



State of West Virginia *Board of Medicine*

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July 28, 2022

SUMMARY OF COMMENTS RECEIVED REGARDING PROPOSED RULE 11 CSR 16, AND RESPONSES OF THE WEST VIRGINIA BOARD OF MEDICINE

During the 2022 legislative session, the West Virginia Legislature passed Senate Bill 606, which modified W. Va. Code § 30-3-14. The changes to the Medical Practice Act implemented by the bill:

1. Provide more specific direction on a practitioner's duty to report certain categories of professional misconduct to the Board, including sexual misconduct with patients;
2. Clarify that sexual misconduct constitutes professional misconduct for which disciplinary action or license denial may occur; and
3. Direct the Board of Medicine to propose rules for legislative approval which define sexual misconduct and identify prohibited sexual misconduct.

On June 24, 2022, the West Virginia Board of Medicine filed a Notice of Comment Period on a new Proposed Rule, 11 CSR 16, *Prohibiting Sexual Misconduct by Health Care Practitioners*. The Notice established a thirty day comment period on the proposed rule, which concluded at 12:00 pm on July 25, 2022. During the comment period, the Board received two comments.¹ The Board has reviewed the comments received, and on July 26, 2022, the following responses were authorized by the Board. A copy of this summary is being provided to each of the commenters.

Commenter	Date Received
1. Gerald Wedemeyer, MD	July 5, 2022

Dr. Wedemeyer identified a typographical error in subdivision 7.1.3. of the proposed rule. As originally filed, this subdivision reads:

¹ Copies of the comments received by the Board and the Board's individual responses thereto are attached to this summary.

7.1.3. The patient was unconscious or otherwise unable to provide consent for the healthcare services and the practitioner's conduct confirmed to the standard of care for the patient presentation in an emergency setting.

The commenter proposed that "confirmed" be replaced with "conformed."

WVBOM Response: The Board appreciates Dr. Wedemeyer's careful review of the rule language. Subdivision 7.1.3. has been modified in conformity with this helpful comment.

Commenter	Date Received
2. Michael Edmond, M.D. Chief Medical Officer West Virginia University Medical Corporation d/b/a/ University Health Associates	July 22, 2022

West Virginia University Medical Corporation d/b/a/ University Health Associates ("UHA") provided written comments which address three aspects of the proposed rule. Foundational to one or more of these comments appears to be the premise articulated by UHA that "W. Va. Code § 30-3-14 subjects health care practitioners to discipline for engaging in 'sexual misconduct' with a patient and creates reporting requirements for any person authorized/licensed by the WVBOM for engaging in sexual misconduct with a patient." UHA Comment, p. 1.

As a preliminary matter, the Board responds that UHA's summary of the changes implemented by Senate Bill 606 is incomplete. Senate Bill 606 identifies "sexual misconduct" generally (as opposed to sexual misconduct targeting patients) as professional misconduct which may result in disciplinary action by the Board.² Senate Bill 606 does not limit professional discipline to instances of sexual misconduct involving patients, and the bill specifically directs the Board to promulgate a rule for legislative approval which identifies and describes sexual

² The board may deny an application for a license or other authorization to practice medicine and surgery or podiatry in this state and may discipline a physician or podiatrist licensed or otherwise lawfully practicing in this state who, after a hearing, has been adjudged by the board as unqualified due to any of the following reasons:

(8) Exercising influence within a patient-physician relationship for the purpose of engaging a patient in sexual activity **or engaging in other sexual misconduct;**

W. Va. Code § 30-3-14(c)(8) (emphasis supplied).

misconduct which may result in professional disciplinary action or license denial.³ In contrast, the duty to report component of the bill located in subsection 14(b) identifies five specific types of professional misconduct which trigger a duty to report to the board, two of which relate specifically to sexual misconduct with patients.⁴

UHA's first comment centers on the definition of sexual impropriety set forth in the proposed rule. Specifically, UHA opines with respect to 11 CSR 16-2.7.8, which includes within the definition of sexual impropriety "[f]ailing to offer the patient the opportunity to have chaperone in the examining room during an examination of the pelvic area, genitals, breasts, rectum, or prostate." UHA commented:

Comment: Adding a requirement that a chaperone be present for any sensitive exam seems overly broad and may present unintended operational burden. Specifically, it is not typical practice that a chaperone be present during all male genital, rectal or prostate examinations. Requiring health care practitioners to make chaperones available during every such exam has the potential to create staffing and scheduling issues, especially at smaller institutions and clinics where staff may not be abundantly available. The necessity for a chaperone should be solely based upon their treatment history and encounters. As such, the failure to offer one should not amount to sexual impropriety.

Whereas § 11-16-2.7.9 exists to protect a patient in situations where the patient requests a chaperone and the provider fails to provide someone, the mere failure to offer the presence of a chaperone has the potential to subject health care practitioners to misconduct reports, even when a patient would not request or require that a chaperone be present and the provider knows that based on the patient-provider relationship.

³ The board shall propose rules for legislative approval in accordance with the provisions of §29A-3-1 *et seq.* of this code which **define sexual misconduct** and identify prohibited professional misconduct, **including sexual misconduct**, for which an application may be denied and/or a license or other authorization to practice may be subject to disciplinary action by the board pursuant to this section.

W. Va. Code § 30-3-14(u). (emphasis supplied).

⁴ Any person licensed or authorized by the board to provide health care services to patients in this state shall submit a written report to the board of any of the following incidents the person reasonably believes to have occurred involving a person licensed or authorized by the board to provide health care services to patients in this state:

- (A) Exercising influence within a provider-physician relationship for the purpose of **engaging a patient in sexual activity**;
- (B) Engaging in **sexual misconduct with a patient**;
- (C) Violating established medical or professional protocols regarding transferring controlled substances or prescribing controlled substances;
- (D) Engaging in conduct which jeopardizes patient safety; or
- (E) Other gross misconduct.

W. Va. Code § 30-3-14(b)(5). (emphasis supplied).

WVBOM Response to First UHA Comment: The Board thanks UHA for this comment and agrees that subdivision 2.7.9 provides adequate patient protection without the inclusion of subdivision 2.7.8. The agency approved version of the rule eliminates a failure to offer a chaperone from the definition of sexual impropriety, and the remainder of the definition is renumbered accordingly.

UHA's second comment focuses on subsection 6.1 of the proposed rule, which originally provided:

6.1. Sexual relationships between practitioners who supervise health care practitioners in training and trainees are unethical and constitute practitioner sexual misconduct. Trainee consent is not a defense to charges of professional misconduct.

UHA commented:

Comment: It is understood that the goal of the new legislation and associated rules is to protect patients from sexual misconduct by their providers. It is unclear how this provision ties back to the objective of patient protection. Nonetheless, to the extent the WVBOM construes trainer / trainee relationships to pose a patient safety concern, the Rule as written would usurp the authority of institutions for management of its own employees. For instance, practitioners at the same level may be married or engaged in a consensual relationship, at which point one decides to seek additional training. Under the present construction of the Rule, any "sexual relationship" between a practitioner that supervises and any supervisee, regardless of whether the supervisor is supervising the supervisee, is prohibited and reportable. There is no clarification in part of the Rule that the prohibition is triggered only if the supervisor-partner is overseeing the training of the trainee-partner.

WVBOM Response to Second UHA Comment: As discussed hereinabove, the goal of Senate Bill 606, as evidenced by the plain language of the statutory amendments, is broader than suggested by the commenter. Nonetheless the Board has no interest in usurping the authority of health care institutions or educational institutions in establishing boundaries and requirements for their employees and students. There are many occasions where the jurisdiction of the Board and the authority of a health care institution overlap or run parallel, and the ability of a health care institution to act, despite Board investigations or disciplinary outcomes, is protected by the Medical Practice Act.⁵

Establishing thresholds for professional misconduct is within the purview of the licensing board, and the standard set forth in subsection 6.1 is consistent with the rulemaking authority

⁵ The filing of a report with the board pursuant to any provision of this article, any investigation by the board, or any disposition of a case by the board does not preclude any action by a hospital, other health care facility, or professional society comprised primarily of physicians or podiatrists to suspend, restrict, or revoke the privileges or membership of the physician or podiatrist.

delegated to the Board and with appropriate standards of conduct for medical professionals with respect to trainees, and is consistent with the American Medical Association's Code of Medical Ethics and the associated Code of Medical Ethics Opinion 9.1.3, which provides, in part:

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

UHA's comment does identify a potential lack of clarity in this rule provision which the Board has elected to remedy by inserting language which clarifies that the prohibition applies to supervisors and those trainees who the supervisor is currently supervising. The new language of subsection 6.1, provides:

6.1. Sexual relationships between practitioners who supervise health care practitioners in training and trainees **currently under their supervision** are unethical and constitute practitioner sexual misconduct. Trainee consent is not a defense to charges of professional misconduct.

The Board is grateful to UHA for identifying this potential lack of clarity and the opportunity to provide more specific language in the rule to avoid an unnecessarily broad interpretation of the provision, to avoid any appearance of intrusion into institutional policies for the management of its employees, and to ensure that the prohibition is clearly limited to supervisors and those trainees for whom a supervisor is providing current supervision.

UHA's final comment appears to relate to its interpretation of the reporting provisions of W. Va. Code § 30-3-14(b)(5) in concert with proposed rule provisions 6.2, 2.7.6 and 2.7.4, which deal with the definition of sexual impropriety and sexual harassment with respect to patients, surrogates, or other people a practitioner encounters during the course of professional practice. UHA comments:

Combined Comment: Based on the language of W. Va. Code § 30-3-14, it is not believed that the legislature intended the WVBOM to circumvent the investigatory and disciplinary processes of health care practitioners by their respective privileging institutions and employers. UHA and the hospitals to which the practitioner is assigned, should be permitted to maintain oversight and control of disciplinary processes related to sexual misconduct or sexual harassment that occurs amongst health care practitioners. However, § 11-16-6.2 undermines these processes by requiring that sexual impropriety and sexual harassment, which generally includes "verbal or physical conduct of a sexual nature" be reported to the WVBOM. The provision further allows the WVBOM to discipline a health care practitioner for any alleged workplace sexual impropriety or sexual harassment.

Moreover, as drafted, other health care providers that donate their time to serving as representatives on medical staff committees governed by the West Virginia peer review protection would be required to facilitate reports to the WVBOM in contradiction to their investigatory participation on these committees, or face potential licensure repercussions themselves.

Further, W. Va. Code § 30-3-14(b)(5), which sets forth reportable events, only requires reporting where the practitioner is "Exercising influence within a provider-physician relationship for the purpose of engaging a patient in sexual activity;" "Engaging in sexual misconduct with a patient;" or "Engaging in conduct which jeopardizes patient safety[.]" Because W. Va. Code § 30-3-14 is intended to protect patient safety through the prevention of sexual activity and sexual misconduct with patients and surrogates, the definition of "sexual impropriety" is overly broad as it subjects practitioners to reportable events and WVBOM discipline for any conversation that may be perceived to be sexual in nature along with any verbal or physical conduct perceived to be sexual in nature outside of patient care.

WVBOM Response to Third UHA Comment: The Board recognizes and appreciates the critical role health care institutions play in establishing safe and appropriate workspaces for health care practitioners. The referenced provisions of this rule do not infringe upon the rights of a medical employer to do so, nor do they prohibit a medical employer to control the employee disciplinary process. Rather, the rule identifies professional ethical standards for practitioners and provides practitioners with clear notice concerning the kind of conduct that may result in disciplinary action against a license.

The fact that certain conduct may violate a health care institution's employment policies and result in employment action does not insulate that conduct from evaluation for possible professional discipline. Likewise, while some institutions, such as the commenter, are very well equipped to develop and implement policies and practices for safe and appropriate workspaces, some are not as sophisticated. This rule is written to govern the professional conduct of all practitioners licensed, registered, or otherwise authorized to practice by this Board, including hospitalists who are working in a highly developed employment ecosystem and solo practitioners who may operate without the benefit of similar institutional infrastructures.

Importantly, there appears to be a misunderstanding of the reporting requirement. Neither the rule, nor W. Va. Code § 30-3-14(b)(5) (which was enacted as part of Senate Bill 606) require a practitioner to report sexual misconduct to the Board *unless the sexual misconduct involves a patient*. Often, the Board learns of physician sexual misconduct with respect to staff through existing reporting requirements that pre-date Senate Bill 606. As an example, if a hospital takes final disciplinary action against a physician, within 60 days it is required to report

the final action to the Board pursuant to long standing reporting requirements enshrined in W. Va. Code § 30-3-14(b)(2). The Board anticipates that this will continue to be the predominant way such issues may come to its attention.

The Board appreciates UHA's concern regarding medical staff committees. Institutional reporting based upon actions taken by a medical staff committee is governed by W. Va. Code § 30-3-14(b)(2) and (3). An individual serving on such a committee is not expected, by virtue of knowledge solely gained through such committee work, to make individual reports to the Board. That would undermine the work of the medical staff committee, and is inconsistent with the intent of W. Va. Code § 30-3-14(b).

In an effort to provide additional clarity and reassurance on the issues raised by this comment, the Board has added an additional section to the rule which addresses the concerns raised by UHA regarding reporting. The new section provides:

§11-16-9. Required Reporting.

9.1. Any person who holds a practice credential issued by the Board shall submit a written report to the Board in conformity with the provisions of W. Va. Code § 30-3-14(b)(5) if he or she reasonably believes that a person licensed or otherwise authorized to practice by the Board has:

9.1.1. Exercised influence within a provider-physician relationship for the purpose of engaging a patient in sexual activity; or

9.1.2. Engaged in other sexual misconduct with a patient.

Provided, that a person does not have an individual obligation to submit a report if the person's knowledge is gained solely through participation on a medical staff committee tasked with investigation and other peer review activities. This exception does not relieve any institutional obligations to comply with the provisions of W. Va. Code §§ 30-3-14(b)(2) or (3).

The Board believes that the additional clarity offered by the additional language addresses the misunderstanding regarding what sexual misconduct must be reported to the Board and provides assurances to members of medical staff committees that the processes of such committees are only reported through institutional mechanisms pursuant to other statutory provisions.

Conclusion

In conclusion, based upon the comments received, the Board's agency approved filing contains the modifications identified hereinabove. The Board again expresses its appreciation to Dr. Wedemeyer and UHA. These comments assisted the Board's review of its proposed rule and resulted in modifications which the Board believes improve the rule.

From: **Wedemeyer, Gerald T.** <gerald.wedemeyer@wvumedicine.org>
Date: Tue, Jul 5, 2022 at 9:32 AM
Subject: Proposed rule regarding sexual misconduct by practitioners
To: [Mark A Spangler@wv.gov](mailto:Mark.A.Spangler@wv.gov) <Mark.A.Spangler@wv.gov>

7.1.3

"... practioners conduct confirmed to the standard of care..." > "practioners
conduct conformed to the standard of care..."

Gerald Wedemeyer, MD
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July 28, 2022

VIA ELECTRONIC MAIL ONLY

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Re: Proposed West Virginia Board of Medicine Rule 11 CSR 16

Dear Dr. Wedemeyer:

Thank you for taking the time to review and comment on the Board's proposed rule 11 CSR 16, *Prohibiting Sexual Misconduct by Health Care Practitioners*.

The Legislative Committee of the Board met on July 26, 2021, to review and consider all of the comments that were received. Discussion occurred, and the Committee approved some modifications to the proposed rule in response to the comments it received. Enclosed please find the Board's *Summary of Comments Received Regarding 11 CSR 16 and Responses of the West Virginia Board of Medicine* (without attachments).

The agency-approved version of 11 CSR 16 will be filed with the West Virginia Secretary of State's Office today and will be available for review on their website at <https://apps.sos.wv.gov/adlaw/csr/>. The enclosed summary along with all comments will also be available on the Secretary of State's website.

Thank you again for your participation in the rulemaking process and for your comments.

Sincerely,

A handwritten signature in black ink that reads "Mark A. Spangler".

Mark A. Spangler

MAS/jcf
Enclosure

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July 22, 2022

Via Certified Mail & Email
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Executive Director
West Virginia Board of Medicine
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Charleston, West Virginia 25311
Mark.A.Spangler@wvbm.gov

RE: Comment to Proposed New Rule 11 CSR 16, Prohibiting Sexual Misconduct

Dear Mr. Spangler:

Below are comments made on behalf of West Virginia University Medical Corporation d/b/a University Health Associates ("UHA") to the proposed rule by the West Virginia Board of Medicine ("WVBOM") regarding sexual misconduct.

W. Va. Code § 30-3-14 subjects health care practitioners to discipline for engaging in "sexual misconduct" with a patient and creates reporting requirements for any person authorized/licensed by the WVBOM for engaging in sexual misconduct with a patient. To further the purported objectives and intent of the new legislation, UHA submits the following comments:

I. Proposed Rule § 11-16-2.7.8: Sexual impropriety includes "Failing to offer the patient the opportunity to have chaperone in the examining room during an examination of the peivic area, genitals, breasts, rectum, or prostate."

Comment: Adding a requirement that a chaperone be present for any sensitive exam seems overly broad and may present unintended operational burden. Specifically, it is not typical practice that a chaperone be present during all male genital, rectal or prostate examinations. Requiring health care practitioners to make chaperones available during every such exam has the potential to create staffing and scheduling issues, especially at smaller institutions and clinics where staff may not be abundantly available. The necessity for a chaperone should be solely based upon their treatment history and encounters. As such, the failure to offer one should not amount to sexual impropriety.

Whereas § 11-16-2.7.9 exists to protect a patient in situations where the patient requests a chaperone and the provider fails to provide someone, the mere failure to offer the presence of a chaperone has the potential to subject health care practitioners to misconduct reports, even where a patient would not request or require that a chaperone be present and the provider knows that based on the patient-provider relationship.

II. Proposed Rule § 11-16-6.1: "Sexual relationships between practitioners who supervise health care practitioners in training and trainees are unethical and constitute practitioner sexual misconduct. Trainee consent is not a defense to charges of professional misconduct."

Comment: It is understood that the goal of the new legislation and associated rules is to protect patients from sexual misconduct by their providers. It is unclear how this provision ties back to the objective of patient protection. Nonetheless, to the extent the WVBOM construes trainer / trainee relationships to pose a patient safety concern, the Rule as written would usurp the authority of institutions for management of its own employees. For instance, practitioners at the same level may be married or engaged in a consenting relationship, at which point one decides to seek additional training. Under the present construction of the Rule, any "sexual relationship" between a practitioner that supervises and any supervisee, regardless of whether the supervisor is supervising the supervisee, is prohibited and reportable. There is no clarification as part of the Rule that the prohibition is triggered only if the supervisor-partner is overseeing the training of the trainee-partner.

III. Proposed Rule § 11-16-6.2: "Engaging in sexual impropriety, including sexual harassment, in the practice of a health profession or in a practitioner's work environment is unethical, may disrupt patient care, and constitutes sexual misconduct."

and

Proposed Rule § 11-16-2.7.4: "Participation by the practitioner in conversation regarding the sexual problems, sexual preferences, or sexual fantasies of the practitioner."

and

Proposed Rule § 11-16-2.7.6: "Sexual harassment, including but not limited to the following Practitioner conduct towards patients, surrogates, or other person the practitioner encounters during the course of the practitioner's professional practice:

- 2.7.6.a. Unwelcome sexual advances;
- 2.7.6.b. Requests for sexual favors; and
- 2.7.6.c. Other verbal or physical conduct of a sexual nature."

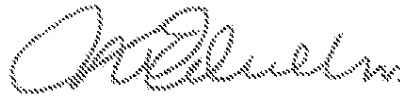
Combined Comment: Based on the language of W. Va. Code § 30-3-14, it is not believed that the legislature intended the WVBOM to circumvent the investigatory and disciplinary processes of health care practitioners by their respective privileging institutions and employers. UHA and the hospitals to which the practitioner is assigned, should be permitted to maintain oversight and control of disciplinary processes related to sexual misconduct or sexual harassment that occurs amongst health care practitioners. However, § 11-16-6.2 undermines these processes by requiring that sexual impropriety and sexual harassment, which generally includes "verbal or physical conduct of a sexual nature" be reported to the WVBOM. The provision further allows the WVBOM to discipline a health care practitioner for any alleged workplace sexual impropriety or sexual harassment.

Moreover, as drafted, other health care providers that donate their time to serving as representatives on medical staff committees governed by the West Virginia peer review protection would be required to facilitate reports to the WVBOM in contradiction to their investigatory participation on these committees, or face potential licensure repercussions themselves.

Further, W. Va. Code § 30-3-14(b)(5), which sets forth reportable events, only requires reporting where the practitioner is "Exercising influence within a provider-physician relationship for the purpose of engaging a patient in sexual activity;" "Engaging in sexual misconduct with a patient;" or "Engaging in conduct which jeopardizes patient safety[.]" Because W. Va. Code § 30-3-14 is intended to protect patient safety through the prevention of sexual activity and sexual misconduct with patients and surrogates, the definition of "sexual impropriety" is overly broad as it subjects practitioners to reportable events and WVBOM discipline for any conversation that may be perceived to be sexual in nature along with any verbal or physical conduct perceived to be sexual in nature outside of patient care.

I appreciate the opportunity to provide comment on the new proposed rule 11 CSR 16. Should you have any questions regarding the above, please feel free to contact me.

Very truly yours,

A handwritten signature in black ink, appearing to read "Michael Edmond".

Michael Edmond, M.D.
Chief Medical Officer



State of West Virginia *Board of Medicine*

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July 28, 2022

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Re: Proposed West Virginia Board of Medicine Rule 11 CSR 16

Dear Dr. Edmond:

Thank you for taking the time to review and comment on the Board's proposed rule 11 CSR 16, *Prohibiting Sexual Misconduct by Health Care Practitioners*.

The Legislative Committee of the Board met on July 26, 2021, to review and consider all of the comments that were received. Discussion occurred, and the Committee approved some modifications to the proposed rule in response to the comments it received. Enclosed please find the Board's *Summary of Comments Received Regarding 11 CSR 16 and Responses of the West Virginia Board of Medicine* (without attachments).

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Thank you again for your participation in the rulemaking process and for your comments.

Sincerely,

A handwritten signature in black ink, appearing to read "Mark A. Spangler".

Mark A. Spangler

MAS/jcf

Enclosure

cc: Sunita G. Kellermeier, Esq.