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Honoring the public trust: curbing the bane of physician sexual misconduct

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ABSTRACT

The Federation of State Medical Boards defines physician sexual misconduct as any ‘behavior that exploits the physician-patient relationship in a sexual way.’ Although several attempts have been made in recent years to clarify its incidence in the United States, physician sexual misconduct is almost certainly underreported. Physician sexual misconduct represents a severe and irreversible violation of the compact underlying the patient-physician relationship and can have far-reaching consequences on the lives of patients and their families. In addition, the credibility of and trust in physicians, both essential to the provision of medical care, could well erode in the eyes of the public at large if egregious cases of physician sexual misconduct are perceived as having gone unpunished. Although all physician licensees accused of sexual misconduct are entitled to the presumption of innocence and due process, complaints made by patients must be taken seriously and vigorously pursued. In this article, we discuss the ongoing

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challenge of physician sexual misconduct and provide recommendations to improve its reporting and curb its incidence.

KEYWORDS: FSMB, NPDB, patients, physician sexual misconduct

On 24 January 2018, Lawrence Gerard Nassar, a family medicine physician entrusted with caring for the U.S. women's national gymnastics team, was sentenced to 40–175 years in prison in the wake of a major sexual misconduct scandal.¹ The case attracted widespread national attention replete with congressional hearings before the Senate Committee on Commerce, Science, and Transportation and the House Committee on Energy and Commerce.² Regrettably, Dr. Nassar was not the only physician to generate national headlines in recent years. Equally appalling cases of physician sexual misconduct have rocked a number of prominent public and private institutions of higher learning.³ In addition, media outlets reporting on the opioid crisis have drawn attention to a previously overlooked kind of physician sexual abuse—when a prescribing physician exploits his power over a patient with a substance use disorder by demanding sex in exchange for drugs.⁴

None of this was lost on the *Federation of State Medical Boards* (FSMB), the relevant policy statement of which (*Addressing Sexual Boundaries: Guidelines for State Medical Boards*) was all but out-of-date.⁵ Aided by a newly commissioned report, *Physician Sexual Misconduct*, the FSMB saw to the updating of its policy with an eye toward redoubling its efforts and those of its allopathic and osteopathic constituents to work

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- 1 James M. DuBois et al., *Preventing Egregious Ethical Violations in Medical Practice: Evidence-Informed Recommendations from a Multidisciplinary Working Group*, 4 J MED REGUL 104, 23–31 (2018), <https://doi.org/10.30770/2572-1852-104.4.23>.
 - 2 'Olympic Abuse: The Role of National Governing Bodies in Protecting Our Athletes. Hearing Before the Subcommittee on Consumer Protection, Product Safety, Insurance, and Data Security of the Committee on Commerce, Science, and Transportation. United States Senate, 115th Congress,' April 18, 2018, <https://www.govinfo.gov/content/pkg/CHRG-115shrg39950/pdf/CHRG-115shrg39950.pdf>; 'Examining the Olympic Community's Ability to Protect Athletes from Sexual Abuse. Hearing Before the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce. United States House of Representatives, 115th Congress,' May 23, 2018, <https://www.govinfo.gov/content/pkg/CHRG-115hhr33664/pdf/CHRG-115hhr33664.pdf>.
 - 3 Nina Agrawal, 'UCLA Handling of Sexual Misconduct Allegations against Physicians "Inadequate," Report Finds,' *The Los Angeles Times*, June 5, 2020, <https://www.latimes.com/california/story/2020-06-05/ucla-sexual-misconduct-allegations-against-physicians>; Matt Hamilton and Harriet Ryan, 'How George Tyndall Went from USC Gynecologist to the Center of LAPD's Largest-Ever Sex Abuse Investigation,' *The Los Angeles Times*, December 19, 2018, <https://www.latimes.com/local/lanow/la-me-george-tyndall-profile-usc-sexual-assault-allegations-20181219-story.html>; Benjamin Weiser, 'N.Y.C. Gynecologist Faces Federal Charges Over 6 Sex Abuse Accusations,' *The New York Times*, September 10, 2020, sec. A; Robin Locke Nagele and Kevin E. Raphael, 'Sexual Harassment by Physicians: Implications on Medical Staff Privileges, Licensure, and Physician Practices,' *AHFA Seminar Papers* 2018, no. 20180625 (n.d.).
 - 4 Olga Khazan, 'The Hard-Partying, Rock-Obsessed Nurse at the Center of a Massive Opioid Bust,' *The Atlantic*, January 28, 2021, <https://www.theatlantic.com/health/archive/2021/01/rock-doc-opioids/617405/>.
 - 5 Federation of State Medical Boards, 'Addressing Sexual Boundaries: Guidelines for State Medical Boards,' 2006, https://www.fsmb.org/siteassets/advocacy/policies/grpol_sexual-boundaries.pdf.

toward zero tolerance.⁶ It is the objective of this article to explore the ongoing challenge of physician sexual misconduct and discuss potential remedies thereof.

I. DEFINITIONS

As defined by the FSMB, physician sexual misconduct comprises any ‘behavior that exploits the physician-patient relationship in a sexual way.’⁷ Whether verbal, physical, or virtual, such behavior may involve ‘expressions of thoughts and feelings or gestures that are of a sexual nature or that a patient or surrogate may reasonably construe as sexual.’⁸ The FSMB further notes that such malfeasance ‘often takes place along a continuum of escalating severity.’⁹ Although ‘sexually inappropriate or improper gestures or language that are seductive, sexually suggestive, disrespectful of patient privacy, or sexually demeaning to a patient’ may be readily identifiable as unacceptable, other, equally inappropriate behavioral patterns may not be immediately apparent.¹⁰ Examples of the latter include ‘grooming’ behaviors such as ‘gift-giving, special treatment, sharing of personal information or other acts or expressions that are meant to gain a patient’s trust and acquiescence to subsequent abuse.’¹¹ Yet other examples of physician sexual misconduct involve ‘physical contact, such as performing an intimate examination on a patient with or without gloves and without clinical justification or explanation of its necessity, and without obtaining informed consent.’¹² At its most extreme, physician sexual misconduct may entail a ‘sexual assault’, that is, ‘any type of sexual activity or contact without consent.’¹³ In that sexual assault constitutes a criminal violation, the adjudication of such cases must be carried out in concert with law enforcement.¹⁴

II. THE PERPETRATORS

At the time of this writing, only a limited body of data addresses itself to the attributes of physician offenders. Anonymous surveys of US physicians reveal that 3–9% of the respondents, mostly men, acknowledge past sexual contact with a patient.¹⁵ A cross-

6 Federation of State Medical Boards, ‘Physician Sexual Misconduct: Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct,’ May 2020; Azza AbuDagga, Michael Carome, and Sidney M. Wolfe, *Time to End Physician Sexual Abuse of Patients: Calling the U.S. Medical Community to Action*, 7 J. GEN. INT. MED. 34, 1330 (2019), <https://doi.org/10.1007/s11606-019-05014-6>; John A. Enbom, Philip Parshley, and Jeffrey Kollath, *A Follow-up Evaluation of Sexual Misconduct Complaints: The Oregon Board of Medical Examiners, 1998 through 2002*, 6 AM. J. OBSTET. GYNECOL. 190, 1642–50; discussion 1650–1653, 6A (2004), <https://doi.org/10.1016/j.ajog.2004.02.058>; Patricia A. King, Humayun J. Chaudhry, and Mark L. Staz, *State Medical Board Recommendations for Stronger Approaches to Sexual Misconduct by Physicians*, JAMA, March 29, 2021, <https://doi.org/10.1001/jama.2020.25775>.

7 Federation of State Medical Boards, ‘Physician Sexual Misconduct: Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct.’

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14 Federation of State Medical Boards.

15 Randy A. Sansone and Lori A. Sansone, *Crossing the Line*, 6 Psychiatry (Edgmont) 6, 45–48 (2009); N K Gartrell et al. *Physician-Patient Sexual Contact. Prevalence and Problems*, 2 WEST. J. MED. 157, 139–43 (1992).

sectional analysis of 1039 US physicians reported to the *National Practitioner Data Bank* (NPDB) for alleged sexual misconduct, in turn, noted 90.1% of the physicians under study to be 40 years of age or older.¹⁶ A more recent study of 101 physician licensees deemed to have committed sexual misconduct found all of the perpetrators to be men, the vast majority of whom (92%) were 39 years of age or older. Most (85%) examined patients alone, in the absence of a chaperone.¹⁷ Lastly, a study of 761 US physicians disciplined for sex-related offenses noted the transgressions committed to include sexual intercourse, rape, sexual molestation, and sexual favors for drugs. As a group, the physicians-in-question proved older than the national physician population and more likely to practice in the specialties of Psychiatry, Child Psychiatry, Obstetrics and Gynecology, and Family and General Practice.¹⁸

III. THE PREVALENCE

Several attempts have been made in recent years to clarify the incidence of physician sexual misconduct in the U.S.¹⁹ The aforementioned efforts notwithstanding, the true extent of such misconduct remains uncertain. The previously mentioned cross-sectional analysis of all of the reports of physician sexual misconduct submitted to the NPDB from 1 January 2003 through 30 September 2013 identified a total of 1039 physician licensees who were the subject of one or more transgressions.²⁰ A contemporaneous investigation by the *Atlanta Journal-Constitution*, for its part, identified over 2400 U.S. physicians who were sanctioned for sexual misconduct between 1999 and 2016.²¹ Our own analysis identified a total of 1721 reports of physician sexual misconduct to the NPDB between 2000 and 2019. These data reveal the annual incidence of sexual misconduct reports to average 10.78 per 100,000 U.S. physician licensees.²²

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- 16 Azza AbuDagga et al., *Cross-Sectional Analysis of the 1039 U.S. Physicians Reported to the National Practitioner Data Bank for Sexual Misconduct, 2003–2013* PLoS ONE 11, e0147800 (2016), <https://doi.org/10.1371/journal.pone.0147800>.
- 17 James M. DuBois et al., *Sexual Violation of Patients by Physicians: A Mixed-Methods, Exploratory Analysis of 101 Cases*, 5 SEX. ABUSE 31, 503–23 (2019), <https://doi.org/10.1177/1079063217712217>.
- 18 C. E. Dehlendorf and S. M. Wolfe, *Physicians Disciplined for Sex-Related Offenses*, 23 JAMA 279, 1883–88 (1998), <https://doi.org/10.1001/jama.279.23.1883>.
- 19 AbuDagga et al., *Cross-Sectional Analysis of the 1039 U.S. Physicians Reported to the National Practitioner Data Bank for Sexual Misconduct, 2003–2013*; Carrie Teegardin et al., *License to Betray: A Broken System Forgives Doctors in Every State*, AJC, July 6, 2016, May 19, 2020.
- 20 AbuDagga et al., *Cross-Sectional Analysis of the 1039 U.S. Physicians Reported to the National Practitioner Data Bank for Sexual Misconduct, 2003–2013*, 2 PLoS ONE 11, e0147800 (2016).
- 21 Teegardin et al., *License to Betray: A Broken System Forgives Doctors in Every State*.
- 22 Aaron Young et al., *A Census of Actively Licensed Physicians in the United States*, 2010, 4 J. MED. REGUL. 96, 10–20 (2010), <https://doi.org/10.30770/2572-1852-96.4.10>; Aaron Young et al., *A Census of Actively Licensed Physicians in the United States*, 2012, 2 J. MED. REGUL. 99, 11–24 (2013), <https://doi.org/10.30770/2572-1852-99.2.11>; Aaron Young et al., *A Census of Actively Licensed Physicians in the United States*, 2014, 2 J. MED. REGUL. 101, 7–22(2015), <https://doi.org/10.30770/2572-1852-101.2.7>; Aaron Young et al., *A Census of Actively Licensed Physicians in the United States*, 2016, 2 J. MED. REGUL. 103, 7–21 (2017), <https://doi.org/10.30770/2572-1852-103.2.7>; Aaron Young et al., *FSMB Census of Licensed Physicians in the United States*, 2018, 2 J. MED. REGUL. 105, 7–23 (2019), <https://doi.org/10.30770/2572-1852-105.2.7>.

IV. ETHICAL CONSIDERATIONS

The professional patient–physician relationship has served as the basis for the provision of medical care for millennia.²³ By its very nature, the relationship in question is fundamentally unequal in that patients are often dependent on the knowledge and expertise of their physicians when it comes to managing their state of health and navigating the healthcare system. Fragile as this relationship may well be, it endured by dint of the trust that generations of patients have been willing to bestow upon their physicians and the medical profession writ large. In particular, patients harbor the expectation that their physicians will have their best interests at heart.

By a number of measures, then, physician sexual misconduct represents a severe and irreversible violation of the compact underlying the patient–physician relationship.²⁴ By exploiting the physical and emotional vulnerability of patients, physician sexual misconduct violates the ethical principles of *beneficence* and *nonmaleficence* as well as the precept of *autonomy*.²⁵ The fiduciary responsibilities held by physicians relative to their patients are similarly compromised.²⁶ It is these facets of the infraction that render physician sexual misconduct especially egregious and deeply unethical.

V. PROFESSIONAL GUIDELINES

An array of ethical and professional guidelines prohibits any and all sexual contact between physicians and their patients. The Hippocratic Oath, for its part, explicitly bans sexual relationships between patients and their physicians.²⁷ A similar proscription was articulated by the *Council on Ethical and Judicial Affairs* of the *American Medical Association* (AMA). Specifically, note was made of the precept that ‘sexual contact or a romantic relationship with a patient concurrent with the physician–patient relationship is unethical’ and that ‘sexual or romantic relationships with former patients are also unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the previous professional relationship.’ Both positions have since been enshrined in the *AMA Code of Ethics*.²⁸ Similar positions have also been assumed by several specialty organizations. The *American College of Obstetricians and Gynecologists*

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- 23 R. Kaba and P. Sooriakumaran, *The Evolution of the Doctor–Patient Relationship*, 1 *INT. J. SURG* 5, 57–65 (2007), <https://doi.org/10.1016/j.ijso.2006.01.005>.
- 24 Andrew P. Roche and Sindy M. Paul, *Physician Sexual Misconduct: Regulations and Ramifications in the State of New Jersey*, 4 *MD ADVISOR* 10, 4–12 (2017).
- 25 T. G. Gutheil, *Ethical Issues in Sexual Misconduct by Clinicians*, *JPN. J. PSYCHIATR. NEUROL.* 48 Suppl 39–44 (1994), <https://doi.org/10.1111/j.1440-1819.1994.tb03037.x>; R. Gillon, ‘*Primum Non Nocere*’ and the Principle of Non-Maleficence, 6488 *BMJ* 291, 130–31 (1985): 130–31, <https://doi.org/10.1136/bmj.291.6488.130>; H. R. Searight and D. C. Campbell, *Physician–Patient Sexual Contact: Ethical and Legal Issues and Clinical Guidelines*, 6 *J. FAM. PRACT.* 36, 647–53 (1993).
- 26 Gutheil, *Ethical Issues in Sexual Misconduct by Clinicians*; Gillon, ‘*Primum Non Nocere*’ and the Principle of Non-Maleficence.
- 27 Roche and Paul, *Physician Sexual Misconduct*; M. L. Campbell, *The Oath: An Investigation of the Injunction Prohibiting Physician–Patient Sexual Relations*, 2 *PERSPECT BIOL MED* 32, 300–308 (1989), <https://doi.org/10.1353/pbm.1989.0011>; S. G. Pérez, R. J. Gelpi, and A. M. Rancich, *Doctor–Patient Sexual Relationships in Medical Oaths*, 12 *J. MED. ETHICS* 32, 702–5 (2006), <https://doi.org/10.1136/jme.2005.014910>.
- 28 *Sexual Misconduct in the Practice of Medicine*. Council on Ethical and Judicial Affairs, *American Medical Association*, 19 *JAMA* 266, 2741–45 (1991); S. H. Johnson, *Judicial Review of Disciplinary Action for Sexual Misconduct in the Practice of Medicine*, 13 *JAMA* 270, 1596–1600 (1993); *American Medical Association, Code of Medical Ethics*, July 9, 2019, <https://www.ama-assn.org/delivering-care/ethics/code-medical-ethics-overview>.

(ACOG), in a recent Committee Opinion, declared that a ‘sexual or romantic interaction between an obstetrician–gynecologist and a current patient is always unethical, is grounds for investigation and sanction, and in some cases should be considered for criminal prosecution.’²⁹ Similar pronouncements were made by the *American Psychiatric Association* (APA), according to which ‘The requirement that the physician conduct himself/herself with propriety in his or her profession and in all the actions of his or her life is especially important in the case of the psychiatrist because the patient tends to model his or her behavior after that of his or her psychiatrist by identification.’ The APA further notes that the ‘necessary intensity of the treatment relationship may tend to activate sexual and other needs and fantasies on the part of both patient and psychiatrist, while weakening the objectivity necessary for control’ and that the ‘inherent inequality in the doctor–patient relationship may lead to exploitation of the patient.’³⁰ Finally, the APA makes it plain that ‘sexual activity with a current or former patient is unethical.’³¹

VI. THE IMPACT

Sexual misconduct perpetrated by physicians can have far-reaching consequences. Patients subjected to sexual abuse by a physician, not unlike other victims of sexual abuse, are at-risk for serious sequelae such as depression, anxiety, substance abuse, and post-traumatic stress disorder.³² Relationships with family members and significant others may suffer as well.³³ Moreover, the credibility of and trust in physicians, both essential to the provision of medical care, could well erode in the eyes of the public at large. Such an outcome is especially likely if and when egregious cases of physician sexual misconduct are perceived by the public as having gone unpunished.

VII. THE REPORTING PIPELINE

The reporting of physician sexual misconduct to the State Medical Board (SMB) by a member of the public, a healthcare facility, and/or a healthcare professional, constitutes a prerequisite for the initiation of disciplinary proceedings against a physician licensee. It follows that SMBs would do well to ‘facilitate the reporting process for patients by offering assistance or educational resources about the reporting process and relevant contact information.’³⁴ Specifically, SMBs must clearly explain how to file complaints as well as offer potential complainants multiple contact avenues (in writing, online, by email, or by phone) through which to file their complaints. SMBs must also ensure that ‘information about the complaints process is made available via

29 Committee on Ethics, *Sexual Misconduct: ACOG Committee Opinion, Number 796*, 1 OBSTET. GYNECOL. 135, e43–50 (2020), <https://doi.org/10.1097/AOG.0000000000003608>.

30 American Psychiatric Association, *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry* (Washington, DC, 2013), <https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Ethics/principles-medical-ethics.pdf>.

31 American Psychiatric Association.

32 DuBois et al., *Sexual Violation of Patients by Physicians*.

33 Rebecca Campbell and Sharon M. Wasco, *Understanding Rape and Sexual Assault: 20 Years of Progress and Future Directions*, 1 J. INTERPERS. VIOLENCE 20, 127–31 (2005), <https://doi.org/10.1177/0886260504268604>.

34 Federation of State Medical Boards, *Physician Sexual Misconduct: Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct*.

translation for complainants who do not speak English.³⁵ SMBs would also do well to ‘educate patients about what is normal and expected during medical examinations and procedures,’ which would facilitate the ability of patients to recognize improper physician behavior.³⁶ When it comes to reporting physician sexual misconduct, the ability to file a complaint anonymously may prove especially important. Although the ability of complainants to ‘remain anonymous to the general public is recommended, complainant anonymity to the state medical board may not be possible.’³⁷

VIII. THE REPORTING BARRIERS

Incidents of sexual misconduct by physician licensees are almost certainly underreported.³⁸ Patients who are the victims of physician sexual abuse are unlikely to come forward for the same reasons that many victims of rape or sexual assault are unlikely to report it.³⁹ And the problem maybe even worse in the context of physician sexual assault; there exists, after all, a substantial power differential between patients and their physicians. It follows that patients who are victims of sexual misconduct may be unwilling or unable to report the incident in question.⁴⁰

This reality is compounded by the observation that physicians may be reluctant to report colleagues who appear to have engaged in inappropriate behavior. A detailed study of this phenomenon concluded that only two-thirds of physicians with direct personal knowledge of an impaired or incompetent physician colleague proceeded to relay their observations to the relevant authorities.⁴¹ The most frequent reason cited by the surveyed physicians for taking no action (19%) was the ‘belief that someone else was taking care of the problem.’⁴² Nearly 12% of those surveyed cited fear of retribution or the belief that ‘nothing would happen as a result of the report.’⁴³ It is likely that similar reservations apply to the reporting of sexual misconduct perpetrated by physician colleagues.⁴⁴ This ‘failure to report’ is not helped by the reality that most states do not require physicians to notify their SMB of alleged cases of sexual misconduct that are revealed to them by a patient.⁴⁵ Still, it is the view of the FSMB that physicians who

35 Federation of State Medical Boards.

36 Federation of State Medical Boards.

37 Federation of State Medical Boards.

38 AbuDagga, Carome, and Wolfe, Time to End Physician Sexual Abuse of Patients, *J. GEN. INTERN. MED.* 34, 1330–1333 (2019).

39 Chelsea Spencer et al., *Factors Related to College Students’ Decisions to Report Sexual Assault*, 21–22 *J. INTERPERS. VIOLENCE* 35, 4666–85 (2020), <https://doi.org/10.1177/0886260517717490>.

40 National Academies of Sciences, Engineering, and Medicine, *Sexual Harassment of Women: Climate, Culture, and Consequences in Academic Sciences, Engineering, and Medicine* (Washington, DC: The National Academies Press, 2018), <https://doi.org/10.17226/24994>.

41 Catherine M. DesRoches et al., *Physicians’ Perceptions, Preparedness for Reporting, and Experiences Related to Impaired and Incompetent Colleagues*, 2 *JAMA* 304, 187–93 (2010), <https://doi.org/10.1001/jama.2010.921>.

42 DesRoches et al.

43 DesRoches et al.

44 P. S. Appelbaum, *Statutes Regulating Patient-Therapist Sex*, 1 *HOSP. COMMUN. PSYCHIATRY* 41, 15–16 (1990), <https://doi.org/10.1176/ps.41.1.15>; Nanette Gartrell et al., *Reporting Practices of Psychiatrists Who Knew of Sexual Misconduct by Colleagues*, 2 *AM. J. ORTHOPSYCHIATR.* 57, 287–95 (1987), <https://doi.org/10.1111/j.1939-0025.1987.tb03539.x>.

45 Michael R. MacIntyre and Jacob M. Appel, *Legal and Ethics Considerations in Reporting Sexual Exploitation by Previous Providers*, 2 *J. AM. ACAD. PSYCHIATRY LAW* 48, 166–75 (2020), <https://doi.org/10.29158/JAA>

fail to report sexual misconduct ‘should be liable for sanction by their state medical board for the breach of their professional duty to report.’⁴⁶ The FSMB further notes that ‘reporting to law enforcement must occur for any instance of child abuse, abuse of a minor, and abuse of a dependent adult, regardless of whether the complainant wants reporting to occur.’⁴⁷

IX. THE DISCIPLINARY PROCESS

Upon receipt of a complaint of an alleged infraction by a physician licensee, the SMB first determines whether or not its statutory authority permits it to investigate the complaint in question under the *Medical Practice Act*.⁴⁸ Complaints deemed to fall under the jurisdictional authority of the SMB are, in turn, prioritized on the basis of their imminent risk to patients. Prioritized complaints trigger an investigation, at which point both the physician licensee and the complainant are formally notified. When deemed appropriate, SMBs may order physician licensees who are the target of an investigation to discontinue patient care or else face suspension of their license. In some cases, however, audits have found that physicians have improperly continued to treat patients even after their licenses were terminated or suspended.⁴⁹

Following a preliminary investigation of the credibility and gravity of the allegations in question, the SMB may file a formal complaint against the physician licensee and thereby trigger a hearing. In some instances, the case in question is settled before the scheduled hearing. Absent a settlement, the SMB will proceed to review and adjudicate the case in question in the context of a disciplinary hearing that is, in most cases, open to the public.⁵⁰ Closed hearings may apply in those cases wherein the protection of the identity of the patient is deemed paramount.⁵¹ Having weighed the evidence and witness testimony, the SMB sets out to determine whether or not the physician licensee violated the *Medical Practice Act* of the state in question. When a physician licensee is found culpable, the SMB is duty-bound to order the appropriate disciplinary action that is to be taken and to enter it into the public record.⁵²

Adverse actions taken by an SMB as the result of formal proceedings may include (but need not be limited to) the ‘revocation or suspension of a license, certification

PL.003911-20; Chinmoy Gulrajani, *A Duty to Protect Our Patients from Physician Sexual Misconduct*, 2 J. AM. ACAD. PSYCHIATRY LAW 48, 176–80 (2020), <https://doi.org/10.29158/JAAPL.200014-20>.

46 Federation of State Medical Boards, *Physician Sexual Misconduct: Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct*.

47 Federation of State Medical Boards.

48 Darren Grant and Kelly C. Alfred, *Sanctions and Recidivism: An Evaluation of Physician Discipline by State Medical Boards*, 5 J. HEALTH POLIT. POLICY LAW 32, 867–85 (2007), <https://doi.org/10.1215/03616878-2007-033>; Federation of State Medical Boards, *U.S. Medical Regulatory Trends and Actions 2018, 2018*, <https://www.fsmb.org/siteassets/advocacy/publications/us-medical-regulatory-trends-actions.pdf>.

49 Beth Wood A., *Medicaid Provider Enrollment, Performance Audit 2021* (State of North Carolina, Office of the State Auditor, February 2021), <https://www.auditor.nc.gov/EPSWeb/reports/performance/PER-2020-444S.pdf>.

50 Michael Spake, *Public Access to Physician and Attorney Disciplinary Proceedings*, 2 J. NATL. ASSOC. ADMIN. LAW JUDICIARY 21, 4 (2001).

51 Federation of State Medical Boards, *Physician Sexual Misconduct: Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct*.

52 Federation of State Medical Boards, *U.S. Medical Regulatory Trends and Actions 2018*.

agreement, or contract for participation in a government health program; reprimand; censure; or probation.⁵³ An option to terminate ongoing formal proceedings may also be considered when the physician under investigation discontinued his/her practice in the state or surrendered his/her license as well as the right to apply for its renewal.

It is worth noting that American medical boards are comprised of a majority of physicians, as this may play into how these decisions are made.⁵⁴ In some states, physicians are involved in every stage of a disciplinary case from the decision to move forward on a complaint to the imposition of a sanction.⁵⁵ Physicians on SMBs are increasingly recognizing the seriousness of physician sexual abuse.⁵⁶ But they still may exhibit a pro-physician bias in judging a member of their own profession, even in cases alleging sexual misconduct.⁵⁷ Relative leniency can often be the result.⁵⁸

It is the view of the FSMB that ‘serious forms of unprofessional conduct should presumptively provide the basis for revocation of a license in order to protect the public.’⁵⁹ Examples of such misconduct include ‘sexual assault, conduct amounting to crimes related to sex . . . egregious acts of a sexual nature . . . [or] instances where a physician has repeatedly committed lesser acts.’⁶⁰ Finally, when and if the transgression of the physician in question is deemed to warrant a non-punitive verdict, remediation, with or without future practice restrictions (including the requirement to utilize practice monitors), may be contemplated and/or offered.⁶¹ Despite these guidelines, permanent revocation of medical licenses, even for sexual abuse, remains rare, and SMBs tend to gravitate toward remedial sanctions.⁶²

X. THE PUBLIC RECORD

Public disciplinary actions taken against physician licensees must be reported to the NPDB, a public database mandated by Congress, the stated goal of which is ‘to improve health care quality, protect the public, and reduce health care fraud and abuse in the U.S.’⁶³ Other disciplinary actions, such as letters of concern or warnings are not

53 National Practitioner Data Bank, Reporting State Licensure and Certification Actions, <https://www.npdb.hrsa.gov/guidebook/EStateLicensureActions.jsp> (accessed Jan. 11, 2021).

54 Rebecca Haw Allensworth, *Foxes at the Henhouse: Occupational Licensing Boards Up Close*, CALIF. LAW REV. 105, 1567 (2017); Marc T. Law and Zeynep K. Hansen, *Medical Licensing Board Characteristics and Physician Discipline: An Empirical Analysis*, 1 J. HEALTH POLIT. POLICY LAW 35, 63–93 (2010), <https://doi.org/10.1215/03616878-2009-041>.

55 Tennessee Board of Medical Examiners, Chapter 0880–02–11, in General Rules and Regulations Governing the Practice of Medicine, <https://www.tn.gov/content/dam/tn/health/documents/0880-02.20091221.pdf> (accessed April 26, 2021).

56 AbuDagga, Carome, and Wolfe, Time to End Physician Sexual Abuse of Patients; Patricia A. King, *Taking Action: How the FSMB’s New Policy on Physician Sexual Misconduct Was Developed*, 2 J. MED. REGUL. 106, 15–16 (2020), <https://doi.org/10.30770/2572-1852-106.2.15>.

57 Timothy Stoltzfus Jost, *Oversight of the Quality of Medical Care: Regulation, Management, or the Market*, ARIZONA LAW REV. 37, 825 (1995).

58 Carrie Teegardin and Danny Robbins, Still Forgiven: Doctors & Sex Abuse, AJC, November 15, 2018.

59 Federation of State Medical Boards, Physician Sexual Misconduct: Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct.

60 Federation of State Medical Boards.

61 Federation of State Medical Boards.

62 Teegardin and Robbins, Still Forgiven: Doctors & Sex Abuse.

63 Ron Wyden, Health Care Quality Improvement Act, HR 5540, 99th Congress (1986), <https://www.congress.gov/bill/99th-congress/house-bill/5540/actions> (accessed Dec. 1, 2020).

reportable, nor are complaint data.⁶⁴ Best known as a repository for malpractice claims against physicians, the NPDB is also the repository of reports of adverse civil, clinical, criminal, and professional actions taken against physician licensees. Reporting organizations include but are not limited to federal agencies (e.g. Drug Enforcement Administration), the United States Department of Health and Human Services Office of Inspector General, state agencies (such as SMBs, hospitals, insurance carriers, professional medical societies), and peer-review and accreditation organizations. Compliance with reporting requirements is imperfect, and for some mandatory reporters, is quite low.⁶⁵

The NPDB maintains an extensive list of ‘Basis for Action’ codes that are used to characterize the adverse action reports it receives.⁶⁶ In the course of physician credentialing and some peer-review activities, hospitals, SMBs, professional medical societies, insurance carriers, and other authorized health care entities will query the NPDB to obtain information on medical malpractice payments, adverse licensure actions, restrictions on professional membership, and negative privileging actions by hospitals.⁶⁷ Although information pertaining to individual physicians is available only to eligible entities through the ‘Query’ process, the aggregate anonymized data (NPDB Public Use Data File) are available to the public for review and to researchers interested in patient safety and healthcare quality. The public, as a rule, cannot, however, query the NPDB to obtain information on malpractice payments and/or on adverse actions against individual physicians, though some SMBs make such information available on their public websites. However, it should be noted that physicians and the healthcare entities that employ them have utilized a number of strategies to evade reporting requirements to the NPDB in the past.⁶⁸

Congressional initiatives intent on enhancing the public transparency of the NPDB have been few and far between. One bill sponsored in this context, the *Patient Protection Act of 2000* (H.R. 5122), brought forth by House Commerce Committee Chairman Tom Bliley (R-VA), was to ‘provide for the availability to the public of information reported to the National Practitioner Data Bank.’⁶⁹ Although never enacted, H.R. 5122 was the subject of two congressional hearings by the House Commerce Committee in both March and September of 2000.⁷⁰

64 National Practitioner Data Bank, What You Must Report to the NPDB, <https://www.npdb.hrsa.gov/hcorg/whatYouMustReportToTheDataBank.jsp> (accessed April 26, 2021).

65 National Practitioner Data Bank, State Licensing Board Compliance Results, <https://www.npdb.hrsa.gov/resources/npdbstats/npdbMap.jsp> (accessed April 26, 2021).

66 National Practitioner Data Bank, NPDB National Practitioner Data Bank, <https://www.npdb.hrsa.gov/index.jsp> (accessed May 30, 2020).

67 U.S. Department of Health and Human Services, Health Resources and Services Administration. NPDB Guidebook (Rockville, Maryland: U.S. Department of Health and Human Services, 2018).

68 Gabriel H. Teninbaum, *Reforming the National Practitioner Data Bank to Promote Fair Med-Mal Outcomes*, 1 WILLIAM & MARY POLICY REV. 5, 83–120 (2013).

69 Thomas J. Bliley, H.R. 5122—Patient Protection Act of 2000. 106th Congress (2000), <https://www.congress.gov/bill/106th-congress/house-bill/5122/actions?r=1&s=4> (accessed Nov. 13, 2020).

70 Public Access to the National Practitioner Data Bank: Hearings Before the Subcommittee on Oversight and Investigations of the Committee on Commerce. United States House of Representatives, 106th Congress, <https://www.govinfo.gov/content/pkg/CHRG-106hrg62975/pdf/CHRG-106hrg62975.pdf> (accessed March 1, 2000); The Patient Protection Act of 2000. Hearing Before the

Finally, note is made of yet another national data repository, the ‘Physician Data Center’ (PDC) of the FSMB, a repository of physician licensure history and disciplinary actions.⁷¹ Access to the PDC is restricted to hospitals, government agencies, credential verification services, managed care facilities, and clinical practices, to name a few. A parallel if less comprehensive publicly available FSMB database, DocInfo, ‘provides professional background information on nearly one million licensed doctors in the U.S.’⁷²

XI. THE LIMITS OF ACCOUNTABILITY

The adjudication of alleged cases of physician sexual misconduct by SMBs often fails to materialize. This outcome is accounted for, at least in part, by the reality that SMBs may, at times, elect to forego the pursuit of allegations of physician sexual misconduct. Again, board membership (mostly physicians) may account for some of this reluctance. Examples include, but are not limited to, complaints of alleged physician sexual misconduct that transpired at a point in time past SMB-defined statutes of limitations. In yet other instances, SMBs may halt an ongoing investigation when and if a physician licensee voluntarily surrenders his/her license permanently. Physician licensees may also enter into confidential settlement agreements with the relevant SMB. The standards of proof as to what constitutes physician sexual misconduct deserving of disciplinary action vary widely between states.⁷³ In those cases wherein an SMB concludes that the evidence available is insufficient or that the alleged infraction does not warrant formal disciplinary action, the SMB may elect to close the case by issuing an advisory letter (also referred to as a ‘letter of concern’) that is not subject to public disclosure or databank reporting.⁷⁴ A recent audit of the *Georgia Composite Medical Board* (GCMB) appears to affirm the aforementioned observations when noting that 81% of all inquiries conducted by the GCMB were closed absent formal disciplinary action.⁷⁵ Although 17% of the GCMB inquiries resulted in letters of concern, only 2% resulted in formal disciplinary action.⁷⁶ It would thus appear that numerous alleged infractions never reach the formal hearing stage and thus are not entered into the public record. Even when SMBs do find against a physician licensee, the public notices issued are often vaguely worded. In addition, non-uniform usage of language across states further complicates the process of establishing an accurate nationwide tally of physicians sanctioned for alleged sexual misconduct.⁷⁷ Viewed collectively, these and related

Committee on Commerce. United States House of Representatives, 116th Congress, <https://www.govinfo.gov/content/pkg/CHRG-106hhrg67118/pdf/CHRG-106hhrg67118.pdf> (accessed Sept. 20, 2000).

- 71 Federation of State Medical Boards, Physician Data Center, <https://www.fsmb.org/PDC/> (accessed Jan. 11, 2021).
- 72 Federation of State Medical Boards, DocInfo, <https://www.docinfo.org/> (accessed Jan. 11, 2021).
- 73 Federation of State Medical Boards, U.S. Medical Regulatory Trends and Actions 2018.
- 74 Jacqueline Landess, *State Medical Boards, Licensure, and Discipline in the United States*, 4 Focus 17, 337–42 (2019), <https://doi.org/10.1176/appi.focus.20190020>; Enbom, Parshley, and Kollath, A Follow-up Evaluation of Sexual Misconduct Complaints.
- 75 Greg S. Griffin and Leslie McGuire, Georgia Composite Medical Board—Physician Oversight (Georgia Department of Audits and Accounts Performance Audit Division, November 2020), <https://www.audits.ga.gov/rsaAudits/download/25338>.
- 76 Griffin and McGuire.
- 77 Lois Norder, Jeff Ernsthause, and Danny Robbins, Why Sexual Misconduct Is Difficult to Uncover, *AJC*, July 6, 2016, http://doctors.ajc.com/sex_abuse_numbers/?ecmp=doctorssexabuse_microsite_nav.

procedural realities doubtlessly contribute to what appears to be an underreporting of cases of physician sexual misconduct.⁷⁸

Nationwide reporting and information sharing are further compromised by the existence of 11 ‘Basis for Action’ codes to describe ‘Misconduct or Abuse’ including ‘Sexual Misconduct.’ Further complications are introduced by the fact that the ‘Basis for Action’ codes are frequently the subject of intense negotiations between the accused physician licensees and the SMB. As a consequence, it is not uncommon for the NPDB to contend with ‘Basis for Action’ codes that fail to capture the full nature and substance of the infraction in question. In some cases, reporting entities, including hospitals, SMBs, federal and state law enforcement agencies, and others, simply fail to report the actions taken against physicians to the NPDB in violation of federal law.⁷⁹ Due to these variables and others, the true extent of underreporting to the NPDB is unknowable.

XII. INTRA- AND INTER-STATE COMMUNICATION

Investigative reporting by the *Atlanta Journal-Constitution* suggests that as many as half of physician licensees who were previously disciplined for sexual misconduct continue to maintain an active medical license.⁸⁰ Sharing the identity of physician licensees previously disciplined for sexual misconduct with other states, let alone with patients, remains a work in progress. The NPDB can be queried for reports of misconduct, including sexual misconduct, but only by authorized queriers, such as hospitals and other health care entities. The public does not have access to the names of the physicians who are reported to the NPDB.⁸¹ Only California and Washington have enacted statutes, which require physicians who were disciplined for sexual misconduct to inform their patients of any and all license stipulations or restrictions at the time of scheduling an appointment.⁸² In addition, as per the FSMB, some SMBs ‘have required licensees to obtain signatures from all patients in their care acknowledging their awareness of an adjudication for professional sexual misconduct.’⁸³ The FSMB thus suggests that other SMBs ‘may wish to consider whether these could be viable options in their states.’⁸⁴

78 Randolph R. Bovbjerg, Pablo Aliagathe, and Josephine Gittler, *State Discipline of Physicians: Assessing State Medical Boards Through Case Studies*. (Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, 2006), <https://aspe.hhs.gov/basic-report/state-discipline-physicians-assessing-state-medical-boards-through-case-studies>.

79 Jeff Ernsthansen, *Dangerous Doctors, Flawed Data*, *AJC*, July 6, 2016, http://doctors.ajc.com/database_explainer/.

80 Teegardin et al., *License to Betray: A Broken System Forgives Doctors in Every State*.

81 National Practitioner Data Bank, Chapter D: Queries, in *The NPDB Guidebook*, 2018, <https://www.npdb.hrsa.gov/guidebook/DOverview.jsp>.

82 Michelle Caldier et al., *Substitute House Bill 1198 (2019–2020)*, <https://app.leg.wa.gov/billsummary?BillNumber=1198&Initiative=false&Year=2019> (accessed Dec. 1, 2020); Jerry Hill and Evan Low, *Senate Bill 1448: Patient’s Right to Know Act (2018)*, https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=#x003D;201720180SB1448 (accessed Dec. 1, 2020); Carrie Teegardin and Saurabh Datar, *How Well Does Your State Protect Patients?*, *AJC*, <http://doctors.ajc.com/states/> (accessed May 30, 2020); Eli Y. Adashi, *Prognosis Is Guarded for California’s “Patient’s Right to Know Act,”* *4 JAMA* 320, 329–30 (2018), <https://doi.org/10.1001/jama.2018.9100>.

83 Federation of State Medical Boards, *Physician Sexual Misconduct: Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct*.

84 Federation of State Medical Boards.

The interstate communication between SMBs is also hardly optimal. Although SMBs do share disciplinary and licensure information on a voluntary basis via the PDC of the FSMB, details of the disciplinary actions taken (short of official adverse actions) are often omitted. Thus, it is not uncommon for physicians who are credibly accused of sexual misconduct in one state to be licensed in another absent any and all restrictions and/or disclosure requirements.⁸⁵

Interstate communication among SMBs, however, may improve in the near future due to the newly minted Interstate Medical Licensure Compact (IMLC).⁸⁶ The compact is ‘an agreement among participating U.S. states to work together to significantly streamline the licensing process for physicians who want to practice in multiple states,’ constitutes ‘a voluntary, expedited pathway to licensure for physicians who qualify.’⁸⁷ As constructed, the IMLC makes it possible for physicians to obtain separate licenses to practice in multiple states with a single application.⁸⁸ The process requires that the State of Principal Licensure issue a formal Letter of Qualification that is to be transmitted to those states wherein the applicant seeks to be licensed.⁸⁹

The IMLC may ease the information sharing burden among states, at least for participating physicians. As per the IMLC, ‘all state medical and osteopathic boards participating in the Compact are required to share complaint/investigative information with each other.’⁹⁰ In addition, ‘if any participating board takes action against the physician who received a license via the Compact, all boards within the Compact are notified and authorized to take similar action through their regular complaint process.’⁹¹ At present, a total of 29 states, the Territory of Guam, and the District of Columbia have enacted the required statutes.⁹² Yet-to-be enacted bills are pending in New York, Ohio, and Pennsylvania.⁹³ There is hope that the IMLC will be endorsed by most if not all of the remaining states and territories of the United States in the future. But it is worth noting that the compact will increase interstate transparency about discipline only for physicians electing to join the compact; at present only 11,347 of the nation’s nearly one million physicians have a compact license.⁷⁷

XIII. THE RISK OF RECIDIVISM

The precise recidivism rate among physician perpetrators of sexual misconduct remains unknown. Prior attempts at studying this question made note of the fact that a substantial proportion of physicians implicated in sexual misconduct are in effect prior offenders.⁹⁴ It follows that SMBs must be cognizant of the risks of recidivism in

85 Norder, Ernsthauten, and Robbins, *Why Sexual Misconduct Is Difficult to Uncover*.

86 Interstate Medical Licensure Compact, accessed December 9, 2020, <https://www.imlcc.org/>.

87 Interstate Medical Licensure Compact.

88 Interstate Medical Licensure Compact.

89 Interstate Medical Licensure Compact.

90 Interstate Medical Licensure Compact.

91 Interstate Medical Licensure Compact.

92 Interstate Medical Licensure Compact.

93 Interstate Medical Licensure Compact.

94 E. Tillinghast and F. Cournos, ‘Assessing the Risk of Recidivism in Physicians with Histories of Sexual Misconduct,’ 6 J. FORENSIC SCI. 45, 1184–89 (2000); N. Gartrell et al., *Psychiatrist-Patient Sexual Contact: Results of a National Survey. I: Prevalence*, 9 AM. J. PSYCHIATRY 143, 1126–31 (1986), <https://doi.org/10.1176/aip.143.9.1126>.

the course of determining whether and how to sanction alleged physician offenders. Although SMBs sometimes mandate that physician offenders complete rehabilitation programs before returning to practice, evidence of the utility of this approach in reducing the risk of recidivism is lacking.⁹⁵ It is in this context that the FSMB policy argues that SMBs 'should also consider revocation in instances where a physician has repeatedly committed lesser acts, especially following remedial efforts.'⁹⁶

XIV. REFORMING THE STATUS QUO

Although there are no easy solutions to eliminating the scourge of physician sexual misconduct, the following initiatives may afford some welcome relief. For one, extensive ongoing preventive education must be afforded across the continuum of medical education and practice as to what constitutes sexual misconduct and how to report suspected cases. Moreover, all medical students, resident physicians, and attending physicians should be taught how to establish clear boundaries with patients, which can serve to protect the integrity of the therapeutic relationship. Boundary crossings, which are not inherently exploitative, may at times even serve to support the therapeutic relationship by creating a sense of shared intimacy with the patient. However, repeated boundary crossings may increase the risk of boundary violations, including of sexual misconduct, which may harm the patient. Although some cases of sexual misconduct by physicians are indeed perpetrated by predatory individuals, others are committed by individuals who commit a series of boundary crossings that ultimately result in the boundary violation of sexual misconduct. Thus, all providers should be thoroughly trained in how to establish and maintain clear boundaries with patients, and how to navigate charged clinical scenarios in which the probability of repeated boundary crossings is high.⁹⁷

In addition, any and all sensitive physical examinations (e.g. pelvic examinations) should only be performed in the presence of an authorized, formally trained practice monitor who is in a position to recognize improper boundary violations.⁹⁸ Such practice monitors must always be in attendance and, if at all possible, sign the medical record with an eye toward 'attesting to their attendance during examination or other patient interactions as appropriate.'⁹⁹ Ongoing efforts must also be invested in educating the public as to the definition of physician sexual misconduct and the process by which it may be reported to the SMB.¹⁰⁰

Relevant data collection must also be improved. All allegations of physician sexual misconduct reported to SMBs should be tabulated and publicly reported in an anonymized format so as to enable accurate state and nationwide tallies. In addition, extant 'Basis for Action' codes should be revisited with an eye toward assuring accurate

95 Carrie Teegardin and Lois Norder, *Abusive Doctors: How the Atlanta Newspaper Exposed a System That Tolerates Sexual Misconduct by Physicians*, 1 AM. J. BIOETHICS 19, 1–3 (2019), <https://doi.org/10.1080/15265161.2018.1546512>.

96 Federation of State Medical Boards, *Physician Sexual Misconduct: Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct*.

97 Cherrie A Galletly, *Crossing professional boundaries in medicine: the slippery slope to patient sexual exploitation*, 7 MED. J. AUST. 181, 380–83 (2004), doi: [10.5694/j.1326-5377.2004.tb06334](https://doi.org/10.5694/j.1326-5377.2004.tb06334).

98 Federation of State Medical Boards.

99 Federation of State Medical Boards.

100 Federation of State Medical Boards.

as well as intelligible reporting. A reduced number of clearly defined, nationally uniform ‘Basis for Action’ codes will go a long way toward documenting the national incidence of physician sexual misconduct. States would also do well to ensure that the ‘Basis for Action’ codes reported by SMBs to the NPDB are commensurate with the alleged offense in question. SMBs should also give serious consideration to the possibility of posting online summaries of disciplinary proceedings with the goal of assuring transparency.

In addition, all SMBs should require that a criminal background check be completed before the issuance of a medical license. As of January 2018, a total of eight US states and territories did not require a criminal background check as a prerequisite for licensure.¹⁰¹ SMBs should also more clearly define which varieties of physician sexual misconduct are to be deemed criminal and thus reportable to law enforcement authorities. As it stands, SMBs often follow local state laws as to when to report instances of sexual misconduct to law enforcement, which often suggest, but do not require, that sex abuse be reported.¹⁰² Best practices dictate, however, that ‘boards have a duty to report to law enforcement anytime they become aware of sexual misconduct or instances of criminal behavior.’¹⁰³ Although consultation with the SMB attorney is recommended, SMBs ‘are encouraged to err on the side of reporting.’¹⁰⁴ Going forward, boards should enhance patient protection by performing criminal background checks and NPDB checks on prospective licensees, and pursue any other opportunities for jurisdictional sharing of past disciplinary records.¹⁰⁵

A fundamental challenge to the elimination of physician sexual misconduct is the patchwork, state-by-state nature of the rules and regulations relating to this problem. One potential way forward might be the crafting of a well-thought-out federal statute with national standards in mind designed to avoid any constitutional challenges. Consideration could also be given to the elimination of state-specific statutes of limitations for the reporting of physician sexual misconduct. State reporting laws of alleged cases of physician sexual misconduct to SMBs must also be strengthened nationwide.¹⁰⁶ States and their SMBs would be well-advised to sanction physicians and institutions who knowingly fail to report incidents of physician sexual misconduct. Loopholes that have allowed physicians and healthcare entities to evade reporting requirements to the NPDB should be closed and noncompliance should be penalized.¹⁰⁷ In addition, disciplinary actions taken against physicians by medical institutions should be reported

101 Federation of State Medical Boards, Criminal Background Checks: Board-by-Board Overview, <https://www.fsmb.org/siteassets/advocacy/key-issues/criminal-background-checks-by-state2.pdf> (accessed Jan. 29, 2018).

102 MacIntyre and Appel, Legal and Ethics Considerations in Reporting Sexual Exploitation by Previous Providers; Teegardin and Datar, How Well Does Your State Protect Patients?; Teegardin and Norder, Abusive Doctors.

103 Federation of State Medical Boards, Physician Sexual Misconduct: Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct.

104 Federation of State Medical Boards.

105 Teegardin and Datar, How Well Does Your State Protect Patients?

106 Federation of State Medical Boards, Physician Sexual Misconduct: Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct.

107 Teninbaum, Reforming the National Practitioner Data Bank to Promote Fair Med-Mal Outcomes.

not only to the NPDB, but also to the SMB. Lastly, far greater emphasis should be placed on the requirement that physicians found guilty of sexual misconduct inform any and all of their future patients. Recently enacted statutes in California and Washington should serve as a model.¹⁰⁸

Stamping out sexual misconduct from the practice of medicine will also require a culture shift. To ensure for a diversity of perspectives in evaluating the severity of physician transgressions, the composition of SMBs could be changed to give physicians a non-controlling voice.¹⁰⁹ Another remedy would be to ensure a diversity of perspectives on disciplinary panels. For example, in the United Kingdom, physicians are disciplined by a three-person panel, which must include a lay person and usually only one physician.¹¹⁰

In this context, special mention must be made of the heavy reliance on rehabilitation rather than the imposition of sanctions. In so doing, SMBs have all too often denied justice to past victims while placing future patients at risk. Rehabilitation must indeed remain an option for lesser infractions of the medical code. However, when and if faced with egregious or repeated violations, SMBs should give full consideration to applying disciplinary measures proportional to the severity of the misconduct.

Finally, SMBs should more extensively involve complainants in the adjudication process. As it stands, complainants may not be heard from in disciplinary hearings, thereby depriving SMBs of the opportunity to take into account these crucial perspectives before their rulings. Greater efforts to accommodate and welcome voluntary participation by complainants in the adjudication process should be encouraged. To this end, SMBs should strongly consider establishing principals who would act as designated patient advocates so as to ensure that the interests of complainants are protected during the adjudication process. In addition, as recommended by the latest FSMB policy, all SMB members and staff involved in the adjudication of sexual misconduct complaints should receive specialized training in victim trauma.¹¹¹

XV. CONCLUDING THOUGHTS

Each act of sexual misconduct perpetrated by a physician licensee violates the compact inherent in the patient–physician relationship. Although all physician licensees accused of sexual misconduct are entitled to the presumption of innocence and due process, complaints made by patients must be taken seriously and vigorously pursued. Nothing less will do if the ‘first, do no harm’ imperative is to be honored.

108 Caldier et al., Substitute House Bill 1198 (2019–2020); Hill and Low, Senate Bill 1448: Patient’s Right to Know Act (2018).

109 Federation of State Medical Boards, Physician Sexual Misconduct: Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct.

110 Medical Practitioners Tribunal Service, Criteria for the Appointment of Tribunal Members, 2018, https://www.mpts-uk.org/-/media/mpts-documents/dc8375-mpts-committee-criteria---tribunal-members_pdf-64048192.pdf.

111 Federation of State Medical Boards, Physician Sexual Misconduct: Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct.

CONFLICT OF INTEREST STATEMENT

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