Preventing the Unforgivable: Sexual Misconduct in the Healthcare Setting

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Conflict of Interest Disclosure

Laura Nordberg and Brett Clayton do not have any real or apparent conflict of interest or vested interest that may have a direct bearing on the subject matter of the continuing education activity.

Learning Objectives

This presentation will enable participants to:

- Define sexual misconduct, including how it differs from sexual harassment;
- Explain who may be potential instigators of sexual misconduct;
- Explain how common examination techniques can be misunderstood to be sexual misconduct;
- List requirements/guidelines/strategies to prevent sexual misconduct.

- According to the Federation of State Medical Boards, sexual misconduct can be subdivided into two categories:
  - *Sexual impropriety* "may comprise behavior, gestures, or expressions that are seductive, sexually suggestive, disrespectful of patient privacy, or sexually demeaning to a patient……."
  - *Sexual violation* "may include physical sexual contact between a physician and a patient, whether or not initiated by the patient, and engaging in any conduct with a patient that is sexual or may be reasonably interpreted as sexual……"

- Within this context, sexual misconduct involves behavior toward patients and does not include sexual harassment. Sexual harassment will not be included in this presentation.
- As defined, “sexual misconduct” is not gender specific and is not limited to heterosexual behavior.
- Because of time constraints, we will be limiting our discussion to the office setting.

Sexual Assault and Misconduct in Healthcare

Federation of State Medical Boards

- 13 states require medical boards to notify law enforcement when healthcare professionals commit sex offenses against patients
- 18 states require those filing a Complaint to disclose their identity
- 10 states publicize submitted Complaints
- Only 1.5% of all Complaints reach the formal hearing stage
- Approximately 50% of time, even when disciplined, healthcare professionals are permitted to continue practicing medicine

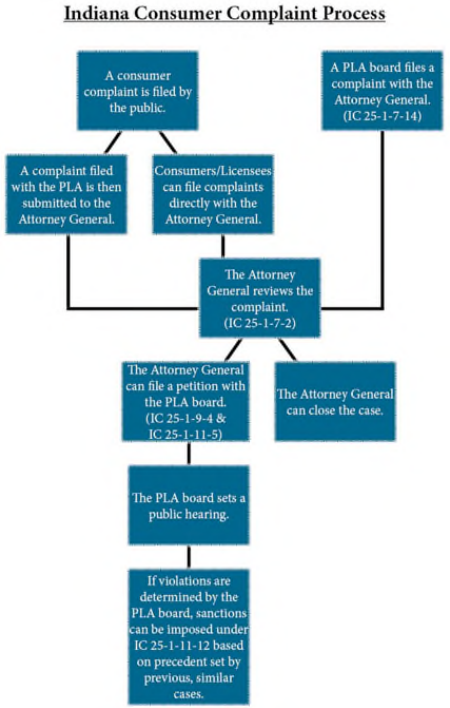
Indiana PLA

- Numerous professions including physicians, nurses, physician assistants, behavioral health, optometrists, optometry, podiatry, *et seq.*
- Consumer complaints are confidential, but Board matters and Orders are public and searchable by licensee name
- No legal requirement for Boards to inform other law enforcement. However, licensees are required to report criminal convictions to Boards.

Polling Question #1: True or False:

In Indiana, the Professional Licensing Agency Board matters and Orders are confidential, and not subject to subpoena or public review.

Indiana Consumer Complaint Process



- Complaints can be filed by a consumer with the Professional Licensing Agency [PLA], the medical licensing board, or the AG.
- Once the AG or the Medical licensing board verifies that the complaint is legitimate, notice of an investigation is sent to the provider and complainant, to which the provider has 30 days to respond.
- The Provider will have an opportunity to appeal a finding by the board in accordance with I.C. 4-21.5.
- Practitioner Violations are reported to National Practitioner Data Bank. I.C. § 25-22.5-2-8.

*Image from *PLA File a* Complaint, IN.gov, https://www.in.gov/pla/3638.htm.

Regulatory Considerations

- Federal Law
  - US Veterans Health Administration: Chaperones required
- State Law (Indiana)
  - AG, PLA & various professional boards.
  - Institutional tort liability considerations
- Federation of State Medical Boards (FSMB): Advisory body, publishes national discipline information
- AMA Guidelines
  - AMA Principles of Medical Ethics (Reaffirmed 1998, Edited 2016)
  - AMA Opinion 1.2.4: Efforts to Provide Considerate and Comfortable Atmosphere
  - AMA Opinion 8.21: Use of Chaperones During Physical Exams
- Specialty society guidelines/recommendations
  - ACOG Committee Opinion: Sexual Misconduct, Number 796, Dec 19, 2019
  - AAFM: No published recommendations
  - ABIM: No published recommendations
  - APA: The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry (2013)
  - AAP Publications
    - Protecting Children From Sexual Abuse by Health Care Providers, Aug 1, 2011
    - AAP Statement on Professionalism: Provides guidance on appropriate provider behavior, 2007
    - AAP Chaperone Policy revised May 2011

Indiana Tort Liability Considerations

Coverage under the Medical Malpractice Act?

- *COVERED* →

  Generally, standard of care issues.

  - *See, Terry v. Community Health Network,* 17 N.E.3d 389 (Ind.Ct.App. 2014).
    - Case brought by rape victim sought to attach liability to healthcare providers for failure to investigate and report. The liability issues were governed by professional standards of care issues, thus covered under Medical Malpractice Act.

  - Other standard of care issues, such as type and manner of examination

- *NOT COVERED* →

  Direct or vicarious liability for sexual assault

  - *Fairbanks Hosp. v. Harrold,* 895 N.E.2d 732 (Ind.Ct.App. 2008)
    - Plaintiff brought lawsuit against hospital based on a hospital employee's sexual assault of a patient. The issue of whether the hospital was negligent in credentialing or hiring the healthcare provider did not fall under the Malpractice Act.
    - Same rational in other cases: *Peters v. Cummins Mental Health,* 790 N.E.2d 572 (Ind.Ct.App. 2003); *Murphy v. Mortell,* 684 N.E.2d 1185, 1187 (Ind.Ct.App. 1997); *Doe by Roe v. Madison Ctr. Hosp.,* 652 N.E.2d 101, 103 (Ind. Ct.App. 1995); *Winona Mem'l Foundation v. Lomax,* 465 N.E.2d 731 (Ind.Ct.App. 1984).

Indiana Tort Liability Considerations

Course and scope defense? *Maybe, maybe not.*

- *Stropes by Taylor v. Heritage House Children's Ctr. of Shelbyville, Inc.* 547 N.E.2d 244, 247 (Ind. 1989)
  - The "common carrier exception" and the duty of "extraordinary care."
  - *C.f. L.N.K. v. St. Mary's Med. Ctr.,* 785 N.E.2d 303 (Ind.Ct.App. 2003). Heightened common carrier duty not applicable as act did not occur during confinement.
  - *Hansen v. Bds. of Trs. of Hamilton Southeastern Sch. Corp.,* 551 F.3d 599 (7th Cir. 2008). Jury issue on whether sexual misconduct is within the scope of employment only when the employee's job duties involved extensive physical contact with the alleged victim, such as undressing, bathing, measuring, or fitting.

Indiana Tort Liability Considerations

Lessons from Jury Verdicts

- *Reyes v. Elkhart General Hospital,* 18 Indiana Jury Verdict Reporter 4 (IN 2016);
- *Margarita De La Rosa v. White Memorial Med. Ctr.,* 2016 Jury Verdict Alert LEXIS 162 (Cal. 2016)201
- *Erikson v. Mid-Columbia Med. Ctr.,* 2015 Jury Verdicts LEXIS 12645 (OR 2015).

Polling Question #2:

In Indiana, health care professionals who engage in sexual misconduct with a patient:

1. Are subject to possible civil liability;
2. Are subject to possible criminal liability;
3. Are subject to possible civil and criminal liability;
4. Are at risk to lose their license only if they are found guilty of a crime.

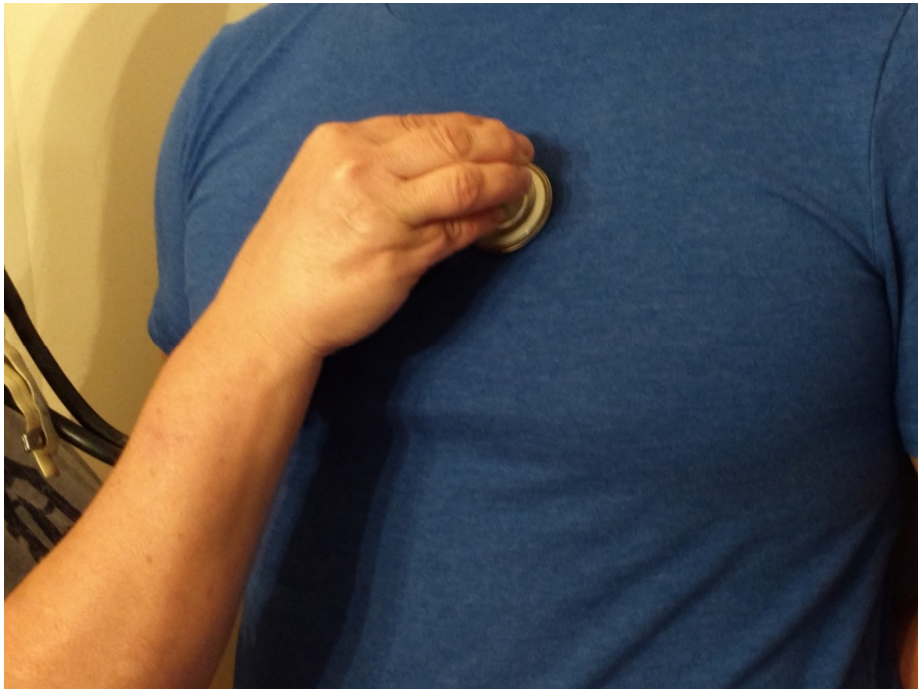
Who may initiate sexual misconduct?

- Physicians
  - Larry Nassar
  - George Tyndall
  - Robert Hadden
  - Daniel Garza
  - Theepa Sundaralingam
  - Earl Bradley
- Staff
- The patient

Appropriate medical examinations can be misunderstood as sexual misconduct

- Examples:
  - Eye exam
  - School physical vs. sports physical
  - Chest auscultation
  - A non-traditional examination technique, whether or not involving “intimate exams”
    - Michigan provider story

Chest Auscultation, Photo #1



Chest Auscultation, Photo #2

Profiles: Patient Victim and Perpetrator

Dehlendorf and Wolfe (1998); DuBois (2017)

Victim Characteristics:

- Minor or elderly
- Female
- Incapacitated
- Sedated
- Behavioral health history
- Neurodevelopmental delays
- New to exam type
- New to US medical care
- Repeated episodes of abuse over several years

Perpetrator Characteristics:

- Ages 40-60 (70%)
- Male
- Non-Board Certified
- In small/solo private practice
- Multiple victims
- 5 Specialties:
  - Psychiatry
  - Fam/Gen Practice
  - OBG
  - Internal Medicine
  - Pediatrics

“Protective” Characteristics

- Board certified physician
- Academic Medical Center setting (presence of students and residents/witnesses)
- Lack of chronic conditions/infrequent visits
- Lack of prescription medications or need for referrals (power imbalance)
- Provider with no history of mental illness
- Provider with no substance use disorder
- Provider with no significant personal problems
- Presence of a chaperone during (intimate) examination*

Why does the problem persist?

- Knowledge deficit or difference of opinion with normal vs. abnormal exam process
- Never reported to the Board or law enforcement
- Navigation of the system
- Complaint Investigation and legal process - Board of Medicine
- Medical Boards are not obligated to report Complaints nor Investigations to law enforcement
- Penalties are inconsistent, temporary and more similar to remediation and recovery
- Even when disciplined, physicians are often permitted to continue practicing medicine
- Reporting of discipline is inconsistent, vague and not readily available

--*Tillinghast & Cournos (2001)*

Polling Question #3: True or False:

It is not appropriate for a healthcare professional to require that a chaperone be present, if the patient declines the offer of a chaperone.

Societal strategies to reduce the incidence of sexual abuse of patients

- Early education
- Recruitment
- Establish a culture of professional integrity
- Provide Peer-Peer Feedback
- Increase oversight by peers, colleagues
- Track wrongdoing and consequences
- Establish more uniform and transparent actions by state Medical Boards
- Permanently remove providers after egregious violations or a persistent failure to serve the goals of medicine
- Partner with law enforcement in appropriate ways
- Educate patients to inform expectations and choices
- Conduct research to understand why ethical violations occur in medicine
- Use chaperones for (intimate) examinations

--Dubois, et al: Journal of Medical Regulation, Vol 104, No 4, Federation of State Medical Boards, (2018)

Risk Management Strategies

- Chaperones
- Policies and procedures addressing harassment and abuse
- Medical Staff Bylaws
- Contract language for providers
  - Indemnify and Hold Harmless clause
  - Termination for conduct inconsistent with a culture of safety
  - Termination for conduct harmful to reputation of hospital or reasonably expected to lead to claims under state or federal law
- Sexual assault training for employees (and non-employees)
- Physical plant deficiencies
- Take credentialing seriously
  - NPDB query
  - Indiana State Licensing Board
  - Primary verification of credentials
  - Fully investigate all patient/family complaints
  - Explore gaps in CVs
  - Explore reasons behind frequent moves (particularly state to state)
  - Evaluate above-average rate of staff turnover
  - Audit physician office practices

Risk Management Strategies: Chaperones

- Why do we chaperone?
  - To protect patients and providers, especially in high risk circumstances:
    - Exams of “intimate areas”: includes breasts, genitalia, anorectal exams
    - Vulnerable patients
      - Age
      - Mentation
      - Sedation
      - Victims of past sexual abuse
    - Power mismatch
    - High anxiety patients
- How do we chaperone?
  - To support the provider delivering care
  - Protect the patient’s dignity and privacy
  - Provide assistance (positioning, draping, specimen collection)

Risk Management Recommendations for Chaperone Use, Part I

- Post signage offering chaperones (in all appropriate languages)
  - See Section 1557 of the ACA, 45 C.F.R. §§ 92.8(b)(1), (d)(1) and (f).
  - See CoPs, Patient's Rights, 42 C.F.R. §482.13.
- Verbally offer a chaperone to every patient
- Include the offer in patient brochures/new patient packets
- Have the patient indicate their preference on their intake form
- Ideally, this is a shared decision between patient and provider, but either may request a chaperone be present
- Document the patient's refusal of the offer for a chaperone
- Establish a policy for the office practice regarding the offer, training and use of chaperones
- Document if the provider is unable to adhere to the office practice's policy or state medical board regulations related to the use of a chaperone

Risk Management Recommendations for Chaperone Use, Part II

- The presence of the chaperone must be documented
- The name and role/title/licensure of the chaperone should be documented
- Consider a standardized, reportable place to document chaperones for audit purposes
- The chaperone must observe the area being examined
- Biological gender of the examiner and patient are irrelevant (AMA)
- Gender identity of the examiner and patient are irrelevant
- Sexual preference of the examiner and patient are irrelevant
- Patient's family members or friends should not be used as chaperones unless:
  - They are specifically requested by the patient to be present; and
  - There is an additional chaperone present
- Parent/Guardian should be present for their child's exam, unless there is evidence that the parent will interfere with the physical examination (AAP)

Polling Question #4:

In Indiana, which of the following are appropriate parts of the hospital's credentialing process for licensed healthcare providers?

1. Criminal background check completion
2. Fingerprinting
3. Application provided to provider
4. Copy of medical degree
5. Two verified personal references
6. Confirmation of Indiana state licensure

Discussion Questions

- Is a chaperone really needed for all examinations? What about conversations?
- What if a chaperone is refused by the patient?
- What if the practice does not have the manpower to provide chaperones in all cases?
- Who can serve as a chaperone?
  - Office manager
  - Biller
  - Student
  - Others
- Can the chaperone do more than one function?
- Should the chaperone be trained? If so, what should the training look like?

Annotated Bibliography

- American College of Obstetrics and Gynecology. Sexual Assault: Resource Overview (undated).
- American College of Obstetrics and Gynecology, Committee on Ethics, ACOG Committee Opinion Nos. 373 and 796: Sexual Misconduct. *Obset. Gynecol*. 2017: 110 (2 pt 1): 441-444 and *Obset. Gynecol*. 2020: 135 (1): 43-50. Opinion Number 796 replaces 373, effective December 19, 2019.
- AMA Opinion 1.2.4: Efforts to Provide Considerate and Comfortable Atmosphere
- AMA Opinion 8.21: Use of Chaperones During Physical Exams
- American Psychiatric Association, The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry (2013 Edition).
- Arora, KS; Douglas, S; Dorr Goold, S. What brings physicians to disciplinary review? A further subcategorization. *American Journal of Empirical Bioethics*. 2014; 5(4): 53-60. Article analyzes a series of cases brought to the American Medical Association Council on Ethical and Judicial Affairs for review, and provides some national data on the frequency and characteristics of physician disciplinary actions.
- Atlanta Journal Constitution. Doctors & Sex Abuse: Indiana State report card. http://doctors.ajc.com/states/indiana_sex_abuse/ (Last accessed, Aug. 20, 2020).
- College of Physicians and Surgeons in British Columbia. Boundary Violations in the Patient-Physician Relationship FAQs. November 22, 2017. Article takes the position that while a chaperone is not necessary for every type of examination, the presence of a chaperone is widely considered as best practice.
- Dehlendorf, CE and Wolfe, SM. Physicians Disciplined for Sex-Related Offenses. *JAMA* 1998; 279: 1883-1888. Article captures 15 years of data and included characteristics of victims, characteristics of perpetrators, and descriptions of different disciplinary activities with prevalence.
- DuBois JM; Walsh, HA; Chibnail, JT. Sexual Violation of Patients by Physicians: A Mixed-Methods, Exploratory Analysis of 101 Cases. PubMed at https://doi.org/10.1177/1079063217712217. Published June 19, 2017, accessed January 26, 2020. Article defines attributes and profiles characteristics of physicians involved in cases of sexual abuse. While the article recommends the use of chaperones, it points out some of the shortcomings in the use of chaperones.
- DuBois JM; Anderson, EA; Chibnail, JT; Diakov, L; Doukas, D; Holmboe, ES; Koenig, HM; Krause, JH; McMillan, G; Mendelsohn, M; Mozersky, J; Norcross, WA; Whelan, AJ. Preventing Egregious Ethical Violations in Medical Practice: Evidence-Informed Recommendations from a Multidisciplinary Working Group. *Journal of Medical Regulation*, 2018: 104(4), 23-31. Article provides ten recommendations to change the way that physicians are recruited, trained, developed and evaluated as a means to decrease the incidence of physician-patient sexual abuse. The article also makes recommendations as to how State Medical Boards can improve their response to violations.

Annotated Bibliography, cont'd

- Grant, D and Alfred, KC. Sanctions and Recidivism: An Evaluation of Physician Discipline by State Medical Boards. *Journal of Health Politics, Policy and Law.* November 2007: 32(5): 867-885. Article captures 8 years of data on how and why sanctioned physicians are subsequently sanctioned again in the future, and notes that there is a very large number of repeat offenders among physicians who have received board sanctions.
- Leape, LL and Fromson, J. Problem Doctors: Is there a System-Level Solution? *Annals of Internal Medicine*, 2006: 144(2): 107-115. Article contains information on all types of inappropriate physician behavior, not specifically sexual assault, as well as underlying causes, and also provides a state-by-state analysis of state remediation programs.
- Mandel, M. Female Oncologist Loses License for Affair with Cancer Patient. *Toronto Sun*. Published January 24, 2019. This news article summarizes an inappropriate relationship between a female oncologist and her male cancer patient. Article was included in the bibliography as it illustrates a more infrequent example of a female physician as the abuser.
- McMurray, RJ; Clarke, OW; Barrasso, JA. Sexual Misconduct in the Practice of Medicine. *JAMA* 1991; 266(19): 2741-2745. Article reviews types of inappropriate relationships between patients and physicians.
- Paturel, A. When the Perpetrators are Patients. American Association of Medical Colleges, *AAMC News*, published October 23, 2018. Article explains an acronym approach "ERASE" to assist female healthcare practitioners to navigate mistreatment by patients in their practice. Expect-Recognize-Address-Support-Establish/Encourage.
- Pediatrics, Vol 127, No 5, May 2011. American Academy of Pediatrics, Policy Statement—Use of Chaperones During the Physical Examination of the Pediatric Patient.
- Pimenta, AL and Giblon, RE. The Case for Medical Chaperones. *Family Practice Medicine*, Sept/Oct 2018, 6-8. Article provides operational steps and suggestions on documentation for integration of chaperones into the examination process at a medical practice.
- Tillinghast, E and Cournos, F. Assessing the risk of recidivism in physicians with history of sexual misconduct. *J. Forensic Sci.* 2001; 45(6): 1184-1189. Article provides clinically-based guidelines for assessing the relative risk of restoring an offending physician's license, based upon the physicians' character patterns and psychological vulnerabilities.
- Viglianti, EM; Oliverio, AL; Meeks, LM. Sexual Harassment and Abuse: When the Patient is the Perpetrator. The *Lancet*, Vol. 392, Aug 4 2018, 368-370. Article contains an algorithm suggested for use with patients who act inappropriately toward female healthcare providers.

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Indiana Society for Healthcare Risk Management

Questions?

Thank you!

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