

**Department of Health**  
**Medical Quality Assurance Commission**

# Policy and Procedure

Title:	Referral of Sexual Misconduct Cases	MD2013-04
References:		
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## Background:

The Medical Quality Assurance Commission is committed to protecting the health and safety of the citizens of Washington. The Commission takes very seriously complaints of sexual misconduct against physicians. The Commission adopted a policy on sexual misconduct in 1992 and adopted rules on sexual misconduct in 2006.

The Medical Commission has a long-standing practice to investigate all complaints of sexual misconduct. The Medical Commission formalized this practice in a written policy on July 14, 2006.

RCW 18.130.062, which took effect on June 12, 2008, governs the processing of sexual misconduct cases. That statute requires that each “board or commission shall review all cases and only refer to the secretary sexual misconduct cases that do not involve clinical expertise or standard of care issues.”<sup>1</sup>

<sup>1</sup> RCW 18.130.062. Authority of Secretary—Disciplinary Process—Sexual misconduct

With regard to complaints that only allege that a license holder has committed an act or acts of unprofessional conduct involving sexual misconduct, the secretary shall serve as the sole disciplining authority in every aspect of the disciplinary process, including initiating investigations, investigating, determining the disposition of the complaint, holding hearings, preparing findings of fact, issuing orders or dismissals of charges as provided in RCW [18.130.110](#), entering into stipulations permitted by RCW [18.130.172](#), or issuing summary suspensions under RCW [18.130.135](#). The board or commission shall review all cases and only refer to the secretary sexual misconduct cases that do not involve clinical expertise or standard of care issues.

**Definitions:**

“Sexual misconduct” means

1. Sexual contact with a patient in violation of RCW 18.130.180(24);
2. Conviction of a sex crime; or
3. A violation of the Commission’s rules on sexual misconduct, WAC 246-919-630 and 246-918-410. See Appendix A.

“Clinical expertise” means the proficiency or judgment that a license holder in a particular profession acquires through clinical experience or clinical practice and that is not possessed by a lay person.<sup>2</sup>

“Standard of care” means the care, skill and learning required of a reasonably prudent practitioner acting in the same or similar circumstances.<sup>3</sup>

“Practitioner” means a physician licensed under RCW 18.71 or a physician assistant licensed under RCW 18.71A.

**Procedure:**

1. A Medical Commission staff member receives a complaint alleging a practitioner engaged in sexual misconduct. The staff member immediately notifies the Executive Director or designee.
2. If the Executive Director or designee determines there is a possibility that there is an immediate threat to the public health and safety, the Commission and its staff follow the Commission’s procedure on emergency cases.
3. If the Executive Director or designee determines there is no immediate threat the public health and safety, the Executive Director or designee brings the complaint to the next Case Management Team (CMT) meeting. A CMT meeting involves Medical Commission staff and a panel of at least three members of the Medical Commission and is held every Wednesday morning.
4. At the CMT meeting, the Medical Commission panel authorizes the investigation, and sets the case as a Priority A. The panel then reviews the complaint to determine whether the complaint involves clinical expertise or standard of care issues in accordance with RCW 18.130.062.
5. If the Medical Commission panel determines the case does not involve clinical expertise or standard of care issues, the panel promptly refers the case to the Secretary. The staff attorney attending the CMT prepares a memo documenting the decision and places the

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<sup>2</sup> RCW 18.130.020(2).

<sup>3</sup> RCW 7.70.040. See also RCW 18.130.020(11).

memo in the case file to be transferred to the Secretary. A representative of the Medical Commission promptly delivers the file to a representative of the Secretary.

6. If the Medical Commission panel determines the case involves clinical expertise or standard of care issues, the panel directs the Chief Investigator to assign an investigator to promptly investigate the case. The staff attorney attending the CMT prepares a memo documenting the decision, places the memo in the case file, and sends a copy of the memo to the representative of the Secretary. During the course of the investigation and adjudication of the complaint, the Commission will inform the representative of all developments and include the representative in all discussions concerning the case.

7. If the Medical Commission panel, after reviewing the complaint, cannot determine if the case involves clinical expertise or standard of care issues, the panel directs the Chief Investigator to assign an investigator to contact the complainant and/or key witness immediately.

8. A Medical Commission investigator immediately contacts the complainant and/or key witness to (a) inform the complainant and/or key witness that the Medical Commission takes the complaint very seriously, (b) ask whether the complainant and/or key witness is willing to waive the right to confidentiality under RCW 43.70.075, (c) obtain more information to determine whether emergency action is warranted, and (d) obtain more information to determine if the complaint involves clinical expertise or standard of care issues.

9. At the next CMT meeting, a Medical Commission panel meets to review the complaint and the memo of the investigator's contact with the complainant and/or key witness. The panel determines if the case involves "clinical expertise or standard of care issues" in accordance with RCW 18.130.062. The Commission then follows steps 5 and 6, above.

10. If there are multiple complaints against a practitioner, the Medical Commission reviews each complaint separately and promptly refers appropriate cases to the Secretary.

11. If, after the Medical Commission transfers a complaint to the Secretary, the Secretary wishes to consult with the Medical Commission regarding issues in the case, the Medical Commission will fully cooperate and provide support and guidance to the Secretary as needed to protect the public.

12. If the Medical Commission transfers a complaint to the Secretary, and the Secretary issues a Statement of Charges against a practitioner, the practitioner may request that the Presiding Officer make a ruling to determine whether the case involves clinical expertise or standard of care issues. The Presiding Officer may set a timeline for this request to be made. If the Presiding Officer determines that the case involves clinical expertise or standard of care issues, the Secretary transfers the case back to the Medical Commission.<sup>4</sup>

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<sup>4</sup> Under RCW 18.130.050(10), a disciplining authority may not delegate to a presiding officer a case "pertaining to standards of practice or where clinical expertise is necessary."

## Appendix A<sup>5</sup>

### WAC 246-919-630 Sexual misconduct

(1) Definitions:

(a) "Patient" means a person who is receiving health care or treatment, or has received health care or treatment without a termination of the physician-patient relationship. The determination of when a person is a patient is made on a case-by-case basis with consideration given to a number of factors, including the nature, extent and context of the professional relationship between the physician and the person. The fact that a person is not actively receiving treatment or professional services is not the sole determining factor.

(b) "Physician" means a person licensed to practice medicine and surgery under chapter 18.71 RCW.

(c) "Key third party" means a person in a close personal relationship with the patient and includes, but is not limited to, spouses, partners, parents, siblings, children, guardians and proxies.

(2) A physician shall not engage in sexual misconduct with a current patient or a key third party. A physician engages in sexual misconduct when he or she engages in the following behaviors with a patient or key third party:

(a) Sexual intercourse or genital to genital contact;

(b) Oral to genital contact;

(c) Genital to anal contact or oral to anal contact;

(d) Kissing in a romantic or sexual manner;

(e) Touching breasts, genitals or any sexualized body part for any purpose other than appropriate examination or treatment;

(f) Examination or touching of genitals without using gloves;

(g) Not allowing a patient the privacy to dress or undress;

(h) Encouraging the patient to masturbate in the presence of the physician or masturbation by the physician while the patient is present;

(i) Offering to provide practice-related services, such as medications, in exchange for sexual favors;

(j) Soliciting a date;

(k) Engaging in a conversation regarding the sexual history, preferences or fantasies of the physician.

(3) A physician shall not engage in any of the conduct described in subsection (2) of this section with a former patient or key third party if the physician:

(a) Uses or exploits the trust, knowledge, influence, or emotions derived from the professional relationship; or

(b) Uses or exploits privileged information or access to privileged information to meet the physician's personal or sexual needs.

(4) To determine whether a patient is a current patient or a former patient, the commission will analyze each case individually, and will consider a number of factors, including, but not limited to, the following:

(a) Documentation of formal termination;

(b) Transfer of the patient's care to another health care provider;

(c) The length of time that has passed;

(d) The length of time of the professional relationship;

(e) The extent to which the patient has confided personal or private information to the physician;

(f) The nature of the patient's health problem;

(g) The degree of emotional dependence and vulnerability.

(5) This section does not prohibit conduct that is required for medically recognized diagnostic or treatment purposes if the conduct meets the standard of care appropriate to the diagnostic or treatment situation.

(6) It is not a defense that the patient, former patient, or key third party initiated or consented to the conduct, or that the conduct occurred outside the professional setting.

(7) A violation of any provision of this rule shall constitute grounds for disciplinary action.

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<sup>5</sup> WAC 246-919-630 applies to physicians. WAC 246-918-410 applies to physician assistants. The two rules are virtually identical. Therefore, WAC 246-918-410 is not repeated here.