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Sexual Misconduct Allegations:

Liability, Ethics, and Professionalism

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Sexual Misconduct Allegations:

Liability, Ethics, and Professionalism

INTRODUCTION

Between 2000 and 2019, there were a total of 1,721 reports of physician sexual misconduct to the National Practitioner Databank. That represents an average annual incidence of 10.78 per 100,000 U.S. physician licensees. (The true extent of such misconduct remains uncertain due to the assumption that it occurs more frequently than it is reported.)[1]

According to one of the founders of the New Jersey Board of Medical Examiners' remedial education programs, a majority of licensees referred to the program because of sexual misconduct violations had not exhibited predatory or addictive sexual behavior. Instead, the physician and patient acted on a mutual attraction, and the complaint was triggered by the demise of the relationship, not the relationship itself.[2] Many physicians referred for sexual misconduct violations are uncertain of the extent of the sexual boundary rules to which they are subject.[3] Education on ethical and legal concepts associated with physician-patient sexual boundaries is a probable means, therefore, of reducing the risk of violations to some extent, which is an objective of this article.

The prohibition of physician-patient sexual misconduct extends at least as far back in history as the Hippocratic Oath (fifth century BC): "In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction, and especially from the pleasures of love with women or with men."[4] The Hippocratic Oath raises important points: Sometimes physicians have sexual feelings toward patients; however, it is up to the physician to keep those feelings from becoming sexual misconduct. The central role of a physician's judgment and self-regulation in these matters has been around for a very long time.

Judgment and self-regulation, however, has failed some physicians in shocking and highly publicized ways (consider, for example, Larry Nassar, George Tyndall, and Robert Hadden). These high-profile cases likely have sensitized many patients to sexual boundary issues surrounding the physician-patient relationship. Cases like these, and victim empowerment movements such as #MeToo, are likely resulting in an increase in patient lawsuits, medical board disciplinary actions, and criminal actions for real or perceived physician sexual misconduct.[5] Public pressure is also likely to result in physicians being held to higher professional boundary standards than they might have been in the past.[6] For example, the Federation of State Medical Boards (FSMB) updated its policy statement on sexual misconduct in May 2020, in which it calls for "shared regulation" that includes addressing sexual misconduct through "meaningful disciplinary action and law enforcement when required."[7] A strategy highlighted to achieve greater regulation is physician reporting of colleague misconduct. Consequently even those physicians who would not consider engaging in sexual misconduct with a patient must be able to recognize it in others.

A different type of sexual misconduct allegation results from patient misinterpretation of procedural touch. Closed claims analysis undertaken for this article indicates that these claims are more often dismissed early in litigation without indemnity payment when medical record documentation and chaperone use provide evidence that the procedural touch was, in fact, appropriate. Risk reduction strategies are provided throughout this article to help reduce the risk of misunderstandings and increase defensibility when these allegations are made.

Medical Treatment of a Former Intimate Partner

Like many claims involving allegations of sexual misconduct based on a sexual relationship between a patient and physician, the closed claim that forms the basis for the first case study in this article included testimony about lascivious, salacious details that were inconsistently reported among witnesses and parties to the lawsuit. The plaintiff patient attempted to portray the defendant physician as a sexual deviant who traded opioids for sex during the physician-patient relationship. According to the defendant physician, he and the patient had a consensual sexual relationship that terminated prior to the commencement of the physician-patient relationship, during which time they remained friends. A good outcome for the defense would require a jury to believe the physician's version of the events. They would also have to agree with the defense team that entering into a physician-patient relationship with a former intimate partner is not a violation of the standard of care. Another challenge for the defense team would be proving the employer had no knowledge of alleged sexual misconduct and, therefore, had no duty to intervene and stop it.

Consider the different legal and ethical issues each party would have encountered as they became aware of the patient's allegations.

CASE ONE

Allegations: 1) The defendant physician engaged in sexual misconduct with the plaintiff patient during the physician-patient relationship, resulting in the patient's emotional injuries that would require future psychological care; and 2) the defendant's employer was aware of his misconduct but failed to notify appropriate authorities.

FACTS NOT IN CONTENTION

The plaintiff and defendant had a friendship that became intimate in approximately 2016. In July 2019 the defendant began treating the plaintiff at the rheumatology practice where the defendant was employed. The plaintiff's last appointment with the defendant was on September 7, 2020. On September 20, 2020, the plaintiff's psychiatrist informed the medical board that the plaintiff had reported the defendant's sexual misconduct to him during counseling sessions. The defendant was asked to leave the rheumatology practice on September 23, 2021, when the lawsuit was served.

Five years earlier a different patient had accused the defendant of engaging in sexual activity with him. The defendant settled the claim with his own funds, did not report the claim to his employer or his insurer, and no lawsuit resulted.

DISCUSSION

Based on the facts that were not in contention, the physician's defense team would argue the treatment of a patient with whom one has had sexual relations is not negligent and does not constitute sexual misconduct. The practice's defense team would argue, even if sexual misconduct occurred, the employer had no knowledge of it and, therefore, had no duty to intervene.

WAS THERE SEXUAL MISCONDUCT?

The determination of whether sexual misconduct occurred would depend on who the jury believed. According to the plaintiff's testimony, he and the defendant had an intimate relationship that started before he became a patient and continued throughout the time the defendant treated him. Although the relationship began consensually, it became a relationship where he exchanged sex for opioid medications. The plaintiff believed he could have resisted the sexual advances if he had not been medicated.

In support of his argument that sexual misconduct did not occur, the physician defendant testified that the sexual relationship with the patient terminated prior to the initiation of the physician-patient relationship. He admitted he and the patient remained friends following their intimate relationship, and they socialized outside of the practice during the physician-patient relationship. Although the defendant described a friendship, the plaintiff described his status with the defendant as "dating." The plaintiff marked no difference in their relationship before and during the physician-patient relationship. The American Medical Association (AMA) provides good advice for a physician entering a physician-patient relationship with a friend who happens to be a former intimate partner: "In keeping with a physician's ethical obligations to avoid inappropriate behavior, a physician who has reason to believe that nonsexual, nonclinical contact with a patient may be perceived as or may lead to romantic or sexual contact should avoid such contact."[8] Consequently, the arrangement admitted by the defendant was arguably not ethical, but probably fell short of sexual misconduct. The defense would advance a theory that the plaintiff mistakenly believed there was an ongoing romantic relationship. After he discovered the defendant was married, he became angry and set out to punish the defendant with fabricated sexual misconduct allegations.

The American Medical Association (AMA) provides good advice for a physician entering a physician-patient relationship with a friend who happens to be a former intimate partner: "In keeping with a physician's ethical obligations to avoid inappropriate behavior, a physician who has reason to believe that nonsexual, nonclinical contact with a patient may be perceived as or may lead to romantic or sexual contact should avoid such contact."[8]

The plaintiff alleged he and the defendant engaged in sexual activity in the examination room and at his home following injections of meperidine. However, there was no evidence of anything out of the ordinary in the patient's treatment records or the practice's medication supplies. According to the patient's record, the defendant regularly ordered meperidine injections for pain relief when the patient presented for appointments. Pursuant to office policy, nurses administered all medications. The physician did not have access to the cabinet where opioids were stored. Records indicated the medication counts were accurate during the time the defendant treated the plaintiff. Furthermore, according to a toxicology consultant, the meperidine ordered by the defendant would not have disabled the patient to the extent that he would be unable to deflect the defendant's alleged sexual advances. These discoveries indicated the plaintiff would have difficulty proving his sex-for-drugs allegations. Despite problems with the plaintiff's case, the defendant decided adverse publicity would irreparably damage his reputation. He therefore requested settlement of the case. The medical board later disciplined the defendant, but he eventually returned to practice.

DID THE EMPLOYER KNOW ABOUT THE DEFENDANT'S ALLEGED SEXUAL INVOLVEMENT WITH THE PLAINTIFF?

If the defense could establish the employer had no knowledge of any alleged sexual misconduct, chances were good the employer could be dismissed from the lawsuit. The chief executive officer (CEO) testified that neither he nor any other member of the leadership team had notice of the defendant's alleged sexual misconduct. Deposition testimony by the CEO was called into question when a physician employee testified that she had informed the CEO of the patient's complaints about the defendant's sexual advances toward him. An employee nurse also testified that she reported to the head of human resources what the plaintiff told her about the defendant's unwanted sexual advances during office visits, and that they were engaged in a drugs-for-sex arrangement. Because of the inconsistencies in testimony, and his belief that it would be difficult to prevail in a sexual misconduct case during the height of the #MeToo movement, the CEO requested settlement of the claims against the practice.

In addition to employer duties associated with maintaining a safe environment for patients, the duty to report sexual misconduct is a standard element of some state medical practice acts, and the FSMB has called on state medical boards to include it in regulations.[7,9] The physician to whom the patient reported the defendant's alleged misconduct was obligated by the state medical practice act and ethical guidelines to report the defendant for sexual misconduct. It is unlikely that her report to her employer, without confirmation that her employer then reported the misconduct to the medical board, would have satisfied that duty.

IS AN ETHICAL VIOLATION A BREACH OF THE STANDARD OF CARE?

Physician consultants had conflicting opinions about whether an intimate relationship with a patient violated the standard of care. There was consensus that there was a fiduciary relationship between the plaintiff and defendant, and that an intimate relationship between a physician and patient was a violation of ethical standards. There also was agreement that an ethical violation was not automatically a breach of the standard of care. One expert thought two consenting adults who were in a physician-patient relationship could maintain a romantic relationship without violating the standard of care. However, this expert also believed repeated and unwanted sexual contact (as the plaintiff alleged) would be a breach. Another expert believed it was a breach of the standard of care, even when the patient was a consenting participant. Notably, the defendant physician testified that in his opinion it was not a breach of the standard of care for a physician to have a sexual relationship with a patient, so long as it was consensual.

The dual nature of treating a friend or former intimate partner can interrupt clinical objectivity and complicate various ethical principles, including beneficence and nonmaleficence, autonomy, and fidelity.

At trial the plaintiff was expected to provide the AMA (and other professional society) ethical guidelines, the FSMB policy on physician sexual misconduct, and the defendant's practice state medical practice act, which all prohibited sexual relationships during the physician-patient relationship, to show an intimate relationship with a patient is a violation of the standard of care. (Some courts accept ethical rules as the standard of care and use them to determine professional responsibility, while other courts consider them mere suggestions.)[10]

Ethical and legal requirements aside, ending an intimate relationship with a former or current patient can be tricky due to the unique potential retaliatory measures available to patients. Unlike typical rejected intimate partners, patients can retaliate against their physicians by filing sexual misconduct reports with the medical board and police, or by filing a malpractice lawsuit. Even when the intimate relationship and patient relationship do not overlap (e.g., a former partner wants to be a patient or a former patient wants to be a partner), it is important to carefully consider and probably avoid one or the other relationship. The dual nature of treating a friend or former intimate partner can interrupt clinical objectivity and complicate various ethical principles, including beneficence (doing what's right for the patient) and nonmaleficence (doing no harm), autonomy, and fidelity.[11,12] As the experts and defendant argued in this case, the fact that physician behavior is unethical does not make it below the standard of care. However, behaviors that create ethical dilemmas can increase the risk of injury,[13] which increases professional liability risk.

RISK REDUCTION STRATEGIES

Consider the following strategies:[14,15]

- Understand and follow ethical guidelines on intimate relationships with former, present, and future patients.
- Understand and follow the medical practice act in the jurisdiction where you practice as it relates to intimate relationships with former, present, and future patients.
- Avoid clinical or nonclinical contact a patient may perceive as a romantic or sexual overture.
- Avoid sexual innuendo, sexually suggestive humor, and sexually provocative remarks in professional settings.
- Refer friends and former intimate partners to other clinicians. If treatment is necessary, make every effort to treat them with the same professional judgment used for other patients, for example, by taking adequate histories, performing thorough physical examinations, providing counseling on sensitive issues, and keeping appropriate medical records.
- Use caution when engaging in nonclinical communication with current patients, including interactions by telephone, email, text messaging, or social media.
- If a romantic relationship with a patient cannot be avoided, and it is allowed by state law, formally terminate the therapeutic relationship before the romantic relationship begins.
  - ► Follow any state laws that set a waiting period between termination of the therapeutic relationship and commencement of an intimate one.
- Use a chaperone. (See additional recommendations about chaperone use below.)

ADDITIONAL RESOURCES

AMA: Romantic or Sexual Relationships with Patients[8]
Code of Medical Ethics Opinion 9.1.1

AMA: Sexual and Romantic Boundary Violations[16]
CME course available at no cost to AMA members that explores why romantic and sexual interactions between physicians and patients undermine trust in the patient-physician relationship

FSMB: Physician Sexual Misconduct: Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct[7]
Policy statement summarizing sexual misconduct issues in medical practice and education with potential solutions and strategies for state medical boards to consider for their jurisdictions

EMPLOYER LIABILITY

Preventing Employee Sexual Misconduct

While the specific definition may vary by state, in the most general sense vicarious liability allows an injured patient to hold a third party financially responsible for the negligence of the person who caused the injury. In malpractice litigation vicarious liability is most frequently associated with an employment relationship. The healthcare employer (e.g., hospital, clinic, group, sole practitioner physician) is deemed vicariously liable for patient injuries caused by the negligence of an employee (e.g., clinical staff member, advance practice professional, physician). Although healthcare employers are generally not vicariously liable for the sexual misconduct of employees, they can be directly liable for negligent hiring, supervision, or retention when a clinician or staff member's criminal behavior results in an injury to a patient.[17]

Consider the following recommendations:

- Independently validate all details of any clinician or staff applicant's qualifications, licensure, and credentials; check references; question and reconcile all gaps in employment history; and perform a comprehensive criminal background check.
- Create a workplace culture that conveys a zero-tolerance policy for sexual misconduct.
- Establish a chaperone policies and protocols. (See additional recommendations below.)
- Create sexual misconduct reporting protocols that cover reports about staff/clinician coworkers and complaints by patients.
- Standardize sexual misconduct investigation procedures.
  - Provide training to individuals who are responsible for investigating allegations of sexual misconduct.
  - Create guidelines for documenting findings.
- Educate clinicians and staff about what behaviors constitute sexual misconduct, the importance of reporting these behaviors, and how to report them.

PROFESSIONAL LIABILITY INSURANCE POLICIES

Sexual Misconduct Exclusions

Professional liability coverage for sexual misconduct claims is limited, as it is usually subject to common exclusions in the policy. As an effect of the exclusions, some policies will not pay for damages and will not be obliged to provide a defense for a suit or claims alleging sexual activity, or acts in furtherance of sexual activity, including when they occur under the guise of professional services. However, some policies will defend such claims with various limitations until the insured is adjudicated to have committed or pleads guilty to the excluded act, at which point the insurer's involvement ceases.

Insureds should always refer to their particular policy for the specific language and exclusions therein.

Procedural Touch Misunderstandings

Allegations of sexual misconduct often involve patient misunderstanding of procedural touch. Routine examinations can be distressing to patients who are not prepared for them, or who may have a history that makes them particularly sensitive. Physicians cannot assume patients understand the necessity, location, and extent of procedural touch. To avoid any misunderstandings, particularly when an intimate area must be touched, a running explanation as the examination progresses is wise.[18,19,20]

In the following claim, after what a family physician (FP) considered an uneventful annual well visit that included cervical cancer screening, the patient made a police and medical board report and filed a medical liability lawsuit. Consider how better physician-patient communication might have changed the outcome.

CASE TWO

Allegation: **The defendant forcefully inserted a speculum into the patient's vagina without warning or consent, causing physical and psychological trauma resulting in permanent injuries.**

A 25-year-old woman presented to an FP for a well visit. She had an extensive behavioral health history. Her history was also significant for never having had sexual intercourse or cervical cancer screening. During the physical exam, the FP took a Pap specimen. He documented the presence of a chaperone and a normal examination.

One month later the patient requested a meeting with the office manager to discuss her suspicion that the cervical screening had injured her. She explained to the office manager that the examination had caused excruciating pain, which continued to that day. She was very agitated. The office manager advised her that a routine screening did not explain her ongoing symptoms, and that she should make an appointment with an OB/GYN to be further examined. After a lengthy discussion, the patient agreed with this plan, and seemed calm and otherwise satisfied when she left the office.

The next week the patient filed a police report and medical board report alleging she had been sexually assaulted by the FP. She alleged that during the encounter, while she was being held down by two nurses, the FP inserted a medical instrument inside her vagina without warning, consent, or explanation. After investigators interviewed the chaperone and physician, the police determined there was no wrongdoing and no charges were brought. Similarly the medical board found no probable cause of a violation, and the matter was closed.

The patient also filed a malpractice claim against the FP and his employer. The factual scenario described by the patient was similar to that described in the other legal actions she filed, but instead of sexual misconduct, the patient alleged that the methods and pressure the defendant used during the cervical cancer screening violated the standard of care and caused her ongoing pain and emotional distress.

DISCUSSION

The police and medical board report focused on allegations of sexual misconduct. The malpractice action, on the other hand, was based on the allegedly negligent manner in which the cervical cancer screening was conducted. The defense team surmised that the patient avoided allegations of intentional sexual misconduct in the medical liability action as a strategy to keep the employer in the case for vicarious liability damages, and to avoid triggering exclusionary language in the defendant's professional liability policy.

Documentation, appropriate chaperone policies and protocols, and a well-trained chaperone were instrumental in the defense of this case.

Although the FP had no independent recollection of the patient, the medical record indicated the examination was standard in all respects. Despite not being documented, it would have been his standard practice to explain the reason for the screening and obtain consent to conduct it. If the patient had made complaints of pain or trauma, it would have been his practice to document it. In addition to the physician's documentation of a chaperone's presence, the chaperone would testify that the standard protocol in the office was for her to be present during the entire time the physician was conducting a cervical cancer screening. Documentation, appropriate chaperone policies and protocols, and a well-trained chaperone were instrumental in the defense of this case.

The lawsuit was eventually abandoned.

RISK REDUCTION STRATEGIES

The patient distress in this case might have been avoided or mitigated with a more effective patient education process for the cervical cancer screening, including the necessity, location, and extent of procedural touch. Consider the following strategies:[14,21]

- Consider each patient's unique tolerance of procedural touch.
- If the patient seems overly anxious, attempt to discover and address the cause.
- Offer patients the opportunity to ask questions or raise concerns about any element of the examination.
- Before procedural touch, explain what you will be doing.
- Do not consider patient silence as consent for procedural touch.
  - ► When indicated or required by state law, obtain written consent for pelvic exams.
- Take the time to educate patients on the U.S. Preventive Services Task Force screening recommendations[22] applicable to their age. If patients decline any aspect of an exam required to follow the standard of care, ensure an informed refusal is well documented.
- Inform patients that examinations can be stopped at any time, and stop the examination if the patient requests it.
- During procedural touch, explain how your touch relates to its clinical purpose, particularly when intimate areas are involved.
- Use only the amount of physical contact necessary for diagnosis and treatment.
- Remain vigilant for patient signs of discomfort (e.g., the patient pulls away when touched).

Incidental Touching of a Patient's Breasts

Many sexual misconduct claims arise from a physician's incidental contact with a patient's breasts. Sexual misconduct allegations in closed claims have been supported by physicians moving the patient's breasts to place EKG leads; examining lymph nodes in the armpits; listening to the patient's heart with the stethoscope in a manner that cups the patient's breast at some point; and moving the breasts aside to assess for costochondritis, which is what occurred in the following case study. Consider how the outcome of the following encounter might have been different if a chaperone had been in the room, the physician had explained his technique and the necessity of handling the patient's breasts as part of his exam, and/or the physician had been more sensitive to the patient's need for privacy and respect.

CASE THREE

Allegation: The physician handled the patient's breasts for his own sexual gratification.

A 30-year-old woman with very large breast implants presented to an FP for chronic chest pain. After hearing the patient's description of symptoms, the FP suspected the patient's chest pain was caused by costochondritis. He explained that in order to evaluate her, she would need to completely disrobe above the waist. When she had removed her shirt and bra, he attempted to evaluate her costosternal and costochondral joints, but had difficulty doing so

because of the patient's breasts. The FP then asked the patient to hold her breasts out of the way so he could complete his evaluation. He ultimately determined that the patient did not have costochondritis and concluded the patient's chest discomfort was most likely due to anxiety. He shared his diagnosis and a treatment plan with the patient and turned to his computer to enter his findings in the medical record while she dressed. He did not request or offer a chaperone prior to the evaluation, did not offer to leave the room while the patient disrobed, did not offer a gown, and did not allow the patient to dress privately.

The patient later sued him, alleging he had handled her breasts for his own sexual gratification.

DISCUSSION

Assuming nothing untoward happened (this case was ultimately dismissed), this case is an excellent example of why physicians should heed the advice of AMA Code of Medical Ethics Opinion 1.2.4 on the issue of respecting patient dignity and using chaperones: "Efforts to provide a comfortable and considerate atmosphere for the patient and the physician are part of respecting patients' dignity. These efforts may include providing appropriate gowns, private facilities for undressing, sensitive use of draping, and clearly explaining various components of the physical examination. They also include having chaperones available. Having chaperones present can also help prevent misunderstandings between the patient and physician."[23]

RISK REDUCTION STRATEGIES

A balance must be struck between providing an appropriate medical examination and accommodating a patient who is perhaps especially sensitive to having her breasts touched. The risks of false allegations of sexual misconduct can be reduced by offering a chaperone, avoiding unnecessary contact with a patient's breasts, being generally aware of patient sensitivity to breast contact, adjusting (to the extent possible) techniques more likely to cause distressing breast contact, explaining the necessity of breast contact during appropriately performed exams, and otherwise supporting patient modesty by considering the following strategies:[23,24,25]

- Use an individualized approach to intimate examinations, considering the patient's vulnerability, and potential apprehension, fear, and embarrassment.
- Communicate the office chaperone policy to patients who are asked to disrobe.
- Explain the purpose of disrobing, when doing so may not be obvious to a layperson.
- Do not ask the patient to disrobe in your presence.
- Give clear instructions about which articles of clothing the patient should remove, and which should remain on.
  - ► Tell the patient where to place/store removed clothing, which can help put them at ease and help avoid allegations that the clinician or staff improperly handled undergarments.
- Provide the patient with a gown, sheet, and/or other appropriate apparel.
  - ► Offer a gown that will provide appropriate coverage (not too big or small) and direct the patient to use the fasteners or ties to close the gown.
- When a reasonable time has passed for the patient to disrobe and drape, knock on the examination room door to announce your reentry into the examination room and wait for a response.
- Introduce the chaperone.
- Wear gloves during examinations.
- Be alert to possible misunderstandings.
- Ask yourself what a neutral outsider would say while observing your conduct.
- At the conclusion of the examination, leave the room and allow the patient adequate time to dress.
- Tell patients what they should do after dressing.
- Document when chaperones are present during the examination, including their full name and job title.

CHAPERONE USE

Policies and Procedures

There is no standard definition for a medical chaperone. As to who can be a chaperone, the AMA Code of Medical Ethics Opinion 1.2.4 requires only that a chaperone be "an authorized member of the health care team."[23] Despite this broad qualification statement, individuals serving as chaperones should be trained to the extent necessary to understand their role and responsibilities, to understand what a legitimate examination entails, and to recognize when clinician behavior has become inappropriate.[24]

Chaperone use can serve dual purposes: It protects patients by discouraging clinicians who are tempted to act on sexual feelings, and it protects clinicians from false allegations of sexual misconduct by providing a witness who can testify to a clinician's appropriate behavior.

RISK REDUCTION STRATEGIES

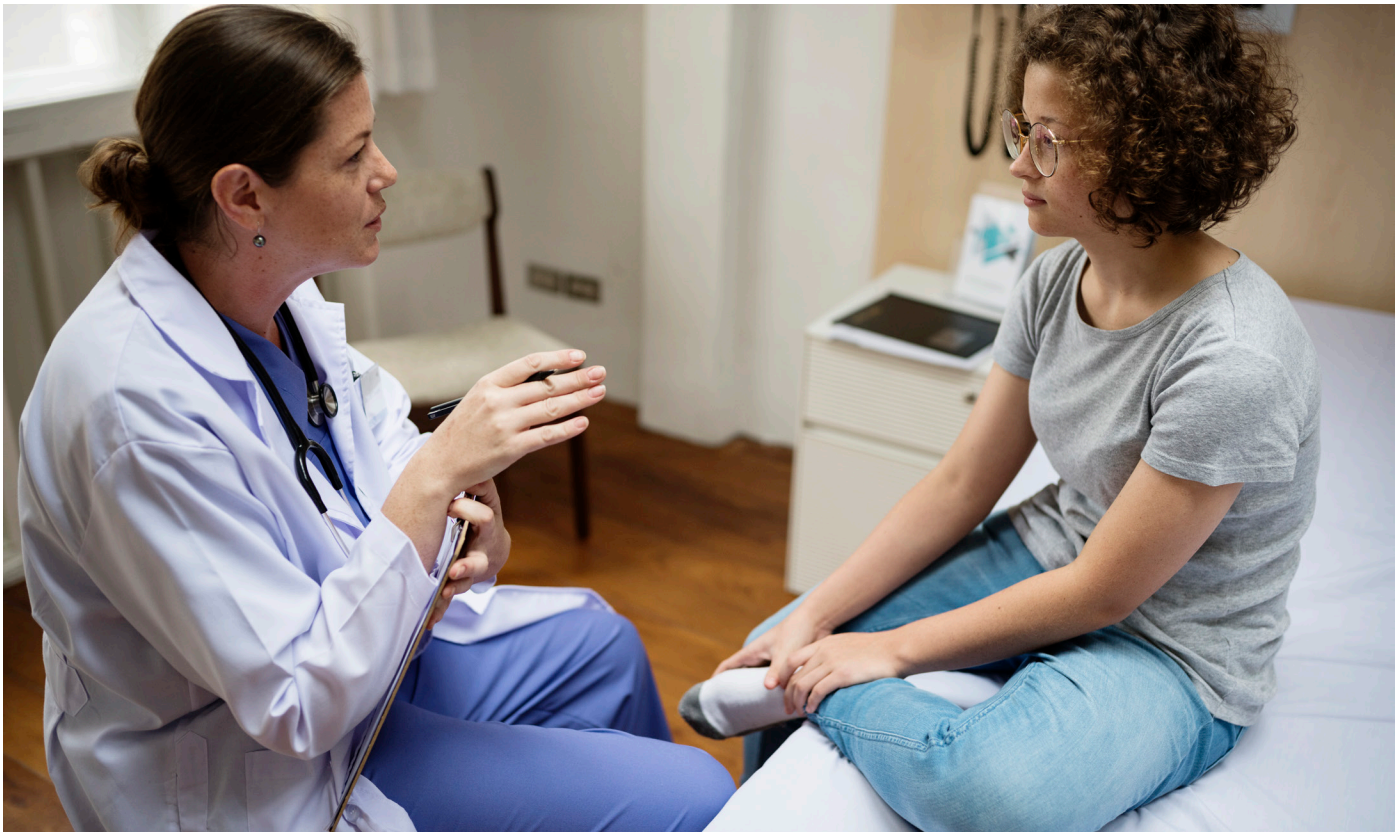
Chaperone policies and procedures can help clinicians and staff determine when chaperones should be offered to patients and the role chaperones serve in the examination process. However, policies and protocols are only effective if they are consistently applied: Some claims involve sexual misconduct allegations arising from an encounter during which an existing chaperone policy was not followed. Consider including the following elements in chaperone policies and protocols:[25]

- Describe how the availability of chaperones will be communicated to patients.
  - Place posters and printed materials in conspicuous locations in waiting rooms and exam rooms, and in patient education packets.
- Identify patients who should be offered a chaperone.
  - Include special directions for pediatric patients.
- List procedures for which chaperones are required.
  - Require chaperones for sensitive examinations.
  - Offer a chaperone for any examination when requested by the patient.
- Explain the process for managing a patient's refusal of a chaperone, including documentation.
- Describe chaperone roles, responsibilities, protocols, and training requirements.
- Explain clinician responsibilities, including documentation of the presence, name, and title of the chaperone in the medical record.
- Set forth methods for monitoring the effectiveness of the chaperone policy.

ADDITIONAL RESOURCES

University of Michigan Health, Michigan Medicine: The Use of Chaperones During Sensitive Examinations and Procedures[24] and **Johns Hopkins Medicine:** Chaperone Policy[26]
Examples of chaperone policies

ProAssurance: Professionalism in Medical Examinations[27]
Two-minute "What's the Risk?" video outlining a chaperone policy



Palpation of External Genitalia in an Adolescent Patient

In many closed claims involving allegations of sexual misconduct based on procedural touch misunderstandings, an examination of an intimate body area took place for a condition a patient might not recognize as being connected to the intimate area. Examples include a breast examination at a hematology appointment, an armpit lymph node examination in a patient with insect bites or, in the following case, palpation of the external genitalia of a 13-year-old girl who presented with flu symptoms. Consider how better communication and the offer of a chaperone could have changed the outcome in the following case.

CASE FOUR

Allegation: It was improper for the physician to perform an external genital examination on an adolescent girl without a chaperone.

A 13-year-old girl presented to an urgent care with her father. She reported worsening flu-like symptoms and had a 103-degree temperature. The physician informed the patient and her father that he wanted to perform a thorough examination. They both consented. No chaperone was offered; however, the father was present during the entire examination.

The physician proceeded with an ungloved examination in a head-to-toe fashion. The overall physical examination included gross examination of mucous membrane surfaces of the eyes, nasopharynx, oropharynx, and external genitalia. No speculum or bimanual examinations were performed, no vaginal cultures were obtained, and the patient was not placed in stirrups or the lithotomy position.

Later that day the patient's mother called to ask why a female chaperone was not present during the genital examination. She then filed a complaint with the county sheriff's department. Although the district attorney's office ultimately determined there was insufficient evidence to file a criminal action against the physician, he was asked to stop seeing patients until the matter was resolved.

DISCUSSION

From the physician's and the defense team's perspective, this examination was appropriate; however, the mother's complaint to the police serves as a reminder that a patient's discomfort about an exam is subjective. It is important to remember that the patient sets the boundaries. In this case it perhaps would have been instructive for the physician to put himself into the shoes of this 13-year-old girl with flu symptoms prior to conducting an examination inside of her underwear. Children are taught from a young age that adult strangers should not touch them in sensitive areas. (See, for example, the U.S. Military resource for families entitled "Teach Your Kids Healthy Body Boundaries.")[28] One could argue the fine points of whether a physician qualifies as a stranger, but perhaps the safer attitude would be to assume a pediatric patient will not be comfortable with an unfamiliar physician touching his or her intimate body areas. Unlike the physician, the patient in this case did not consider the genital examination routine. A general consent for a head-to-toe examination was clearly not enough for this patient or her parents. Had the physician explained the reason for the genital examination in relation to flu symptoms, worn gloves, and requested and obtained further consent to perform the genital exam, it is less likely the patient and her family would have pursued their various complaints.

Finally a chaperone was not offered in this case. In the mother's opinion, one should have been offered. Confusingly in this scenario, the urgent care chaperone policy did not require the presence of a chaperone for an external genital exam, instead indicating that the patient's parent could fulfill that role. Often policies and protocols provide minimum requirements. In this case offering a chaperone, even if the policy did not require it, could have reduced the risk of the parents pursuing a criminal action against the physician.

RISK REDUCTION STRATEGIES

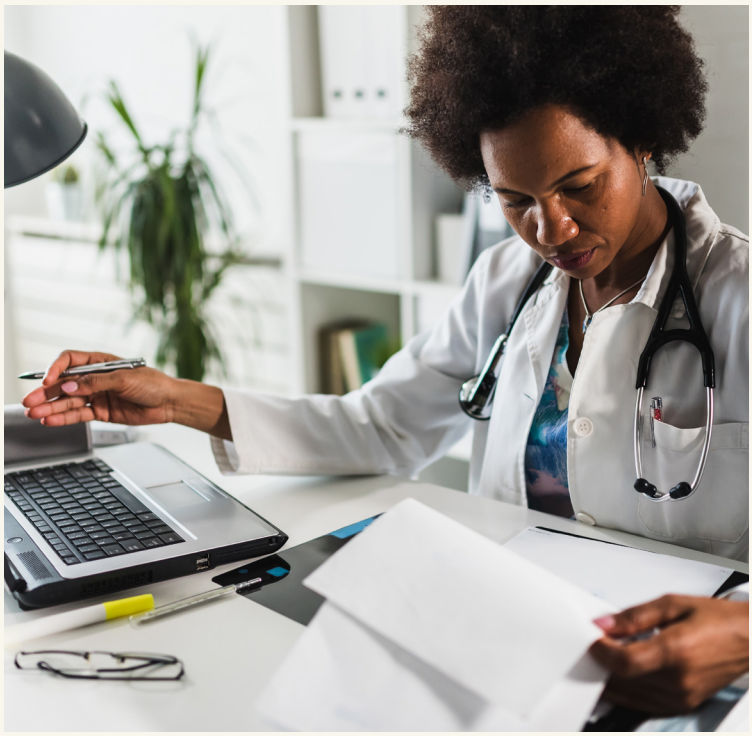
Consider the following strategies:[24,29]

- Offer a chaperone prior to inspecting or palpating the breast, or the anorectal or genital region of a postpubertal patient or placing your finger(s) or anything else into the vagina or rectum of any pediatric patient.
  - Consider pediatric patient and/or parent characteristics and the type of examination when deciding whether a parent or staff member should serve as a chaperone.
  - Use a chaperone of the same gender as the patient.
  - Ensure the chaperone hears the explanation of the examination and the patient's/parent's consent.
- Document the presence of a chaperone, his or her identity (name and full job title), or patient/parent refusal of a chaperone, or why a chaperone was not used when indicated.
- Educate patients/parents about why a particular examination is necessary and what it entails so they can give fully informed consent.
- Never assume an examination is routine for a patient.
- Use standard precautions for all patient care, including the use of gloves when examining mucous membranes to prevent the spread of infection.

RESPONDING TO ALLEGATIONS OF SEXUAL MISCONDUCT

Policies and Procedures

If a patient makes an allegation of sexual misconduct, the best response is one that is thoughtful and organized. Such a response is best achieved by following a policy that includes guidance for reporting the allegation, documenting the event and process, and conducting the investigation.[30] Consider the following strategies:[30]



- Determine whether the patient requires additional medical care, and either refer the patient or offer care from a physician other than the accused.
  - Refer the patient to the emergency department for a sexual assault examination when appropriate.
- Assure the patient that his or her allegations are being taken seriously and that an appropriate investigation will occur.
- Document the allegations in an incident report. (Keep this documentation separate from the physician's documentation in the medical record related to medical care.)
  - Include the patient's statement, starting with a statement such as, "The patient alleges," and care/referrals offered/provided in response to the patient's allegations.
  - Do not include subjective feelings or beliefs, speculation or blame, references to investigation results or event analysis, or references to communications with a malpractice carrier or attorney.
- Notify your professional liability insurer's Claims department immediately to determine the extent of your coverage.
- Investigate the allegations pursuant to the practice policies and protocols.
- Analyze the allegations to prevent recurrence.
- Limit communications about the allegations in a manner consistent with HIPAA and state privacy laws.
- Discipline accused clinicians and staff when investigation reveals policy/protocol violations.
  - Provide the accused individuals with due process in relation to disciplinary actions.

Sexual Misconduct Allegations:
Liability, Ethics, and Professionalism

CONCLUSION

A key to reducing the risk of sexual misconduct allegations is always placing a patient's welfare above self-interest. Carefully consider all of the ramifications before engaging in an intimate relationship with a past, current, or future patient. From an ethical, legal, and professional perspective, these relationships are rarely, if ever, defensible. Even when an argument can be made that an intimate relationship with a patient is not a technical violation of the standard of care, in a physician-patient relationship, a jury will be made to understand that the physician-patient relationship exists solely for the patient's benefit, that the defendant physician's emotional or sexual needs are not relevant, and the consensual manner of the relationship is not a strong defense. These cases are very difficult to defend.

Not all sexual misconduct cases involve intimate relationships. Many involve misunderstood procedural touch. For practical purposes every patient encounter presents a risk management opportunity. The stage can be set for respectful medical treatment by offering a chaperone, allowing the patient to dress and undress in privacy, and encouraging the patient to inform you if he or she becomes uncomfortable. Throughout the examination, patients can be educated about what to expect and the medical necessity of procedural touch, particularly when the touch involves an intimate part of the body. Instituting a chaperone policy and ensuring every clinician and staff member understands how to comply and why it is important to do so can reduce the risk of sexual misconduct and false allegations of it. Finally documentation of an appropriately chaperoned examination can be strong evidence in the defense of a sexual misconduct allegation.

Every physician has a duty to refrain from sexual misconduct—that is a given. But physicians are also wrongly accused of sexual misconduct due to patient misunderstandings of procedural touch and retaliation. The risk reduction strategies in this article can help physicians avoid wrongful accusations and quickly resolve legal or disciplinary actions that arise once allegations have been made.

ENDNOTES

The NORCAL Group documents referenced in this article, along with many other risk management resource documents and past editions of *Claims Rx*, are available in the Risk Solutions area of MyACCOUNT, or by policyholder request at 855-882-3412.

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