FREQUENTLY ASKED QUESTIONS (FAQs) - Sexual Abuse Allegations

1. What does the term sexual misconduct include?

Sexual misconduct is an umbrella term used by the medical community to denote sexualized behavior perpetrated by a healthcare provider against a patient, a patient's family member, or some other individual in the health care setting, including employees.

The AMA's Council on Ethical and Judicial Affairs indicates that healthcare providers may perpetrate sexual misconduct against their patients in a variety of ways, including:

(1) becoming involved in personal relationships with patients that are concurrent with but independent of treatment,

(2) using their position to gain sexual access to their patients by representing sexual contact as part of care or treatment, and

(3) assaulting patients by engaging in sexual contact with incompetent or unconscious patients.[1]

The AMA's council further indicates that for some providers, sexual misconduct against a patients is "the conscious (and usually repeated) use of [providers'] professional positions to manipulate or exploit their patients' vulnerabilities for their own gratification … [and that] self-gratification is the only basis for the behavior of providers who engage in sexual contact with incompetent or unconscious patients."[2]

The AMA extends its definition of sexual misconduct to include sexual or romantic relationships between providers and key third parties who play an integral role in the patient-provider relationship, such as patients' spouses, partners, parents, guardians, and proxies.[3] The AMA advises that all healthcare providers and physicians "should refrain from sexual or romantic interactions with key third parties when it is based on the use or

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[1] Council on Ethical and Judicial Affairs, American Medical Association. Sexual misconduct in the practice of medicine. *JAMA*. 1991;266(19):2741-2745.

[2] Ibid.

[3] American Medical Association. The AMA code of medical ethics' opinions on observing professional boundaries and meeting professional responsibilities. *AMA J Ethics*. 2015;17(5):432-434.

exploitation of trust, knowledge, influence, or emotions derived from a professional relationship."[4]

2. **Should we use the term sexual abuse or sexual misconduct?**

The term "sexual abuse" should be used instead of the term "sexual misconduct" when referring to any sexual contact between a provider and a patient or any behavior or remarks of a sexual nature by a provider toward a patient because of the breach of trust and exploitative nature of such actions.[5] Any characterization that does not involve the term "abuse" fails to connote the profound unethical nature of physical sexual contact or relations and sexual interactions between providers and their patients.

3. **How should healthcare organizations approach the issue of sexual abuse allegations against a provider?**

Hospitals and healthcare organizations should adopt, as some groups have,[6] an explicit "zero-tolerance" standard against all forms of provider sexual abuse of patients. This standard should be incorporated into all applicable policies and regulations governing providers and should be used in credentialing and privileging decisions.

4. **Should a chaperone be mandatory for all patient intimate exams?**

Health care institutions' best practices are to affirmatively and automatically provide trained chaperones to act as "practice monitors" during breast, full-body skin, genital, and rectal exams at a minimum. Poster, flyers, and other patient educational materials on chaperones may be useful, however the default position should be that a chaperone will be present during examinations or treatment that might be considered sensitive/intimate in nature regardless of the sex of the patient and provider. A male provider/male patient or female provider/female patient still require a chaperone if the exam is sensitive/intimate in nature.

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[4] Ibid.

[5] AbuDagga A, Carome M, Wolfe SM. Time to end physician sexual abuse of patients: Calling the U.S. medical community to action. *J Gen Intern Med*. 2019;34(7):1330-1333.

[6] Medical Council of New Zealand. Sexual boundaries in the doctor-patient relationship. November 2018. https://www.mcnz.org.nz/assets/standards/3f49ba8048/Sexual-boundaries-in-the-doctor-patient-relationship.pdf.

5. **What is a chaperone?**

A chaperone is a person who acts as a witness for a patient and a health professional during a medical examination or procedure. A chaperone should stand in a location where they can assist as needed and observe the examination, therapy, or procedure.

A chaperone may be a health care professional or a trained unlicensed staff member. This may include medical assistants, nurses, technicians, therapists, residents, and fellows.

6. **How should the provider explain to the patient the need for a chaperone?**

Whether or not to use a chaperone during an examination should be a shared decision between the patient and the provider, however ultimately it should be standard practice for their use with intimate exams. During this conversation, providers should explain the practice's policy and the purpose and role of the chaperone. If the patient makes comments that one is not needed or refuses the use of a chaperone the provider will need to consider not providing the exam (so long as not of an emergent nature) and/or to spend additional time with the patient explaining the practice standard to use one as well as understanding the patients fears or concerns regarding the use of the chaperone.

7. **Should the chaperone be the same gender as the patient?**

Whenever possible, but not required, the chaperone should be the gender that the patient feels most comfortable with. A chaperone may also assist the health professional or provide support to the patient with personal hygiene, toileting or undressing/dressing requirements if requested, or needed by the patient.

8. **Does this apply to both male and female physicians?**

While historically most complaints have involved female patients and male providers, the practice of chaperone use should be in place regardless of the provider's gender.[7]

9. **What qualifications should a chaperone have?**

Training of practice monitors (chaperones) should be documented as part of the employee file. Training best practices include what constitutes appropriate exams and when such

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[7] Committee on Ethics, American College of Obstetricians and Gynecologists. ACOG Committee opinion no. 373: Sexual misconduct. *Obs Gynecol*. 2007;110(2 Pt 1):441-444.

exams are needed. It is also best that the practice monitors (chaperones) to independent of (i.e., not supervised by) the provider being monitored.

A chaperone should be trained that they have a right to stop a sensitive procedure, examination, or care if they feel that the health professional's behavior is inappropriate or unacceptable. A chaperone who witnesses inappropriate or unacceptable behavior on the part of the health professional will immediately report this to their manager or another senior manager, even if they did not stop the procedure while it was ongoing.[8]

10. Can a patient's family member or companion act as a chaperone?

The best practice is to have a staff member act as a chaperone. If it's appropriate and safe under the circumstances, a practice can allow the patient to bring in a companion. Relying on someone with a connection with the patient to be the chaperone poses additional risks, including misunderstandings.

11. What if the patient declines a chaperone?

Patients refuse chaperones for several reasons, the most common being increased embarrassment that another person will witness the examination. The first step should be to identify the reason behind the refusal. Proposing an alternative provider or chaperone may be an acceptable way to resolve the situation. There is little guidance available on whether chaperones should be used against patient's informed wishes. Conversations with risk management may be necessary to explore the situation's specific details, but it may be prudent to reschedule the exam or procedure. Providers are not obligated to continue providing care to patients who refuse chaperones if they feel uncomfortable with the patient's decision.

12. Should chaperone use be documented in the medical record? If so, how?

Best practices for documentation include documenting the presence of the chaperone and their name and job title. If allegations arise later, it will be important to know who chaperoned the exam.

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[8] The Use of Chaperones During Sensitive Examinations and .... https://www.uofmhealth.org/patient-visitor-guide/patients/use-chaperones-during-sensitive-examinations-and-procedures

13. How can organizations encourage reporting of patient complaints or concerns?

Encourage and facilitate patient and patient surrogate reporting of all forms of provider sexual abuse. This recommendation can be accomplished by having health care institutions establish standardized processes, which should be made known to patients and their surrogates, for filing complaints regarding any provider sexual abuse they may have experienced or witnessed. Importantly, these processes need to consider that victims typically are reluctant to report sexual abuse. These processes also need to provide informal, formal, and proxy reporting options to address fears surrounding the reporting of provider sexual abuse incidents.

14. What should healthcare organizations do to facilitate provider or staff reporting of sexual abuse complaints or concerns?

The medical community should mandate reporting, including an allowance for anonymous reporting, by all health care professionals when there is reason to believe that an individual (patient or nonpatient) has experienced sexual abuse by a healthcare provider and should institute necessary measures to prevent reprisal against individuals who make such reports and to protect them from legal liability for such reporting. Strict penalties for failing to report provider sexual abuse of patients should be set and enforced. Educational bystander intervention training should be encouraged to equip all health care professionals with the skills necessary to take appropriate action if they witness or suspect provider sexual abuse of patients.

15. How should complaints or concerns be investigated?

Health care institutions should investigate each complaint of alleged provider sexual abuse of patients and conduct hearings if there are grounds for proceeding (while providing due process for the accused provider and patient witnesses). Importantly, first responders and investigators of sexual offenses at medical boards and health care organizations should undergo sensitivity training to be better equipped to help the victims without retraumatizing them. Current guidelines are urgently needed to determine the best practices for handling sexual abuse by providers. Such guidelines should be developed with input from patient advocates and other nonphysician stakeholders. Innocent providers may be falsely accused of sexual abuse; therefore, all complaints of alleged provider sexual abuse of patients should be pursued fairly and through due process.

16. **How should healthcare organizations respond to providers that have engaged in sexual abuse?**

Health care institutions should take effective disciplinary actions against providers who are found to have engaged in any form of sexual abuse of patients. Health care institutions should be required to report providers found to have engaged in such behavior to the appropriate medical/licensing board, regardless of the extent of any clinical-privileges action taken against the offending provider. Clear mandatory penalties (including suspension and revocation of medical license and clinical privileges) should be established and enforced by the medical community. A best practice is mandatory revocation of any provider's license found to have engaged in sexual abuse involving physical sexual acts (including intercourse, sodomy, etc.). The severity and length of these penalties should be based on the severity and the form of sexual abuse. In no case should public safety be compromised for any other consideration. Penalties should never be deferred because, too often providers engage in further sexual abuse of patients after lenient disciplinary actions for sexual misconduct. Better safeguards are needed to prevent providers who have been banned from practicing medicine due to sexual abuse or other offenses in one state from obtaining a license in other states.

17. **Should provider sexual abuse be reported to the police or law enforcement?**

Health care institutions should report providers who were found to have engaged in sexual intercourse or other forms of physical sexual contact or relations with a patient to law enforcement authorities in all cases, not just when the patient victim is a child.

18. **How should health care organizations treat providers being disciplined for sexual abuse?**

A noted practice by some healthcare institutions has been to require providers on disciplinary probation for sexual abuse and other offenses to notify their patients of these offenses, so patients can make informed decisions regarding receiving medical care from such physicians. This practice has been required in California since 2019.[9] Other noted practices have been to require/mandate a trained medical chaperone to accompany said provider for every exam (regardless if intimate or not) and/or restrict the providers services to no intimate/sensitive exams.

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[9] California Legislative Information. Senate Bill-1448 Healing arts licensees: probation status: disclosure. September 19, 2018. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180SB1448. Accessed May 6, 2020.