] [H]e was then notified thereafter of his summary suspension of*

medical staff membership and all clinical privileges and removed from hospital premises. [Hospital Y's] medical staff leadership were notified of [Hospital X's] actions, and due to nature of [the] incident and safety of our patients[,] [the physician] was summarily suspended [at Hospital Y]."

Case 22: *"[D]uring [the] trial [of the male occupational medicine specialist in his fifties], he admitted that the [overly affectionate, romantic] relationship with the [female patient] started after she was referred to him subsequent to manifesting suicidal ideations. [T]he relationship involved private dinners and socializing at her residence. She referred to him as 'daddy;' he referred to her as 'my princess' and 'little one.'… [The physician] admitted at trial that he had knowledge of her existing mental health issues, including a [posttraumatic stress disorder (PTSD)] diagnosis. [S]till, [the physician] invited her to live with him in his apartment after she lost her housing. [H]e continued to serve as part of her medical team while she was living with him. [S]he lived with him for three months. [S]he finally moved out of his apartment only after she was involuntarily admitted to a psychiatric treatment facility after an apparent psychotic break…The physician] also served as the medical provider for [the patient]. [H]is knowledge of her mental health issues, including [PTSD] and panic attacks, is documented in electronic communications logs that were entered into evidence. [T]hese logs document the fact that during the course of his inappropriate relationship, he was prescribing her [X]anax. [D]uring the trial and in a signed stipulation of fact, he admitted to engaging in a sexual relationship with [the patient] and that he had sex with her on 10-20 occasions. [H]e received a criminal conviction… [T]his criminal conviction is the basis of permanently revoking his clinical privileges."*

3.6.2 Examples of State Medical Board Leniency With Physicians Who Engaged in Sexual Misconduct and Had Sexual-Misconduct–Related Licensing Reports

Consent Orders and Withheld Serious Actions

Content analysis of the narrative descriptions showed that the licensing actions for 223 (19.7%) of the 1,133 physicians with sexual-misconduct–related licensing reports were a result of consent or stipulated agreements between medical boards and offending physicians. These agreements are essentially negotiated settlements or plea bargains to which both the boards and offending physicians mutually agree.

Another way that medical boards accommodate physicians who committed sexual misconduct is by taking suspension or revocation licensing action but later staying these actions and replacing them with restriction actions, such as probation or chaperone requirements. Content analysis of the narrative descriptions showed that 79 (7.0%) of the physicians with licensing actions due to sexual misconduct had suspension or revocation actions that were stayed and replaced by less serious actions that permitted the physician to continue to practice (four of these stays were identified as partial and one stay of already lenient conditions imposed by a licensing board was issued by a state supreme court).

Heeding Personal Circumstances of Sexual Offender Physicians

The following example excerpts from the narrative descriptions of sexual-misconduct–related licensing reports demonstrate how medical boards (or in one case, a state supreme court) sympathized with physicians who committed sexual misconduct:

> Case 23: *"[The male family medicine/general practice physician in his forties] engaged in sexual intercourse with [a female] patient…, which constitutes gross or repeated malpractice or professional misconduct… [The physician] began treating [the patient], with a preliminary diagnosis of anxiety and depression and wrote [the patient] a prescription for [Z]oloft. [The physician] saw [the patient] at eight office visits between [date] and [date,] and many of these visits were 'psych visits' and in addition to [Z]oloft, a prescription for ten [X]anax pills was [provided] at one visit… [A]t some point following, [the physician] and [the patient] began a sexual relationship and frequently had sexual intercourse in his office after normal office hours.[The] sexual relationship [occurred] at a time [when] both [the physician] and [the patient] were separated from their respective spouses. In its consideration of the entirety of the evidence, the board is mindful of the mitigating circumstances presented. [T]he sexual misconduct that occurred appears to be a single occurrence, albeit a repeated and continuing act. [S]ince that time, [the physician] has rebuilt his marriage and his life with his wife and family, and his current remorse appears genuine. [A]lthough the violations occurred long ago, the board believes the conduct is sufficiently serious to warrant a period of active suspension and a period of probation, along with re-education on medical ethics and maintaining appropriate boundaries with patients. [T]he board ordered the license of [the physician to be]…suspended for three years… the first [x] days of said suspension to be active, with the remainder to be stayed and served as probation, contingent on compliance with the terms of this order and the laws governing the practice of medicine and surgery… [The physician] is to successfully complete courses in boundary issues and ethics to be pre-approved by the board[,] and he is to submit proposed satisfaction of these requirements to the board for approval."*

> Case 24: *"[The male surgeon in his fifties] engaged in an intimate relationship with [a female] while she was his patient… [The physician] admitted he had engaged in a brief [three-encounter] inappropriate relationship with [the patient]… [The physician] further stated his inappropriate physical contact with [the patient] took place outside of business hours and not during patient visits. [The physician] accepted responsibility for his acknowledged lapse in judgement in engaging in an unprofessional, personal relationship with a patient. [The physician] explained during his testimony before the committee that he was involved in a difficult divorce proceeding during the course of these encounters[,] which he contended left him particularly vulnerable and thus, more susceptible to having a lapse in judgment… [T]he board ordered and [the physician] agreed to a reprimand… [The physician] is to take and successfully complete a course in boundaries"*

> Case 25: *"[T]he board is of the view that rather than adopt the administrative law judge's recommendation that [the physician's] license be revoked, the board felt it should have a more thorough understanding of the psychological status of [the physician] and the measures that would best protect the public. [T]he board ordered [the physician's] license to be suspended and will not entertain any application for reinstatement for a minimum of six months…and if such application is made[,] it must be supported by documentation to*

the satisfaction of the board. [The physician] must successfully complete an intensive course pre-approved by the board, focused upon boundary issues; he is to submit to a full psycho-social evaluation specializing in the evaluation of sexual misconduct and boundary violations; and he has to follow all of the recommendations of the professional assistance program." However, the physician appealed the board's suspension action to the state supreme court and was granted a motion of stay of this suspension conditioned on his compliance with the board's requirement "that he have a board-approved chaperone present during examinations" of female patients."

Minor Disciplinary Actions (A Fine, Other Licensing Action [Not Classified], Reprimand, or Censure) When the Primary Form of Sexual Misconduct Described in Licensing Reports was Physical Sexual Contact or Relations

Case 26: *"[I]n lieu of proceeding to an adjudicatory hearing the [male family medicine/general practice physician in his fifties] agrees to accept a reprimand from the board. In addition, within six (6) months of the execution of the consent agreement[,] the licensee will enroll in and successfully complete a board[-]approved course in general ethics and boundaries and provide the board with documentary proof of the completion of such course. [T]his action is based on inappropriate sexual contact with a patient."*

Case 27: *The female family medicine/general practice physician in her fifties is subjected to a permanent reprimand or censure of license. This action is based on "abuse of a client or patient or sexual contact with a client or patient." Other bases for this action include "incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient…be harmed[,] violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice[,] failure to adequately supervise auxiliary staff to the extent that the consumer's health or safety is at risk[,] current misuse of alcohol[, and] current misuse of controlled substances and/or current misuse of legend drugs."*

Laxity With Prolonged Incompetence, Malpractice, and Negligence Culminating in Sexual Misconduct with Controlled Substance User Patients

Case 28: *The male obstetrics and gynecology physician in his forties had six NPDB reports over the course of 11 years before his sexual-misconduct–related licensing report:*

(1) Two malpractice-payment reports indicating that two female victims had died (the first was due to "improper choice of delivery method" and the second was due to "failure to recognize a complication"). These reports noted total malpractice payments of approximately $537,000.

(2) Three clinical-privileges reports: (a) the first report was six years after the first malpractice-payment report and involved indefinite other restriction/limitation of clinical privileges due to substandard or inadequate skill level; (b) the second report was from a year after report (a) and involved removal of the restriction/limitation of clinical privileges in the same state but also included a new six-month restriction/limitation of clinical privileges; (c) the third report was from two years after report (b) and entailed an indefinite denial of clinical privileges due to "other/not classified" reasons.

(3) A licensing report seven years after the first malpractice-payment report involving an indefinite reprimand or censure action of license due to malpractice, incompetence, and negligence.

Finally, the sexual-misconduct–related licensing report noted that the physician "had a sexual relationship with approximately 11 different women, subsequently saw them as patients[,] and prescribed controlled substances for them. Many of the prescriptions were not documented or mentioned in medical records and [the physician] believed that some of the controlled substances were being sold by his patient[s]. [The physician] also sometimes consumed some of the controlled substances that he prescribed for one of his patients. [The physician] prescribed controlled substances to about 19 additional women without creating or maintaining any medical records whatsoever. [His] employer has no record of any of those individuals having been seen as patients at the practice. [The physician] was ordered to obtain 10 continuing education hours and met all requirements except in the year of … due to attending treatment programs with [state] medical foundation. [The physician] also successfully completed treatment at [a facility]…[,] attended and completed a recommended treatment program to address his sexual compulsion disorder at [a] behavioral medical institute[,]… and subsequently entered into a 'contract for maintenance treatment' with them. [The physician] entered into a [five-year] contract with [the state] medical foundation."

Surrenders of License In Lieu of Disciplinary Actions

Additionally, review of the narrative descriptions showed that medical boards often allow physicians with sexual misconduct to resign instead of taking a licensing action:

Case 29: *A male internal medicine physician in his sixties "was arrested and charged with 15 counts of delivery of a schedule [II] narcotic. [T]he criminal complaint alleges that…[the physician] exchanged prescriptions for controlled substances for sexual acts with individuals, including patients. [The physician] lost his [DEA] registration… [His] medical practice was closed. [The physician] then notified the board that he intends to permanently retire from the practice of medicine. In light of his interest in retirement, and to protect the public without the need to conduct a complete investigation and public hearing, the board and [the physician] voluntarily entered into a consent order in which [the physician] permanently surrendered his [state] medical license."*[50] *Notably, this physician also had a clinical-privileges report in the same year as the sexual-misconduct–related licensing report in which the bases for action were immediate threat to health or*

safety and violation of by-laws, protocols, or guidelines. His clinical privileges were revoked due to these actions.

Psychiatric Treatment/Referral to Professional Rehabilitation, Then Return to Practice

Offending physicians often were referred to professional assistance programs, psychiatric evaluation and education.

Case 30: "*[The male psychiatrist in his fifties] admitted that on two occasion[s], he hugged and kissed [a former female patient]. He further testified that [this patient] was transferred to another doctor for further care until she was discharged and that he has had no further contact with her. Since the incidents…[the physician] has attended individual therapy, voluntarily enrolled in the professional assistance program[,]…and successfully completed [an] ethics course. [The physician] also testified that during the pendency of the investigation, he has not seen patients, but anticipates returning to the active practice of psychiatry upon resolution of this matter. The board order[ed] and [the physician] agreed [that he will be] reprimanded for his behavior… [The physician] must submit to a full psycho-sexual evaluation by a program pre-approved by the board which specializes in the evaluation of sexual misconduct and boundary violations. [The physician] will obtain a recommendation for an appropriate program from…the executive medical director of the professional assistance program…and submit this recommendation to the board for approval. [The physician] must pay a civil penalty."*

Case 31: *"[The male family medicine physician in his forties] had sexual contact with four women with whom he had other relationships. [T]hree of the women were his patients; one was not a regular patient but saw him one time in consultation. [N]one of these women reported him to the [state] medical board. [The physician] disclosed his behavior to two partners[,] who recommended that he report himself or they would. [The physician] then self-reported himself to his employer and to the board. [The physician] has been evaluated and treated by a psychiatrist… [H]e had an evaluation performed by a psychologist[,] who concluded that he is fit to practice medicine. [B]y engaging in sexual contact or other sexual behavior with these patients[,] he has engaged in unprofessional conduct. [Therefore,] his license is suspended for 18 months. The suspension is stayed and shall remain stayed as long as [the physician] is in compliance with the terms and conditions of the [board's] order."*

According to a prior clinical-privileges report two years earlier, the physician's employer had terminated the physician's medical staff membership and clinical privileges due to the same sexual misconduct.

Only Probation and Chaperone Requirement Actions for Sexual Misconduct Described in Licensing Reports

Case 32: *"[W]ithout medical justification, [the male internal medicine physician in his fifties] fondled the breasts of a patient pursuant to an initial physical examination. [N]o chaperone was present during the exam… [Additionally, the physician] is alleged to have inappropriately touched, to include vaginal penetration, another patient without medical justification. [T]he patient was or had been an employee at the [physician's] office. [C]riminal charges were filed against [the physician] related to the complaints made to the police by both patients. [B]oth criminal cases appear in….county clerk of court records*

online as having been dismissed… [S]ince his license has been suspended, [the physician] has taken certain steps to ensure that the public interest is protected if he were to return to practice. [A]dditionally, he has passed the spex examination [a computerized, multiple-choice examination of current knowledge requisite for the general, undifferentiated practice of medicine] to demonstrate clinical competency. [T]he board finds and concludes that with the conditions imposed, the public interest is adequately protected, and [the physician's] license…be conditionally reinstated. [T]he [physician's] request for reinstatement is granted. [P]robationary status for two years, subject to strict compliance with the following conditions outlined in a safety plan presented to the board: a. [S]upport staff must undergo training regarding professional sexual misconduct. b. [S]upport staff must be given a copy of an employee bill of rights to sign. c. [S]upport staff will provide patient surveys to be completed daily by all patients for the first 12 weeks of [the physician's] return to practice, followed by patient surveys for one week each quarter thereafter. d. [E]ach patient will be provided a copy of the patient's bill of rights which will be documented in each patient's chart. e. [E]ach patient will be given a copy of the principles of medical practice, which will also be documented in the patient's chart. f. [The physician] must maintain 24 hour security camera system in his office that is operational to record continuously for at least six months at a time in the waiting room, staff areas and break room (but not patient exam rooms and restrooms)...[The physician] must adhere to all board requirements, conduct practice in a manner that is beyond reproach and in adherence to the [AMA's] ethical guidelines. [The physician] is not to treat family members [and is to] adhere to boundary protection plan and all of its requirements, utilize medical assistant chaperone, must have a practice monitor, quarterly reports to the board, practice shall be limited to site approved by the board, [and the physician] must obtain approval by the board prior to changing practice sites."

Case 33: *"[The male psychiatrist in his thirties] wrote prescriptions for controlled substances for [a female] patient, an acquaintance and not pursuant to a doctor-patient relationship… [The psychiatrist] and [this woman entered] into a romantic relationship that ended in [month, year]… [The psychiatrist] entered [the woman's] home uninvited, entered [her]bedroom[,] and began to grab her and attempt to hug and kiss her. [The woman] screamed for [the psychiatrist] to leave and called 911… [P]olice officers moved the [psychiatrist] to another area so they could speak with each person individually. [D]uring this time, the [psychiatrist] used his cell phone to call and text [the woman] as she spoke with officers… [The psychiatrist] appeared before the criminal court…and was placed on judicial diversion for 11 months and 29 days for (1) count of aggravated criminal trespassing and one (1) count of stalking. [The psychiatrist] was to have no contact with [the woman], pay costs[,] and complete a treatment plan… [He] completed a multidisciplinary assessment…and was found to be fit to practice medicine. [The assessment organization] recommended a monitoring agreement, continuing education on prescription boundaries, [utilizing] a chaperon[e] when seeing females in an addiction/suboxone treatment context[,] and [receiving] hormone replacement treatment. [L]icense on probation. [A]sessment of civil [monetary] penalties… plus costs."*

Case 34: *"[The male anatomic/clinical pathology physician in his fifties] has been convicted of a crime that has a direct bearing on his ability to practice competently and is harmful to the public in that he has been convicted of sexual battery and criminal confinement and is a registered sex offender. [The physician] is on probation but cannot*

practice [in the state] until at least 6 months and must receive prior permission from the board."

Case 35:*"The board finds that [male emergency medicine physician's] past inappropriate actions, previous license suspensions in [state 1 and state 2], and the denial of licensure by [state 3] are grounds…to support an order requiring [the] licensee's license [in state 4] be subject to disciplinary action in the form of a limitation for a period of at least 2 years. [L]icensee's application for a license to practice osteopathic medicine and surgery is granted subject to disciplinary action in the form of a limitation: for a period of at least 2 years, licensee shall not practice medicine and surgery with female patients unless he has a female chaperone present with him at all times. [The physician] shall attend and successfully complete the live lecture format [professional boundaries and ethics] course."*

Probation and Return to Practice After Abusing a Minor

Case 36: *A male internal medicine physician in his forties had a licensing report due to sexual misconduct; conduct evidencing moral unfitness; and violation of federal or state statutes, regulations, or rules, as well as a criminal conviction resulting from "plead[ing] guilty to two counts of sexual exploitation of a minor," which indicated that the physician voluntarily surrendered his medical license. A subsequent licensing report three years later that cited most of the same previous bases for action indicated that the physician was put on probation after having "completed 34 months of probation, 600 hours of community service, and 8 polygraph tests that found [the physician] was not deceptive [and having] received inpatient treatment and [been] evaluated." The report indicated that "a statement was provided that [the physician] can safely practice as a physician.*"

Just Probation After a Physician Aborted Fetus That He Conceived With a Patient and After Other Malpractice

Case 37: *A male obstetrics and gynecology physician in his thirties had his clinical privileges "terminated for a minimum of one year" by a health care organization due to a pregnancy that resulted from sexual intercourse with a patient. The physician then deceptively convinced the victim to give consent for an abortion that he performed to get rid of the fetus: "1) [P]rovider developed a personal, intimate relationship with an employee that advanced to include a patient/physician relationship, which is clearly a breach of [AMA/ACOG] standards of conduct. (2) [T]here is suggestion that the [patient] might have been given misleading information by the provider that suggested a higher incidence of miscarriage than the literature supports, in order to obtain consent or justify the need for the procedure. (3) [P]rovider violated hospital policy in performing an unnecessary interruption of a potentially viable pregnancy without obtaining prior consent and review by appropriate hospital personnel… (4) [T]here is substandard or poor documentation of medical records in relation to the office visit and a transvaginal ultrasound that were done prior to admission to the hospital." In the following year, the medical board took a three-year probation action against the physician due to sexual misconduct, as well as negligence; substandard or inadequate care; and violation of federal or state statutes, regulations, or rules. Three years later, the medical board lifted the probation restriction, permitting the physician to practice freely.*

Relapse After Lenient Licensing Actions

> Case 38: *An initial licensing report indicated that "a consent decree [was] entered into by [a male physician in his thirties (specialty not specified)] and…members of the [medical] board. The consent decree was entered as a result of [the physician] admitting to an inappropriate personal relationship with a patient." The decree included [that the physician] shall attend and successfully complete a professional/medical education boundaries course that is preapproved [by the board], within six (6) months ...[and] will be placed on a two (2) year probationary period with the board." Eight months later, a second licensing report against this physician indicated that "the [medical] board was notified that…[the physician] allegedly had sexual contact with a patient during a scheduled appointment… During that same office visit, [the physician] allegedly [provided] the patient with a prescription for…tramadol, a controlled substance. [T]hese allegations were confirmed during an interview with the patient… [T]he board's prosecuting attorney contacted [the physician's] counsel, advised him of the allegations, and advised that, in the prosecutor's opinion, [the physician's] actions since returning from the boundaries course posed an imminent threat to the public health, safety and welfare. [T]he board prosecutor advised [the physician's] attorney that [the physician] could request a voluntary suspension of his [state] medical license in lieu of a board-ordered summary suspension… [The physician] sent notice to the board requesting the board approve a voluntary suspension of his medical license. [T]he board voted to accept the voluntary suspension."*

3.6.3 Examples of Health Care Organization Leniency With Physicians Who Engaged in Sexual Misconduct and Had Sexual-Misconduct–Related Clinical-Privileges Reports

Reporting Sexual Misconduct as "Other" Basis for Action

> Case 39: *A male obstetrics and gynecology physician had two clinical-privileges reports in which the basis for action was reported as "other (not specified)" and the reported action was "voluntary leave of absence while under/to avoid investigation." Yet, a licensing action in the same state as the institutions from which these clinical-privileges reports for this physician originated indicated that sexual misconduct was the basis for action. The narrative description for the licensing report indicated that a "partial interim suspension order [was] issued" and restrictions were imposed requiring that "a third[-]party chaperone [be] present while consulting, examining or treating all female patients." The board filed a subsequent revision-of-action report in the same year restoring the license of this physician. Over the following two years, the same board filed two additional revision-of-action reports, first suspending and then revoking the physician's license. However, it was not until four years after the initial sexual-misconduct–related clinical-privileges report that this physician had a sexual-misconduct–related malpractice-payment report that provided details about the nature of sexual abuses of a patient by this physician. The malpractice-payment report concerned a female patient in her sixties who was referred to the physician for evaluation of vaginal prolapse. The narrative description of the malpractice-payment report discussing the case indicates that the physician was convicted of two separate incidents of criminal penetration by a foreign object due to his abuses of the patient. After the second incident of sexual abuse involving the patient, which occurred during her vaginal examination, the patient collected DNA evidence of the sexual*

abuse and used this evidence to bring this physician to justice:"[A]ccording to the patient, [the physician] entered the examination room alone… [S]he was told to pull down her pants and lie on her side facing the wall… [The physician] then pulled her pants and underwear down to her knees. [W]hile she was facing the wall, [the physician] began tapping/hitting her on the shoulder and gradually began moving down her arm and midway to her lower back. [S]he felt [the physician] move his other gloved hand between her legs and believed he was palpating her prolapsed uterus. [T]he patient informed [the physician] his tapping began to hurt and put her hand behind her to stop him. [S]he stated she felt the shaft of his penis (she originally told law enforcement it was through his pants, but testified it was his bare penis in the criminal preliminary hearing). [The physician] then backed up[,] and she heard him pull up his zipper… [T]he patient was admitted to hospital…for surgery… [Following surgery and] prior to discharge, the patient states she was advised by a nurse to take a shower because [the physician] was going to examine her. [W]hen [the physician] arrived he told the patient the surgery went well. [The physician then] instructed her to lie on her side and face the curtain away from him. [S]he states [the physician] told her he was going to place some gauze in her vagina. [D]ue to pain and reduced sensation, she did not feel the gauze. [A]ccording to the patient, [the physician] had his gloved hand inside her vagina for approximately ten minutes, but she did not feel bare flesh or anything unusual. [The physician] occasionally asked "does this hurt?" [A]fter [the physician] left her side, the patient stated she felt moisture in the area of her lower back. [I]nstead of blood, she stated she found semen. [The physician] returned and cleaned the patient's back stating she would be discharged shortly. [A]fter [the physician] left, the patient took the examination sheet, put it in plastic and took it home. Her stated intent was to have her daughter confirm the semen. There are no entries in the hospital record regarding whether a nurse was present for the exam… [The patient's] daughter spoke with her sister and was told to take their mother to [the police]… According to [the police, the patient had] refrigerated the [the examination sheet]. [A] felony criminal complaint was filed against [the physician] for two counts of sexual penetration by foreign object. [I]n the course of the investigation, [the police] crime lab was able to confirm the presence of semen on the examination sheet. [The physician's DNA] was obtained and found to be a match to the [DNA] profile of the semen. [The physician] pled no contest for violating [the applicable] penal code section… the physician and the [state] medical board entered into a stipulated revocation of [the physician's] medical license pursuant to the facts of the patient's allegations of sexual assault during a medical examination."

Serial Sexual Abuser Physician Sent to Rehabilitation

Case 40: *"[The] chief of [obstetrics and gynecology] at [x] community hospital, [who was in his forties,] self-disclosed to the hospital [director] that he performed pelvic exams on approximately 24 patients without gloves, or with the fingers cut out of the gloves. [C]haperones were present at each of the encounters, but no reports were made. He entered inpatient treatment at … [another] facility… and was determined to suffer from sexual addiction. [H]e was enrolled in [an] impaired healthcare provider program (IHPP) upon his return, and he was assigned to medical informatics duties. [S]ubsequently, he was awarded general medical… privileges.], male patients only, and he was transferred to [another medical facility] for possible re-entry into [obstetrics and gynecology] practice. [T]he…[IHPP] determined an assured monitoring program could not be established, due*

> *to…the fact that [the physician's] incidents occurred in the presence of, and were undetected by, chaperones. [The physician] continued to request [obstetrics and gynecology] privileges. He was awarded [general medical] privileges, and those privileges were subsequently suspended for consideration of permanently removing his [obstetrics and gynecology] privileges, and that action was pending at the time of his retirement. [H]e was enrolled in the [IHPP] for continued monitoring up to his retirement."*

Sexually Abusive Physician Allowed to Surrender Clinical Privileges

> Case 41: *"[A male obstetrics and gynecology physician in his forties] voluntarily surrendered his [obstetrics and gynecology] and reproductive endocrine and in-vitro privileges in order to seek treatment for potentially recurring patient boundary issues. [H]e was previously reported to the [NPDB] by [x] and his [states] of licensure … for sexual misconduct with a patient. [O]n [date] [the physician] requested general medical…privileges. His request was denied, and the denial was upheld throughout due process proceedings. [R]ationale for the denial included that evidence confirmed a nine-year history of behavior and interactions incompatible with expectations [of a physician]; the perceived benefits of his clinical expertise do not outweigh the risk that recurrence of his prior indiscretions pose to patient safety; and he does not exhibit appreciation of the extent of his boundary violations or the impact on patients."*

Restriction/Limitation of Clinical Privileges or Other (Not Classified) Actions for Physical Sexual Contact or Relations in Sexual-Misconduct–Related Clinical-Privileges Report

> Case 42: *A male family medicine/general practice physician in his forties had engaged in "professional misconduct by starting and continuing a sexual relationship with one of his patients after he had established and continued a professional therapeutic relationship with her" As a result, the following clinical-privileges action was taken against him: "restriction of clinical privileges for 12 months as follows: 1) a chaperone will be required to be in the exam room or office at all times when in the presence of a female patient[,] 2) completion of at least 20 hours of ethics training to focus on physician-patient boundaries[,] 3) denial of permission to participate in any [outside] employment until further notice[, and] 4) monthly appointment for the next 12 months with the chief of the medical staff to obtain mentoring with a focus on professional ethics."*

4. Discussion

There is a lack of research on physician sexual abuse of patients. The present study sought to address this gap by analyzing 15 years of NPDB reports to provide a comprehensive account of this public-health problem in the context of physicians who faced "reportable" consequences for this unethical behavior in the U.S. The following sections discuss our current findings and how they relate to previous evidence, as applicable. We highlight multiple oversight failures that have created a systemic tolerance in many cases for physician sexual abuse of patients within the self-regulated medical system. We conclude with a list of recommendations as initial steps to mitigate this problem.

Although our study has examined physician sexual misconduct in NPDB reports pertaining to all victims (patients and nonpatients), our discussion of the results and implications focuses primarily on patient victims. This is because our line of research and advocacy is directed at protecting patients from abusive physicians. Additionally, patient sexual abuse by physicians has received scarce attention from researchers even after the prominence of the #MeToo movement.

4.1 Extent of Physician Sexual Misconduct Reported to the NPDB Relative to Prior Studies

This national-level analysis of NPDB reports showed that only 1,354 (0.2%) of the nation's licensed physicians in the U.S. faced "reportable" consequences for sexual misconduct from January 1, 2003, to December 31, 2017. These reports also accounted for only 1.1% of the total physician NPDB reports that met our criteria. Seventy-seven percent of these 1,354 physicians were reported only by state medical boards (identified by the presence of licensing action reports), 8.4% were reported only by health care organizations (identified by the presence of clinical-privileges reports), and 7.7% were reported only by malpractice insurers (identified by the presence of malpractice-payment reports). The remaining 7.3% of these physicians had more than one type of these reports.

These findings are consistent with our 2016 NPDB analysis, predating the #MeToo movement, which showed that 1,039 physicians had sexual-misconduct–related reports from January 1, 2003, to September 2013.[51] The findings also are aligned with those from our NPDB analysis for nurse sexual misconduct, which showed that only 882 U.S. registered nurses, advanced practice nurses and licensed practical nurses or licensed vocational nurses were reported to the NPDB from January 1, 2003, to June 30, 2016, due to sexual misconduct.[52] However, our analysis for nurses was limited to licensing and malpractice-payment reports because nurses typically do not have clinical privileges. Submission of clinical-privileges reports to the NPDB is legally required only for the few nurses who have clinical privileges.[53]

[51] AbuDagga A, Wolfe SM, Carome M, Oshel RE. Cross-sectional analysis of the 1039 U.S. physicians reported to the National Practitioner Data Bank for sexual misconduct, 2003–2013. *PLoS One*. 2016;11(2):e0147800.
[52] AbuDagga A, Wolfe SM, Carome M, Oshel RE. Crossing the line: Sexual misconduct by nurses reported to the National Practitioner Data Bank. *Public Health Nurs*. 2019;36(2):109-117.
[53] Department of Health and Human Services. National Practitioner Data Bank guidebook. October 2018. https://www.npdb.hrsa.gov/resources/NPDBGuidebook.pdf. Accessed May 6, 2020.

The number of physicians who faced reportable consequences for sexual misconduct in our present study is lower than the numbers from other sources. For example, investigative reporters at the *Atlanta Journal-Constitution (AJC)* who analyzed various national-level medical board documents, court records, and news reports for disciplined physicians from 1999 to 2015 found that more than 3,100 physicians were "publicly cited for sexual misconduct."[54,55] After attempting to find probable matches between the physicians that they identified in their investigation and those reported to the NPDB due to sexual misconduct, the *AJC* reporters found that "about 70 percent more physicians [were] accused of sexual misconduct than the 466 classified as such in the public version of the data bank from 2010 to 2014."[56] The reporters propose that this inconsistency could be due to a failure of medical boards to use the "sexual misconduct" code in the related NPDB report that they have submitted for these physicians – a speculation with which we concur based on our assessment of the NPDB reports in this study.

Furthermore, the proportion of physicians with sexual-misconduct–related reports in our study is much lower than that of the physicians who self-reported sexual contact with patients in anonymous surveys. For example, a 1996 anonymous random national survey of U.S. physician members of the AMA showed that 3.4% of the respondents reported a history of personal sexual contact (genital-genital, oral-genital, or anal-genital) with one or more patients.[57] Other anonymous physician surveys showed that 7% to 10% of male physicians and 3% to 4% of female physicians admitted past sexual contact with a patient.[58] Thus, the rate at which U.S. physicians are disciplined or had malpractice payments due to reported sexual misconduct offenses is not commensurate with the number of physicians who self-reported engaging in this unethical behavior in U.S. survey studies of physicians.

4.2 Triggers of Actions Taken Against Physicians With Sexual-Misconduct–Related Licensing and Clinical-Privileges Reports

Report narrative descriptions provided information about the triggers of the disciplinary process for only 198 (17.5%) and 94 (57.7%) of the physicians with sexual-misconduct–related licensing and clinical-privileges reports, respectively. Unsurprisingly, narrative description for only 0.4% and 1.8% of the physicians with sexual-misconducted–related licensing and clinical-privileges reports, respectively, indicated self-reporting of their unethical behavior.

[54] Teegardin C, Norder L. Abusive doctors: How the Atlanta newspaper exposed a system that tolerates sexual misconduct by physicians. *Am J Bioeth*. 2019;19(1):1-3.

[55] Teegardin C, Robbins D. The #MeToo movement and public outcry over Dr. Larry Nassar's sex abuse have not reformed the system that disciplines doctors. *The Atlanta Journal-Constitution*. April 26, 2018. https://www.ajc.com/news/national/still-forgiven/SwR8vihQZ3qcaQhKGv05BM/ Accessed May 6, 2020.

[56] Ernsthausen J. Why a national tracking system doesn't show the extent of physician sexual misconduct. 2016. http://doctors.ajc.com/sex_abuse_national_database/?ecmp=doctorssexabuse_microsite_nav. Accessed May 6, 2020.

[57] Bayer T, Coverdale J, Chiang E. A national survey of physicians' behaviors regarding sexual contact with patients. *South Med J*. 1996;89(10):977-982.

[58] Tillinghast E, Cournos F. Assessing the risk of recidivism in physicians with histories of sexual misconduct. *J Forensic Sci*. 2000;45(6):1184-1189.

Similarly, narrative descriptions very infrequently noted whistleblowing by colleagues of the reported physicians: None of the physicians with sexual-misconduct–related licensing actions had a report narrative describing reporting of their sexual misconduct by their colleagues, and only 3.1% of those with sexual-misconduct–related clinical-privileges actions had a narrative noting reporting by their colleagues or by other witnesses.

Actions taken by the legal justice system (including charges, indictments, convictions, imprisonments, police reports, and court actions) for sexual misconduct were cited as the precipitating trigger for disciplinary actions in the narrative descriptions for 10.2% and 12.3% of the physicians with sexual-misconduct–related licensing and clinical-privileges reports, respectively. Small proportions — 2.1% and 3.7% — of the physicians with sexual-misconduct–related licensing and clinical-privileges reports, respectively, had report narratives indicating that the reported disciplinary actions were predicated on actions taken by other medical boards or by health care organizations.

Notably, there were two extreme cases of physicians who had sexual-misconduct–related clinical-privileges sanctions only after their health care institutions found about their misconduct from the media or other publicly disclosed information.

Finally, our study found that complaints by victims or their proxies were the precipitating triggers for disciplinary actions cited in the narrative descriptions for 3.7% and 35.6% of the physicians with sexual-misconduct–related licensing and clinical-privileges reports, respectively. However, these proportions likely would have been higher had we had complete information about how the disciplinary processes were initiated for all physicians with sexual-misconduct–related disciplinary reports. Indeed, a prior study of medical board actions in Oregon showed that complaints by victims or their families accounted for 72% of the total complaints for physician sexual misconduct.[59]

4.3 Characteristics of Physicians With Sexual-Misconduct–Related Reports

Prior research showed that most of the physicians who engage in sexual misconduct were men aged 40 or older.[60,61] Consistent with this prior research, 94.4% of the physicians with sexual-misconduct–related NPDB reports in the present study were men, and (89.9%) of them were aged 40 or older.

There were sexual-misconduct–related reports in the present study for physicians in every major specialty. Previous research showed that psychiatrists accounted for the highest proportion of state medical board actions related to sexual offenses, followed by family and general practice

[59] Enbom JA, Thomas C. Evaluation of sexual misconduct complaints: The Oregon Board of Medical Examiners, 1991 to 1995. *Am J Obs Gynecol*. 1997;176(6):1340-1348.
[60] Dubois JM, Walsh HA, Chibnall JT, et al. Sexual violation of patients by physicians: A mixed-methods, exploratory analysis of 101 cases. *Sex Abuse*. 2019;31(5):503-523.
[61] Enbom JA, Thomas C. Evaluation of sexual misconduct complaints: The Oregon Board of Medical Examiners, 1991 to 1995. *Am J Obs Gynecol*. 1997;176(6):1340-1348.

physicians and obstetrics and gynecology physicians.[62] In contrast, the present study found that family medicine/general practice physicians accounted for the highest proportion of physicians with NPDB sexual-misconduct–related reports, followed by internal medicine and internal medicine subspecialty (allergy and immunology, pulmonary medicine, and gastroenterology) physicians, psychiatrists, surgeons, and obstetrics and gynecology physicians. However, in concurrence with prior research, [63] the current study showed that there were more psychiatrists and family medicine/general physicians with sexual-misconduct–related reports relative to the representation of each of these specialties in the overall U.S. physician population (3.7- and 2.4-fold overrepresentation, respectively). In contrast, there were fewer internal medicine and surgery physicians with sexual-misconduct–related reports relative to the representation of each of these specialties in the U.S (0.9- and 0.6-fold underrepresentation, respectively).

4.4 Characteristics of Victims of Physician Sexual Misconduct

Generally, previous work on physician sexual misconduct seemed to have focused on victims who were either patients or workplace colleagues, but not both. A study of state medical boards actions from 1981 through 1996 found that 75% of the sex-related offenses by physicians involved patients.[64] Similarly, the *AJC* investigation found that 77% of the physician sexual abuse cases involved patients.[65] Proportions of victim types from previous physician sexual-misconduct studies involving malpractice payments or clinical-privileges sanctions are not available.

The mix of victim types in our study varied across report types for the physicians with sexual-misconduct–related NPDB reports. Specifically, 61.8% of the 1,133 physicians with licensing reports for these offenses had only patient victims identified in the report narrative descriptions. In addition, 1.8% of these 1,133 physicians had only nonpatient-employee victims, 1.1% had only nonpatient-other victims, and 2.9% had multiple types of victims (32.5% had narrative description that did not specify the victim types). Among the 163 physicians with sexual-misconduct–related clinical-privileges reports, 47.2% had only patient victims, 27.0% had only nonpatient-employee victims, 1.2% had only nonpatient-other victims, and 4.9% had multiple types of these victims (19.6% had unspecified victim types). The majority (93.2%) of the physicians with sexual-misconduct–related malpractice-payment reports had only patient victims identified in the report narrative descriptions and 0.6% had only nonpatient-employee victims (6.2% had unspecified victim types).

Information on the gender of victims was reported in the narrative descriptions for 26%, 30%, and 52% of the sexual-misconduct–related licensing, clinical-privileges, and malpractice-payment reports, respectively, that were included in our study. In more than 90% of these reports, the victims were identified as female, which is consistent with prior research showing that the vast majority of physician sexual abuse victims are women.[66]

[62] Dehlendorf CE, Wolfe SM. Physicians disciplined for sex-related offenses. *JAMA*. 1998;279(23):1883-1888.
[63] *Ibid*.
[64] *Ibid*.
[65] Norder L, Ernsthausen J, Robbins D. Why sexual misconduct is difficult to uncover. July 6, 2016. http://doctors.ajc.com/sex_abuse_numbers/. Accessed May 6, 2020.
[66] DuBois JM, Anderson EE, Chibnall JT, et al. Serious ethical violations in medicine: A statistical and ethical analysis of 280 cases in the United States From 2008-2016. *Am J Bioeth*. 2019;19(1):16-34.

Prior research found that vulnerable patients are at greater risk of physician sexual abuse. For example, 38% of the cases of physician rape of patients analyzed by DuBois et al. involved patients who had cognitive impairment (for example, due to anesthesia or severe mental illness) or who belonged to a protected class (including minors and the elderly).[67] Consistent with these findings, we found that 16.9%, 14.1%, and 50.3% of the physicians with sexual-misconduct–related licensing, clinical-privileges, and malpractice-payment reports, respectively, had victims with certain vulnerability factors. However, information about victim vulnerability was not consistently reported; therefore, the true extent of vulnerability among the victims of these physicians is likely higher. Mentally ill victims and minors accounted for most of the vulnerable victims identified in the sexual-misconduct–related reports included in our study. Other less common types of vulnerable victims included patients who were under anesthesia or in the operating room, were incarcerated, or had addiction problems at the time of the sexual misconduct. Also, one victim had a history of sexual abuse. Aside from these factors, it is important to keep in mind that all patients are vulnerable: They typically present with health concerns and are generally expected to comply with physicians' directions and orders, including undressing and being subjected to physically examination. Patients also tend to be vulnerable when seeking medical care due to illness or anxiety. In the course of seeking medical care, patients also frequently disclose personal information and weaknesses, which may be used by sexually abusive physicians to take advantage of them.

Previous studies showed that sexually abusive physicians tend to practice in nonacademic settings.[68] The NPDB data do not include information about this variable. Instead, the NPDB includes a variable in malpractice-payment reports only regarding whether the malpractice allegation occurred in an inpatient or outpatient setting. Our study showed that 84.5% of the physicians with sexual-misconduct–related malpractice-payment reports committed their misconduct in outpatient settings.

4.5 Primary Forms of Sexual Misconduct Committed by Physicians

Our study showed that physical sexual contact or relations was the primary form of sexual misconduct for 41.0% of those physicians with licensing reports, 47.2% for those with clinical-privileges reports, and 60.9% for those with malpractice-payment reports that involved sexual-misconduct–related offenses. Additionally, nonspecific sexual misconduct (including "boundary violation," "sexual act," "sexual harassment," and "trading drugs/prescriptions/treatment for sexual favor") was the primary form of sexual misconduct for 31.2% for the physicians with licensing reports, 39.9% for those with clinical-privileges reports, and 32.9% for those with malpractice-payment reports that involved sexual-misconduct–related offenses.

Importantly, our data likely underestimate the proportions of physicians with each type of sexual-misconduct–related report whose primary form of sexual misconduct was physical sexual contact or relations. As we noted in our methods, our approach to categorization of the primary form of sexual misconduct for each physician was conservative. In particular, for some of the physicians whose primary form of sexual misconduct was categorized as "nonspecific" based on sexual behaviors or actions identified in the narrative descriptions, the sexual misconduct likely

[67] *Ibid*.

[68] Dubois JM, Walsh HA, Chibnall JT, et al. Sexual violation of patients by physicians: A mixed-methods, exploratory analysis of 101 cases. *Sex Abuse*. 2019;31(5):503-523.

involved behaviors or actions that would have otherwise been categorized as physical sexual contact or relations.

Inappropriate comments or communication was the primary form of sexual misconduct for 1.2%, 4.3%, and 0.6% of the physicians with licensing reports, clinical-privileges reports, and malpractice-payment reports, respectively, that involved sexual-misconduct–related offenses. Information about the nature of the sexual misconduct was undescribed for 26.0%, 8.0%, and 5.6% of the physicians with sexual-misconduct–related licensing, clinical-privileges, and malpractice-payment reports, respectively.

Like our study, previous studies showed that physical sexual contact or relations accounted for a majority of sexual misconduct by physicians. For example, a 1998 national study analyzing data for physicians with medical board actions due to sexual offenses found that physical sexual contact or intercourse occurred in 50% of the cases.[69] Although the DuBois et al. study was not nationally representative, it found that 67% of the cases of sexual abuse by physicians involved physical sexual relations (rape, sodomy, purportedly consensual sex, and child molestation).[70]

4.6 Past as Prelude: Multiple Victims, Recidivism, and Other Offenses

Previous studies showed that physicians who were disciplined for sexual misconduct often had multiple victims.[71,72] Similarly, we found that at least 18.5% and 36.8% of the physicians with sexual-misconduct–related licensing and clinical-privileges reports, respectively, had multiple victims. Additionally, at least 17.4% of the physicians with sexual-misconduct–related malpractice-payment reports had multiple victims (as evidenced mostly by having multiple reports involving different victims). Previous studies also showed that physicians who engage in sexual misconduct tend to repeat their abuses and that they have a high probability of recidivism.[73] Similarly, our study showed that 34 (3.0%) and 32 (19.6%) of the physicians with sexual-misconduct–related licensing and clinical-privileges reports, respectively, had a history or pattern of sexual misconduct before they were finally disciplined.

Our report-level analysis also showed that 52.2% and 41.1% of the physician sexual-misconduct–related licensing and clinical-privileges reports, respectively, had at least one other basis for actions other than sexual misconduct. These bases included unprofessional conduct; violations of federal or state laws, regulations, or rules; negligence; criminal convictions; patient abuse; being an immediate threat to health or safety; and narcotics or other drug statutes violations. Twenty-one percent of the physician sexual-misconduct–related malpractice-payment reports had a malpractice allegation in addition to sexual misconduct, such as improper conduct, improper management, failure or delay in referral or consultation, and assault and battery.

[69] Dehlendorf CE, Wolfe SM. Physicians disciplined for sex-related offenses. *JAMA*. 1998;279(23):1883-1888.
[70] Dubois JM, Walsh HA, Chibnall JT, et al. Sexual violation of patients by physicians: A mixed-methods, exploratory analysis of 101 cases. *Sex Abuse*. 2019;31(5):503-523.
[71] *Ibid*.
[72] Enbom JA, Thomas C. Evaluation of sexual misconduct complaints: The Oregon Board of Medical Examiners, 1991 to 1995. *Am J Obs Gynecol*. 1997;176(6):1340-1348.
[73] Tillinghast E, Cournos F. Assessing the risk of recidivism in physicians with histories of sexual misconduct. *J Forensic Sci*. 2000;45(6):1184-1189.

4.7 Insufficient Licensing and Clinical-Privileges Actions

Our analysis of physician sexual-misconduct–related licensing and clinical-privileges reports showed that when medical boards and health care organizations took disciplinary actions against physicians for sexual misconduct, their actions tended to be more serious than those taken against physicians for other offenses. A concerning finding, however, is that 510 (37.7%) of the physicians with sexual-misconduct–related NPDB reports continued to have active licenses and clinical privileges in the states where they were disciplined, or had a malpractice payments due to their sexual offenses. Because some physicians may have had active licenses and clinical privileges in states other than the ones in which they were disciplined, an even higher proportion of physicians may have been able to continue practicing medicine because medical boards and health care organizations in these other states may not have taken disciplinary actions against these physicians that resulted in revocation or suspension of their licenses and clinical privileges.

Another concerning finding of our study is that 221 (69.7%) of the 317 physicians with one or more sexual-misconduct–related clinical-privileges or malpractice-payment reports did not have any medical board actions taken against them for sexual misconduct. This was the case despite the fact that 27.6% of these 221 physicians had multiple victims and 52.5% had physical sexual contact or relations as the primary form of sexual misconduct identified in their report narrative descriptions. Similarly, a previous NPDB analysis showed that medical boards had not taken disciplinary actions against more than half of 10,672 physicians who had been subjected to serious sanctions by hospitals and other health care organizations (including revocations or restrictions of their clinical privileges) from 1990 to 2009.[74] Notably, hospitals and malpractice insurers send copies of their NPDB reports directly to the pertinent state medical board, as mandated by the HCQIA, the law that established the NPDB.[75] In addition, medical boards can query the NPDB for their licensed physicians anytime or enroll these physicians in "continuous query," a feature that automatically sends copies of new reports submitted to the NPDB by other entities anywhere in the U.S. regarding their enrolled physicians. The use of this query tool is particularly valuable when physicians are licensed in multiple states because only the board of the state in which a clinical-privileges action is taken or a malpractice payment is made would automatically receive a copy of the report of such action or payment that is submitted to the NPDB.

The failure of medical boards to act against physicians with evidence of sexual misconduct or other offenses leaves patients at risk. Without state medical board action, transgressing physicians, including those with sexual misconduct, can still practice and hurt more patients: After these physicians have been sanctioned by one hospital, they can pursue medical practice at another facility or practice without hospital clinical privileges if their medical licenses remain valid. Therefore, there is an urgent need for medical boards to improve how they obtain and act on information related to physician sexual misconduct in order to meet their obligation to protect the public.

[74] Levine A, Oshel R, Wolfe S. State medical boards fail to discipline doctors with hospital actions against them. March 2011. https://www.citizen.org/wp-content/uploads/1937.pdf. Accessed May 6, 2020.
[75] Health Care Quality Improvement Act of 1986 (1986). Public Law 99–660, Title IV. 42 USC Sec. 11134(c).

4.8 Factors That Keep Physician Sexual Misconduct in the Dark

The number of physicians reported to the NPDB for sexual misconduct only scratches the surface of the full extent of physician sexual misconduct in the U.S. As previously noted, the rate at which physicians were disciplined or had malpractice payments due to sexual misconduct is not commensurate with the number of physicians who self-reported engaging in this unethical behavior in survey studies. In this section, we highlight several factors that we gleaned from the literature and identified from our study that can explain why most physician sexual misconduct remains a hidden and persistent problem in the U.S.

4.8.1 Underreporting by Victims

The Rape, Abuse and Incest National Network estimates that fewer than one in four cases of sexual assault in the U.S. is reported to police.[76] It is likely that even fewer patient victims of physician sexual abuse report their abusers because both the incapacitating effects of sexual trauma on the victims and the power imbalance between the victims and the abusive physicians make it very difficult for patient victims to come forward.

For example, a study showed that the majority of 16 female patients who were subjected to sexually abusive pelvic examinations by one male gynecologist did not stop the examinations because they believed they had a serious internal medical problem that necessitated the examinations, they trusted that the physician was conducting ethical examinations, or they felt powerless to interrupt the physician.[77] An experienced medical consultant who participated in the Oregon medical board's investigation of a gynecologist who was accused of raping several women during pelvic examination stated that these women all reported the following strikingly similar reactions following their sexual abuse: (1) "this can't be happening," (2) "doctors take an oath not to do this," (3) "I must have a dirty mind even to be thinking this," and (4) "it's his word against mine and who would believe me?"[78] Similar feelings of shock, disbelief, and fear were illustrated in the testimonies and statements of many of the victims of Dr. Larry Nassar and other abusive physicians whom we know about from the media.[79] Victims of physician sexual abuse also frequently feel shame at being unable to avoid the sexual exploitation and abuse, which is another obstacle to their willingness to break their silence.[80]

Like many other victims of sexual abuse in a non-medical setting, victims of physician sexual abuse tend to blame themselves instead of the perpetrator or they obsess over whether they could have stopped the abuse.[81]

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[76] The Rape, Abuse and Incest National Network. The criminal justice system: statistics. https://www.rainn.org/statistics/criminal-justice-system. Accessed May 6, 2020.

[77] Burgess AW. Physician sexual misconduct and patients' responses. *Am J Psychiatry*. 1981;138(10):1335-1342.

[78] Enbom JA, Thomas C. Evaluation of sexual misconduct complaints: The Oregon Board of Medical Examiners, 1991 to 1995. *Am J Obs Gynecol*. 1997;176(6):1340-1348.

[79] Gibbons L. What Larry Nassar's victims said when they confronted him in court. *mLIVE*. May 20, 2019. https://www.mlive.com/news/2018/01/what_larry_nassars_victims_sai.html. Accessed May 6, 2020.

[80] Ost S. Breaching the sexual boundaries in the doctor-patient relationship: Should English law recognise fiduciary duties? *Med Law Rev*. 2016;24(2):206-233.

[81] Hart A, Teegardin C. In their own words: Six women. Six stories of pain. *The Atlanta Journal-Constitution*. December 9, 2016. http://doctors.ajc.com/part_5_hurt_that_doesnt_heal/. Accessed May 6, 2020.

Meyer and Price highlighted additional factors that discourage victims of physician sexual abuse from complaining to authorities:

> "In the authors' experience, complainants typically view themselves as less powerful than the [alleged offending] physicians and perceive themselves as taking on a stronger adversary. They usually are apprehensive that their complaints will be bureaucratically disregarded. The slow pace of adjudication may heighten those concerns and foster the belief that the [physician] peer review is in fact a *de facto* shield for the physician… Rightly or wrongly, complainants may feel that they have been ignored, abandoned, blamed, cheated, shown disrespect, or subjected to private or public humiliation and, as a result, have been dishonored or have lost face."[82]

Not all state medical boards assure confidentiality for individuals who report violations in good faith, and 22 boards require that those filing a complaint disclose their identity,[83] which also makes some victims hesitant to come forward.

Additionally, victims of physician sexual abuse may not know how to navigate the regulatory system to seek redress for the harms of physician sexual abuse, such as filing complaints with the state medical boards that licensed the physicians, the hospital or facility in which the abuse had occurred, or the police. In fact, a recent FSMB-funded survey showed that only 34% of adult Americans who have filed a complaint against or reported a physician who they believed was acting unethically or unprofessionally or providing substandard care have filed the complaint or report with a state medical board.[84]

Importantly, when victims of physician sexual abuse file complaints, they can be retraumatized by the investigation and legal procedures, which may lead them to withdraw their complaints.

4.8.2 Underreporting by Colleagues

Our study showed that for a very small proportion of the physicians with sexual-misconduct–related licensing or clinical-privileges reports, the sexual misconduct was reported by their colleagues. Although this finding may underrepresent the actual proportion of reports that were triggered by a complaint from physicians' colleagues due to the fact that most narrative descriptions lacked data regarding the informants of physician sexual misconduct, previous research shows that physicians often are unwilling to report their misbehaving colleagues. For example, results of a nationally representative survey of U.S. physicians published in 2007 showed that although 96% of physicians agreed that physicians should report their impaired or incompetent

[82] Meyer DJ, Price M. Peer review committees and state licensing boards: Responding to allegations of physician misconduct. *J Am Acad Psychiatry Law*. 2012;40(2):193-201.
[83] Federation of State Medical Boards. U.S. medical regulatory trends and actions 2018. December 3, 2018. http://www.fsmb.org/siteassets/advocacy/publications/us-medical-regulatory-trends-actions.pdf. Accessed May 6, 2020.
[84] Harris On Demand, The Harris Poll. State medical boards awareness study. May 30, 2019. http://www.fsmb.org/siteassets/advocacy/news-releases/2018/harris-poll-executive-summary.pdf. Accessed May 6, 2020.

colleagues to relevant authorities, when the "rubber met the road," nearly one-half of those who had encountered such colleagues did not report them.[85]

Among the reasons that physicians and other health care professionals fail to report unethical breaches by their colleagues include not wanting to damage the reputation of these colleagues; fear of retaliation; not wanting to be seen as disloyal or a "snitch;" not knowing where to report a colleague's sexual misconduct; and inadequate education about sexual boundaries.[86] In addition, few states have legal mandates for such reporting, which decreases the motivation for reporting sexually abusive physicians. This "conspiracy of silence" enables sexually abusive physicians and allows them to harm additional victims.

4.8.3 Inadequate Guidelines for Addressing Physician Sexual Misconduct

An important factor for the persistence of physician sexual misconduct in the U.S. is the historical lack of standardized and well-vetted guidelines for investigating and processing these cases. The AMA does not offer specific guidance in this area. In 2006, the FSMB offered brief guidelines for addressing physician "sexual boundary" issues.[87] Developed with input from a handful of members of state medical boards, these guidelines were high-level in nature and were directed at state medical boards only. On May 2, 2020, the FSMB quietly unveiled long-awaited updated guidelines.[88] The newly revised guidelines, which use the term "sexual misconduct" in lieu of "sexual violations," draw on input from multiple organizations and stakeholders in the U.S. and internationally, acknowledge the impact of trauma on survivors of physician sexual misconduct, and offer recommendations for state medical boards as well as the medical profession for addressing this problem.

While the revised FSMB guidelines are an important initial step in the right direction, they are not binding on state medical boards; the FSMB does not have the authority to require its state medical board members to follow the guidelines. Guidelines also are urgently needed for health care organizations for preventing and addressing physician sexual misconduct.

4.8.4 State Medical Board Shortcomings

There are 70 state medical boards in the U.S. and its territories that are responsible for licensing and disciplining of physicians. Some of these boards license only allopathic medical doctors, some license only osteopathic medical doctors, and some license both. These boards are intended to act as gatekeepers of the medical profession, collectively regulating nearly 1 million physicians nationwide. Although their primary client is the public, medical boards are largely influenced by state medical associations, are mostly comprised of physicians, and have little effective oversight from public (nonphysician) members. This self-regulation subjects state

[85] Campbell EG, Regan S, Gruen RL, et al. Professionalism in medicine: Results of a national survey of physicians. *Ann Intern Med*. 2007;147(11):795-802.

[86] Glass LL. Where the rubber meets the road: The challenge of reporting colleagues' boundary violations. *AMA J Ethics*. 2015;17(5):435-440.

[87] Federation of State Medical Boards of the United States, Inc. Addressing sexual boundaries: Guidelines for state medical boards. May 2006. https://www.fsmb.org/siteassets/advocacy/policies/grpol_sexual-boundaries.pdf. Accessed May 6, 2020.

[88] Federation of State Medical Boards. Physician sexual misconduct: Report and recommendations of the FSMB Workgroup on Physician Sexual Misconduct. May 2020. http://www.fsmb.org/siteassets/advocacy/policies/report-of-workgroup-on-sexual-misconduct-adopted-version.pdf. Accessed May 7, 2020.

medical boards to "professional capture," resulting in a culture in which physician board members give deference to their peers, sometimes at the expense of public safety.

Medical boards also have limited financial and human resources. Therefore, they take a reactive rather than proactive approach to physician discipline: They do not typically define prevention as part of their responsibility, instead primarily focusing on investigating complaints and disciplining physicians after they offend.[89] Moreover, because of their limited resources, medical boards often are unable to investigate all the complaints that they receive against physicians, instead focusing on those thought to be of the highest priority while leaving others unexamined.[90]

Likewise, a federally funded report found that two-thirds of all cases involving complaints received by medical boards were closed due to inadequate evidence to support the charges or because the cases were resolved informally through a notice of concern or a similar communication with the involved physician.[91] The report noted that only approximately 1.5% of the complaints to medical boards reached the formal-hearing stage. Overall, less than 0.5% of licensed physicians face serious discipline annually.[92] Therefore, it is likely that a significantly greater number of physicians engage in inappropriate behavior, including sexual misconduct, than those who are ever disciplined by state medical boards for such behavior. In addition, medical boards may not be very responsive to patients, often taking a long time to investigate complaints and notify complainants of case resolutions.

Although there is no evidence that the distribution of physicians who engage in misconduct varies across the U.S., there are wide differences in the rates of serious licensing action taken against physicians across state medical boards. For example, a 2012 analysis of the rates of serious licensing actions (revocations, surrenders, suspensions, and probation/restrictions of license) per 1,000 physicians found a fivefold variation in such rates between the state with the highest rate and the one with the lowest rate.[93] Similarly, a more recent analysis of state medical board actions reported to the NPDB showed a significant fourfold variation in the annual rates of board actions between states even after controlling for confounding factors, such as data reliability, year-to-year variation, physician labor supply, and malpractice climate in each state.[94]

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[89] Bal AK, Bal BS. Medicolegal sidebar: State medical boards and physician disciplinary actions. *Clin Orthop Relat Res*. 2014;472(1):28-31.

[90] Sawicki NN. Character, competence, and the principles of medical discipline. *J Heal Care Law Policy*. 2010;101(13):285-323.

[91] Bovbjerg RR, Aliaga P, Gittler J. State discipline of physicians: Assessing state medical boards through case studies. Washington, D.C: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services; February 2006. https://aspe.hhs.gov/basic-report/state-discipline-physicians-assessing-state-medical-boards-thruogh-case-studies. Accessed May 6, 2020.

[92] Sawicki NN. Character, competence, and the principles of medical discipline. *J Heal Care Law Policy*. 2010;101(13):285-323.

[93] Wolfe SM, Williams C, Zaslow A. Public Citizen's Health Research Group ranking of the rate of state medical boards' serious disciplinary actions, 2009–2011. May 17, 2012. http://www.citizen.org/documents/2034.pdf. Accessed May 6, 2020.

[94] Harris JA, Byhoff E. Variations by state in physician disciplinary actions by US medical licensure boards. *BMJ Qual Saf*. 2017;26(3):200-208.

Our study illustrates a variety of ways that medical boards may accommodate or deal leniently with physicians with sexual misconduct. For example, we found that medical boards took their licensing actions through consent-decree or stipulated-order agreements for 19.7% of the physicians that they disciplined for sexual misconduct. The process for executing such agreements — which are essentially negotiated settlements or plea bargains to which the boards and offending physicians mutually agree — is less expensive, less labor-intensive, and faster for medical boards and physicians than the process for imposing more serious disciplinary actions.[95] These arrangements generally eliminate the need for hearings, which can result in more serious punishments for physicians. For example, a study showed that among 30 cases involving stipulated orders for physicians who had engaged in a sexual relationship with a patient, the physicians were permitted to retire in 11 cases, had license revocation in three cases, and had license revocation that was stayed with other terms in two cases.[96]

We found that 413 (36.4%) of the overall physicians with sexual-misconduct–related licensing reports had licensing actions that permitted them to continue practicing medicine in their respective active states in which they were disciplined by medical boards for sexual misconduct. Disciplinary actions against these physicians were limited to probation or restrictions of license (such as seeing male patients only), usually with some sort of required treatment or professional boundaries education. This finding is consistent with prior studies that showed that a substantial proportion of physicians who were disciplined for sexual offenses were permitted to either continue or return to practice.[97,98]

Importantly, medical board actions only affect a physician's license in the state that took these actions. Therefore, a physician who was disciplined in one state can still practice in another state if he or she is already licensed there, unless the other state also suspends or revokes the physician's license in that state. It also is possible for physicians to apply for and obtain a license in other states while investigations against them are underway in one or more states. In fact, state medical boards are not always aware of the licensing actions taken elsewhere against physicians because they fail to query the NPDB, a fee-based task, for actions against the physicians that they license. An investigation by *MedPage Today* and the *Milwaukee Journal Sentinel* showed that in 2017, 30 state medical boards queried the NPDB fewer than 100 times and that 13 boards failed to query the database at all, according to the search records at HRSA.[99] As of mid-2019, only nine state medical boards have subscribed more than 500 of their physicians for the continuous query feature of the NPDB,[100]which sends automatic email notifications about disciplinary actions

[95] Crowley CF. Medical board softer on doctors. August 20, 2012. https://www.timesunion.com/local/article/Medical-board-softer-on-doctors-3798607.php. Accessed May 6, 2020.
[96] Haley K, Fisher K. State medical boards self-examination: Analysis of Oregon data 2009 - 2012. *J Med Regul*. 2015;101(2):35-38.
[97] Dehlendorf CE, Wolfe SM. Physicians disciplined for sex-related offenses. *JAMA*. 1998;279(23):1883-1888.
[98] Hart A. *AJC* doctors & sex abuse investigation sparks improved patient protection. *The Atlanta Journal-Constitution*. December 21, 2016. https://www.ajc.com/news/ajc-doctors-sex-abuse-investigation-sparks-improved-patient-protection/SL3rJSmuYvkfU52zH9bL1J/. Accessed May 6, 2020.
[99] Wynn M, Fauber J. NPDB records often ignored in docs' licensing. *Milwaukee Journal Sentinel/MedPage Today*. March 7, 2018. https://www.medpagetoday.com/special-reports/states-of-disgrace/71600. Accessed May 6, 2020.
[100] Marso A. This tool can help state medical boards spot problem doctors. Why do so few use it? *The Kansas City Star.* June 21, 2019. https://www.kansascity.com/news/business/health-care/article231444518.html. Accessed May 6, 2020.

involving individual physicians within 24 hours of receipt of new reports for them. Six states and the district of Columbia enrolled fewer than 15 physicians in the continuous NPDB query and the remaining 35 states did not enroll any of their physicians in this feature. Although medical boards may be checking information about physicians from the FSMB's physician data center, which are provided free of charge for board members, the FSMB data do not include information regarding clinical-privileges actions or malpractice payments. The investigation by *MedPage Today* and the *Milwaukee Journal Sentinel* found that at least 500 physicians who were disciplined by state medical boards for sexual misconduct and other reasons from 2011 to 2016 were practicing under different licenses in other states, mostly due to lapses in querying the NPDB.[101] This finding demonstrates that some physicians with serious unprofessional behavior can "slip through the cracks," potentially harming other patients.

Another way that medical boards may contribute to the secrecy around physician sexual misconduct is by capitulating to pressures from the physicians and their legal representatives to circumvent the declaration of "sexual misconduct" as the basis-for-action code in the legally mandated disciplinary action reports that these boards submit to the NPDB. As an attorney who represented sexually abusive physicians argued, "as long as [the negotiated basis-for-action code] is accurate, there may be several ways of reporting something."[102] Therefore, medical boards (and other reporting entities) may use vague umbrella basis codes (such as "unprofessional conduct," "conduct evidencing moral unfitness," "conduct evidencing ethical unfitness," "other unprofessional conduct," and "violation of federal or state statutes, regulations, or rules") to conceal sexual-misconduct by physicians in the reports that they submit to the NPDB. In fact, we observed in this study that many of the physicians with sexual-misconduct–related reports had prior or subsequent licensing or clinical-privileges reports with these vague codes, which may indicate avoidance of the specific sexual misconduct basis code. The NPDB regulations do not preclude reporters from using any of the aforementioned general basis codes rather than an explicit sexual misconduct code.

Although state medical boards generally publicly disclose on their websites information about the physicians whom they disciplined for various reasons, including sexual misconduct, such information often is incomplete, unclear, or hard to find, making it difficult for patients to find out whether their physicians may pose a threat. For example, a 2016 analysis showed that serious reasons for physician discipline (including sexual misconduct and substance abuse) often were buried in complicated legal language on many state medical board websites.[103] Fifty-four percent of state medical board websites did not include a "plain English" summary of board actions, 31% did not provide links to the actual disciplinary board orders that provided details of the cases, and

[101] Fauber J, Wynn M, Fiore K. Prescription for secrecy: Is your doctor banned from practicing in other states? State licensing system keeps patients in the dark. *Milwaukee Journal Sentinel/MedPage Today*. February 28, 2018. https://projects.jsonline.com/news/2018/2/28/is-your-doctor-banned-from-practicing-in-other-states.html. Accessed May 6, 2020.

[102] Ernsthausen J. Why a national tracking system doesn't show the extent of physician sexual misconduct. July 6, 2016. http://doctors.ajc.com/sex_abuse_national_database/?ecmp=doctorssexabuse_microsite_nav. Accessed May 6, 2020.

[103] Cronin C, McGiffert L, Henry S. Seeking doctor information online: A survey and ranking of state medical and osteopathic board websites in 2015. March 29, 2016. https://www.informedpatientinstitute.org/Seeking%20Doctor%20Information%20Online.pdf. Accessed May 6, 2020.

72% did not provide information about these physicians from other states. This analysis also showed that no state medical board provided information about the complaints it received against physicians unless the complaints resulted in formal charges or board actions. Also, the *AJC* investigation found that medical board websites in some cases make no mention of pending criminal charges against physicians.[104] These are troubling findings because this information can alert patients to potentially dangerous physicians who have multiple substantive complaints against them.

Another way that medical boards may shield physicians with sexual misconduct is by choosing to discipline them through informal private reprimand letters, making it impossible for the public to know about these actions. The *AJC* investigators became aware of these letters in certain cases in which physicians who had received them had subsequent sexual offenses that led to public medical board orders.[105] The investigators noted that several state medical boards use private orders routinely for first-time offenders. This finding is troubling because as of 2006, 43% of state medical boards could issue private reprimands.[106]

Media reports recount many instances in which physicians who sexually abused their patients volunteered or agreed to enroll in impaired health care provider programs at the suggestion or direction of state medical boards and *without* formal licensing actions against them by the boards.[107] Notably, HRSA advises that medical boards should not report physicians in these situations to the NPBD.[108] The extent to which physicians and medical boards opt for these programs to circumvent investigations and subsequent licensing actions and NPDB reporting for sexual misconduct is unknown. Little information exists on the effectiveness of these programs in terms of preventing recidivism and possible harm to future patients.[109]

Two other important aspects of the performance of medical boards are their response to information from other sources about physicians with reports of unprofessional behavior (including sexual misconduct) and the extent to which applicable laws require state or local law enforcement agencies to report information about physician misconduct to state medical boards. In terms of the former aspect, we found that medical boards did not take sexual-misconduct–related licensing actions against 69.7% of the physicians who had clinical-privilege or malpractice-payment reports due to sexual misconduct — a finding that highlights a deficiency in medical board responses to information about documented sexual misconduct. With regards to the latter aspect, applicable laws for only 22 of the 70 U.S. medical boards require that state or local law

[104] Teegardin C, Norder L. Abusive doctors: How the Atlanta newspaper exposed a system that tolerates sexual misconduct by physicians. *Am J Bioeth*. 2019;19(1):1-3.
[105] Norder L, Ernsthausen J, Robbins D. Why sexual misconduct is difficult to uncover. *The Atlanta Journal-Constitution*. 2016. http://doctors.ajc.com/sex_abuse_numbers/. Accessed May 6, 2020.
[106] Bovbjerg RR, Aliaga P, Gittler J. State discipline of physicians: Assessing state medical boards through case studies. Washington, D.C: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services; February 2006. https://aspe.hhs.gov/basic-report/state-discipline-physicians-assessing-state-medical-boards-thruogh-case-studies. Accessed May 6, 2020.
[107] Norder L, Ernsthausen J, Robbins D. Why sexual misconduct is difficult to uncover. *Atlanta Journal Constitution*. 2016. http://doctors.ajc.com/sex_abuse_numbers/. Accessed May 6, 2020.
[108] Department of Health and Human Services. National Practitioner Data Bank guidebook. October 2018. https://www.npdb.hrsa.gov/resources/NPDBGuidebook.pdf. Accessed May 6, 2020.
[109] AbuDagga A, Carome M, Wolfe SM. Time to end physician sexual abuse of patients: Calling the U.S. medical community to action. *J Gen Intern Med*. 2019;34(7):1330-1333.

enforcement agencies to notify the boards about possible misconduct (including sexual misconduct) by physicians.[110] However, we could not determine the extent of this practice in our study due to lack of such information.

4.8.5 Health Care Organization Shortcomings

Physicians often self-regulate in health care organizations, resulting, in many cases, in a culture of deference for impaired physicians, including those who sexually abuse their patients and other health care workers. One manifestation of this deference is ignoring reports of sexual abuse, thereby granting "shady" physicians free reign to abuse patients under the guise of health care. Two of our findings for sexual-misconduct–related clinical-privileges reports suggest that in numerous cases, many victims were harmed before these physicians finally faced sanctions. First, more than one-third of these physicians had multiple victims. Second, nearly one-quarter of the physicians with these reports had a history or pattern of sexual misconduct according the narrative descriptions of the reports, and their abuse often affected multiple victims.

Such pervasive patterns of physician sexual abuse in health care organizations are seen in almost every single case of physician abuse that has made headlines in recent years. For example, Nassar had reports of sexual abuse against him in the early 1990s, but he went on to abuse nearly 200 girls and women before an overwhelming series of complaints in 2016 led the State of Michigan to finally charge him with multiple counts of criminal sexual conduct, for which he was subsequently convicted.[111] An independent investigation of the factors underlying Nassar's abuses concluded that numerous individuals and institutions, including medical professionals and administrators, enabled Nassar's abuse by ignoring red flags, dismissing clear calls for help from his patient victims, and failing to stop him.[112]

Another example of long inaction by health care organizations against sexually abusive physicians is the case of Richard Strauss, a former Ohio State University (OSU) physician who sexually abused at least 177 former student patients from 1979 to 1997 according to a recently completed independent investigation.[113] This investigation of Strauss's sexual abuses found that university personnel knew of complaints about these abuses as early as the first year of his employment at the university but they failed to investigate these complaints. Although the university reported him to the State Medical Board of Ohio in 1996, it did not report him to law enforcement.[114] OSU also allowed Strauss to retire in 1998 with emeritus status. OSU President

[110] Federation of State Medical Boards. U.S. medical regulatory trends and actions 2018. December 3, 2018. http://www.fsmb.org/siteassets/advocacy/publications/us-medical-regulatory-trends-actions.pdf. Accessed May 6, 2020.

[111] McPhee J, Dowden JP. Report of the independent investigation. The constellation of factors underlying Larry Nassar's abuse of athletes. December 10, 2018. https://www.nassarinvestigation.com/en. Accessed May 6, 2020.

[112] *Ibid.*

[113] Trombino C., Funk M. Report of the independent investigation. Sexual abuse committed by Dr. Richard Strauss at the Ohio State University. May 15, 20019. https://presspage-production-content.s3.amazonaws.com/uploads/2170/finalredactedstraussinvestigationreport-471531.pdf?10000. Accessed May 6, 2020.

[114] Ohio State University. Independent investigation finds Ohio State doctor Richard Strauss abused students from 1979 to 1998. May 17, 2019. https://news.osu.edu/independent-investigation-finds-ohio-state-doctor-richard-strauss-abused-students-from-1979-to-1998. Accessed May 6, 2020.

Michael Drake acknowledged a "fundamental [institutional] failure" at the time of Strauss's employment to prevent abuses of patients by Strauss.

Importantly, a 2016 position statement by the FSMB on the duty to report noted that it had heard from state medical boards that hospitals and other health care organizations "regularly ignore reporting requirements, find ways to circumvent them, or provide reports that are too brief and general to equip the board with relevant information" that they need to take action against unsafe physicians.[115] The statement further indicates that medical boards have reported having to resort to subpoenaing hospital medical directors and threatening disciplinary action, among other things, to obtain information about unprofessional physicians and that in some cases failures to report have resulted in "additional avoidable adverse events to patients."[116]

Consistent with the FSMB's concerns, a 2009 report cited evidence that hospitals exploit loopholes in the HCQIA to get around the requirement to report certain actions they take.[117] For example, the law requires hospitals to report only physicians whose clinical privileges were revoked or restricted for more than 30 days. To skirt that requirement, hospitals may revoke or suspend clinical privileges for 30 days or less. Alternatively, hospitals may take a nonreportable action in lieu of reportable actions, including suspensions or revocations of the clinical privileges of unprofessional physicians.

Instead of taking reportable clinical-privileges actions against sexually abusive physicians and risking litigation by these physicians, leaders of health care organizations may permit these physicians to resign or terminate their privileges through private agreements and settlements — a practice that violates the HCQIA. Importantly, we are not aware of any instances in which HRSA has investigated or taken action against a hospital or other health care organization for failing to report physicians who were disciplined for more than 30 days (due to sexual misconduct or any other offenses) to the NPDB since the launch of the database in 1990. Therefore, there is no information about the extent of such failure to report.

Furthermore, health care organizations are not legally mandated to reveal sexual abuses of physicians to future employers of those physicians. Therefore, past health care organizations may be sued for invasion of privacy if they release embarrassing information about their previously employed or credentialed physicians.

These practices shield sexually abusive physicians and make it possible for perpetrators to seek new jobs, keep past abuse secret, and harm additional patients.

4.9 Study Limitations and Need for Future Research

We acknowledge several limitations that impact the interpretation of our study findings. Mainly, the context of our study is physicians who faced consequences for sexual misconduct that led to NPDB reports. For several reasons that we discuss in the previous section, the results of our study do not capture a likely large number of sexually abusive physicians whose offenses were

[115] Federation of State Medical Boards. Position statement on duty to report. April 2016. www.fsmb.org/globalassets/advocacy/policies/position-statement-on-duty-to-report.pdf. Accessed May 6, 2020.
[116] *Ibid.*
[117] Levine A, Wolfe SM. Hospitals drop the ball on physician oversight. May 27, 2009. https://www.citizen.org/wp-content/uploads/migration/18731.pdf. Accessed May 6, 2020.

never reported or investigated or never resulted in sanctions that require reporting to the NPDB during our study period.

Our results also do not capture an unknown number of physicians who were sanctioned by state medical boards or health care organizations for sexual misconduct and reported to the NPDB but the reporting entities did not specify "sexual misconduct" as a basis for action in their submitted reports. Additionally, our results do not capture physicians who had clinical-privileges actions for sexual misconduct but the disciplining hospital or health care organization exploited loopholes in the HCQIA and avoided the legal requirements for submitting reports to the NPDB regarding these physicians.

Because the NPDB contains only malpractice payments for physicians made in response to a written claim, our results from the analysis of malpractice-payment reports do not include the unknown number of physicians who had sexual-misconduct claims for which no payment was made or that were settled without a written demand. Our results also do not include malpractice claims made by institutions that do not name individual physicians, thereby not triggering the NPDB reporting requirements for malpractice payments. The extent of this "corporate shielding" of physicians is not known, although it is most likely to occur in situations in which physicians and hospitals are covered by the same liability insurers, in tightly integrated health care systems, or in places where physicians have substantial control.[118] Furthermore, malpractice-payment reports due to physician sexual misconduct have likely decreased in overall number and payment size due to so-called "tort reform" laws.[119]

Another important limitation of our study is that the NPDB was not designed as a research tool. Therefore, it does not include standardized variables about the history of physician sexual misconduct, the victims, the nature of physician sexual misconduct, and the detailed circumstances of these cases. Although we tried to extract this information retrospectively from the narrative descriptions of the reports that met our study criteria, data for several of our extracted variables differed in completeness and depth across NPDB reports. The absence of information about these variables in certain reports does not necessarily mean that the information was not available to the entities filing the reports; it only means that the information was not available to us. This limitation subjects our findings to underreporting bias. Despite the aforementioned limitations, the NPDB serves as an extremely useful flagging system for medical malpractice payments and certain adverse actions related to physicians and other health care practitioners in the U.S. and is the only legally required national reporting system for data of the type collected. Therefore, it is worthwhile to analyze NPDB data and warn about their context and limitations.

Our study period (January 1, 2003, through December 2017) largely predates the prominence of the #MeToo movement, which started in October 2017 in the entertainment industry.[120] Because it often takes longer than one year after sexual misconduct by physicians for state medical boards to take action and submit relevant licensing reports to the NPDB, it is too early to assess whether the #MeToo movement has had an effect on the rate of actions taken by

[118] Studdert DM, Bismark MM, Mello MM, et al. Prevalence and characteristics of physicians prone to malpractice claims. *N Engl J Med*. 2016;374(4):354-362.

[119] Paik M, Black B, Hyman DA. The receding tide of medical malpractice litigation: part 1 — national trends. *J Empir Leg Stud*. 2013;10(4):612-638.

[120] Field A, Bhat G, Tsvetkov Y. Contextual affective analysis: a case study of people portrayals in online #MeToo stories. In: *Thirteenth International Conference on Web and Social Media*. Munich, Germany; 2019:158-169.

medical boards against physicians for sexual misconduct during our study period. Similarly, it is too soon to assess the effect of this movement on the rate of malpractice payments related to sexual misconduct by physicians because it takes years after malpractice incidents for malpractice claims to be closed and payments made. Notably, it appears that reporting trends of physicians to the NPDB for sexual misconduct have not changed in the most recent eight quarters: a separate analysis that we ran on physician reports in the NPDB Public Use Data File showed only an additional 177 physicians have had sexual-misconduct–related reports from January 1, 2018, through December 31, 2019.

Future research is needed to uncover the full extent of physician sexual misconduct in the U.S. Ideally, this information can be determined by nationally representative surveys of physicians and patient populations. In the meantime, existing data about complaints and investigations of alleged sexual offenses by physicians, which are collected by state medical boards, professional medical organizations, and large health care systems, should be made available to researchers. More research also is needed to determine the factors that increase reporting of physician sexual abuse, as well as the strategies that most effectively prevent these offenses from happening in the first place.

4.10 Actionable Recommendations to Get to a Zero-Tolerance Standard Against Physician Sexual Misconduct

We repeat our call for the medical community to embrace an explicit zero-tolerance standard against all forms of sexual abuse by physicians and urge it to act to eradicate this problem. Sexual exploitation of patients, employees, and others at the hands of physicians should not be tolerated for any reason, including the revenue generated by the offending physicians or their status or influence. We call on the medical community, particularly health care organizations and state medical boards, to classify sexual abuse by physicians as "never events": No patient should ever experience any form of sexual abuse, or fear of being subjected to such behavior, by a physician.

This standard must be coupled with regulatory, institutional, and cultural changes to realize its promise. In a recent perspective article that we published in the *Journal of General Internal Medicine*, we proposed a number of initial recommendations for addressing and preventing physician sexual misconduct in the U.S. We present these recommendations and a few others based on the findings of the current study.

(1) Replace the term "sexual misconduct" currently used in the U.S. medical community with the term "sexual abuse" when referring to any physician conduct that meets the Ontario Regulated Health Professions Act's definition (see Section 1.3 of this report) of the latter term. Furthermore, the U.S. medical community and all state medical practice acts, as the government of Ontario and the Medical Council of New Zealand[121] did, should adopt an explicit "zero-tolerance" standard against all forms of physician sexual abuse of patients. This standard should be incorporated into all applicable policies and regulations governing U.S. physicians. Additionally, state medical boards

[121] Medical Council of New Zealand. Sexual boundaries in the doctor-patient relationship. November 2018. https://www.mcnz.org.nz/assets/standards/3f49ba8048/Sexual-boundaries-in-the-doctor-patient-relationship.pdf. Accessed May 6, 2020.

should work with their state legislatures to criminalize all forms of physician sexual abuse of patients.

(2) Educate physicians at every stage of their training and careers about the enormity of the impact of sexual abuse of patients, how to avoid it, and how to seek help if they are struggling with challenges to their professional boundaries with patients. This will help to instill a strong culture of professional integrity throughout the medical profession.

(3) Educate the public about how to prevent, recognize, and report physician sexual abuse. This should be a shared responsibility between state medical boards and health care institutions. Particularly, state medical boards should establish detailed guidelines for medical services (including examinations, procedures, or treatments) involving breast, full-body, genital, and rectal exams and should make these guidelines available to the public. All medical offices and health care organizations should maintain and protect medical records referencing these examinations and procedures.

(4) Encourage and facilitate patient and patient surrogate reporting of all forms of physician sexual abuse. This recommendation can be accomplished by having health care institutions and medical boards establish standardized processes, which should be made known to patients and their surrogates, for filing complaints regarding any physician sexual abuse they may have experienced or witnessed and hiring patient-advocate professionals with whom patients and their surrogates can be encouraged to discuss such allegations. Importantly, these processes need to take into account that victims typically are reluctant to report sexual abuse. These processes also need to provide options for informal, formal, and proxy reporting to address fears surrounding reporting of incidents of physician sexual abuse.

(5) The medical community should mandate reporting, including an allowance for anonymous reporting, by physicians and other health care professionals when there is reason to believe that an individual (patient or nonpatient) has experienced sexual abuse by a physician and should institute necessary measures to prevent reprisal against individuals who make such reports and to protect them from legal liability for such reporting. Strict penalties for failing to report physician sexual abuse of patients should be set and enforced. Educational bystander intervention training should be encouraged to equip physicians and other health care professionals with the skills necessary to take appropriate action if they witness or suspect physician sexual abuse of patients.

(6) Medical boards and health care institutions should investigate each complaint of alleged physician sexual abuse of patients and conduct hearings if there are grounds for proceeding (while providing due process for the accused physician and for patient witnesses). Importantly, first responders and investigators of sexual offenses at medical boards and health care organizations should undergo sensitivity training to be better equipped to help the victims without retraumatizing them. Current guidelines are urgently needed to determine the best practices for handling sexual abuse by physicians. Such guidelines should be developed with input from consumer advocates and other nonphysician stakeholders. We acknowledge that innocent physicians may be falsely accused of sexual abuse. Therefore, all complaints of alleged physician sexual abuse of patients should be pursued fairly and through due process.

(7) Health care institutions and medical boards should take effective disciplinary actions against physicians who are found to have engaged in any form of sexual abuse of patients. Health care institutions should be required to report physicians found to have engaged in such behavior to the appropriate medical board, regardless of the extent of any clinical-privileges action taken against the offending physician. Clear *mandatory* penalties (including suspension and revocation of medical license and clinical privileges) should be established and enforced by the medical community. We recommend mandatory revocation of the license of any physician found to have engaged in sexual abuse involving physical sexual acts (including intercourse, sodomy, etc.). The medical community must enforce this penalty in all cases. The severity and length of these penalties should be based on the severity and the form of sexual abuse. In no case should public safety be compromised for any other consideration. Penalties should never be deferred because too often physicians engaged in further sexual abuse of patients after lenient disciplinary actions for sexual misconduct. Better safeguards are needed to prevent physicians who have been banned from practicing medicine due to sexual abuse or other offenses in one state from obtaining a license in other states.

(8) Health care institutions and medical boards also should report physicians who were found to have engaged in sexual intercourse or other forms of physical sexual contact or relations with any patient to law enforcement authorities in all cases, not just when the patient victim is a child.

(9) Medical boards should disclose on their websites complete information concerning all disciplinary actions against physicians who have been found to have sexually abused their patients.

(10) Health care institutions and medical boards should require physicians who are on disciplinary probation for sexual abuse and other offences to notify their patients of these offenses, so patients can make informed decisions regarding receiving medical care from such physicians, as has been required in California since July 1, 2019.[122]

(11) Health care institutions and medical boards should establish and fund programs to provide subsidized psychological counseling for all patients who were found to have been sexually abused by their physicians. These institutions can seek reimbursement for such costs from the sexually abusive physicians.

(12) Health care institutions should offer to provide trained chaperones to act as "practice monitors" during breast, full-body skin, genital, and rectal exams, having previously discussed this issue when patients first seek care.[123] The offer should be made regardless of the physician's gender.[124] Training of practice monitors should include what constitutes appropriate exams and when such exams are needed. Also, it is best that the practice monitors to be independent of (not supervised by) the physician being monitored.

[122] California Legislative Information. Senate Bill-1448 Healing arts licensees: probation status: disclosure. September 19, 2018. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180SB1448. Accessed May 6, 2020.

[123] Pimienta AL, Giblon RE. The case for medical chaperones. *Fam Pract Manag*. 2018;25(5):6-8.

[124] Committee on Ethics, American College of Obstetricians and Gynecologists. ACOG Committee opinion no. 373: Sexual misconduct. *Obs Gynecol*. 2007;110(2 Pt 1):441-444.

(13) Medical boards should work with their state legislature to lengthen or eliminate statutes of limitations for criminal offenses involving sexual abuse of patients by physicians.

(14) To improve the usefulness and utility of the NPDB, HRSA should take the following actions: (a) seek increased legal authority to investigate compliance with reporting requirements by hospitals and other health care organizations and malpractice insurers and take legal actions against noncompliant entities, (b) establish and enforce requirements for reporting entities to include appropriate, specific basis-for-action or specific-malpractice-allegation codes as applicable in their NPDB reports and for submitting complete and detailed narrative descriptions for all applicable NPDB reports, and (c) make individually identifiable information in the NPDB publicly available to consumers because the benefits of doing so far outweigh the harms to individual physicians or physician interest groups.

4.11 Conclusions

The relatively small number of physicians who were reported to the NPDB due to sexual misconduct represents the tip of the iceberg of sexual abuse of patients at the hands of their physicians in the U.S. We have illustrated how the current self-regulated medical system is disproportionately skewed against patients and how the current safeguards for protecting patients from physician sexual abuse are inadequate.

Unfortunately, the medical community has not adequately stepped up to its responsibility to tackle this problem. Specifically, the prohibitions of sexual misconduct by the AMA, ACOG, APA, and other professional medical organizations fall short of embracing a zero-tolerance standard against physician sexual abuse.

As consumer advocates, we hope that the findings and recommendations of this study will enhance much-needed discussions about this problem that will bring forth tangible changes to protect the public from sexually abusive physicians — effectively making physician sexual abuse "never events" in the near future so that all forms sexual misconduct by physicians are eliminated in the U.S.

Appendices

Appendix A. NPDB Codes Used to Select Study Reports

We identified licensing and clinical-privileges reports using NPDB Public Use Data File report type report codes "301 = state-licensing action legacy report" or "302 = state licensing action updated report," and "401 = clinical-privileges action legacy report" or "402 = clinical-privileges action updated report.".

We identified malpractice-payment reports using codes "101 = insurance company malpractice payments" or "102 = non-insurance company malpractice payments."

We identified sexual-misconduct–related reports using code "D1 = sexual misconduct" in any of the five basis-for-action variables in licensing or clinical-privileges reports or code "717 = sexual misconduct" in either of the two specific malpractice act or omission variables in malpractice-payments reports.

Appendix B. Revision-to-Action Codes in Licensing and Clinical-Privileges Reports

Revision to Action Codes in Licensing Reports

- 1144 Reprimand, censure, voluntary surrender of license (legacy report only)[125]
- 1280 License restored or reinstated (complete)
- 1282 License restored or reinstated (conditional)
- 1283 License restored or reinstated (partial)
- 1285 License reinstatement denied
- 1295 Reduction of previous licensing action
- 1296 Extension of previous licensing action
- 1297 Modification of previous licensing action

Revision to Action Codes in Clinical-Privileges Reports

- 1680 Clinical privileges/panel membership restored/reinstated (complete)
- 1681 Clinical privileges/panel membership restored/reinstated (conditional)
- 1682 Clinical privileges/panel membership restored/reinstated partial)
- 1689 Clinical privileges/panel membership reinstatement denied
- 1690 Reduction of previous action (clinical privileges/panel membership)
- 1695 Extension of previous action (clinical privileges/panel membership)
- 1696 Modification of previous action (clinical privileges/panel membership)

[125] We excluded reports that did not include any codes other than this code (n = 6) because it lumps two different types of actions (reprimands and censures) into "voluntary surrenders." Whereas the former action is nonserious, the second is serious. Thus, we chose to exclude the codes to avoid this inconsistency.

Appendix C. Hierarchical Categories of Forms of Sexual Misconduct Extracted from the Narrative Descriptions

i. Physical sexual contact or relations:
   (a) aggravated sexual battery
   (b) assault (physical attack)
   (c) battery (unlawful physical act)
   (d) cohabitation (victim moved in with physician or vice versa)
   (e) ejaculation on victim
   (f) fondling in improper sexual manner (of breasts, etc.)
   (g) frotteurism (deriving sexual pleasure or gratification from rubbing, especially the genitals, against another person)
   (h) improper conduct during examination
   (i) inappropriate contact
   (j) inappropriate examination
   (k) inappropriate touching
   (l) inappropriate touching during examination/procedure
   (m) indecent assault (offensive sexual act or series of acts exclusive of rape committed against victim without consent)
   (n) intercourse
   (o) intercourse resulting in pregnancy (abortion of fetus conceived with victim)
   (p) intercourse resulting in pregnancy (fathering child)
   (q) intimate physical conduct
   (r) kissing
   (s) marriage
   (t) oral sex
   (u) penetration
   (v) physical conduct
   (w) physical contact
   (x) physical encounter
   (y) physical relationship
   (z) physical sexual activity
   (aa) physical sexual conduct
   (bb) physical sexual contact
   (cc) rape
   (dd) sex
   (ee) sexual affair
   (ff) sexual battery (unlawful sexual physical act)
   (gg) sexual conduct (criminal)
   (hh) sexual contact
   (ii) sexual imposition
   (jj) sexual molestation
   (kk) sexual penetration
   (ll) sexual relation
   (mm) sexual relationship
   (nn) sexual touching
   (oo) sodomy

(pp) touched victim's genitals or breasts without medical reason
(qq) unnecessary examination[126]
(rr) unsolicited or unwanted hugging

ii. Nonspecific (in the absence of physical sexual contact or relations):
(a) boundary issues
(b) boundary violation
(c) close relationship
(d) crossed professional boundaries
(e) dual relationship
(f) harassment
(g) inappropriate action
(h) inappropriate behavior or interactions
(i) influencing to engage in sexual activity
(j) intimate encounter
(k) intimate relationship
(l) lascivious acts
(m) lewdness
(n) moral offense
(o) morally unfit conduct
(p) personal relation
(q) personal relationship
(r) proposition for sexual favor (not granted)
(s) romantic advances
(t) romantic conduct
(u) romantic involvement
(v) romantic relationship
(w) sexual abuse
(x) sexual act/action
(y) sexual activity
(z) sexual advance
(aa) sexual behavior
(bb) sexual conduct
(cc) sexual encounter
(dd) sexual exploitation
(ee) sexual harassment
(ff) sexual involvement
(gg) sexual impropriety
(hh) sexual misconduct
(ii) sexual offense
(jj) sexual violation
(kk) trading drugs/prescriptions/treatment for sexual favors
(ll) transference issues
(mm) undue familiarity
(nn) unethical conduct

[126] Because this constitutes unnecessary touching.

(oo) unprofessional misconduct
(pp) violation

iii. Inappropriate comments or communication (in the absence of any of the aforementioned forms of sexual misconduct):
(a) flirtatious messages
(b) flirting
(c) inappropriate comment
(d) inappropriate electronic communication
(e) inappropriate letter/note
(f) online solicitation (online sexual importuning)
(g) romantic communication
(h) sexting
(i) sexual calls, messages, remarks, or conversations
(j) unprofessional comments

iv. Other (in the absence of any of the aforementioned forms of sexual misconduct):
(a) ejaculation in presence of others/masturbation in presence of others
(b) engaging in video voyeurism (gaining sexual pleasure from watching others when they are naked) during medical practice
(c) indecent exposure (exposing private parts in presence of others)
(d) patronizing (soliciting) a prostitute
(e) possession of pornography (of child or adult)
(f) showing harmful material
(g) stalking
(h) trespassing residence

v. Undescribed sexual misconduct (in the absence of any of the aforementioned forms of sexual misconduct)

Appendix D. Midpoint Amounts for Calculations of Malpractice Payments

Payment amounts were coded by HRSA staff in the malpractice-payment reports in ranges as follows:

- All payments of $100 or less were coded as $50;
- Payments from $101 to $500 were coded as $300;
- Payments from $501 to $1,000 were coded as $750;
- Payments between $1,001 and $5,000 were coded as the midpoint of $1,000 increments, e.g., payments between $1,001 and $2,000 were coded as $1,500, payments between $2,001 and $3,000 were coded as $2,500, etc.;
- Payments between $5,001 and $100,000 were coded as the midpoint of $5,000 increments, e.g., payments between $30,001 and $35,000 were coded as $32,500, etc.;
- Payments between $100,001 and $1,000,000 were coded as the midpoint of $10,000 increments;
- Payments between $1,000,001 and $10,000,000 were coded as the midpoint of $100,000 increments;
- Payments between $10,000,001 and $20,000,000 were coded as the midpoint of $1,000,000 increments;
- Payments between $20,000,001 and $50,000,000 were coded as the midpoint of $5,000,000 increments;
- Payments between $50,000,000 and $100,000,000 were coded as the midpoint of $10,000,000 increments; and
- Any payment of $100,000,001 or more was coded as $105,000,000.