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Submitted electronically

Comments Regarding New Jersey's Proposed Rule on Sexual Misconduct Education and Prevention (PRN 2024-041)

Public Citizen, a national nonprofit consumer advocacy organization with more than 500,000 members and supporters nationwide, submits the below comments regarding New Jersey's (NJ's) proposed rule on sexual misconduct education and prevention, published in the NJ Register on April 15, 2024.[1]

For years, Public Citizen's Health Research Group has called for classifying all forms of sexual misconduct by health care professionals against patients as "sexual abuse," urged the health care community to embrace an explicit zero-tolerance standard against such abuse, and called for undertaking cultural, institutional, and regulatory changes to eradicate this problem.[2,3,4,5]

We commend NJ's Office of the Attorney General, Division of Consumer Affairs, and state Board of Medical Examiners (hereafter, the board) for their work on creating this proposed rule and for their efforts to address the pervasive public-health problem of sexual abuse of patients at the hands of their health care professionals. Mainly, the proposed rule entails the following actions pertaining to physician licensees: (1) increasing the number of continuing medical education (CME) credit hours related to sexual misconduct prevention that physicians need from one to two and (2) establishing an explicit right to have an observer present during sensitive examinations by physicians and informing patients about this right.

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[1] New Jersey Register. Proposed rule number: 2024-041, sexual misconduct education and prevention. April 15, 2024. https://www.njconsumeraffairs.gov/ProposalPDF/bme-04152024-proposal.pdf. Accessed June 14, 2024.

[2] AbuDagga A, Carome M, Wolfe SM, Oshel RE. 15-year summary of sexual misconduct by U.S. physicians reported to the National Practitioner Data Bank, 2003 — 2017. In-depth, updated evidence on white coat betrayal. May 26, 2024. https://www.citizen.org/wp-content/uploads/2523.pdf. Accessed June 14, 2024.

[3] 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.

[4] AbuDagga A, Wolfe SM, Carome M, Oshel RE. Crossing the line: Sexual misconduct by nurses reported to the National Practitioner Data Bank. *Public Heal Nurs*. 2019;36(2):109-117.

[5] AbuDagga A, Wolfe SM, Carome M, Oshel RE. Cross-sectional analysis of the 1039 U.S. physicians reported to the National Practitioner Data Bank for sexual misconduct, 2003–2013. *PLoS One*. 2016;11(2):e0147800.

Our comments discuss certain aspects of the proposed rule that can be improved as well as additional actions that are not currently incorporated into this rule but would be essential to preventing physician sexual abuse of patients.

I. Ensuring adequacy of mandatory education about sexual abuse

The proposed rule increases the number of CME credit hours about sexual misconduct prevention — required for biennial renewal of physician licenses — from one to two. The rule indicates that this requirement can be satisfied with any course(s) that cover specific topics: understanding sexual misconduct forms and types, obtaining informed consent for sensitive procedures, understanding how to interact with victims of sexual abuse or harassment, understanding the power dynamics underlying sexual misconduct in the health care field, knowing what to do when one has experienced unwanted sexual contact, understanding bystander intervention and the duty to report, and identifying cases of human trafficking and understanding how to treat human-trafficking victims.

We agree with the proposed CME topics regarding sexual misconduct prevention. However, to best protect the public, any educational requirements regarding these topics should not be limited to license renewals — the rule should extend this requirement to initial licensing of physicians. In addition, we believe that a two-hour educational course is unlikely to be sufficient to cover the specified sexual misconduct topics with enough depth. Also, the rule should stipulate a process for ensuring the adequacy of this training because CME programs tend to vary in the extent to which they cover the complexity of these topics. The rule would be improved by requiring the board to review education programs before approving them. Another cost-effective option would be for the board to design and offer standardized online training regarding these topics. For example, the State Medical Board of Ohio offers a one-hour online course regarding the duty to report physician misconduct, including sexual misconduct.[6]

II. Need to extend the right to a trained observer to *all* clinical encounters and *mandate* use of trained observers during sensitive examinations in *all* health care settings

First, we applaud that the proposed rule acknowledges the importance of observers for patient protection and value the requirement that physicians provide a conspicuous post and a written notice to patients (and any other person who is to be examined) about the right to have an observer present in office settings. We also appreciate the fact that the rule requires observers to be "medically knowledgeable and trained" and indicates that only health care professionals licensed by the board or NJ's Board of Nursing or who are certified medical assistants (CMAs) can serve as observers. However, the rule does not specify whether additional education or specific training beyond the two-hour CME described earlier will be required for physician observers and does not mention any details regarding the requirements for nurse and CMA observers. It is critical for the rule to address this issue because without mandating adequate training of observers, their

[6] State Medical Board of Ohio. Duty to report. https://med.ohio.gov/for-licensees/duty-to-report. Accessed June 14, 2024.

presence will just offer an "illusion of safety"[7] and will allow sexually abusive physicians to continue to harm patients, undermining the intended goals of the rule.

Second, the proposed rule only *offers* patients and other examinees the explicit right to a trained observer during sensitive examinations (breast, pelvic, genital, or rectal) performed by physicians. We believe the final rule should *mandate* the routine use of a trained observer for all sensitive examinations to ensure patient protection, consistent with guidelines by the American College of Obstetricians and Gynecologists.[8] Also, we ask that the rule make it clear that use of trained observers applies to sensitive examinations in *both* inpatient and outpatient settings, including diagnostic procedures and labor. The rule can stipulate various measures to minimize the intrusiveness of the presence of observers, such as proper draping during examinations, presence of a support person for the patient (such as a friend or relative), and discussing private details in the absence of observers or others, as needed.

Third, because sexual abuse can occur outside of sensitive examinations, we recommend revising the rule to expand the right to a trained observer to all clinical encounters in all medical settings, as preferred by patients. Therefore, the proposed rule should make it clear that patients can request an observer *anytime* during their examinations, procedures, and other interactions with physicians.

Fourth, by not referencing female and male sexes with respect to the right to an observer, the proposed rule appropriately makes this right applicable to all patient gender identities or expressions. However, the rule fails to explicitly state that this right is irrespective of gender identities or expressions of physicians as well. Therefore, because most patients prefer an observer of the same gender, it also is important for the rule to indicate that the observer should be a person acceptable to the patient, including their preferred gender identity or expression.

Fifth, to enhance patient protection, the rule should stipulate that observers should not have past criminal, disciplinary, or malpractice history. In all cases, the identity of the observer also should be documented in patient medical records.

III. Promoting independence of observers

The proposed rule does not seem to promote — to the extent possible — the independence of observers from the health care professionals they observe (and report on, when needed). Instead, the rule emphasizes the use of employees of physicians or others who are contracted by physicians to serve as their observers. This is concerning because dependence on payment can discourage observers from reporting sexual abuse perpetrated by physicians.

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[7] Federation of State Medical Boards. Physician sexual misconduct. Report and recommendations of the FSMB workgroup on physician sexual misconduct. May 2020. http://www.fsmb.org/siteassets/advocacy/policies/report-of-workgroup-on-sexual-misconduct-adopted-version.pdf. Accessed June 14, 2024.

[8] American College of Obstetricians and Gynecologists. Sexual misconduct: ACOG committee opinion, number 796. Sexual misconduct. *Obs Gynecol*. 2020;135(1):e43-e45.

Therefore, the rule should stipulate best practices regarding this issue. For example, in some states, observers are required to be active licensees of another health profession to strengthen their professional duty to report.[9] Another good practice is to use a panel of different observers who continually rotate among observed physicians to minimize the chance of developing a collegial relationship between an observer and a specific physician. These practices would be particularly easy to implement in health care systems and group practices.

Also, it is important for the rule to undertake and enforce appropriate regulatory measures to address concerns of retaliation when observers report instances of observed or suspected sexual abuse of patients.

IV. Replacing use of board-mandated observers for abusive and potentially abusive physicians with other, more effective measures to protect patients

The proposed rule notice indicates that the distinction between patient- or physician-requested observers and board-mandated observers is maintained in state documents, as the latter usually report to the board and are imposed as a "disciplinary condition" when a physician is under investigation for, or has been found guilty of, sexual abuse. The Federation of State Medical Boards recommends that a board-mandated observer should "always [be] in attendance" and sign medical records attesting to their presence during examinations or other patient interactions, as a possible condition after a physician has been found guilty of patient sexual misconduct.[10] However, a robust independent review by an Australian expert (Professor Ron Paterson) found that board-mandated observers are ineffective in protecting patients from inappropriate "relationship" type physician sexual abusers because "failures will inevitably occur because of the interpersonal dynamics inherent in abuse[; for example,] an abuser will make strenuous efforts to evade observation and the victim will have difficulty stopping the abuse."[11] This led Australian regulators in 2017 to phase out use of board-mandated observers.[12] In fact, Professor Paterson called for imposing gender-based restrictions on the practice of these physicians or suspending them and recommended that observers can *only* be imposed in exceptional, low-level cases of sexual misconduct in which (a) the allegation involves a single patient; (b) if proven, it will not be considered a criminal offense; and (c) the practitioner does not have a history of sexual-misconduct-related complaints or discipline.

Therefore, we ask that the rule stipulate removal of the use of board-mandated observers as an interim protective measure. Instead, the board should establish and enforce clear mandatory serious licensing penalties (mainly suspension and revocation) against all

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[9] Federation of State Medical Boards. Physician sexual misconduct. Report and recommendations of the FSMB workgroup on physician sexual misconduct. May 2020. http://www.fsmb.org/siteassets/advocacy/policies/report-of-workgroup-on-sexual-misconduct-adopted-version.pdf. Accessed June 14, 2024.

[10] *Ibid*.

[11] Paterson R. Independent review of the use of chaperones to protect patients in Australia. February 2017. https://www.nhpo.gov.au/sites/default/files/2020-08/Chaperone-review-report-WEB.pdf. Accessed June 14, 2024.

[12] Paterson R. Physicians, patients, sex and chaperones: rethinking medical regulation. *J Med Regul*. 2021;107(2):17-24.

physicians who have been found guilty of patient sexual abuse. Importantly, we recommend mandatory revocation of the license of any physician found to have engaged in sexual abuse involving physical sexual acts (such as intercourse or sodomy).

V. Other recommendations

Physician education about sexual misconduct and its prevention and the use of trained observers are only part of the solution to preventing patient sexual abuse. Several other integral measures are included in NJ's 2021 attorney general administrative executive directive for addressing sexual misconduct by licensed professionals and applicants.[13] Therefore, we urge state officials to promptly implement the remaining measures outlined in the directive, particularly those pertaining to promoting licensure accountability for sexual misconduct (such as promptly investigating complaints of sexual misconduct and enforcing the duty to report all types of observed or suspected sexual abuse by health care professionals) and ensuring support to victims.

A particularly critical aspect of sensitive examination that is missing from the proposed rule is the provision of educational materials about sexual abuse to patients during health care encounters. The rule would be significantly enhanced by incorporating the provision of such materials — such as what constitutes a proper sensitive examination and how to recognize deviations from those — to patients and their proxies. The additional cost of developing these materials can be minimized by using existing standardized materials, such as those from the North Carolina Medical Board's "Know the Signs of Sexual Misconduct" and "Undergoing a Physical Examination: Your Rights" brochures.[14] The benefits of providing such materials will far outweigh the cost of providing them.

Furthermore, we call on state officials to enact patient's right to know regulations, which require physicians with any disciplinary history due to sexual abuse of patients to inform their patients about these offenses so that patients can make informed decisions regarding whether they want to receive health care from them.

Public Citizen's recent analysis of serious disciplinary licensing actions against allopathic medicine physicians reported to the National Practitioner Data Bank found that, on average, New Jersey took a serious licensing action against fewer than 0.5 per 1,000 physicians, which led to a 41st ranking among all states and the District of Columbia.[15] Therefore, we ask the board to take more serious disciplinary actions against sexually abusive physicians as well as those responsible for negligent medical care, as appropriate, to protect the public from dangerous physicians.

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[13] State of New Jersey, Office of the Attorney General. Attorney General administrative executive directive (No. 2021-3) re. addressing sexual misconduct by licensed professionals and applicants. April 6, 2021. https://www.nj.gov/oag/dcj/agguide/directives/ag-directive-2021-3_DCA-Sexual-Misconduct-Prosecutions.pdf. Accessed June 11, 2024.

[14] North Carolina Medical Board. Resources & information. Brochures. https://www.ncmedboard.org/resources-information/consumer-resources/brochures. Accessed June 13, 2024.

[15] Wolfe SM, Oshel RE. Ranking of state medical boards' serious disciplinary actions, 2019-2021. August 16, 2023. https://www.citizen.org/wp-content/uploads/230816_StateMedicalDisciplinaryReport.pdf. Accessed June 14, 2024.

Moreover, the board should post on its website detailed disciplinary history and malpractice information (and the reasons for these actions) for its licensed physicians, as applicable. Currently, the board limits disciplinary actions against licensed physicians on its website to the past 10 years only.[16]

Finally, the proposed rule, the 2021 directive, and other related documents should explicitly embrace a zero-tolerance standard of all forms of sexual exploitation of patients and should replace the term "sexual misconduct" with the term "sexual abuse" when referring to any form or type of sexual abuse of patients by health care professionals because of the breach of trust and exploitative nature of such offenses. We maintain that any characterization that does not involve the term "abuse" fails to emphasize the profound unethical nature of physical sexual contact or relations and sexual interactions between physicians and their patients.

VI. Conclusions

Public Citizen supports this important proposed rule regarding sexual misconduct education and prevention. We hope you will consider our suggestions as you finalize this rule and plan future ones to engender positive changes to protect the people of New Jersey from sexually abusive health care professionals and provide a good example to follow across the United States and internationally.

Thank you for the opportunity to comment on this important proposed rule.

Sincerely,

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[16] Cronin C, McGiffert L. Looking for doctor information online. A survey and ranking of state medical and osteopathic board websites in 2021. January 2022. https://www.patientsafetyaction.org/wp-content/uploads/2022/03/Looking-for-Doctor-Information-Online-1-7-22.pdf. Accessed June 14, 2024.