# Executive Committee Meeting

Virginia Board of Medicine

December 6, 2019

8:30 a.m.

# Executive Committee

**Friday, December 6, 2019 @ 8:30 a.m.**
**9960 Mayland Drive, Suite 200**
**Richmond, VA 23230**
**Board Room 4**

**Page**

**Call to Order of the Executive Committee**—Ray Tuck, Jr., DC, President, Chair



**NEW BUSINESS:**



**Announcements**

**Next scheduled meeting: April 10, 2020**

**Adjournment**

--- DRAFT UNAPPROVED --

# VIRGINIA BOARD OF MEDICINE
# EXECUTIVE COMMITTEE MINUTES

Friday, August 2, 2019 Department of Health Professions Henrico, VA

**CALL TO ORDER:** Dr. Tuck called the meeting of the Executive Committee to order at 8:36 a.m.

**ROLL CALL:** Ms. Opher called the roll; a quorum was established.

**MEMBERS PRESENT:**
Ray Tuck, DC - President
Blanton Marchese - Secretary-Treasurer
David Archer, MD
Alvin Edwards, MDiv, PhD
Karen Ransone, MD

**MEMBERS ABSENT:**
Syed Salman Ali, MD
Lori Conklin, MD - Vice-President
Kenneth Walker, MD

**STAFF PRESENT:**
William L. Harp, MD - Executive Director
Jennifer Deschenes, JD - Deputy Director for Discipline
Colanthia Morton Opher - Deputy Director for Administration
Michael Sobowale, LLM - Deputy Director for Licensure
Barbara Matusiak, MD - Medical Review Coordinator
Barbara Allison-Bryan, MD - DHP Chief Deputy Director
Elaine Yeatts - DHP Senior Policy Analyst
Erin Barrett, JD - Assistant Attorney General

**OTHERS PRESENT:**
W. Scott Johnson, JD - MSV
Jennie Wood - Board of Medicine

## EMERGENCY EGRESS INSTRUCTIONS

Mr. Marchese provided the emergency egress instructions.

## APPROVAL OF MINUTES OF DECEMBER 7, 2018

Dr. Edwards moved to approve the meeting minutes from December 7, 2018 as presented. The motion was seconded and carried unanimously.

## ADOPTION OF AGENDA

Dr. Edwards moved to adopt the agenda as presented. The motion was seconded and carried unanimously.

## PUBLIC COMMENT

There was no public comment.

## DHP DIRECTOR'S REPORT

Dr. Allison-Bryan began by informing the Committee of the events surrounding the passing of Dr. Hughes Melton. Dr. Melton was the Commissioner of the Department of Behavioral Health and Developmental Services and was very active in the medical community. He taught and inspired many practitioners and was a big contributor to her interest in substance use disorders. The Committee members observed a moment of silence for Dr. Melton and his family and the young woman who was tragically killed in the crash and her family.

Dr. Allison-Bryan also provided an overview of two workgroups generated by the 2019 General Assembly.

1. Telemedicine - This workgroup is looking at ways to enhance a physician's ability to provide care through telemedicine, thereby creating greater access for patients in need. It is also looking to maintain the principle that the practice of medicine occurs where the patient is located. Dr. Brown will be leading the group, and Dr. O'Connor will be a participant.

2. International Medical Graduates Work Group: Barriers to Licensure and Opportunities for the Commonwealth - Dr. Allison-Bryan said that at least 63 individuals in Virginia were physicians in their home country but have been unable to get a license in the Commonwealth. This workgroup is hoping to level the playing field for international graduates.

Dr. Archer recalled that the current requirement for IMG's is one year of residency.

Dr. Allison-Bryan said that, prior to 2016, the regulations required two years of postgraduate training for IMG's. Then the Board reduced it to one year for both US and Canadian graduates. A significant issue is that there are not a lot of residency slots to go around. Some IMG's have had full residencies overseas and practiced in another country. However, such training and experience does not meet the licensure requirements in Virginia. It is anticipated that the workgroup will have some recommendations regarding how to help IMG's clear some of the hurdles to licensure.

## PRESIDENT'S REPORT

Dr. Tuck had no report and invited Dr. Edwards to provide a report on his attendance at FSMB's Education Committee meeting. The Committee is responsible for planning next year's Annual Meeting.

Dr. Edwards stated that he was on the Committee to bring the perspective of a non-physician. He noted that the Virginia Board was well regarded by the members of the Committee. One of his suggestions was a glossary of terms for non-physician fellows. FSMB said such a tool already exists. The 2019 Annual Meeting was evaluated along with discussion of potential speakers for next year's meeting, which will be in San Diego. The Committee is looking for best practices and new ways of doing things in medical regulation.

## EXECUTIVE DIRECTOR'S REPORT

Dr. Harp introduced Michael Sobowale, the new Deputy for Licensure, and provided the Committee a little about his experience in health care regulation and supervision of staff.

Mr. Sobowale told the Committee that he was pleased to be a part of Board staff. He noted that he has worked in the regulatory field for over 18 years and brings his experience and understanding of the healthcare regulatory environment.

## NEW BUSINESS

### Chart of Regulatory Actions

Ms. Yeatts provided a brief overview of the regulatory actions as of July 19, 2019. She noted that all actions are moving along very well.

### Board Action on Fee Reduction

Ms. Yeatts referred to the financial report showing the Board's current surplus and reviewed the proposed reduction of 20% in renewal fees for all professions in 2020-2021. She noted that the amended regulations fall under an exemption from the Administrative Process Act. The regulations should be in effect prior to the time that renewal notices for January 2020 are sent.

**MOTION:** Dr. Edwards moved to approve the amended regulations as presented; the motion was properly seconded. Mr. Marchese stated that, in discussing this matter with Dr. Harp, he understands that Dr. Brown fully supports this action.

The motion carried unanimously.

### DHP-Medicine Regulatory/Policy Actions – 2019 General Assembly

Ms. Yeatts provided a brief overview of the regulatory and policy actions affecting the Board of Medicine. She fielded questions about HB2457 – Retiree license, and advised that this item will be on the Legislative Committee meeting September 6, 2019. This report was for informational purposes only.

### Adoption of exempt action – Physician Assistants

Ms. Yeatts presented the draft proposed amendment to 18 VAC85-50-50 – Regulations Governing the Practice of Physician Assistants, noting that the amendment will authorize the issuance of a license by endorsement to a physician assistant who is the spouse of an active duty military member.

**MOTION:** Dr. Edwards moved to adopt the amended regulation as an exempt action. The motion was properly seconded and carried unanimously.

Adoption of Regulations for Waiver of Electronic Prescribing by Emergency Action

Ms. Yeatts reviewed the amendments to §54.1-3408.02, and 18 VAC85-21-21, which require electronic prescribing of opioids by July 1, 2020. She stated that the General Assembly decided to grant a one-year exemption to those physicians who provided proof of hardship for not being able to meet the deadline. She also noted that the Board will need to delegate authority to Dr. Harp to grant an exemption. She then informed the members that the enactment clause requires adoption of regulations within 280 days, so the Board must accomplish this by an emergency action.

**MOTION**: After a brief discussion, Dr. Edwards moved to adopt the emergency regulations and a Notice of Intended Regulatory Action (NOIRA) to replace the emergency regulations as presented. The motion was properly seconded and carried unanimously.

Adoption of Regulations for Physician Assistants by Emergency Action

Ms. Yeatts reviewed the amendments to §§54.1-2900, 54.1-2951.1 through 54.1-2952.1, 54.1-2957 and 18 VAC85-50-10 et. seq – Regulations Governing the Practice of Physician Assistants

Ms. Yeatts advised that the amendments would change supervision of physician assistants to practice with a patient care team physician.

Ms. Yeatts also stated that the enactment clause on HB1952 requires adoption of regulations within 280 days, so the Board must amend the regulations by an emergency action.

**MOTION:** Dr. Archer moved to adopt the emergency regulations as presented. The motion was properly seconded and carried unanimously.

**MOTION:** Dr. Edwards then moved to adopt a Notice of Intended Regulatory Action (NOIRA) to replace the emergency regulations as presented. The motion was properly seconded and carried unanimously.

2. Licensure by Endorsement

Dr. Harp provided the Committee with the following staff notes:

Since the application for Licensure by Endorsement was posted in December 2018, Board staff has been able to take note of steps in the process that work, don't work, or need further clarification.

At the June Board meeting, Board staff reported that it had provided the option to applicants that had started in the traditional pathway to switch to the endorsement pathway if they qualified, and if it had been less than 30 days since they submitted the traditional application. Over time, this became somewhat burdensome. Board staff asked the Board to make it a policy that such switching would cease as of July 1, 2019. The Board agreed.

In regulation, the first 5 requirements of Licensure by Endorsement are essentially YES or NO. However, the 6th requirement reads:

6. Have no grounds for denial based on provisions of § 54.1-2915 of the Code of Virginia or regulations of the board.

The instructions for the applicant to read prior to submitting an application by Endorsement include:

6) Provide answers to the questions in the online application. NOTE: FOR ANY "YES" ANSWERS FOR QUESTIONS 4-17, you must provide a narrative in the space provided.

Board staff asks that the language above "you must provide a narrative in the space provided" be replaced with "you do not qualify for Licensure by Endorsement and must file through the traditional pathway."

Ms. Barrett spoke in support of this change and stated that the endorsement pathway is meant to be the express train with no stops, so the application should be clean.

Ms. Hickey inquired as to whether question #9 was sufficient for capturing necessary information to deem the applicant eligible for endorsement. She suggested that "or past" be inserted after pending.

**MOTION:** Dr. Edwards moved to accept the changes presented by staff, and the amendment to question #9. The motion was properly seconded and carried unanimously.

3. <u>Proposed 2020 Board Meeting Dates</u>

The Committee unanimously agreed to accept the dates as presented with the following changes:

- Full Board – February 20-21 amended to February 20-22
- Legislative – September 4th – possibly moving meeting date (Ms. Opher will check room availability)

## ANNOUNCEMENTS

Dr. Harp announced that Dr. Matusiak would like the Board members to review some disciplinary cases after adjournment.

The next meeting of the Committee will be December 6, 2019 at 8:30 a.m.

## ADJOURNMENT

With no additional business, the meeting adjourned at 9:36 a.m.

Ray Tuck, Jr., DC
President, Chair

William L. Harp, MD
Executive Director

Colanthia M. Opher
Recording Secretary

Agenda Item: Executive Director Report

Staff Note: On the following pages you will find the Board's cash balance for FY2020 so far, and the Federation of State Medical Boards Advocacy Network News. A verbal report on licensure by endorsement will be provided.

Action: For information only; no action anticipated.

| | 102- Medicine |
|---|---|
| **Board Cash Balance as June 30, 2019** | $ 9,382,219 |
| **YTD FY20 Revenue** | 1,032,736 |
| **Less: YTD FY20 Direct and Allocated Expenditures** | 2,930,903 |
| **Board Cash Balance as October 31, 2019** | $ 7,484,052 |

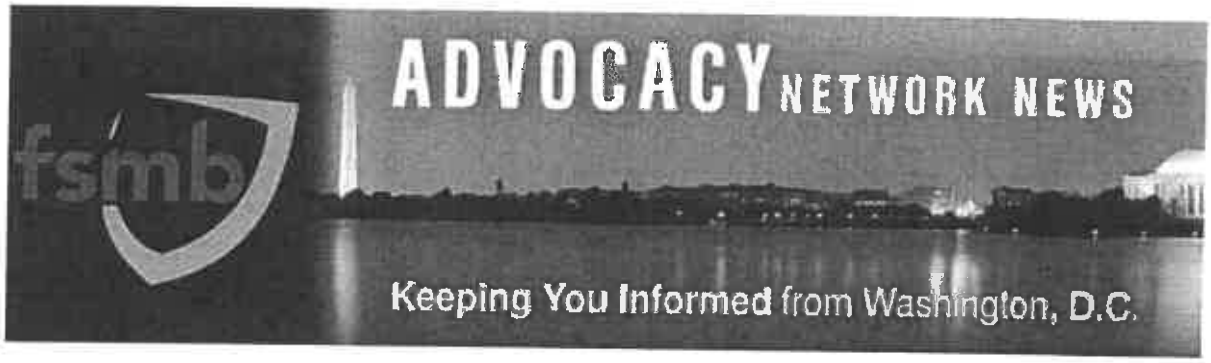
Commonwealth of Virginia

Harp, William <william.harp@dhp.virginia.gov>

# FSMB Advocacy Network News

1 message

**Federation of State Medical Boards, D.C.** <jknickrehm@fsmb.org> Wed, Nov 20, 2019 at 1:09 PM
Reply-To: jknickrehm@fsmb.org
To: william.harp@dhp.virginia.gov




Contact Us

**Lisa Robin**
**Chief Advocacy Officer**

**FSMB**
**1300 Connecticut Avenue NW**
**Suite 500**
**Washington, D.C. 20036**

**Phone: (202) 463-4000**
**lrobin@fsmb.org**

**November 20, 2019**

## Looking Ahead to 2020

Lawmakers on Capitol Hill are facing a looming budget deadline of Thursday to continue funding the government through December 20. Leadership on both sides of the aisle remain confident that an agreement can be reached, but a short-term spending bill will push negotiations right up to the December holiday recess. This timing threatens a repeat of last year's historic government shutdown that lasted 34 days over a standoff on border security funding.

The FSMB federal and state policy teams are continuing to track thousands of pieces of legislation that are of interest to state medical boards and the medical regulatory community. Forty-six state legislatures will gavel into session in 2020, with a number of states already beginning to pre-file legislation in anticipation of a busy calendar year. We look forward to keeping you apprised of important bills from Washington and state capitals across the country and wish you and your families a happy and healthy Thanksgiving holiday.

**Lisa Robin**
Chief Advocacy Officer
Federation of State Medical Boards

## Federal Legislative News

### House Judiciary Subcommittee Hearing on Competition in the Labor Market

The **House Judiciary Subcommittee on Antitrust, Commercial and Administrative Law** held a hearing on October 29th entitled: ***Antitrust and Economic Opportunity: Competition in Labor Markets.*** Witnesses included staff from the Federal Trade Commission, the Department of Justice, and Rick Masters who represents the Council of State Governments National Center for Interstate Compacts.

The FTC discussed the ***NC Dental*** decision and testified that antitrust concerns and portability continue to be an issue in the licensed professions. Mr. Masters provided testimony regarding the ongoing efforts licensed professions have

made to promote license portability, highlighting several health professions compacts including the Interstate Medical Licensure Compact.

The hearing and testimony can be accessed here.

## Legislation of Interest

### Telemedicine

**FSMB Endorses CONNECT for Health Act**

- The CONNECT for Health Act (S. 2741/H.R. 4932), a bipartisan bill introduced by **Sen. Brian Schatz (D-HI)** and five co-sponsors that would increase access to telehealth in the Medicare program. The bill was reintroduced for the 116th Congress and would allow for waivers of certain originating site and geographic requirements for telehealth benefits, including mental health services and emergency care. A House companion was introduced by **Rep. Mike Thompson (D-CA)**. The bill respects state law and licensure requirements and has been widely supported by more than 120 organizations.
- The National Defense Authorization Act for 2020 (S. 1790) is still in negotiations and would provide funding for the development of interstate compacts for license portability for military spouses. It would also establish a pilot program intended to expand access to broadband, including for telehealth services for military families located in underserved areas.
- The Telehealth Across State Lines Act of 2019 (H.R. 4900) was introduced in the House by **Rep. David Roe (R-TN)** and mirrors the legislation introduced in the Senate by **Sen. Marsha Blackburn (R-TN)**. The bills would require the Secretary to issue guidance on uniform best practices for the provision of telehealth across state lines. The bills do not specifically mention licensure, but the FSMB is actively engaging with Senate staff on this issue to emphasize the importance of state medical licensure to patient safety.
- The Asthma Care and Prevention in Rural Communities Act of 2019 (H.R. 4548), introduced by **Rep. Juan Vargas (D-CA)**, would authorize the Centers for Disease Control and Prevention (CDC) to award grants to underserved counties for mobile clinics and telemedicine to diagnose and treat children with asthma.

### Opioids

- The Opioid Prescription Verification Act of 2019 (H.R. 4810) was introduced by **Rep. Rodney Davis (R-IL)** and would require the Secretary of Health and Human Services (HHS), within one year of bill enactment, to create materials for training pharmacists on circumstances under which they may decline to fill a prescription. The bill would also allow the CDC to use a set of preferences in awarding grants, including the use of PDMPs by physicians and pharmacists.
- The Ensuring Compliance Against Drug Diversion Act of 2019 (H.R. 4812), introduced by **Rep. Morgan Griffith (R- VA)**, would provide for the modification, transfer, and termination of a registration to manufacture, distribute, or dispense controlled substances under the Controlled Substances Act under certain circumstances, including when a registrant: dies, ceases legal existence, discontinues business or professional practice or surrenders such registration.
- The RESTORE Act of 2019 (H.R. 4563), introduced by **Rep. Brian Fitzpatrick (R-PA)**, would repeal the provisions of the Ensuring Patient Access and Efficient Drug Enforcement Act of 2016.
- The DEBAR Act of 2019 (H.R. 4806), introduced by **Rep. Bob Latta (R-OH)**, would allow the Attorney General to prohibit any person from being registered to manufacture, distribute, or dispense a controlled substance or a list I chemical under certain circumstances.

## Veterans Affairs

**FSMB Provides Comments to Department of Veterans Affairs**

The FSMB responded to a letter from the Department of Veterans Affairs (VA) asking for comments on a proposal to expand VA telehealth rules to trainees. In the response letter, the FSMB highlighted the importance of only allowing licensed practitioners to practice telemedicine in any setting.

**FSMB Provides Written Testimony for House Veterans Affairs Committee Hearing**

The FSMB provided a letter to the House Committee on Veterans' Affairs for a hearing entitled **"Broken Promises: Assessing VA's Systems for Protecting Veterans from Clinical Harm."** The letter highlighted the importance of requiring the VA to report adverse actions to state licensing boards.

During the hearing, several Committee members asked about VA reporting to state medical boards - an issue that the FSMB continues to engage on.

The hearing and testimony can be accessed here.

- The Improving Confidence in Veterans' Care Act (H.R. 3530), introduced by **Rep. Michael Cloud (R-TX)**, was amended by **Rep. Mark Takano (D-CA)** in markup to include several quality improvement measures, including: verification of credentials, reporting to state licensing boards and the NPDB, and limitations on settlement agreements.

- The Ensuring Quality Care for Our Veterans Act (H.R. 4858), introduced by **Rep. Ralph Norman (R-SC)**, mirrors the language in the Senate version introduced by **Sen. Joni Ernst (R-IA)**. The bill would require third party reviews of VHA appointees who had a license terminated for cause by a state licensing board for care or services rendered at a non-VHA facility. It would also require that persons treated by such appointees be given notice if it is determined that care or services they received was below the standard of care.

## Funding and Education

**FSMB Endorses the HEALTHIER Act for the 116th Congress**

- The HEALTHIER Act (H.R. 2216), introduced in the 116th Congress by **Rep. Tim Burchett (R-TN)**, would create grants for states wishing to allow Volunteer Health Professionals to provide care in their states under certain circumstances. The FSMB previously endorsed this legislation in the 115th Congress.

- The EMPOWER for Health Act of 2019 (H.R. 2781), introduced by **Rep. Janice Schakowsky (D-IL)**, would reauthorize Public Health Service Act programs relating to the health professions workforce. The bill passed the House and was referred to the Senate HELP Committee.

- The College Affordability Act (H.R. 4674), introduced by **Rep. Bobby Scott (D-VA)**, was amended to include a U.S. Government Accountability Office (GAO) study on state practices related to the denial, suspension, or revocation of an individual's professional or driver's license as a penalty for student loan default. It includes the requirement that the Comptroller General conduct outreach with state and local licensing boards and other entities. The bill was reported favorably out of the Committee and now heads to the House floor.

## Workforce

- The Pathways to Health Careers Act (H.R. 3398), introduced by **Rep. Danny Davis (D-IL)**, would create grant programs for demonstration projects to address health professions workforce needs. One opportunity grant program would require that a state, "has in effect policies or laws that permit certain allied health and behavioral health care credentials to be awarded to people with certain arrest or conviction records," among other provisions.

- The DEMO Act (H.R. 3336), also introduced by **Rep. Danny Davis (D-IL)**,would create grants for demonstration projects to provide career pathways in the health professions for certain individuals with an arrest or conviction record.

# Regulatory News

The FSMB submitted a comment on **CMS Proposed Rule (CMS-1715-P)** that raised concerns over a proposal to allow CMS to expand its authority to revoke or deny physicians' and other healthcare providers' Medicare billing privileges in instances where providers have been subject to prior board disciplinary actions based on conduct that resulted in patient harm. The FSMB highlighted issues over the scope of the proposal and asked for clarity on procedures that would be used in determining patient harm.

CMS has announced that it plans to finalize the proposed rule, but will remove certain factors it had originally included that would have been considered in making a determination of revocation or billing privileges based on patient harm. The factors to be removed include:

- participation in rehabilitation or mental/behavioral health programs,
- required abstinence from drugs or alcohol and random drug testing, and
- "any other information that CMS deems to be relevant to its determination."

The full text of the final rule and final interim rule with commentary for CMS-1715-F can be viewed here. CMS also announced that it has added additional telehealth codes to the Medicare PFS for 2020.

The FSMB's federal legislative staff will continue to track and monitor legislation and regulations of interest to state medical boards. If there is specific legislation you would like us to assist with, please contact **Kandis McClure**, Director, Federal Advocacy and Policy at kmcclure@fsmb.org, or by phone at (202) 463-4003.

## State Legislative News

**Interstate Medical Licensure Compact**

Twenty-nine (29) states, Guam and the District of Columbia have enacted the IMLC, including: Alabama, Arizona, Colorado, Georgia, Idaho, Illinois, Iowa, Kansas, Kentucky, Maine, Maryland, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, North Dakota, Oklahoma, Pennsylvania, South Dakota, Tennessee, Utah, Vermont, Washington, West Virginia, Wisconsin, and Wyoming.

IMLC legislation is actively pending in Florida, New Jersey and South Carolina. On September 17, the South Carolina Senate Medical Affairs Subcommittee held a hearing on House Bill 3101, which previously passed the House of Representatives. The FSMB submitted a letter of support for the Compact. The legislation was reported favorably out of the Subcommittee and now awaits action by the full Committee.

As of October 30, 2019, the Interstate Medical Licensure Compact Commission (IMLCC) has processed 5,556 applications in Compact member states resulting in 7,599 licenses issued.

FSMB staff is currently assisting states that have expressed interest in introducing Compact legislation during the 2020 legislative session, as well as identifying additional states where legislative introductions may be possible.

The model Compact legislation and other resources can be found on the Interstate Medical Licensure Compact Commission's website at www.imlcc.org.

**Legislation of Interest**

Thousands of bills focusing on issues relating to state medical boards and the practice of medicine have been introduced during the 2019 legislative session. Below are some of the bills that have been enacted into law this year.

- **North Carolina HB 228-** Enacted August 1, mandates that every licensee has a duty to report in writing to the Board within 30 days any incidents that the licensee reasonably believes to have occurred involving sexual misconduct, fraudulent prescribing, drug diversion, or

theft of controlled substances. Failure to report shall constitute unprofessional conduct. The newly enacted law also decreases the amount of graduate medical education required for international medical school graduates from three years to two years, or proof of certification by an approved specialty board.

- **California AB 241** - Enacted October 2, requires that by January 1, 2022 all continuing education courses for physicians, nurses, and physician assistants to contain curriculum that includes specified instruction in the understanding of implicit bias in treatment.

- **California AB 528** - Enacted October 9, requires dispensing pharmacies, clinics, or other dispensers to report specified information to the state's PDMP no more than one workday after a controlled substance is released to a patient. It also requires that the dispensing of a Schedule V controlled substance to be reported to the PDMP. Authorized health care practitioners are also required to consult the PDMP to review a patient's history at least once every six months after the first time, instead of the current requirement of every four months.

- **Alaska SB 44** - Enacted October 23, permits physician assistants to diagnose, provide treatment, and prescribe, dispense, or administer a non-controlled substance prescription drug to a person without conducting a physical examination. A physician or physician assistant may not prescribe or dispense in response to an internet questionnaire or email without a prior patient-physician relationship.

As a handful of state legislatures are still in the 2019 legislative session, other state legislatures have begun pre-filing for the 2020 legislative session. Among the states where pre-filed legislation has been submitted, the following bills may be of interest to state medical boards:

- **Florida HB 309/SB 500** - Authorizes the Department of Health to impose penalties upon individuals who knowingly and falsely use the name or title "physician," "surgeon," "medical doctor," "osteopath," among other titles, or any other words, letters, abbreviations or insignia indicating or implying they are authorized to practice as such.

- **Florida HB 331/SB 120** - Permits a public school to buy a supply of naloxone from a wholesale distributor or manufacturer to use in the event of a student having an opioid overdose. The school district must adopt a protocol developed by a licensed physician.

- **Florida HB 409** - Adds an exemption for licensure requirements for the treatment of veterans if a physician has an unencumbered license to practice in another state or territory and if they are currently employed by the Department of Veterans Affairs. The physician would only be able to provide medical services to veterans, pursuant to their employment with the VA, and in designated hospitals.

- **Kentucky BR 8**- Requires a practitioner to offer a prescription for naloxone when prescribing an opioid, as well as provide education on overdose prevention and on opioid depression reversal drugs.

The FSMB's state legislative staff will continue to track and monitor legislation and regulations of interest to state medical boards. If there is specific legislation you would like us to assist with, please contact **John Bremer**, Director of State Legislation and Policy, at jbremer@fsmb.org, or by phone at (202) 463-4021.

## FSMB Advocacy Network

Working from offices in Texas and Washington, D.C., the FSMB provides advocacy services ranging from monitoring of legislation to liaison with key federal agencies. Contact us to learn more about our work on state and federal legislative issues, administration initiatives and the legislative process.

**Agenda Item:** **Regulatory Actions - Chart of Regulatory Actions**
**As of November 26, 2019**

| | | Action / Stage Information |
|---|---|---|
| [18 VAC 85 - 20] | Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic | Conversion therapy [Action 5412]<br>NOIRA - *At Secretary's Office for 22 days* |
| [18 VAC 85 - 20] | Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic | Addition of American Board of Podiatric Medicine [Action 5316]<br>Fast-Track - *Register Date: 9/16/19 Effective: 11/1/19* |
| [18 VAC 85 - 20] | Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic | Handling fee [Action 5411]<br>Fast-Track - *DPB Review in progress* |
| [18 VAC 85 - 21] | Regulations Governing Prescribing of Opioids and Buprenorphine | Waiver for e-prescribing of an opioid [Action 5355]<br>Emergency/NOIRA - *Register Date: 9/30/19*<br>*Board to adopt proposed regulations: 12/6/19* |
| [18 VAC 85 - 50] | Regulations Governing the Practice of Physician Assistants | Practice with patient care team physician [Action 5357]<br>Emergency/NOIRA - *Register Date: 10/14/19*<br>*Board to adopt proposed regulations: 12/6/19* |

# Legislative Report as of November 26, 2019

**HB 39 Health benefit plans; enrollment by pregnant individuals.**
*Chief patron:* Samirah
*Summary as introduced:*
**Health benefit plans; enrollment by pregnant individuals.** Requires health carriers to allow pregnant individuals to enroll in a health benefit plan at any time after the commencement of the pregnancy, with the pregnant individual's coverage being effective as of the first of the month in which the individual receives certification of the pregnancy. The measure applies to such agreements that are entered into, amended, extended, or renewed on or after January 1, 2021.

**HB 41 Adverse childhood experiences; Board of Medicine to adopt regulations for screening.**
*Chief patron:* Samirah
*Summary as introduced:*
**Board of Medicine; regulations; screening for adverse childhood experiences.** Directs the Board of Medicine to adopt regulations requiring every health care practitioner licensed by the Board who provides primary health care services to, at the time of a patient%92s first appointment, (i) provide to the patient information regarding the impact of adverse childhood experiences on physical and mental health and the risks and benefits of screening patients for adverse childhood experiences and (ii) screen patients for adverse childhood experiences that may impact a patient's physical or mental health or the provision of health care services to such patient.

**HB 42 Health care providers; screening of patients for prenatal and postpartum depression, training.**
*Chief patron:* Samirah
*Summary as introduced:*
**Health care providers; screening of patients for prenatal and postpartum depression; training.** Directs the Boards of Medicine and Nursing to adopt regulations requiring licensees who provide primary, maternity, obstetrical, or gynecological health care services to complete a training program on prenatal and postnatal depression in women. Such training program shall include information on risk factors for and signs and symptoms of prenatal and postnatal depression, resources for the treatment and management of prenatal and postnatal depression, and steps the practitioner can take to link patients to such resources. The bill also requires the Board of Medicine to adopt regulations requiring licensees who provide primary, maternity, obstetrical, or gynecological health care services to screen all patients who are pregnant or who have been pregnant within the previous five years for prenatal or postnatal depression or other depression, as appropriate.

**Agenda Item: Adoption of Regulation for Waiver of Electronic Prescribing by Emergency Action**

Included in agenda package:

Copy of Notice on Townhall

Amendments to 18VAC85-21-10 et seq. – Regulations Governing Prescribing of Opioids and Buprenorphrine

Staff note:

Proposed amendments are identical to the emergency regulations that became effective on 9/18/19. There were no comments on the Notice of Intended Regulatory Action to replace emergency regulations.

Board action:

Motion to adopt the proposed regulations that replace emergency regulations for a temporary waiver for e-prescribing of opioids

Virginia.gov Agencies | Governor

VIRGINIA REGULATORY TOWN HALL

Agency **Department of Health Professions**

Board **Board of Medicine**

Chapter **Regulations Governing Prescribing of Opioids and Buprenorphine [18 VAC 85 - 21]**

Action: Waiver for e-prescribing of an opioid

## Emergency/NOIRA Stage

Action 5355 / Stage 8714

Edit Stage | Go to RIS Project | Request Emergency Extension

| Documents | | |
|---|---|---|
| Emergency Text | 8/7/2019 8:11 am | Sync Text with RIS |
| Agency Statement | 8/7/2019 | Upload / Replace |
| Attorney General Certification | 8/14/2019 | |
| Governor's Review Memo | 9/18/2019 | |
| Registrar Transmittal | 9/18/2019 | |

| Status | |
|---|---|
| Public Hearing | Will be held at the **proposed** stage |
| Emergency Authority | 2.2-4011 |
| Exempt from APA | No, this stage/action is subject to article 2 of the *Administrative Process Act* and the standard executive branch review process. |
| Attorney General Review | Submitted to OAG: 8/7/2019<br>Review Completed: 8/14/2019<br>Result: Certified |
| DPB Review | Submitted on 8/14/2019<br>Policy Analyst: Melanie West<br>Review Completed: 8/28/2019<br>*DPB's policy memo is "Governor's Confidential Working Papers"* |
| Secretary Review | Secretary of Health and Human Resources Review Completed: 9/10/2019 |
| Governor's Review | Review Completed: 9/18/2019<br>Result: Approved |
| Virginia Registrar | Submitted on 9/18/2019<br>The Virginia Register of Regulations<br>Publication Date: 9/30/2019 Volume: 36 Issue: 3 |
| Comment Period | Ended 10/30/2019<br>0 comments |
| Effective Date | 9/18/2019 |

go back | open in word

**Project 6085 - Emergency/NOIRA**

**BOARD OF MEDICINE**

**Waiver for e-prescribing of an opioid**

**18VAC85-21-21. Electronic prescribing.**

A. Beginning July 1, 2020, a prescription for a controlled substance that contains an opioid shall be issued as an electronic prescription consistent with § 54.1-3408.02 of the Code of Virginia.

B. Upon written request, the board may grant a one-time waiver of the requirement of subsection A of this section, for a period not to exceed one year, due to demonstrated economic hardship, technological limitations that are not reasonably within the control of the prescriber, or other exceptional circumstances demonstrated by the prescriber.

**Agenda Item: Adoption of Proposed Regulation for Physician Assistants**

Included in agenda package:

Copy of Notice on Townhall

Amendments to 18VAC85-50-10 et seq. – Regulations Governing the Practice of Physician Assistants

Staff note:

Proposed amendments are identical to the emergency regulations that became effective on 10/1/19. There were no comments on the Notice of Intended Regulatory Action to replace emergency regulations.

Board action:

Motion to adopt the proposed regulations that replace emergency regulations for practice of physician assistants with a patient care team physician

Virginia.gov Agencies | Governor

VIRGINIA REGULATORY TOWN HALL

Agency Department of Health Professions

Board Board of Medicine

Chapter Regulations Governing the Practice of Physician Assistants [18 VAC 85 - 50]

**Action**: Practice with patient care team physician

## Emergency/NOIRA Stage

Action 5357 / Stage 8716

Edit Stage | Go to RIS Project | Request Emergency Extension

| Documents | | |
|---|---|---|
| Emergency Text | 8/7/2019 12:04 pm | Sync Text with RIS |
| Agency Statement | 8/7/2019 (modified 8/22/2019) | Upload / Replace |
| Attorney General Certification | 8/14/2019 | |
| Governor's Review Memo | 9/30/2019 | |
| Registrar Transmittal | 9/30/2019 | |

| Status | |
|---|---|
| Public Hearing | Will be held at the **proposed** stage |
| Emergency Authority | 2.2-4011 |
| Exempt from APA | No, this stage/action is subject to article 2 of the *Administrative Process Act* and the standard executive branch review process. |
| Attorney General Review | Submitted to OAG: 8/7/2019<br>Review Completed: 8/14/2019<br>Result: Certified |
| DPB Review | Submitted on 8/14/2019<br>Policy Analyst: Jeannine Rose<br>Review Completed: 8/27/2019<br>*DPB's policy memo is "Governor's Confidential Working Papers"* |
| Secretary Review | Secretary of Health and Human Resources Review Completed: 9/10/2019 |
| Governor's Review | Review Completed: 9/30/2019<br>Result: Approved |
| Virginia Registrar | Submitted on 9/30/2019<br>The Virginia Register of Regulations<br>Publication Date: 10/14/2019 Volume: 36 Issue: 4 |
| Comment Period | Ended 11/13/2019<br>0 comments |
| Effective Date | 10/1/2019 |

go back | open in word

**Project 6083 - Emergency/NOIRA**

**BOARD OF MEDICINE**

**Practice with patient care team physician**

Part I

General Provisions

**18VAC85-50-10. Definitions.**

A. The following words and terms shall have the meanings ascribed to them in § 54.1-2900 of the Code of Virginia:

"Board."

"Collaboration."

"Consultation."

"Patient care team physician."

"Patient care team podiatrist."

"Physician assistant."

B. The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Group practice" means the practice of a group of two or more doctors of medicine, osteopathy, or podiatry licensed by the board who practice as a partnership or professional corporation.

"Institution" means a hospital, nursing home or other health care facility, community health center, public health center, industrial medicine or corporation clinic, a medical service facility, student health center, or other setting approved by the board.

"NCCPA" means the National Commission on Certification of Physician Assistants.

"Practice agreement" means a written or electronic agreement developed by the ~~supervising~~ patient care team physician or podiatrist and the physician assistant that defines the ~~supervisory~~

relationship between the physician assistant and the physician or podiatrist, the prescriptive authority of the physician assistant, and the circumstances under which the physician or podiatrist will see and evaluate the patient.

~~"Supervision" means the supervising physician has on-going, regular communication with the physician assistant on the care and treatment of patients, is easily available, and can be physically present or accessible for consultation with the physician assistant within one hour.~~

**18VAC85-50-35. Fees.**

Unless otherwise provided, the following fees shall not be refundable:

1. The initial application fee for a license, payable at the time application is filed, shall be $130.

2. The biennial fee for renewal of an active license shall be $135 and for renewal of an inactive license shall be $70, payable in each odd-numbered year in the birth month of the licensee. For 2019, the fee for renewal of an active license shall be $108, and the fee for renewal of an inactive license shall be $54.

3. The additional fee for late renewal of licensure within one renewal cycle shall be $50.

4. A restricted volunteer license shall expire 12 months from the date of issuance and may be renewed without charge by receipt of a renewal application that verifies that the physician assistant continues to comply with provisions of § 54.1-2951.3 of the Code of Virginia.

~~5. The fee for review and approval of a new protocol submitted following initial licensure shall be $15.~~

~~6.~~ 5. The fee for reinstatement of a license pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.

~~7.~~ 6. The fee for a duplicate license shall be $5.00, and the fee for a duplicate wall certificate shall be $15.

~~8.~~ 7. The fee for a returned check shall be $35.

~~9.~~ 8. The fee for a letter of good standing or verification to another jurisdiction shall be $10.

~~10.~~ 9. The fee for an application or for the biennial renewal of a restricted volunteer license shall be $35, due in the licensee's birth month. An additional fee for late renewal of licensure shall be $15 for each renewal cycle.

Part II

Requirements for Practice as a Physician's Assistant

**18VAC85-50-40. General requirements.**

A. No person shall practice as a physician assistant in the Commonwealth of Virginia except as provided in this chapter.

B. All services rendered by a physician assistant shall be performed only ~~under the continuous supervision of~~ in accordance with a practice agreement with a doctor of medicine, osteopathy, or podiatry licensed by this board to practice in the Commonwealth.

**18VAC85-50-57. Discontinuation of employment.**

If for any reason the physician assistant discontinues working ~~in the employment and under the supervision of a licensed practitioner~~ with a patient care team physician or podiatrist, a new practice agreement shall be entered into in order for the physician assistant either to be reemployed by the same practitioner or to accept new employment with another ~~supervising physician~~ patient care team physician or podiatrist.

Part IV

Practice Requirements

**18VAC85-50-101. Requirements for a practice agreement.**

A. Prior to initiation of practice, a physician assistant and his ~~supervising~~ patient care team physician or podiatrist shall enter into a written or electronic practice agreement that spells out the roles and functions of the assistant and is consistent with provisions of § 54.1-2952 of the Code of Virginia.

1. The ~~supervising~~ patient care team physician or podiatrist shall be a doctor of medicine, osteopathy, or podiatry licensed in the Commonwealth who has accepted responsibility for ~~the supervision of~~ the service that a physician assistant renders.

2. Any such practice agreement shall take into account such factors as the physician assistant's level of competence, the number of patients, the types of illness treated by the physician or podiatrist, the nature of the treatment, special procedures, and the nature of the physician or podiatrist availability in ensuring direct physician or podiatrist involvement at an early stage and regularly thereafter.

3. The practice agreement shall also provide an evaluation process for the physician assistant's performance, including a requirement specifying the time period, proportionate to the acuity of care and practice setting, within which the ~~supervising~~ physician or podiatrist shall review the record of services rendered by the physician assistant.

4. The practice agreement may include requirements for periodic site visits by ~~supervising licensees who supervise and direct~~ the patient care team physician or podiatrist to collaborate and consult with physician assistants who provide services at a location other than where the ~~licensee~~ physician or podiatrist regularly practices.

B. The board may require information regarding the ~~level~~ degree of ~~supervision with which the supervising~~ collaboration and consultation by the patient care team physician ~~plans to supervise the physician assistant for selected tasks~~ or podiatrist. The board may also require the ~~supervising~~ patient care team physician or podiatrist to document the physician assistant's competence in performing such tasks.

C. If the role of the physician assistant includes prescribing drugs and devices, the written practice agreement shall include those schedules and categories of drugs and devices that are within the scope of practice and proficiency of the ~~supervising~~ patient care team physician or podiatrist.

D. If the initial practice agreement did not include prescriptive authority, there shall be an addendum to the practice agreement for prescriptive authority.

E. If there are any changes in ~~supervision~~ consultation and collaboration, authorization, or scope of practice, a revised practice agreement shall be entered into at the time of the change.

**18VAC85-50-110. Responsibilities of the ~~supervisor~~ patient care team physician or podiatrist.**

The ~~supervising physician~~ patient care team physician or podiatrist shall:

1. Review the clinical course and treatment plan for any patient who presents for the same acute complaint twice in a single episode of care and has failed to improve as expected. The ~~supervising~~ physician or podiatrist shall be involved with any patient with a continuing illness as noted in the written or electronic practice agreement for the evaluation process.

2. Be responsible for all invasive procedures.

a. Under supervision, a physician assistant may insert a nasogastric tube, bladder catheter, needle, or peripheral intravenous catheter, but not a flow-directed catheter, and may perform minor suturing, venipuncture, and subcutaneous intramuscular or intravenous injection.

b. All other invasive procedures not listed in subdivision 2 a of this section must be performed under supervision with the physician in the room unless, after directly observing the performance of a specific invasive procedure three times or more, the ~~supervising~~ patient care team physician or podiatrist attests on the practice agreement to the competence of the physician assistant to perform the specific procedure without direct observation and supervision.

3. Be responsible for all prescriptions issued by the physician assistant and attest to the competence of the assistant to prescribe drugs and devices.

4. Be available at all times to collaborate and consult with the physician assistant.

**18VAC85-50-115. Responsibilities of the physician assistant.**

A. The physician assistant shall not render independent health care and shall:

1. Perform only those medical care services that are within the scope of the practice and proficiency of the ~~supervising~~ patient care team physician or podiatrist as prescribed in the physician assistant's practice agreement. When a physician assistant is ~~to be supervised by an alternate supervising physician~~ working outside the scope of specialty of the ~~supervising~~ patient care team physician or podiatrist, then the physician assistant's functions shall be limited to those areas not requiring specialized clinical judgment, unless a separate practice agreement has been executed for that alternate ~~supervising~~ patient care team physician or podiatrist.

2. Prescribe only those drugs and devices as allowed in Part V (18VAC85-50-130 et seq.) of this chapter.

3. Wear during the course of performing his duties identification showing clearly that he is a physician assistant.

B. An alternate ~~supervising~~ patient care team physician or podiatrist shall be a member of the same group, professional corporation, or partnership of any licensee who ~~supervises~~ is the patient care team physician or podiatrist for a physician assistant or shall be a member of the same hospital or commercial enterprise with the ~~supervising~~ patient care team physician or podiatrist. Such alternating ~~supervising~~ physician or podiatrist shall be a physician or podiatrist licensed in the Commonwealth who has accepted responsibility for the ~~supervision of the~~ service that a physician assistant renders.

C. If, due to illness, vacation, or unexpected absence, the ~~supervising~~ patient care team physician or podiatrist or alternate ~~supervising~~ physician or podiatrist is unable to supervise the activities of his physician assistant, such ~~supervising~~ patient care team physician or podiatrist may temporarily delegate the responsibility to another doctor of medicine, osteopathic medicine, or podiatry.

Temporary coverage may not exceed four weeks unless special permission is granted by the board.

D. With respect to physician assistants employed by institutions, the following additional regulations shall apply:

1. No physician assistant may render care to a patient unless the physician or podiatrist responsible for that patient has signed the practice agreement to act as ~~supervising~~ patient care team physician or podiatrist for that physician assistant.

2. Any such practice agreement as described in subdivision 1 of this subsection shall delineate the duties which said patient care team physician or podiatrist authorizes the physician assistant to perform.

~~3. The physician assistant shall, as soon as circumstances may dictate, report an acute or significant finding or change in clinical status to the supervising physician concerning the~~

~~examination of the patient. The physician assistant shall also record his findings in appropriate institutional records.~~

E. Practice by a physician assistant in a hospital, including an emergency department, shall be in accordance with § 54.1-2952 of the Code of Virginia.

**18VAC85-50-117. Authorization to use fluoroscopy.**

A physician assistant working under ~~the supervision of~~ a practice agreement with a licensed doctor of medicine or osteopathy specializing in the field of radiology is authorized to use fluoroscopy for guidance of diagnostic and therapeutic procedures provided such activity is specified in his protocol and he has met the following qualifications:

1. Completion of at least 40 hours of structured didactic educational instruction and at least 40 hours of supervised clinical experience as set forth in the Fluoroscopy Educational Framework for the Physician Assistant created by the American Academy of Physician Assistants (AAPA) and the American Society of Radiologic Technologists (ASRT); and

2. Successful passage of the American Registry of Radiologic Technologists (ARRT) Fluoroscopy Examination.

**18VAC85-50-140. Approved drugs and devices.**

A. The approved drugs and devices which the physician assistant with prescriptive authority may prescribe, administer, or dispense manufacturer's professional samples shall be in accordance with provisions of § 54.1-2952.1 of the Code of Virginia:

B. The physician assistant may prescribe only those categories of drugs and devices included in the practice agreement. The ~~supervising~~ patient care team physician or podiatrist retains the authority to restrict certain drugs within these approved categories.

C. The physician assistant, pursuant to § 54.1-2952.1 of the Code of Virginia, shall only dispense manufacturer's professional samples or administer controlled substances in good faith for medical or therapeutic purposes within the course of his professional practice.

**18VAC85-50-160. Disclosure.**

A. Each prescription for a Schedule II through V drug shall bear the name of the ~~supervising~~ patient care team physician or podiatrist and of the physician assistant.

B. The physician assistant shall disclose to the patient that he is a licensed physician assistant, and also the name, address and telephone number of the ~~supervising~~ patient care team physician or podiatrist. Such disclosure shall either be included on the prescription or be given in writing to the patient.

**18VAC85-50-181. Pharmacotherapy for weight loss.**

A. A practitioner shall not prescribe amphetamine, Schedule II, for the purpose of weight reduction or control.

B. A practitioner shall not prescribe controlled substances, Schedules III through VI, for the purpose of weight reduction or control in the treatment of obesity, unless the following conditions are met:

1. An appropriate history and physical examination are performed and recorded at the time of initiation of pharmacotherapy for obesity by the prescribing physician, and the physician reviews the results of laboratory work, as indicated, including testing for thyroid function;

2. If the drug to be prescribed could adversely affect cardiac function, the physician shall review the results of an electrocardiogram performed and interpreted within 90 days of initial prescribing for treatment of obesity;

3. A diet and exercise program for weight loss is prescribed and recorded;

4. The patient is seen within the first 30 days following initiation of pharmacotherapy for weight loss, by the prescribing physician or a licensed practitioner with prescriptive authority working under the supervision of the prescribing physician, at which time a recording shall be made of blood pressure, pulse, and any other tests as may be necessary for monitoring potential adverse effects of drug therapy; and

5. The treating physician shall direct the follow-up care, including the intervals for patient visits and the continuation of or any subsequent changes in pharmacotherapy. Continuation of prescribing for treatment of obesity shall occur only if the patient has continued progress

toward achieving or maintaining a target weight and has no significant adverse effects from the prescribed program.

C. If specifically authorized in his practice agreement with a ~~supervising~~ patient care team physician, a physician assistant may perform the physical examination, review tests, and prescribe Schedules III through VI controlled substances for treatment of obesity as specified in subsection B of this section.

**Agenda Item:** **Question Regarding Waiver for Electronic Prescribing of Opioids**

**Staff Note:** Board staff received a request for a waiver of 1 year for electronic prescribing of opioids from Mid-Atlantic Permanente Medical Group. The inquiry and staff response follow. Section 54.1-3408.02 of the Code of Virginia is also included for your review.

**Action:** To determine if the request by MAPMD for a blanket waiver for 1,700 prescribers can be met.

Commonwealth of Virginia

Harp, William <william.harp@dhp.virginia.gov>

# RE: 18VAC85-21-21A Regulations governing prescribing of Opioids and Buprenorphine: Request for more information on how to file a waiver

1 message

**Nancy E. Doellgast** <Nancy.E.Doellgast@kp.org> Tue, Nov 5, 2019 at 2:26 PM
To: "Harp, William" <william.harp@dhp.virginia.gov>
Cc: "Nancy E. Doellgast" <Nancy.E.Doellgast@kp.org>

Thank you, Dr. Harp, for your quick response.

I have checked with our Pharmacy leaders and we will not have the technology fix in place by 7/1/2020 to comply with the law and will file the waiver.

The timing of the filing of the waiver will be dependent on what information is required to apply for the waiver for the +1700 physicians.

Are we required to have each physician apply for the waiver or can the medical group apply on behalf of all the licensed MAPMG Virginia physicians?

What information is needed to file the waiver?

**Nancy E Doellgast, MPA CHC, CHPC**

MAPMG Director of Compliance

MAPMG Privacy and Security Officer

MAS Regional Research FCOI Officer

MAS Regional Research Integrity Officer

Link to MAPMG Compliance Resources: http://kpnet.kp.org/mas/work/medgrouphr/compliance.htm

If you have any compliance questions or concerns, please email MAPMGCompliance@kp.org

**MID-ATLANTIC PERMANENTE Medical Group**

Compliance

2101 East Jefferson Street

Rockville MD 20852

Office: 301-816-5860

Cell: 301-456-6422

Upcoming Out of the Office:

**From:** Harp, William <william.harp@dhp.virginia.gov>
**Sent:** Tuesday, November 5, 2019 1:53 PM
**To:** Nancy E. Doeligast <Nancy.E.Doeligast@kp.org>
**Subject:** Re: 18VAC85-21-21A Regulations governing prescribing of Opioids and Buprenorphine: Request for more information on how to file a waiver



Dear Ms. Doeligast:

Thank you for your message.

The requirement is not effective until July 1, 2020.

Perhaps you would like to ask for a waiver closer to time, if by then KP is still anticipating technological limitations?

Kindest regards,

William L. Harp, MD

Executive Director

Virginia Board of Medicine

On Tue, Nov 5, 2019 at 12:45 PM Nancy E. Doeligast <Nancy.E.Doeligast@kp.org> wrote:

Dr Harp-

I am the compliance director for the Mid-Atlantic Medical Group and in reviewing these emergency regulations, the medical group wants to request a one-time waiver of the requirement of 18VAC85-21-21A due to technological limitations of our e-prescribing system for approximately 1700 physicians.

I left a voice mail message on 1-804-367-4558. I am now following up in writing requesting instructions on how to apply for this waiver and what information is needed to file since the emergency regulations did not provide any instructions on how to request this waiver.

Please advise.

**Nancy E Doellgast, MPA CHC, CHPC**

MAPMG Director of Compliance

MAPMG Privacy and Security Officer

MAS Regional Research FCOI Officer

MAS Regional Research Integrity Officer

Link to MAPMG Compliance Resources: http://kpnet.kp.org/mas/work/medgrouphr/compliance.htm

If you have any compliance questions or concerns, please email MAPMGCompliance@kp.org

MID-ATLANTIC PERMANENTE Medical Group

Compliance

2101 East Jefferson Street

Rockville MD 20852

Office: 301-816-5860

Cell: 301-456-6422

Upcoming Out of the Office:



**NOTICE TO RECIPIENT:** If you are not the intended recipient of this e-mail, you are prohibited from sharing, copying, or otherwise using or disclosing its contents. If you have received this e-mail in error, please notify the sender immediately by reply e-mail and permanently delete this e-mail and any attachments without reading, forwarding or saving them. Thank you.

KAISER PERMANENTE®

PERMANENTE MEDICINE®

# Mid-Atlantic Permanente Medical Group, P.C.

Mid-Atlantic Permanente Medical Group (MAPMG) is a team of over 1,500 world-class physicians spanning more than 50 medical and surgical specialties and sub-specialties. Our Permanente physicians are responsible for the full continuum of medical care for 750,000 Kaiser Permanente members in Maryland, Virginia, and Washington, D.C.

MAPMG is an innovator in high-acuity outpatient care. The launch of our "hubs" — large, free-standing medical centers not located on a hospital campus that include clinical decision/observation units open to patients 24/7, ambulatory surgery centers, high-end imaging, and co-located specialists — has dramatically reduced medically unnecessary emergency room and inpatient hospital use, and brought to life new outpatient surgical programs such as joint replacement.

MAPMG has emerged as a leader in telemedicine, achieving high rates of adoption across several clinical use cases. MAPMG also helps to advance the body of medical knowledge through its Mid-Atlantic Permanente Research Institute (MAPRI).

Highlights of our results at MAPMG include having hundreds of our physicians on "Top Doctor" lists, Patient Centered Medical Home recognition, and helping Kaiser Permanente of the Mid-Atlantic States earn

No. 1 rates in the nation for cervical cancer screening, blood pressure control, and several other quality measures.

Visit the Mid-Atlantic Permanente Medical Group website

# Fast facts

## Headquarters: Rockville, Maryland

Physicians

1,536

Non-Physician Staff

263

Medical Offices

31

Members Served

# 750,500+

Richard S. Isaacs, MD FACS

CEO and Executive Director
The Permanente Medical Group

President and CEO
Mid-Atlantic Permanente Medical Group

Co-Chief Executive Officer
The Permanente Federation, LLC

Read full bio

Code of Virginia
Title 54.1. Professions and Occupations
Chapter 34. Drug Control Act

This section has more than one version with varying effective dates. Scroll down to see all versions.

# § 54.1-3408.02. (Effective until July 1, 2020) Transmission of prescriptions.

Consistent with federal law and in accordance with regulations promulgated by the Board, prescriptions may be transmitted to a pharmacy by electronic transmission or by facsimile machine and shall be treated as valid original prescriptions.

2000, c. 878.

# § 54.1-3408.02. (Effective July 1, 2020) Transmission of prescriptions.

A. Consistent with federal law and in accordance with regulations promulgated by the Board, prescriptions may be transmitted to a pharmacy as an electronic prescription or by facsimile machine and shall be treated as valid original prescriptions.

B. Any prescription for a controlled substance that contains an opioid shall be issued as an electronic prescription.

C. The requirements of subsection B shall not apply if:

1. The prescriber dispenses the controlled substance that contains an opioid directly to the patient or the patient's agent;

2. The prescription is for an individual who is residing in a hospital, assisted living facility, nursing home, or residential health care facility or is receiving services from a hospice provider or outpatient dialysis facility;

3. The prescriber experiences temporary technological or electrical failure or other temporary extenuating circumstance that prevents the prescription from being transmitted electronically, provided that the prescriber documents the reason for this exception in the patient's medical record;

4. The prescriber issues a prescription to be dispensed by a pharmacy located on federal property, provided that the prescriber documents the reason for this exception in the patient's medical record;

5. The prescription is issued by a licensed veterinarian for the treatment of an animal;

6. The FDA requires the prescription to contain elements that are not able to be included in an electronic prescription;

7. The prescription is for an opioid under a research protocol;

8. The prescription is issued in accordance with an executive order of the Governor of a declared emergency;

9. The prescription cannot be issued electronically in a timely manner and the patient's condition is at risk, provided that the prescriber documents the reason for this exception in the patient's medical record; or

10. The prescriber has been issued a waiver pursuant to subsection D.

D. The licensing health regulatory board of a prescriber may grant such prescriber, in accordance with regulations adopted by such board, a waiver of the requirements of subsection B, for a period not to exceed one year, due to demonstrated economic hardship, technological limitations that are not reasonably within the control of the prescriber, or other exceptional circumstances demonstrated by the prescriber.

2000, c. 878; 2017, cc. 115, 429; 2019, c. 664.

The chapters of the acts of assembly referenced in the historical citation at the end of this section may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.

11/26/2019

Agenda Item: Report of the FSMB Workgroup on Physician Sexual Misconduct

Staff Note: FSMB seeks comments from all member boards on the DRAFT model policy that begins after this page.

Action: Review, discuss and provide feedback to FSMB on the document and any suggested revisions, additions or deletions.

# Report of the FSMB Workgroup on Physician Sexual Misconduct

## DRAFT

## Section 1: Introduction and Workgroup Charge

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

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

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

In carrying out its charge, the Workgroup adopted a broad lens with which to scrutinize not only the current practices of state medical boards and other professional regulatory authorities in the United States and abroad, but also elements of professional culture within American medicine, including notions of professionalism, expectations related to reporting instances of misconduct or impropriety, evolving public expectations of the medical profession, and the impact of trauma on survivors of sexual misconduct. In analyzing these issues, the Workgroup benefited tremendously from discussions with several of the FSMB's partner organizations and stakeholders that also have a role in addressing the issue of physician sexual misconduct. The

Workgroup extends its thanks, in particular, to the American Association of Colleges of Osteopathic Medicine (AACOM), Association of American Medical Colleges (AAMC), Student Osteopathic Medical Association (SOMA), Australian Health Practitioner Regulation Agency (AHPRA), American Medical Association (AMA), American Medical Women's Association (AMWA), American Osteopathic Association (AOA), Council of Medical Specialty Societies (CMSS), Federation of Medical Regulatory Authorities of Canada (FMRAC), Federation of State Physician Health Programs (FSPHP), several provincial medical regulatory colleges from Canada, subject matter experts from Justice3D, PBI Education, and additional physician experts, and especially the victim and survivor advocates who were brave enough to share their experiences with Workgroup members. This report has been enriched by these partners' valuable contributions.

Sexual harassment is common in medicine, and particularly in academic medicine.[1] The National Academies of Sciences reports that organizational culture plays a primary role in enabling harassment and that sexually harassing behaviors are not typically isolated incidents. Medical students and trainees who work within such cultures are often impacted by them; women in medicine who become victims of sexual harassment, beyond suffering from their victimhood, are also undermined in their professional and education attainment, resulting in loss of talent; men educated in these environments, if not the object of sexual harassment themselves, are also impacted; and ultimately patients experience some of the most significant and most dire consequences of such a culture.

Does a culture that is permissive of sexual harassment result in greater permissiveness of physician sexual misconduct with patients? Are bystanders in such a culture more accepting of that culture and less likely to report abuses? These questions emphasize the critical need for promoting a diverse, inclusive, and respectful environment for medical education and care.

The overwhelming majority of physicians carefully observes the boundaries between themselves and their patients and surrogates and, therefore, a small minority of physicians is responsible for the majority of cases of sexual misconduct. However, the Workgroup acknowledged the existence of several highly problematic aspects of sexual misconduct in medical education and practice, many of which permeate the prevailing culture of medicine and self-regulation. These go beyond the many instances, both reported and unreported, of sexual assault and boundary violations to include various aspects of the investigative and adjudicatory processes designed to address them; the professional responsibility of health care practitioners to report suspected instances of sexual misconduct and patient harm; transparency of state medical board processes and actions; a widespread need for education and training among medical regulators, board investigators, attorneys, and law enforcement personnel about trauma and how it might impact complainant accounts and the investigative process; and certain nuances involved in difficult decisions about re-entry to practice and remediation. This report is designed to summarize many of these problematic elements so that they may be more widely appreciated, while offering potential solutions and strategies for state medical boards to consider for their jurisdictions.

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

The workgroup acknowledges variation in state medical boards policies and processes, as well as in state laws. This report aspires to provide best practice recommendations and highlight existing strategies and available tools that allow boards, including board members, executive directors, staff, and attorneys, to best protect the public while working within their established frameworks and resources.

## Section 2: Principles

The bulk of the content contained in this report is informed by the following principles:

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

## Section 3: Terminology:

*Sexual Misconduct:*

Physician sexual misconduct is behavior that exploits the physician-patient relationship in a sexual way. Sexual behavior between a physician and a patient is never diagnostic or therapeutic. This behavior may be verbal or physical, can occur in-person or virtually,[3] and may include expressions of thoughts and feelings or gestures that are of a sexual nature or that reasonably may be construed by a patient or patient's surrogate[4] as sexual. While the focus of this report is on the patient and the patient's surrogate, physician sexual misconduct can also take place

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

between a physician and colleagues, staff, students and trainees. Hereinafter, the term "patient" includes the patient and/or patient surrogate whose sexual boundaries have been violated.

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

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

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

The level of severity of sexual misconduct rises in instances where physical sexual contact takes place between a physician and patient, whether or not initiated by the patient, and where any conduct with a patient is indeed sexual or may be reasonably interpreted as sexual. So-called "romantic" behavior between a physician and a patient is never appropriate, regardless of the appearance of consent on the part of the patient. Such behavior would at least constitute grooming, depending on the nature of the behavior, if not actual sexual misconduct, and should be labeled as such.

The term "sexual assault" refers to any type of sexual activity or contact without consent (such as through physical force or threats of force) and may be used in investigations where there is a need to emphasize the severity of the misconduct and any related trauma. Sexual assault is a criminal or civil violation and would typically be initially handled by law enforcement.

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

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

*Trauma:*

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

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

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

*Patient*:

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

Sexual misconduct may still occur following the termination of a physician-patient relationship, especially in long-standing relationships or ones involving a high degree of emotional dependence. Time elapsed between termination of the relationship is insufficient in many contexts to determine that sexual contact is permissible. Other factors that should be considered in assessing the possible permissibility of consensual sexual contact between consenting adults following the termination of a physician-patient relationship can include documentation of formal termination; transfer of the patient's care to another health care provider; the length of time of the professional relationship; the extent to which the patient has confided personal or private information to the physician; the nature of the patient's health problem; and the degree of emotional dependence and vulnerability.[8] Termination of a physician-patient relationship for the purposes of allowing sexual contact to legally occur is unacceptable and would still constitute sexual misconduct because of the trust, inherent power imbalance between a physician and patient, and patient vulnerability that exist leading up to, during and following the decision to terminate the relationship. A patient is not capable of providing free, full and informed consent to sexual activity with their physician.

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

[7] *Id.*

[8] Washington Medical Commission, *Guideline on Sexual Misconduct and Abuse*, 2017.

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

*Informed Consent and Shared Decision-Making*

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

The consent process should take place well in advance of any procedure so that the patient has an opportunity to consider the proposed procedure in the absence of competing considerations about cancellation or rescheduling. Requiring decisions at the point of care puts patients at a disadvantage because they may not have time to consider what is being proposed and what it means for themselves and their values. The consent process should also include information about the effects of anaesthesia, including the possibility of amnesia. Use of understandable (lay, or common) language during the consent process is essential.

*Communication and Patient Education*

Communication between a physician and patient should occur throughout any examination or procedure, including conveying the medical necessity, what the examination or procedure will involve, the benefits and risks, and any findings. This is especially important during the performance of an intimate examination. In such instances, it may also be helpful for physicians to acknowledge the intimate and invasive nature of the examination while offering as much explanation and justification as possible.

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

## Section 5: Complaints and the Duty to Report

In order for state medical boards to effectively address instances of sexual misconduct, they must have access to relevant information about licensees that have harmed or pose a significant risk of harming patients. The complaints process and physicians' professional duty to report instances of sexual misconduct are therefore central to a regulatory board's ability to protect patients.[9]

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

*Complaints and Barriers to Complaints*

It is essential for patients or their surrogates to be able to file complaints about their physicians to state medical boards in order that licensees who pose a threat to patients may be investigated and intervention can occur when needed. However, studies have estimated that sexual misconduct by physicians is significantly under reported, and several challenges which may dissuade patients from filing complaints must be overcome.[10] These include institutional distrust in the ability or willingness of state medical boards, hospitals and other health care institutions and sites to take action in instances of sexual misconduct; fear of abandonment or retaliation by the physician; societal or personal factors related to stigma and shame, embarrassment and not wanting to relive a traumatic event; a lack of awareness about the role of state medical boards and how to file complaints; or uncertainty that what has transpired is, indeed, unprofessional and unethical.

State medical boards can play an important role in providing clarity about the complaints process through the provision of information to the public about this process and how, why, and when to file a complaint. State medical boards can also restore public trust and confidence in this process by demonstrating appropriate action on verified complaints. The complaints process should also be accessible to patients with information about filing complaints that is clearly posted on state medical board websites. State medical boards, the FSMB and its partner organizations representing medical specialties whose members perform intimate examinations and procedures may also wish to provide education to patients about the types of behavior that should be expected of physicians, what types of behavior might warrant a complaint, what to do in the event that actions on the part of a physician make a patient uncomfortable, and circumstances that would warrant a report to law enforcement.

The ability to file a complaint anonymously may be especially important in instances of sexual misconduct, given the trauma and fear associated with sexual misconduct. These can serve as barriers to legitimate complaints, especially when anonymity is not granted.

Complaints related to sexual misconduct should be prioritized by state medical boards and addressed as quickly as possible for the benefit and protection of the complainant and other patients.

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

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

*Duty to Report*

In a complaint-based medical regulatory system, it is imperative that state medical boards have access to the information they require to effectively protect patients.[11] In addition to a robust complaints process, it is essential that patients, physicians and everyone involved in healthcare adopt a position of speaking up whenever something unusual, unsafe or inappropriate occurs. Institutions, including state medical boards, hospitals and private medical clinics also have a duty to report instances of sexual misconduct and other serious patient safety issues and events.

Early reporting of instances of sexual misconduct is critical, including reporting of those forms of misconduct at the less egregious end of the spectrum falling under potential grooming behaviors. Evidence exists which demonstrates that less egregious violations that go unreported frequently lead to more egregious ones. These egregious acts are almost always committed in private or after hours where they cannot be witness by parties external to the physician-patient encounter and therefore go unreported. Early reporting is therefore one of the only ways in which sexual abuse of patients can be prevented from impacting more patients.

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

Alternative strategies and approaches should be considered, rather than relying on professional or moral duties alone. State medical boards should have the ability to levy fines against institutions for failing to report instances of egregious conduct. While many states already have statutory ability to do so, they are reluctant to engage in legal proceedings with hospitals or other institutions with far greater resources at their disposal.

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

In situations where professional hierarchies exist and there are concerns about retaliation related to medical school matriculation, training positions, careers or promotions, reporting parties should be empowered to uphold professional standards in the interests of patients and the

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

profession. Cultivation of positive behavior through role modelling and clear guidance based on the values of the profession should be set by multiple parties, not the state medical board alone. A broader notion of professionalism should be adopted that goes beyond expectations for acceptable conduct to include a duty to identify instances of risk or harm to patients, thereby making non-reporting professionally unacceptable. Physicians who fail to report known instances of sexual misconduct should be liable for sanction by their state medical board for the breach of their professional duty to report.

Unscrupulous, frivolous or vexatious reporting motivated by competition is counterproductive to fulfilling this notion of professionalism and protecting the public, so it should be met with disciplinary action. Processes for reporting and complaints should be normalized by making them a collective, rather than individual, responsibility to help physicians feel less like investigators and more like responsible stewards of professional values. Those physicians and other individuals who do report in good faith should be protected from retaliation and given the option to remain anonymous.

State medical boards also have a duty to report egregious violations or instances of criminal behavior to law enforcement. When reporting requirements are unclear, consultation with a board attorney is recommended.

## Section 6: Investigations

*State Medical Board Authority*

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

Each complaint should be investigated and judged on its own merits. Where permitted by state law, the investigation should include a review of previous complaints to identify any such patterns of behavior, including malpractice claims and settlements. In the event that such patterns are identified early in the investigation, or the physician has been the subject of sufficient previous complaints to suggest a high likelihood that the physician presents a risk to future patients, or in the event of evidence supporting a single egregious misconduct event, the state medical board should have the authority to impose terms or limitations, including suspension, on the physician's license prior to the completion of the investigation.

The investigation of all complaints involving sexual misconduct should include interviews with the physician, complainant(s) and/or patient and/or patient surrogate. The investigation may

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

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

*Complainant Sensitivity to Investigation*

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

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

Where state medical boards have access to investigators of different genders, boards should seek the complainant's preference regarding the gender of investigators and assign them accordingly. State medical boards should also allow inclusion of patient advocates in the interview process and treat potential victims (survivors) with empathy, humanity, and in a manner that encourages healing. Questioning of both complainants and physicians should take the form of an information-gathering activity, not an aggressive cross-examination.

## Section 7: Comprehensive Evaluation

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

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

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

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

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

## Section 8: Hearings

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

*Initiation of Charges*

In assessing whether sufficient evidence exists to support a finding that sexual misconduct has occurred, corroboration of a patient's testimony should not be required. Although establishing a pattern of sexual misconduct may be significant, a single case is sufficient to proceed with a formal hearing. State medical boards should have the authority to amend formal charges to include additional complainants identified prior to the conclusion of the hearing process.

*Open vs Closed Hearings*

If state medical boards are required, by statute, to conduct all hearings in public, including cases of sexual misconduct, many patients may be hesitant to come forward in a public forum and relate the factual details of what occurred. State medical boards should have the statutory authority to close the hearing during testimony which may reveal the identity of the patient. The decision to close the hearing, in part or in full, should be at the discretion of the board. Neither the physician nor the witness should control this decision. Boards should allow the patient the option of having support persons available during both open and closed hearings.

*Patient Confidentiality*

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

*Testimony*

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

*Implicit Bias*

In any case that comes before a state medical board, it is important for those responsible for adjudicating the case to be mindful of any personal bias that may impact their review and adjudication. Bias can be particularly strong where board members themselves have been victims of sexual assault or have been subject to previous accusations regarding sexual misconduct. Training about implicit bias is recommended for board members and staff in order to help identify implicit bias and mitigate the impact it may have on their work.[12]

[12] Project Implicit, accessed November 13, 2019 at https://implicit.harvard.edu/implicit/

## Section 9: Discipline

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

Findings of even a single case of sexual misconduct are often sufficiently egregious as to warrant revocation of a physician's medical license. A physician's license should be automatically revoked if they are judged to have committed sexual assault, illegal activity, egregious acts of a sexual nature, or knowingly caused significant patient harm or the threat of harm. State medical boards should also consider revocation in instances where a physician has repeatedly committed lesser acts, especially following remedial efforts.

It is likely that any instance of sexual misconduct would provide sufficient grounds for revocation of licensure. However, in a limited set of instances, state medical boards may find that mitigating circumstances do exist and, therefore, stay the revocation and institute terms and conditions of probation or other practice limitations. In the event that the board makes a finding of sexual impropriety, the board may consider a less severe sanction than for a finding of sexual violation.

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

| Table 1: Considerations in determining appropriate disciplinary response | |
|---|---|
| • Patient Harm[13]<br>• Severity of impropriety or inappropriate behavior<br>• Context within which impropriety occurred<br>• Culpability of licensee<br>• Psychotherapeutic relationship<br>• Existence of a physician-patient relationship<br>• Scope and depth of the physician-patient relationship<br>• Inappropriate termination of physician-patient relationship | • Age and competence of patient<br>• Vulnerability of patient<br>• Number of times behavior occurred<br>• Number of patients involved<br>• Period of time relationship existed<br>• Evaluation/assessment results<br>• Prior professional misconduct/disciplinary history/malpractice<br>• Recommendations of assessing/treating professional(s) and/or state physician health program<br>• Risk of reoffending |

Boards should not routinely consider romantic involvement, patient initiation or patient consent a legal defense. A patient shall be presumed to be incapable of giving free, full, and informed consent to sexual activity with his or her physician.

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

The potential existence of a physician workforce shortage or maldistribution, or arguments related to particular restrictions being tantamount to taking a physician "out of work" should also not be used as reasons for leniency or for allowing patients to remain in harm's way. In cases involving sexual misconduct, it is simply not true that unsafe or high-risk care is better than no care at all. A single instance, let alone many instances, can cause an extremely high degree of damage to individuals and the communities in which they reside. However, staying true to the principle of proportionality also means considering the fact that some forms of discipline,

[13] Broadly understood as inclusive of physical and emotional harm, resulting distrust in the medical system and avoidance of future medical treatment, and other related effects of trauma.

including public notifications, generate significant shame upon the disciplined physician. This can compound the degree of severity of a disciplinary action and may be taken into consideration by state medical boards.

*Temporary or Interim Measures*:

In the event that a state medical board decides to remove a licensee from practice or limit the practice of a licensee as a temporary measure in order to reduce the risk of patient harm while an investigation takes place, there are several different interim measures that can be used. Common measures include an interim or summary suspension/cessation of practice, restrictions from seeing patients of a certain age or gender, restrictions from seeing patients altogether, or the mandatory use of a practice monitor (sometimes referred to as a chaperone) for all patient encounters.[14] The appropriateness of age and gender-based restrictions should be considered carefully before being imposed by state medical boards. Sexual misconduct often occurs for reasons related to power, rather than because of a sexual attraction to a particular gender or age group, thereby making these restrictions ineffective to protect patients in many cases. Boards should also consider whether a physician who is willing to commit acts of sexual misconduct involving a patient of any gender or age should be permitted to continue to treat patients, or whether their actions were sufficiently egregious and contrary to the principles of the profession to justify a restriction from seeing patients altogether. If gender-based restrictions are used by state medical boards, consideration may also be given to coupling these restrictions with additional regulatory interventions such as education, monitoring or other forms of probation.

*Remediation*

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

The members of the workgroup acknowledge that shortcomings exist in the current evidence base regarding the effectiveness of remediation in instances of sexual misconduct. The model for remediation proposed in this report is, therefore, extrapolated from the generally accepted model for addressing gaps in knowledge and performance[15] and applied to the context of sexual misconduct, which may not be the ideal model. The workgroup feels that further research is needed in this area.

In determining whether remediation is feasible for a particular physician, state medical boards may wish to make use of a risk stratification methodology that considers the severity of actions committed, the mitigating and aggravating factors listed in section 9 above (Discipline), the character of the physician, including insight and remorse demonstrated, as well as an

[14] Please refer to the discussion about practice monitors and chaperones below.
[15] Hauer, et al. Remediation of the Deficiencies of Physicians Across the Continuum from Medical School to Practice: A Thematic Review of the Literature, *Acad Med*, Vol. 84, No. 12 / December 200.9

understanding of why their actions were morally wrong, and the perceived likelihood that they may reoffend. The consequences to patients and the general public of allowing a physician to engage in remediation and re-enter practice after a finding of sexual misconduct should be considered, including any erosion of the public trust in the medical profession and the role of state medical boards.

The goals of the remediation process should be clearly outlined, including expectations for acceptable performance on the part of the physician. The process of remediation should relate to the physician's offense and be targeted to identified gaps in understanding of their particular vulnerabilities and other risks for committing sexual misconduct. Assessment and remediation partners should therefore be provided access to investigative information in order to properly tailor remedial education to the particular context in which the misconduct occurred. Finally, state medical boards should be mindful that remediation cannot typically be said to have "occurred" following successful completion of an educational course. Rather, a longitudinal mechanism should be established for maintaining the physician's engagement in a process of coming to terms with their misconduct and avoiding the circumstances that led to it.

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

*License Reinstatement/Removal of License Restriction(s)*

In the event of license revocation, suspension, or license restriction, any petition for reinstatement or removal of restriction should include the stipulation that a current assessment, and if recommended, successful completion of treatment, be required prior to the medical board's consideration to assure the physician is competent to practice safely. Such assessment may be obtained from the physician's treating professionals, state physician health program (PHP),[16] or from an approved evaluation team as necessary to provide the board with adequate information upon which to make a sound decision.

*Transparency of board actions:*

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

[16] "A Physician Health Program (PHP) is a confidential resource for physicians, other licensed healthcare professionals, or those in training suffering from addictive, psychiatric, medical, behavioral or other potentially impairing conditions. PHPs coordinate effective detection, evaluation, treatment, and continuing care monitoring of physicians with these conditions." Source: Federation of State Physician Health Programs.

The public availability of sufficient facts to justify a regulatory decision and link it to a licensee's behavior and the context in which it occurred can help state medical boards to explain and justify their decision.

The ability to disclose particular details of investigative findings and disciplinary actions is limited by state statute in many jurisdictions. State medical boards are encouraged to convey this fact to the public in order to protect the trust that patients have in boards, but also make efforts to achieve legislative change, allowing them to publicize information that is in the public interest. Where disclosure is possible, boards should select means for conveying information that will optimally reach patients. This should include making information available on state medical board websites and reporting to the FSMB Physician Data Center, thereby also making information about disciplinary actions publicly available through FSMB's docinfo.org website, and the National Practitioner Data Bank. Boards should also consider additional means of communicating, such as through mobile phone applications,[17] notices in newspapers and other publications. California and Washington both require that patients be notified of sexual misconduct license stipulations/restrictions at the time of making an appointment and that the patient verify this notification.

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

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

## Section 10: Monitoring

Following a finding of sexual misconduct, if a license is not revoked or suspended, it is essential that a state medical board establish appropriate monitoring of the physician and their continued practice. Monitoring in the context of sexual misconduct occurs differently from monitoring substance use disorders and the resources available to boards differ from state to state. Many PHPs do not offer monitoring services for physicians who have faced disciplinary action because

[17] The Medical Board of California has launched a new mobile application allowing patients to receive updates about their physician, including licensure status and practice location.

of sexual misconduct and even where such monitoring by a PHP is possible, it is typically only part of a way forward, rather than a solution on its own.

For the purposes of this report, the members of the workgroup understand the use of a *chaperone* as an informal arrangement of impartial observation, typically initiated by physicians themselves. A chaperone in this context is meant to protect the doctor in the event of a complaint, although their presence may also offer comfort to the patient.[18] The patient may request that the chaperone not be present for any portion of the clinical encounter. The workgroup acknowledges that the use of chaperones has been discontinued in some international jurisdictions and by particular state medical boards, because of a belief that they merely provide the illusion of safety and may therefore allow harmful behaviors to go unnoticed. There is risk of this occurring in instances where a chaperone is untrained or uninformed about their role, is an employee or colleague of the physician being monitored or does not adequately attend to their responsibilities.

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

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

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

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

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

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

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

**Table 2: Possible Conditions of Practice Following a Finding of Sexual Misconduct**

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

## Section 11: Education

Education and training about professional boundaries in general and physician sexual misconduct in particular should be provided during medical school and residency, as well as throughout practice as part of a physician's efforts to remain current in their knowledge of professional expectations. This should include education about the prevalence of victimization and abuse in the general population and the fact that more than half of patients who are exploited sexually by physicians have been exploited before. State medical boards and the FSMB should take a proactive stance to educate physicians, board members and board staff about sexual misconduct and the effects of trauma. Members of state medical boards and those responsible for adjudicating cases involving sexual misconduct can also experience trauma. Education for dealing appropriately with traumatic elements of cases and finding appropriate help and resources would also be valuable for board members.

Education and training should include information about professionalism and the core values of medicine; the nature of the physician-patient relationship, including the inherent power imbalance and the foundational role of trust; acceptable behavior in clinical encounters; and methods of reporting instances of sexual misconduct. For both medical schools and residency

programs, this education and training should also include tracking assessment across the curriculum, identification of deficiencies in groups and individuals, remediation, and reassessment for correction, appropriate self-care, and the potential for developing psychiatric illness or addictive behaviors. Early identification of risk for sexual misconduct and unprofessionalism is central to public protection and maintaining public trust.

For practicing physicians, because of lack of education or awareness, physicians may encounter situations in which they have unknowingly violated the medical practice act through boundary transgressions and violations. A reduction in the frequency of physician sexual misconduct may be achieved through education of physicians and the health care team.

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

State medical boards should develop cooperative relationships with state physician health programs, state medical associations, hospital medical staffs, other organized physician groups, and medical schools and training programs to provide physicians and medical students with educational information that promotes awareness of physician sexual misconduct. This information should include a definition of physician sexual misconduct, what constitutes appropriate physician-patient boundaries, how to identify and avoid common "grooming" behaviors, and the potential consequences to both the patient and the physician when professional boundaries are not maintained. Physicians should be educated regarding the degree of harm patients experience as a result of sexual misconduct.

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

## Section 12: Summary of Recommendations

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

The recommendations in this section include specific requests of individual entities, as well as general ones that apply to multiple parties, including state medical boards, the FSMB and other relevant stakeholders. The Workgroup felt strongly that effectively addressing physician sexual

misconduct requires widespread cultural and systemic changes that can only be accomplished through shared efforts across the medical education and practice continuum.

**Culture:**

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

**Transparency:**

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

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

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

5. The means of conveying information to the public about medical regulatory processes, including professional expectations, reporting and complaints processes, and available resources should be carefully examined to ensure maximal reach and impact. New means of communicating should be considered, including through medical board and physician practice websites; as part of the scheduling and registration process for appointments; via mobile apps and other media. These should be considered in addition to traditional media such as print and online.

**Complaints:**

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

patient uncomfortable, and circumstances that would warrant a report to law enforcement.

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

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

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

**Reporting:**

10. State medical boards should have the ability to levy fines against institutions for failing to report instances of egregious conduct.

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

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

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

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

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

**Investigations:**

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

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

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

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

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

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

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

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

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

**Comprehensive Evaluation:**

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

**Hearings:**

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

**Discipline:**

27. A physician's license should be automatically revoked If they are found to have committed sexual assault, illegal activity, egregious acts of a sexual nature, or knowingly caused significant patient harm or the threat of harm. State medical boards should also consider revocation in instances where a physician has repeatedly committed lesser acts, especially following remedial efforts.

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

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

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

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

32. Following remedial activities, state medical boards should monitor physicians to ensure that they are actively avoiding circumstances that led to their sexual misconduct.

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

**Education:**

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

35. State medical boards and the FSMB should provide education to physicians, board members and board staff about sexual misconduct and the effects of trauma. This should include resources to help physicians develop better insight into their own behavior and its impacts on others. Resources and materials should be developed in collaboration with

state physician health programs, state medical associations, hospital medical staffs, other organized physician groups, and medical schools and training programs.

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

37. The FSMB, state medical boards, medical schools, residency programs, and medical specialty and professional societies should provide renewed education on professionalism and the promotion of professional culture.

## Appendix A: Sample Resources

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

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

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

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