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Oregon
Kate Brown, Governor

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WORKGROUP ON SEXUAL MISCONDUCT

Meeting Agenda
November 17, 2021, 5:00PM
Videoconference

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
Charlotte Lin, MD
Ali Mageehon, PhD
Chere Pereira
Chris Poulsen, DO
Jill Shaw, DO

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

1	**Welcome and Review of Workgroup Charter Revision**	**LOUIE**
2	**Public Comment**	**LOUIE**
3	**Statement of Philosophy: Sexual Misconduct**	**MAGEEHON**
4	**OAR 847-010-0130: Medical Chaperones**	**PEREIRA**
5	**Educational Brochure** *The Workgroup will review the "What to Expect in a Physical Exam" brochure.*	**SHAW**
6	**Planning for Future Discussion Topics and Next Meeting Date**	**LOUIE**

ADJOURN

WORKGROUP CHARTER

Reconvening in Fall 2021/Winter 2022

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~~ **Four** licensed professional members of the Board **whose current practice includes conducting sensitive exams**

Administrative support will be provided by Oregon Medical Board staff, specifically the Medical Director, Executive Director, Legislative & Policy Analyst, and Executive Assistant.

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

Public meetings will be held **approximately November through January**. 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 adopting educational materials, amending or adopting administrative rules, and suggesting 2023 legislative concept(s).

Workgroup recommendations will be reviewed by the Administrative Affairs Committee on December 8, 2021, and the full Board on January 6-7, 2022.

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.

MEMORANDUM

TO:	Sexual Misconduct Workgroup
SUBJECT:	Medical Chaperone Rulemaking Comments
DATE:	November 8, 2021

The Oregon Medical Board requested public comment on proposed OAR 847-010-0130, which requires medical chaperones for all sensitive exams conducted by OMB licensees. An updated Hearing Officer's Report follows this memo, summarizing and providing copies of all written comments received. This memo is an abridged version of comments with questions for the Workgroup's consideration. The questions in this memo are intended to be prompts rather than an exclusive outline of the Workgroup's discussion(s).

Practice Areas (Specialties)
The proposed rule requires licensees to utilize a medical chaperone who will directly observe all breast, genital, and rectal examinations performed in outpatient and inpatient settings for all genders and ages. Comments from the public included requests for clarity in the following specialty-specific practice areas.

Pediatrics
Exceptions were requested for infant and pediatric patient exams in the hospital, such as at the time of or shortly after delivery, during diaper changes, etc. Exceptions were also requested for office visits for children under one year of age where parents are typically present.

- **Does the Workgroup recommend exemptions for hospital in-patients? If so, what criteria?**
- **Does the Workgroup recommend exemptions and/or allowances for patients under one year of age when performing sensitive exams? If so, what criteria?**
- **Does the Workgroup recommend exemptions and/or allowances for other pediatric patients when performing sensitive exams? If so, what criteria?**

Comments asked whether the chaperone must directly observe the exam under all circumstances. For example, a medical assistant (MA) may be present during a teen genital exam but will not directly observe the evaluation. Instead, the MA may look away or turn their back to respect the teenager's privacy and modesty.

- **Does the Workgroup recommend clarifying the meaning of direct observation?**
- **Does the Workgroup recommend pediatric/teen exceptions regarding direct observation? If so, under what criteria?**

Dermatology
An exception for full-body dermatology exams was requested. These skin exams include viewing the genital and breast areas. The provider may have patients lift their breasts or scrotum/genitals from side to side and spread their legs to examine inner thighs, but there is no contact.

- **Does the Workgroup recommend exemptions for full-body skin checks?**

Urology, Colon and Rectal Surgery & Male Exams
For some specialities, every patient has a rectal, prostate, or testicular exam. Some practices reported a 5-10% acceptance rate when chaperones are offered. One commenter asked whether the Board receives complaints regarding these specialty-specific examinations.

- **Does the Workgroup recommend exemptions and/or allowance for certain speciality providers when performing sensitive exams? If so, which ones? What criteria?**
- **Does the Workgroup have other recommendations to mitigate this concern?**

Emergency Department
Comments provided multiple of these exams are performed in every ED shift. It will be a challenge to coordinate the timing of the exam within the patient care workflow so that the physician and chaperone are present. EDs often treat victims of rape or abuse, who specifically ask for everyone else to leave the room because the act of exposing themselves and undergoing such an exam is incredibly traumatic.

- **Does the Workgroup recommend exemptions and/or allowance for certain speciality providers when performing sensitive exams? If so, which ones? What criteria?**
- **Does the Workgroup have other recommendations to mitigate this concern?**

Emergency Exception
The proposed rule does not require a chaperone where failure to examine the patient would result in significant and imminent harm to the patient, such as during a medical emergency. Comment asked if this exception applies to emergency departments.

- **Does the Workgroup recommend clarifying the medical emergency exception?**

Chaperone Requirement Generally
The proposed rule requires the licensee utilize a medical chaperone for sensitive exams. Comments suggested that a third person in the room may feel intrusive and uncomfortable for patients. During a pandemic, a third person increases exposure to the COVID-19 virus. If only female chaperones are available for male prostate and testicular exams, the male patients may feel uncomfortable.

- **Does the Workgroup have recommendations to mitigate these issues?**

Chaperone Qualifications
The proposed rule specifies that the chaperone may not be a personal friend of the patient or the licensee. Commenters asked who is considered a personal friend. For example, some medical offices encourage and foster a collegial environment among staff. In another example, a pediatric patient's family member may attend the exam.

- **Does the Workgroup have guidance for how to determine whether a chaperone is a personal friend of the patient or the licensee?**
- **Does the Workgroup recommend allowing patients to bring their own chaperone?**
- **May a parent or guardian serve as a chaperone for a pediatric patient?**
- **Does the workgroup recommend defining "personal friend" and "relative"? How?**

Chaperone Training
The proposed rule requires chaperones to complete a Board-approved medical chaperone course unless the chaperone is a licensed health care professional. Comments noted the cost and time to take the course and suggested that certified MAs be exempt from the requirement in recognition of the training they receive through MA certification courses or that the chaperone training requirement be removed from the proposed rule all together.

- **Does the Workgroup recommend allowing certain MA certification training to satisfy the chaperone training requirement?**
- **Does the Workgroup recommend removing the chaperone training requirement entirely?**

Extenuating Circumstances
A comment provided proposed rule needs flexibility for clinician judgment for extenuating circumstances. A medical chaperone requirement may exacerbate some patients with PTSD and other conditions.

- **Does the Workgroup recommend providing flexibility for extenuating circumstances?**

Patient Initiating Exposure
A comment provided proposed rule does not address instances outside of the licensee's control, such as if a patient were to expose the sensitive body part before the provider finds a chaperone.

- **Does the Workgroup recommend an exception for this situation?**

Patient Opt-Out – Deferring Care
A comment noted that delayed exams could lead to delayed care and diagnosis, especially pelvic and breast cancers.

- **Does the Workgroup have recommendations to mitigate this issue?**

Patient Opt-Out – Who may Decline the Chaperone or Exam
The proposed rule allows a patient to decline a chaperone or the exam, but the rule does not include the authority for a parent or legal guardian to decline or what to do when a parent/legal guardian's wishes contradict those of the patient.

- **Does the Workgroup recommend adding that a patient's parent, legal guardian, or representative may decline the chaperone or the exam?**

Patient Opt-Out – Timing of the Opportunity to Decline
Certain groups may disproportionately decline a chaperone and defer care, which may further health disparities among population groups. Some comments suggested advance notice with an opportunity to request or decline a chaperone at the time of scheduling or confirmation of the appointment or at the time of signing in on the day of the appointment.

- **Does the Workgroup recommend requiring advance notice that a medical chaperone will be offered? When? How?**

Patient Opt-Out – Process
Comment requested that the opt-out process include a requirement that the patient be explicitly informed about when and how exams are performed (e.g., what is included in a sports physical).

- **Does the Workgroup recommend requiring a form be signed by the patent (or the patient's representative) to opt out of a chaperone for a sensitive exam?**

Patient Opt-Out – Patient Opt-In
Comment that patients usually decline a chaperone when asked, requests the rule require providers ask if the patient wants a chaperone prior to sensitive exams.

- **Does the Workgroup recommend an opt-in process?**

Definition of Exam
A comment provided there is ambiguity on what constitutes an "exam."

- **Does the Workgroup recommend defining "exam" or some other alterative to address the possible ambiguity?**

Documentation
The proposed rule requires the presence of the chaperone be documented in the patient chart, but it is silent as to what should be included (e.g., the chaperone's name, credentials, etc.).

- **Does the Workgroup recommend adding specific items to the rule or to provide general guidance in this area? If so, what details should be included in the chart?**

Impact on Small Businesses
Comments were received about the financial and workflow impact of hiring new staff. Several commenters noted that the rule will be cost prohibitive in a practice where every exam would require a chaperone. In addition, repurposing existing staff will slow workflow and reduce the number of patients seen. Further, the proposed rule may impact smaller providers in rural and underserved areas with limited staff.

- **Should there be criteria for small health care providers?**
- **Does the Workgroup have other recommendations to mitigate this issue?**

Impact on Women's Health Services
Comment noted the proposed rule may inadvertently decrease the number of clinicians offering necessary women's health services in Oregon.

- **Does the Workgroup have recommendations to mitigate this issue?**

Rule Effective Date
The proposed rule requires compliance as of January 1, 2023. Commenters noted the pandemic challenges and the need to further assess health care staff needs.

- **Does the Workgroup recommend delaying the effective date of the rule?**
- **Does the Workgroup recommend withdrawing the rulemaking proposal?**

OREGON ADMINISTRATIVE RULES

CHAPTER 847, DIVISION 010 – OREGON MEDICAL BOARD

DRAFT REVIEW – NOVEMBER 2021

The proposed rule adopts the American College of Obstetricians and Gynecologists (ACOG) recommendation for a chaperone to be present for all breast, genital, and rectal examinations. The requirement for a chaperone would apply to examinations performed by Oregon Medical Board licensees in the outpatient and inpatient settings, effective January 1, 2023. This rulemaking recommendation comes from the Oregon Medical Board's Workgroup on Sexual Misconduct, which met monthly between February and April 2021.

The Workgroup on Sexual Misconduct noted that the presence of a trained 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 provider. The chaperone also serves as a witness to the events taking place should there be any misunderstanding or concern for misconduct.

The proposed rule would allow a patient to decline or "opt-out" of a chaperone, but it should be explained that the chaperone is an integral part of the clinical team whose role includes protecting the patient and the physician. If the patient declines, the proposed rule would allow the licensee to defer the examination for the protection of the patient and the licensee.

The proposed rule requires a licensee to use trained chaperones if the chaperone does not hold an active Oregon license to practice a health care profession. Licensees should ensure that chaperones understand their responsibilities to protect patients' privacy and the confidentiality of health information. Use of trainees (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.

The Board recognizes that requiring trained chaperones for breast, genital, and rectal examinations may require some practices to adjust staffing procedures. There also may be concerns about the time and resources needed to implement changes and their potential effect on patient care. However, the Board proposes to implement this requirement due to the evidence of the detrimental effects of sexual misconduct on patients' well-being, the patient–physician relationship, and public trust in the medical profession. There is a need to institute routine chaperoning to reduce the risk of sexual misconduct for Oregon patients.

[The following language is new. For readability, it is not bolded/underlined.]

847-010-0130
Medical Chaperones

(1) As of January 1, 2023, a licensee must have a trained chaperone physically present for all breast, genital, and rectal examinations.

(2) The licensee must ensure that the chaperone:

(a) Is not a personal friend or relative of the patient or licensee; and

(b)(A) Holds an active Oregon license to practice a health care profession; or

(B) Completes a course for medical chaperones approved by the Oregon Medical Board.

(3) During a breast, genital, or rectal examination, the chaperone may not participate in acts that would obstruct or distract the chaperone from observing the licensee's behavior and actions throughout the exam, procedure, or clinical encounter.

(4) The presence of the chaperone must be documented in the patient chart.

(5) The patient may decline the presence of a chaperone for a breast, genital, and rectal examination. If the patient declines, the licensee:

(a) Must document the decision in the medical record.

(b) May defer the breast, genital, or rectal examination for the protection of the patient and the licensee.

(c) May perform an unchaperoned examination with the rationale documented in the medical record.

(6) A licensee is not required under this rule to have a chaperone present 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.

Statutory/Other Authority: ORS 677.265
Statutes/Other Implemented: ORS 677.265

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Date: August 25, 2021 *updated November 8, 2021*

To: Hearing Attendees
Administrative Affairs Committee
Oregon Medical Board

From: Elizabeth Ross, Legislative & Policy Analyst, Hearing Officer

Subject: Hearing Officer's Report on Rulemaking Hearing for OAR 847-010-0130

Hearing Officer's Report

Hearing Date: August 24, 2021, 10 a.m.
Hearing Location: Oregon Medical Board, videoconference
Rule Number: OAR 847-010-0130
Rule Title: Medical Chaperone

The rulemaking hearing on the proposed rule convened at 10:03 a.m. Attendees were informed of the procedures for taking comments. They were also told that the hearing was being recorded. The purpose of the hearing was to provide an opportunity for public comment on the rule proposed by the Oregon Medical Board requiring board licensees to utilize a medical chaperone for all breast, genital, and rectal examinations performed in outpatient and inpatient settings by January 1, 2023.

Public Present:
Amber Grasmick-Black, Women's Healthcare Associates
Barbara Holtry, Oregon State Board of Nursing
Daniel Rosenberg, MD
JJ
Mark Bonanno, Oregon Medical Association
Rebecca Jacobs

Staff Present:
Elizabeth Ross, Legislative & Policy Analyst
Gretchen Kingham, Executive Assistant

SUMMARY OF ORAL COMMENTS:
The following persons testified at the hearing. Their testimony is summarized below.

Amber Grasmick-Black, Women's Healthcare Associates
Women's Healthcare Associates is a large multi-location OB-GYN practice in the Portland metro area. The practice currently has an opt-out program for medical chaperones, and Ms. Grasmick-Black provided comments on the training requirement and definition of personal friend for who

can serve as a medical chaperone. To help mitigate the expense and operational challenges, Ms. Grasmick-Black asked if training for non-licensed staff can be provided internally by the practice or easily accessible via online training modules. The practice would face a challenge where no licensed staff person is available to attend an exam to serve as a chaperone. If they could have a larger number of staff trained, such as medical assistants, that would help reduce the financial and logistical burden to ensure an exam is not delayed.

Ms. Grasmick-Black understands the intent to not allow a friend or family member serve as the chaperone and for the chaperone to be impartial and not create a conflict of interest. The challenge the practice faces is they encourage a collegiate environment among staff. How is personal friend defined (for example: someone you get coffee with or Facebook friends)? She asks for further clarification on this requirement.

Daniel Rosenberg, MD
Dr. Rosenberg is a family physician in Portland. He submitted written comments around infant and pediatric patient exams in the hospital and outpatient setting. Dr. Rosenberg asks the Board to consider the practical considerations that it would take at the time of delivery or shortly after when an infant is hospitalized to get another staff member to chaperone the exam, especially if the parents are already present. Also, the considerations for having staff come in during office visits for infants and kids under one year of age, if that is a concern, is best addressed by having a chaperone present or if its reasonable think that parents and guardians already present may provide that service in leu of a medical chaperone.

JJ
JJ asked the Board to consider when a patient chooses to opt out and not have a chaperone in the room, there should be information that the patient immediately reads and signs which states explicitly when and how exams are performed (for example: what is included in a sports physical).

Mark Bonanno, Oregon Medical Association
Mr. Bonanno provided the Oregon Medical Association submitted written comments and supports the use of chaperones to further patient safety and comfort. The written comments address the financial and practical considerations.

The public hearing adjourned at 10:16 a.m.

SUMMARY OF WRITTEN COMMENTS #1:
Written comments were accepted until August 24, 2021, 5 p.m. The following persons submitted written comments, which are summarized below.

Kelsey Fisher, Licensed Direct-Entry Midwife
Ms. Fisher appreciates the intent to protect both providers and consumers of medical care during vulnerable exams. She provides that given the prevalence of trauma and abuse history, it's important to support patient autonomy during examinations of this nature. The rule allows a patient to decline a medical chaperone, but also allows the provider to decline to perform the

exam. This may force the patient to reschedule and cause a significant cost (childcare, transportation, missed work, not accessing care, etc). This will disproportionately affect people impacted by poverty including women; single parents; Black, Indigenous, or people of color; members of the LGBTQ community; people with disabilities; and especially those people who identify within multiple oppressed or marginalized groups. She also provides there are existing factors that can create barriers to people scheduling these types of exams in the first place. She worries that attempting to obtain consent for a medical chaperone at the moment of the appointment will be coercive. She suggests these consequences can be mitigated with a requirement to give advance notice to patients about the medical chaperone rule at the time of scheduling or appointment confirmation. That would allow the patient time to carefully consider whether they consent or not. It also allows patients who want to decline a medical chaperone the ability to schedule with a provider who is comfortable with that decision.

Kevin Grayson, MD
Dr. Grayson is a pediatrician in Eastern Oregon. He lauds the intention of the rule but asks for clarity regarding pediatric patients. As written, the rule would require a chaperone for a newborn exam or even a diaper change performed at the parent's bedside. He notes a parent would not be able to opt out for their child to have a chaperone present because the rule only allows for a patient to decline. For older pediatric patients there is the question of when the patient themselves can decline or request a chaperone or override a parent's wishes.

Daniel Rosenberg, MD
Dr. Rosenberg provides for newborn and infant exams, parents are typically present, including the first exam in the hospital. Brief exams in the office could more practically include a chaperone than finding a nurse who could document their chaperone role in the hospital. Dr. Rosenberg suggest the Board solicit input from parent representatives if they feel it would improve their sense of safety and care if during infant examinations a chaperone observed. Dr. Rosenberg is aware that clinicians may abuse even the youngest patients but hopes the Board will consider balancing practical considerations in clinician offices, the comfort of parents with chaperones present in these circumstances, and the need to keep our patients safe.

W. Mark Dukeminier, MD
Dr. Dukeminier commented the proposed rule applies to all genders and ages, but references the ACOG policy which applies only to women patients. Overall, he finds the proposed rule is far too broad. He asked if for a prostate or testicular exam requiring his female MOA to be present as a chaperone would make the male patient more or less uncomfortable. He questioned how many actual valid complaints the board receives for such exams that are unchaperoned. Dr. Dukeminier commented that a breast exam on a female has been part of a routine PE forever, and getting his MOA for each such exam is not a trivial matter. The MOA would likely be rooming another patient and would cause a delay of 5-10 minutes. He thinks breast exams are very different from genital exams. Dr. Dukeminier commented that a chaperone for a female patient getting a genital or rectal exam by a male physician makes total sense.

Scott M. Browning, MD, FACS, FASCRS
Dr. Browning has a colon and rectal surgery practice and nearly every patient has a rectal exam which would require a chaperone for each exam room. He provides patients do not want this. They offer a chaperone and about 5% accept and twice that request no unnecessary personnel be present during the exam. Additionally, they do not have staff to meet this requirement, despite

being a small practice they have unfilled positions due to the current economic situation. If they cannot fill the mission critical slots, it would be difficult to hire four more FTEs as chaperones and they cannot afford the additional expense. Dr. Browning offers the could rearrange the desks of some administrative staff into the exam rooms where they can carry out their normal duties in addition to chaperoning, but that would not be practical. Overall, the rule would profoundly disrupt if not close his practice and patients do not want this.

Jeffrey Manchio, MD
Dr. Manchio is a colorectal surgeon and most of his patient visits include the type of exams covered by the rule requiring a chaperone. His primary concern is patient comfort and many of his patients struggle with a problem for months and years before talking with their doctor, let alone have this very sensitive exam. His practice offers a chaperone and less than 10% of patients accept. Most patients want as few individuals in the room during the exam. He offers that the current rule language seems to indicate a provider must go out of their way to stress the need for chaperone regardless of how uncomfortable the patient already is with the whole idea of even being in the doctor's office for their given issue.

Dr. Manchio is concerned about the financial and office workflow implications. Unless there is an increase in service payment by all Oregon based insurance plans to offset the expense of hiring chaperones, it is cost prohibitive in a practice where every exam would require a chaperone. Repurposing already existing office staff to remain in the room for every proctologic exam would slow office work flow and reduce the number of patients that could be seen. Also, the pandemic has provided significant challenges in finding adequate office staff.

Dr. Manchio disagrees with this proposed rule change and at the very least suggests allowing the patient to check a yes/no box on their intake paperwork asking if they desire a chaperone instead of requiring the conversation when a patient declines that would add to the degree of patient anxiety while increasing office expense and decreasing efficiency.

Abigail Haberman, MD
Dr. Haberman is a dermatologist and looks at genital and breast areas for full skin exams every day, and sometimes the peri-rectal area. Dr. Haberman has female patients lift their breasts, male patients move their scrotum/genitals from side to side, and both spread their legs to examine inner thighs but there is no contact. She does have contact when a patient has a lesion that needs to be palpated or when doing a biopsy in those areas. Dr. Haberman asked for clarification if she would need a chaperone for all skin exams or just when having contact with those areas. The rule would require additional staff time and/or additional staff to implement.

Ian Loewen-Thomas, MD, Salem Clinic
Dr. Loewen-Thomas asks for clarification in the following areas: if the rule would apply to all ages and genders/gender identities; training requirements for medical assistants; and should they include the chaperone’s name and credentials when documenting the presence of a chaperone.

Mark A. Bonanno, Oregon Medical Association
The Oregon Medical Association fully supports standards that guard against patient abuse and generally offers guidance to their members that support use of medical chaperones to further patient comfort and safety. However, the OMA provides the rule appears too broad and imposes unintended administrative and financial burdens on all medical practices. OMA notes the

proposed rule takes a "recommendation" of a national medical organization and creates a mandatory rule for all licensees, not just obstetricians or gynecologists. The rule includes many types of exams and requires unlicensed staff to complete a course to serve as a chaperone. Additionally, OMA points out cost concerns to add new staff for this role and implications if trained staff call in sick. OMA requests the proposed rule be withdrawn until further study and a clearer assessment of what the Board is attempting to do by mandating based upon a national specialty organization's recommendation.

Ben Johnson, PA-C and Leza Hayes, PA-C, Oregon Society of Physician Assistants
The Oregon Society of Physician Assistants appreciates the work the Board put into the area and understands the vital goal of patient safety. OSPA requests the Board consider impacts on staffing. OSPA notes some larger health systems already require this practice and have more adequate staffing levels to accommodate the requirement. OSPA is concerned about the impact on smaller providers, particularly in rural and underserved areas with limited staff. A last-minute staffing change could negatively impact a smaller provider's ability to provide a chaperone and delay an exam. This could have a negative impact on timely patient access to care.

OSPA notes the broad language requiring a provider to "ensure a chaperone is not a personal friend or relative of both patient and licensee" may create challenges in smaller care settings. OSPA requests defining these terms ("personal friend" or "relative"). OSPA is also concerned about language allowing an "opt out" of medical chaperones. If a patient does decline, despite a provider's explanation of the importance of a chaperone, the exam may still be delayed out of an abundance of caution for the provider and the patient's safety. OSPA is concerned this could potentially lead to delayed care and diagnosis for patients as providers may be hesitant to examine patients without a chaperone.

OSPA also requested clarification on the rule section allowing a person who "holds an active Oregon license to practice a health care profession" to serve as a medical chaperone without additional training and if that included all Oregon licensed health care professionals with an active license.

Erik Vanderlip, MD, MPH, ZoomCare
Dr. Vanderlip provided the Board's draft reflects what should be best practices across all health care settings. ZoomCare recently formalized its own chaperone policy, which aligns completely with the Board's proposal, being implemented at each of their clinics across Oregon, Washington, Idaho, and Colorado. ZoomCare provides the proposed rule would be an important step to ensure patients and providers alike are protected from inappropriate behavior when sensitive exams are medically indicated. They support adoption of the draft proposed rule at the earliest opportunity.

SUMMARY OF WRITTEN COMMENTS #2:
The comment period was extended until 12 p.m. on October 6, 2021. The following persons submitted written comments, which are summarized below.

Abigail Haberman, MD
Dr. Haberman is a dermatologist who previously provided comments, but had additional thoughts. Dr. Haberman feels the proposed rule punishes all medical providers for the misdeeds of a few. She provides the purpose of the Board is to discipline providers not acting with

integrity, but not to discipline all. The rule literally makes all licensees pay for the actions of others by requiring additional staff or having current staff work additional hours. She already took steps to streamline her practice to reduce cost in the face of other regulations and insurance requirements. She views the proposed rule as adding another layer of difficulty and complication to an already very challenging terrain in which to practice medicine. Dr. Haberman continues to consider earlier retirement because of the stressful and negative impact of providing care.

Dr. Haberman and her staff agree having a chaperone (third person) in the room would feel more intrusive and uncomfortable to patients. She adds that requiring a third person in an exam during a pandemic would increase exposure, especially those with a compromised immune system.

She wanted to ensure that large clinics, hospitals, and administrative staff were made aware of the proposed rule. She felt the comment period was short and doubts providers even saw the information embedded in the newsletter/report until it was too late.

Dr. Haberman proposes several solutions: notify patients with signage that they can request a medical chaperone, have patients sign a waiver form (but providers are already drowning in paperwork), or allow patients to bring someone in with them (but would not protect the provider). She notes these solutions would increase the complexity of an already too complex situation, rather Dr. Haberman strongly requests the proposed rule not be implemented and that the Board continue on in its purpose to only discipline providers who are acting inappropriately.

Don Thieman, MD
Dr. Thieman is very concerned that the broad scope of the proposed rule will result in missed diagnoses, especially pelvic and breast cancers if these exams are omitted. Most patients do not love those examinations and if postponed the exam may not get done at all. Dr. Thieman understands the goal of reducing abuse situations, but predicts the consequences from deferred or canceled exams will be large. Dr. Thieman provides it will be difficult to measure the positive and negative consequences of the proposed rule and the rule could sail on for a long time doing more harm than good.

Kirsten E. Crowley, MD
Dr. Crowley is a pediatrician suggesting the rule require a chaperone for any child that is alone for a breast, genital, or rectal exam. However, if the child has a parent present, the parent could serve as the chaperone. She believes the staffing required to have a chaperone in the room for every exam, including those that have a parent present, would not be possible in a busy outpatient clinic. She asks if the intent is for the chaperone to directly observe the exam and notes that for teen exams, a medical assistant is in the room. However, the medical assistant does not directly observe the evaluation rather she has them turn their back as the patient is often uncomfortable with another person being in the room.

Elizabeth O'Neill, MD
Dr. O'Neill is a pediatrician and understands the intent to protect patients from misconduct. She asks the Board to consider not requiring medical chaperones when a parent is present. She asks if there are cases of abuse or mistreatment of minors when parents are present. Dr. O'Neill provides they have a staffing crisis in hospitals and clinics and do not envision that crisis ending soon. She would not be able to hire sufficient staff to fulfill this obligation at every senitive physical exam from infancy through childhood. Dr. O'Neill agrees with chaperoning of minors who are not accompanied by parents.

Lori Gluck, MD
Dr. Gluck is a family physician and understands the important intent to protect patients from misconduct, but provides chaperones should not be required in all situations. She requests the Board consider when parents are present, medical chaperones not be required. Dr. Gluck also expressed concern about the required chaperon training. With a staffing crisis that may last for years, Dr. Gluck provides a person with specialized training standing in a room as a chaperone is an unnecessary barrier to patient care. Dr. Gluck requests that utilizing chaperones be a recommendation and only required for exams of unaccompanied minors, but not require the chaperone receive formal training.

SUMMARY OF WRITTEN COMMENTS #3:
The comment period was extended until 5 p.m. on November 8, 2021. The following persons submitted written comments, which are summarized below.

Brittany Arnold, MD
Dr. Arnold is an emergency physician opposing the rule as written, but suggests all providers be required to ask patients if they want a chaperone prior to these exams, an opt-in for patients, not an opt-out rule. In the ED she performs multiple of these exams every shift and provides it would be a challenge to find an individual to serve as a chaperone and coordinate the timing of the exam within the patient care workflow so that both herself and the chaperone could be present. Dr. Arnold notes the nursing shortage in EDs across the country, with already unsafe staffing ratios, and creating this additional requirement would be more harmful than beneficial to patient care. Additionally, she provides the rule is intrusive to victims of prior rape or abuse. Patients of different genders, specifically ask for everyone else to leave the room because the act of exposing themselves and undergoing such an exam is incredibly traumatic. Dr. Arnold always asks her patients if they would prefer a chaperone, but more often than not they decline.

Brian Duty, MD, Oregon Urological Society
Dr. Duty on behalf of the Oregon Urological Society (OUS) opposes the proposed rule. The OUS represents over two hundred urologists in Oregon with a mission to promote the highest standards of urological clinical care through education, research, and the formulation of health care policy. They do not disagree with the spirit of the measure (patient protection), but worry that many of their patients will choose to forgo important prostate cancer screening due to the presence of an additional person within the exam room. They provide the proposed rule will have a huge fiscal impact on a private urological practice. A urology practice evaluates multiple male patients who require rectal exams every day. Urology practices will have to hire a state licensee with appropriate training. The OUS opposes the proposed rule as it represents an unwarranted regulatory intrusion into medical practice and would result in significant economic burden on private urology practices (small businesses). They request the Board withdraw the proposed rule.

Katy King, Oregon Chapter of the American College of Emergency Physicians
The Oregon Chapter of the American College of Emergency Physicians (OR-ACEP) recognizes that having medical chaperones are a good standard of practice but caution the rule may not be appropriate in all circumstances for providing optimal medical care. They comment there is also ambiguity on what constitutes an "exam."

For example, they provided:

(1) Patients wishing to limit the number of healthcare professionals in the room, requiring a chaperone could be a trigger and serve as a hinderance, including patients with past traumas.
(2) The rule does not address instances outside of the provider's control, if a patient exposes the sensitive body part during the history or before the provider has a chance to obtain the help of a chaperone.
(3) Prolonged exams and the evidence collection performed by a SANE nurse for the entire exam which takes over an hour puts strain on resources and may not provide further reassurance to the patient or even be wanted by the patient. OR-ACEP offers the SANE advocate could be trained as a medical chaperone so to not require an additional staff member for this purpose.
(4) It is unclear if this rule extends to include infants or children with parents in the room.
(5) It may be challenging in the emergency medical setting to have appropriate personnel available. OR-ACEP notes there is an exception in instances if failure to examine would result in significant and imminent harm to the patient, such as during a medical emergency, but it's not clear that if that section applies to emergency departments.

OR-ACEP recommends patients should always be offered a chaperone, even during a lengthy medical exam. The patient should have the option to "opt-out" of a chaperone, however the clinician should also have the right to refuse to perform the exam in the absence of a chaperone.

Katy King, Oregon Psychiatric Physicians Association
The Oregon Psychiatric Physicians Association (OPPA) supports offering patients chaperones for all breast, genital, and rectal examinations. OPPA provided that mandating a medical chaperone may be intrusive in certain circumstances and the decision should be left to the patient and provider. They provided there needs to be flexibility for clinician judgment for extenuating circumstances. A medical chaperone requirement may exacerbate some patients with PTSD and other conditions and complicate an already short-staffed health care system. It may also inadvertently decrease the number of clinicians offering necessary women's health services in Oregon.

From: Kelsey Fisher <[redacted]>
Sent: Tuesday, August 24, 2021 10:44 AM
To: Elizabeth Ross
Subject: Comment on Proposed Rules 847-010-0130, use of medical chaperones

First, I want to say that I do appreciate the intent to protect both the providers and consumers of medical care during vulnerable exams. I have been on both sides of these kinds of exams, as a midwife and a patient. Unfortunately, I do have concerns over the impact of the rule as written. The majority of my concern surrounds patients declining the presence of a medical chaperone.

Given the prevalence of trauma and abuse history in our population, it is of utmost importance to support patient autonomy during examinations of this nature. As currently written, a patient may decline a medical chaperone, but in turn the provider may also decline to perform the examination. If this forces the patient to have to reschedule, that may cause a significant cost in the form of childcare, transportation, missed work, etc. This will disproportionately affect people impacted by poverty including women, single parents, Black, Indigenous, or people of color, members of the LGBTQ community, people with disabilities, and especially those people who identify within multiple oppressed or marginalized groups. People may not have the resources to reschedule and end up not accessing the care they need.

Additionally, there are already historical, emotional, cultural, or societal factors that can create barriers to people scheduling these types of exams in the first place. I worry that attempting to obtain consent for a medical chaperone at the moment of the appointment will be coercive. Given the sensitive nature of these types of examinations, patients might already be experiencing stress and may not feel comfortable declining, even if that's what they actually want to do.

I think that these consequences can be mitigated with a requirement to give advance notice to patients about the rules and policies around medical chaperones. If the use of medical chaperones is presented at the time of scheduling or appointment confirmation, that allows the patient time to carefully consider whether they consent or not. It also allows patients who want to decline a medical chaperone the ability to schedule with a provider who is comfortable with that decision. I do think that the responsibility for notifying the patients needs to be on the providers, and it needs to be done enough in advance (when possible) that the patients can truly decline.

Overall, I suspect that this rule change will be welcomed by patients and providers alike, but it's essential that we fully understand the impact and protect those who will be unintentionally harmed by it.

-Kelsey Fisher, Licensed Direct-Entry Midwife
Portland, OR

From: Kevin D. Grayson <[redacted]>
Sent: Tuesday, August 24, 2021 2:42 PM
To: Elizabeth Ross
Subject: ADOPT: 847-010-0130

Dear Ms. Ross,

I am a pediatrician in Eastern Oregon. I am writing to comment on the proposed rule 847-010-0130. In reading the proposed rule, it appears that some clarity might be needed regarding pediatric patients. As written, it would seem that I would not be able to perform a full initial newborn exam (or even change a diaper) at the parent's bedside without a nurse (or chaperone) present.

In a similar vein, a parent would not be able to opt-out for their younger child/toddler/infant to have a chaperone present during routine well child exams. As I read the proposed rule it only allows for the "a patient" to decline a chaperone. Of course for older pediatric patients there is the question of when the patient themselves can decline or request a chaperone or override a parent's wishes.

I laud the intention of this rule but it looks as though it needs some fine tuning in wording in regards to pediatric patients.

Sincerely,

Kevin Grayson, MD
MD23354

From: Rosenberg, Daniel M <[redacted]>
Sent: Friday, August 6, 2021 11:52 AM
To: Elizabeth Ross
Cc: O'Neill, Elizabeth MD (she/her)
Subject: Medical chaperone rulemaking question

Follow Up Flag: Follow up
Flag Status: Flagged

Ms/Dr Ross —

Regarding the proposed rules for medical chaperones, are there are pending proposals for the examination of newborns and infants?

Parents are typically present for exams of their infant children, including the first exam in the hospital (often at birth if the delivery is done by a family physician). Similar brief exams in the office could more practically include a chaperone than finding a nurse who would document their chaperone role in the hospital. But, I wonder if we might solicit input from parent representatives — would they feel it improves their sense of safety and care if during infant examinations we had a chaperone observing and documenting their role in the record?

I am aware that clinicians may abuse even the youngest patients, as evinced by recent cases in our state, and can't claim to have an ideal solution in mind, but hope we can consider such cases in rule-making to balance practical considerations in clinician offices, the comfort of parents with chaperones present in these circumstances, and the need to keep our patients safe. I hope this will be considered on the agenda for the meeting.

Thanks kindly,
Daniel Rosenberg MD
Portland OR

From: mark dukeminier <[redacted]>
Sent: Saturday, August 7, 2021 9:09 AM
To: Elizabeth Ross
Subject: Comment on proposed rule regarding chaperones

I may be misunderstanding the proposed rule, but as stated it applies to "all genders and ages". Yet, it references the policy of the ACOG which applies only to women patients. So I'm confused.

Are we to require a chaperone every time a prostate or testicular exam is done? Do you think having my female MOA present while doing such an exam will make the male patient more or less uncomfortable? How many actual valid complaints does the board get for such exams that are unchaperoned? How about an 80 year old male complaining of gynecomastia?

Really, a chaperone for every such exam by a female OB-GYN? For a rectal surgeon? For a female breast surgeon?

I would also remind the board that a breast exam on a female has been part of a routine PE forever, and that going out to get my MOA for each such exam is not a trivial matter. She will likely be rooming another patient, so a delay of 5-10 minutes would be typical. I think breast exams are very different from genital exams and have never had a complaint in over 40 years of practice.

A chaperone for a female patient getting a genital or rectal exam by a male physician makes total sense. But as stated, the proposed rule is far too broad in my opinion.

W. Mark Dukeminier, MD

From: Browning, Scott <[redacted]>
Sent: Monday, August 23, 2021 1:28 PM
To: Elizabeth Ross
Subject: Written Comment RE: 847-010-0130

Attn: Oregon Medical Board

RE: Proposed rule 847-010-0130: Medical Chaperones

Our practice is a colon and rectal surgery practice and therefore nearly every patient entering our office will have a rectal exam. This would mean providing a dedicated chaperone for each exam room all day long. This is a terrible idea. I will try to condense my thoughts into 3 items below.

1) PATIENTS DO NOT WANT THIS: Every patient entering our office is offered a chaperone. About 5% accept the chaperone. Interestingly, about twice that number go beyond simply declining the chaperone and spontaneously request that no unnecessary personnel (medical assistants, chaperones, students, etc.) be present during the exam.
2) WE DO NOT HAVE THE STAFF FOR THIS: Despite being a small practice we have had several staff openings for the better part of a year. We simply cannot fill them. We get applications, some even accept interviews, but none show up for interviews. They all seem to be much happier being paid to stay home and are simply putting in the applications to check that box for maintaining their government benefits. If we cannot fill the mission critical slots within our staff, there is no way we can additionally fill four more FTEs for the position of standing in the corner staring at butts.
3) Even if the state stops paying people to stay home and people return to the work force, we cannot afford four additional FTEs that accomplish nothing but complying with your rule. The only way we could even tretend to comply with this rule would be to move the desks of some of our administrative staff into the exam rooms where they can carry out their normal duties while exams go on beside them. This of course would be absurd.

In short this proposed rule is a terrible idea that would profoundly disrupt if not close our practice and which benefits no one. Above all, the patients do not want this, and I can virtually guarantee you that 95% of our patients will refuse the chaperone.

Scott M Browning, MD, FACS, FASCRS

From: Jeffrey Manchio <[redacted]>
Sent: Monday, August 23, 2021 3:56 PM
To: Elizabeth Ross
Subject: Proposal 847-010-0130 - requirement to use medical chaperones

Dear OMB,

I wish to submit my written comment on Proposal 847-010-0130 - requirement to use medical chaperones. As a colorectal surgeon, I am performing exams of the nature to which this rule directly applies for the vast majority of my patient visits in our office. I have a number of concerns pertaining to this proposed rule change requiring a medical chaperone be present.

Primarily among my concerns is that of patient comfort with this requirement. Many of our patients have been struggling with the problem that they finally muster up enough courage to come see us about for months, if not years, before they are willing to even talk with their doctor about it, let alone have this very sensitive examination performed. We ask them all if they would desire a chaperone be present and less than 10% state that they want one. The majority of the patients want as few individuals in the room during this particular part of the visit as possible. The current wording on the rulemaking information sheet would seem to indicate that the provider/practice must go out of their way to stress to the patient the need for chaperone regardless of how uncomfortable the individual already is with the whole idea of even being in the doctor's office for their given issue in the first place.

As pointed out in the rulemaking information sheet, there is certainly also the cumbersome matter of the requirement in and of itself, both financially and on office workflow efficiency. Unless there is going to be an across-the-board increase in service payment by all Oregon based insurance plans to offset the expense of hiring chaperones, then it is simply cost prohibitive in a practice where essentially every examination would require a chaperone. Repurposing already existing office staff such as a medical assistant to remain in the room throughout the duration of every proctologic examination would drastically slow office work flow and reduce the number of patients we can offer our services to in the course of a day of clinic. All of this of course does not even take into account the near impossibilities that the pandemic has brought with it in finding adequate office staff even in the absence of this increased demand.

In summary, I disagree with this proposed rule change. At the very least, I would strongly encourage the wording be changed in a way that would simply reflect permitting the patient to check a yes/no box on their intake paperwork asking if they desire a chaperone be present to serve as adequate. Insisting a much more uncomfortable conversation ensue with any patient that declines chaperone simply adds to the degree of patient anxiety, something that most patients are already plenty anxious about, while simultaneously increasing office expense and decreasing efficiency. Thank you for your consideration. I would be happy to discuss directly if you desire contacting me.

Sincerely,
Jeffrey Manchio, MD
Colorectal Health NW
[redacted]

From: Elizabeth Ross
Sent: Friday, August 20, 2021 7:25 AM
To: [redacted]
Subject: RE: Questions regarding chaperone rule

Dr. Haberman,

Thank you for providing thoughtful points to consider for this rulemaking. I will include your comments for review by the Administrative Affairs Committee on September 8, 2021 and the Oregon Medical Board on October 7-8, 2021. As currently written, the proposed draft rule would include the types of exams you describe requiring a medical chaperone to be present. The committee and board can review your comments and discuss further.

Please let me know if you have additional questions.

Best regards,

Elizabeth Ross
Legislative & Policy Analyst
Oregon Medical Board
1500 SW 1st Avenue Suite 620
Portland, OR 97201-5847
Phone: 971-673-2667 | Fax: 971-673-2670
https://oregon.gov/omb

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-----Original Message-----
From: ah <[redacted]>
Sent: Friday, August 13, 2021 11:55 AM
To: Elizabeth Ross <Elizabeth.Ross@omb.oregon.gov>
Subject: Questions regarding chaperone rule

I am a dermatologist and look at genital and breast areas for full skin exams every day, sometimes peri-rectal area if patient has a concern there.

I have female patients lift their breasts, male patients move their scrotum/genitals from side to side, and both spread their legs to examine inner thighs but there is no contact.

I do have contact when a patient has a lesion that needs to be palpated or I'm doing a biopsy in those areas.

How would these scenarios fit into the rule making process? Would the new rules make it necessary for me to have a medical chaperone in the room for all skin exams? Or just when having contact with those areas?

This rule would require additional staff time and/or additional staff to implement.

Abigail Haberman MD

From: Elizabeth Ross
Sent: Tuesday, August 24, 2021 3:55 PM
To: [redacted]
Subject: RE: Oregon Medical Board Rulemaking -- Medical Chaperones

Dr. Loewen-Thomas,

Thank you for providing these thoughtful points to consider for this rulemaking. I will include your comments for review by the Administrative Affairs Committee on September 8, 2021 and the Oregon Medical Board on October 7-8, 2021.

To answer some of your questions, as written the proposed rule would apply to all ages and genders/gender identities. Also as drafted, the chaperone would need to hold an active Oregon license to practice a health care profession or if not licensed complete a board approved training for medical chaperones. During the upcoming meetings, the board will review and discuss if there are certain medical assistant certification trainings that include areas covered in a medical chaperone training and may be able to satisfy the requirement. If this draft rule moves forward and is adopted, we would provide additional information through newsletter articles and a topic of interest webpage, to include guidance on how to document the presence of a chaperone in a medical chart.

Please let me know if you have additional questions.

Best regards,

Elizabeth Ross
Legislative & Policy Analyst
Oregon Medical Board
1500 SW 1st Avenue Suite 620
Portland, OR 97201-5847
Phone: 971-673-2667 | Fax: 971-673-2670
https://oregon.gov/omb

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Data Classification Level 2 - Limited

---------- Forwarded message ---------
From: **Loewen-Thomas MD, Ian** <[redacted]>
Date: Fri, Jul 23, 2021 at 9:12 AM
Subject: RE: Oregon Medical Board Rulemaking -- Medical Chaperones
To: kathleen harder <kmharder76@gmail.com>

I think it looks fairly straight forward, but I do have a few comments about things that might need clarification:

1. The background paragraph highlights the ACOG recommendation for a chaperone. I am assuming however, that the Medical Board's chaperone requirement is for all genders/gender identities.

2. Is the rule for all patients (children and adults) ?

3. The chaperone is to hold an active Oregon license to practice a health care profession, which would imply that Medical Assistants with certification (and not licenses) would not be acceptable. (without doing an approved medical chaperone course)

4. When documenting the presence of a chaperone, does this need to include chaperone's name and credentials?

Thanks

Ian

Ian G. Loewen-Thomas, MD | **Medical Director**

[redacted]

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From: Mark Bonanno <[redacted]>
Sent: Monday, August 23, 2021 4:58 PM
To: Elizabeth Ross
Cc: Nicole Krishnaswami; Bryan Boehringer; Courtni Dresser
Subject: OMB Proposed Rules Public Comment
Attachments: 2021-08-23 OMB Proposed Rule Comments.pdf

Elizabeth,

Attached are public comments from the OMA on a few of the OMB's proposed rules. We believe an extension of time for the comment period would be helpful as well given the unanticipated and critical COVID surge in Oregon is taxing the health care community. This has not allowed for an appropriate focus and an opportunity for dialogue at the OMA on what appear to be complex rules.

We are glad to supplement written comments with discussion and follow up commentary. Thank you.

Mark

Mark A. Bonanno, JD, MPH
General Counsel and Vice President of Health Policy
Oregon Medical Association
[redacted]

The OMA is working remotely during the COVID-19 pandemic.

August 23, 2021

Via Email Elizabeth.Ross@omb.oregon.gov
Elizabeth Ross, Rules Coordinator
Oregon Medical Board
1500 SW 1st Ave, Suite 620
Portland, OR 97201

Re: Proposed Rules 847-001-0024, 847-010-0073, and 847-010-0130

Dear Ms. Ross,

The Oregon Medical Association (OMA) represents over 8,000 physicians and physician assistants in the State of Oregon. We value the opportunity to comment on proposed administrative rules. The following comments are submitted in response to the Oregon Medical Board's (OMB's) proposed rules OAR 847-001-0024, 847-010-0073, and 847-010-0130 filed with the Secretary of State on July 12, 2021.

General Comment

We recognize that it is important to continue the patient safety work of the OMB especially during this COVID-19 pandemic. We also recognize the proposed rules were filed on July 12, 2021, shortly after the Governor rescinded COVID-specific orders on June 30, 2021. Unfortunately, just six weeks later, Oregon is now experiencing the most challenging patient surge of this entire pandemic. The OMA's leadership, members and staff mostly are redeployed to support the health care community and the issues being faced in the field. Given that the proposed rules raise complex policy issues that should have broader discussion, we believe that an extension of the commenting deadline past August 24, 2021, would be helpful and appreciated. ***We offer a general comment to delay the comment period for proposed rules OAR 847-001-0024, 847-010-0073, and 847-010-0130 for two months until October 24, 2021.***

Comment on OAR 847-001-0024

The proposed rule states that the Board will enroll active licensees with allegations of sexual misconduct in the National Practitioner Data Bank (NPDB) for two years from the date of the last allegation. The OMA supports efforts to address a robust response to conduct of any licensee that is determined to involve sexual misconduct. We may be misinterpreting the proposed rule, however, and our understanding is that any allegation, even an unsubstantiated allegation, could subject a licensee to NPDB reporting. Our understanding is that the NPDB only accepts reported actions from a licensing board that are the result of formal proceedings. THE NPDB GUIDEBOOK, Chapter E, *Reporting State Licensure and Certification Actions*. In other words, unless and until the allegations presented to the Board result in an adverse action, they are not reportable. This form of long-standing due process called for under the NPDB reporting law and guidance allows for the important and critical assessment of any allegation against a licensee. If our interpretation of the proposed rule is accurate, we believe the rule needs to be amended. ***We offer the following comment to amend the proposed rule to state: "The Board will enroll active licensees with an adverse action that involves allegations of sexual misconduct in the National Practitioner Data Bank Continuous Query for two years from the date of the last allegation."***

Comment on OAR 847-010-0073

The proposed rule significantly redefines the term "unprofessional conduct." Much of our commentary addresses the vagueness associated with some of the proposed amendments to existing provisions of the rule and new provisions. We will address each instance below and the rationale for the comment.

Paragraph (3)(b)(A)(iii) adds a new term to unprofessional conduct to include: "Any conduct, practice, or condition which does or might adversely affect a provider's ability to safely and skillfully practice medicine, podiatry, or acupuncture." The term specifically uses vague language such as the word "might." This is too speculative and potentially discriminatory. For example, a licensee with a diagnosed mental illness that is treated or is not impacting competency, could result in a complaint because the condition might affect competency even though it has not. ***We offer the following comment to amend the proposed rule to state: "Any conduct, practice, or condition which ~~does or might~~ adversely affects a provider's ability to safely and skillfully practice medicine, podiatry, or acupuncture."***

Paragraph (3)(b)(E) removes language that ties conduct to competency so that any instance of alleged "disruptive behavior" in a health care setting is seemed unprofessional conduct. So, for example, if in a board of directors meeting of a health care setting, a licensee engages in discussion that dissents from the majority of the board members about a proposed board decision, someone might subjectively conclude such dissention is disruptive and make a complaint to the Board. This is not healthy for the medical profession nor patient safety. Licensees need the ability to engage in the concept of dissention about decisions in health care settings some of which may ultimately benefit patient safety. We believe that the proposed rule goes too far in stripping out language that ties conduct to competency to practice. ***We offer the following comment to amend the proposed rule to state: "Repeated instances of disruptive behavior in the health care setting that could adversely affect the delivery of health care to patients."***

Paragraph (3)(b)(G) appears to add conduct that is contrary to or inconsistent with recognized standards of a licensee's profession to the definition of unprofessional conduct. This is a significant amendment that needs broader consideration and involvement of licensees who are subjected to standards of ethics that are not rules or law but generally agreed upon guidelines for respective professions. In some instances, national standards are different from local standards, and frankly, local law. For example, the American Medical Association Code of Medical Ethics Opinion 5.7 provides that physician-assisted suicide is fundamentally incompatible with the physician's role as a healer. So, if a physician in Oregon participates under any provision of Oregon's Death With Dignity Act, they could find themselves subject to Board discipline. We are not commenting at all on any physician's role under the Act. All we are commenting on is the potential incompatibility with national ethical standards with local law. As such, we believe this addition to OAR needs further and more detailed analysis. ***We offer the following comment that this proposed rule be withdrawn until there can be a clearer assessment of what the Board is attempting to do by blanketly incorporating national professional standards into the definition of unprofessional conduct that may be contrary to local law.***

Paragraph (3)(b)(H) adds a new term about financial conflicts of interest to unprofessional conduct. The term is vague and could use more specific detail about what type of financial relationship could result in Board discipline. For example, a licensee enters into a non-medical business venture with a former patient. The business relationship sours as many business relationships do and the licensee sues the former patient to obtain control of the business venture. The former patient files a complaint with the Board. How will the Board effectively evaluate this financial relationship which has nothing to do with a standard of care? ***We offer the following comment that this proposed rule be withdrawn until there can be a clearer assessment of what the Board is attempting to do by labeling a financial relationship unprofessional conduct.***

Paragraph (3)(b)(I) adds a new term that makes it unprofessional conduct for a licensee, or any person authorized to act on behalf of the licensee to knowingly contact a complainant prior to a contested case. We certainly understand and support the policy behind this proposed rule, but it too does not seem to accommodate scenarios that normally occur in health care settings. For example, a patient may file a complaint about a licensee. The licensee may not know the patient has filed a complaint. A billing clerk for the licensee contacts the patient about an unpaid invoice for services. This act on its face appears to violate the proposed rule because the billing clerk is knowingly contacting the patient about the invoice. ***We offer the following comment to amend the proposed rule to state: "Knowingly contacting the complainant in an investigation, or allowing any person authorized to act on behalf of the licensee to knowingly contact the complainant in an investigation, unless and until the licensee has requested a contested case hearing and the Board has authorized the taking of the complainant's deposition pursuant to ORS 183.425. 'Knowingly contact' means that the individual knows the identity of the complainant and contacts them regarding the complaint or investigation."***

Comment on OAR 847-010-0130

The proposed rule creates a new mandate on all licensees to have a "trained chaperone" physically present for all breast, genital, and rectal examinations. The proposed rule appears to codify a recommendation of the American College of Obstetricians and Gynecologists that a chaperone be present for certain examinations. The OMA fully supports standards that guard against any form of patient abuse and generally offers guidance to members that supports of the use of medical chaperones to further patient comfort and safety. The proposed rule, however, appears too broad in its application and imposes what we believe are unintended administrative and financial burdens on all medical practices. The proposed rule also takes a "recommendation" of a national medical organization and creates a mandatory rule to apply to all licensees of the Board not just obstetricians or gynecologists. So, for example, an emergency room or urgent care clinic physician does a general external wellness check of a pediatric patient who presents with general abdominal pain. The family might be present but there is no medical chaperone when the physician generally checks the chest and genital area of the patient. The rule appears violated. The physician has as scribe present at examinations of patients and performs a wellness check and rectal exam of a male patient. The scribe is typing notes into the electronic health record and has not completed a course in chaperoning. The rule appears violated. Adding new assistant staff whose sole role might be to serve as a chaperone could add significant cost of a small medical practice. Or, in another example, a medical assistant trained as a medical chaperone calls in sick to a medical practice. Rather than cancel appointments for the entire day, the practice's physician assistant sees patients who already are present in the waiting room and show up for scheduled appointments. If the physician assistant conducts any breast, genital or rectal examinations that have specifically been scheduled, the rule appears violated unless every patient is asked to decline the presence of a chaperone. The proposed rule would benefit from further study and input from the medical community given it appears to create a strict disciplinary standard for every licensee of the Board that we do not believe was intended by ACOG when it made its recommendation. ***We offer the following comment that this proposed rule be withdrawn until there can be further study and a clearer assessment of what the Board is attempting to do by mandating by rule based upon a national specialty organization's recommendation.***

Thank you for your consideration of our comments. We would be glad to supplement our comments with discussion with the Board at any time.

Sincerely,

Mark A. Bonanno, JD, MPH
General Counsel and Vice President of Health Policy

August 23, 2021

RE: Proposed OAR 847-010-0130 (Medical Chaperones)

Dear Chair Harder:

On behalf of the Oregon Society of Physician Assistants (OSPA), we would like to thank you for the opportunity to submit testimony regarding the Oregon Medical Board's proposed rules requiring the use of medical chaperones for all breast, genital, and rectal examinations performed in outpatient and inpatient settings.

OSPA appreciates the work that the OMB has put into the drafting of the proposed OAR 847-010-0130, including the OMB's Workgroup on Sexual Misconduct, and understands the vital goal of patient safety which these draft rules aim to achieve. With that in mind, we would like to offer some thoughts about the likely impacts of these rules for the OMB to consider.

While some larger health systems have required this practice they generally have more adequate staffing levels to accommodate this requirement. We are concerned about the impact these draft rules will have on smaller providers, particularly in rural and underserved areas where staffing may already be limited. In these circumstances, a last-minute staffing change could negatively impact a smaller provider's ability to meet the chaperone requirements and inadvertently delay an exam from occurring. This could have a negative impact on timely patient access to care. The broadness of the draft language requiring a provider to "ensure a chaperone is not a personal friend or relative of both patient and licensee" may also create challenges in smaller care settings. We request that the OMB consider further defining these terms ("personal friend" or "relative") to provide more straightforward guidance to providers.

Additionally, we are concerned about the language allowing an "opt-out" of medical chaperones. If a patient does "opt-out" of a chaperone, despite a provider's explanation of the importance of a chaperone, the exam may still be delayed out of an abundance of caution for the provider and the patient's safety. OSPA is concerned this could potentially lead to delayed care and diagnosis for patients as providers may be hesitant to examine patients without a chaperone.

As the OMB deliberates on these draft rules, we respectfully request your consideration of the concerns we have raised. We stand ready to assist the OMB in implementing administrative rules that ensure Oregon patients safety and timely care.

Sincerely,

Ben Johnson, PA-C
President
Oregon Society of Physician Assistants

Leza Hayes, PA-C
Chair, Government Affairs Committee
Oregon Society of Physician Assistants

zoomcare®

August 11, 2021

Ms. Elizabeth Ross
Legislative & Policy Analyst
Oregon Medial Board
1500 SQW 1st Avenue, Suite 620
Portland, OR 97201-5847

Dear Ms. Ross:

Thank you for the opportunity to comment on OMB's draft proposed rule to require medical chaperones for certain sensitive examinations.

OMB's draft reflects what should be best practices across all health care settings. Coincidentally, Zoom Care recently formalized its own chaperone policy, which aligns completely with OMB's proposal. We are implementing the new policy at each of our 63 clinics this month across Oregon, Washington, Idaho and Colorado.

The OMB's draft proposed rule, if adopted, would be an important step to ensure that patients and providers alike are protected from inappropriate behavior when sensitive exams are medically indicated. We support adoption of the draft proposed rule at the earliest opportunity.

Best regards,

Erik Vanderlip, MD, MPH

Chief Medical Officer

From: Abigail Haberman <[redacted]>
Sent: Tuesday, September 7, 2021 4:31 PM
To: Elizabeth Ross
Subject: Re: Questions regarding chaperone rule

I have had additional thoughts since sending the original email to you and wanted to add them to my comments.

I feel that this proposed rule punishes all medical providers for the misdeeds of a few. The purpose of the medical board is to discipline those providers not acting with integrity…but not to discipline all of us. This rule makes the rest of us literally pay for the actions of others. We already pay our medical board fees. But this rule would require us to also pay by hiring additional staff and having current staff work additional hours as they would be taken from their other work.

I have done everything I can think of to streamline my practice to reduce the cost of providing medical care but this just adds to the cost of care. I wonder if large clinics and hospitals and their administrative staff were made aware of this proposed rule in a timely fashion as well as this affects their staffing and hiring needs also. In the face of increasing healthcare costs, this will just add to the problem.

This rule increases the health hazards during the Covid pandemic. I have a compromised immune system and the rule would require having a third person in a small room. I have done all that I can to protect myself, my staff, and my patients but this would increase our risks, particularly mine, for exposure to Covid.

I was concerned by the short notice and period to respond to this proposed rule. I received the OMB report on August 6th, a Friday afternoon, and response was required by August 24th. I usually scroll through my emails, looking for ones that require an urgent reply, but don't sit down and thoroughly read emails such as the OMB report until I have some time on the weekend to do so. I doubt that many providers even saw the information embedded in the report until it was too late.

I have tried to downsize and simplify in every way possible in the face of CLIA, OSHA, MOC, CME, Covid, unbelievable difficulties with insurance companies refusing to pay for the care that has already been provided, etc. etc. etc. This proposed rule just adds another layer of difficulties and complications to an already very challenging terrain in which to practice medicine. I continue to try to persevere amidst it all because of the care that I provide my patients and for which they are so appreciative. But I continue to consider earlier retirement because of the stressful and negative impact that all the other aspects surrounding providing that care has on me.

I have read of many stories of early retirement because of the pandemic. This may likely be another hoop to jump through such that other providers will consider doing the same. There is already a shortage of healthcare workers due to the pandemic and early retirement taken by many. This rule will likely increase the numbers taking early retirement and further complicate the problem.

In discussing this proposed rule with my staff, there was agreement that having an additional person/chaperone in the room would feel more intrusive to patients, making them feel more uncomfortable.

One solution would be to notify patients with signage that they can request the presence of a medical chaperone if they would like. I would consider proposing having patients sign a waiver form, but we are already drowning in paperwork.

Another solution would be for patients to bring someone with them. It does nothing to protect the provider from those who make a complaint when nothing was done, but it might provide a layer of protection for patients.

But rather than these solutions, which increase the complexity of an already too complex situation, I would strongly request that the proposed rule not be implemented and that the board continue on in its purpose to only discipline providers who are acting inappropriately.

Thank you for taking into consideration my additional comments,

Abigail Haberman MD

> On Aug 20, 2021, at 7:24 AM, Elizabeth Ross <Elizabeth.Ross@omb.oregon.gov> wrote:
>
> Dr. Haberman,
>
> Thank you for providing thoughtful points to consider for this rulemaking. I will include your comments for review by the Administrative Affairs Committee on September 8, 2021 and the Oregon Medical Board on October 7-8, 2021. As currently written, the proposed draft rule would include the types of exams you describe requiring a medical chaperone to be present. The committee and board can review your comments and discuss further.
>
> Please let me know if you have additional questions.
>
> Best regards,
>
> Elizabeth Ross
> Legislative & Policy Analyst
> Oregon Medical Board
> 1500 SW 1st Avenue Suite 620
> Portland, OR 97201-5847
> Phone: 971-673-2667 | Fax: 971-673-2670 https://oregon.gov/omb
>
> OUR MISSION: To protect the health, safety, andwellbeing of Oregon citizens by regulating the practice of medicine in a manner that promotes access to quality care.
> Data Classification Level 2 - Limited
>
> -----Original Message-----
> From: ah <[redacted]>
> Sent: Friday, August 13, 2021 11:55 AM
> To: Elizabeth Ross <Elizabeth.Ross@omb.oregon.gov>
> Subject: Questions regarding chaperone rule
>
> I am a dermatologist and look at genital and breast areas for full skin exams every day, sometimes peri-rectal area if patient has a concern there.
>
> I have female patients lift their breasts, male patients move their scrotum/genitals from side to side, and both spread their legs to examine inner thighs but there is no contact.
>
> I do have contact when a patient has a lesion that needs to be palpated or I'm doing a biopsy in those areas.
>
> How would these scenarios fit into the rule making process? Would the new rules make it necessary for me to have a medical chaperone in the room for all skin exams? Or just when having contact with those areas?
>

> This rule would require additional staff time and/or additional staff to implement.
>
> Abigail Haberman MD
>
>
>

From: Donald Thieman, MD <[redacted]>
Sent: Tuesday, September 7, 2021 9:42 AM
To: Elizabeth Ross
Subject: Proposed chaperone rule concerns

Ms. Ross:
I know it's too late for inclusion in this week's discussion, but wanted to share my concern nonetheless.
If I understand this proposal correctly, to be as broad as it appears, I am very concerned it will be a well-intentioned action with foreseeable consequences in missed diagnoses, perhaps of pelvic and breast cancers especially.
I come from 16 years of family medicine practice in Alaska, followed by 29 years as a medical administrator in the Portland/Vancouver area. The number of omitted pelvic exams where one would like to see them, in gyn surgery authorization request files, for instance, speaks to how easily the expedience of time saving can creep into practice habits. The goal of reducing abuse situations is important and understandable, but the consequences on the other side will be large I am afraid, from deferred exams that happen very late or never. Most patients do not love those examinations, and if missed "today" may just not get done at all.
It will be very difficult to measure both positive and negative consequences, so once such a rule is in place, data to support it -- or its discontinuance -- will be unreliable. It could sail on for a very long time doing more harm than good.
Thank you for considering my concerns.
Don Thieman MD

CareOregon

Donald E. Thieman MD | Associate Medical Director
www.careoregon.org | [redacted]

CareOregon Advantage | Columbia Pacific CCO | Jackson Care Connect

From: Elizabeth Ross
Sent: Friday, October 1, 2021 9:27 AM
To: [redacted]
Subject: RE: Chaperones

Dr. Crowley,

Thank you for providing thoughtful points to consider for this rulemaking. I will include your comments for the Board's review next week. As currently drafted, the rule provides during the exam the chaperone may not participate in acts that would obstruct or distract the chaperone from observing the licensee's behavior and actions throughout the exam encounter. You bring up a good point to consider about directly observing the evaluation.

Please let me know if you have additional questions.

Best regards,

Elizabeth Ross (she/her)
Legislative & Policy Analyst
Oregon Medical Board
1500 SW 1st Avenue Suite 620
Portland, OR 97201-5847
Phone: 971-673-2667 | Fax: 971-673-2670
https://oregon.gov/omb

OUR MISSION: To protect the health, safety, andwellbeing of Oregon citizens by regulating the practice of medicine in a manner that promotes access to quality care.
Data Classification Level 2 - Limited

From: Crowley, Kirsten E <[redacted]>
Sent: Thursday, September 30, 2021 11:02 PM
To: Elizabeth Ross <Elizabeth.Ross@omb.oregon.gov>
Subject: Chaperones

I'm a pediatrician with Providence Medical Group—clinic medical director. I examine children every day. I think it would be important to call out in the rule that presence of a chaperone should be required for any child that is alone for a breast, genital, or rectal exam. If the child (of any age) has a parent present, that parent would serve as the chaperone as they are consenting to the exam simply by being present. The manpower required to have a chaperone in the room for every exam, including those that have a parent present, would not be possible in a busy outpatient clinic.

Is the intent to have the chaperone directly observe the exam? For our teen exams, we have an MA in the room with us. But, they do not directly observe the evaluation. I have them turn their back as the patient is often uncomfortable with another person being in the room.

Thanks!
Kirsten

Kirsten E. Crowley, MD

Providence Medical Group, Scholls Pediatrics
12442 SW Scholls Ferry Road, Suite 205
Portland, Oregon 97223
[redacted]

Compassion – Matthew 11:28-30 | Dignity – Genesis 1:27 | Justice – Micah 6:8 | Excellence – Colossians 3:23 | Integrity - 1 John 3:18

From: O'Neill, Elizabeth MD (she/her) <[redacted]>
Sent: Saturday, October 2, 2021 1:23 PM
To: Elizabeth Ross
Subject: chaperones

Hello,

I am a Providence Family Physician and I am concerned about potential for a good idea leading to unintended negative consequences, in regard to the requirement for medical chaperones for children of all ages including infancy and regardless of presence of parents.

I understand the important intent to protect patients from misconduct. I would request consideration that when parents are present, medical chaperones are not required. Do we have cases of abuse/other mistreatment of minors when parents are present?

We have a staffing crisis in hospitals and clinics and I do not envision that crisis ending anytime soon. I cannot imagine being able to hire sufficient medical chaperones to fulfill an obligation for chaperone presence at every single physical exam (involving genital or rectal examination) from infancy through childhood.

I absolutely agree w chaperoning of minors who are not accompanied by parents.

Thank you,

Elizabeth O'Neill, MD
Clinic Medical Director
Providence Medical Group
Gateway Family Medicine

From: Gluck, Lori F <[redacted]>
Sent: Tuesday, October 5, 2021 1:49 PM
To: Elizabeth Ross
Cc: Gluck, Lori F
Subject: medical chaperone proposal

Hello,

I am a Family Physician and I am concerned about the new proposed requirement for medical chaperones for all patients.
I understand the important intent to protect patients from misconduct but this should not an across the board requirement in all situations. I would request consideration that when parents are present, medical chaperones are not required.
I also have concerns about the requirement for official training to act as a chaperone. We are in a staffing crisis currently and this will likely last for many years so the idea of a person standing in a room as a chaperone needing a specialized form of training seems like an unnecessary barrier to patient care. And the idea of needing a chaperone for all situations, also seems unnecessary. It should be RECOMMENDED but not required.
I absolutely do agree that unaccompanied minors should require a chaperone. (but not a "formally trained one").

Thank you,

Lori Gluck, MD
Value Based Care Medical Director, Providence Medical Group Oregon

From: Brittany Arnold <[redacted]>
Sent: Thursday, November 4, 2021 4:08 PM
To: Katy King; Elizabeth Ross
Subject: Re: OMB Medical Chaperone Rulemaking Update

Hello Ms. King and Ms. Ross,

As a female emergency physician I would oppose this rule and propose something slightly similar - that all providers be required to ask patients if they want a chaperon prior to these exams.

In the ED I am performing multiple of these exams every shift. If I had to find a chaperon for these exams every time it would be quite a challenge to not only find an individual to help, but also to time the exam so that both myself and the chaperon were at a good stopping point in our patient care workflow to pause and go in together. This would be a large additional time burden for myself, the patient, and staff who would be resultantly pulled away from other more critical duties. Currently we have a dire nursing shortage in EDs across the country, with already unsafe staffing ratios, and creating this additional requirement I think would be more harmful than beneficial to patient care. I imagine in smaller outpatient clinics with limited personnel this would also present a similar challenge.

I also strongly agree with your comment that this rule is intrusive to victims of prior rape or abuse. Many times I have patients, of different genders, specifically ask me to have everyone else leave the room because the act of exposing themselves and undergoing such an exam is incredibly traumatic for them. I always ask my patients if they would prefer a chaperon, and I do think this should be the norm, but more often than not they decline.

I believe all providers should be required to present patients with the option of a chaperoned exam, however chaperons should be an opt IN for patients, not an opt out rule.

Thank you,
Brittany Arnold MD

From: Brian Duty <[redacted]>
Sent: Saturday, November 6, 2021 1:58 PM
To: Elizabeth Ross
Subject: Proposed Rulemaking Notice Update: Medical Chaperones - Oregon Urologic Society Written Comment
Attachments: OMB Medical Chaperone Opposition Letter.pdf

Ms. Ross,

I am writing on behalf of the Oregon Urological Society to oppose the measure as written. Please see the attached letter. Thank you for your consideration.

Please do not hesitate to contact me if the OMB would like further clarification regarding our position.

Brian Duty, MD, MBA
President, Oregon Urological Society

November 6th, 2021

Elizabeth Ross, Rules Coordinator
Oregon Medical Board
1500 SW 1st Avenue, Suite 620
Portland, Oregon 97201

RE: Response to proposed Oregon Medical Board Rule 847-010-0130: Establishes requirements for Oregon Medical Board licensees to use medical chaperones.

On behalf of the Oregon Urological Society (OUS), I am writing to express our opposition of Proposed Rule of the Medical Board 847-010-0130: Establishes requirements for Oregon Medical Board licensees to use medical chaperones. The OUS represents over two hundred urologists in Oregon. Our mission is to promote the highest standards of urological clinical care through education, research, and the formulation of health care policy.

The proposed rule requires physicians to utilize a medical chaperone for all breast, genital, and rectal examinations performed in outpatient and inpatient settings by January 1, 2023. This proposed rule was recommended by the Oregon Medical Board's Workgroup on Sexual Misconduct to adopt the American College of Obstetricians and Gynecologists recommendation for medical chaperones. While we do not disagree with the spirit of the measure (patient protection), we worry that many of our patients will choose to forgo important prostate cancer screening due to the presence of an additional person within the exam room.

Furthermore, the medical board states it, "is unable to estimate the number of small businesses that may be impacted by the proposed rule." We assure you it will have a huge fiscal impact on a private urological practice. A typical general urology practice evaluates multiple male patients who require rectal exams on an average day. Should the language of the proposed regulation be implemented, urology practices will be required to hire a state licensee, who has completed a medical chaperone course (two hours at $79) to comply. It is unclear how this is not considered an adverse small business impact. The Board does concede, "This may require additional staff that would not normally be available during these types of exams." Yes, additional staff would need to be hired.

The OUS stands in opposition to the Oregon Medical Board's proposed regulation requiring the presence of chaperones during "breast, genital, or rectal examination" as it represents an unwarranted regulatory intrusion into medical practice and would result in significant economic burden on private urology practices. We request the Board withdraw this regulatory proposal. Please do not hesitate to contact us for further discussion.

Sincerely,

Brian Duty, MD, MBA
President, Oregon Urological Society

Oregon Chapter
American College of
Emergency Physicians

To: Elizabeth Ross, Legislative and Policy Analyst
Oregon Medical Board

From: Katy King, Government Relations Director
Oregon Chapter of the American College of Emergency Physicians

RE: Proposed Medical Chaperone Rule

Dear Ms. Ross,

Thank you for the opportunity to comment on the proposed rule that would require your board licensees to utilize a medical chaperone for all breast, genital, and rectal examinations performed in outpatient and inpatient settings by January 1, 2023. The proposed rule was recommended by the Oregon Medical Board's Workgroup on Sexual Misconduct to adopt the American College of Obstetricians and Gynecologists (ACOG) recommendation for medical chaperones.

The Oregon Chapter of the American College of Emergency Physicians (OR-ACEP) recognizes that having medical chaperones are a good standard of practice but want to caution that this rule may not be appropriate in all circumstances for providing optimal medical care. Some examples;

a. Some patients wish to limit the number of healthcare professionals in the room for sensitive exams or conversations; requiring a chaperone increasing the number of people in the room could be a trigger for some patients and serve as a hinderance to care informed by past traumas.
b. As healthcare professionals we have the great privilege of having many patients who are comfortable sharing very personal history and exposing sensitive body parts for medical care. While a medical chaperone is usually helpful for these exams, some patients may not want this or may expose the sensitive body part during the history or before the provider has a chance to obtain the help of a chaperone. A rule requiring a chaperone doesn't take into account these instances that can be outside of the provider's control.
c. There are times where there are prolonged exams that may need to be performed like an exam and the evidence collection performed by a SANE nurse. Requiring a chaperone to be present for the entirety of that exam which commonly take over an hour puts great strain on resources and may not provide the patient with further reassurance or even be wanted by the patient during this sensitive and extensive process. The SANE advocate should be trained as a medical chaperone so that there is not an expectation that the ED will provide an RN or other staff member for this purpose.
d. It is unclear if this rule extends to include infants or children with parents in the room.

e. It may be challenging in the emergency medical setting to have appropriate personnel available. While there is an exception in instances if failure to examine would result in significant and imminent harm to the patient, such as during a medical emergency, it's not clear that if the rule applies to emergency departments or if there is an exception. There is also some ambiguity on what constitutes an "exam."

OR-ACEP recommends that the patients should always be offered a chaperone, even during a lengthy medical exam. The patient should have the option to "opt-out" of a chaperone, however the clinician should also have the right to refuse to perform the exam in the absence of a chaperone.

We appreciate the opportunity to add comment on the proposed rule and to support implementation of best practices.

From: Katy King <[redacted]>
Sent: Monday, November 8, 2021 5:10 PM
To: Elizabeth Ross
Subject: Re: OMB Medical Chaperone Rulemaking Update

November 8, 2021

Elizabeth Ross
Legislative and Policy Analyst
Oregon Medical Board

Dear Ms. Ross,

The Oregon Psychiatric Physicians Association would like to provide some input to consider as the OMB Sexual Misconduct Workgroup proposes to change the medical chaperone rule. OPPA supports offering patients chaperones for all breast, genital, and rectal examinations. However, mandating a medical chaperone may be intrusive in certain circumstances and the decision should be left to the patient and provider.

A patient may decide to opt-out due to PTSD or other conditions. A provider may not be comfortable not having a chaperone. There needs to be flexibility for clinician judgment for extenuating circumstances. A medical chaperone requirement may exacerbate some patients with PTSD and complicate an already complicated and short-staffed health care system. It may also inadvertently decrease the number of clinicians offering necessary women's health services in Oregon.

We appreciate the opportunity to provide input on this rule.

Contact: Katy King, for OPPA

From: Kyle, Christopher <[redacted]>
Sent: Tuesday, November 16, 2021 12:15 PM
To: Elizabeth Ross
Subject: chaperone concerns

Follow Up Flag: Follow up
Flag Status: Flagged

Ms. Ross,
I am a private practice urologist in Eugene, Oregon.
I apologize for the late notice of this email, but I'd like to comment on the impact of the proposed chaperone rule for our practice.
I received your contact information from Dr. Chris Paulson who is a fellow Eugene physician and he encouraged me to reach out to you.

First, I recognize that the board deals with complaints of sexual misconduct and therefore has a great deal of insight into boundaries that are crossed and the impact on patient safety. Second, although men can be the victims of boundary crossing, there is a difference between a speculum pelvic exam and a digital rectal/prostate exam. As a urologist, my primary concern is with the requirements for male exams.
I am concerned that this well-intentioned rule, however, will have serious detrimental effects on the practice of medicine in this state, particularly with regard to urologic care.

Our concerns:

1. **Prostate cancer screening**. Prostate cancer is the most common cancer in men and the second cause of cancer death in men. Screening for prostate cancer includes a digital rectal exam and a blood test (PSA). As the only urology practice in Lane County we have unique insight into the prevalence of prostate cancer in our community and we are seeing an increase in patients presenting with advanced, palpable disease. We are often told by our patients that their PCPs do not want to do a rectal exam. I think the chaperone rule will further decrease cancer screening by our primary care colleagues.
2. **Staffing**. The practice of urology focuses on the genitourinary tract and therefore frequently involves a genital and/or rectal exam. Any man over the age of 40 who presents to our clinic will need at least an annual rectal exam with rare exceptions. If we need a chaperone for the vast majority of our patients then our clinic throughput will grind to a halt. Our medical assistants already have voluminous documentation required for each patient; pulling them away for each patient exam would slow the clinics dramatically. We will be forced to hire a large number of back office staff. Our rough estimate would be an additional 20 full-time employees, which is a huge financial cost. Like most practices around the country, we are having trouble with staffing. Our current staffing is inadequate for our current needs, despite our best efforts to recruit additional employees.
3. **Access to Care**. Outside of the larger cities, there is a shortage of urologists around the state. South of Eugene there is no urologist until Medford. There is no urology on the central coast. Coos Bay will not have urology (per our understanding) starting in 2022. To help with this coverage, we have opened satellite clinics in Roseburg and Florence. These are typically booked out 3-4 months in advance, which reflects the enormous need. If we needed to have chaperones for the majority of our clinic visits, we would have to drastically cut back the clinic volume (which reduces access to care) or bring more staff (which is not feasible with our current capacity and would decrease our ability to care for our local Eugene/Springfield patients). Ultimately, we would likely decrease our presence at these satellites.
4. **Patient Preference**. In the past (pre-COVID), I worked with an in-person scribe. The vast majority of my male patients requested that the scribe leave the room during the genital/rectal exam. This chaperone rule would be

the opposite scenario and I predict (based on my experience) that patient preference would be for an outsider NOT to be present during the prostate exam.

5. **Catheters**. We have many patients who are managed with indwelling catheters, which need to be changed monthly. We have catheter clinics in Springfield as well as at our satellite offices in Florence and Roseburg to help these patients. This is typically a nurse-run clinic and the patient comes in monthly for the catheter to be exchanged. A catheter change by definition involves the genitals. I recognize that our medical assistants/nurses are not regulated by the OMB, but if we are to maintain a consistent practice then these catheter clinics would need to be double staffed which would be difficult if not impossible. We would likely shut down the satellite catheter clinics . This would be a huge imposition to patients who would be forced to drive from the coast or Roseburg or further every month to have their catheters changed. This is typically a more medically fragile patient population.

In summary, I think this is a well-intentioned proposed rule; however, I do think there will be serious unintended consequences.

I thank you for your consideration
-Chris Kyle, MD, MPH
Oregon Urology Institute

What to Expect During a Physical Examination

Physical exams are an important part of a provider's delivery of preventative care and diagnostic process. While medical professionals receive extensive training in a variety of hands-on techniques commonly used during physical exams, you have the right to ask your provider what they are doing and why at any time.

Common Physical Examination Techniques:

- **Inspection:** The provider carefully assesses the patient, looking for normal conditions and irregularities. The provider may lightly hold, turn, or adjust the part of the body they are examining.
- **Palpation:** Touching a patient to feel for abnormalities. Areas of the body commonly examined include the neck, chest, and abdomen.
- **Percussion:** Tapping on a patient's body, either with fingers, hands, or small instruments, to produce sound vibrations that can confirm the presence of air, fluid, and solids, as well as organ characteristics.
- **Auscultation:** Listening to the heart, lungs, neck, or abdomen using a stethoscope.

Your Rights During a Physical Examination

During a physical exam, you have the right to know what physical contact may occur and why. Your provider should:

- Request your consent before any exam.
- Give professional explanations about each component.
- Communicate their actions in advance.
- Respect your privacy while you dress or undress and provide a gown.
- Perform the minimum amount of physical contact required for diagnosis and treatment.
- Have a chaperone present during sensitive exams and anytime when requested.
- Utilize draping to minimize your exposure.
- Offer chances for you to ask questions or raise concerns.

If your provider's actions make you feel uncomfortable or unsure, you have the right to take the following actions:

- Tell your provider to stop the exam or that you need a break. For example, you may use firm language and hold up your hands to indicate stop.
- Ask for an explanation of what the provider is doing/will do.
- Ask to transfer your care to another provider.

Filing a Report to the Board

The Oregon Medical Board takes accusations of sexual misconduct extremely seriously. Reporting a provider's inappropriate behavior during an exam (be it their demeanor, words, or actions) is the best way to fully address and resolve the issue.

To file a report with the Board, visit **omb.oregon.gov/investigations** to complete the Complaint Form, or submit a letter to the Board that includes the following information:

- The full name of the provider.
- The patient's name, mailing address, phone number, and date of birth. If you are not the patient, provide your contact information.
- A description of the incident, including the date(s) when it happened and where (clinic, doctor's office, etc.). Please provide as much detail as possible.
- If any other providers treated the patient before or after the incident, please include their name.

Written complaints should be mailed to:

Oregon Medical Board, Investigations Manager
1500 SW 1st Ave. #620
Portland, OR 97201

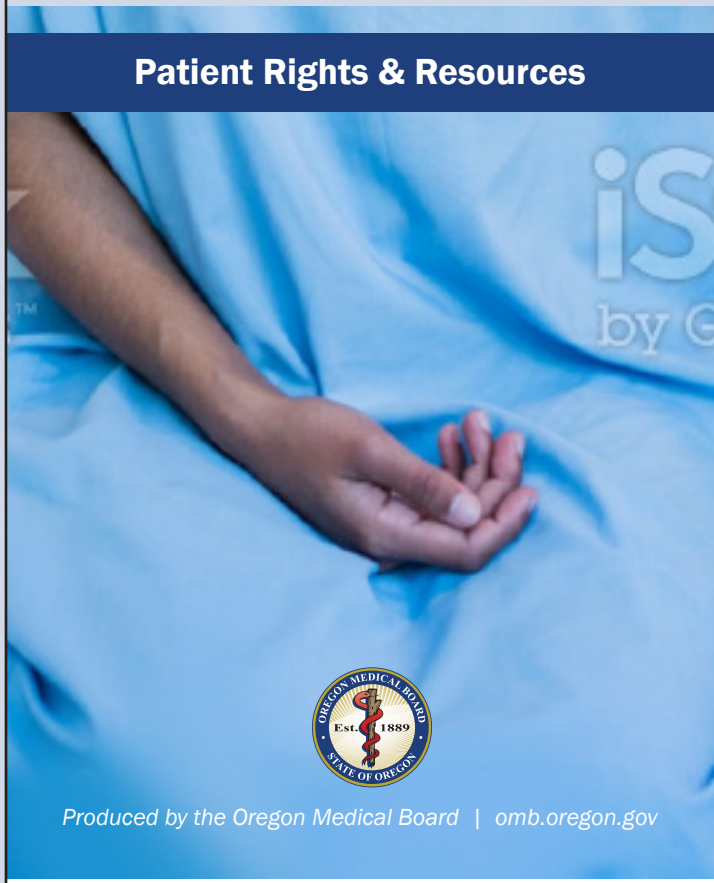
If you have questions, contact the Board's Complaint Resource Staff at **complaintresource@omb.oregon.gov**. You may also call **971-673-2702** (toll free: **877-254-6263**). ***Emails are not confidential; do not submit complaint information via email.***

Notice of Confidentiality

ORS 676.175 requires information provided to the Board be kept confidential. The information gathered during investigations will not be generally available to the public. This means that the specifics of the investigation cannot be publically shared, including the complainant or patent names. If a violation is found and the Board issues an Order, the Order is public information. Public Orders are available at **omb.oregon.gov/verify** or by request. Persons who file a complaint or provide information during an investigation and do so in good faith are protected and are not subject to an action for civil damages for providing information per ORS 677.335 and 677.425.

What to Expect During a Physical Exam

Patient Rights & Resources



Produced by the Oregon Medical Board | omb.oregon.gov

Types of Physical Exams

During any exam, your health care provider should tell you exactly what they are doing at each step so that nothing comes as a surprise to you.

Sports Physical Exam: Your provider will ask about medical history, ability to exercise in different situations, and prior injuries; perform a physical exam; check your heart, lungs, and abdomen; and evaluate your posture, joints, and flexibility. A sensitive exam is not included in a typical sports physical.

Well Child and Adolescent Exams: In order to track healthy growth and development, the exam will include looking at the chest/breasts and genitalia. For females, palpation of the breasts is generally not necessary. For males, a testicular exam is performed by palpating the testicle to make ensure placement and check for lumps or hardening. No pelvic or rectal exam is required routinely.

Well Woman Exam: A well woman exam may include a breast and/or pelvic exam, as well as a pap smear depending on your age and risk.

Breast Exam: Your provider will use the pads of their fingers to check the entire breast, including the underarm and collarbone. If they spot a lump, they will note features and check whether it moves.

Pelvic Exam: Your provider will examine female reproductive organs. This is not recommended for women under 21 unless medical history or symptoms indicate a need. You will be asked to take off your underwear and lie at the end of the table with your feet in stirrups and a sheet covering your stomach and legs. A pelvic exam includes:

- **External Exam:** Your provider visually inspects the area outside of the vagina.
- **Bimanual Exam:** Your provider inserts two gloved, lubricated fingers into your vagina and feels both your uterus and ovaries while placing pressure on the lower part of your belly with the other hand. This may cause pressure or some discomfort, but should not be painful.
- **Pap Test:** Your provider inserts a speculum (a small medical tool) into the vagina and gently opens to see the vaginal canal and cervix. They will insert a sterile swab in your vagina and gently scrape your cervix to obtain a cell sample. This test may be uncomfortable.
- **Rectal Exam:** Your provider may also perform a rectal exam by inserting a gloved and lubricated finger into your rectum to check for tenderness or other irregularities.

Male Physical Exams: Your provider will examine your genitals, including the penis, testicles, and scrotum. They may ask you to cough while examining the groin to help check for inguinal hernias.

- **Digital Rectal Exam:** You will be asked to take off your underwear and provided a gown or cloth to cover yourself. You will either stand and bend forward at the waist or lie on your side in the fetal position on a table. Your provider will gently insert a gloved, lubricated finger into the rectum to check for tenderness/irregularities. They will inspect the prostate and wall of the lower colon or rectum. The exam may be uncomfortable but should not be painful and is brief.

Recognizing Misconduct

Any instance of a health care professional initiating sexual contact in the context of a medical exam is highly inappropriate and a violation of medical ethics. This includes the suggestion that sexual contact is necessary or beneficial to the patient's health and any sexual contact that occurs while a patient is incapacitated.

Because of the inherent position of trust and power afforded to medical professionals, a patient cannot give consent to a sexual interaction. This is true even when the patient suggests a sexual relationship or accepts a provider's invitation to begin one. In rare circumstances, it may also be hard to spot "grooming" behavior.

Examples of "Red Flag" inappropriate behavior include:

- Telling sexual jokes.
- Lingering stares or glances at a patient's breasts or other sexual body parts.
- Divulging information about the provider's love life or sexual preferences.
- Offering gifts or favors.
- Contacting patients for non-medical reasons.
- Attempting to schedule appointments outside of typical office hours or away from their practice.
- Inviting patients to lunch or other "date-like" activities.

Serious examples of inappropriate behavior include:

- Asking for details about the patient's sexual experiences or preferences without valid medical reason.
- Deliberately watching a patient dress or undress.
- Inappropriate comments about or to the patient, such as sexualizing a patient's body or underclothing, or sexualized/sexually demeaning comments to a patient.
- Performing genital/rectal exams without gloves or medical need.
- Touching the patient in a way that seems sexual, such as groping/touching of the breasts, buttocks, or genitals.
- Kissing, oral to genital contact, or other sexual contact.

Medical Chaperones

Medical chaperones are used during intimate physical exams and other patient interactions to serve as a witness to the events taking place should there be any misunderstanding or concern for misconduct. The presence of a trained chaperone can provide reassurance about the professional context and content of the exam and the intent of the provider.

The Oregon Medical Board recommends all physicians and physician assistants have a trained chaperone physically present for all breast, genital, and rectal exams. You may request a medical chaperone if one is not offered by your provider.

Sexual Trauma Support

Resources available to you:

- **oregonsatf.org/help-for-survivors**
  Oregon Attorney General's Sexual Assault Task Force, information for nonprofits in your area
- **RAINN.org** (Spanish: **RAINN.org/es**)
  24/7 online chat for **RAINN** (Rape, Abuse & Incest National Network), the nation's largest anti-sexual violence organization
- **800-656-HOPE (4673)**
  National Sexual Assault Hotline