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Contextualizing and Strengthening State Medical Board Responses to Physician Sexual Misconduct

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CONTEXTUALIZING AND STRENGTHENING STATE MEDICAL BOARD RESPONSES TO PHYSICIAN SEXUAL MISCONDUCT

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ABSTRACT

As the instrument through which states regulate the professional conduct of medical practitioners, state medical boards play a critical role in addressing physician sexual misconduct. Sexual misconduct in the medical profession is particularly troubling given that physicians are often privy to the most intimate aspects of their patients' lives. Patients place a profound trust in their physician, and the resulting relational dynamic may impact how a patient perceives or reacts to a physician's conduct. State medical boards are often criticized for failing to respond appropriately to instances of sexual misconduct. However, some of these criticisms fail to consider historical attempts by these boards to address this issue; they particularly fail to recognize that medical boards are just as proactive as other professional organizations in addressing and sanctioning sexual misconduct. Criticisms also fail to fully appreciate the impact of the complaint-based structure of state medical regulatory law, the lack of information sharing between other stakeholders in health care and state medical boards, and structural and legal constraints that impact the ability of state boards to investigate accusations of misconduct and discipline licensees accordingly. In sum, most critiques of state board actions in legal literature fail to properly contextualize state board responses and thus present solutions that miss the mark. The purpose of this paper is to contextualize the responses of state medical boards and highlight the efforts that have already been made by individual medical boards and the Federation of State Medical Boards (FSMB) to address sexual misconduct. Particular focus will be given to the FSMB's Workgroup on Physician Sexual Misconduct and the 2020 FSMB Report on Physician Sexual Misconduct (FSMB Report). The FSMB Report illustrates the

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barriers that prevent medical boards from responding more robustly to reports of sexual misconduct. It also provides recommendations in furtherance of the FSMB's effort to improve identification of improper physician behaviors. The proactive efforts of the FSMB to address sexual misconduct serve as a critical foundation for more expansive collaborative efforts across health care to eradicate sexual harassment, abuse, and other forms of misconduct.

I. INTRODUCTION

At the outset of their careers, most physicians recite a version of the Hippocratic Oath in front of their friends, family, and peers,[1] pledging "to dedicate [their lives] to the service of humanity" and promising to "practi[c]e [their] profession with conscience and dignity."[2] Most practitioners live up to these goals, continuing to practice even amid harrowing circumstances and burnout.[3] But there are some physicians who abuse the trust placed in them, utilizing their knowledge and situational power to exploit patients for financial gain, sexual gratification, or other self-interested purposes.[4] In the United States, state medical and osteopathic boards (hereinafter "medical boards" or "boards") are the regulatory bodies tasked with implementing state police powers by licensing and disciplining physicians.[5] As such, each state board plays a crucial role in addressing physician misconduct.

Sexual misconduct in medicine has proved intractable throughout history and across continents, but the full scope of the sexual misconduct problem in contemporary medical practice came to light at the end of the twentieth century amid a broader cultural shift in sexual ethics.[6] Medical boards in the United States, like their international equivalents in countries such as Canada,[7] Great Britain,[8] New Zealand,[9] and Australia,[10] have made incremental improvements but have at times struggled to address this issue.

1. S.J. Huber, *The White Coat Ceremony: A Contemporary Medical Ritual*, 29 J. MED. ETHICS 364, 364 (2003).

2. Ramin Walter Parsa-Parsi, *The Revised Declaration of Geneva: A Modern-Day Physician's Pledge*, 318 JAMA 1971, 1971 (2017).

3. Pamela Hartzband & Jerome Groopman, *Physician Burnout, Interrupted*, 382 NEW ENG. J. MED. 2485, 2486 (2020); AGENCY FOR HEALTHCARE RSCH. AND QUALITY, PHYSICIAN BURNOUT (2017), https://www.ahrq.gov/prevention/clinician/ahrq-works/burnout/index.html (last visited Oct. 30, 2021).

4. Patricia A. King et al., *State Medical Board Recommendations for Stronger Approaches to Sexual Misconduct by Physicians*, 325 JAMA 1609, 1609 (2021).

5. Nadia N. Sawicki, *Character, Competence, and the Principles of Medical Discipline*, 13 J. HEALTH CARE L. & POL'Y. 285, 286, 289, 295 (2010) ("As an extension of the state's police power, the medical board's disciplinary authority is aimed at protecting medical consumers from the harms they may incur at the hands of incompetent or dishonest physicians.").

6. *See infra* Section I.A (describing the evolving cultural awareness of the prevalence and harm caused by sexual misconduct that began concurrent with the sexual revolution in the 1970s).

7. Sanda Rodgers, *Health Care Providers and Sexual Assault: Feminist Law Reform?*, 8 CAN. J. WOMEN & L. 159, 159 (1995) ("This paper considers the response of Canadian courts to allegations of sexual assault by health care providers.").

8. Nigel Fisher & Thomas Fahy, *Sexual Relationships Between Doctors and Patients*, 83 J. ROYAL SOC'Y MED. 681, 681 (1990).

9. Katherine H. Hall, *Sexualization of the Doctor–Patient Relationship: Is It Ever Ethically Permissible?*, 18 FAM. PRAC. 511, 511 (2001).

10. Cherrie Ann Galletly, *Sexual Misconduct by Doctors: A Problem That Has Not Gone Away*, 213 MED. J. AUSTL. 216, 216 (2020).

In response to the pervasive sexual misconduct problem, the national membership organization of medical boards, the Federation of State Medical Boards (FSMB) convened a Workgroup on Physician Sexual Misconduct (hereinafter the "Workgroup") in 2017 to help medical boards in the United States lay the groundwork for accountability frameworks and address this critical problem.[11] The FSMB does not itself have the power to sanction physicians for misconduct—and as quasi-government entities, medical boards are bound by state law and constitutional due process requirements. The law does not always reflect and keep pace with professional ethical standards,[12] so despite the official policies of regulatory and professional bodies, medical boards must navigate the complex interplay between professional ethics and state law. In addition to these legal constraints, medical boards have limited resources[13] and are subject to statutory limitations on public disclosure of internal proceedings, even though this may give a public appearance of inaction.[14] Medical boards also face political pressures and have in some instances been bullied into silence by more powerful political actors.[15] When evaluating the responses of medical boards to incidences of sexual misconduct, it is critical to examine all these factors and to consider the ways in which other health care industry stakeholders—physicians, health systems, and government agencies—can work alongside medical boards to implement trustworthy and robust accountability frameworks. Understanding the context and the role of stakeholders is critical for the success of such well-intentioned objectives.

To provide this context, Part II of this Article provides a historical examination of physician sexual misconduct, highlights early medical board efforts to address this problem, and outlines contemporary critiques of board actions which led to the FSMB convening the Workgroup. Part III summarizes

11. Fed'n of State Med. Bds., *Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct*, J. MED. REGUL., July 2020, at 17, 17.

12. *Code of Medical Ethics Preface & Preamble*, AMA, https://www.ama-assn.org/about/publications-newsletters/code-medical-ethics-preface-preamble (last visited Oct. 30, 2021) ("The relationship between ethics and law is complex. Ethical values and legal principles are usually closely related, but ethical responsibilities usually exceed legal duties. Conduct that is legally permissible may be ethically unacceptable. Conversely, the fact that a physician who has been charged with allegedly illegal conduct has been acquitted or exonerated in criminal or civil proceedings does not necessarily mean that the physician acted ethically.").

13. Susan A. Chesteen & Joan M. Lally, *Physician Licensing Boards: Saints or Sinners in the Public Eye?*, 15 BUS. F., no. 4, 1991, at 36, 36–37 ("One of the problems directly related to state administration is that while the [medical board] may be willing to actively pursue its mission, state government may refuse to adequately fund the board enough for it to be effective. In Wisconsin, for example, the Medical Licensing Board recently requested re-licensure fees be increased to fund the hiring of more investigators. The legislature refused.").

14. *See infra* Part III (discussing the financial, statutory, and structural challenges to medical board action).

15. *Id.*

the product of the Workgroup—the 2020 FSMB Report on Physician Sexual Misconduct (hereinafter "FSMB Report" or "Report")—which was thereafter unanimously adopted as policy by the FSMB's House of Delegates, the organization's official policy-making body.[16] Part IV outlines persistent barriers to systemic change and discusses methods of addressing these barriers. Finally, Part V highlights the notable successes of several medical boards and discusses innovative solutions that may help all boards implement the key principles of the FSMB Report.

II. HISTORICAL CONTEXT OF SEXUAL MISCONDUCT AND MEDICAL REGULATION

While critical assessment of the ways in which medical boards have addressed the physician misconduct problem is warranted, the role of medical boards cannot be abstracted from the historical treatment of sexual misconduct in the United States or the statutory constraints that contemporary medical boards face, nor can the role of medical boards be abstracted from the duties of other institutional stakeholders to identify and report physician sexual misconduct. The public is right to demand better solutions to physician sexual misconduct—understanding the context in which medical boards operate allows outside commentators and medical boards themselves the opportunity to craft tailored recommendations. Instead of solving the surface-level problems that contribute to sexual misconduct, they can address its systemic roots and thereby engage in more informed strategic decision-making. In turn, this will strengthen physician accountability and help create a safer, more equitable, and just health care system.

A. A Historical View of Physician Sexual Misconduct

Sexual contact arising out of a physician-patient relationship has long been considered ethically forbidden,[17] but evolving social mores in the 1970s brought this issue out into the open.[18] *Roy v. Hartogs*—a case in which a female patient

16. *Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct*, *supra* note 11.

17. Tanya J. Dobash, *Physician-Patient Sexual Contact: The Battle Between the State and the Medical Profession*, 50 WASH. & LEE L. REV. 1725, 1725 (1993); *see* Huber, *supra* note 1.

18. Seymour L. Zelen, *Sexualization of Therapeutic Relationships: The Dual Vulnerability of Patient and Therapist*, 22 PSYCHOTHERAPY 178, 178 (1985) ("Sexual intimacies with patients have become open problems for the therapeutic professions. Feminism, consumerism, and a humanistic egalitarian therapeutic orientation have all contributed to the present acute awareness of the problem."); *see also* Jacob M. Appel, *Ethics Consult: Report Alleged Improper Doctor-Patient Relationship? MD/JD Weighs In*, MEDPAGE TODAY (Jan. 29, 2021), https://www.medpagetoday.com/opinion/ethics-consult/90945 ("Rules governing psychiatrist-patient sex were far more fluid until the 1970s. Many prominent figures in the psychiatric field, including Carl Jung and Bruno

successfully brought a malpractice claim against her psychiatrist for engaging her in a sexual relationship—was a tipping point.[19] This case gripped the nation's attention and the story was adapted into print and film iterations.[20] Following these revelations, the American Psychological Association became the first major American medical organization to explicitly prohibit any physician-patient sexual contact as part of its ethical code.[21] The breadth and scope of the problem became even clearer when the first prevalence studies released in 1979 revealed that twelve percent of male psychiatrists and three percent of female psychiatrists reported having a sexually intimate relationship with a patient or former patient.[22]

The public and academic focus largely remained on psychiatry until reports emerged in the late 1980s and early 1990s that similar problems existed in other medical specialties such as family medicine, obstetrics, and internal medicine.[23] Studies conducted during the 1980s and 1990s revealed that a substantial minority of physicians in different practice areas did not believe all sexual contact between physicians and their patients to be unethical[24] and indicated that sexual relationships between physicians and patients were widespread.[25] Articles in medical journals reveal that there was continued debate on the boundaries of sexual misconduct—and what qualified as misconduct—with articles asking questions such as "*Sexualization of the Doctor-Patient Relationship: Is It Ever Ethically Permissible?*"[26] and "*Sexual Intimacies With*

Bettelheim, are alleged to have had affairs with their patients; a 1972 study found that 10% of Los Angeles psychiatrists admitted to sexual relations with individuals under their care.").

19. Roy v. Hartogs, 381 N.Y.S.2d 587, 587 (N.Y. App. Term 1976); *see also* Linda Jorgenson et al., *The Furor Over Psychotherapist-Patient Sexual Contact: New Solutions to an Old Problem*, 32 WM. & MARY L. REV. 645, 652 (1991); *see* Dobash, *supra* note 17, at 1751.

20. Zelen, *supra* note 18.

21. AM. PSYCHIATRIC ASS'N, THE PRINCIPLES OF MEDICAL ETHICS: WITH ANNOTATIONS ESPECIALLY APPLICABLE TO PSYCHIATRY 1, 4 (2013 ed.).

22. Kenneth S. Pope & Valerie A. Vetter, *Prior Therapist-Patient Sexual Involvement Among Patients Seen by Psychologists*, 28 PSYCHOTHERAPY 429, 429 (1991) ("The two earliest national prevalence studies based on anonymous surveys of psychologists (Holroyd & Brodsky, 1977; Pope, Levenson & Schover, 1979) suggest that perhaps as many as 12% of male therapists and 3% of female therapists engaged in sexual intimacies with at least one patient[.]").

23. H. Russell Searight & David C. Campbell, *Physician-Patient Sexual Contact: Ethical and Legal Issues and Clinical Guidelines*, 36 J. FAM. PRAC. 647, 647–48 (1993) ("In the past 10 years, sexual relationships between mental health professionals and their patients have been the focus of considerable legal and ethical attention. However, this issue has only begun to be addressed among nonpsychiatric physicians.").

24. Fisher & Fahy, *supra* note 8.

25. *See* Kenneth S. Pope, *How Clients Are Harmed by Sexual Contact with Mental Health Professionals: The Syndrome and Its Prevalence*, 67 J. COUNSELING & DEV. 222, 222–23 tbl.1 (1988) (summarizing results in a chart of eight surveys of mental health professionals conducted between 1973 and 1987).

26. Hall, *supra* note 9, at 511–12.

Clients After Termination: Should a Prohibition Be Explicit?"[27] Given the continued development of sexual ethics in the twenty-first century, wholesale condemnation of physician-patient sexual contact in all medical specialties might seem like a foregone conclusion, but these conclusions were not entirely unanimous, even throughout the early 2000s.[28]

A review of legal literature from this era shows that courts, legal scholars, and regulatory bodies also struggled to define the scope of sexual misconduct and to fit this ethical violation into extant legal doctrine.[29] Sexual misconduct is an ethical violation, and while ethics inform the law, the two are not always in sync.[30] Courts differed in the way they construed a physician's fiduciary duty to patients, with some courts finding that "a physician who induces sexual relations with a patient is liable for professional negligence only if the sexual affair was misrepresented as part of the treatment."[31] Outcomes like this created a murky line between sexual misconduct and consent; despite the widespread cultural and professional condemnation of sexual misconduct, proving sexual misconduct had occurred and holding doctors legally accountable for their actions remained difficult. Many victims of physician sexual predation were still left with limited legal recourse against their abusers.

Over time, most legislators, scholars, and regulatory bodies concluded that given the inherent power imbalance in the patient-physician relationship and the possibility of transference,[32] there are virtually no instances in which sexual

27. Melba J.T. Vasquez, *Sexual Intimacies with Clients After Termination: Should a Prohibition Be Explicit?*, 1 ETHICS & BEHAV. 45, 45–47 (1991).

28. Hall, *supra* note 9, at 511, 514–15 ("[T]he ethics of such a relationship between a doctor and former patient is more debatable . . . the argument is made here that such relationships are almost always unethical due to the persistence of transference[.]").

29. Scott M. Puglise, *"Calling Dr. Love": The Physician-Patient Sexual Relationship as Grounds for Medical Malpractice – Society Pays While the Doctor and Patient Play*, 14 J.L. & HEALTH 321, 322, 346 (2000) ("This note examines 'consensual' sexual relationships between non-mental health physicians and patients. More specifically, it examines whether such relationships ever amount to medical malpractice.").

30. *Code of Medical Ethics Preface & Preamble*, *supra* note 12 (discussing the AMA's statement on the complex interplay between the law and ethics, noting that what is unethical is not always illegal).

31. 3 BARRY A. LINDAHL, MODERN TORT LAW: LIABILITY AND LITIGATION § 24:26 (2d ed., June 2021 update) ("[T]here is also authority that a doctor's duty to refrain from sexual misconduct, a separate intentional act, does not give rise to a medical malpractice action, although other potential causes of action might exist."); Am. Health Laws. Ass'n, *Casenotes: Malpractice: Physician's Sexual Misconduct Constitutes Malpractice Only if Represented as Part of Treatment*, 20 J. HEALTH & LIFE SCIS. L. 210, 210 (1987).

32. Denise LeBoeuf, *Psychiatric Malpractice: Exploitation of Women Patients*, 11 HARV. WOMEN'S L.J. 83, 97 (1988) ("Transference is a theoretical construct which purports to explain the 'transfer' of the patient's emotions onto her therapist, and which is held to be a necessary stage in therapy.").

contact with a current or former patient is ever permissible.[33] The American Medical Association (AMA) first explicitly condemned physician sexual misconduct in 1991, and then expanded and clarified the scope of misconduct in 2015.[34]

Calls for medical boards to strengthen responses to sexual misconduct date to the early 1990s, when medical boards faced criticism for "lack[ing] the ability . . . to maintain high ethical standards in the medical profession" and "handling sexual abuse cases 'inconsistently[.]'"[35] While these critiques were valid, they failed to both critically examine the reasons behind medical boards' inconsistencies and to view medical boards' failures in their historical context. Critiques of medical boards for failing to hold physicians accountable to modern professional standards emerged concurrent to the development of the standards themselves.

However, board responses to sexual misconduct kept pace with those of other professional organizations. While many point to medical boards' silence in the face of physician misconduct and cast low rates of disciplinary action as clear "failures to act," when viewed in light of the broader professional disciplinary culture, "[t]he rate at which medical professionals face serious discipline annually is comparable to the rate of serious professional discipline in other professions, including law. It is also comparable to the rate of felony convictions among the American public."[36] According to FSMB data, of the 1,018,776 physicians with active licenses in the United States,[37] 3342 were disciplined in 2020.[38] Comparatively, in the most recent report compiled by the American Bar Association (ABA), of the 1,257,772 attorneys with active

33. Hall, *supra* note 9, at 511, 515.

34. RICHARD J. MCMURRAY, SEXUAL MISCONDUCT IN THE PRACTICE OF MEDICINE 165–73 (AMA House of Delegates Interim Meeting Proc., Rep. of Council on Ethical & Jud. Aff., 1990), https://ama.nmtvault.com; Am. Med. Ass'n, *The AMA Code of Medical Ethics' Opinions on Observing Professional Boundaries and Meeting Professional Responsibilities*, 17 AMA J. ETHICS 432, 434 (2015) (expanding on its 1991 statement, where the AMA Council on Ethical and Judicial Affairs released an opinion in 2015 which unequivocally stated that "[s]exual contact that occurs concurrent with the patient-physician relationship constitutes sexual misconduct.").

35. Andrew L. Hyams, *Expert Psychiatric Evidence in Sexual Misconduct Cases Before State Medical Boards*, 18 AM. J.L. & MED. 171, 174–75 (1992) ("Various theories, including inadequate funding, outdated medical practice acts, and the organized profession's dominance of medical boards, have been posited to account for what is widely perceived as an unsatisfactory system of professional discipline.").

36. Sawicki, *supra* note 5, at 299.

37. *Physician Licensure*, FED'N OF STATE MED. BDS. (2020), https://www.fsmb.org/u.s.-medical-regulatory-trends-and-actions/u.s.-medical-licensing-and-disciplinary-data/physician-licensure.

38. *Physician Discipline*, FED'N OF STATE MED. BDS. (2020), https://www.fsmb.org/u.s.-medical-regulatory-trends-and-actions/u.s.-medical-licensing-and-disciplinary-data/physician-discipline/.

licenses, 2872 were subject to disciplinary action by a state bar association.[39] Thus, the rate at which medical boards discipline physicians with active licenses is slightly greater than the rate at which state bar associations discipline attorneys. This reveals that "an unmediated focus on the rate of medical discipline alone is unlikely to tell us much about [medical] boards' overall effectiveness in protecting public interests."[40] The rate of board action is reflective of trends in broader culture and professional regulatory board actions; the rates of discipline alone cannot be considered de facto proof of medical boards' failure or negligence.

B. Early Medical Board Actions and Incremental Progress

Individual medical boards and the FSMB have, for decades, been working to address physician sexual misconduct.[41] These efforts have kept pace with evolving ethical standards and scholarly revelations on the scope of the sexual misconduct problem in medicine—a narrative that is notably missing from most critiques of current medical board responses to sexual misconduct cases.

Sexual misconduct was a regular topic of FSMB annual educational conferences beginning in 1988,[42] and by the early 1990s, a number of medical boards were in the process of conducting internal investigations into sexual misconduct.[43] In 1993, the FSMB established an annual series of workshops aimed at bringing together board attorneys, investigators, and others to promote collaboration and develop solutions to these ethical challenges.[44] The first of these workshops "focused on the challenges inherent to investigating quality of care and sexual misconduct cases."[45] In 2006, the FSMB developed a policy that set guidelines for medical boards on how to handle physician sexual boundary violations. To help medical boards implement these guidelines, the FSMB

39. AM. BAR ASS'N, ABA PROFILE OF THE LEGAL PROFESSION 104 (2020).

40. Sawicki, *supra* note 5, at 299.

41. *See supra* notes 29–31; FED'N OF STATE MED. BDS., CHALLENGE & CHANGE: ADAPTING WITH INNOVATION: ANNUAL REPORT 7 (2021) (demonstrating that the FSMB and some medical boards have sought to address this issue since the late 1980s).

42. Hyams, *supra* note 35, at 175, n.20; Catherine S. Leffler, *Sexual Conduct Within the Physician-Patient Relationship: A Statutory Framework for Disciplining This Breach of Fiduciary Duty*, 1 WIDENER L. SYMP. J. 501, 502 (1996).

43. Leffler, *supra* note 42, at 502 ("This public interest has prompted fifteen states or provinces to establish task forces to study the problem, and the Federation of State Medical boards of the United States has acknowledged the importance of this issue by including it as a session topic at four consecutive annual meetings.").

44. DAVID A. JOHNSON & HUMAYUN J. CHAUDHRY, MEDICAL LICENSING AND DISCIPLINE IN AMERICA: A HISTORY OF THE FEDERATION OF STATE MEDICAL BOARDS (2012) (ebook) (The FSMB has played a key supportive role in training state board staff on investigative methodologies, providing policy recommendations, and creating opportunities for cross-collaboration between individual medical boards.).

45. *Id.*

hosted a five-part series of webinars on the policy and provided education on the sexual misconduct problem.[46] In 2017, the FSMB saw the need to bring renewed focus to medical board processes for handling physician sexual misconduct allegations, and so a new Workgroup was convened to review and update the 2006 policy.[47] Along with this Workgroup, the FSMB hosted multiple related sessions at the 2018 and 2019 FSMB annual meetings with a goal to educate and hear the concerns of medical boards and receive additional input for the Workgroup. Ultimately, the Workgroup produced the FSMB Report, discussed at length in the second part of this Article. In September 2020, after the Workgroup's report was formally and unanimously adopted as FSMB policy, the FSMB conducted a virtual educational program session on physician sexual misconduct that reviewed and discussed the recommendations.[48] Presentations and discussions between the FSMB and individual medical boards continue to take place in an effort to implement the recommendations contained in the FSMB's policy.

Nonetheless, medical boards still face many barriers which inhibit their ability to holistically address the sexual misconduct problem.[49] Chief among these barriers is a dearth of misconduct reporting to medical boards. This is particularly problematic because boards operate within a complaint-based system and are thus often prevented by state statute from acting in the absence

46. Peter Graham & Scott C. Stacy, Boundary Violations: Why Don't They Go Away?, Address at the Federation of State Medical Board's Web Series Seminar "Sexual Boundary Violations: A National Conference for Regulatory Boards" (Jan. 5, 2006); Steven I. Altchuler, FSMB Policy Statement re: Sexual Boundary Violations, Address at the Federation of State Medical Board's Web Series Seminar "Sexual Boundary Violations: A National Conference for Regulatory Boards" (Jan. 12, 2006); Scott C. Stacy & Peter Graham, The Boundary Violation Formula©: A New Paradigm for Understanding Boundary Violations and Their Prevention, Address at the Federation of State Medical Board's Web Series Seminar "Sexual Boundary Violations: A National Conference for Regulatory Boards" (Jan. 19, 2006); Gene G. Abel, Treatment and Rehabilitation, Address at the Federation of State Medical Board's Web Series Seminar "Sexual Boundary Violations: A National Conference for Regulatory Boards" (Jan. 26, 2006); Gregory E. Skipper & Gary D. Carr, Risk and Benefits of Utilizing PHPs in Boundary Cases, Address at the Federation of State Medical Board's Web Series Seminar "Sexual Boundary Violations: A National Conference for Regulatory Boards" (Feb. 2, 2006); Gregory E. Skipper et al., Faculty Panel Discussion, Address at the Federation of State Medical Board's Web Series Seminar "Sexual Boundary Violations: A National Conference for Regulatory Boards" (Feb. 9, 2006).

47. *See Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct*, *supra* note 11 ("In May of 2017, Patricia King, M.D., PhD., Chair at the time of the Federation of State Medical Boards (FSMB), created and led a Workgroup on Physician Sexual Misconduct[.]").

48. Patricia A. King, Physician Sexual Misconduct: New Policies and Approaches, Virtual Educational Program Session, FSMB 2020 Annual Meeting Webinar (Sep. 10, 2020).

49. *See infra* Part IV (discussing in greater depth the barriers medical boards face). The assertions in this paragraph are drawn from Part IV, unless noted otherwise.

of this reporting. Boards contend with other statutory barriers such as stringent due process requirements which limit disclosure, financial constraints, political pressure, and other hurdles. Over the decades, medical boards have made positive incremental changes in their response to sexual misconduct despite these barriers—but as many critics note, further progress is required.

C. Contemporary Critiques of Medical Boards

In recent years, there have been several highly public reports in which medical boards have been criticized for not taking timely steps to revoke or suspend the licenses of physicians who were reported to have committed acts of sexual misconduct. A cross-sectional analysis of physicians who were reported to the National Practitioner Data Bank (NPDB) for sexual misconduct between 2003 and 2013 found that "[s]eventy percent of the physicians with a clinical-privileges or malpractice-payment report due to sexual misconduct were not disciplined by medical boards for this problem."[50] In 2016 and 2018, the Atlanta Journal-Constitution conducted an in-depth investigation on sexual misconduct in medicine and "uncovered 450 cases of doctors who were brought before medical regulators or courts for sexual misconduct or sex crimes . . . [and found] [i]n nearly half of those cases . . . the doctors remain[ed] licensed to practice medicine."[51] The trial and conviction of Team USA Gymnastics physician Larry Nassar also encouraged other victims of physician sexual abuse to come forward, resulting in additional scrutiny of medical board practices.[52]

The Nassar case was followed by additional high-profile cases addressing egregious sexual abuse committed by University of Southern California gynecologist George Tyndall[53] and Ohio State University athletic team physician Richard Strauss,[54] the latter of which resulted in the Governor's Working Group on Reviewing of the Medical Board's Handling of the

50. Azza AbuDagga et al., *Cross-Sectional Analysis of the 1039 U.S. Physicians Reported to the National Practitioner Data Bank for Sexual Misconduct, 2003-2013*, PLOS ONE, Feb. 3, 2016, at 1, 1.

51. Carrie Teegardin & Danny Robbins, *Still Forgiven: The #MeToo Movement and Public Outcry over Dr. Larry Nassar's Sex Abuse Have Not Reformed the System that Disciplines Doctors*, ATLANTA J.-CONST., https://doctors.ajc.com/still_forgiven/?ecmp=doctorssexabuse_microsite_nav (last visited Oct. 30, 2021).

52. Christine Hauser & Maggie Astor, *The Larry Nassar Case: What Happened and How the Fallout Is Spreading*, N.Y. TIMES (Jan. 25, 2018), https://www.nytimes.com/2018/01/25/sports/larry-nassar-gymnastics-abuse.html.

53. Matt Hamilton & Harriet Ryan, *Must Reads: How George Tyndall Went from USC Gynecologist to the Center of LAPD's Largest-ever Sex Abuse Investigation*, L.A. TIMES (Dec. 19, 2018, 5:00 AM), https://www.latimes.com/local/lanow/la-me-george-tyndall-profile-usc-sexual-assault-allegations-20181219-story.html.

54. Rick Maese, *Ohio State Team Doctor Sexually Abused 177 Students over Decades, Report Finds*, WASH. POST (May 17, 2019), https://www.washingtonpost.com/sports/2019/05/17/ohio-state-team-doctor-sexually-abused-students-over-decades-report-finds/.

Investigation Involving Richard Strauss.[55] In 2018, a report from the National Academies of Sciences, Engineering, and Medicine identified sexual misconduct as being widespread in scientific communities, especially in medicine.[56] These reports raised important issues and presented an opportunity for medical boards to think critically about identifying, sanctioning, and alerting the public about physician sexual misconduct.

III. THE 2020 FSMB REPORT ON PHYSICIAN SEXUAL MISCONDUCT

In response to growing public awareness of physician sexual misconduct via high-profile egregious cases of sexual misconduct and criticism of individual board action (and inaction), the FSMB and its member boards renewed focus on the sexual misconduct problem. The FSMB took initiative by forming a national Workgroup that, over the course of two years, intensively studied multiple aspects of sexual misconduct, examined critical board functions, and continuously solicited input from multiple stakeholders in medicine, including students, and, most importantly, survivors of physician sexual misconduct.[57] The functions and processes of medical boards that the Workgroup scrutinized included reporting processes, investigation methodologies, procedures for data sharing and ensuring data transparency, education, discipline, and adjudication, among others.[58] The perspectives of stakeholders and survivors alike were incorporated throughout the process; the results of this intensive study of the issue were published in the FSMB Report.

55. *Transparency*, STATE MED. BD. OHIO, https://med.ohio.gov/Transparency (last visited Oct. 30, 2021).

56. NAT'L ACADS. OF SCIS., ENG'G, & MED., SEXUAL HARASSMENT OF WOMEN: CLIMATE, CULTURE, AND CONSEQUENCES IN ACADEMIC SCIENCES, ENGINEERING, AND MEDICINE 62 (2018).

57. *See Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct*, *supra* note 11, at 17–18 ("In analyzing these issues, the Workgroup benefited tremendously from discussions with . . . the FSMB's partner organizations and stakeholders. . . . The Workgroup extends its thanks, in particular, to the American Association of Colleges of Osteopathic Medicine (AACOM), Association of American Medical Colleges (AAMC), Student Osteopathic Medical Association (SOMA), Australian Health Practitioner Regulation Agency (AHPRA), American Medical Association (AMA), American Medical Women's Association (AMWA), American Osteopathic Association (AOA), Council of Medical Specialty Societies (CMSS), Federation of Medical Regulatory Authorities of Canada (FMRAC), Federation of State Physician Health Programs (FSPHP), several provincial medical regulatory colleges from Canada, subject matter experts from Justice3D, PBI Education, and additional physician experts, and especially the victim and survivor advocates who bravely shared their experiences with Workgroup members.").

58. *Id.* at 17.

A. Primary Goal and Key Principles Underlying the FSMB Report

The primary goal of the Workgroup and the FSMB Report was to provide medical boards with best practice recommendations for effectively addressing sexual misconduct and deterring future instances of misconduct. After forming the Workgroup, the Chair of the FSMB charged the members of the Workgroup with:

1) collecting and reviewing available disciplinary data, including incidence and spectrum of severity of behaviors and sanctions, related to sexual misconduct;
2) identifying and evaluating barriers to reporting sexual misconduct to medical boards, including, but not limited to, the impact of state confidentiality laws, state administrative codes and procedures, investigative procedures, and cooperation with law enforcement on the reporting and prosecution/adjudication of sexual misconduct;
3) evaluating the impact of medical board public outreach on reporting;
4) reviewing the FSMB's 2006 policy statement, *Addressing Sexual Boundaries: Guidelines for State Medical Boards,* and revising, amending or replacing it, as appropriate; and
5) assessing the prevalence of sexual boundary/harassment training in undergraduate and graduate medical education and developing recommendations and/or resources to address gaps.[59]

To carry out this charge, "the Workgroup adopted a broad lens with which to scrutinize not only the current practices of state medical boards . . . but also elements of professional culture . . . evolving public expectations of the medical profession, and the impact of trauma on survivors of sexual misconduct."[60] The Workgroup thus identified four key principles, detailed below, providing a critical ideological framework upon which its recommendations could be built.

1. Trust

As "[t]he physician-patient relationship is built upon trust,"[61] trust, defined as "a confident belief on the part of the patient in the moral character and competence of their physician,"[62] was the first key principle identified by the group. In discussing trust, the group found physicians have a duty to safeguard the trust that patients place in them, as a breach of this trust can have a lasting negative impact on the patients involved and on the public. Individual physicians who violate patient trust also undermine the trustworthiness of the medical

59. *Id.*

60. *Id.*

61. *Id.* at 18.

62. *See Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct*, *supra* note 11, at 18 (detailing the foundational importance of trust in the physician-patient relationship).

profession.[63] Thus, the group concluded to maintain patient trust and fulfill physicians' general duty to advance the medical profession, physicians must act according to underlying ethical principles.

2. Professionalism

Professional ethical principles hold physicians to a high standard of conduct that is proportionate to the level of trust that patients place in the physician; the Workgroup thus identified professionalism as the second key principle.[64] While the scope of what constitutes sexual misconduct has undergone transformation in recent decades, the avoidance of sexual relationships with patients has been "a principle of professionalism since at least the time of Hippocrates."[65] This notion has been reaffirmed by recent statements on physician conduct, such as the Declaration of Geneva and the AMA Code of Ethics.[66]

3. Fairness

To effectively hold physicians accountable to these principles of professional ethics, it is critical that the process is fair for all. The principle of fairness—the third key principle identified by the Workgroup—applies to both patients and physicians.[67] Individuals[68] who have been impacted by physician sexual abuse "must be granted fair treatment throughout the regulatory process and be afforded opportunities to seek justice for wrongful conduct committed against them."[69] Medical boards have a duty to protect the public from bad actors, ensuring that all who practice as state licensed physicians are worthy of the immense trust that patients place in them.

However, medical boards also have a duty to balance physician accountability and public disclosure of board actions within the limitations of

63. AbuDagga et al., *supra* note 50, at 2, 11.

64. *See Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct*, *supra* note 11, at 18.

65. *Id.*

66. *Id.* at 34; *WMA Declaration of Geneva*, WORLD MED. ASS'N (July 9, 2018), https://www.wma.net/policies-post/wma-declaration-of-geneva/.

67. *See Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct*, *supra* note 11, at 18.

68. *See Key Terms and Phrases: Victim or Survivor?*, RAINN, https://www.rainn.org/articles/key-terms-and-phrases (last visited Nov. 23, 2021) ("'Should I use the term victim or survivor?' Both terms are applicable. RAINN tends to use the term 'victim' when referring to someone who has recently been affected by sexual violence; when discussing a particular crime; or when referring to aspects of the criminal justice system. We often use 'survivor' to refer to someone who has gone through the recovery process, or when discussing the short- or long-term effects of sexual violence." As sexual misconduct impacts not only the individual patient but others as well, this short article highlights the importance of nomenclature when discussing this issue.).

69. *See Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct*, *supra* note 11, at 18.

state law. The fairness principle also applies to physicians as they "must be granted due process in investigative and adjudicatory processes."[70] Furthermore, not all forms of sexual misconduct are the same. While all constitute an ethical violation, there is a continuum of behaviors which demand different responses; when applied to physicians, the fairness principle also dictates that "proportionality should be considered in disciplinary actions."[71] Ensuring a fair process when a patient accuses a physician of failing to adhere to the core principle of professionalism helps to build trust in medical boards; maintaining transparency throughout the complex decision-making and evidentiary review processes is also critical.

4. Transparency

The final key principle identified by the Workgroup was transparency, as transparency is important for the purposes of maintaining the public trust in the profession itself, as well as its individual members.[72] Transparency in board actions can be difficult at times; in some instances, boards are not able to publicly disclose data or other information on physician misconduct due to competing factors such as fairness to the accused, restrictions on publication of personal or sensitive information, or stipulations between the board and the physician.[73] This is particularly problematic when state boards are unable to publicly respond to highly publicized misconduct. Disclosure limitations thus contribute to the perception that medical boards turn a blind eye to physician misconduct. As medical boards operate within a complaint-based system, they cannot act if the public does not know—or trust—that coming to the board with their concern will result in action. Because the continued ability of any profession to regulate its members is contingent upon society's approval of how regulatory responsibilities are fulfilled,[74] the Workgroup found that medical boards need to balance the limitations of a complaint-based system and legal limitations on disclosure with the need for transparency.

These four principles—trust, professionalism, fairness, and transparency—are integral to maintaining a safe, effective, and just system for all. The public needs to trust that medical boards will adjudicate complaints about physician misconduct fairly; that trust is built by physicians adhering to core ethical

70. *Id.*

71. *Id.*

72. *See id.* at 19, 28 (discussing the importance of transparency for developing trust and accountability).

73. *See id.* at 28 ("The ability to disclose particular details of investigative findings and disciplinary actions is limited by state statute in many jurisdictions.").

74. *See Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct*, *supra* note 11, at 28 (explaining that instances of sexual misconduct affect both individual patients and the public at large, so effective self-regulation of the medical profession happens through mechanisms that foster mutual trust and transparency).

principles of the profession and by board transparency in their evaluations of physician conduct. The Workgroup embodied these values by soliciting the perspectives of industry stakeholders—including physician groups and academic experts—alongside survivors of physician sexual misconduct. The Workgroup incorporated the input of these groups throughout the entire process of drafting and evaluating the recommendations made in the Report and placed particular importance on the perspectives of survivors in its discussions on trauma-informed investigations.[75]

B. The Workgroup Recommendations and A Call for Cultural Change

Along with identifying key principles, the Report sought to highlight key issues and barriers to implementation of these best practices, among which are elements of the current professional culture in medicine. As critical as medical boards are in the disciplinary process, "effectively addressing physician sexual misconduct requires widespread cultural and systemic changes that can only be accomplished through shared efforts across the medical education and practice continuum."[76] However, the current medical culture often permits or enables sexual misconduct and sexually harassing behaviors, either with colleagues, trainees, or patients.

To support a cultural shift and to achieve clarity and consensus about the FSMB's recommendations, the Report provided an updated definition of sexual misconduct.[77] Sexual misconduct was defined as occurring along a continuum of escalating severity.[78] At one end of the continuum are less egregious forms of sexual misconduct, often referred to as "grooming behaviors," such as special treatment, seemingly innocent touching, and comments that could be construed to be romantic or inappropriately flattering.[79] Behaviors at the more severe end of the spectrum would include overt sexual comments, gestures, acts, and relationships, whether there is "consent" from the recipient of these behaviors or not.[80] The rationale for defining sexual misconduct in this manner is both to recognize that it can take many forms, and to illustrate that a pattern of seemingly innocuous behaviors is worthy of regulatory attention because it can constitute grooming and may escalate into more overt sexual behavior that is harmful to patients and others.

The FSMB Report also placed a high degree of importance on communication in the physician-patient relationship, in part through the

75. *Id.* at 23–24.

76. *Id.* at 31.

77. *Id.* at 19 ("For the purposes of this report, physician sexual misconduct is understood as behavior that exploits the physician-patient relationship in a sexual way. . . .").

78. *Id.*

79. *Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct*, *supra* note 11, at 19.

80. *Id.*

informed consent process, to ensure that the nature of and clinical indications for examinations and procedures, especially intimate ones, are understood by the patient and not misinterpreted as inappropriate.[81] This was meant to support the professional responsibility of communication and encourage a culture of transparency and respect for patient autonomy while safeguarding the trust that exists between a patient and their physician. A benefit of enhanced communication is that patients are better equipped with information about what might constitute inappropriate behavior in other clinical encounters. Patients may therefore recognize and be more willing to report such behavior when it occurs.

The Report acknowledges, however, that the most significant changes in the professional culture must be brought about by the profession itself.[82] While medical education plays a key role in inculcating appropriate behavior through teaching and role modeling, physicians must also learn to speak up, both through conversations with colleagues when sexual misconduct occurs and through formal reporting of such behaviors to employment authorities and medical boards. To argue that a duty to report puts physicians in an awkward or unfair position is to accept harmful and unprofessional elements of the prevailing culture in medicine.

C. The Workgroup Recommendations

After a lengthy open consultation on a set of draft recommendations that saw participation not only from medical boards, but also from multiple organizations in the United States, patient advocates, survivors of sexual assault, and regulatory authorities from around the world, the Workgroup's efforts culminated in the FSMB Report.[83] This Report provided thirty-eight recommendations for medical board processes for improved public protection.[84]

These recommendations focus on transparency of regulatory data and decisions, and provide guidance for timely and sensitive approaches to complaints and complainants.[85] Particularly, medical boards are encouraged to incorporate trauma-informed techniques into the investigatory process and act in a strong and decisive manner to address misconduct.[86] The guidelines also call for improved education of the public on the role of medical boards and how to make a complaint to a medical board.[87] Emphasis on professional responsibility and normalizing the process of speaking up address the perceived

81. *Id.* at 20.

82. *Id.* at 18.

83. *Id.* at 17–18.

84. *Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct*, *supra* note 11, at 31–34.

85. *Id.* at 31–32.

86. *Id.* at 32.

87. *Id.* at 31–32.

code of silence among health care professionals and within the workplace.[88] Finally, the recommendations stress the importance of education about sexual misconduct at all stages of the educational and practice continuum.[89] The Key Recommendations are summarized in Table 1.

TABLE 1: KEY FSMB RECOMMENDATIONS[90]

Topic	*Recommendation*
Culture	• Promotion and support of professionalism • Zero tolerance of sexual misconduct
Transparency	• Information made publicly available to justify and provide rationale for regulatory decisions • Clear coding of disciplinary actions, linking discipline to behavior • Consistent terminology for disciplinary actions across medical boards
Complaints	• Education and guidance for patients about the complaints process • Frequent communication with complainants throughout the investigative process • Prioritization of processing complaints related to sexual misconduct • Inclusion of specially trained patient liaisons on medical board staff
Reporting	• Stronger legislation mandating institutional and individual reporting and ability to levy fines for not reporting egregious conduct • Reporting requirements for results of peer review processes that uncover sexual misconduct

88. *Id.* at 31–34.

89. *Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct*, *supra* note 11, at 31, 33–34.

90. *Id.* at 31–34.

Investigations	• Medical board intervention when investigation indicates reasonable probability that sexual misconduct has occurred • Ability to impose interim terms or limitations, including suspension, on a physician's license prior to completion of investigation • Implementation of trauma-informed procedures when interviewing and interacting with complainants and adjudicating cases • Complainant's preference for gender of investigators respected
Discipline	• Automatic license revocation for egregious acts of a sexual nature or repeated commission of lesser acts, especially following remedial efforts • Discontinuation of chaperone model for monitoring, and implementation of "Practice Monitors," subject to specific conditions • Consideration of remedial action following sexual misconduct only under strict conditions
Education	• Provision of education about professionalism, professional boundaries, sexual misconduct, and the effects of trauma at all career stages and to medical board members and staff

IV. CHALLENGES MOVING FORWARD: BARRIERS TO IMPLEMENTING CHANGE

Evaluating a board's implementation of best-practice recommendations such as those outlined in the FSMB Report must involve consideration of the statutory, cultural, and structural limitations on medical board actions. As others have acknowledged, statutory changes are in some cases needed to fully implement best practices.[91] Implementing best practices is sometimes frustrated by the complex interplay of law, society, and limited resources.

A. Input Challenge: Resource Scarcity

Medical boards face a critical dearth of information that impacts their ability to proactively address misconduct. As the current regulatory system is complaint-based, medical boards are generally reliant upon others to provide critical information before investigations commence. This information can be

91. *See id.* at 20, 32. *See also* Elizabeth Pendo et al., *Protecting Patients from Physicians Who Inflict Harm: New Legal Resources for State Medical Boards*, 15 ST. LOUIS U. J. HEALTH L. & POL'Y 7, 14 (2022).

provided from different sources, but often is not shared.[92] Patients, hospitals, health systems, insurers, and practitioners themselves all play key roles in the complaint-based disciplinary system. Whether these stakeholders remain silent out of fear, a lack of knowledge, or out of self-interest, the impact is the same. When stakeholders do not report misconduct to medical boards, these boards do not receive the information that they need to initiate an investigation or meet evidentiary requirements necessary to suspend or revoke an offending physician's license. As discussed in the FSMB Report, when boards publicly fail to sanction physicians or otherwise fail to be transparent, patient trust in the system erodes.[93] This in turn results in a vicious cycle of silence, inaction, and potentially, further abuse.

One important source of information is the patients themselves or their surrogates. Patients who have been harmed by a physician are often in possession of information sufficient to trigger an investigation by a medical board to prevent the physician from continuing to engage in harmful conduct. However, victims of physician misconduct have low rates of reporting, with a Harris Poll—commissioned by the FSMB—finding that only thirty-three percent "of those who believe they experienced unethical, unprofessional, or substandard care reported the misconduct or filed a complaint."[94] Some scholarly estimates are even lower, with one study estimating that fewer than one in ten patient-victims chooses to file a report.[95]

There are many factors that contribute to patients not reporting physician abuse. Victims of sexual crimes are often hesitant to come forward, and reporting rates for sexual crimes are low on a national level; according to the most recent data available from the Department of Justice, only 33.9% of rape or sexual assault victims reported the crime to police.[96] In the case of physician misconduct, institutional mistrust, fear of retaliation, fear of social stigma, shame, and even a lack of awareness about the role of medical boards can all play a role in non-reporting. Of the 33% of patients who reported misconduct, the FSMB-commissioned Harris poll found that "only 34% [of those who reported misconduct] took their complaint to a state medical board."[97] Patients

92. FED'N OF STATE MED. BDS., POSITION STATEMENT ON DUTY TO REPORT 1 (2016), https://www.fsmb.org/siteassets/advocacy/policies/position-statement-on-duty-to-report.pdf.

93. *Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct*, *supra* note 11, at 27.

94. *National Survey Indicates Majority of Physician Misconduct Goes Unreported*, FED'N OF STATE MED. BDS. (May 30, 2019), https://www.fsmb.org/advocacy/news-releases/national-survey-indicates-majority-of-physician-misconduct-goes-unreported/.

95. James M. DuBois et al., *Sexual Violation of Patients by Physicians: A Mixed-Methods, Exploratory Analysis of 101 Cases*, 31 SEXUAL ABUSE 503, 504 (2019).

96. RACHEL E. MORGAN & JENNIFER L. TRUMAN, BUREAU OF JUST. STAT., U.S. DEP'T OF JUST., NCJ 255113, CRIMINAL VICTIMIZATION, 2019 (2020).

97. *National Survey Indicates Majority of Physician Misconduct Goes Unreported*, *supra* note 94; THE HARRIS POLL, STATE MEDICAL BOARDS AWARENESS STUDY (2018), https://www.fsmb

need to know where to report and feel empowered to report; they need to be able to trust that their report will be confidential and trust that their report could make an impact.[98] Thus, targeted efforts to educate the public on the role that boards play in physician discipline are essential, as are the creation of reporting systems that are easy-to-use, accessible-to-all, and trustworthy.[99] The FSMB-conducted Harris poll also found that about a third of patients reported the misconduct directly to the physician's hospital or practice.[100] This is a logical place for patients to turn, and thus institutional stakeholders—including hospitals, physician groups, and private clinics—and all members of the health care team also play a critical role in providing information to medical boards. Hospitals and other health care stakeholders have a legal and ethical duty to report, but as the FSMB Report noted, this duty "has proven insufficient in recent years[.]"[101] A culture of silence among many medical professionals, limited incentives for individual or institutional reporting, and weak enforcement mechanisms all contribute to the problem. As a result, "[h]ospitals or physician employers sometimes ignore reports of abuse or push for a resignation rather than reporting physicians to medical boards or law enforcement."[102]

Many state statutes permit medical boards to assess fines against hospitals that fail to report egregious conduct, but these boards are often outmatched by the comparatively vast resources of large health systems.[103] Federal law, specifically the Health Care Quality Improvement Act (HCQIA) has the effect of disincentivizing such reporting. Congress intended that the HCQIA would "prevent . . . injustices by making available to employers and licensure agencies critical information about adverse actions taken against licensed health care professionals"[104] by requiring hospitals to report actions taken against

.org/siteassets/advocacy/news-releases/2018/harris-poll-executive-summary.pdf (study was prepared for the FSMB).

98. *Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct*, *supra* note 11, at 28.

99. *Id.* at 33.

100. THE HARRIS POLL, *supra* note 97 (indicating that thirty-one percent reported the physician to their office/hospital/group and twenty-five percent reached out to a lawyer).

101. *Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct*, *supra* note 11, at 21.

102. DuBois et al., *supra* note 95.

103. *Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct*, *supra* note 11, at 22 ("State medical boards should have the ability to levy fines against institutions for failing to report instances of egregious conduct. While many boards already have statutory ability to do so, they are reluctant to engage in legal proceedings with hospitals or other institutions with far greater resources at their disposal.").

104. RON SCOTT, PROMOTING LEGAL AND ETHICAL AWARENESS: A PRIMER FOR HEALTH PROFESSIONALS AND PATIENTS 77 (2009).

physicians and through the creation of a NPDB.[105] However, under the HCQIA, hospitals are not required to report patient complaints or even allegations of egregious misconduct; rather, they are required to report "a professional review action that adversely affects the clinical privileges of a physician for a period longer than 30 days."[106] Furthermore, the HCQIA provides hospitals with "broad-based immunity from liability for all professional review actions which meet its standards and which are made in the conduct of professional review activity."[107] In other words, the HCQIA gives hospitals and health administrators wide latitude to internally handle physician misconduct as long as a hospital's review process conforms to the standards set forth in the statute[108] and only requires reporting when the review results in an adverse action against the physician. Thus, the protections afforded to the peer review process under the HCQIA curb the flow of information from hospitals to medical boards; this statute incentivizes hospitals to handle allegations of physician misconduct through internal review processes, and medical boards are left without key data that could be used in furtherance of their duty to regulate the practice of medicine.

Individual physicians and other members of a patient's health care team are a critical source of information. As highlighted in the FSMB Report, there are "highly problematic aspects of sexual misconduct in medical education and practice, many of which permeate the prevailing culture of medicine and self-regulation."[109] There has long been a breakdown in reporting within the health care profession, as "[h]ealth care providers who sexually assault patients sometimes commit the act in the presence of other medical professionals, who may actually witness the sexual misconduct;" even those who witness this conduct do not report, as there "seems to be a 'code of silence' [among] some health care providers."[110] A cultural shift within medicine that normalizes the reporting of misconduct must take place. Recent FSMB recommendations thus

105. Mark A. Colantonio, *The Health Care Quality Improvement Act of 1986 and Its Impact on Hospital Law*, 91 W. VA. L. REV. 91, 92–93 (1988).

106. 42 U.S.C. § 11133(a)(1)(A).

107. Colantonio, *supra* note 105, at 93–94.

108. 42 U.S.C. § 11112 ("For purposes of the protection set forth in section 11111(a) of this title, a professional review action must be taken—(1) in the reasonable belief that the action was in the furtherance of quality health care, (2) after a reasonable effort to obtain the facts of the matter, (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).").

109. *Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct*, *supra* note 11, at 18.

110. Nanci Hamilton, *Stopping Doctor Evil: How to Prevent the Prevalence of Health Care Providers Sexually Abusing Sedated Patients*, 45 HOFSTRA L. REV. 299, 306–07 (2016).

also include strengthening accountability models for physicians and other health care providers who fail to report sexual misconduct.[111]

This necessary culture shift depends on individual action—but institutional support from hospitals and health systems is also critical. The FSMB Report acknowledges "physicians may also avoid reporting because of the moral distress . . . and the impracticality of reporting where power dynamics exist and where stakes are high for reporters."[112] Some physicians may reasonably fear that coming forward will result in personal or institutional retaliation.

Several recent cases illustrate the importance of hospitals reporting to medical boards and reinforce the need to implement FSMB recommendations for greater hospital accountability in reporting to medical boards. In July 2021, Susan Kryhoski filed a lawsuit against New York Presbyterian Hospital, alleging that she had been assaulted there years prior by Dr. Joseph Silverman.[113] Early reports revealed that she was at least the second person to come forward with these claims, yet no record of the hospital reporting to the New York State Office of Professional Medical Conduct could be located.[114]

The same pattern of institutional inaction and secrecy is also present in the case of Dr. Ricardo Cruciani. Cruciani, a neurologist who was charged with sexual assault and stripped of his Pennsylvania medical license following an internal investigation at Drexel University, faces ongoing litigation with patients he treated during his tenure at Beth Israel Medical Center in New York and Capital Health System in New Jersey.[115] One suit alleges that Cruciani was able to get away with his behavior because "hospital administrators and staff members ignored reports that Mr. Cruciani was sexually assaulting patients . . . never warning other hospitals, state authorities or the police."[116] This claim is substantiated by officials at Drexel University, who have publicly "pointed the finger at other hospitals for failing to take action or to warn them [stating] 'Drexel hired Cruciani after conducting a thorough background check . . . None

111. *Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct*, *supra* note 11, at 23, 32 ("Physicians who fail to report known instances of sexual misconduct should be liable for sanction by their state medical board for the breach of their professional duty to report.").

112. *Id.* at 22.

113. Kara Grant, *NewYork-Presbyterian Sued for Allegedly Ignoring Child Sexual Abuse*, MEDPAGE TODAY (Aug. 2, 2021), https://www.medpagetoday.com/special-reports/exclusives/93854.

114. *Id.*; Mary Murphy, *Woman Sues Prominent NY Hospital; Says Anorexia Doctor Raped Her There as a 11-Year-Old Patient*, PIX 11 LOC. NEWS (July 29, 2021, 5:58 PM), https://pix11.com/news/local-news/woman-sues-prominent-ny-hospital-says-anorexia-doctor-raped-her-there-as-11-year-old-patient/.

115. Roni Caryn Rabin, *After Years of Sexual Abuse Allegations, How Did This Doctor Keep Working?*, N.Y. TIMES (Oct. 11, 2021), https://www.nytimes.com/2021/10/11/health/ricardo-cruciani-sexual-abuse.html.

116. *Id.*

of these hospitals ever notified Drexel about Cruciani's conduct.'"[117] These cases are highly publicized examples but are indicative of an insidious and widespread problem; even preeminent institutions at times shield physicians from misconduct allegations.[118]

There needs to be a pipeline of information going to medical boards so they can effectively investigate and respond to allegations of misconduct. Obtaining information about misconduct is critical—without information, boards have limited ability to investigate or act. There is a need for patients and health care providers alike to recognize the important role they play in addressing physician sexual misconduct. To make this a possibility, medical boards must make targeted attempts to educate patients, to provide clear, trustworthy mechanisms that facilitate swift reporting, and to have robust enforcement mechanisms for holding institutional actors accountable. The FSMB Report and the work of other scholars[119] show that legislative changes on this front are warranted.

B. The Impact of Structural Limitations, Resource Scarcity, and Statutory Constraints on Disciplinary Efforts

Even when a medical board may be "aware" of alleged misconduct, its ability to discipline may be limited by statute as well as requisite resources to conduct a thorough investigation and gather evidence that would satisfy the burden of proof required to take severe disciplinary action against a physician. Moreover, undue political influence exerted on the board may limit its ability to act independently in furtherance of public protection.

Generally, state medical practice acts provide boards broad powers to investigate and discipline in the public interest, but this latitude is not inviolable to subsequent amendment. For example, in 2015, and against the objections of the medical board, Louisiana enacted a law that restricted the ability of the board's executive director from directing investigations and narrowly bound the time in which the board could initiate and complete an investigation.[120] Additionally, some states are limited in their ability to share information about pending investigations with other medical boards where a physician may be licensed. In fact, one provision of the Interstate Medical Licensure Compact allows medical boards to conduct joint investigations and share confidential information about physicians licensed under the Compact.[121] Under some prior

117. *Id.*

118. Anthony T. DiPietro, *The Role of Institutions in Enabling Sexual Abuse*, DIPIETRO L. FIRM (June 3, 2018), https://www.atdlaw.com/2018/06/03/the-role-of-institutions-in-enabling-sexual-abuse/.

119. Pendo et al., *supra* note 91.

120. LA. STAT. ANN. § 37:1270(A)(9) (2007); LA. STAT. ANN. § 37:1285.2(A) (2015).

121. RULE ON COORDINATED INFO. SYS., JOINT INVESTIGATIONS & DISCIPLINARY ACTIONS §§ 6.4(b), (i) (INTERSTATE MED. LICENSURE COMPACT COMM'N 2018) ("Upon initiating a joint investigation, the lead investigative Board shall notify the Interstate Commission of the joint

state statutes, boards were prohibited from sharing confidential information, even with other medical boards.

The nature of the appointment processes creates a structural constraint that should be considered if one is to objectively critique board activities and conclude a board failed to sufficiently act in the public interest. The common refrain that regulatory boards are captured by the profession is hyperbolic and does not accurately reflect experience on a medical board and the important role of public members.[122] The need for independent board members is a hallmark of FSMB policy on the structure of medical boards.[123] This policy further recommends that *at a minimum* public members constitute twenty-five percent of the number of board members.[124] Since California added the first public member to its medical board in 1961, states have heeded the call for more diverse representation and made changes to composition to ensure that the board reflects the diversity of the public it is there to protect.[125]

However, board appointments are subject to approval of a politically elected individual, most often the governor.[126] And while boards operate independently and procedures exist that shield the expert decision making of medical board members, the nature of appointment and regulation in general make it difficult for even the most irreproachable board member to avoid entanglement with the political process. Boards may proceed on some disciplinary issues cautiously, balancing the need to discipline to the full extent possible with the reality that such action may limit the ability of the board to achieve other objectives. A strong action against a physician with political connections may raise the ire of an influential member of the legislature or the appointing authority itself. And unfortunately, retribution against a medical board that acts decisively in the public interest is more than conjecture—it is a reality board members must confront in their decision-making process on how best to regulate in the public interest.[127]

investigation and inform the Interstate Commission which member Boards are part of the joint investigation. The Interstate Commission shall notify any other member Boards where the Compact physician is licensed of the identity of the individual under investigation and the contact information for the lead investigative Board.").

122. Stephen E. Heretick, *The Role of Public Members on State Medical Boards*, J. MED. REGUL., Mar. 1, 2010, at 6, 6–9.

123. FED'N OF STATE MED. BDS., GUIDELINES FOR THE STRUCTURE AND FUNCTION OF A STATE MEDICAL AND OSTEOPATHIC BOARD 14 (2021), https://www.fsmb.org/siteassets/advocacy/policies/guidelines-for-the-structure-and-function-of-a-state-medical-and-osteopathic-board.pdf.

124. *Id.*

125. *E.g.*, OR. REV. STAT. § 676.400 (2018).

126. GUIDELINES FOR THE STRUCTURE AND FUNCTION OF A STATE MEDICAL AND OSTEOPATHIC BOARD, *supra* note 123, at 16.

127. *Political Ties Cited in Perry's Intervention in Oklahoma Medical Probe*, DALL. MORNING NEWS (Nov. 4, 2015, 1:20 PM), https://www.dallasnews.com/news/politics/2015/11/04/political-ties-cited-in-perrys-intervention-in-oklahoma-medical-probe/ (In 2010, the Oklahoma Board of

Scarcity of board resources also factors into the approach taken to discipline. The majority of medical boards are self-funded, meaning their budget is contingent on funds generated by board activities and licensing fees.[128] In some states, revenue collected from licensure fees is the only source of funds to carry out the totality of regulatory obligations, and any punitive fees collected from licensees for noncompliance may be subject to transfer to a state's general funds. Financial limitations and the costs of vigorous investigations limit effective disciplinary enforcement by medical boards.[129] Thus, for each complaint, investigation, and disciplinary proceeding, medical boards must consider the impact the chosen action has on the ability of the board to reserve funds for equally important aspects of medical regulation.[130] This impact further factors into the decision to pursue an agreed order if facts presented in a complaint and investigation make it difficult to ascertain whether the evidentiary threshold can be met.[131]

Together, these concepts factor into the ultimate approach a board takes toward investigating and disciplining misconduct. While the strong call for investigatory transparency and discipline to the full extent possible is appreciated, it must be balanced against the primary concern of the medical boards, which is protection of the public.

At their core, medical boards are important state-sanctioned instruments whose task is to promote public safety by balancing risk against harms. Each decision a board makes must take into account the "holistic view of regulation and risk management[] and conceptualize[] risks as interrelated and as having potential consequences for broader social, economic and political environments."[132] Any decision that a state board makes in the process of handling a case in which a physician is accused of misconduct reverberates far beyond the individuals involved in that particular case. This may mean that in certain circumstances, boards may opt for an action with greatest immediate impact, such as using an Agreed Order, in order to restrict a physician's ability

Medical Examiners investigated a physician accused of serious violations involving over twenty patients, which included billing fraud, paralysis, and even death. As the investigations continued, the governor inserted herself into the board's investigation and adjudication of the matter, presumably after being urged to do so by another governor, who just so happened to be the recipient of campaign donations from the physician in question. Ultimately, the board refused to accede to governor's request, creating tensions that impacted the Board's independence to regulate in the public interest.).

128. FED'N OF STATE MED. BDS., U.S. MEDICAL REGULATORY TRENDS AND ACTIONS 59–60 (2018), https://www.fsmb.org/siteassets/advocacy/publications/us-medical-regulatory-trends-actions.pdf.

129. *Id.*; Sawicki, *supra* note 5, at 315.

130. Sawicki, *supra* note 5, at 301, 315.

131. *Id.*

132. Bridget M. Hutter, *A Risk Regulation Perspective on Regulatory Excellence*, *in* ACHIEVING REGULATORY EXCELLENCE 101, 106 (Cary Coglianese ed., 2017).

to provide care in lieu of a full investigation.[133] For example, a board may decide to enter an Agreed Order with a physician, even though the board suspects that the Agreed Order may not provide a full and complete account of the facts underlying the decision per the terms of the agreement. In that instance, the terms of the Agreed Order may be, in the board's estimation, the most efficient way of managing the societal risk presented by the physician.

Fully informed future recommendations and effective changes to the processes designed to address physician misconduct can only be realized alongside an understanding of the need for boards to manage risk, the statutory limitations placed on actions and disclosures, an awareness that boards often lack critical resources (like the information necessary to initiate investigations), and an acknowledgment of some boards' inability to hold other stakeholders accountable for failing to report misconduct.

V. STATE MEDICAL BOARD SUCCESSES: HOPE FOR THE FUTURE

While boards must grapple with these barriers, there are innovative ways in which they can work to improve the status quo—including and in addition to adopting the recommendations contained in the FSMB Report. Medical boards can use emerging technologies to implement better systems for identifying physicians whose records contain "red flags." In this way, physicians, especially those who are guilty of serial abuse, would be less able to fly under the radar and avoid accountability. One of the key issues with physician accountability is identifying those who are or who could become serial offenders. A recent study of over 90,000 physician records in the state of Illinois found that physicians with two or more disciplinary actions account for only 0.47% percent of physicians, but 28% of all disciplinary actions; similarly, the study found that physicians with two or more paid medical malpractice claims account for 2.37% of all licensed physicians, but 53% of paid claims and payouts for medical malpractice claims.[134] Utilizing technology to adopt a risk management strategy could target these bad actors and thus ultimately reduce malpractice and physician misconduct.

Just as "the advance of computer technology and the creation of the National Practitioner Data Bank allowed boards to better coordinate oversight efforts among the states and . . . led to a significant increase in the number of serious disciplinary actions . . . in the late 1980s and early 1990s,"[135] medical boards today can utilize technology to improve regulatory processes. Technology can be used to consolidate and share information almost instantaneously, utilize

133. U.S. MEDICAL REGULATORY TRENDS AND ACTIONS, *supra* note 128, at 10.

134. David A. Hyman et al., *Medical Malpractice and Physician Discipline: The Good, The Bad and The Ugly*, 18 J. EMPIRICAL LEGAL STUD. 131, 131, 138–40 (2021).

135. Ross D. Silverman, *State Medical Boards and the Politics of Public Protection*, 21 J. LEGAL MED. 143, 145 (2000).

artificial intelligence and algorithmic solutions to assess risk, and thus continue to improve physician accountability. Data interoperability is critical if medical boards are to distill insight from regulatory output data and then reuse it for systemic improvements and prevention of harm. Just as other industries have applied data and machine learning to profoundly evolve historically limiting business practices and derive greater impact,[136] so too should regulatory bodies concerned with preventing and disciplining physician sexual misconduct.

A. Improvements to Board Action Language

Standardization of disciplinary data and improved data sharing across the health care and regulatory ecosystem brings with it the promise that medical boards can utilize artificial intelligence strategically and improve their ability to address all forms of physician misconduct—not just for sexual misconduct. Properly labeled data sets are an essential component of this effort,[137] and one which will be difficult to achieve because many of the databases were not designed to interoperate. But once this occurs, medical boards would be able to use this data to uncover patterns of concerning and unreported behavior, intervene proactively to prevent harm, and engage in remedial and educational efforts, where appropriate.

The FSMB is in a unique position to analyze and assist in the standardization of disciplinary orders. Today, information is disseminated electronically through FSMB's Physician Data Center (PDC).[138] The PDC receives copies of 8000 disciplinary actions (on more than 4000 physicians) each year.[139] Medical boards also query the FSMB more than 100,000 times and receive nearly 15,000 disciplinary alerts annually.[140]

The full value of a centralized repository of disciplinary actions has not been fully realized. One major constraint is that the actions the FSMB receives are as varied as the boards themselves, and there is no standard manner in the presentation of factual background and legal conclusions. To address this dissonance, after the FSMB receives a copy of a disciplinary action, its PDC staff reviews the order to discern the action(s) taken by the board and the reason(s) for those action(s). While final determination generally comes from the "findings of fact" and/or "conclusions of law," the reasons for those actions (based solely on the findings of fact), can be indistinct. In some cases, the basis for discipline can only be categorized in general terms such as "unprofessional

136. THOMAS M. SEIBEL, DIGITAL TRANSFORMATION: SURVIVE AND THRIVE IN AN ERA OF MASS EXTINCTION 75–82 (Eric Marti ed., 2019).

137. MELANIE MITCHELL, ARTIFICIAL INTELLIGENCE: A GUIDE FOR THINKING HUMANS 111 (1st ed. 2019).

138. U.S. MEDICAL REGULATORY TRENDS AND ACTIONS, *supra* note 128, at 8, 18.

139. *Id.* at 19.

140. *Id.* at 18.

conduct" or the order is so opaque that the reason for discipline must be labeled "not provided," or "undetermined."[141]

In 2018, recognizing the need for reform and consistency in reporting, the FSMB established an internal Workgroup to conduct a more detailed review of disciplinary actions with focus on the narrative section. Initial analysis revealed: (1) documents received from boards vary in quality and detail which creates coding challenges, particularly in the case of reciprocal actions (e.g., some boards do not provide documentation supporting the reciprocal actions); (2) the way basis codes are assigned can sometimes create redundancies (e.g., alcohol abuse, inappropriate use of alcohol, intemperate use of alcohol); (3) sometimes codes can be derived from the findings of fact (e.g., moral unfitness), but provide little insight into what happened (e.g., excessive prescribing); and (4) often there is meaningful information beyond the findings of fact in the narrative contained in the disciplinary action or in the instance of reciprocal action, in the original disciplinary action.

In 2019, the FSMB's PDC established a new process for coding a secondary set of research basis codes based on the findings of fact and board order narrative. In addition to coding the standard board action and basis code data, the PDC reviewed—through both manual and machine learning techniques—board orders with 5096 actions for 2575 physicians to determine if additional research basis codes could be added. A preliminary analysis of this data revealed that 554 orders were identified and coded with additional research basis codes, providing greater insight into the facts behind disciplinary actions. Though less common, meaningful increases in rates were also observed in physician-patient boundary issues (eight orders added), sexual misconduct (sixteen added), and sexual boundary issues (nine added).

The 2020 FSMB Report encourages medical boards and others to implement clear coding processes for board actions that provide accurate descriptions of cases, and clearly link licensee behaviors to disciplinary actions; where sexual misconduct has occurred, the case should be labeled as such.[142] A label of "disruptive physician behavior" or even "boundary violation" is less helpful than the more specific label of "sexual misconduct."[143] In furtherance of this goal, the FSMB has joined with the NPDB and other stakeholders in the house of medicine to develop consistent terminology that allows a violation and the underlying causes of discipline to be stated explicitly, thereby promoting greater understanding for the public and the medical boards, while also enabling the tracking of trends, frequencies, recidivism, and the impact of remedial measures.

141. *See generally* King et al., *supra* note 4, at 1609–10.

142. *Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct*, *supra* note 11, at 28.

143. *Id.*

B. Greater Use of Technology in the Regulatory Process and Risk-Based Transformation

Efforts to utilize advanced data analytics in the regulatory process are increasing. The North Carolina Medical Board, through improvements to its Safe Opioid Prescribing Initiative, effectuated greater use of data analytics to proactively screen and identify prescribers of interest where no complaint has been received.[144] Internationally, the Australian Health Practitioner Regulation Agency is developing and has already piloted new risk-based approaches to managing complaints against health practitioners, including a risk-assessment tool that cross references complaint data against known features of a practitioner and the circumstances of their practice in order to allocate regulatory resources more quickly and effectively.[145] These efforts are evidence that regulators are diligent in their efforts to fulfill their statutory mandates.

This shift on the part of medical boards to utilize technology for automated regulatory and administrative decision making systems is a dramatic shift from the status quo that will no doubt raise concerns that boards would be out of compliance with due process and other legal requirements.[146] Proponents of integrating artificial intelligence into the toolbox used by regulators argue that existing legal doctrines need not create insuperable barriers to governmental use of machine learning so long as the operational frameworks behind them are understandable.[147] Critics may also cite that the data necessary to train the systems may exacerbate human biases, or pose problematic considerations related to privacy, data usage, and government accountability. But these issues have coexisted with artificial intelligence from the outset. And while these questions may not be easily answered, recognition of the issues and collaborative efforts to address them during the deployment of technology-enabled regulatory solutions allows the benefits to be realized and the promise of improved regulation to be embraced.[148]

144. In 2017, the North Carolina Medical Board sought legislative changes that would allow it to access data on patient and prescriber characteristics to improve assessment of behaviors commonly associated with inappropriate opioid prescribing and to identify additional licensees for investigation. N.C. GEN. STAT. § 90-113.74(b2) (2019).

145. AUSTRALIAN HEALTH PRAC. REGUL. AGENCY, ANNUAL REPORT 2017/18: NOTIFICATIONS AND MONITORING (2018), http://www.ahpra.gov.au/annualreport/2018/notifications.html.

146. CARY COGLIANESE, A FRAMEWORK FOR GOVERNMENTAL USE OF MACHINE LEARNING (2020) (report to the Admin. Conf. of the U.S.).

147. Cary Coglianese & David Lehr, *Regulating by Robot: Administrative Decision Making in the Machine-Learning Era*, 105 GEO. L.J. 1147, 1176, 1222 (2017).

148. *See* ADMIN. CONF. OF U.S., STATEMENT #20, AGENCY USE OF ARTIFICIAL INTELLIGENCE (2020), https://www.acus.gov/sites/default/files/documents/Statement%2020%20Agency%20Use%20of%20Artificial%20Intelligence.pdf (discussing the possible application of AI to aggregated data on professional conduct).

Properly implemented, a risk-based approach to regulation can improve allocation of scarce regulatory resources, identify physicians that need additional support and in doing so, avert misconduct *before* it occurs, and ultimately improve the protection of the public and its trust of the system as a whole.

VI CONCLUSION

Sexual misconduct in medicine is a critical problem that requires innovative solutions and sustained attention from medical boards. However, sexual misconduct relates fundamentally to the prevailing culture within the profession of medicine and in health care generally. Overcoming the most significant challenges to addressing it will therefore only be possible with support from all stakeholders within the health care system and must involve an ongoing reexamination of the nature of medical professionalism, including the duties held towards patients and colleagues. All stakeholders play a role in addressing physician sexual misconduct, and it is imperative that the culture around reporting physician misconduct shifts. Practitioners and health care institutions must understand the role that they play in perpetuating this problem by their silence; their failure to report makes it impossible for medical boards to act. From the clinic to the boardroom, moving forward, there must be greater accountability for institutional failure to report.

Medical board responses to physician sexual misconduct must be evaluated in light of their historical context, statutory constraints, and structural limitations. While some critiques of medical boards fail to consider these cultural features and discount the positive incremental changes that boards have made, this does not in any way diminish the need for boards to continue to make progress. Innovative solutions, such as utilizing technology to supplement the complaint-based system and to develop risk-focused strategies, are possible. Contextualizing medical board responses can help boards, legislators, and other stakeholders think critically about the physician sexual misconduct problem and craft solutions that will effectuate change.