Maine Medical Association

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TESTIMONY OF THE MAINE MEDICAL ASSOCIATION

IN OPPOSITION TO

L.D. 13, AN ACT TO REQUIRE CERTAIN LICENSING BOARDS TO REPORT CASES OF SEXUAL ABUSE OF A PATIENT OR CLIENT BY A LICENSEE TO A LAW ENFORCEMENT AGENCY OR THE DEPARTMENT OF HEALTH & HUMAN SERVICES

Joint Standing Committee on Labor, Commerce, Research, & Economic Development
Room 208, Cross State Office Building
Tuesday, January 31, 2017, 1:00 p.m.

Good afternoon Senator Volk, Representative Fecteau, and Members of the Joint Standing Committee on Labor, Commerce, Research, & Economic Development. My name is Andrew MacLean and I am Deputy Executive Vice President & General Counsel of the Maine Medical Association and I am speaking in opposition to L.D. 13, *An Act to Require Certain Licensing Boards to Report Cases of Sexual Abuse of a Patient or Client by a Licensee to a Law Enforcement Agency or the Department of Health & Human Services*.

The Maine Medical Association is a professional organization representing more than 4000 physicians, residents, and medical students in Maine whose mission is to support Maine physicians, advance the quality of medicine in Maine, and promote the health of all Maine citizens.

The MMA appreciates the concern of Representative Espling and the co-sponsors of the bill for patients who may be subjected to inappropriate sexual behavior by a clinician and our opposition to the bill certainly does not mean that we condone such behavior. Our opposition is based, first, on a belief that the health professions licensing boards in Maine understand and take seriously their public protection role and deserve discretion in carrying out their disciplinary function when considering issues that arise in the licensee-patient relationship. Second, even if the Committee were to decide this level of oversight for health professions licensing boards is necessary, we see some technical, drafting issues with the bill.

<u>Current ethical and legal guidance on inappropriate sexual behavior by clinicians</u>

I will focus my comments here on the ethical and legal guidance for the Board of Licensure in Medicine because that is the health professions licensing board with whom we are most familiar. The *Code of Medical Ethics* of the American Medical Association, a standard of the profession of medicine, includes two opinions that are relevant to your consideration of L.D. 13: Opinion 9.1.1, *Romantic or Sexual*

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Relationships with Patients and Opinion 9.1.2, *Romantic or Sexual Relationships with Key Third Parties*. The first sentence of Opinion 9.1.1 is clear in stating that "[r]omantic or sexual interactions between physicians and patients that occur concurrently with the patient physician relationship are unethical." The two physician licensing boards also have developed an administrative rule called Joint Rule Chapter 10, *Sexual Misconduct*. This ethical and legal guidance is directly applicable to inappropriate sexual behavior by a physician towards a patient, commonly called "boundary violations." I have attached the two ethics opinions and the joint rule to my testimony for your review. Two provisions of the Maine Criminal Code, 17-A M.R.S.A., Part 2, Chapter 11, *Sex Assaults* and Chapter 12, *Sexual Exploitation of Minors* may also be applicable to some situations. Finally, in some situations, the licensing authorities might consider the application of the child abuse and neglect reporting laws, 22 M.R.S.A., Chapter 1071, Subchapter 2, *Reporting of Abuse or Neglect*.

The MMA submits that the health professions licensing boards, with the advice of their assistant attorneys general, can properly review a set of facts before them through a complaint and determine the appropriate course of action – action against the licensee by the board or referral to a law enforcement agency, the Department of Health & Human Services, or other governmental entity - without the specific guidance of the legislature as suggested in L.D. 13.

A psychiatrist who participated in our Legislative Committee discussion of this bill, later expressed a concern that this bill could be an infringement on the rights of victims of boundary violations.

> Unfortunately boundary problems happen with healthcare professionals from time to time. When they do, it is psychologically important for victims to be able to make complaint and seek redress with autonomy over the process. For personal reasons, some victims will choose to seek redress through criminal, civil or regulatory channels. They may choose regulatory channels (i.e. Board complaint) because it offers much more privacy than a legal proceeding. If this bill automatically adds a legal proceeding to the process, then they lose the privacy they had sought.

<u>Technical, drafting issues with the bill</u>

Based upon the discussion above, the MMA urges the Committee not to proceed with the bill. But, should the Committee decide to do so, we suggest that you give some further thought to the scope of the reporting obligation in the bill. The various ethical and legal provisions cited above use some defined terms, but I do not believe any of them use the term "sexual abuse" as contained in the bill but not defined. Also, the bill should apply to all Maine licensed health care professionals, not just those covered in the bill as drafted. Nurses would be just one large group of licensees who have frequent face-to-face interactions with patients who are not covered in the bill.

Thank you for considering the views of the Maine Medical Association on L.D. 13. I would be happy to respond to any questions you may have.

CHAPTER 9: OPINIONS ON PROFESSIONAL SELF-REGULATION

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

9.1 Sexual Boundaries

9.1.1 Romantic or Sexual Relationships with Patients
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9.2 Physician Education & Training

9.2.1 Medical Student Involvement in Patient Care
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9.2.3 Performing Procedures on the Newly Deceased
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9.3 Physician Wellness

9.3.1 Physician Health & Wellness
9.3.2 Physician Responsibilities to Impaired Colleagues

9.4 Peer Review & Disciplinary Action

9.4.1 Peer Review & Due Process
9.4.2 Reporting Incompetent or Unethical Behavior by Colleagues
9.4.3 Discipline & Medicine
9.4.4 Physicians with Disruptive Behavior

9.5 Physician Involvement in Health Care Institutions

9.5.1 Organized Medical Staff
9.5.2 Staff Privileges
9.5.3 Accreditation
9.5.4 Civil Rights & Medical Professionals
9.5.5 Gender Discrimination in Medicine

9.6 Physician Promotion & Marketing Practices

9.6.1 Advertising & Publicity
9.6.2 Gifts to Physicians from Industry
9.6.3 Incentives to Patients for Referrals
9.6.4 Sale of Health-Related Products
9.6.5 Sale of Non-Health-Related Goods
9.6.6 Prescribing & Dispensing Drugs & Devices
9.6.7 Direct-to-Consumer Advertisement of Prescription Drugs
9.6.8 Direct-to-Consumer Diagnostic Imaging Tests
9.6.9 Physician Self-Referral

9.7 Physician Interactions with Government Agencies

9.7.1 Medical Testimony
9.7.2 Court-Initiated Medical Treatment in Criminal Cases

9.1.1 Romantic or Sexual Relationships with Patients

Romantic or sexual interactions between physicians and patients that occur concurrently with the patient physician relationship are unethical. Such interactions detract from the goals of the patient-physician relationship and may exploit the vulnerability of the patient, compromise the physician's ability to make objective judgments about the patient's health care, and ultimately be detrimental to the patient's well-being.

A physician must terminate the patient-physician relationship before initiating a dating, romantic, or sexual relationship with a patient.

Likewise, sexual or romantic relationships between a physician and a former patient may be unduly influenced by the previous physician-patient relationship. Sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the previous professional relationship, or if a romantic relationship would otherwise foreseeably harm the individual.

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.

AMA Principles of Medical Ethics: I,II,IV

9.1.2 Romantic or Sexual Relationships with Key Third Parties

Patients are often accompanied by third parties who play an integral role in the patient-physician relationship, including, but not limited to, spouses or partners, parents, guardians, or surrogates. Sexual or romantic interactions between physicians and third parties such as these may detract from the goals of the patient-physician relationship, exploit the vulnerability of the third party, compromise the physician's ability to make objective judgments about the patient's health care, and ultimately be detrimental to the patient's well-being.

Third parties may be deeply involved the in the clinical encounter and in medical decision making. The physician interacts and communicates with these individuals and often is in a position to offer them information, advice, and emotional support. The more deeply involved the individual is in the clinical encounter and in medical decision making, the stronger the argument against sexual or romantic contact between the physician and a key third party. Physicians should avoid sexual or romantic relations with any individual whose decisions directly affect the health and welfare of the patient.

For these reasons, physicians should refrain from sexual or romantic interactions with key third parties when the interaction would exploit trust, knowledge, influence, or emotions derived from a professional relationship with the third party or could compromise the patient's care.

Before initiating a relationship with a key third party, physicians should take into account:

(a) The nature of the patient's medical problem and the likely effect on patient care.

(b) The length of the professional relationship.

(c) The degree of the third party's emotional dependence on the physician.

(d) The importance of the clinical encounter to the third party and the patient.

(e) Whether the patient-physician relationship can be terminated in keeping with ethics guidance and what implications doing so would have for patient.

AMA Principles of Medical Ethics: I,II

9.1.3 Sexual Harassment in the Practice of Medicine

Sexual harassment can be defined as unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

Sexual harassment in the practice of medicine is unethical. Sexual harassment exploits inequalities in status and power, abuses the rights and trust of those who are subjected to such conduct; interferes with an individual's work performance, and may influence or be perceived as influencing professional advancement in a manner unrelated to clinical or academic performance harm professional working relationships, and create an intimidating or hostile work environment; and is likely to jeopardize patient care. Sexual relationships between medical supervisors and trainees are not acceptable, even if consensual. The supervisory role should be eliminated if the parties wish to pursue their relationship.

Physicians should promote and adhere to strict sexual harassment policies in medical workplaces. Physicians who participate in grievance committees should be broadly representative with respect to gender identity or sexual orientation, profession, and employment status, have the power to enforce harassment policies, and be accessible to the persons they are meant to serve.

AMA Principles of Medical Ethics: II,IV,VII

9.2.1 Medical Student Involvement in Patient Care

Having contact with patients is essential for training medical students, and both patients and the public benefit from the integrated care that is provided by health care teams that include medical students. However, the obligation to develop the next generation of physicians must be balanced against patients' freedom to choose from whom they receive treatment.

All physicians share an obligation to ensure that patients are aware that medical students may participate in their care and have the opportunity to decline care from students. Attending physicians may be best suited to fulfill this obligation. Before involving medical students in a patient's care, physicians should:

(a) Convey to the patient the benefits of having medical students participate in their care.

(b) Inform the patients about the identity and training status of individuals involved in care. Students, their supervisors, and all health care professionals should avoid confusing terms and properly identify themselves to patients.

02 DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

373 BOARD OF LICENSURE IN MEDICINE

and

383 BOARD OF OSTEOPATHIC LICENSURE

Chapter 10: SEXUAL MISCONDUCT

SUMMARY: This chapter defines sexual misconduct by physicians and physician assistants and sets forth the range of sanctions applicable to violations of this rule pursuant to Title 32 §§ 3269 (7) and 3270-A, B, C., and 32 M.R.S.A. §§ 2562, 2594-C.

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§1 DEFINITIONS

1. "Physician" an individual who is qualified and licensed according to the provisions of 32 M.R.S.A. §3270 *et seq.* and 32 M.R.S.A. §2571 *et seq.*

2. "Physician Assistant" an individual who is qualified and licensed or certified according to the provisions of 32 M.R.S.A. §§ 3270-A and 3270-B and 32 M.R.S.A. §§ 2594-A and 2594-B.

3. "Physician/physician assistant sexual misconduct" is behavior that exploits the physician/physician assistant-patient relationship in a sexual way. This behavior is nondiagnostic and/or nontherapeutic, may be verbal or physical, and may include expressions or gestures that have a sexual connotation or that a reasonable person would construe as such. Sexual misconduct is considered incompetence and unprofessional conduct as defined by 32 M.R.S.A §2591-A(2) and 32 M.R.S.A. §3282 -A(2).

   There are two levels of sexual misconduct: sexual violation and sexual impropriety. Behavior listed in both levels may be the basis for disciplinary action.

   A. "Sexual violation" is any conduct by a physician/physician assistant with a patient that is sexual or may be reasonably interpreted as sexual, even when initiated by or consented to by a patient, including but not limited to:

      1. sexual intercourse, genital to genital contact;

      2. oral to genital contact;

      3. oral to anal contact or genital to anal contact;

      4. kissing in a sexual manner (e.g. - french kissing);

5. any touching of a body part for any purpose other than appropriate examination, treatment, or comfort, or where the patient has refused or has withdrawn consent;

6. encouraging the patient to masturbate in the presence of the physician/physician assistant or masturbation by the physician/physician assistant while the patient is present; and,

7. offering to provide practice-related services, such as drugs, in exchange for sexual favors.

B. "Sexual impropriety" is behavior, gestures, or expressions by the physician/physician assistant that are seductive, sexually suggestive, or sexually demeaning to a patient, including but not limited to:

1. kissing;

2. disrobing, draping practices or touching of the patient's clothing that reflect a lack of respect for the patient's privacy; deliberately watching a patient dress or undress, instead of providing privacy for disrobing;

3. subjecting a patient to an examination in the presence of another when the physician/physician assistant has not obtained the verbal or written consent of the patient or when consent has been withdrawn;

4. examination or touching of genitals without the use of gloves;

5. inappropriate comments about or to the patient, including but not limited to making sexual comments about a patient's body or underclothing; making sexualized or sexually demeaning comments to a patient, criticizing the patient's sexual orientation (homosexual, heterosexual, or bisexual); making comments about potential sexual performance during an examination or consultation (except when the examination or consultation is pertinent to the issue of sexual function or dysfunction); requesting details of sexual history or sexual likes or dislikes when not clinically indicated;

6. using the physician/physician assistant-patient relationship to solicit a date or initiate romantic relationship;

7. initiation by the physician/physician assistant of conversation regarding the sexual problems, preferences, or fantasies of the physician/physician assistant; and,

8. examining the patient without verbal or written consent.

§2 SANCTIONS

If the Board finds that a licensee has engaged in sexual misconduct as defined in section 1 of these rules the licensee shall be disciplined in accordance with these rules.

1. All disciplinary sanctions under 32 M.R.S.A. §2591-A, §3282-A and 10 M.R.S.A. §8003 are applicable.

2. Sexual Violations - Findings of sexual violations are egregious enough to warrant revocation of a physician/physician assistant's medical license. Boards may, at times, find that mitigating circumstances do exist and, may impose a lesser sanction.

3. Sexual Impropriety - Findings of sexual impropriety will result in harsh sanction, which may include revocation. Special consideration should be given to at least the following when determining an appropriate sanction:

   A. patient harm;

   B. severity of impropriety;

   C. culpability of licensee;

   D. psychotherapeutic relationship;

   E. inappropriate termination of physician/physician assistant-patient relationship;

   F. age of patient;

   G. physical /mental capacity of patient;

   H. number of times behavior occurred;

   I. number of patients involved;

   J. period of time relationship existed; and,

   K. evaluation/assessment results.

STATUTORY AUTHORITY: Title 32 M.R.S.A. §§ 3269 (7) and 3270-A, B, C.
Title 32 M.R.S.A. §§ 2562, 2594-C.

EFFECTIVE DATE:
March 12, 1997