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A follow-up evaluation of sexual misconduct complaints: The Oregon Board of Medical Examiners, 1998 through 2002

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KEY WORDS
Sexual misconduct
Sexual violation
Sexual impropriety
Physician/patient boundary

Objective: The current study presents an analysis of sexual misconduct allegations that were closed from 1998 through 2002 and is compared with allegations from 1991 through 1995 (study 1). One hundred complaints were closed in study 1, which involved 80 licensees; 23.8% of those complaints resulted in reportable board actions.

Study design: Retrospective analyses of 47 allegations that were closed and that involved 46 practitioners were evaluated statistically and compared with the previous study.

Results: Sexual misconduct was the allegation in 3.1% of all closed complaints, compared with 5.9% in study 1. Of the allegations, 36.2% of the sexual misconduct allegations were for sexual impropriety with no reportable disciplinary outcomes, and 63.8% of the complaints were for sexual violation that resulted in 25 reportable disciplinary actions. Family medicine, psychiatry, and obstetrics/gynecology again reported the highest proportion of total complaints, but psychiatry and obstetrics/gynecology improved both in total complaints and disciplinary actions. Multiple complaints improved significantly in study 2.

Conclusion: Physician and patient awareness and board actions reduced total complaints of sexual misconduct. Family medicine was an exception, with 12 reportable board actions compared with 4 in study 1. Reportable disciplinary actions involved revocations, suspensions, and surrender of license; the disciplinary actions most often involved probation, education, counseling and/or psychiatric therapy, and practice limitation. Education, the identification of high-risk practitioners, and the appropriate use of deterrence continue to be areas of recommended focus.

"Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption, and further, from the seduction of females or males, of freemen or slaves" (Oath of Hippocrates: Harvard Classics volume 38, 1910). This ancient ethical guideline has received a great deal more attention in the last 25 years as the importance of physician/patient boundaries and sexual misconduct has been appreciated. The American Psychiatric Association first condemned sexual contact with active patients in 1973 and added that sexual contact with present and former patients was unethical in 1993.[1,2] The

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21. Oberlander J, Marmor T, Jacobs L. Rationing medical care: rhetoric and reality in the Oregon Health Plan. CMAJ 2001;164:1583-7.
22. Bodenheimer T. The movement for universal health insurance: finding common ground. Am J Public Health 2003;93:112-5.
23. Harrison B. A historical survey of national health movements and public opinion in the United States. JAMA 2003;289:1163-4.
24. Bitton A, Kahn JG. Government share of health expenditures. JAMA 2003;289:1165.
25. Detsky AS, Naylor CD. Canada's health care system: reform delayed. N Engl J Med 2003;349:804-10.
26. Woolhandler S, Campbell T, Himmelstein DU. Costs of health care administration in the United States and Canada. N Engl J Med 2003;349:768-75.
27. Woolhandler S, Himmelstein DU, Angell M, Young QD. Proposal of the Physicians' Working Group for Single-Payer National Health Insurance. JAMA 2003;290:798-805.
28. Physicians for a National Health Program [accessed November 2, 2003]. Available at: www.pnhp.org
29. McLennan CE. Time for a change: presidential address. Am J Obstet Gynecol 1974;119:277-83.

American Medical Association Council of Ethical and Judicial Affairs (1989) addressed professional boundaries and stated that sexual misconduct violates the trust that a patient places in the physician and is unethical.[3] This position was further modified in 1991 to add that a sexual or romantic relationship with former patients is unethical if the practitioner uses or exploits trust, knowledge, emotions, or influence that was derived from a previous professional relationship.[4]

Canada, New Zealand, the American Medical Association, professional societies (such as the American College of Obstetrics and Gynecology), and the Oregon Medical Association published guidelines and recommended disciplinary actions for sexual misconduct in the early and mid 1990s.[5-9] Professional and public awareness of sexual boundaries increased in Oregon in 1994 when a Portland obstetrician gynecologist was accused of multiple acts of sexual misconduct that dominated the news and the attention of the Oregon Board of Medical Examiners (OBME) for months.[10,11] This case and the increasing body of literature prompted the OBME to modify their protocols for the investigation of sexual misconduct complaints. Enbom and Thomas[12] evaluated closed OBME sexual misconduct complaints for the years 1991 through 1995 (study 1). One hundred complaints with allegations of sexual misconduct were closed that involved 80 licensees and 5.9% of all closed complaints and that resulted in 19 disciplinary actions that were reported to the National Practitioner Data Bank. Sexual misconduct complaints increased with the age of the practitioner groups and were highest in Obstetrics and Gynecology, Psychiatry, and Family Medicine.

In 1995 Gabbard and Nadelson[13] further defined professional boundaries in the physician-patient relationship. The Federation of State Medical Boards published the a report on sexual boundary issues, defined sexual misconduct (impropriety and violation), recommended guidelines for investigation and hearings, and recommended guidelines for disciplinary and physician monitoring options.[14] Dehlendorf and Wolfe[15] published a review of data that were gathered by the Public Citizen's Health Research Group and involved physicians who were disciplined for sexual misconduct from actions by state medical boards and federal agencies for the years 1989 through 1996, which demonstrated that 4.1% of the actions involved reportable sex-related offenses of total reported actions. Physicians who were 35 to 64 years old had the highest relative percentage of reportable sexual misconduct complaints; the specialties of psychiatry, child psychiatry, obstetrics and gynecology, and family medicine reported significantly higher relative percentages of reportable disciplinary actions. This follow-up study (study 2) analyzed sexual misconduct complaints that were closed during the years 1998 through 2002 in Oregon.

Material and methods

A retrospective analysis of all closed complaints with allegations of sexual misconduct or misconduct that was considered to be sexual in nature during a subsequent investigation was conducted for the years 1998 through 2002 at the OBME. The cases of 46 licensees with 47 closed complaints were analyzed by medical degree, age group, sex, specialty, source of the complaint, and final disposition. Sexual misconduct allegations were classified by the criteria that are outlined by the Federation of State Medical Boards into sexual impropriety or sexual violation.[14] Sexual impropriety involves behavior, gestures, or expressions that are seductive, sexually suggestive, or sexually demeaning to a patient. Sexual violation includes sexual intercourse, oral to genital contact, oral to anal contact, kissing in a romantic or sexual manner, and sexualized touching of body part for any purpose other than appropriate examination or treatment or in cases in which the patient has refused consent. In study 1, a 3-tiered classification of sexual misconduct was used: (1) sexual impropriety or inappropriate comments, gestures, or privacy violations; (2) sexual transgression or sexualized or inappropriate touching; (3) sexual violation or sexual relationship with a patient, regardless of who initiated the relationship.[7,12] Combining categories 2 and 3 in study 1 approximated the definition of sexual violation from the Federation of State Medical Boards. The Federation of State Medical Boards system was used in study 2 to be consistent with the current recommended classification system for state licensing boards.

The analysis of OBME files of 46 licensees was conducted for the years 1998 through 2002 (study 2) and compared with the data from study I. Statistical analysis was used to determine current and comparative significance: S-PLUS software (Insightful, Seattle, Wash) for Fisher's exact test and Pearson chi-squared test and STATGRAPHICS*Plus software (Manugistics, Inc, Rockville, Md) for binomial formula testing. All personal references to both licensees and patients were omitted for confidentiality. Permission for data retrieval and review of case files was granted by the OBME.

Results

Total complaints were similar (study 1 [1697 complaints] vs study 2 [1537]), but the total with reportable actions decreased from 19.9% of total complaints to 11.3% ($P = .0001$). Sexual misconduct was the allegation (Table I) for 47 complaints that were closed and that involved 46 licensees for the years 1998 through 2002 (study 2), which was a 3.1% 5-year average (range, 1.9%-4.2% of total complaints) and an improvement from the 5.9% average (range, 4.3%-8.3%) in the 1991 through 1995 study ($P = .0002$). Disciplinary Actions that were reportable to the National Practitioner Data

Table I Complaints of sexual misconduct closed: OBME, 1998-2002

Action	Year 1998	1999	2000	2001	2002	Study 2 1998-2002	Study 1* 1991-1995	*P* value†
Total complaint cases closed (n)	236	311	310	332	348	1537	1697	
Total cases closed with reportable outcome (n)	28	30	41	35	39	173	337	
Percentage of total cases: reportable cases closed (%)	11.9	9.6	13.2	10.5	11.2	11.3	19.9	.0001
Sexual misconduct complaint cases closed (n)	6	7	11	14	9	47	100	
Sexual misconduct cases: Total cases closed (%)	2.5	1.9	3.5	4.2	2.6	3.1	5.9	.0002
Sexual misconduct cases closed: Reportable outcome (n)	3	4	5	7	6	25	19	
Reportable sexual misconduct cases of total closed (%)	1.3	1.3	1.6	2.1	1.7	1.6	1.1	.275
Sexual misconduct percentage of total reportable cases‡ (%)	10.7	13.3	12.2	20.0	15.4	14.5	5.6	.0014
Reportable sexual misconduct percentage of total sexual misconduct cases§ (%)	50.0	57.1	45.5	50.0	66.7	53.2	19.0	.001

* Data from Enbom JA, Thomas CD. Evaluation of sexual misconduct complaints: the Oregon Board of Medical Examiners, 1991 to 1993. Am J Obstet Gynecol 1997;176:1340-8.

† Proportion (percent/100): Pearson Chi-square with Yates continuity correction.

‡ 1998-2002 Proportion (percent/100) by year:no significant difference; P=.8641, Fisher's exact test.

§ 1998-2002 Proportion (percent/100) by year:no significant difference; P=.9361, Fisher's exact test.

Bank were found in 1.6% of the total closed cases for study 2, compared with 1.1% in the initial study 1 ($P = .275$). The percentage of reportable sexual misconduct actions in relation to total reportable disciplinary actions increased in study 2 from 5.6% to 14.5% ($P = .0014$), which is a factor of 2. The percentage and total number of reportable disciplinary actions were also higher when an evaluation was undertaken of the actions that were taken on only sexual misconduct complaints (19% for study 1 and 53.2% for study 2; $P = .0001$). In study 2, the year-to-year proportion of reportable sexual misconduct to all closed complaints was similar (range, 1.3 %-2.1%), as was the proportion of reportable sexual misconduct to all reportable actions by the OBME (range, 10.7%-20.0%; $P = .7562$) and the proportion of reportable disciplinary to total sexual misconduct complaints (range, 45.5%-66.7%; $P = .9311$).

Active licensees increased by 112% between the end of the 2 study periods, and the percentage of female licensees increased from 20% to 26%. Two female licensees had 2 complaints of sexual misconduct in study 2, with 1 reportable outcome and 1 nonreportable outcome; 1 female physician was investigated for sexual misconduct in study 1 without a reportable finding. One complaint in study 2 alleged sexual misconduct that involved a male physician and male patient, but the allegation was not sustained; 1 female physician was investigated for allegations of sexual misconduct that involved female patients and inappropriate prescribing that resulted in a reportable disciplinary action.

Study 1 found an increasing odds ratio of sexual misconduct complaints of 1.44 per increasing decade of age. The proportion of sexual misconduct complaints was well below average for practitioners <40 years of age ($P = .0047$; Table II) in study 2, while the 50 to 59-year old group ($P = .0221$) and the >70 years old group ($P = .0481$) were higher than expected. The 50 to 59-year old licensees were found to have the highest proportion of reportable disciplinary actions ($P = .0345$). Osteopathic licensees again had higher proportions of

Table II Age groups of sexual misconduct files closed: OBME 1998-2002

Active licensees	Total active licensees		Total sexual misconduct complaints			Reportable sexual misconduct complaints			P value: study 1 vs study 2*
	N	Percent	N	Proportion by age group	P value*	N	Proportion by age group	P value*	
<40 Y	3191	30.0	3	0.0009	.0047	2	0.00063	.0624	
40-49 Y†	3435	32.3	16	0.0047	.9974	9	0.00262	.8603	
50-59 Y‡	2759	25.9	20	0.0072	.0221	12	0.00435	.0345	.0002
60-69 Y	953	8.9	3	0.0031	.6436	1	0.00105	.5331	
>70 Y	313	2.9	4	0.0128	.0481	1	0.00319	~1.0	.2750
TOTAL	10651	100	46			25			.0014
Average proportion				0.0043			0.00235		.0001

* Binomial formula testing, if proportion different from average proportion.
† Includes 1 female physician.
‡ One physician and 2 complaints.

sexual misconduct complaints ($P = .0062$) and the highest proportion of disciplinary complaints ($P = .0298$).

Family medicine, obstetrics and gynecology, internal medicine, neurology, and plastic surgery had higher-than-average proportions of complaints for sexual misconduct for specialty groups, with > 1 complaint in study 2 (Table III). Family practice had significantly higher sexual misconduct complaints ($P = .022$) and reportable disciplinary actions ($P = .0008$). Table IV shows comparative data for internal medicine, family medicine, psychiatry, and obstetrics and gynecology. Obstetrics and gynecology improved in total complaints (8 in study 1 and 5 in study 2) and in reportable disciplinary actions (5 in study 1 and 0 in study 2; $P = .025$). Psychiatry improved both in total complaints (down from 9 complaints to 2 complaints) and in disciplinary actions (from 7 to 2; $P = .104$); family medicine improved in total complaints (36 down to 16) but increased in reportable disciplinary actions (from 4 in study 1 to 12 in study 2; $P = .176$) or a 2.46-fold increase in odds of a reportable disciplinary action if a complaint was filed.

In the 1991 to 1995 study, 80 licensees (9523 total active licensees) were investigated for sexual misconduct complaints, which decreased to 46 licensees in 1998 through 2002 (10651 total active licensees; $P = .0003$). Reportable disciplinary actions in study 1, 19 of 100 complaints were investigated (19% of total sexual misconduct complaints), which increased to 25 reportable disciplinary actions in study 2 from 47 complaints (53.2%) of sexual misconduct ($P = .001$), a 4.84-fold increase in odds that a filed sexual misconduct complaint resulted in a reportable disciplinary action.

In study 2, the source of complaint by patient or associate (spouse, partner, or friend) was highest (57%): 16 patients, 3 husbands, 1 patient and husband, 1 patient and previous partner, and 1 patient and other provider. This source accounted for 49% in study 1.

The final disposition of cases with allegations of sexual misconduct is listed in Table V for both studies. All allegations of sexual impropriety were closed, with a finding of no violation of the Oregon Medical Practice Act. In study 2, the OBME used more stipulated orders in 18 of 25 reportable disciplinary actions; Table VI details the key elements of the stipulated orders.

Table VII lists the allegations for 17 complaints that were classified as sexual impropriety. No licensee had > 1 sexual impropriety complaint, and none of the complaints were closed with a reportable disciplinary action in study 2. Tables VIII and IX list the 30 allegations of sexual misconduct that were classified as sexual violation. These allegations included sexual relationship with patients, sexualization/voyeurism, and child pornography. Twenty-five complaints (83.3%) were closed with reportable disciplinary actions, and the remaining 5 complaints were closed without disciplinary actions. One physician had 2 complaints (1 complaint in each category) and did receive a reportable disciplinary action for the more serious complaint. In study 1, 100 complaints were closed against 80 licensees: 1 licensee with 6 complaints, 3 licensees with 3 complaints, and 9 licensees with 2 complaints.

Comment

There was a substantial improvement in the total number of sexual misconduct complaints in study 2 (100 complaints [5.9% of total complaints] vs 47 complaints [3.1%]) and the number of licensees with multiple complaints but did not find a concomitant drop in the reportable sexual misconduct actions, as was noted for the total reportable actions in study 2 (173 complaints) versus study 1 (337 complaints). Family medicine, obstetrics and gynecology, internal medicine, plastic

Table III Clinical specialty with complaints closed for sexual misconduct: OBME 1998-2002

Specialty*	Total practitioners: Sexual misconduct complaints				Practitioners: Reportable complaints		
	Total licenses (n)	Complaints (n)	Proportion	*P* value†	Complaints (n)	Proportion	*P* value†
Family Medicine	1600	16	0.01	.0022	12	0.0075	.0005
Internal medicine‡§	1742	9	0.0052	.7157	5	0.0029	.8046
Obstetrics/gynecology	519	5	0.0096	.0777	0	0.0000	.4196
Psychiatry	469	2	0.0043	.5331	2	0.0043	.6335
Neurology	173	2	0.0116	.1733	1	0.0058	.3340
Plastic Surgery	74	2	0.0270	.0414	1	0.0135	.1596
Acupuncture	477	2	0.0042	.5215	0	NA	NA
Total specialty with 1 complaint*	2847	8	NA				
Number in specialty w/o complaint	2783						
Subtotal of license category with complaint	7868						
TOTAL	10651	46			25		
Average proportion			0.0043			0.0023	

NA, Not applicable.
* Includes specialties with ≥2 complaints only; $P > .1$ for all with only 1 complaint.
† Binomial formula, testing, if proportion different from average proportion.
‡ Includes subspecialties (1 physician with 2 complaints).
§ Includes subspecialties.

Table IV Higher risk clinical specialty with complaint cases closed for sexual misconduct: OBME 1998-2002 and 1991-1995

Specialty	Study 2: Closed 1998-2002				Study 1*: Closed 1991-1995				Study 1 vs 2: Change in reportable actions
	Total practitioners		Reportable disciplines		Total practitioners		Reportable Disciplines		
	Complaints (n)	Proportion	Complaints (n)	Proportion	Complaints (n)	Proportion	Complaints (n)	Proportion	
Family medicine	16	0.0010	12	0.0075	36	0.0276	4	0.0031	8
Obstetrics/ gynecology	5	0.0096	0	0.0000	8	0.0222	5	0.0139	−5
Internal medicine†‡	9	0.0052	5	0.0029	15	0.0120	2	0.0016	−3
Psychiatry	2	0.0043	2	0.0043	9	0.0231	7	0.0179	−5
Average proportion		0.0043		0.0023		0.0087		0.0021	

* Data from Enbom JA, Thomas CD. Evaluation of sexual misconduct complaints: the Oregon Board of Medical Examiners, 1991 to 1993. Am J Obstet Gynecol 1997;176:1340-8.
† Includes subspecialties and 1 physician with 2 complaints.
‡ Includes 1 female physician.

surgery, and neurology continued to have higher than average proportions of total complaints. Obstetrics and gynecology had no reportable disciplinary actions in study 2, which was down from 5 reportable actions in study 1; psychiatry improved from 9 reportable actions in the initial study to 2 reportable actions in study 2. Psychiatry and obstetrics/gynecology had been singled out in previous articles, which included study 1 and the Public Citizens Health Research Group, and formulated strong policies in the 1990s regarding physician/patient boundaries.[12,15] Current complaints against the obstetric/gynecology physicians were related to a lack of understanding about the nature of the examination or perceived inappropriate comments during

Table V Final disposition with complaints of sexual misconduct: OBME 1998-2002 and 1991-1995

	Study 2: 1998-2002 (n)		Study 1:* 1991-1995	
Final disposition	Closed no discipline	Closed reportable	Closed no discipline	Closed reportable
No violation of medical practice act	13		43	
Letter of concern before committee appearance†	6		4	
No violation after interview	2		4	
Letter of concern after interview	1		4	
No violation of medical practice act after Board review	0		1	
Referral to remedial program/not reportable			1	
Accept retirement			1	
Letter of agreement			1	
Letter of concern after Board w/o interview			2	
Revocation of license with stay of revocation‡		1		6
Retire of surrender of license under investigation‡		1		5
Revocation of license‡		1		5
Reprimand‡		2		2
Denial of Oregon license‡		1		
Stipulated order†‡§		18		
Final order‡		1		
Voluntary limitation‡				1
TOTAL	22	25	61	19

* Data from Enbom JA, Thomas CD. Evaluation of sexual misconduct complaints: the Oregon Board of Medical Examiners, 1991 to 1993. Am J Obstet Gynecol 1997;176:1340-8.

† Same physician with 2 complaints closed (1999 and 2001).

‡ Board actions reported to the National Practitioner Data Bank.

§ Includes 1 female physician.

examination. Both psychiatric complaints involved sexual activity with active therapy patients and did result in revocation or surrender of license. Of greatest concern was the increase for family medicine from 4 reportable actions in 1991 to 1995 to12 reportable actions in the current study. Eleven reportable actions included sexual activity with patients and 1 action that was based on the finding of child pornography. Family medicine had higher than expected proportions of sexual misconduct complaints and reportable actions in study 1 and was 1 of the highest clinical specialties in the findings that were published by the Public Citizens Heath Research Group in 1998.

The OBME used more letters of concern (not public record) on the closure of nonreportable actions in study 2, which outlines an area of concern or recommended improvement and also gives notice to the licensee that this complaint could be used in the future if repeat complaints were received. More stipulated orders, agreements between opposing parties that outlined relevant findings, sanctions, and remedies were found in study 2. A thoroughly investigated case with credible witnesses and/or admission of sexual misconduct by the licensee reduced contested case hearings and allowed for the use of board orders, which usually included probation, counseling, practice limitation, and appropriate compliance monitoring. Most practitioners were allowed to continue to work with practice limitation or modification, monitoring for compliance, and on-going therapy. Psychiatric evaluation and/or psychologic testing was incorporated in the investigational process or required before a decision was made about fitness to practice. Probation typically included continued psychotherapy and/or counseling, courses in physician/patient boundaries, the use of chaperones, and/or the limitation of practice that included the prohibition of patients of 1

Table VI Oregon Board of Medical Examiners 1998-2002: Elements of reported stipulated orders

Element	N
Revocation of license with stay, reprimand, probation with terms	3
Suspension stayed, reprimand, probation with terms	1
Surrender of license under investigation	2
Suspension of license, probation with terms	
Suspension, reprimand, probation with terms	1
Reprimand, probation with terms	4
Probation with terms	3
Reprimand with terms	4
TOTAL	18

Table VII Oregon Board of Medical Examiners closed sexual misconduct complaints 1998-2002: Sexual impropriety*

Allegation	N
Inappropriate breast or genital examination	12
Inappropriate comments during examination	1
Inappropriate comments about clinical findings	1
Inappropriate contact: Kissing or hugging family member of deceased	1
Improper socializing and alcohol with patient	1
Improper comments and privacy violation with examination	1
Total closed	17
Closed with disciplinary action	0

* No licensee with >1 complaint in category 1 complaint for 1998-2002.

Table VIII Oregon Board of Medical Examiners closed sexual misconduct complaints 1998-2002: Summary of sexual violation complaints (n = 30) closed with reportable disciplinary actions

Allegation	N
Sexual relationship with active patient	16
Therapist: Sexual relationship with active patient	2
Sexual relationship with multiple active patients	1
Sexual relationship and inappropriate prescribing	2
Sexual relationship (multiple) and inappropriate prescribing	1
Sexualization and voyeurism	2
Child pornography	1
Total closed with disciplinary action	25
Percentage closed with disciplinary action	83.3%

sex. If alcohol or substance abuse was a factor, participation in the Oregon Health Professionals Program (drug and alcohol diversion program) was mandated.

Licensing boards have unified guidelines for investigation and disciplinary actions and an awareness of the public harm sexual violations cause.[14] The study by Dehlendorf and Wolfe was critical of state actions suggesting that state board orders and sanctions were inadequate and that it was difficult to assess the potential for successful and sustained rehabilitation.[15] The OBME has not demonstrated the need to revoke the license of all physicians who were involved in sexual misconduct. None of the actions in study 2 involved a violation of terms of licensees who were on probation for sexual misconduct violations or involved the submission of new sexual violation complaints against probationers. The OBME has experience and data that are related specifically to sexual misconduct violations since 1991 and uses a thorough compliance regimen for all probationers. Public protection is always the primary focus of any consideration.

The incidence of multiple patient complaints essentially disappeared in study 2. In study 1, one physician had 6 complaints; 3 physicians had 3 complaints, and 6 investigations included 2 complaints. In 1994 the OBME instituted a more stringent investigation policy regarding sexual misconduct complaints, incorporated more prompt investigation, interviewed all willing complainants, and issued reportable disciplinary actions for licensees who were found in violation. In the early to mid 1990s practice guidelines by the American Medical Association, American Psychiatric Association, American College of Obstetricians and Gynecologists, and the Oregon Medical Association articulated issues of physician/patient boundaries and misconduct.[2,4,8,9] The OBME published articles in 1997, 1998, and 2001 that documented their experience and emphasized prevention.[16-18] The authors contend that the improvement in multiple and total complaints, especially sexual impropriety complaints, has been the result of more aggressive disciplinary board action, better informed

practitioners, and greater patient awareness of professional boundaries, which includes sexual harassment policies in the workplace.

Sexual impropriety complaints involved allegations of inappropriate breast or genital examination in 12 of the 17 investigations. Most allegations resulted from a lack of proper explanation of the scope, nature, or necessity of the examination which included touching or brushing the breast during examination of the chest, rubbing the upper vulva during vaginal ultrasound scanning, touching near the groin during musculoskeletal or neuromuscular examination, lack of respect for privacy while undressing, or inadequate covering during the examination. Even though sexual impropriety complaints were down substantially, there is still a need to anticipate patient concerns or the potential for misunderstanding by incorporating explanation, proper covering, limiting examination to required areas of focus based on patient complaint, using appropriate chaperones, and carefully considering language and questions during the interview and examination.

Twenty-five allegations in study 2 resulted in reportable disciplinary actions (1.6% of total closed complaints and 53.2% of sexual misconduct allegations). Twenty-two allegations involved sexual activity with ≥ 1 patients; 1 allegation involved child pornography, and 2 allegations involved voyeurism or sexualization of patient examination. Five sexual violation complaints were not found to have merit. Two complaints related to practitioners who had severed their professional relationship before initiating a social relationship, and no evidence of a physician-patient relationship was evident in the third allegation. Two other complaints were investigated thoroughly, and the board was unable to find substantial evidence or a credible witness to support the sexual misconduct allegation. The total number and percentage of reportable actions was not significantly higher (19 actions [1.1%] in study 1 and 25 actions [1.6%] in study 2), but zero tolerance should still be the gold standard.[15] The 25 sexual violation allegations that resulted in exploitation and significant harm to patients and their families and violated the practitioner's fiduciary responsibility, which is a relationship of trust in which 1 person (medical provider) is under a duty to act for the benefit of the other (the patient) on matters within the scope of their relationship.

Prevention of the more serious sexual violation complaints is more involved. Most sexual violations occurred outside the office, hospital setting, or after business hours, which makes detection and investigation more difficult. It is important to enhance our understanding of physicians and patients who may be at greater risk for exploitation. Prevention or early intervention remains the primary goal and can be achieved by the recognition of risk factors, deterrence, and adherence to practice standards. Publications from disciplinary boards (such as the BME report) should target current higher risk practitioner groups (such as the licensees in their 50s and >70 years old, family medicine licensees, and osteopathic physicians).

Table IX Oregon Board of Medical Examiners closed sexual misconduct complaints 1998-2002: Sexual violation complaints (n = 30) closed with no reportable disciplinary action

Allegation	N
Sexual relationship with patient: Patient properly dismissed before relationship	2
Sexual relationship with patient: No evidence of physician-patient relationship established	1
Request for sexual favors: Deceptive patient with failed polygraph examination	1
Inappropriate examination/genital manipulation Criminal and Board of Medical Examiners investigation: posttraumatic mentally incompetent patient, significant doubt about veracity of complaint	1
Closed	5
Percentage closed without disiplinary action	16.7%

Personal characteristics and/or psychiatric disorders of both physicians and patients can place them at risk for sexual transgressions, and recognition of these risk factors can play an important role in prevention. *Physician Sexual Misconduct*, edited by Bloom, Nadelson, and Notman[19] provides an outline of subtle to gross boundary violations that cross the line (such as personal disclosure to the patient or a conscious or unconscious bid for help) and lists 4 physician circumstances: (1) physicians may have a personal crises or loss that causes them to be more vulnerable and to seek out a patient who appears to provide support, (2) a mentally compromised therapist, with possible psychotic disorder, especially affective type (manic or hypomania) may be at higher risk, (3) a physician may have antisocial personality disorder or psychopathic personality, (4) a schizoid or paraphilic physician may exploit (voyeurism or exhibitionism) for gratification of the paraphilia.

Gabbard and Nadelson[13] recommended vigilance for predatory physicians or physicians who claim that sex is for therapeutic purpose, abuse examination procedures (not indicated or inappropriate/eroticized), ask for a date, or sexually harass patients with erotic or suggestive comments. Patients and physicians are cautioned to be vigilant about long-standing clinical relationships that could develop into a love-sickness or infatuation. It may be especially difficult to maintain proper boundaries in smaller or isolated communities in which essentially anyone who is a potential romantic partner is a patient.

Patient vulnerability is also a significant factor for physician sexual misconduct. Van der Kolk[20] described possible causes of vulnerability (such as present distress, recent loss, dependency, and a psychophysiologic addiction) to abusive relationships. Patients with borderline personality are also more vulnerable and tend to be involved in litigation more frequently. Gutheil[21] listed predisposing factors for borderline patients (such as rage, entitlement, boundary confusion, and psychotic transference).

Physician knowledge of possible consequences of sexual misconduct with a patient can serve as a strong deterrent to such behavior and may include discipline from medical boards, litigation, and criminal prosecution. Disciplinary actions provide notice to the public, hospitals, and provider groups and may involve license revocation and/or limitations in scope or location of practice. Tort liability is also a deterrence with legal complaints that are public, expensive to defend, and personally traumatic and may include liability policy exclusions for undue familiarity or limited/capped malpractice coverage for acts deemed negligent. By 1998, 16 states had statutes that criminalized sexual misconduct for therapists.[19] An Idaho statute expanded the criminalization of sexual misconduct to include health care providers other than therapists that states that a medical care provider who is found guilty of sexual exploitation may be charged with assault and battery, punishable by incarceration and/or a fine.[22] States usually have language in their medical practice statutes that is similar to Oregon that requires notice by physicians or medical institutions who have significant concerns about physicians who may have violated medical practice standards, who are impaired, or who have acted in an unprofessional manner.[23] Even if not sanctioned, the request to respond to or appear before a disciplinary board is a traumatic and embarrassing experience and usually can be prevented by simple safeguards.

Prevention should incorporate multiple elements including professional behavior with maintenance of proper boundaries during examination and a confidential time for questions. Examination and procedures should be preceded by an explanation and the patient should be allowed privacy, a time to undress and cover properly. Chaperones should be available for all patient examinations, especially during breast and pelvic examination, and patients should be informed orally or by written notice of chaperone availability if not used routinely.[24,25] Physicians must be constantly aware of their ethical and legal responsibilities and recognize their own vulnerabilities so that they may react properly to patient care situations. Medicine has an obligation to help identify colleagues who are at risk and to report suspected infractions of sexual misconduct. Medical licenses are granted by the state, and its citizens deserve medical care to be delivered within acceptable practice standards and ethical behavior from their caregivers.[26]

The Federation of State Medical Boards has provided a well-considered and thorough policy that defines sexual impropriety and sexual violations with recommendations regarding investigations, hearings, and disciplinary options and should serve as a model for the evaluation and processing of sexual misconduct complaints.[14]

The OBME has demonstrated significant improvement in total sexual misconduct complaints between study 1 and study 2, but the number of reportable actions has remained relatively stable rather than showing a concomitant drop, as the total disciplinary actions did in study 2. Psychiatry and obstetrics and gynecology improved in total sexual misconduct complaints and reportable disciplinary actions, but family medicine increased in reportable disciplinary actions. Osteopathic physicians and older physicians continue to demonstrate higher than average complaints. Multiple complaints occurred in only 1 instance, and no licensees who had been disciplined previously for sexual misconduct received a sexual violation complaint or additional reportable disciplinary action in study 2. The reduction in allegations of sexual misconduct continues to be the long-range goal of the OBME and requires education, practice prevention measures, and recognition of at-risk practitioners and vulnerable patients. Disciplinary boards and professional societies should continue regularly to present studies and detail practice management guidelines for the prevention of physician/patient boundary violations. Often well-formulated policies are presented initially, only to be archived in practice standard or policy books without periodic reconsideration. The appropriate use of deterrence that includes medical board actions, civil litigation, and criminal sanctions will continue to be important components. Physician rehabilitation is possible, but public protection is paramount.

Editor's note: This manuscript was revised after these discussions were presented.

Discussion

Dr Hampton Irwin, Spokane, Wash. The authors present their second 5-year study of sexual misconduct complaints among Oregon's medical and osteopath doctors. Statistical markers that were established by the first study are continued. Also included, as recommended by the Federation of State Medical Boards, is a separation of cases into sexual impropriety and sexual violation. The result is a system for tracking trends of sexual misconduct complaints within the entire scope of Oregon's medical disciplinary experience. One is struck by the consistency during the 10 years of study, despite the small numbers of actions.

Of significance is the persistence of a larger incidence in the older age group, the predominance within family practice, internal medicine, and psychiatry, and the emergence of plastic surgery and neurology into the mix.

This work is an important contribution to the cause of medical quality assurance. With this second 5-year study, we now have a validated model for analyzing sexual misconduct complaints for other state boards to adopt and even to adapt for other disciplinary categories. This type of trend analysis is in short supply in the United States. The Federation of State Medical Boards makes repeated pleas for creative mining of the rich veins of data that are collected in all of the states.

To prepare for this commentary, I obtained permission and assistance to produce a parallel study of sexual misconduct in the State of Washington. Using similar ratios for a bigger pool of physicians who serve a larger state, I will illustrate the Washington experience for the same years (1998-2002; Table I).

Compared with the Oregon percentage ratios, Washington has a modestly lower rate of action (reportable) cases. But the numbers are small because very few practitioners succumb to the urge to cross the boundaries of sexual propriety and because an unknown, and possibly large, number of transgressions are either not reported or insufficiently verified for cases to go forward. Part of the explanation for Washington's lower rates can be explained by 2 major legislative mandates that act to discourage women from registering complaints of sexual impropriety or violation: One is the Whistleblower law, which mandates that cases cannot go forward until the complainant releases her identity; the other is the recent Washington Supreme Court decision that calls for evidence to be clear and convincing rather than a preponderance of evidence to justify action.

In this time of immigrant diversity within our 2 states, many women are deprived culturally of a clear sense of their right to object to abuse by powerful authority figures. Many women are unaware of their right to complain or how to complain. Until they do register a complaint, the powers vested in our commissions cannot be brought to bear on their behalf. So we are left with good data from which we can learn much about why complaints are generated, about the practitioners who are the object of those complaints, and about what happens to complaints as they pass through our legislated systems. Unsettled is what to do about those many cases in which the evidence is insufficient to charge but doubts remain. Oregon has a tool that we in Washington do not have: the letter of concern. This is a nonreportable warning notice for those borderline cases that do not rise to the level of deviation of care.

1. What are your suggestions for lowering the misconduct rate in the 40- to 60-year-old group?

Table I Ratio comparisons (1998-2002)

	Oregon	Washington
Total complaints (n)	1537	4071
Total complaints with action (n)	173	311
Percentage of action to total (%)	11.3	7.6
All sex misconduct complaints (n)	47	112
Percentage of sex complaints (%)	3.1	2.8
Sex misconduct action cases (n)	25	24
Percentage of total complaints (%)	1.6	0.6
Percentage of sex action to total action (%)	14	7.7

2. Do your panels have a mechanism to protect the privacy of complainant victims?
3. Can you comment on the effectiveness of psychologic evaluation to identify sexual predators?

Dr Gainer Pillsbury, Jr, Long Beach, Calif. I was on a committee for gynecologic practice for The College a few years ago, and this subject was discussed. At that time, there were more complaints about female physicians than male physicians. Do you have any data about that? Are there any data about the use of chaperones? I believe most male obstetrician-gynecologists use chaperones, which could explain the relatively low incidence of complaints in our specialty. Family practitioners, internists, and even female physicians may feel that it is not necessary, but perhaps they should reconsider.

Dr Donald Barford, Everett, Wash. Is this characteristically a male provider, female patient issue? What are the numbers as far as this is concerned?

Dr Kirsten Eberhardt, Walla Walla, Wash. The ages were stressed, but maybe there are more younger female physicians, which could alter the numbers if you look at how many female physicians versus male physicians are in the younger age groups. That might be interesting.

Dr Mike Brady, Phoenix, Ariz. I am interested in the high ratio between complaints to and the actions taken by State Medical Boards. In your opinion, what is the best way to evaluate the job that State Medical Boards are doing?

Dr Roger Hoag, Berkeley, Calif. The malpractice insurance company that we used in Alameda/Contra Costa County has a provision that you are not covered if you are prosecuted for sexual misconduct. Do other professional liability insurers have that same provision, or was that a peculiar one to us?

Dr Jerry Shefren, Palo Alto, Calif. In California, typically there is a complaint and then the Medical Board evaluates that complaint and determines whether

to file charges. Once charges are filed, it becomes public information. All of that occurs before the physicians have had a chance to defend themselves. In a previous life as a Medical Director for a health plan, it was typical for us to remove that physician from the roster and not allow the physician to see patients of the health plan before the physician had an opportunity to actually defend herself/himself against the charge. Do you have any information about that?

Dr Enbom (Closing). The <40-year-old group actually had a lower than average risk, but how to address the high-risk groups is a very important question. Publications from the licensing board are our number 1 priority and then the evaluation of age-related subgroups with an increased risk (family medicine and the osteopathic physicians). After giving this paper to the OBME, I have already been invited to speak at the Oregon Family Practice Academy in May 2004 to talk about this very issue. I plan to emphasize the same information to the osteopathic members of the Board, of which there are 2, for their dissemination.

In Oregon, we have different issues of public notice on record than in Washington. One is that there is no confrontation or notice as to who the complainant is until a contested case level occurs. There is a great deal of latitude and exploration and investigation before there is any knowledge of who the complainant is to the physician and visa versa. You can look at that 2 ways, but the complainants do not have the fear of coming forward and being confronted immediately. It gives them a chance to express themselves. On the other hand the physicians and their attorneys tend to say that this is not a fair process, but it does bring the public into the office more readily.

Regarding psychologic testing, anyone who has a substantial complaint of sexual misconduct will undergo extensive psychologic or clinical psychologist testing. So far, the data have not shown that there has been recurrence from people who are on probation. Hopefully, those who have true underlying psychiatric disorders or who might be considered predatory in nature have been weeded out and not allowed to practice or are under strict supervision. I believe that has been one of Oregon's strengths to date and that it is working, but it is always a real concern. There is always a concern that a predatory physician or a physician with an underlying psychiatric problem will be missed. Public protection is really the issue.

Dr Pillsbury, I do not have data on the number that did and did not have chaperones, but I would agree with you that most people probably do now in our specialty. When I gave the first paper in 1996, we had a straw vote in the room and about one half of the people said that they did not use chaperones at that time. We do not have time to do that again now, but I think it is an issue that needs to be addressed continually. The medical director of the OBME addressed the subject of chaperones in the BME Report in 2001 based on the 1998 AMA guidelines.

Regarding male versus female physicians, our active licenses increased 112% between this study and the first study, and the female licenses increased from 20% to 26%. There were complaints against 2 female physicians in study 1 and against 2 female physicians in the second study. In study 1, neither of the complaints was substantial nor violated the medical practice. In study 2, 1 complaint was a female/female complaint and involved inappropriate prescribing and a sexual relationship.

Dr Hoag's question about professional liability is interesting. I cannot speak to every company, but my reading suggests that most companies, if not all, significantly limit coverage for sexual misconduct, inappropriate familiarity, or inappropriate transference. In some instances there may be limited coverage for defense or appearance before licensing boards.

Dr Shefren, in Oregon, the complaint process requires action if the Board has concern that this person is an immediate threat to the public at the time of the initial investigation. They may carry out an emergency suspension, which would be a notice to the public and to practitioner databases. However, if the Board carries out an emergency suspension, the time threshold to the final order and potential contested case hearing is significantly condensed and may make it more difficult for the Board to thoroughly investigate the allegations in the shortened statutory time frame. Therefore, the Board tends not to use emergency suspensions unless there is a high probability of imminent risk to the public at the time of initial notice of a complaint or during the preliminary investigation. Otherwise, in Oregon, public notice does not occur until the Board has completed the full investigation, carried out appropriate interviews, and the final action has been reached and verified to be a reportable action.

References

1. American Psychiatric Association. The principles of medical ethics with annotations especially applicable to psychiatry. Washington (DC): American Psychiatric Association; 1973.
2. American Psychiatric Association. The principles of medical ethics with annotations especially applicable to psychiatry. Washington (DC): American Psychiatric Association; 1993.
3. Council on Ethical and Judicial Affairs, American Medical Association. Current opinions of the council on ethical and judicial affairs 1989, opinion 8.14, sexual misconduct. Chicago (IL): American Medical Association; 1989.
4. Council on Ethical and Judicial Affairs, American Medical Association. Sexual misconduct in the practice of medicine. JAMA 1991;266:2741-5.
5. Committee on Physician Sexual Misconduct. Crossing the boundaries: the report of the committee on physician sexual misconduct. Vancouver, Canada: College of Physicians and Surgeons of British Columbia; 1992.
6. College of Physicians and Surgeons of Ontario. The final report of the task force on sexual abuse of patients. Toronto: College of Physicians and Surgeons of Ontario; 1991.

7. Medical Council of New Zealand. Sexual abuse in the doctor-patient relationship: discussion document for the profession. Newslett Med Council NZ 1992;6: 4-5.
8. American College of Obstetricians and Gynecologists, Committee on Ethics. Sexual misconduct in the practice of obstetrics and gynecology: ethical considerations. Washington (DC): The College; 1994 Report No.: 144.
9. Oregon Medical Association. Guidelines for physicians-sexual issues. Portland (OR): Oregon Medical Association; 1995.
10. Bella R. Police launch criminal probe. The Oregonian (Portland, Ore) 1994 September 29; fourth edition, Local Stories Section: A01.
11. Bella R. Gynecologist accused of sexual abuse surrenders. The Oregonian (Portland, Ore) 1994 December 28; fourth edition, Local Stories Section: A01.
12. Enbom JA, Thomas CD. Evaluation of sexual misconduct complaints: the Oregon Board of Medical Examiners 1991-1995. Am J Obstet Gynecol 1997;176:1340-8.
13. Gabbard GO, Nadelson C. Professional boundaries in physician--patient relationship. JAMA 1995;273:1445-9.
14. Federation of State Medical Boards. Ad hoc committee on physician impairment report on sexual boundary issues. Fed Bull: J Med Licens Discipl 1995;4:208-16.
15. Dehlendorf C, Wolfe S. Physicians disciplined for sex-related offenses. JAMA 1998;279:1883-8.
16. Enbom JA, Thomas CD. Oregon Board of Medical Examiners: Sexual boundary allegations: BME. BME Rep 1997;Spring/-Summer:1-3.
17. Hicks JA. Oregon Board of Medical Examiners: sexual misconduct revisited. BME Rep 1998;Spring/Summer:1-5.
18. Parshley P, Sherman M. Chaperones and communication. BME Rep 2001;Fall/Winter:1-4.
19. Bloom JD, Nadelson CC, Notman MT, editors. Physician sexual misconduct. Washington (DC): American Psychiatric Press; 1999.
20. Von der Kolk BA. The compulsion to repeat the trauma: reenactment, revictimization, and masochism. Psych Clin North Am 1989;12:389-411.
21. Gutheil TG. Borderline personality disorder violations, and patient-therapist sex: medicolegal pitfalls. Am J Psychiatry 1989; 146:597-602.
22. Idaho Stat §18-919 (Sexual exploitation by a medical care provider).
22. Bloom JD, Nadelson CC, Notman MT, editors. Physician sexual misconduct. Washington (DC): American Psychiatric Press; 1999.
23. Oregon Revised Stat §677.415 (2) (Investigation of incompetence; reports to board).
24. American Medical Association. Use of chaperones during physical examination, AMA policy E-8.2. Chicago: American Medical Association; 1998.
25. American College of Obstetrics and Gynecology. Ethics in obstetrics and gynecology: sexual misconduct in the practice of obstetrics and gynecology: ethical considerations. Washington (DC): The College; 2002.
26. Oregon Revised Stat §677.015 (Statement of purpose).