Report of the FSMB Workgroup on Physician Sexual Misconduct

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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

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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.

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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.

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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.

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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.

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[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.

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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

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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.

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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

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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.

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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.

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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/

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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**.

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

Boards should not routinely consider romantic involvement, patient initiation or patient consent 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.

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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

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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.

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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.

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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.

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- 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**.

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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

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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

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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

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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.

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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.

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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

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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.

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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

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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)

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