Regulatory Analysis Form

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INDEPENDENT REGULATORY REVIEW COMMISSION

(1) Agency

Department of State, Bureau of Professional and Occupational Affairs, State Board of Osteopathic Medicine

(2) I.D. Number (Governor's Office Use)

16A-539

IRRC Number: 2262

(3) Short Title

Sexual Misconduct

(4) PA Code Cite

49 Pa. Code §§25.215 and 25.216

(5) Agency Contacts & Telephone Numbers

Primary Contact: **Amy L. Nelson (717) 783-7200**
Counsel-State Board of Osteopathic Medicine
Secondary Contact: **Joyce McKeever (717) 783-7200**
Deputy Chief Counsel
Department of State

(6) Type of Rulemaking (check one)

__ Proposed Rulemaking
X Final Order Adopting Regulation
__ Final Order, Proposed Rulemaking Omitted

(7) Is a 120-Day Emergency Certification Attached?

X No
__ Yes: By the Attorney General
__ Yes: By the Governor

(8) Briefly explain the regulation in clear and nontechnical language.

The regulation will better protect consumers of medical services and provide guidance to Board-Regulated Practitioners on issues relating to sexual misconduct between licensees and current or former patients or immediate family members of patients.

(9) State the statutory authority for the regulation and any relevant state or federal court decisions.

Sections 10.1(c), 15(a)(8), 15(b)(9) and 16 of the Osteopathic Medical Practice Act, the Act of December 20, 1985, P.L. 398, No. 108, as amended, 63 P.S. §§ 271.10a(c), 271.15(a)(8), 271.15(b)(9) and 271.16.

Regulatory Analysis Form

(10) Is the regulation mandated by any federal or state law or court order, or federal regulation? If yes, cite the specific law, case or regulation, and any deadlines for action.

No.

(11) Explain the compelling public interest that justifies the regulation. What is the problem it addresses?

It is axiomatic that sexual contact between health care practitioners and patients is unethical. Nevertheless, every year complaints are filed by patients who are harmed by practitioners who violate this principle.

The regulation will better protect consumers and provide guidance to the profession on issues relating to sexual contact between practitioners and current patients, former patients or immediate family members of patients.

(12) State the public health, safety, environmental or general welfare risks associated with nonregulation.

Specific regulations will help educate consumers and professionals about the boundaries of the professional relationship.

(13) Describe who will benefit from the regulation. (Quantify the benefits as completely as possible and approximate the number of people who will benefit.)

Consumers as well as the profession as a whole will benefit from the guidance to be provided by the regulations.

Regulatory Analysis Form

(14) Describe who will be adversely affected by the regulation. (Quantify the adverse effects as completely as possible and approximate the number of people who will be adversely affected.)

There are no perceived people or groups of people who would be adversely affected by this regulation.

(15) List the persons, groups or entities that will be required to comply with the regulation. (Approximate the number of people who will be required to comply.)

All licensees of the Board will be required to comply with the regulation. Currently, there are over 10,000 licensees of the Board.

(16) Describe the communications with and input from the public in the development and drafting of the regulation. List the persons and/or groups who were involved, if applicable.

A notice of the proposed rulemaking was published at 32 Pa.B. 1734 (April 6, 2002) and was submitted to the House Professional Licensure Committee and the Senate Consumer Protection and Professional Licensure Committee as well as the Independent Regulatory Review Commission (IRRC). The Board also received comments from members of the public. In preparing the final rulemaking, the Board considered the comments received from IRRC and the public. The Committees did not comment on the proposed regulation.

(17) Provide a specific estimate of the costs and/or savings to the regulated community associated with compliance, including any legal, accounting or consulting procedures which may be required.

There should be no cost to the regulated community associated with compliance with this regulation. Savings to the regulated community are not specifically quantifiable.

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(18) Provide a specific estimate of the costs and/or savings to local governments associated with compliance, including any legal, accounting or consulting procedures which may be required.

N/A

(19) Provide a specific estimate of the costs and/or savings to state government associated with the implementation of the regulation, including any legal, accounting, or consulting procedures which may be required.

N/A

Regulatory Analysis Form

(20) In the table below, provide an estimate of the fiscal savings and costs associated with implementation and compliance for the regulated community, local government, and state government for the current year and five subsequent years.

	Current FY Year	FY +1 Year	FY +2 Year	FY +3 Year	FY +4 Year	FY +5 Year
SAVINGS:	$N/A	$N/A	$N/A	$N/A	$N/A	$N/A
Regulated						
Local Government						
State Government						
Total Savings						
COSTS:	$N/A	$N/A	$N/A	$N/A	$N/A	$N/A
Regulated Community						
Local Government						
State Government						
Total Costs						
REVENUE LOSSES:	$N/A	$N/A	$N/A	$N/A	$N/A	$N/A
Regulated Community						
Local Government						
State Government						
Total Revenue Losses						

(20a) Explain how the cost estimates listed above were derived.

N/A

Regulatory Analysis Form

(20b) Provide the past three year expenditure history for programs affected by the regulation.
N/A

Program	FY –3 99 - 00	FY –2 00 - 01	FY –1 01 - 02	Current FY 02 – 03
State Board of Osteopathic Medicine	**405,527.84**	**457.338.63**	**503,718.72**	**1,172,000.000**

(21) Using the cost-benefit information provided above, explain how the benefits of the regulation outweigh the adverse effects and costs.

There should be no adverse effects and costs associated with compliance with the regulation. The benefits of the regulation are described in paragraphs 11 and 13 above.

(22) Describe the non-regulatory alternatives considered and the costs associated with those alternatives. Provide the reasons for their dismissal.

Non-regulatory alternatives were not considered by the Board for two reasons: (1) A policy statement on the issue of sexual intimacies would not have the force or the effect of law; (2) Waiting for court decisions to address the issues addressed by the regulation would benefit neither consumers nor the profession.

(23) Describe alternative regulatory schemes considered and the costs associated with those schemes. Provide the reasons for their dismissal.

No other regulatory schemes were considered.

Regulatory Analysis Form

(24) Are there any provisions that are more stringent than federal standards? If yes, identify the specific provisions and the compelling Pennsylvania interest that demands stronger regulation.

There are no applicable federal standards, however, the regulation is consistent with the ethics code of the American Osteopathic Association to which many State Board of Osteopathic Medicine licensees adhere.

(25) How does this regulation compare with those of other states? Will the regulation put Pennsylvania at a competitive disadvantage with other states?

The regulation is consistent with the ethics code of the American Osteopathic Association and with the laws of other states. Compared to other states, such as Maryland, New Jersey and New York, the regulation contains similar prohibited acts of sexual misconduct by a physician. Maryland has a specific law that prohibits sexual misconduct by licensees under the Health Occupation Board and provides examples of such circumstances and disciplinary actions. 1 Md. Code Ann. § 1-212(a), (b) and (e) (2000). In New Jersey, the sexual misconduct regulation begins by defining relevant terms to interpreting the section. 13 N.J.A.C. § 35-6.3. It also lists a wide variety of conduct that is prohibited. Id. New York does not have a specific section dedicated to sexual misconduct, but instead uses three broad sections within its professional misconduct statute to prosecute this area of law. 8 NY Educ. § 6530(20), (31) and (44). Therefore, the Pennsylvania regulation will not place Pennsylvania at a competitive disadvantage compared to other states because the regulation is typical among other states.

(26) Will the regulation affect existing or proposed regulations of the promulgating agency or other state agencies? If yes, explain and provide specific citations.

No.

(27) Will any public hearings or informational meetings be scheduled? Please provide the dates, times, and locations, if available.

In light of the extensive public outreach already conducted in promulgation of this regulation, the Board has scheduled no public hearings or informational meetings regarding this regulation. However, the Board meets in public session on the second Wednesday of every month. Comments from the public are always welcome.

Regulatory Analysis Form

(28) Will the regulation change existing reporting, record keeping, or other paperwork requirements? Describe the changes and attach copies of forms or reports which will be required as a result of implementation, if available.

No.

(29) Please list any special provisions which have been developed to meet the particular needs of affected groups or persons including, but not limited to, minorities, elderly, small businesses, and farmers.

The Board is not aware of any group with special needs that should be excluded from this regulation.

(30) What is the anticipated effective date of the regulation; the date by which compliance with the regulation will be required; and the date by which any required permits, licenses or other approvals must be obtained?

The regulation will be effective upon publication as an Order of Final Rulemaking in the Pennsylvania Bulletin. Compliance will be required as of that date.

(31) Provide the schedule for continual review of the regulation.

The Board continuously reviews its regulations, periodically communicates with licensees through newsletters and obtains information and feedback from its licensees on a frequent basis.

administered portions which were not successfully completed in written format.

(1) A candidate who has not passed both parts of Division B: Site Design on or before June 30, 1996, will be required to successfully complete the Site Planning part.

(2) A candidate who did not successfully complete Division C: Building Design on or before June 30, 1996, will be required to successfully complete the Building Planning and Building Technology parts.]

GRADING AND REVIEW

§ 9.131. **[Examination grading] (Reserved).**

[The ARE shall be graded using procedures developed by NCARB in consultation with a professional testing organization. Examination results shall be recorded by the Board in the record of the candidate and shall be maintained in accordance with § 9.27 (relating to inactive records).]

§ 9.132. **[Grading compilation] (Reserved).**

[To qualify for licensure, a candidate shall receive a passing grade on each part or division of the examination. Grades received in individual parts or divisions will not be averaged. A candidate will have unlimited opportunities, subject to § 9.46(3) (relating to requirements for examination eligibility), to retake those portions of the examination which were failed.]

[Pa.B. Doc. No. 02-524. Filed for public inspection April 5, 2002, 9:00 a.m.]

STATE BOARD OF OSTEOPATHIC MEDICINE

[49 PA. CODE CH. 25]
Sexual Misconduct

The State Board of Osteopathic Medicine (Board) proposes to adopt § 25.215 (relating to sexual misconduct) to read as set forth in Annex A.

Effective Date

This proposed regulation will be effective upon publication as an order of final-form rulemaking in the *Pennsylvania Bulletin*.

Statutory Authority

Under sections 10.1(c), 15(a)(8) and (b)(9) and 16 of the Osteopathic Medical Practice Act (63 P. S. §§ 271.10a(c), 271.15(a)(8) and (b)(9) and 271.16), the Board has authority to establish standards of professional conduct for Board regulated practitioners under its jurisdiction. These individuals include osteopathic physicians, physician assistants and respiratory care practitioners. Proposed § 25.215 identifies when sexual contact by Board regulated practitioners with patients, and under certain circumstances, immediate family members of patients, will be deemed unprofessional conduct.

Background and Purpose

It should be axiomatic that it is unprofessional conduct for a health care practitioner to engage in sexual contact with patients. Past decisions of the Board which have been upheld by the Commonwealth Court; the Code Ethics, as published by the American Osteopathic Association; and responsible professional publications addre ing the issue denounce sexual contact between pra tioner and patient. Nevertheless, complaints are fi each year by consumers who have been harmed by Bo regulated practitioners who engage in this conduct.

Description of Proposed Regulation

The proposed regulation seeks to better protect patie by providing guidance to the profession and the public to prohibited conduct relating to sexual contact betw practitioners and patients. The proposed regulation wo prohibit any sexual contact between a Board regula practitioner and a current patient. The proposed regu tion would further prohibit any sexual contact betwee Board regulated practitioner and a former patient prio the 2 year anniversary of the termination of the pro sional relationship when the Board regulated practitio has been involved with the management or treatment patient for a mental health disorder. This 2-year per was developed from professional literature which in cates that an imbalance of power between health c practitioners and patients continues after the professio relationship ends.

The proposed regulation would also prohibit sex exploitation by a Board regulated practitioner of a rent or former patient or immediate family member patient. "Sexual exploitation" is defined by the regulat as sexual behavior that uses the trust, knowledge, e tions or influence derived from the professional relati ship. The Board believes that it is appropriate to pro immediate family members from sexual exploitation Board regulated practitioners because immediate fan members are often as vulnerable as the patients.

The proposed regulation would also provide that Bo regulated practitioners who engage in prohibited sex contact with patients or former patients will not eligible for placement in the Board's impaired pro sional program in lieu of disciplinary or corrective tions. The impaired professional program is unable effectively monitor Board regulated practitioners have engaged in sexual misconduct.

The proposed regulation would also provide that tient consent will not be considered a defense to discip ary action in these cases. The imbalance of power inl ent in the health care practitioner—patient relations not only serves as the basis for the prohibition but undermines the patient's ability to consent to the sex contact as an equal. Indeed, the Board's experience adjudicating these cases has repeatedly demonstrated reality of the inherent imbalance of the relationship the patient's inability to give meaningful consent sexual contact.

Fiscal Impact and Paperwork Requirements

The proposed regulation should have no fiscal imp on the Commonwealth or its political subdivisions. L wise, the proposed regulation should not necessitate legal, accounting, reporting or other paperwork requ ments.

Sunset Date

The Board continuously monitors the cost effectiver of its regulations. Therefore, no sunset date has b assigned.

Compliance with Executive Order 1996-1

In compliance with Executive Order 1996-1, the Board extended an invitation to comment on early drafts of this proposal to numerous parties who have indicated an interest in the Board's regulatory activities. The list of these persons is available upon request from the contact person listed in this Preamble. Five physicians commented on the early version. Those commenting on the regulation seemed to agree that the sexual exploitation of patients is improper and should subject the Board regulated practitioner to disciplinary action. Some of the physicians were concerned that innocent behavior may be prohibited by the proposal and only the issue of exploitation should be addressed. Others misunderstood the language of the proposed regulation, and were concerned that the proposal would prohibit a sexual relationship with any patient for 2 years following the physician-patient relationship. The Board is satisfied that the current proposal adequately protects the public without unduly burdening Board licensees.

Regulatory Review

Under section 5(a) of the Regulatory Review Act (71 P. S. § 745.5(a)), on March 27, 2002, the Board submitted a copy of this proposed regulation to the Independent Regulatory Review Commission (IRRC) and the Chairpersons of the House Professional Licensure Committee and the Senate Consumer Protection and Professional Licensure Committee. In addition to submitting the proposed regulation, the Board has provided IRRC and the Committees with a copy of a detailed regulatory analysis form prepared by the Board in compliance with Executive Order 1996-1, "Regulatory Review and Promulgation." A copy of this material is available to the public upon request.

Under section 5(g) of the Regulatory Review Act, if IRRC has objections to a portion of the proposed regulation, it will notify the Board within 10 days of the close of the Committees' review period. The notification shall specify the regulatory review criteria which have not been met by that portion. The Regulatory Review Act specifies detailed procedures for the Board, the Governor and the General Assembly to review these objections before final publication of the proposed regulation.

Public Comment

Interested persons are invited to submit written comments, suggestions or objections regarding the proposed regulation to Amy L. Nelson, Counsel, State Board of Medicine, 116 Pine Street, P. O. Box 2649, Harrisburg, PA 17105-2649, within 30 days of publication of this proposed regulation.

DANIEL D. DOWD, Jr., D.O.,
Chairperson

Fiscal Note: 16A-539. No fiscal impact; (8) recommends adoption.

Annex A

TITLE 49. PROFESSIONAL AND VOCATIONAL STANDARDS

PART I. DEPARTMENT OF STATE

Subpart A. PROFESSIONAL AND OCCUPATIONAL AFFAIRS

CHAPTER 25. STATE BOARD OF OSTEOPATHIC MEDICINE

Subchapter D. MINIMUM STANDARDS OF PRACTICE

§ 25.215. Sexual misconduct.

(a) *Definitions.* The following words and terms, when used in this section, have the following meanings, unless the context clearly indicates otherwise:

Immediate family member—A parent or guardian, child, sibling, spouse or other family member with whom a patient resides.

Sexual behavior—Any sexual conduct which is nondiagnostic and nontherapeutic; it may be verbal or physical and may include expressions of thoughts and feelings or gestures that are sexual in nature or that reasonably may be construed by a patient as sexual in nature.

Sexual exploitation—Any sexual behavior that uses trust, knowledge, emotions or influence derived from the professional relationship.

(b) *Unprofessional conduct: sexual exploitation.* Sexual exploitation by a Board regulated practitioner of a current or former patient, or of an immediate family member of a patient, constitutes unprofessional conduct, is prohibited, and subjects the practitioner to disciplinary action.

(c) *Unprofessional conduct: sexual behavior.* Sexual behavior that occurs with a current patient constitutes unprofessional conduct, is prohibited, and subjects the practitioner to disciplinary action.

(d) *Sexual behavior prior to 2-year anniversary.* When the practitioner is involved with the management or treatment of a patient for a mental health disorder, sexual behavior with that former patient which occurs prior to the 2-year anniversary of the termination of the professional relationship constitutes unprofessional conduct, is prohibited, and subjects the practitioner to disciplinary action.

(e) *Impaired professional program.* A practitioner who engages in conduct prohibited by this section will not be eligible for placement into an impaired professional program in lieu of disciplinary or corrective actions.

(f) *Consent.* Consent is not a defense to conduct prohibited by this section.

[Pa.B. Doc. No. 02-525. Filed for public inspection April 5, 2002, 9:00 a.m.]

NOTICES

INDEPENDENT REGULATORY REVIEW COMMISSION

Notice of Comments Issued

[32 Pa.B. 3050]

Section 5(d) of the Regulatory Review Act (71 P. S. § 745.5(d)) provides that the designated standing Committees may issue comments within 20 days of the close of the public comment period, and the Independent Regulatory Review Commission (Commission) may issue comments within 10 days of the close of the Committee comment period. The Commission comments are based upon the criteria contained in section 5.1(h) and (i) of the Regulatory Review Act (71 P. S. § 745.5a(h) and (i)).

The Commission has issued comments on the following proposed regulation. The agency must consider these comments in preparing the final-form regulation. The final-form regulation must be submitted within 2 years of the close of the public comment period or it will be deemed withdrawn.

Reg. No.	Agency/Title	Close of the Public Comment Period	IRRC Comments Issued
16A-539	State Board of Osteopathic Medicine Sexual Misconduct (32 Pa.B. 1734 (April 6, 2002))	5/6/02	6/7/02

State Board of Osteopathic Medicine Regulation No. 16A-539

Sexual Misconduct
June 7, 2002

We submit for consideration the following objections and recommendations regarding this regulation. Each objection or recommendation includes a reference to the criteria in the Regulatory Review Act (71 P. S. § 745.5a(h) and (i)) which have not been met. The State Board of Osteopathic Medicine (Board) must respond to these comments when it submits the final-form regulation. If the final-form regulation is not delivered within 2 years of the close of the public comment period, the regulation will be deemed withdrawn.

We note that this regulation is identical to the State Board of Medicine's Regulation #16A-497 relating to sexual misconduct. We continue to have concerns with the same issues and as a result, our comments on the proposed regulations are similar.

1. Section 25.215. Sexual misconduct.--Clarity.

General

As proposed, § 25.215 contains both definitions and substantive regulatory provisions. To be consistent with regulatory framework existing in Chapter 25, the Board should create two separate sections. The definitions should remain in § 25.215. The substantive provisions should be placed in a separate section following the definitions.

Subsection (a)

This subsection defines "immediate family member." It is unclear if the phrase "other family member" contained in the definition includes a relationship by blood, marriage or law. In addition, the inclusion of the phrase, "with whom a patient resides" in the definition limits the scope of this regulation. Finally, the definition does not address a patient's relationships with nonfamily members.

Subsection (b)

This subsection refers to "Board regulated practitioner." The Board should define "Board regulated practitioner" by adding the term to the definitions section and referencing section 271.2 of the Osteopathic Medical Practice Act (63 P. S. § 271.2).

Subsections (b)--(d)

These subsections include the phrase "and subjects the practitioner to disciplinary action." Where can the disciplinary action be found? A cross-reference to the appropriate citation for disciplinary action should be provided in the subsections.

Subsection (d)

The Board uses the phrase "mental health disorder" in this subsection. The meaning of this phrase is vague. The regulation should either define or reference the categories of mental health disorders. For instance, the Board could refer to patients who are diagnosed under the Diagnostic and Statistical Manual of Mental Disorders--IV (DSM-IV) or subsequent publications.

2. Behavioral examples.--Clarity.

A commentator noted that the regulations proposed by the State Board of Medicine and the Board were too vague and provided several scenarios in which innocent behavior would be in violation of the regulation. Given this possibility, the Board should consider providing examples of the type of behavior it considers inappropriate.

JOHN R. MCGINLEY, Jr.,
Chairperson

[Pa.B. Doc. No. 02-1117. Filed for public inspection June 21, 2002, 9:00 a.m.]

E NOBLE WAGNER PC
424 CENTRAL AVE
CHELTENHAM, PA 19012-2198
(215) 379-3444
Fax (215) 663-9430

E Noble Wagner DO FACOFP

FAMILY PRACTICE / OSTEOPATHIC MEDICINE

June 8, 2001

Amy L. Nelson, Counsel
State Board of Osteopathic Medicine
Legal Office
116 Pine Street, PO Box 2649
Harrisburg, PA 17105-2649

RE: Title 49 Subpart A, Chapter 25 SBOM
16A-539 Sexual Misconduct

Dear Ms Nelson:

I find it difficult to fully understand the need for defined parameters for sexual misconduct.

As physicians professional decorum is expected and implied in our Oath.

The real problem is the patients interpretation of the physicians actions and even a mis-interpretation of a "double entendre".

As a hands on Osteopathic Physician (and that is a very important part of our Credo), I would almost need to have a lengthy disclaimer to explain many of the manipulative procedures we utilize.

The whole "effort" provides patients and the legal community with unnecessary (I feel) litiginous guide lines.

Sincerely,

Earle Noble Wagner DO FACOFP
Earle Noble Wagner, DO, FACOFP

ENW/csg

HOLMESBURG FAMILY MEDICINE ASSOCIATES, P.C.
8019 Frankford Avenue
Philadelphia, PA 19136

D. O.

JOSEPH V. PONGONIS D.O.
MONIKA VAN SANT D.O.

215-332-1300
FAX: 215-332-5219

June 19, 2001

Commonwealth of Pennsylvania
Governor's Office of General Counsel
Department of State Legal Office
116 Pine Street
P.O. Box 2649
Harrisburg, PA 17105-2649
ATTN: Amy Nelson

RE: Supposed Regulations of SBOM-16A-539, Sexual Misconduct

Dear Ms. Nelson:
I have, as chairman for District I, reviewed the pre-draft of 16A-539, Sexual Misconduct as requested by Mario Lanni, our Executive Director. It is my feeling that sexual exploitation of a patient by a physician has to be discouraged. As a physician, we are supposed to be caring individuals and many times have to discuss things which are very delicate in nature and may involve some aspects of the patient's family life and sexual history. Many patients are lonely and depressed and are looking for attention and love.

My only concern in adopting a regulation on Sexual Misconduct is that some way of verifying the information be a part of our policy so that a physician is not drawn into a disciplinary action for Sexual Misconduct without proper verification. This could be disastrous on a physician, as well as, his family if the action is unwarranted. Also, in Definitions Article 3, which states that immediate or family member is a parent or guardian of a child, siblings, spouse, or other family member with whom the patient resides. I feel there should be a qualifying factor, which states that the physician is aware that the patient lives with this family member and that the relationship would in some way influence the patient. I could conceive of instances where the physician is not aware that the person in question resides with the patient.

Sincerely,

Joseph V. Pongonis, D.O.
Chairman, District I Pennsylvania Osteopathic Medical Association

CC: Pennsylvania Osteopathic Medical Association
1330 Eisenhower Boulevard
Harrisburg, PA 17111-2395

Nelson, Amy

From: Jacobson, Dr. Mark [MJACOBSON@GSHLEB.com]

Sent: Wednesday, June 06, 2001 9:39 AM

To: 'anelson@state.pa.us'

Cc: 'poma@poma.org'

Subject: Comments regarding draft Annex of the Sexual Misconduct regulatio

I have reviewed this draft and have a question regarding the wording/intent of section (d). The section ends with "...of a patient for a mental health disorder." Does that mean that (d) only is in effect if the patient in question has been managed/treated for a mental disorder, or is the intent of the section to include ALL patients prior to the two year anniversary no matter what their specific diagnosis?

Mark Jacobson, DO

JACOBUS
MEDICAL CENTER
KIEREN P. KNAPP, D.O.
55 NORTH MAIN STREET
JACOBUS, PENNSYLVANIA 17407
TELEPHONE 428-1911

June 4, 2001

Amy L. Nelson
Counsel
State Board of Osteopathic Medicine
Department of State Legal Office
116 Pine Street
PO Box 2649
Harrisburg, PA 17105-2649

Dear Attorney Nelson:

I have reviewed the proposed Sexual Misconduct regulation, 25.215. While I understand the concept,there are always exceptions to the rules. With the broad based language with the regulations, it would be a violation and punishable offense for a young single physician in a small rural town to date a patient for the two year period after severence of the physician/ patient relationship. In a rural setting, or with a closed panel health care plan, this could create undo burden on both a physician and a patient. Historically, I know of several physicians who have married former patients.

Again, I understand the background and purpose for this regulation, but feel it would create more problems than solve.

Sincerely,

Kieren P. Knapp, D.O., F.A.C.O.F.P.
KPK/pe
cc: Dan Dowd, D.O.
Chairman

Mario Lanni, Executive Director POMA

-----Original Message-----
From: McHugh, D.O., James [mailto:James.McHugh@crozer.org]
Sent: Tuesday, June 26, 2001 2:46 PM
To: 'anelson@state.pa.us'
Cc: 'mlanni@POMA.org'; 'docwert3@AOL.com'
Subject: 16A-539:Sexual Misconduct

Dear Counselor:

I believe your draft, if passed in its current form, will paint a lot of DO's into a corner for the following reasons:

1. The definition of "sexual exploitation" appears to be an incomplete sentence ("that uses..." to do what?)
2. Referencing section (b), "immediate family member", I have known many physicians to date and marry family members of patients. This would penalize such innocent and normal human activity.
3. Referencing section (c), I know physicians who treat their wives/husbands; again there is no ill intent to this activity, and my wife would be quite angry if I refused to re-fill her Allegra-D
4. Referencing section (d), I have known physicians to marry patients within your "two year anniversary"; again normal and honorable

behavior. Also the words that follow "disciplinary action" are a dangling participle; none of those words are necessary. Do you mean mental health only, or treatment of a physical disorder is different than treatment for a mental disorder.

5. Referencing section (f), are we not going beyond the legal principal of "consenting adults"?
6. No where does your draft mention that the Osteopathic physician must be convicted of inappropriate behavior. Allegations are not to used to render punishment. Should a panel be appointed by the Board? Should a hearing be before a judge?

The draft appears poorly constructed. I suggest throwing the whole thing out and starting from scratch.

James E. McHugh, DO, FACOI, MBA
Director, Osteopathic Medical Education
Crozer-Keystone Health System
610.284.8230

June 23, 2002

Daniel D. Dowd, Jr., D.O., Chairman
State Board of Osteopathic Medicine
116 Pine Street
Harrisburg, PA 17105

Re: Regulation #16A-539 (IRRC #2262)
State Board of Osteopathic Medicine
Sexual Misconduct

Dear Chairman Dowd:

As an interested party and concerned citizen of the Commonwealth, I would like to comment on your proposed regulation for sexual misconduct. I realize that the time of the public comment period has lapsed, however I was not aware of the proposed regulation until recently.

I am aware that you have received the comments from the IRRC and will begin the process of final-form regulation. I have also submitted my comments to the IRRC.

Guidelines should be given to physicians regarding appropriate behaviors in the area of sexuality such as:

- The patient be provided privacy to disrobe and provided appropriate covering such as sheet or gown, and be given privacy to dress when the exam is completed.
- The patient be offered a chaperone when sensitive areas of the body are to be examined such as breasts, pelvic, rectal area.
- The patient be given a full explanation as to the reason for doing a particular exam when the exam will involve the touching of breasts, pelvic, or rectal area.

I have also enclosed for the Board's review a copy of Recommendations to State Medical Boards for Improving the Management of Physician Sexual Misconduct Cases: Empowerment of Victims.

You may find this informative.

Thank you for your time and consideration.

Sincerely,

Linda J. Lindrose

Linda J. Lindrose

The Minnesota Board of Medical Practice retained the services of a group of nationally recognized experts on the topic of sexual misconduct by health professionals to provide recommendations on the disposition of complaints of sexual misconduct by physicians. The following report was submitted by these experts to the Minnesota Board of Medical Practice.

Recommendations to State Medical Boards for Improving the Management of Physician Sexual Misconduct Cases: Empowerment of Victims.

Submitted to:
Minnesota Board of Medical Practice
by
Consultation Group on
Physician Sexual Misconduct
May 13th & 14th, 1995

Table of Contents

The Minnesota Board of Medical Practice commissioned a consultation group to provide recommendations for the appropriate disposition of sexual misconduct complaints. The Consultation Group met at the Mall of America Grand Hotel in Bloomington, Minnesota, May 13th and 14th, 1995.

Participants:

Facilitator:
John J. Ulwelling
Executive Vice President, Foundation for Medical Excellence.
Designer of educational programs for physicians on Board of Medical Practice Issues. Former Executive Director, Oregon State Medical Board. 15165 SW 100th, Tigard, OR 97224. (503) 222-4422.

Report Author:
Alison J. Coulter-Knoff, M.D.
Medical Coordinator, Minnesota Board of Medical Practice.
Chair, Hennepin County Medical Society Abuse Prevention Project.
Board Certified Family Practitioner. Physicians Neck & Back Clinic, 3050 Centre Pointe Drive, Roseville, MN 55113. (612) 639-9150.

Experts:

Laurie Auger
Anoka County Victims Services. Coordinator, sexual assault program for victims. 1081 139th Lane, Andover, MN 55304. (612) 323-5620.

Joe Bloom, M.D.
Dean of Oregon Health Sciences University School of Medicine. Psychiatrist with background in forensics. Consultant to State Medical Board; developed programs in area of impaired physicians and then started work in area of sexual misconduct. 3181 SW Sam Johnson Park Road, Portland, OR 97201. (503) 494-6689.

Ted Boadway, M.D.
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Introduction

The experts giving testimony, the facilitator and the report author wish to congratulate the Minnesota State Board of Medical Practice for taking on the issue of physician sexual misconduct. To our knowledge, no other state medical board has brought in experts to review and help it improve its process. This action on the part of the Board displays their exemplary initiative and innovative standing in the field. We also acknowledge the enormous amount of time and resources that the Board has allocated to this effort. Further, that each one of the Board members as well as the participants of this consultation group are continuing to learn as we proceed. The recommendations that are included in this report reflect, in our opinion, the current state of the art but will undoubtedly require revision as our learning continues.

The individual human factors of the victims as well as those of the physician perpetrators, combined with legal concerns, can make the complexities of dealing with this issue all but overwhelming at times. We have all wrestled with this problem and acknowledge that there are no perfect solutions or any one single set of guidelines that will fit appropriately into the workings of every state medical board. However, we all remain unified in the fundamental belief that patients should not be victims of sexual misconduct at the hands of health care professionals. In the rare event that it does occur, it must be dealt with swiftly and effectively.

The Consultation Group, organized by the Minnesota Board of Medical Practice, was charged with making recommendations to assist state boards in their deliberations over sexual misconduct complaints. The Consultation Group participants were selected by the Chair of the Minnesota Board, James Knapp, M.D., together with the Executive Director, H. Leonard Boche, under the direction of the entire Board. The participants were selected because of their expertise in dealing with matters related to sexual misconduct as well as physician discipline, rehabilitation of physicians, treatment of victims, ethics and professional boundaries in the practice of medicine and/or the proceedings of state medical boards.

The deliberations focused on the emotional and other human needs of the victim together with strategies to better educate professionals and the public. The recommendations were arrived at carefully and thoughtfully and our sincere hope is that they will be of benefit to the Minnesota Board as well as other boards across the United States and Canada.

The recommendations of the Consultation Group are intended to be generic and applicable by all medical boards. The Group was called by the Minnesota Board, and discussion, of necessity, centered on Minnesota law and experience. All boards should view these recommendations in light of their own local law and operating history.

The following report is respectfully submitted by the Consultation Group on Physician Sexual Misconduct.

EXECUTIVE SUMMARY

Recommendations

The Minnesota Board of Medical Practice Consultation Group on Physician Sexual Misconduct arrived at the following recommendations to be considered by state medical boards. Unless otherwise specified these recommendations pertain to the issue of sexual misconduct.

THE CONSULTATION GROUP RECOMMENDS:

- **1.** That legal notice of a hearing before an administrative law judge or hearing officer be made a public document.
- 2. That the findings and conclusions of the administrative law judge or hearing officer be made public.
- **3.** That contested case arguments before a state medical board be made open to the public.
- 4. That every state medical board vote be conducted using a roll call vote and be a matter of public

record.

- **5.** That state medical boards be granted the ability to report criminal matters to appropriate law enforcement agencies.
- **6.** That state medical boards develop a position paper for physicians and other health care providers regarding appropriate behaviors in the area of sexuality. For example, provide a private area for patients to undress; do not make comments about body parts unless clinically appropriate; explain the reason for doing a particular exam; etc.
- **7.** That every new state medical board member, complaint staff, medical coordinator, attorney, investigator, and administrative law judge involved in the disciplinary process be given a careful orientation in substantive issues related to physician sexual misconduct, supplemented by relevant reading materials.
- **8.** That psychiatrist(s) with expertise in sexual misconduct cases be retained to provide consultative services to help improve a state medical board's processes including review of difficult cases, evaluations and monitoring of physicians.
- **9.** That the medical leadership of a state (e.g. State Board, Medical Associations, and Academia) meet to explore the nature of physician sexual involvement with patients.
- **10.** That an annual educational program to address issues in the area of sexual misconduct be established. This program should include board members and all supporting staff.
- **11.** That state medical boards sanction boundary violation infractions.
- **12.** That state medical boards discipline professionals who fail to report colleagues of whom they have personal knowledge of misconduct.
- **13.** That state medical boards support/provide educational opportunities for professionals in the area of boundaries.
- **14.** That state medical boards develop methods to educate the public, in general, and the complainant, specifically on their procedures and decision making process.
- **15.** That in the case where sexual misconduct is proven, serious consideration be given to revocation of the physician's license. The following aggravating and mitigating factors are taken from *Crossing the Boundaries, The British Columbia Experience,* 1992:

Aggravating factors:

- Degree of exploitation by the physician of the doctor-patient relationship;
- actual or threatened bodily harm or violence by the physician;
- previous convictions of the physician;
- cruelty to the patient;
- vulnerability of the patient due to age, infirmity, history of prior sexual abuse, institutionalization, medical condition, or other causes;
- evidence of multiple victims or multiple incidents;
- evidence of a serious psychiatric impairment (such as the presence of a paraphilia), or serious personality disorder in the physician;
- evidence of planned or premeditated activity by the physician.

Additional aggravating factors as stated by the Consultation Group:

- Failure to respond to rehabilitation;
- evidence that drugs were administered or provided to a patient to facilitate the sexual misconduct, especially if the patient was a minor;
- evidence that the physician demonstrated predatory grooming behavior, i.e. progressive testing of a victim's receptiveness to personal space violations by the physician.

Mitigating factors:

- Absence of previous convictions;
- temporary physical or mental impairment of the physician;

  - evidence of restitution or compensation by the physician;
  - inexperience of the physician;
  - evidence of genuine understanding of the inappropriateness of the physician's behavior and the harm it caused;
  - evidence of genuine efforts at rehabilitation.
- **16**. That the alleged subject of the misconduct (patient) be more involved in the entire process. This should include: That staff have the ability to inform the patient of the status of the complaint even in cases where the patient was not the complainant of record. That the patient appear before the complaint committee and the administrative law judge or hearing officer in all cases, if the patient is willing.
- **17**. That state medical boards develop a system of support for the patient. This should include referral information regarding advocacy programs provided to the patients from their very first contact with a board.
- **18**. That it is imperative that the Chair of a state medical board (or designee) establish for a board an open process in which all views of board members will be encouraged. Specifically, differences of opinion on a continuum, from dismissal to revocation should be opened up by the Chair.
- **19.** That a mechanism be created to provide continuity in institutional memory for state medical boards.
- **20**. That performance standards relating to the length of time required to complete each stage of the complaint process be established. Further that a system be developed to monitor these standards and problem solve should delays occur.
- **21.** That the resources of a state medical board and its legal staff be fully committed and utilized to address sexual misconduct cases and the backlog which too often exists.
- **22**. That a periodic internal review and critique of the administrative procedures of state medical boards be conducted.
- **23**. That a merit based system for appointment to a state medical board be developed. One component of such a system should include documentation of the appointee's interest and past demonstration of a desire to protect the public from harm.
- **24**. That members of a state medical board be remunerated with a per diem based on current market value and should include both actual meeting time as well as preparatory time.

Discussion

The percentage of physicians who report that they have had sexual contact with a patient is between one and twelve percent. (1) The percentage of physicians who have felt a sexual attraction toward a patient has been reported to be as high as eighty percent. (2) The number of all types of complaints made to state medical boards has increased dramatically in recent years. The issue of physician sexual misconduct was rarely heard about as few as ten years ago and has now become a major issue for patients, physicians, and state medical boards as well.

It is now well established that a sexual relationship between physician and patient is almost always damaging to the patient. The damage includes, but is not limited to, sexual dysfunction, anxiety disorders, depression, increased risk of suicide and dissociative behavior. (3) Such a relationship also destroys both individual and public trust in the profession.

The medical community is also wrestling with establishing guidelines that will protect the public and allow physicians to continue to genuinely "care" for their patients. Most complaints of a sexual nature,

made against providers, represent a failure on the part of the physician due to a knowledge gap, some form of miscommunication, or a simple mistake. It is the rare physician who is truly a predator. However, because that represents the most severe and potentially devastating form, the Consultation Group focused much of their discussion on this small group.

In discussing the predatory physician, the Consultation Group looked briefly at the issue of treatment of the predator. The Group strongly believed that the prognosis for the true predator is extremely poor, and this belief is reflected in a number of the recommendations which follow.

Many states, including Minnesota, have enacted laws that criminalize physician-patient sex. (4) In addition, recent legislation in Minnesota mandates revocation of a physician's license for felony level sexual misconduct. There is, however, considerable misunderstanding regarding lesser boundary violations as is witnessed by the steady stream of complaints this Board has received over the past decade.

Three major themes recurred throughout the two days of discussion. These were concern for the victim, confidentiality and education.

The first and most important theme was the extreme concern all of the participants felt for the victims of physician sexual misconduct. Many of the recommendations were made out of this deep concern. Victims need to be heard; victims should be kept informed of the process; charges of sexual misconduct should be a matter of public record; support resources should be made known to the victims; resolution of complaints should be prompt in order to prevent victimization of others; and a public statement should be written and distributed to educate the public about the expected standards of physician behavior.

A second theme was that of confidentiality. While it was recognized that in the event of a false complaint, the physician's reputation and even ability to practice can be severely compromised if the charges are a matter of public record, the percentage of false complaints is thought to be very low. A rather dated FBI study looking at the rate of false accusations for other types of violent crime found that it occurred in only two percent of cases. The sexual assault literature often quotes this number to dispel the myth that women cry rape, without just cause, with great frequency. While there do not appear to be any reliable numbers available, it is clear that the experts practicing in this area believe them to be very small. Gary Schoener writes that his "experience with more than 1,000 cases of sexual exploitation has yielded only a few in which, we believe, misleading or false information was presented by a complainant." (5) It is often very difficult for a patient/victim to come forward and file a sexual misconduct complaint, for the very same reasons as victims of other types of sexual assault, such as: shame; a feeling that they were to blame; distrust of the system i.e. a fear that they will be further victimized through the process of investigation and hearing; a lack of power and stature in the community relative to the physician; and/or they may not want the physician punished, they may just want the behavior to stop and not happen to anyone else. The Consultation Group also recognized that victims of physician sexual misconduct are likely to have a history of prior abuse which can make it even more difficult for them to report. (6) All of these factors support that the false accusation rate is very low.

Another concern is for the victim's confidentiality. It is possible that the victim might be harmed by the charge being public. The victim's advocacy groups, however, maintain that with appropriate supportive measures this can be minimized, and should not be a reason to keep charges confidential.

The third concern regarding the issue of confidentiality was that state medical boards should be held

accountable for their decisions. The Consultation Group felt that the degree of confidentiality in some jurisdictions is excessive and unprecedented in any other area of the law. The final concern cited was that if the public is well informed on how medical boards handle complaints and reassured that appropriate discipline occurs, individuals will be more trusting of not only the board, but their physicians as well.

The Consultation Group was fully aware of the need for confidentiality for both the patient and the physician, as well as the need for due process to protect both parties. Full discussion of these issues resulted in the Group's recommendations regarding confidentiality after careful weighing of state medical boards' responsibility to protect the public.

A third theme that the Consultation Group devoted much discussion to was education. Certainly board members and support staff involved with any aspect of sexual misconduct must be adequately informed. Most serious sexual misconduct complaints are preceded by lesser boundary violation behaviors on the part of the physician, the so-called "slippery slope." (3) Physician-patient sex rarely occurs in isolation. An "exploitation index" has been designed by Epstein and Simon as a learning tool for therapists to identify problem areas that may lead to damaging boundary violations. (7) It is important that the individuals involved in the investigation right on through to those charged with making final decisions recognize factors that may suggest that a physician is likely to have further complaints or problems.

Education of physicians is also critical. With societal expectations changing so rapidly, many physicians are uncertain as to the yard stick by which they will be measured. For example, the Commonwealth of Massachusetts Board of Registration in Medicine adopted a policy in 1994 related to the maintenance of boundaries in the practice of psychotherapy by physicians which is clear and covers a wide variety of situations. (8) The policy addresses such issues as appointment place and time, billing practices, physical contact, self disclosure, gifts, non-sexual social relations, patients' families, and when to consider terminating a patient because of a patient's challenge to the physician's boundaries. Educating the public in addition, not only provides them with useful information, but aids in educating physicians as well. Education of both groups should include information on expected behavior, as well as how and what actions a board may take if a complaint is filed. Two examples of position papers (Ohio and Washington State) are cited in the references and available on request. (9,10) In addition to the guidelines that those papers suggest, the consultation group felt it would be important to include that physician-patient sex is always the physician's "fault", and responsibility.

Both position papers suggest that a chaperone be present, or at least offered, for exams of breasts, genitals and rectum. This recommendation is made to protect the patient as well as the physician, however, this practice does not represent standard of care in all states. The ramifications of developing a policy statement including this recommendation should be carefully weighed before implementation.

Disagreements and misunderstandings have been known to occur among state medical boards and various medical associations and academic medical institutions. Because of the sensitive and ever-changing nature of physician sexual misconduct, open communication and information sharing among these three factions within medicine will improve their relationship. It should also promote education of physicians beginning in the early stages of their training. Maintenance of professional boundaries is an integral, every day essential in the practice of medicine and is best learned when it is role-modeled and practiced over time.

Recommendations

The Minnesota Board of Medical Practice Consultation Group on Physician Sexual Misconduct arrived at the following recommendations to be considered by state medical boards. Unless otherwise specified these recommendations pertain to the issue of sexual misconduct.

THE CONSULTATION GROUP RECOMMENDS:

1. *That legal notice of a hearing before an administrative law judge or hearing officer be made a public document.*

Rationale: The intent of making the notice of hearing public is that it would alert other victims, past or potential, of a professional's nature, especially if the professional has predatory characteristics. The Consultation Group felt that this was an appropriate place in the process to be opened up as the state board makes the determination that a possible violation has occurred. By not opening the process before this point, most complaints will still remain confidential, which would be appropriate, given that there are no findings prior to this point. This recommendation was not supported unanimously by the Consultation Group, due to information regarding the Canadian experience on this issue. The notice of hearing is not only public in some parts of Canada, it is published in a newspaper in the physician's community. This has resulted in a strong backlash from physicians.

2. *That the findings and conclusions of the administrative law judge or hearing officer be made public.*

Rationale: The Consultation Group strongly felt that the protocols of state medical boards may adhere to a high degree of confidentiality for physicians which is excessive and unprecedented. Further that this would encourage a board to assume overall responsibility and accountability for the entire process. Board deliberation would still remain confidential.

3. *That contested case arguments before a state medical board be made open to the public.*

Rationale: Same as recommendation number 2.

4. *That every state medical board vote be conducted using a roll call vote and be a matter of public record.*

Rationale: Same as recommendation number 2.

5. *That state medical boards be granted the ability to report criminal matters to appropriate law enforcement agencies.*

Rationale: In some jurisdictions, if a board discovers criminal activity such as fraud or sexual misconduct, it is prohibited from notifying law enforcement agencies. All a board can do is encourage the complainant or victim to do so. This creates cognitive dissonance for mandated reporter board members and does not serve the public.

6. *That state medical boards develop a position paper for physicians and other health care providers regarding appropriate behaviors in the area of sexuality. For example, provide a private area for patients to undress; do not make comments about body parts unless clinically appropriate; explain the reason for doing a particular exam; etc.*

Rationale: To educate physicians regarding ongoing changes in societal expectations. It is the rare physician who is truly a predator. Many complaints arise out of inappropriate behavior on the part of the

physician and may be due to a knowledge deficit.

7. *That every new state medical board member, complaint staff, medical coordinator, attorney, investigator, and administrative law judge involved in the disciplinary process be given a careful orientation in substantive issues related to physician sexual misconduct, supplemented by relevant reading materials.*

Rationale: As indicated in the introductory segment of this report, this is a very complex issue about which no one person, physician or otherwise, has all the answers. It is a rapidly changing area and requires ongoing education. In addition, there are some specific indicators that the Consultation Group felt, if present, would indicate the need for more severe sanctions. The persons involved with the process cannot recognize these indicators if they are unaware of what they are.

8. *That psychiatrist(s) with expertise in sexual misconduct cases be retained to provide consultative services to help improve a state medical board's processes including review of difficult cases, evaluations and monitoring of physicians.*

Rationale: Sexual misconduct cases are extremely complicated. Many of the predatory type sexual misconduct cases first come to a Board's attention as a result of more minor complaints, often in the area of boundary violations. state medical boards need their own psychiatric consultants. These psychiatrists would assist boards improving their investigative, evaluative and monitoring processes. These psychiatrists would not do evaluations on physicians under investigation, but rather advise medical boards.

9. *That the medical leadership of a state (e.g. State Board, Medical Associations, and Academia) meet to explore the nature of physician sexual involvement with patients.*

Rationale: To promote and disseminate relevant current thinking on the standard of behavior and societal expectations, as well as to educate physicians regarding disciplinary processes and possible sanctions.

10. *That an annual educational program to address issues in the area of sexual misconduct be established. This program should include board members and all supporting staff.*

Rationale: Again to provide ongoing education surrounding a rapidly changing and challenging problem.

11. *That state medical boards sanction boundary violation infractions.*

Rationale: Although it is recognized that not all minor boundary violations regularly lead to sexual misconduct, the Consultation Group strongly felt that relatively minor violations often precede more serious sexual misconduct. Usually physicians are not disciplined for these minor violations. Yet experience tells us that many, if not most, future, more serious infractions will be committed by these same physicians. Serious sexual misconduct violations are preceded by what appear to be relatively minor boundary infractions. Wherever possible, the Consultation Group recommends that physicians be disciplined to discourage future transgressions.

12. *That state medical boards discipline professionals who fail to report colleagues of whom they have personal knowledge of misconduct.*

Rationale: The Consultation Group felt that sexual misconduct is an extreme violation of patient trust and should not be tolerated within the profession.

13. *That state medical boards support/provide educational opportunities for professionals in the area of boundaries.*

Rationale: Same as recommendation number 6.

14. *That state medical boards develop methods to educate the public, in general, and the complainant, specifically on their procedures and decision making process.*

Rationale: In order to develop a level of trust in the public eye that the board is reasonable and effective in dealing with the professionals under its jurisdiction.

15. *That in the case where sexual misconduct is proven, serious consideration be given to revocation of the physician's license. The following aggravating and mitigating factors are taken from* ***Crossing the Boundaries, The British Columbia Experience, 1992:***

Aggravating factors:

- Degree of exploitation by the physician of the doctor- patient relationship;
- actual or threatened bodily harm or violence by the physician;
- previous convictions of the physician;
- cruelty to the patient;
- vulnerability of the patient due to age, infirmity, history of prior sexual abuse, institutionalization, medical condition, or other causes;
- evidence of multiple victims or multiple incidents;
- evidence of a serious psychiatric impairment (such as the presence of a paraphilia), or serious personality disorder in the physician;
- evidence of planned or premeditated activity by the physician.

Additional aggravating factors as stated by the Consultation Group:

- Failure to respond to rehabilitation;
- evidence that drugs were administered or provided to a patient to facilitate the sexual misconduct, especially if the patient was a minor;
- evidence that the physician demonstrated predatory grooming behavior, i.e. progressive testing of a victim's receptiveness to personal space violations by the physician.

Mitigating factors:

- Absence of previous convictions;
- temporary physical or mental impairment of the physician;
- evidence of restitution or compensation by the physician;
- inexperience of the physician;
- evidence of genuine understanding of the inappropriateness of the physician's behavior and the harm it caused;
- evidence of genuine efforts at rehabilitation.

16. *That the alleged subject of the misconduct (patient) be more involved in the entire process. This*

should include: That staff have the ability to inform the patient of the status of the complaint even in cases where the patient was not the complainant of record. That the patient appear before the complaint committee and the administrative law judge or hearing officer in all cases, if the patient is willing.

Rationale: Victims of crime have a desire to be heard and involved in the process. The practice of allowing victims to give their statements in court can assist them in coming to personal resolution and provide better information to the deliberating body.

17. *That state medical boards develop a system of support for the patient. This should include referral information regarding advocacy programs provided to the patients from their very first contact with a board.*

Rationale: Sexual misconduct victims tend to be more vulnerable individuals and in fact that is often why they were the chosen targets. There is often a reluctance to testify. An advocate can provide emotional support for the patient throughout the process.

18. *That it is imperative that the Chair of a state medical board (or designee) establish for a board an open process in which all views of board members will be encouraged. Specifically, differences of opinion on a continuum, from dismissal to revocation should be opened up by the Chair.*

Rationale: Given that the average duration of appointment to a board of any individual member is only two and a half years, and that at any one time some of its members may be very inexperienced; further that final deliberations are often conducted without benefit of board staff to provide institutional memory. The Consultation Group felt strongly that Chair Persons of state medical boards encourage all board members to participate and encourage diversity of opinion. This would avoid the possibility of either inexperience or excessive experience on the part of a board or its individual members from inappropriately swaying board decisions. This process will help mitigate against both excessive protection of or retribution towards an accused health care provider.

19. *That a mechanism be created to provide continuity in institutional memory for state medical boards.*

Rationale: The rationale for this recommendation shares that of recommendation number 18, with the added concern that in many instances, due process considerations may seriously impede good decision making by boards by overly isolating the portion of the board making the decision, effectively forcing decisions to be made in a vacuum.

20. *That performance standards relating to the length of time required to complete each stage of the complaint process be established. Further that a system be developed to monitor these standards and problem solve should delays occur.*

Rationale: Time delays of twelve months and longer were strongly felt by the Consultation Group to unduly potentially expose additional patients to harm. Further, in the case of false accusation of the professional, prompt resolution of the charges was felt to be in accordance with due process.

21. *That the resources of a state medical board and its legal staff be fully committed and utilized to address sexual misconduct cases and the backlog which too often exists.*

Rationale: Information presented to the consultation group revealed that there is currently a twelve to eighteen month delay in bringing cases of sexual misconduct to conclusion largely as a result of insufficient investigating staff.

22. *That a periodic internal review and critique of the administrative procedures of state medical boards be conducted.*

Rationale: The intent of this recommendation is to engage more fully the entire board in its own workings. To create a greater sense of ownership of its own system. Further to identify and establish a method of rectifying system problems and/or failures. The Consultation Group felt strongly that the degree of confidentiality (secrecy) that some state medical boards adhere to in making final decisions is excessive, and unprecedented. The legal framework within which a medical board works may contribute to its inability to protect the public, and therefore needs to be part of the review.

23. *That a merit based system for appointment to a state medical board be developed. One component of such a system should include documentation of the appointee's interest and past demonstration of a desire to protect the public from harm.*

Rationale: Given that the ultimate charge from the legislature to a state medical board is to protect the public from harm, this recommendation is made to insure that appointees' motives are known and can be demonstrated. The Consultation Group also supported the recommendation of Dr. Barbara Schneidman that she and Mr. Ulwelling through their association with the Federation of State Medical Boards work to design a presentation for the National Governors Conference to educate appointments offices.

24. *That members of a state medical board be remunerated with a per diem based on current market value and should include both actual meeting time as well as preparatory time.*

Rationale: It is unreasonable to expect that within the current climate of practice that physicians or public members of a board essentially volunteer their time. It was the feeling of the Consultation Group that without adequate reimbursement, recruitment of currently practicing, interested, qualified board members is severely handicapped. Further, it was stated that under-payment of board members in many other states has been shown to have a negative impact on the operations of a board.

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10. Washington State Medical Disciplinary Board. *Sexual Misconduct Statement and Policy of the Medical Disciplinary Board.* State of Washington, Department of Health, Washington State Medical Disciplinary Board;1992.

MINCAVA's mission is to support research, education, and access to information related to violence. MINCAVA is directed by Jeffrey L. Edleson, PhD and coordinates the following projects: MINCAVA Electronic Clearinghouse website, The Link Research Project, Child Abuse Prevention Studies (CAPS) program, Violence Against Women Online Resources website, and the applied research section of the VAWnet website. We are housed out of the School of Social Work at the University of Minnesota.

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INDEPENDENT REGULATORY REVIEW COMMISSION

333 MARKET STREET, 14TH FLOOR, HARRISBURG, PA 17101

June 7, 2002

Daniel D. Dowd, Jr., D.O., Chairman
State Board of Osteopathic Medicine
116 Pine Street
Harrisburg, PA 17105

Re: Regulation #16A-539 (IRRC #2262)
State Board of Osteopathic Medicine
Sexual Misconduct

Dear Chairman Dowd:

Enclosed are the Commission's Comments which list objections and suggestions for consideration when you prepare the final version of this regulation. These Comments are not a formal approval or disapproval; however, they specify the regulatory criteria which have not been met.

The Comments will soon be available on our website at www.irrc.state.pa.us. If you would like to discuss them, please contact my office at 783-5417.

Sincerely,

Robert E. Nyce
Executive Director
wbg
Enclosure
cc: Honorable Mario J. Civera, Jr., Majority Chairman, House Professional Licensure Committee
Honorable William W. Rieger, Democratic Chairman, House Professional Licensure Committee
Honorable Clarence D. Bell, Chairman, Senate Consumer Protection and Professional Licensure Committee
Honorable Lisa M. Boscola, Minority Chairman, Senate Consumer Protection and Professional Licensure Committee
Honorable Michael C. Weaver, Acting Secretary, Department of State

Comments of the Independent Regulatory Review Commission

on

State Board of Osteopathic Medicine Regulation No. 16A-539

Sexual Misconduct

June 7, 2002

We submit for your consideration the following objections and recommendations regarding this regulation. Each objection or recommendation includes a reference to the criteria in the Regulatory Review Act (71 P.S. § 745.5a(h) and (i)) which have not been met. The State Board of Osteopathic Medicine (Board) must respond to these Comments when it submits the final-form regulation. If the final-form regulation is not delivered within two years of the close of the public comment period, the regulation will be deemed withdrawn.

We note that this regulation is identical to the State Board of Medicine's Regulation #16A-497 relating to sexual misconduct. We continue to have concerns with the same issues and as a result, our comments on the proposed regulations are similar.

1. Section 25.215. Sexual misconduct. - Clarity.

General

As proposed, Section 25.215 contains both definitions and substantive regulatory provisions. In order to be consistent with regulatory framework existing in Chapter 25, the Board should create two separate sections. The definitions should remain in Section 25.215. The substantive provisions should be placed in a separate section following the definitions.

Subsection (a)

This subsection defines "immediate family member." It is unclear if the phrase "other family member" contained in the definition includes a relationship by blood, marriage or law. In addition, the inclusion of the phrase, "with whom a patient resides" in the definition limits the scope of this regulation. Finally, the definition does not address a patient's relationships with non-family members.

Subsection (b)

This subsection refers to "Board regulated practitioner." The Board should define "Board regulated practitioner" by adding the term to the definitions section and referencing Section 271.2 of the Osteopathic Medical Practice Act (63 P.S.§ 271.2).

Subsections (b), (c), and (d)

These subsections include the phrase "and subjects the practitioner to disciplinary action." Where can the disciplinary action be found? A cross-reference to the appropriate citation for disciplinary action should be provided in the subsections.

Subsection (d)

The Board uses the phrase "mental health disorder" in this subsection. The meaning of this phrase is vague. The regulation should either define or reference the categories of mental health disorders. For instance, the Board could refer to patients who are diagnosed under the Diagnostic and Statistical Manual of Mental Disorders -- IV (DSM-IV) or subsequent publications.

2. Behavioral examples. - Clarity.

A commentator noted that the regulations proposed by the State Board of Medicine and the State Board of Osteopathic Medicine were too vague and provided several scenarios in which innocent behavior would be in violation of the regulation. Given this possibility, the Board should consider providing examples of the type of behavior it considers inappropriate.

Pennsylvania
MEDICAL SOCIETY®

April 12, 2002

Amy L. Nelson
Counsel
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649

Dear Ms. Nelson:

The Pennsylvania Medical Society reviewed the proposed rulemaking by the State Board of Osteopathic Medicine concerning sexual misconduct [49 PA Code CH. 25] [32 Pa.B 1734]. In the proposal, the Board cites the intention to adopt 25.215 relating to sexual misconduct.

You may recall that we wrote to you expressing a number of concerns when the State Board of Medicine published a similar proposal several months ago. In order to refresh your memory, we've attached a copy of that letter.

We noted with dismay that the same problems we cited with the Board of Medicine's proposed regulations in our letter in November of 2001 exist in this proposal by the State Board of Osteopathic Medicine. It was our conclusion then that these regulations serve no purpose since they do not provide guidance. They actually create more questions. In addition, we fail to see why they are necessary for prosecution since physicians who exploit patients are already subject to disciplinary action.

Sincerely,

Howard A Richter MD

Howard A. Richter, MD
President

Attachment

CC: Daniel D. Dowd, Jr., DO
Charles D. Hummer, Jr., MD
John R. McGinley, Jr., Esq

777 East Park Drive
P.O. Box 8820
Harrisburg, PA 17105-8820

Tel: 717-558-7750
Fax: 717-558-7840
E-Mail: *stat@pamedsoc.org*
www.pamedsoc.org

November 29, 2001

Amy L. Nelson
Counsel, State Board of Medicine
116 Pine Street
P.O. Box 2649
Harrisburg, PA 17105-2649

Dear Ms. Nelson:

We reviewed the Medical Board's recently published draft regulations (Chapter 16, Subchapter H, 16.110 Sexual Misconduct) and have the following comments.

First, please understand that the Pennsylvania Medical Society does not in any way condone sexual advances by any physician toward a patient. We abhor such behavior and strongly condemn any physician who disgraces the profession in this way. However, the Medical Society does have concerns about the language of these regulations.

The Society objected to earlier versions of these regulations because they were too vague. We are now convinced that it is impossible to write regulations for sexual misconduct that clearly define prohibited behavior without also creating the possibility of prosecution for innocent behavior. The Society is aware that the Medical Board attempted to address the concerns we've expressed previously but we still see problems. This leads one to conclude that these regulations are more problematic than helpful. The Medical Board does currently prosecute physicians for sexual misconduct so one wonders what purpose these regulations serve if they create ambiguities rather than resolving them.. Therefore, we believe that the Medical Board should abandon the attempt to pass these regulations.

The Medical Society perceives several scenarios that illustrate our concerns about the regulations. At (b), the regulations prohibit sexual exploitation of a patient or immediate family member. This may appear reasonable until one reads the definition of "sexual exploitation" and note that it includes the use of any knowledge derived from the professional relationship. Imagine the scenario where a patient believes that the physician would get along well with the patient's sibling who resides with the patient and gives the physician the telephone number. The physician derived that information from the professional relationship so if he or she develops a romantic relationship with the patient's sibling, he or she violates the law.

Section (d) deals with creating a two-year period during which the physician cannot establish a sexual relationship with a former patient if he or she provided mental health sevices. How are mental health services defined? Mental health services could be counseling provided by a psychiatrist but they could also be less clear. Would the family practice physician who treats a patient for a painful condition be included if he or she wrote a prescription for an antidepressant to help the patient deal with the pain? This section provides little guidance to physicians in this situation.

We are told that the Board hopes the regulations will provide guidance to practitioners about exactly what behavior is forbidden. However, we fear they create questions instead of providing guidance. If they don't serve to provide guidance and are not needed to prosecute physicians who exploit patients, they serve no purpose and the Medical Board should abandon the attempt to promulgate the regulations.

Sincerely,

Howard A Richter MD

Howard A. Richter, MD
President

FACE SHEET
FOR FILING DOCUMENTS
WITH THE LEGISLATIVE REFERENCE BUREAU

(Pursuant to Commonwealth Documents Law)

#2262 DO NOT WRITE IN THIS SPACE

Copy below is hereby approved as to form and legality. Attorney General

BY: _____
(DEPUTY ATTORNEY GENERAL)

_____
DATE OF APPROVAL

Copy below is hereby certified to be a true and correct copy of a document issued, prescribed or promulgated by:

_____
(AGENCY)

DOCUMENT/FISCAL NOTE NO. 16A-539

DATE OF ADOPTION: _____

BY: Thomas R. Czarnecki
Thomas R. Czarnecki, D.O.

TITLE: Chairman
(EXECUTIVE OFFICER, CHAIRMAN OR SECRETARY)

Copy below is approved as to form and legality. Executive or Independent Agencies.

BY: Ira J. Dunlap

9/30/03
~~8/19/03~~
DATE OF APPROVAL

Executive
(Deputy General Counsel
(~~Chief Counsel~~,
~~Independent Agency~~
Strike inapplicable title)

[ ] Check if applicable
Copy not approved.
Objections attached.

[ ] Check if applicable. No Attorney General approval or objection within 30 day after submission.

NOTICE OF FINAL RULEMAKING
COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF OSTEOPATHIC MEDICINE
49 PA. CODE, CHAPTER 25
SEXUAL MISCONDUCT

The State Board of Osteopathic Medicine (Board) amends its regulations at 49 Pa. Code by adding §§25.215 and 25.216 (relating to sexual misconduct) to read as set forth in Annex A.

A. Effective Date

The regulation will be effective upon publication as an Order of Final Rulemaking in the Pennsylvania Bulletin.

B. Statutory Authority

Under Sections 10.1(c), 15(a)(8) and (b)(9) and 16 of the Osteopathic Medical Practice Act (63 P.S. §§ 271.10a(c), 271.15(a)(8) and(b)(9) and 271.16), the Board has authority to establish standards of professional conduct for Board-regulated practitioners under its jurisdiction. These individuals include osteopathic physicians, physician assistants, respiratory care practitioners and athletic trainers. These regulations identify when sexual contact by Board-regulated practitioners with patients, and under certain circumstances, immediate family members of patients, will be deemed unprofessional conduct.

C. Background and Purpose

It should be axiomatic that it is unprofessional conduct for a health care practitioner to engage in sexual contact with patients. Past decisions of the Board which have been upheld by the Commonwealth Court; the Code of Ethics, as published by the American Osteopathic Association; and responsible professional publications addressing the issue denounce sexual contact between practitioner and patient. Nevertheless, complaints are filed each year by consumers who have been harmed by Board-regulated practitioners who engage in this conduct.

The regulation seeks to better protect patients by providing guidance to the profession and the public as to prohibited conduct relating to sexual contact between practitioners and patients. The regulation prohibits any sexual contact between a Board-regulated practitioner and a current patient. The regulation further prohibits any sexual contact between a Board-regulated practitioner and a former patient prior to the 2-year anniversary of the termination of the professional relationship when the Board regulated practitioner has been involved with the management or treatment of a patient for a mental health disorder. This 2-year period was developed from professional literature which indicates that an imbalance of power between health care practitioners and patients continues after the professional relationship ends. The regulation specifically exempts spouses of Board-regulated practitioners from its provisions prohibiting sexual contact with patients.

The regulation also prohibits sexual exploitation by a Board-regulated practitioner of a current or former patient or immediate family member of a patient. "Sexual exploitation" is defined by the regulation as sexual behavior that uses the trust, knowledge, emotions or influence derived from the professional relationship. The Board believes that it is appropriate to protect immediate family members from sexual exploitation by Board-regulated practitioners because immediate family members are often as vulnerable as the patients.

The regulation further provides that Board-regulated practitioners who engage in prohibited sexual contact with patients or former patients will not be eligible for placement in the Board's impaired professional program in lieu of disciplinary or corrective actions. The impaired professional program is unable to effectively monitor Board-regulated practitioners who have engaged in sexual misconduct.

The regulation also provides that patient consent will not be considered a defense to disciplinary action in these cases. The imbalance of power inherent in the health care practitioner – patient relationship not only serves as the basis for the prohibition but also undermines the patient's ability to consent to the sexual contact as an equal. Indeed, the Board's experience in adjudicating these cases has repeatedly demonstrated the reality of the inherent imbalance of the relationship and the patient's inability to give meaningful consent to sexual contact.

D. Summary of Comments and Responses on Proposed Rulemaking

Notice of the proposed rulemaking was published at 32 Pa. B.1734 (April 6, 2002). The Board received comments from the Independent Regulatory Review Commission (IRRC) and the Pennsylvania Medical Society (PMS). The Board also received public comments from five Osteopathic Physicians and one member of the public, including representatives of the Pennsylvania Osteopathic Medical Association (POMA).

IRRC recommended that the definitions section be separated from the substantive portions of the regulation. The Board agreed that this change would improve clarity and created a new section 25.216 for the substantive portions of the regulation. Additionally, IRRC recommended amending the definition of "immediate family member" to clarify whether the phrase "other family member" included those related by blood, marriage or law. The Board amended the language to indicate that it included those related by blood or marriage. The Board declined IRRC's recommendation to extend the regulation's protections to non-family members and to those immediate family members not residing with the patient because it felt that the current definitions included those individuals most likely to be victims of sexual exploitation. Expanding the definition would increase the risk of prosecution for innocent behavior.

IRRC further recommended that the term "Board-regulated practitioner" in subsection (b) (now §25.216(a)) be defined. Although this term is already defined by the Osteopathic Medical Practice Act, the Board accepted IRRC's request that it be included in the definition section of the regulation. The Board also accepted IRRC's recommendation that a cross reference be made to the disciplinary provisions of the Act in subsections (b), (c) and (d) (now §25.216(a), (b) and (c)).

The Board declined to accept IRRC's recommendation that it further define the term "mental health disorder" in section (d) (now §25.216(c)). IRRC recommended that the Board refer to patients who are diagnosed under the Diagnostic and Statistical Manual of Mental Disorders – IV (DSM-IV). The Board chose to retain the term "mental health disorder", believing that it encompassed a wider variety of mental and emotional conditions that would potentially make a patient more vulnerable to inappropriate sexual advances by a Board-regulated practitioner.

The Board also declined IRRC's invitation to provide examples of behavior deemed inappropriate under this regulation. It has been the Board's experience that when examples are used, situations not depicted are often deemed acceptable. The Board does not wish to inadvertently approve sexual misconduct by omission.

The House Professional Licensure committee declined to comment until these final-form regulations are published.

The Board did receive comments from the Pennsylvania Medical Society (PMS) expressing their opinion that it is impossible to write regulations for sexual misconduct that clearly define prohibited behavior without creating the possibility of prosecution for innocent behavior. Several commentators also expressed similar concerns. While the Board agrees that these are difficult regulations to write, it believes that sexual contact with patients and certain vulnerable family members so severely threatens public safety that an effort must be made to put physicians on further notice that the conduct is prohibited. While some Board-regulated practitioners are currently being prosecuted for sexual exploitation of patients, the Board feels strongly that it must be as clear as possible that a health care practitioner - patient relationship must never contain elements of sexual behavior. Moreover, prosecutors are routinely responsible for exercising professional judgment in regard to matters more complex than these.

PMS expressed concern that innocent behavior will be subject to punishment. The regulation is directed at behavior that is exploitive of the health care practitioner-patient relationship; that is, situations in which the health care practitioner abuses his/her position of power over the patient. Clearly the scenario that PMS suggests, i.e., a patient offering the phone number of the patient's sibling, cannot in any way be considered exploitive.

PMS' concerns about the 2-year "cooling off" period for health care practitioners involved in the management or treatment of a patient for a mental health disorder are unpersuasive. The scenario suggested by PMS, i.e., a physician who prescribes an antidepressant to a patient suffering from a painful condition, does not meet the regulation's requirement that the practitioner be managing or treating a mental health disorder. If the patient has a related mental health disorder that the practitioner is, in fact, treating, then the practitioner is prohibited from engaging in sexual behavior with that patient for 2 years from the termination of the health care practitioner-patient relationship.

Several Osteopathic Physicians wrote to express their concern that innocent behavior will be subject to prosecution. As noted above, the Board prosecutors routinely exercise professional judgment in these types of matters. Two of the doctors requested clarification of the 2-year "cooling off" period and one recommended grammatical changes to the proposed regulation.

One individual urged the Board to consider amending the regulations to include specific directions regarding the use of gowns and chaperones. Because this regulation is intended to prohibit sexual misconduct, and not to address practice policies, the Board declined to adopt the recommendation.

The Governor's Policy Office recommended that the regulation specifically exempt spouses of Board-regulated practitioners from the provisions prohibiting sexual contact with patients. The Board amended its regulation to comply with this request.

E. Compliance with Executive Order 1996-1

The Board reviewed this final-form rulemaking and considered its purpose and likely impact on the public and regulated population under the directives of Executive Order 1996-1.

F. Fiscal Impact and Paperwork Requirements

The regulation should have no fiscal impact on the Commonwealth or its political subdivisions. Likewise, the regulation should not necessitate any legal, accounting, reporting or other paperwork requirements.

G. Sunset Date

The Board continuously monitors its regulations. Therefore, no sunset date has been assigned.

H. Regulatory Review

Under section 5(a) of the Regulatory Review Act (71 P.S. §745.5(a)), on March 27, 2002, the Board submitted a copy of the notice of proposed rulemaking, published at 32 Pa. B.1734 (April 6, 2002), to IRRC and to the chairpersons of the House Professional Licensure Committee and the Senate Consumer Protection and Professional Licensure Committee for review and comment.

Under section 5(c) of the Regulatory Review Act, IRRC and the Committees were provided with copies of the comments received during the public comment period, as well as other documents when requested. In preparing the final-form rulemaking, the Board has considered the comments received from IRRC, the Committees and the public.

Under section 5.1(j.2) of the Regulatory Review Act (71 P.S. §745.5a(j.2)), on _____, 2003, this final-form regulation was (deemed) approved by the Committees. Under section 5.1(e) of the Regulatory Review Act, IRRC met on _____ to approve the final-form rulemaking.

I. Contact Person

Interested persons may obtain information regarding the final-form rulemaking by writing to Amy L. Nelson, Board Counsel, State Board of Osteopathic Medicine, P.O. Box 2649, Harrisburg, PA 17105-2649.

J. Findings

The Board finds that:

(1) Public notice of proposed rulemaking was given under sections 201 and 202 of the act of July 31, 1968 (P.L. 769, No. 240) (45 P.S. §§ 1201 and 1202) and the regulations promulgated thereunder at 1 Pa. Code §§ 7.1 and 7.2.

(2) A public comment period was provided as required by law and all comments were considered.

(3) The final-form rulemaking is necessary and appropriate for administration and enforcement of the authorizing act identified in Part B of this preamble.

(4) These amendments are necessary and appropriate for administration and enforcement of the authorizing act identified in Part B of this preamble and do not enlarge the purpose of the proposed rulemaking published at 32 Pa. B. 1734.

k. Order

The Board, acting under its authorizing statutes, orders that:

(a) The regulations of the Board, 49 Pa. Code Chapter 25, are amended by adding §§ 25.215 and 25.216 to read as set forth in Annex A.

(b) The Board shall submit this order and Annex A to the Office of General Counsel and to the Office of Attorney General as required by law.

(c) The Board shall certify this order and Annex A and deposit them with the Legislative Reference Bureau as required by law.

(d) This order shall take effect on publication in the Pennsylvania Bulletin.

Thomas R. Czarnecki, D.O.,
Chairperson

ANNEX A

TITLE 49. PROFESSIONAL AND VOCATIONAL STANDARDS

PART I. DEPARTMENT OF STATE

SUBPART A. PROFESSIONAL AND OCCUPATIONAL AFFAIRS

CHAPTER 25. STATE BOARD OF OSTEOPATHIC MEDICINE

Subchapter D. MINIMUM STANDARDS OF PRACTICE

* * *

§25.215. ~~Sexual Misconduct~~ DEFINITIONS.

~~(a). Definitions.~~ The following words and terms, when used in this ~~section~~ SUBCHAPTER, have the following meanings, unless the context clearly indicates otherwise:

BOARD-REGULATED PRACTITIONER – AN OSTEOPATHIC PHYSICIAN, PHYSICIAN ASSISTANT, RESPIRATORY CARE PRACTITIONER, ATHLETIC TRAINER, ACUPUNCTURIST OR AN APPLICANT FOR A LICENSE OR CERTIFICATE ISSUED BY THE BOARD.

Immediate family member - A parent or guardian, child, sibling, spouse, or other family member, WHETHER RELATED BY BLOOD OR MARRIAGE, with whom a patient resides.

Sexual behavior – Any sexual conduct which is nondiagnostic and nontherapeutic; it may be verbal or physical and may include expressions of thoughts and feelings or gestures that are sexual in nature or that reasonably may be construed by a patient as sexual in nature.

Sexual exploitation - Any sexual behavior that uses trust, knowledge, emotions, or influence derived from the professional relationship.

§25.216. SEXUAL MISCONDUCT.

~~(b) Unprofessional conduct: sexual exploitation.~~

(a) Sexual exploitation by a Board-regulated practitioner of a current or former patient, or of an immediate family member of a patient, constitutes unprofessional conduct, is prohibited, and subjects the practitioner to disciplinary action UNDER SECTION 15(A)(8) AND (B)(9) OF THE OSTEOPATHIC MEDICAL PRACTICE ACT (63 P.S. §271.15(A)(8) AND (B)(9)).

~~(c) Unprofessional conduct: sexual behavior.~~

(b) Sexual behavior that occurs with a current patient OTHER THAN THE BOARD-REGULATED PRACTITIONER'S SPOUSE, constitutes unprofessional conduct, is prohibited, and subjects the practitioner to disciplinary action UNDER SECTION 15(A)(8) AND (B)(9) OF THE OSTEOPATHIC MEDICAL PRACTICE ACT (63 P.S. §271.15(A)(8) AND (B)(9)).

~~(d) Sexual behavior prior to 2-year anniversary.~~

(c) When ~~the~~ A BOARD-REGULATED practitioner has been involved with the management or treatment of a patient OTHER THAN THE PRACTITIONER'S SPOUSE for a mental health disorder, sexual behavior with that former patient which occurs prior to the 2-year anniversary of the termination of the professional relationship constitutes unprofessional conduct, is prohibited, and subjects the practitioner to disciplinary action UNDER SECTION 15(A)(8) AND (B)(9) OF THE OSTEOPATHIC MEDICAL PRACTICE ACT (63 P.S. §§271.15(A)(8) AND (B)(9)).

~~(e) Impaired professional program.~~

(d) A practitioner who engages in conduct prohibited by this section will not be eligible for placement into an impaired professional program in lieu of disciplinary or corrective actions.

~~(f) Consent.~~

(e) Consent is not a defense to conduct prohibited by this section.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF OSTEOPATHIC MEDICINE
Post Office Box 2649
Harrisburg, Pennsylvania 17105-2649
(717) 783-4858

October 8, 2003

The Honorable John R. McGinley, Jr., Chairman
INDEPENDENT REGULATORY REVIEW COMMISSION
14th Floor, Harristown 2, 333 Market Street
Harrisburg, Pennsylvania 17101

Re: Final Regulation
State Board of Osteopathic Medicine
Sexual Misconduct: 16A-539

Dear Chairman McGinley:

Enclosed is a copy of a final rulemaking package of the State Board of Osteopathic Medicine pertaining to Sexual Misconduct.

The Board will be pleased to provide whatever information the Commission may require during the course of its review of the rulemaking.

Sincerely,

Thomas R. Czarnecki D.O., Chairperson
State Board of Osteopathic Medicine

TRC:ALN:kp
Enclosure
c: Andrew Sislo, Chief Counsel
Department of State
Scott J. Messing, Deputy Commissioner
Bureau of Professional and Occupational Affairs
Joyce McKeever, Deputy Chief Counsel
Department of State
Cynthia Montgomery, Regulatory Counsel
Department of State
Gerald S. Smith, Senior Counsel in Charge
Department of State
Amy L. Nelson, Counsel
State Board of Osteopathic Medicine
State Board of Osteopathic Medicine

TRANSMITTAL SHEET FOR REGULATIONS SUBJECT TO THE REGULATORY REVIEW ACT

I.D. NUMBER:	16A-539
SUBJECT:	Sexual Misconduct (State Board of Osteopathic Medicine)
AGENCY:	DEPARTMENT OF STATE

TYPE OF REGULATION

Proposed Regulation

X Final Regulation

Final Regulation with Notice of Proposed Rulemaking Omitted

120-day Emergency Certification of the Attorney General

120-day Emergency Certification of the Governor

Delivery of Tolled Regulation
a. With Revisions b. Without Revisions

RECEIVED
2003 OCT -8 AM 10: 35
INDEPENDENT REGULATORY REVIEW COMMISSION

FILING OF REGULATION

DATE	SIGNATURE	DESIGNATION
10/8/03	Sandra J. Thayer	HOUSE COMMITTEE ON PROFESSIONAL LICENSURE
10/8/03	Mary Walmer	SENATE COMMITTEE ON CONSUMER PROTECTION & PROFESSIONAL LICENSURE
10/8/03	Elena Page	INDEPENDENT REGULATORY REVIEW COMMISSION
		ATTORNEY GENERAL (for Final Omitted only)
		LEGISLATIVE REFERENCE BUREAU (for Proposed only)