Intro music: 0:00

Podcast Introduction: 0:10
Hello and welcome. I'm your host, Jean Fisher Brinkley, Communications Director for the North Carolina Medical Board. On today's episode of MedBoard Matters we are going to be discussing some new resources the medical board has created to help patients better understand what to expect during a physical examination.

I'll just say it: physical examinations, especially the kind where you have to take your clothes off, are never fun. Most people have to psych themselves up a little bit to get through one. And usually, patients get through them just fine.

In recent years, however, medical boards nationally have become increasingly concerned about situations where physical examinations are not fine. Situations where, in fact, the medical professional abuses his or her position to inappropriately touch patients.

Now is as good a place as any to mention that we will be discussing sexual misconduct by medical providers in this episode. It is an important but sensitive topic that may be upsetting to some.

A huge catalyst for the conversations the North Carolina Board and other medical boards are having about sexual misconduct was the case of Dr. Larry Nassar.

Nassar is the former USA Gymnastics national team doctor who was accused in 2015 of assaulting at least 265 young women and girls. He was convicted and is currently serving multiple consecutive prison sentences.

The Nassar case sparked a period of intense self-reflection and change among medical regulators that continues to this day.

The North Carolina Medical Board has made numerous changes, but today, we are going to talk about some new educational resources the Board has developed. How were they inspired by the Nassar case? Well, in looking at that case there were a couple of things that especially jumped out.

First, in the more than 20 years during which Nassar was abusing his young patients not one person ever thought to report him to his licensing board. Not one. Basic awareness that medical boards exist and can be a resource for patients who have had a problem with a provider is a huge challenge.

And second, in many instances a parent or other adult was in the room when Nassar inappropriately touched his patients. Clearly, there's a need for more patient education about appropriate physical examination techniques. Patients should also understand that they have the right to ask for an explanation or even refuse to continue the examination if a provider does something that seems strange.

The new resources we've developed cover these topics and more. So, let's get started.

Interview with Dr. Haynes: 2:49
JFB: I have with me now, Dr. Karen Burke Haynes. She is our Chief Medical Officer here at NCMB and a trained pediatrician. I've asked Dr. Haynes to talk with me about a resource that we call the power of touch. Dr. Haynes, as you know, the medical board decided to develop resources to educate patients about what they could expect during a physical examination. And as I got started with that writing

project, it occurred to me that most people have certainly experienced physical examinations. Probably many physical examinations. But as laypeople, we may not always fully understand what the clinician is doing and why they're doing it. And that was really the genesis of this brochure. What I'd like to have you do is ask you just to go over the four main techniques that clinicians use during a physical examination. The first of those is inspection. Can you take me through what that is?

KBH: Certainly, Jean. Thank you for the opportunity to comment on this. Inspection is the process by which a clinician simply stands back and using their knowledge base, assesses the patient in various ways. The expression they may have on their faces. Is there anxiety there? Is there a tense body posture? We're looking at skin color, skin texture. We are looking at respiratory pattern. Is it a peaceful tempo? Is it rapid? Is it hard? We're also looking at overall body posture. Those are just some of the things that might give us a hint about what's happening with the patient.

JFB: OK, and are there any particular reasons that you would use inspection as your first technique?

KBH: There is a tremendous amount of information that you can garner on inspection. As a pediatrician, the best examples come out of that environment. So you have particularly in your nonverbal age group, individuals who can't tell you a lot about how their feeling. So you are looking very keenly at non-verbals. The demeanor. What is the posture? What is the expression? What is the color? But that gives us ideas about breathing, respiratory, heart function, lung function and so on.

JFB: OK, great. Well, the second technique that I'd like to ask you about is called palpation. What is palpation?

KBH: Palpation is a very fancy way of saying touching. It is the method that we use and the language that we use for that is also therapeutic touching of the human frame. And an abdominal exam for instance, or exam of a stomach area, I use the term abdomen, involves the use of the hand in a certain way to inspect for tension in the belly. We can detect masses in the belly and so on. It's very important part of determining the vigor of a particular part of the body.

JFB: Great! And then the next technique is percussion, and I know this one as a child, this always fascinated me because the little hammers would come out, so I hope I haven't stolen your thunder there, but talk with me about percussion and what that is.

KBH: There are two aspects to percussion. The percussion hammer that's typically the scenario that you see with the clinician assessing reflexes, and that's always a clever little thing to do when we're dealing with children that…that…that unplanned jerking of the knee, for instance, that's part of that touching process. The other element of percussion is using the hand and the finger and pounding, tapping on that finger, let's say over the stomach or over the lung field, and that tells us a lot of information about the tissue that the nature of that tissue that you're dealing with as you're examining.

JFB: Hmmm, ok…great. I have to admit, even as an adult patient, that when I have experienced percussion during an examination, I have wondered what in the world are they doing? Thank you for filling that in. The final technique that that we cover on this brochure is called auscultation which is a bear of a word. Tell me what that is.

KBH: Auscultation is the process by which we use our ears to listen for and to sounds that emanate from the body and the classic space for that to be applied is the chest. As we're listening to breath sounds and

also listening to the heart and its rhythm. We do that also very classically with the abdomen listening for very much the same thing.

JFB: Now can you mention…I'm cheating a little bit, because I did write the brochure. What tool…what tool do you use when you're doing auscultation? Because I think that our…our listeners will instantly recognize it as you say it.

KBH: The stethoscope is what we use for that.

JFB: OK, so…so when someone listens to you with a stethoscope, they are using auscultation. So, add that to your word of the day calendar, I guess. Thank you for doing that. OK, well, great and you can you just say, I mean, one of the reasons that we created this resource was really just to make the very simple point that touch is still really very critically important. I think in medicine, I think sometimes we think of all of you know the diagnostic imaging tools and the laboratory tests and all of the sciency things that we use in medicine to make a diagnosis. But touch is still pretty critical, isn't that true?

KBH: Absolutely…absolutely. I do think it's an important point that you are emphasizing. We are experiencing that big push towards virtual delivery of care, and I absolutely value, I think it has its…its place in the toolkit that clinicians offer. But the idea of touch is still very, very important. There are years of stored information a clinician will accumulate overtime, over hundreds of examinations, hundreds of scenarios and that information literally is stored in that interface between your hands, your brain and that patient. So, it's extremely important.

JFB: OK, well great. Well Dr. Haynes, thank you so very much for your time and your expertise. I really hope that this is helpful to our listeners.

KBH: Thank you Jean for the chance to share.

Two-minute drill Segment: 9:59
In this short segment, I'll cover basic patient rights during a physical examination. This information can be found in the brochure Undergoing a Physical Examination: Your Rights.

Patients have the right to be treated with dignity and sensitivity. In the context of a physical examination, your medical practice should honor this by:

Ensuring that your examination is conducted in a private room

Providing you with a place to undress and redress in private; You should also be given a gown or a robe to cover up with. You should never be expected to take your clothes off in front of the medical provider or any member of the practice staff.

During the examination the provider should use cloth or paper drapes to cover parts of your body that are not part of the examination to avoid unnecessarily exposing your body.

If the provider is conducting an intimate internal examination, such as a rectal examination or a vaginal examination, gloves should be always be worn. Gloves may or may not be worn during a breast examination. Many providers feel they can better detect lumps with bare hands.

What about chaperones?

A chaperone is a member of the medical staff who remain in the room as an observer during a physical examination. Chaperones are not required by law in NC but using them is a best practice for most intimate examinations.

The American Medical Association Code of Ethics recommends that clinicians provider chaperones if requested by patients.

Can patients decline chaperones? It depends. For some patient visits it may be possible to ask that you be alone with the provider. For intimate examinations, the practice may require a chaperone for their protection as well as the patient's.

If you have something you wish to discuss with the provider in private, you may ask that the chaperone step out of the room once the physical examination is complete.

What should you do if you are uncomfortable, afraid or unable to continue with a physical examination?

Speak up. Say "stop" or "I can't continue" and use body language, such as holding up your hands to indicate "stop". Yes, this is an inconvenience and the provider may not be able to get all the information they need.

Just remember that medical professionals generally want you to be comfortable and would prefer you let them know if you are not.

What if something inappropriate happens during a physical examination?

It depends on what happened and how serious it was, but you may want to do one or more of the following:

You can notify the practice manager of the behavior that made you uncomfortable.

If you believe the provider behaved unethically or unprofessionally, you please report the incident to the North Carolina Medical Board.

If you believe the medical professional has committed a crime, such as assault, report to local law enforcement. It's not an either or situation – you are welcome to report to both law enforcement and to the medical board

Interview with Brain Blakenship: 12:53

JFB: I have asked Brian Blankenship who is Deputy General Counsel for the North Carolina Medical Board and also a prosecuting attorney for the Board to join me to talk about our third and final brochure which is called Know the Signs of Sexual Misconduct. Now, Brian in addition to the roles I mentioned, you've also become over the past few years, you've become the Board's, sort of de facto spokesman when it comes to professional sexual misconduct, which is the reason why I asked you to be the one to go over this brochure with me. I wanted to start just by asking, again the title of the brochure is Know the Signs of Sexual Misconduct, that sounds like it would be straightforward, but as it turns out, in medicine it's surprisingly tricky and I wondered if we could talk about some of the reasons that is so.

BB: Sexual misconduct cases involving health care practitioners is tough. It can be tough for patients to recognize and as a prosecuting attorney it can be tough [to] prosecute. It can also be tough for the jury

or in my case, the…the Board members to get a clear picture of what happened and the factors that make it difficult are that in a number of cases, the alleged inappropriate, touching or the alleged sexual misconduct occurs during the course of a physical examination.

JFB: right?

BB: So, doctors, unlike pretty much any other profession, are performing a physical examination, on occasion an intimate physical examination, and they may have a legitimate medical reason to touch a patient's breasts or…or other sensitive parts of their body. So, on the on, the one hand, there may be a legitimate explanation for the doctor touching the patient. On the other hand, that provides an opportunity for a doctor with nefarious intent to use the physical examination to satisfy their sexual gratification, not for legitimate medical purpose and that can be that can be difficult, because very often the only evidence that we have is the patient's statement and the doctor's statement an…and a medical record that may be consistent with the Doctor's statement. So, the patient will describe a physical examination and describe why it made them feel uncomfortable. And the doctor in the medical record, would seem to substantiate that it was a legitimate medical examination. And the doctor's intent, the doctor's communication, what the patient understood the examination to be for can make it a very…a very gray area, not black and white.

JFB: Yeah, yeah, let's talk about some other examples of red flag behaviors that might signal that the provider is looking to exploit that relationship.

BB: We've seen inappropriate sexual jokes that you know could be viewed as an effort by the clinician to breakdown the professional barrier. Make it more personal. We've seen sexually suggestive comments that really don't seem to have anything to do with the purpose of the visit or the nature of the medical issue. Making…you know…clinicians making comments about the body or the attractiveness of the patient. We've seen clinicians making comments like, "well, if I were your husband or I were your boyfriend, I would do this." You know, again, breaking down that barrier between professional and personal. So sexually suggestive comments, comments that would seem to indicate a more personal relationship versus a professional relationship. Things that again, maybe well-intentioned, but could be red flags either on their own or…or compared to…added to some additional behavior you know, handing out you know, personal cell phone, texting the patient, engaging in a personal back and forth on social media. Anything like that…that would seem to indicate breaking down the professional relationship and making it more personal.

JFB: One question that I had for you that I think would be helpful to our listeners, especially listeners who are patients, is should they report to the medical Board if their provider is exhibiting these kinds of behaviors?

BB: Absolutely yeah. If the patients concerned, if the patient thinks that they experience something inappropriate in the in a medical exam room or that the clinician is inappropriately making comments to them. Then they should file a complaint and we will investigate and get the clinician's side of the story. Try to determine if there are any witnesses and to the best of our ability, investigate to determine what occurred and what the intent of the of the physician was. For example, one we get not infrequently is a patient will complain because the clinician hugged them as they were as they were leaving the office.

And very often it's a…it's a patient who's seen the clinician on several occasions and it may have a history and then at some point the…the clinician hugs them, and they feel weird about it. It's unusual. They don't understand why the clinician would invade their personal space and hug them after a visit. And we…we look into those. And very often, the response from the clinician was that, you know, they were trying to provide some additional comfort to the to the patient. So that's another one of those…it could be completely well intentioned by the clinician but could be interpreted by the patient as something else. And you know, to jump ahead a little bit you know, what would we do in that type of case? It may be based on all the information we gather, that we would send the doctor a private letter of concern and we would express to the clinician our concern about him hugging the patient. We will discuss the discomfort it caused to the patient and we'll caution the physician about engaging in that conduct in the future because of the opportunity for a misunderstanding. That will become very important in the future if we get another complaint from a patient who complains about the physician hugging them. That's where it starts to look more like the doctor was trying to break down that professional barrier and engage in a personal relationship versus a well-intentioned hug to ease the patient's concerns.

JFB: Right…right. And I think you've just raised a good point that this is why, the Board wants patients to report these things. If there is a pattern of behavior, then letting the board know about that, allows us to create a record, establish that pattern, and do something about it, if it's necessary.

BB: Yeah, no, that's…that's…that's critical and I think it's critical for patients to know that we will look into their complaint. We will investigate their complaint. We may determine, based on the sufficiency of evidence or the lack of evidence, that we cannot take public disciplinary action. But it…you know those complaints don't go away. We, we maintain in our system..that the physician's history, which includes any prior complaints, any actions taken by the Board, prior statements. So, once we resolve a complaint, it doesn't go away. We still have access to it and if we receive a future complaint, we will be able to look back into the physician's past and see, "Have we had similar complaints? Similar misconduct allegations? And what was the doctor's response? What was the Board's response? And that could be having…having received a prior complaint even if we took prior action, that may be what tips the balance into us taking public disciplinary action in a future complaint.

JFB: I would like to move on to talk about more serious examples. We've been again exploring this sort of the gray areas where you just don't know if it is an attempt at grooming or if it is well intentioned. There are other things that, if these things occur, it's pretty hard to find a valid explanation of why. For example, performing a genital examination without the use of gloves. Another example would be performing an intimate examination like a genital examination or a breast exam when there was no legitimate medical need. And then of course just the overt sexual advances, groping, touching, kissing. You know all of those things clearly over the line.

BB: Yeah, no you know the inappropriate exams, obviously never appropriate, and that's why I think it's…it's really important. It really goes back to the purpose of these brochures to empower and educate patients that if…if they go in with a chief complaint that in their experience would not require a genital examination or a breast examination and the clinician asks the patient if he or she can perform a breast examination or genital examination, the patient needs to ask why. The patient needs to ask what is…what does that have to do with my…with my sore throat. One of the reasons that that's important, not only so the patients understand what's going on and why, but very often there's another person in

the room. Now that person may be referred to as a chaperone. But very often these people are not there necessarily, just to chaperone the visit. If they're are medical assistant or nurse, they may have other duties, including typing notes into an electronic medical records, so they maybe three feet away, but you know they may be typing notes. It may be a family member and that family member is…is, you know, may be there but doesn't know what the doctor is doing or…or why the doctor is doing it. And I think you know most of us, as patients, we assume that there's a legitimate medical purpose for whatever the doctor wants to do. And for most clinicians, there is. You know we're talking about a small but significant subset of the physician and PA population that engages in this kind of conduct. But it's important if there is someone else in the room, when they hear the patient say, "you know Doctor, you know why are you doing this? You know I came in…I came in because of a sore throat and you want to do a breast examination. Why do you want to do that?" That will…that will force the clinician hopefully in front of the witness to explain the legitimate medical purpose, if there is one, for the examination. And especially if there's a medical assistant or a nurse, you know that could be when they pause whatever it is, it is there doing and pay attention, and that could be very important from a prosecutor standpoint, from an evidentiary standpoint, proving that the doctor's intent and whether there was medical necessity.

JFB: Mm-hmm. Yeah, I…I think that's great advice. I…I know, certainly, in the brochures we…we do encourage people. Just of course you do have the right. I don't know how comfortable some patients are. Some patients do as you mentioned, defer to the clinician and they just assume, well, I guess they know what they're doing. It must be appropriate. But yes, absolutely. I think a lot of this is about trusting your instincts, and if it seems strange, feels strange, definitely speak up.

BB: Yeah in..in…yeah it's very difficult and it's sad it's one of the things that makes these…these kinds of cases so tragic is, very often the patient based on their experience as a patient having under gone other examinations, the hair will raise up on the back of their neck when the doctor or PA is doing something inappropriate and they will internally ask questions. But they doubt themselves. There's the assumption that the doctor must have a reason for doing it. And very often the patient will leave. Will not say anything to the doctor, to anyone else in the office. But then when they get in the car, they will call a family member. They'll call a friend and explain what happened and it'll be that third party who will say no, that's not right. You…you were correct in knowing that…that something wasn't occurring correctly and then you know, sometimes we get, we get a complaint and that that conversation with third party could occur that afternoon. It could occur two weeks, two weeks later. So, in my experience, more often than not, when we get a complaint, the patient knew at the time something wasn't right. I think there's certainly a shock value to what's occurring. They don't, you know, maybe feel comfortable confronting the physician or…or asking questions. But to the extent you…you feel comfortable and empowered, you know, speak up, ask questions. If the doctor has a legitimate medical purpose and the doctor is appropriately treating you, they should not get offended by you asking, "hey, can you explain to me why it's necessary you do this? This seems unusual. I'm sure you don't mean to, but it's making me uncomfortable. Can you just help me understand why you want to do this?" If the doctors well intentioned, they should have no problem explaining to you what it what it is they're doing, and why they're doing it.

JFB: Yes, and I think also just to bring it home is that you know. The medical board is always here as a resource. If something happened that, even after the fact you realize was not right, please report it. That is the only way that the medical board can look into it and determine what happened. Determine if

there's some need for intervention. So, I think that's as good as good to note as any to…to end on. I really hope that these resources are helpful to people and that you know we can get them out into as many hands as possible. Alright, thanks, Brian.

BB: Thanks for having me.

Closing: 30:04
That brings us to the end of our episode. Thank you for joining me.

You can find all three of the brochures discussed on today's episode of MedBoard Matters at ncmedboard.org/brochures. Feel free to download and share them.

The North Carolina Medical Board has a lot more to say on the topic of professional sexual misconduct. Be sure to join me in January, when we will discuss the experiences of patients what been the targets of sexual misconduct by a medical professional and talk about some of the things the North Carolina Medical Board is doing to support victims.

As always, if you have any questions or comments about today's episode you can send them to us at podcast@ncmedboard.org.