IC'S EXHIBITS ADMITTED INTO EVIDENCE

EXHIBIT 1

EXHIBIT 1

NEVADA STATE BOARD OF MEDICAL EXAMINERS

9600 Gateway Drive
Reno, NV 89521

Victor M. Muro, M.D.
Board President

Edward O. Cousineau, J.D.
Executive Director

September 2, 2021

George Chambers, M.D.
[redacted]

RE: BME CASE #: [redacted]
PATIENT: [redacted]

Dear Dr. Chambers:

We have received information and a complaint regarding your disruptive behavior towards the above named patient. The complaint alleges your unprofessional demeanor and treatment and care of the patient may have fallen below the standard of care which may have had an adverse impact on the quality of care rendered to the above named patient.

It is alleged:

1. The patient presented to you on November 17, 2020, for a consult on perineal repair. The patient was also interested in learning about vaginoplasty and labiaplasty.

2. Before you left the room to allow the patient to prepare for an exam, you advised the patient to keep her cell phone, as you would use it to take pictures.

3. After coming back into the exam room, you left the door open.

4. The patient expressed her discomfort at having the door left open during the exam and was assured by you no one was in the office and all the doors were locked so no one could enter.

5. As you proceeded with the exam, you instructed the patient to put her feet together and open her legs a far as possible, instead of putting her legs in the traditional stirrups during a vaginal exam.

6. During the exam, you began pressing on different areas of the patients vagina and asked if she was feeling any discomfort. You took several pictures and continued to ask if the patient was feeling any pain or discomfort.

7. You began a very uncomfortable exam and the patient felt as if you were stretching her to see how far her vagina would stretch.

8. During this stretching, you stated to the patient you were surprised she was not hurt.

9. After the exam, you pulled out what should have been your fingers, but was much too painful and large to have only been your fingers.

10. After the exam, you took more pictures and then proceeded with a rectal exam.

11. You inserted one finger into the patient's rectum at the same time asked the patient to remove the soiled glove from your other hand so you could take more pictures.

12. You took a total of 12 pictures. After the exam, you asked the patient to text you 2 of the 12 pictures so you could print them out and review with the patient.

13. You printed the pictures, returned to the exam room, and told the patient that during the exam you had done something called "fisting" where you tried to insert your entire fist into the patient's vagina.

14. You showed the patient how much of your fist you got inside, then compared the size of your fist to the size of a man's penis and told the patient her vagina was too big for a man's penis.

It is further alleged;

1. You showed the patient videos of previous patients and their experiences.

2. You then showed the patient pictures of the previous patient's before and after pictures of her vulva.

3. You explained to the patient that you do the surgeries in your office under a local anesthetic instead of at a surgery center or hospital with staff and general anesthesia.

4. You also told the patient during the surgery you would stimulate her clitoris multiple times and it was okay for the patient to come if she needed.

5. You then asked the patient specifically about her sex life with her husband.

6. After leaving your office, the patient experienced pain in her vulva and vagina. She had a pelvic exam done and it was determined the Bartholin gland had been swollen due to a trauma to her vagina and vulva.

According to these allegations, you may have violated the Nevada Medical Practice Act, Nevada Revised Statutes, Chapters 629 and 630, and Nevada Administrative Code, Chapters 629 and 630 (NMPA).

In order to determine whether or not there has been a violation of the NMPA, **please provide a written response to each allegation noted above.** Please include any further information you

believe would be useful for the Board to make a determination in this matter. **Please reply to this request within 30 calendar days.**

The Nevada State Board of Medical Examiners investigates all information received concerning possible violations of the NMPA. We make no determination as to whether or not there has been a violation of the NPMA until a thorough investigation is completed.

As a physician under investigation by the Board, you are required by the NMPA to provide the requested information, and your cooperation is not subject to the whistle-blower protections provided to physicians in NRS 630.364(3).

Please be advised that if the particular allegations referenced above did occur, and depending on the facts and circumstances, then you may have violated the NMPA, specifically including but not limited to: NRS 630.301(5)(6)(7)(9).

Respectfully,

Johnna S. LaRue, CMBI
Deputy Chief of Investigations

The Investigative Committee of the Board of Medical Examiners of the State of Nevada

* * * * *

In the Matter of the Investigation of:)
)
) Case No. [redacted]
George Chambers, M.D.)
)
License No. **10476**)
_____)

ORDER TO PRODUCE HEALTH CARE RECORDS

The Investigative Committee (IC) of the Board of Medical Examiners of the State of Nevada sends greetings to:

George Chambers, M.D.
[redacted]

Pursuant to the authority of Nevada Revised Statute (NRS) 630.311(1), the IC directs you to produce and deliver to the Nevada State Board of Medical Examiners, the materials as set forth in this Order:

1. Properly authenticated and complete copies of any and all health care records of **Patient:** [redacted] **from January 1, 2020 through the present date**.
2. The name and contact information for any entity, facility, or person that you believe may possess the health care records of **Patient:** [redacted] **from January 1, 2020 through the present date**.
3. If health care records are provided electronically, they must be in a **searchable** format.

Said records shall be provided to an investigator of the Nevada State Board of Medical Examiners **within 21 days of service** of this Order (Investigation Division, Attn. Johnna LaRue, CMBI, Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada 89521). Failure to comply and produce said records in the aforesaid manner may subject you to potential

disciplinary action, to include a violation of NRS 630.3065(2)(a) and NRS 630.3062(1)(d); further, the Investigative Committee may seek administrative sanctions as set forth in NRS 630.352.

Additionally, compliance with this order is deemed compulsory and shall not be deemed to be cooperation subject to the protections provided to a physician pursuant to NRS 630.364(3).

Dated this 2nd day of September 2021.

NEVADA STATE BOARD OF MEDICAL EXAMINERS
INVESTIGATIVE COMMITTEE

Bret Frey, M.D., Chairman
Victor M. Muro, M.D., Chairman
Nevada State Board of Medical Examiners
Investigative Committee

EXHIBIT 2

EXHIBIT 2

Chambers & Associates

OBGYN and Gynecological Surgery, PLLC

Competent, Compassionate & Reliable Care for Women™

George P. Chambers Jr., M.D., FACOG
Medical Director

Johnna S. LaRue, CMBI
Deputy Chief of Investigations
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

January 20, 2022

Re: BME CASE #: [redacted]
PATIENT: [redacted]

Dear Ms. LaRue:

This is my response to the allegations that my "unprofessional demeanor and treatment and care of the patient may have fallen below the standard of care which may have had an adverse impact on the quality of care …" After perusing the two-page document entitled "Vaginal Repair Consultation" given to me by [redacted] at her consultation on 11/20/2020, I used the document as a guide and answered all the questions that she had written. I also wondered why she had consulted so many experienced and skilled OB/GYNs regarding this matter. Her visit was chaperoned by my office manager (Casey). After the examination, she stood at the counter in the patient care area with Casey and me. We all talked for about 15 to 20 minutes about how excited she was to finally do this surgery. Imagine my surprise when I received a letter dated 04/19/2021 from Det. C. Vensand [redacted] stating that "a report has been filed with the Las Vegas Metropolitan Police Department listing you as a suspect to an alleged crime." I called Det. Vensand and asked what was my alleged crime? He said that "[redacted] reported that you 'fisted' her during the exam for your sexual pleasure." I then chose to be interviewed without an attorney, because I had nothing to hide, by Det. Vensand and two other detectives for 2.5 hours on 05/03/2021 in my office. Before leaving my office, all three detectives (two men and one woman) informed me that no charges would be filed, but they were obligated to investigate the complaint. Casey was also interviewed separately by them. I asked Casey to write a summary of her memory of our encounter with [redacted] I included said summary with the copy of [redacted] medical record.

In terms of the allegations:

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1. **The patient presented to you on November 17, 2020, for a consult on perineal repair. The patient was also interested in learning about vaginoplasty and labiaplasty.**

[redacted] presented to me with a reported referral from Dr. Michelle Lewis because I have post-residency training in GYN cosmetic surgery and I am certified in sexual health medicine. [redacted] stated that "the doctor (who delivered her children) did a poor job repairing the tear leaving me open and in pain and discomfort." In addition, she also stated that she has rare fecal incontinence, has occasional stress urinary incontinence, has discomfort wearing tight clothes, has to constantly shift in her seat to avoid tugging or pinching of her labia minora, has perineal pain, *et cetera*.

2. **Before you left the room to allow the patient to prepare for an exam, you advised the patient to keep her cell phone, as you would use it to take pictures.**

Yes, I did make this request. Since medical school I have used illustrations to explain my clinical findings and planned surgical approach. Patients generally appreciate my drawings, but a photograph of the patient's own body is generally more educational for them. During the initial consultation for GYN cosmetic surgery, I always ask potential patients' permission to use their mobile phones to take pictures of their genitalia. It also serves to create realistic expectations of possible outcomes. The patients maintain control of their pictures if they choose another surgeon for their surgery. If they select me to do the surgery, a formal consent is signed and I take official before and after photographs.

3. **After coming back to into the exam room, you left the door open.**

After I had taken a thorough history and was about to leave the exam room, I took the time to explain to [redacted] the measures that I had implemented to protect my patients, staff and me from covid-19. I told her that I do not allow more than three patients in my office lobby at a time and no more than one patient in the patient care area at a time. I told her that spouses or partners are not allowed in the office and that they are welcomed to attend the appointment via FaceTime. I told her that I no longer close the exam room door during examinations because I do not want my patient, the chaperone and I to be trapped in a small exam room given the risk of getting covid-19. Remember, no vaccination was available in November 2020. I asked her as I did with every patient at that time if that was ok with her and she looked at the door between the office lobby and the patient care area. So, I further explained that the two doors between the office lobby and patient care area are security doors and cannot be opened without a key from the

lobby. Therefore, her privacy would be guaranteed. I asked again if leaving the door open would be ok with her and she said yes. So, I left the door open with Casey standing outside the door with full view of me and [redacted] whilst labelling charts.

4. **The patient expressed her discomfort at having the door left open during the exam and was assured by you that no one was in the office and all the doors were locked so no one could enter.**

See #3 above. And yes, the only people in the patient care area of the office during her visit were her, Casey and me.

5. **As you proceeded with the exam, you instructed the patient to put her feet together and open her legs as far as possible, instead of putting her legs in the traditional stirrups during a vaginal exam.**

There is no requirement for an OB/GYN to use the stirrups during a pelvic examination. In fact, I have yet to meet a patient who finds the stirrups comfortable. I only use the stirrups if I am going to be inserting a speculum into the patient's vagina. If I am only doing a manual pelvic examination, I instruct my patient on how to place her legs in a frog-legged position. It is preferred by most patients because unlike when the stirrup is used, they have more control of their legs in frog-legged position. It is how we examine patients in labour in the United States of America. This position was not new to [redacted] because she has had four vaginal deliveries.

6. **During the exam, you began pressing on different areas of the patient's vagina and asked if she was feeling any discomfort. You took several pictures and continued to ask if the patient was feeling any pain or discomfort.**
7. **You began a very uncomfortable exam and the patient felt as if you were stretching her to see how far her vagina would stretch.**
8. **During this stretching, you stated to the patient you were surprised she was not hurt.**

Ms. Ross sought evaluation for treatment of her dyspareunia and pelvic/perineal pain. In OB/GYN we tend to lump the assessment of genital pain under one heading, pelvic pain. However, in sexual health medicine, determining the location of the pain is essential for proper diagnosis and treatment. I needed to know if her pain was insertional (as this accounts for 80% of all dyspareunia), vaginal, or deep in the pelvis.

In evaluating Ms. Ross' pain, I was very methodical in order to find any trigger points of pain. Externally, I used a cotton Q-tip to touch lateral then medial to Hart's line. I touched the vestibule at 1 o'clock and 11 o'clock adjacent to the urethral opening and Skene's glands. I also touched the vestibule at 4 o'clock and 8 o'clock at the Bartholin's glands. I also touched the vestibule at the 6 o'clock position. As I palpated the aforementioned areas, I asked Ms. Ross if she felt pain or pressure. She responded by saying, "pressure," except at the 6 o'clock position where she said, "pain."

In order to evaluate her pelvic floor muscles, I inserted one finger into her vagina. I then palpated her pubococcygeus, transverse perinei and obturator internus muscles. As I palpated each muscle, I asked her if she felt pain or pressure. I then inserted my two examining fingers to check the tonicity of her pubococcygeus muscles by asking her to squeeze her vagina. Her muscles were extremely weak. I palpated her urinary bladder transvaginally to evaluate for pain. I palpated the pudendal nerves bilaterally at the ischial spines to see if there was pain. At no time did she say she was in pain. She said that she had some discomfort. So, knowing that a regular patient would report discomfort when her ischial spines are palpated, I told Ms. Ross that I was surprised that I could not trigger the pain that she had reported.

9. **After the exam, you pulled out what should have been your fingers, but was much too painful and large to have only been your fingers.**

Given her sensitive vagina, she may have had the perception that my fist was in her vagina. I wear size 8 gloves; nonetheless, my bimanual examinations have always been reported as being gentle. Prior to my internal examination of [redacted] I used a single Cardinal Health™ Lubricating Jelly (0.11 oz.) packet to lubricate my two fingers. I did not fist [redacted]. Had I done so, she would have screamed and it would have been witnessed by Casey (who is also my patient). "Fisting" is a sexual activity that I will never understand because I believe it is abusive and can result in damage, including laceration, to a woman's pelvis. Furthermore, on Labour and Delivery I hate it when I must do a manual extraction of a retained placenta. In this maneuver, I use betadine to rinse my gloved right hand. I then lubricate my entire right hand with copious amounts of lubrication to reach all the way up to the uterine fundus to separate placenta intact from the uterine wall. It is best done if the patient has an epidural; if not, I generally have the nurses use IV narcotics or ask the anaesthesiologist to do IV sedation. So, the fact that [redacted] would accuse me of "fisting" her is complete lunacy.

10. After the exam, you took more pictures and then proceeded with a rectal exam.

Yes, I did do this.

11. You inserted one finger into the patient's rectum at the same time asked the patient to remove the soiled glove from your other hand so you could take more pictures.

I use my right hand in all examinations. My left hand is generally used to separate the patient's labia. I did not ask [redacted] to remove any gloves. My left glove was essentially clean. My soiled glove was still in her rectum when I took the photograph.

[redacted] reported rare fecal incontinence. She also wrote that she has "extra skin around anus and possible rectal prolapse? My rectum can protrude when having a bowel movement. A few times I've had some bowel leakage. Often have an urge to poo but cannot go." Prior to performing the rectovaginal examination, I had her bear down and there was no rectal prolapse. I did find a rectocele and I used my left hand to take a photograph of it so I could explain what it was and how it could be repaired.

12. You took a total of 12 pictures. After the exam, you asked the patient to text you 2 of the 12 pictures so you could print them out and review with the patient.

I took many photographs; how many, I do not know. I did ask her to send me only two of them that would allow me to properly do pre-surgical markings so she could see what would be done. Those photographs are included with her medical records that I am providing to you.

13. You printed the pictures, returned to the exam room, and told the patient that during the exam you had something called "fisting" where you tried to insert your entire fist into the patient's vagina.

To reiterate, this is pure fiction and lunacy! I have never "fisted" any patient's vagina.

14. You showed the patient how much of your fist you got inside, then compared the size of your fist to the size of a man's penis and told the patient her vagina was too big for a man's penis.

[redacted] read what she had written to me. "I feel like my vagina is just too open and not supported. I do Kegels on my own or tightening during sex and I feel the tightening in the upper part of my vagina but closer to the opening I feel like I just can't get it tight. It feels unsupported. It feels like everything is just open and coming out. When I am uncomfortable sitting down I try tightening that area but can't tighten it enough to feel comfortable." She also stated that tampons sometimes fall out of her vagina.

I have never been comfortable telling any patient that her vagina is loose because I am aware of the negative psychological impact of such a statement. Therefore, I would never compare the size of my fist with a penis and tell any patient that "her vagina was too big for a man's penis." During my bimanual exam and sizing of her introitus, I determined that her introitus was 7cm wide. So after the examination, I opened my two fingers to 7cm and told her that your vaginal opening is this wide. I said that "I understand why you cannot feel your husband's penis." I explained that the posterior colporrhaphy or vaginoplasty would correct the vaginal canal to its proper anatomical shape and create a sensation of a tighter feel.

It is further alleged:

1. **You showed the patient videos of previous patients and their experiences.**

I do not videotape my patients. So, this is a blatant lie.

2. **You then showed the patient pictures of the previous patient's before and after pictures of her vulva.**

Every patient who seeks GYN cosmetic surgery wants to know my credentials in performing these procedures and wants to see samples of my work. [redacted] was no different, she read from her list of questions. She asked "how often do you do this surgery?" "How satisfied are your patients?" … "Do you have training in cosmetic surgery?"

I answered all her questions. I also showed her before-and-after photos on a "B/A" App that slides the photos back and forth. I also showed her a Power Point presentation of before-and-after photos. This is no different that a plastic surgeon who shows before-and-after photos of augmented breasts or buttocks. These pictures are taken for medicolegal, advertisement, educational and teaching purposes. Interestingly, she also asked about Dr. Red Alinsod who

taught me about the importance of medical photography in GYN cosmetic surgery. She wrote that "I saw some terms on a urogynecologist's website, Dr. Red Alinsod." Therefore, she knew that before-and-after photographs are a standard necessity.

3. **You explained to the patient that you do the surgeries in your office under local anesthetic instead of at a surgery center or hospital with staff and general anesthesia.**

I was trained to perform these procedures using sterile technique in the office by Dr. Michael Goodman who has authored one of the only textbook in GYN cosmetic surgery and who is regarded as one of the "founding fathers" of this new and upcoming subspeciality of OB/GYN. By performing these procedures in the office, the cost is significantly lower than if they were done in the hospital. It offers a more discrete and comfortable environment as well as decreased the risk from general anaesthesia. In terms of pain control, after her vulva has been prepped using betadine or hexadine, a topical local anaesthetic is applied to her vulva. Thereafter, local anaesthesia using bupivacaine 0.5% with epinephrine buffered with 0.25 mL of bicarbonate is injected. She is also given an oral anxiolytic with an oral narcotic. The patient's vitals are monitored and recorded. The procedure room is equipped with an AED. Intravenous fluid hydration is available if necessary. I am assisted by a registered nurse and we both wear sterile gowns and gloves. The patient is draped in surgical drapes as is done in the hospital.

4. **You also told the patient during the surgery you would stimulate her clitoris multiple times and it was okay for the patient to come if she needed.**

I never said this. [redacted] seems to have forgotten that there was a chaperone present. To reiterate, her visit was chaperoned by Casey (who is now studying nursing and knows the difference between ethical and unethical behaviour). Not only would this behaviour have been unethical on my part, it would have made no sense as a topical anesthetic agent is applied to the entire vulva at the start of the surgery to prevent her from feeling any sensation.

5. **You then asked the patient specifically about her sex life with her husband.**

[redacted] is being disingenuous. She sought a consultation with me because I sub-specialise in sexual health medicine. In fact, to my knowledge, I am the only board certified OB/GYN in the state of Nevada who is also certified in sexual health medicine. She brought up her sex life. She

read the following statements and asked the following questions from the document that she gave me:

"Sex can be painful if not very well lubricated. My husband has learned some areas not to touch, Lubricant used to be an occasional thing that we didn't use very often, now it is necessary in abundance for any touching or penetration."

"The inner labia seem to be tugged a lot when I'm sitting or during sex and it's uncomfortable. Often I have to manually open the labia for sex. And they get tugged during sex which is uncomfortable."

"It takes more clitoral stimulation to orgasm now and orgasms are less intense."

"How will this change feeling/sex? How likely is the surgery to decrease sexual pleasure?"

Was I not supposed to address her concerns or answer her questions?

6. **After leaving your office, the patient experienced pain in her vulva and vagina. She had a pelvic exam done and it was determined the Bartholin's gland had been swollen due to a trauma to her vagina and vulva.**

I can assure the investigative committee of the NSBME that I performed the standard Q-tip touch test and bimanual examination for the evaluation of pelvic pain on [redacted] Nothing I did would have caused edema of the Bartholin's gland. An edematous Bartholin's gland is a result of a clogged gland that results in a cyst and when infected an abscess. There is nothing that an OB/GYN does in the office or surgery that would result in a problem with the Bartholin's gland. This is just totally absurd.

I did not violate the Nevada Medical Practice Act, Nevada Revised Statutes, Chapters 629 and 630, and Nevada Administrative Code, Chapters 629 and 630 (NMPA). If I had done what [redacted] accused me of doing, I would have been arrested, dragged disgracefully in front of the media and ruined. Rather, I suspect that [redacted] was an agent for my ex-wife. My ex-wife was referred to her divorce attorney by her dentist. They are friends. [redacted] husband is a dentist. Is this a coincidence? I do not know, but it is highly suspicious. I once told my ex-wife that the fastest way to end an OB/GYN is to accuse him of a sexual misconduct. Both her and her divorce attorneys were obsessed with two things during the divorce, my money and how

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many NSBME complaints had been filed against me in the previous 10 years. Both of their first and second sets of interrogatories were sent and answered before these three complaints were filed against me. A third was sent after they insured that I had been notified by the NSBME. The plan was to use the NSBME to discredit me in hopes that the family court judge would grant her full custody of our children.

Being granted primary legal and physical custody would have ensured that she would not need to work for the next 16 years as she would survive on my child support payments. Despite joint legal and physical custody being granted, my ex-wife continues to scheme to this day. In a text conversation on June 7, 2021, I asked her why she would try to destroy me by collaborating with two of my patients; one of whom tried to extort me. Her response was that "you filed a restraining order against me. I was pissed!" I had filed a restraining order on her after she was arrested for domestic violence against me in November 2020.

This concludes my response. Thank you for your patience with me in getting this document back to you. I can be reached at (702) 901-1249.

Respectfully,

George P. Chambers, Jr., MD, FACOG
Board Certified, Obstetrician and Gynecologist
Certified, Sexual Health Medicine

EXHIBIT 3

EXHIBIT 3

MEDICAL RECORDS

This exhibit contains personal medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310.

EXHIBIT 4

EXHIBIT 4

MEDICAL RECORDS

This exhibit contains personal medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310.

EXHIBIT 5

EXHIBIT 5

NEVADA STATE BOARD OF MEDICAL EXAMINERS

9600 Gateway Drive
Reno, NV 89521

Victor M. Muro, M.D.
Board President

Edward O. Cousineau, J.D.
Executive Director

February 3, 2022

George Chambers, M.D.
[redacted]

RE: BME CASE #: [redacted]
PATIENT: [redacted]

Dear Dr. Chambers:

We have received information and a complaint regarding your disruptive behavior towards the above-named patient. The complaint alleges your unprofessional demeanor and treatment, and care of the patient may have fallen below the standard of care which may have had an adverse impact on the quality of care rendered to the above named patient.

It is alleged:

1. The patient presented to you on October 29, 2018, for an exam.
2. You asked your staff to leave the exam room so you could speak with the patient privately.
3. You then asked if the patient would model nude for you. You said you would pay the patient $1000 for the gig telling the patient you are the photographer.
4. You described what you tell your other patients that model for you, such as "fuck the camera" and other things of that nature.
5. You told the patient after the photo shoot you would offer to give a copy of the photos to the patient but that she cannot tell her husband you were the photographer.
6. You also asked the patient to stand up, while she was naked on the exam chair, so you could see what she looked like naked from that angle.
7. You gave the patient your approval and reminded the patient not to tell her husband.
8. You told the patient to think about it and to text you with her decision but to not use any details in the text.

According to these allegations, you may have violated the Nevada Medical Practice Act, Nevada Revised Statutes, Chapters 629 and 630, and Nevada Administrative Code, Chapters 629 and 630 (NMPA).

In order to determine whether or not there has been a violation of the NMPA, **please provide a written response to each allegation noted above, including, as well as complete health care records for the aforesaid patient[s]. Include copies of any imaging, x-ray or other films that were produced during treatment of this patient.** Please include any further information you believe would be useful for the Board to make a determination in this matter. **Please reply to this request within 30 calendar days.**

The Nevada State Board of Medical Examiners investigates all information received concerning possible violations of the NMPA. We make no determination as to whether or not there has been a violation of the NPMA until a thorough investigation is completed.

As a physician under investigation by the Board, you are required by the NMPA to provide the requested information, and your cooperation is not subject to the whistle-blower protections provided to physicians in NRS 630.364(3).

Please be advised that if the particular allegations referenced above did occur, and depending on the facts and circumstances, then you may have violated the NMPA, specifically including but not limited to: NRS 630.301(5)(6)(7)(9).

Respectfully,

Johnna S. LaRue, CMBI
Deputy Chief of Investigations

The Investigative Committee of the Board of Medical Examiners of the State of Nevada

* * * * *

In the Matter of the Investigation of:)
)
) Case No. [redacted]
George Chambers, M.D.)
)
License No. **10476**)
_____)

ORDER TO PRODUCE HEALTH CARE RECORDS

The Investigative Committee (IC) of the Board of Medical Examiners of the State of Nevada sends greetings to:

George Chambers, M.D.
[redacted]

Pursuant to the authority of Nevada Revised Statute (NRS) 630.311(1), the IC directs you to produce and deliver to the Nevada State Board of Medical Examiners, the materials as set forth in this Order:

1. Properly authenticated and complete copies of any and all health care records of **Patient:** [redacted]**; from January 1, 2018 through the present date**.
2. The name and contact information for any entity, facility, or person that you believe may possess the health care records of **Patient:** [redacted] **from January 1, 2018 through the present date**
3. If health care records are provided electronically, they must be in a **searchable** format.

Said records shall be provided to an investigator of the Nevada State Board of Medical Examiners **within 21 days of service** of this Order (Investigation Division, Attn. Johnna LaRue, CMBI, Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada 89521). Failure to comply and produce said records in the aforesaid manner may subject you to potential

disciplinary action, to include a violation of NRS 630.3065(2)(a) and NRS 630.3062(1)(d); further, the Investigative Committee may seek administrative sanctions as set forth in NRS 630.352.

Additionally, compliance with this order is deemed compulsory and shall not be deemed to be cooperation subject to the protections provided to a physician pursuant to NRS 630.364(3).

Dated this 3rd day of February 2022.

NEVADA STATE BOARD OF MEDICAL EXAMINERS
INVESTIGATIVE COMMITTEE

Bret W. Frey, M.D., Chairman
Victor M. Muro, M.D., Chairman
Nevada State Board of Medical Examiners
Investigative Committee

EXHIBIT 6

EXHIBIT 6

Chambers & Associates

OBGYN and Gynecological Surgery, PLLC

Competent, Compassionate & Reliable Care for Women™

George P. Chambers Jr., M.D., FACOG
Medical Director

March 17, 2022

Ms. Johnna LaRue
NSBME
9600 Gateway Drive
Reno, NV 89521

Re: BME Case # [redacted]
Patient: [redacted]

Dear Ms. LaRue:

First, let me convey that I have not violated the Nevada Medical Practice Act, Nevada Revised Statues, Chapters 629 and 630, and Nevada Administrative Code, Chapters 629 and 630 (NMPA). During my hearing last month, it was suggested that my chaperones are employed by me so their testimonies will not be objective. The American College of Obstetricians and Gynecologists recommends chaperones so that there is a third party present. I have given you a list of staff, former medical students, a nurse practitioner and a registered nurse who will provide testimony as to my behaviour in the office with my patients. I maintain that this is part of a conspiracy between my now ex-wife and disgruntled former patients whom she tracked down after reading their negative online reviews of me. [redacted] is no exception.

In 2012 I decided to pursue doing business with women who work in the adult entertainment industry. I started to advertise my GYN cosmetic surgery and sexual health medicine services in the awards ceremony program for the Adult Video Network (AVN). In the Fall of 2018, as we began getting ready for my ad for the 2019 AVN award ceremony, I placed an 8.5" x 11" recruitment notice behind the door of the patient lavatory in my office. This way, they would see it as they unlock the door after using the bathroom. I offered $1000 to anyone who was willing to model for the ad.

[redacted] saw the notice during her last visit to my office and asked what it was about. I explained to her that Obamacare had scared the crap out of me because I thought we were going to a form of socialise medicine in America so I went and got trained in GYN cosmetic surgery and sexual health medicine so I could set up a cash-pay medical practice. I thought the adult industry would be the perfect source of income for my services. I also explained that I also donate to a group called the Cupcake Girls that offer spa-like treatment for the actresses during the award ceremony. It was one way to rescue young women in the adult entertainment industry who were being trafficked.

I told her that I hired a professional boudoir photographer to take the photographs for my ad. I informed her that if she were interested that there was one rule. That is, she was not allowed to bring her husband on the day of the shoot. I jokingly said, don't even tell him about the shoot. I explained that the husbands and boyfriends

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are disruptive for the photographer because they want to control the poses used and sometimes the model cannot relax because they are present. Thus, the photographer did not want them at the shoot. I added that I have to pay the photographer for her time whether or not we get a photograph that is usable. Furthermore, I also offer the model, in addition to the $1000, a USB copy of the boudoir shots so she may present them to her partner. I did not ask her to stand up naked so I could look at her.

The vast majority of my patients are given my mobile phone number so they may have direct access to me. It is something that I have done since I was a resident physician to ensure that I knew when my pregnant patients were in labour so that I would deliver their babies. [redacted] later sent me a text message which I have since deleted as I have since changed mobile phones. In the text message she excoriated me because she thought I was up to no good when I told her that her husband could not attend the shoot. I was visibly livid as she was the one whose curiosity lead her to ask me about the notice on the door. I was at home when I read the text message and I shared it with my now ex-wife. I responded to the message attempting to clarify what I had told her. That was the last time that I communicated with her.

Thank you for your time. I can be reached at (702) 901-1249.

Sincerely,

George P. Chambers, Jr., MD, FACOG
Board Certified, Obstetrics and Gynecology
Certified, Sexual Health Medicine

7220 S. Cimarron Road • Suite 200 • Las Vegas, NV 89113 • ph 702-463-0800 • fax 702-463-0801

EXHIBIT 7

EXHIBIT 7

MEDICAL RECORDS

This exhibit contains personal medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310.

EXHIBIT 8

EXHIBIT 8

NEVADA STATE BOARD OF MEDICAL EXAMINERS

9600 Gateway Drive
Reno, NV 89521

Victor M. Muro, M.D.
Board President

Edward O. Cousineau, J.D.
Executive Director

February 17, 2022

George Chambers, M.D.
7220 S. Cimarron Road, Suite 200
Las Vegas, NV 89113

RE: BME CASE # [redacted]
PATIENT: [redacted]

Dear Dr. Chambers:

We have received information and a complaint regarding your disruptive behavior towards the above-named patient. The complaint alleges your unprofessional demeanor and treatment, and care of the patient may have fallen below the standard of care which may have had an adverse impact on the quality of care rendered to the above-named patient.

It is alleged:

1. The patient presented to you on October 15, 2019, for an exam.
2. During the patient's appointments, you regularly made comments about porn stars and his personal experiences of sexual intercourse.
3. You called the patient under the pretense of going over test results and offered the patient $1000 to do a photoshoot of her vagina for his portfolio.
4. You advised the patient boyfriend or husband was not allowed to come with her.
5. You told the patient, "I do this all the time. Boyfriends and husbands get very jealous and cannot come."
6. You were very aware the patient was struggling financially based on her insurance and had previously given her healthcare saving coupons.
7. The patient felt you used your position of power to take advantage of the patient and her situation.

According to these allegations, you may have violated the Nevada Medical Practice Act, Nevada Revised Statutes, Chapters 629 and 630, and Nevada Administrative Code, Chapters 629 and 630 (NMPA).

In order to determine whether or not there has been a violation of the NMPA, **please provide a written response to each allegation noted above, including, as well as complete health care records for the aforesaid patient[s]. Include copies of any imaging, x-ray or other films that were produced during treatment of this patient.** Please include any further information you believe would be useful for the Board to make a determination in this matter. **Please reply to this request within 30 calendar days.**

The Nevada State Board of Medical Examiners investigates all information received concerning possible violations of the NMPA. We make no determination as to whether or not there has been a violation of the NPMA until a thorough investigation is completed.

As a physician under investigation by the Board, you are required by the NMPA to provide the requested information, and your cooperation is not subject to the whistle-blower protections provided to physicians in NRS 630.364(3).

Please be advised that if the particular allegations referenced above did occur, and depending on the facts and circumstances, then you may have violated the NMPA, specifically including but not limited to: NRS 630.301(5)(6)(7)(9).

Respectfully,

Johnna S. LaRue, CMBI
Deputy Chief of Investigations

The Investigative Committee of the Board of Medical Examiners of the State of Nevada

* * * * *

In the Matter of the Investigation of:)
)
) Case No. [redacted]
George Chambers, M.D.)
)
License No. **10476**)
)

ORDER TO PRODUCE HEALTH CARE RECORDS

The Investigative Committee (IC) of the Board of Medical Examiners of the State of Nevada sends greetings to:

George Chambers, M.D.
[redacted]

Pursuant to the authority of Nevada Revised Statute (NRS) 630.311(1), the IC directs you to produce and deliver to the Nevada State Board of Medical Examiners, the materials as set forth in this Order:

1. Properly authenticated and complete copies of any and all health care records of **Patient:** [redacted]**; from January 1, 2018 through the present date**.
2. The name and contact information for any entity, facility, or person that you believe may possess the health care records of **Patient:** [redacted] **from January 1, 2018 through the present date**.
3. If health care records are provided electronically, they must be in a **searchable** format.

Said records shall be provided to an investigator of the Nevada State Board of Medical Examiners **within 21 days of service** of this Order (Investigation Division, Attn. Johnna LaRue, CMBI, Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada 89521). Failure to comply and produce said records in the aforesaid manner may subject you to potential

disciplinary action, to include a violation of NRS 630.3065(2)(a) and NRS 630.3062(1)(d); further, the Investigative Committee may seek administrative sanctions as set forth in NRS 630.352.

Additionally, compliance with this order is deemed compulsory and shall not be deemed to be cooperation subject to the protections provided to a physician pursuant to NRS 630.364(3).

Dated this 17th day of February 2022.

NEVADA STATE BOARD OF MEDICAL EXAMINERS
INVESTIGATIVE COMMITTEE

Bret W. Frey, M.D., Chairman
Victor M. Muro, M.D., Chairman
Nevada State Board of Medical Examiners
Investigative Committee

EXHIBIT 9

EXHIBIT 9

Chambers & Associates

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George P. Chambers Jr., M.D., FACOG
Medical Director

March 17, 2022

Ms. Johnna LaRue
NSBME
9600 Gateway Drive
Reno, NV 89521

Re: BME Case #: [redacted]
Patient: [redacted]

Dear Ms. LaRue:

First, let me convey that I have not violated the Nevada Medical Practice Act, Nevada Revised Statues, Chapters 629 and 630, and Nevada Administrative Code, Chapters 629 and 630 (NMPA). During my hearing last month, it was suggested that my chaperones are employed by me so their testimonies will not be objective. The American College of Obstetricians and Gynecologists recommends chaperones so that there is a third party present. I have given you a list of staff, former medical students, a nurse practitioner and a registered nurse who will provide testimony as to my behaviour in the office with my patients, including during [redacted] visits. I maintain that this is part of a conspiracy between my now ex-wife and disgruntled former patients whom she tracked down after reading their negative online reviews of me. [redacted] is no exception.

[redacted] is a liar. I personally do not give results to patients over the telephone. I have always felt that giving results over the telephone was another way of taking advantage of physicians. Patients want to talk for 30 minutes, avoid waiting in the office and the physician is not compensated. Besides, I didn't have time in my daily schedule for phone calls. Furthermore, when it came to diseases, such as gonorrhea, chlamydia, trichomonas, mycoplasma or *Ureaplama*, in which I treated the sexual partner, a visit to my office was necessary. As you will note from my notes, [redacted] had many medical issues. My medical assistant, however, was permitted to notify my patients of benign vaginitis diagnoses, such as candidiasis and bacterial vaginosis. She would call for their pharmacy number and I called in the prescriptions.

In 2012 I decided to pursue doing business with women who work in the adult entertainment industry. I started to advertise my GYN cosmetic surgery and sexual health medicine services in the awards ceremony program for the Adult Video Network (AVN). In the Fall of 2019, as we began getting ready for my ad for the 2020 AVN award ceremony, I offered $1000 to anyone who was willing to model for the ad. Furthermore, I also offer the model, in addition to the $1000, a USB copy of the boudoir shots so she may present them to her partner.

I recalled that [redacted] had mentioned to me during her initial visit that she was having financial hardship. I thought I was helping her when I told her that I was seeking models for my advertisement. I told

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her that the ad would be printed in the award ceremony program for the Adult Video Network. I did not discuss the porn stars nor did I share information regarding my private sex life with her. The only time sex was discussed was when I talked to her about how she might have gotten the mycoplasma/*Ureaplasma*.

I told her that I hired a professional boudoir photographer to take the photographs for my ad. I informed her that if she were interested that there was one rule. That is, she was not allowed to bring her husband on the day of the shoot. I jokingly said, don't even tell him about the shoot. I explained that the husbands and boyfriends are disruptive for the photographer because they want to control the poses used and sometimes the model cannot relax because they are present. Thus, the photographer did not want them at the shoot. I added that I have to pay the photographer for her time whether or not we get a photograph that is usable.

Thank you for your time. I can be reached at (702) 901-1249.

Sincerely,

George P. Chambers, Jr., MD, FACOG
Board Certified, Obstetrics and Gynecology
Certified, Sexual Health Medicine

7220 S. Cimarron Road • Suite 200 • Las Vegas, NV 89113 • ph 702-463-0800 • fax 702-463-0801

EXHIBIT 10

EXHIBIT 10

MEDICAL RECORDS

This exhibit contains personal medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310.

EXHIBIT 11

EXHIBIT 11

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

ACOG COMMITTEE OPINION

Number 796 *(Replaces Committee Opinion No. 373, August 2007)*

Committee on Ethics

This Committee Opinion was developed by the American College of Obstetrician and Gynecologists' Committee on Ethics in collaboration with committee member David I. Shalowitz, MD, MSHP.

Sexual Misconduct

ABSTRACT: The practice of obstetrics and gynecology includes interaction in times of intense emotion and vulnerability for patients and involves sensitive physical examinations and medically necessary disclosure of private information about symptoms and experiences. The patient–physician relationship is damaged when there is either confusion regarding professional roles and behavior or clear lack of integrity that allows sexual exploitation and harm. Sexual misconduct by physicians is an abuse of professional power and a violation of patient trust. Although sexual misconduct is uncommon in clinical care, even one episode is unacceptable. Routine use of chaperones, in addition to the other best practices outlined in this Committee Opinion, will help assure patients and the public that obstetrician–gynecologists are maximizing efforts to create a safe environment for all patients.

Recommendations and Conclusions

On the basis of the principles outlined in this Committee Opinion, the American College of Obstetricians and Gynecologists (ACOG) makes the following recommendations and conclusions:

- Sexual misconduct by an obstetrician–gynecologist is an abuse of power and a violation of patients' trust. Sexual or romantic interaction between an obstetrician–gynecologist and a current patient is always unethical, is grounds for investigation and sanction, and in some cases should be considered for criminal prosecution.
- It is unethical for obstetrician–gynecologists to misuse the trust, knowledge, or influence from a professional relationship in pursuing a sexual or romantic relationship with a former patient.
- Physical examinations should be explained appropriately, undertaken only with the patient's consent, and performed with the minimum amount of physical contact required to obtain data for diagnosis and treatment. Draping should be used to minimize patients' exposure during examinations. Patients should be offered the opportunity to ask questions or raise concerns about any element of the examination.
- It is recommended that a chaperone be present for all breast, genital, and rectal examinations. The need for a chaperone is irrespective of the sex or gender of the person performing the examination and applies to examinations performed in the outpatient and inpatient settings, including labor and delivery, as well as during diagnostic studies such as transvaginal ultrasonography and urodynamic testing.
- Obstetrician–gynecologists are obligated ethically and professionally to report sexual misconduct or suspected sexual misconduct by any health care professional to appropriate authorities, such as supervisors, department chairs or other institutional officials, peer review organizations, and professional licensing boards. Law enforcement should be involved in cases of sexual or physical assault.
- Institutions should have clear guidelines that allow clinical staff to report sexual misconduct or suspected sexual misconduct without concern for retaliation. Patients, family members, and loved ones should have the opportunity to express concerns about interactions with clinical staff without fear of adversely affecting clinical care.
- Medical students and trainees in obstetrics and gynecology should be educated about the inherent power imbalance in the patient–physician relationship, avoidance of sexually offensive or denigrating language, risk factors for sexual misconduct, and procedures for reporting suspected misconduct.

Introduction

The practice of obstetrics and gynecology includes interaction in times of intense emotion and vulnerability for patients and involves sensitive physical examinations and medically necessary disclosure of private information about symptoms and experiences. The relationship between obstetrician–gynecologists and their patients therefore requires a high level of trust and professional responsibility. The patient–physician relationship is damaged when there is either confusion regarding professional roles and behavior or clear lack of integrity that allows sexual exploitation and harm. Sexual misconduct by an obstetrician–gynecologist is an abuse of power and a violation of patients' trust (1).

Although sexual misconduct is uncommon in clinical care, even one episode is unacceptable. The ethical prohibition of sexual misconduct is forceful, and its application in medical practice is essential (2). This Committee Opinion has been revised to incorporate current data on the prevalence of physician sexual misconduct, to delineate ACOG's expectations for obstetrician–gynecologists' interactions with their patients to ensure that all patients are cared for safely and professionally (2), and to provide clinical best practice recommendations to support obstetrician–gynecologists' mission to provide the highest quality health care to their patients.

Background

Definition

The Federation of State Medical Boards categorizes the range of behaviors that constitute sexual misconduct into "sexual impropriety" (behavior, gestures, or expressions that are seductive, sexually suggestive, disrespectful of patient privacy, or sexually demeaning to a patient) and "sexual violation" (physical sexual contact between a physician and patient, whether or not initiated or consented to by the patient, and engaging in any conduct with a patient that is sexual or may be reasonably interpreted as sexual) (Box 1) (3). Examination of the breast or genitals without appropriate consent from a patient or surrogate decision maker qualifies as sexual misconduct under both of these categories. Sexual misconduct may be grounds for disciplinary action, and sexual misconduct that falls under the category of sexual violation also may meet the criteria for criminal prosecution (eg, sexual assault). The U.S. Department of Justice defines s*exual assault* as "any nonconsensual sexual act proscribed by Federal, tribal, or State law, including when the victim lacks capacity to consent" (4). Sexual assault encompasses a continuum of sexual activity that ranges from sexual coercion to contact abuse (unwanted kissing, touching, or fondling) to rape (5, 6).

Scope of the Problem

It is difficult to estimate accurately the incidence of sexual misconduct. Available data rely heavily on patient reporting, and it is estimated that less than 10% of patients subjected to sexual misconduct report their experience (7). One prominent report by *The Atlanta Journal-Constitution* identified 3,100 individual physicians named in sexual misconduct reports brought to state medical boards between 1999 and 2016. *The Atlanta Journal-Constitution* identified an additional 450 physicians from allegations during 2016 and 2017 (8). Additionally, between 2003 and 2013, 1,039 physicians had at least one sexual misconduct-related report filed with the National Practitioner Data Bank by hospitals, state medical boards, or other eligible entities (9). A review of cases brought to the American Medical Association (AMA) Council on Ethical and Judicial Affairs between 2004 and 2008 found that 32 of 298 cases were related to possible sexual misconduct (10). However, this number may be an underestimate because sanctions related to sexual misconduct may not be identified as such (11).

Limited data suggest that the greatest number of reported allegations of sexual misconduct involves physicians who practice family medicine, psychiatry, internal medicine, and obstetrics and gynecology (12, 13). An analysis of 101 cases of sexual abuse of patients by physicians revealed a strong, consistent association with male physician gender (100% of cases), age more than 39 years (92%), lack of board certification (72% of cases involving "nonconsensual sex"), consistent examination of patients without a chaperone (85%), and practice in nonacademic medical settings (94%) (14).

Sexual misconduct by clinicians during labor and delivery may be more prevalent than previously thought. A large survey of U.S. and Canadian obstetric support personnel raised concern that clinicians may at times use sexually degrading language with laboring women or perform genital examinations or procedures without appropriate consent or despite the patient's refusal (15). Again, although sexual misconduct during obstetric care likely is uncommon, the experience of sexual violation during childbirth may be associated with long-lasting consequences for patients' mental health. Intimate examinations and procedures performed without consent or under circumstances perceived by the patient to be coercive are associated with psychological trauma during childbirth (16, 17). Likewise, patients may find being physically exposed to more personnel than necessary for their clinical care during childbirth to be a dehumanizing and traumatic experience (16). Patients who experience childbirth as a traumatic event are at high risk of developing depression and posttraumatic stress disorder in the postpartum period (18). Although the interpretation and generalizability of these data are limited by the studies' methods, patients' vulnerability to perceived sexual violation during childbirth deserves special consideration, especially given the sometimes intensive and acute nature of intrapartum care.

Box 1. Examples of Physician Sexual Misconduct From the Federation of State Medical Boards

Sexual Impropriety

Sexual impropriety may comprise behavior, gestures, or expressions that are seductive, sexually suggestive, disrespectful of patient privacy, or sexually demeaning to a patient that may include, but are not limited to, the following:

- Neglecting to employ disrobing or draping practices respecting the patient's privacy, or deliberately watching a patient dress or undress
- Performing an intimate examination or consultation without clinical justification or appropriate consent
- Subjecting a patient to an intimate examination in the presence of medical students or other parties without the patient's informed consent or in the event such informed consent has been withdrawn
- Examination or touching of genital mucosal areas without the use of gloves
- Inappropriate comments about or to the patient, including but not limited to, making sexual comments about a patient's body or underclothing, making sexualized or sexually demeaning comments to a patient, criticizing the patient's sexual orientation, making nonclinically relevant comments about potential sexual performance during an examination
- Using the patient–physician relationship to solicit a date or romantic relationship
- Initiation by the physician of conversation regarding the sexual problems, preferences, or fantasies of the physician
- Requesting details of sexual history or sexual likes or dislikes when not clinically indicated for the type of examination or consultation

Sexual Violation

Sexual violation may include physical sexual contact between a physician and patient, whether or not initiated by the patient, and engaging in any conduct with a patient that is sexual or may be reasonably interpreted as sexual, including but not limited to the following:

- Sexual intercourse, genital-to-genital contact
- Oral-to-genital contact
- Oral-to-anal contact, genital-to-anal contact
- Kissing in a romantic or sexual manner
- Touching breasts, genitals, or any sexualized body part for any purpose other than appropriate examination or treatment, or when the patient has refused or has withdrawn consent
- Encouraging the patient to masturbate in the presence of the physician*
- Masturbation by the physician while the patient is present
- Offering to provide practice-related services, such as drugs, in exchange for sexual favors

*ACOG recognizes the value of physician-guided sexual health counseling in the proper clinical context by an appropriately trained provider.

Modified from Federation of State Medical Boards. Federation of State Medical Boards. Addressing sexual boundaries: guidelines for state medical boards. Adopted as policy by the House of Delegates of the Federation of State Medical Boards. May 2006. Euless (TX): FSMB; 2006. Available at: https://www.fsmb.org/siteassets/advocacy/policies/grpol_sexual-boundaries.pdf.

Ethical and Professional Guidelines

Romantic or Sexual Relationships With Current Patients

Sexual or romantic interaction between an obstetrician–gynecologist and a current patient is always unethical, is grounds for investigation and sanction, and in some cases should be considered for criminal prosecution. Such interactions may exploit patients' vulnerability, compromise physicians' ability to make objective judgments about patients' health care, and ultimately be detrimental to patients' long-term health (19, 20). Furthermore, an uncomfortable or traumatic experience in a physician's office may become a major barrier to seeking needed health care in the future.

Sexual or romantic behavior by a physician toward a current patient constitutes misconduct regardless of whether a patient appears to initiate or consent to such behavior. Physicians' professional codes of ethics have historically precluded the initiation of romantic or sexual contact with a patient because such a relationship is likely to compromise the physician's objectivity regarding treatment decision making and may exploit a power differential for personal gain (1, 21). The inherent imbalance of power in the patient–physician relationship makes coercion or its appearance more likely; for example, there may be an explicit or implicit suggestion that continued care is contingent on the patient's willingness to accept sexual contact. Additionally, obstetrician–gynecologists should be aware of the possibility that a patient's apparent desire for a romantic or sexual relationship with a treating

physician may be a manifestation of a transference reaction related to gratitude for clinical care (22, 23). For these reasons, a patient's apparent consent to enter into a romantic or sexual relationship with a treating physician does not make the relationship permissible.

Romantic or Sexual Relationships With Former Patients

Consensual romantic or sexual relationships between physicians and former patients are ethically challenging because of the potential for these relationships to be unduly influenced by the power dynamic accompanying the former patient–physician relationship. The Committee on Ethics agrees with the AMA that it is unethical for obstetrician–gynecologists to misuse the trust, knowledge, or influence from a professional relationship in pursuing a sexual or romantic relationship with a former patient (21). For example, it would be unethical for an obstetrician–gynecologist to coerce a former patient into a romantic or sexual relationship under the threat of disclosing private information obtained during treatment. Treating a person who is not a current patient, but with whom the obstetrician–gynecologist has a current romantic or sexual relationship, may not be sexual misconduct but instead may violate ethical proscriptions against treating family members (24).

Obligation to Report Misconduct

In addition to involving harm to the victim, an episode of sexual misconduct may not be isolated and could indicate a history of misconduct toward other patients or a risk of future misconduct. Furthermore, physician misconduct damages public trust in medical professionals. The ACOG Code of Professional Ethics states that "obstetrician–gynecologists should strive to address through the appropriate procedures the status of those physicians who demonstrate questionable competence, impairment, or unethical or illegal behavior. In addition, the obstetrician–gynecologist should cooperate with appropriate authorities to prevent the continuation of such behavior" (1). Therefore, to protect patients and colleagues, obstetrician–gynecologists are obligated ethically and professionally to report sexual misconduct or suspected sexual misconduct by any health care professional to appropriate authorities, such as supervisors, department chairs or other institutional officials, peer review organizations, and professional licensing boards. Law enforcement should be involved in cases of sexual or physical assault (see the "Definition" section earlier in this document). Additional guidance on reporting unethical behavior by colleagues is available from the AMA and the Federation of State Medical Boards (25–27).

Best Practices for Clinical Care

The American College of Obstetricians and Gynecologists is invested in ensuring that the standards for an obstetrician–gynecologist's behavior in a clinical encounter are transparent. In some situations, patients may have experienced sexual misconduct as part of an obstetric or gynecologic encounter but not recognized or reported it as such. Conversely, patients may perceive an interaction as sexual or romantic when in fact there was no such intent on the part of the obstetrician–gynecologist. The following clinical best practices are recommended to decrease the risk of misunderstandings related to the provision of appropriate clinical care and to increase patients' ability to recognize and report inappropriate interactions in the clinical setting.

Maintaining Appropriate Boundaries

Regardless of intent, any clinical or nonclinical contact with a patient that may be perceived as a romantic or sexual overture should be avoided. For example, clinical evaluation of a patient outside of a usual clinical setting may blur the boundaries between professional and nonprofessional interactions and, therefore, is discouraged; however, exceptions may include emergency care or a medically indicated home visit. Likewise, obstetrician–gynecologists should strictly avoid sexual innuendo, sexually suggestive humor, and sexually provocative remarks in professional settings. Nonclinical communication with current patients, including interactions by telephone, e-mail, text-messaging, or social media, should be approached with caution, and professional boundaries should be maintained at all times (28).

Under some circumstances, limited physical contact between physician and patient (eg, hugging or holding a patient's hand) may be a valuable, therapeutic expression of support. However, obstetrician–gynecologists should be careful to ensure that patients are open to such contact and that its duration is appropriately limited. If inappropriate contact is initiated by a patient, obstetrician–gynecologists should feel empowered to separate themselves from the patient, reinforce professional boundaries, and request assistance if needed.

Physical Examinations

Physical examinations should be explained appropriately, undertaken only with the patient's consent, and performed with the minimum amount of physical contact required to obtain data for diagnosis and treatment. Draping should be used to minimize patients' exposure during examinations. Patients should be offered the opportunity to ask questions or raise concerns about any element of the examination. The Committee on Ethics re-emphasizes that patients capable of decision making must provide consent for all procedures, and that patients have the right to refuse any and all examinations and procedures (29). Best practices for physical examination also apply to diagnostic tests involving instrumentation of the genital, urinary, or lower gastrointestinal tracts, such as transvaginal ultrasonography or urodynamics.

Photography and Video Recordings

Patients must consent to any photograph or video taken of them, and consent should be documented in the medical record. Photographs of pathology and unclothed or internal anatomy must be de-identified to the extent possible and used only for clinical documentation or academic purposes, including education of colleagues and trainees and publication in peer-reviewed medical literature. Identifiable images should be stored and sent (if necessary) in a secure manner, and images no longer being used for the above purposes should be destroyed securely.

Trauma-Informed Care

For some patients with a history of sexual trauma, even commonly used gestures and language may trigger memories of past physical or sexual abuse and may cause discomfort or fear during a clinical encounter. Because trauma often involves an experience of powerlessness, it is important to refrain from behaviors that a patient may perceive as overpowering or threatening (30–33). Common triggers include leaning over a patient during a discussion or pelvic examination, using commands such as "try to relax" before an internal examination, and exposing or touching parts of a patient's body during a physical examination without adequate warning (32, 33). All obstetrician–gynecologists should become familiar with the principles of trauma-informed care and seek to integrate them into general practice (34). Issues related to the care of survivors of sexual abuse, intimate partner violence, and reproductive and sexual coercion are detailed in other ACOG documents (35–37).

Chaperones

The presence of a third party, or "chaperone," in the examination room can provide reassurance to the patient about the professional context and content of the examination and the intent of the obstetrician–gynecologist. The chaperone also serves as a witness to the events taking place should there be any misunderstanding or concern for misconduct. In the obstetric setting, chaperones may decrease the risk of patient-perceived trauma during childbirth by advocating for patients and serving as a deterrent to potentially inappropriate behavior. The American College of Obstetricians and Gynecologists previously recommended an "opt-in" approach regarding the presence of chaperones, in which a chaperone was required if mandated by a clinical practice's policy or if requested by the patient or obstetrician–gynecologist. Given the profoundly negative effect of sexual misconduct on patients and the medical profession and the association between misconduct and the absence of a chaperone, ACOG now believes that the routine use of chaperones is needed for the protection of patients and obstetrician–gynecologists. Therefore, it is recommended that a chaperone be present for all breast, genital, and rectal examinations. The need for a chaperone is irrespective of the sex or gender of the person performing the examination and applies to examinations performed in the outpatient and inpatient settings, including labor and delivery, as well as during diagnostic studies such as transvaginal ultrasonography and urodynamic testing. Chaperones currently are required by the U.S. Veterans Health Administration health care system, and routine use of chaperones is considered essential by the Royal College of Obstetricians and Gynaecologists (38, 39).

Exceptions should be made in circumstances in which it is likely that failure to examine the patient would result in significant and imminent harm to the patient, such as during a medical emergency. If a patient declines a chaperone, it should be explained that the chaperone is an integral part of the clinical team whose role includes assisting with the examination and protecting the patient and the physician. Any concerns the patient has regarding the presence of a chaperone should be elicited and addressed if feasible. If, after counseling, the patient refuses the chaperone, this decision should be respected and documented in the medical record. Under such circumstances, obstetrician–gynecologists may defer breast, genital, or rectal examinations for the protection of the patient and the physician. If an unchaperoned examination is performed, the rationale for proceeding should be documented. This approach allows patients to opt out of a chaperoned examination if they feel strongly but does not compel physicians to examine the patient without the protection of a chaperone, except in the case of a medical emergency, as discussed previously.

Chaperones should clearly understand their responsibilities to protect patients' privacy and the confidentiality of health information. Obstetrician–gynecologists also should ensure that an opportunity exists for private conversation with patients so that the presence of a chaperone does not inhibit the communication of information important to the clinical encounter. Although chaperones may deter or discourage sexual misconduct by physicians (14), sexual misconduct still can occur in their presence. Chaperones should, therefore, be trained in the requirements of best clinical practices as stated previously and empowered to report concerning behavior through a process independent of the health care provider being chaperoned. Family members should not be used as chaperones and should be present for physical examination only if requested by the patient (40). Use of trainees (eg, medical students or residents) as chaperones generally is discouraged unless they are trained in appropriate clinical practices and empowered to report concerns about the health care provider's behavior during an examination.

Implementation of Routine Chaperoning

The Committee on Ethics recognizes that recommending the routine use of chaperones for obstetric, gynecologic, and diagnostic examinations may require some practices

to adjust staffing procedures. There also may be concern about the time and resources needed to implement changes and their potential effect on patient care. Although these concerns merit study, there is robust evidence of the detrimental effects of sexual misconduct on patients' well-being, the patient–physician relationship, and public perception of the medical profession. Therefore, there is a need for obstetrician–gynecologists and clinical practices to institute routine chaperoning as an ethical best practice measure to reduce the risk of sexual misconduct (41). Steps taken to prioritize patients' safety and comfort likely will improve public trust in obstetric and gynecologic care and may thereby improve patients' willingness to seek care when indicated.

Institutional Responsibilities

Examination areas should protect patients' privacy, and staffing should be adequate to permit routine use of chaperones for physical examination and procedures. Institutions and clinical practices also should consider providing patients with a "what to expect" guide before obstetric or gynecologic appointments so that patients are prepared for their clinical encounters and better able to recognize deviations from proper medical practice. For example, see ACOG's related patient education resource, *Your First Gynecologic Visit* (42).

Institutions should have clear guidelines that allow clinical staff to report sexual misconduct or suspected sexual misconduct without concern for retaliation. Patients, family members, and loved ones should have the opportunity to express concerns about interactions with clinical staff without fear of adversely affecting clinical care. All such reports should be promptly and thoroughly investigated, and appropriate disciplinary or remedial action, or both, should be taken.

Medical Education

Teaching physicians are expected to be exemplars of appropriate behavior for trainees; likewise, residents and fellows-in-training should model best practices for medical students and other trainees. Relevant elements of the clinical examination should be highlighted specifically when appropriate (eg, draping methods, explanation of examination to patient, use of trauma-sensitive language, appropriate use of chaperones, and solicitation of questions and permission to proceed with an examination). Trainees taking part in patient care should be introduced, and the patient should be given the opportunity to agree to their participation. Breast, genital, and rectal examinations (including examinations under anesthesia) that are for educational purposes only may not be performed without patients' specific informed consent (43).

Medical students and trainees in obstetrics and gynecology should be educated about the inherent power imbalance in the patient–physician relationship, avoidance of sexually offensive or denigrating language, risk factors for sexual misconduct, and procedures for reporting suspected misconduct (44–47). Although education may not eliminate the possibility of misconduct, formalized clinical and didactic training will help to make best clinical practices routine and may assist obstetrician–gynecologists in managing the boundaries between clinical care and inappropriate behavior and in identifying and reporting when these boundaries have been crossed by others.

Conclusion

Sexual misconduct by physicians is an abuse of professional power and a violation of patient trust. Such behavior jeopardizes the well-being of patients and carries immense potential for harm. Obstetrician–gynecologists should implement best clinical practices to ensure that patients are afforded a safe environment for their health care. Routine use of chaperones, in addition to the other best practices outlined in this Committee Opinion, will help assure patients and the public that obstetrician–gynecologists are maximizing efforts to create a safe environment for all patients. Obstetrician–gynecologists are ethically obligated to model responsible clinical practices and to report sexual misconduct or suspected sexual misconduct. Health care institutions, likewise, should provide resources to support best clinical practices and to ensure that patients are protected to the greatest extent possible.

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EXHIBIT 12

EXHIBIT 12

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

AUGS
Advancing Female Pelvic Medicine and Reconstructive Surgery

INTERIM UPDATE

ACOG PRACTICE BULLETIN

Clinical Management Guidelines for Obstetrician–Gynecologists

NUMBER 214

(Replaces Practice Bulletin Number 185, November 2017)

Committee on Practice Bulletins—Gynecology and American Urogynecologic Society. This Practice Bulletin was developed by the Committee on Practice Bulletins—Gynecology and the American Urogynecologic Society in collaboration with Paul Tulikangas, MD.

INTERIM UPDATE: This Practice Bulletin is updated as highlighted to reflect the U.S. Food and Drug Administration (FDA) order to stop the sale of transvaginal synthetic mesh products for the repair of pelvic organ prolapse.

Pelvic Organ Prolapse

Pelvic organ prolapse (POP) is a common, benign condition in women. For many women it can cause vaginal bulge and pressure, voiding dysfunction, defecatory dysfunction, and sexual dysfunction, which may adversely affect quality of life. Women in the United States have a 13% lifetime risk of undergoing surgery for POP (1). Although POP can occur in younger women, the peak incidence of POP symptoms is in women aged 70–79 years (2). Given the aging population in the United States, it is anticipated that by 2050 the number of women experiencing POP will increase by approximately 50% (3). The purpose of this joint document of the American College of Obstetricians and Gynecologists and the American Urogynecologic Society is to review information on the current understanding of POP in women and to outline guidelines for diagnosis and management that are consistent with the best available scientific evidence.

Background

Definition

Pelvic organ prolapse is the descent of one or more aspects of the vagina and uterus: the anterior vaginal wall, posterior vaginal wall, the uterus (cervix), or the apex of the vagina (vaginal vault or cuff scar after hysterectomy) (4). This allows nearby organs to herniate into the vaginal space, which is commonly referred to as cystocele, rectocele, or enterocele. Mild descent of the pelvic organs is common and should not be considered pathologic. Pelvic organ prolapse only should be considered a problem if it is causing prolapse symptoms (ie, pressure with or without a bulge) or sexual dysfunction or if it is disrupting normal lower urinary tract or bowel function. Pelvic organ prolapse can be defined using patient-reported symptoms or physical examination findings (ie, vaginal bulge protruding to or beyond the hymen). Most women feel symptoms of POP when the leading edge reaches 0.5 cm distal to the hymenal ring (5).

Epidemiology

According to the National Health and Nutrition Examination Survey, approximately 3% of women in the United States report symptoms of vaginal bulging (3). In one review, the prevalence of POP based on reported symptoms was much lower (3–6%) than the prevalence identified by examination (41–50%) (6). This discrepancy likely occurs because many women with POP are asymptomatic. Pelvic organ prolapse usually is due to global pelvic floor dysfunction, so most women will present with POP in multiple compartments (anterior, apical, and posterior vaginal wall) (7).

There are few studies of the natural history of POP. In one study that monitored women with symptomatic, untreated POP for an average of 16 months, 78% of the women had no change in the leading edge of the prolapse (8). Most of the women had stage II–IV pelvic organ prolapse (Box 1). In women who do not want treatment for their POP, most will have no change or only a small increase in the size of the POP over the next year (9).

Box 1. Stages of Pelvic Organ Prolapse

Stages are based on the maximal extent of prolapse relative to the hymen, in one or more compartments.

Stage 0: No prolapse; anterior and posterior points are all −3 cm, and C or D is between −TVL and − (TVL − 2) cm.

Stage I: The criteria for stage 0 are not met, and the most distal prolapse is more than 1 cm above the level of the hymen (less than −1 cm).

Stage II: The most distal prolapse is between 1 cm above and 1 cm below the hymen (at least one point is −1, 0, or +1).

Stage III: The most distal prolapse is more than 1 cm below the hymen but no further than 2 cm less than TVL.

Stage IV: Represents complete procidentia or vault eversion; the most distal prolapse protrudes to at least (TVL − 2) cm.

Abbreviations: C, cervix; D, posterior fornix; TVL, total vaginal length.
Data from Bump RC, Mattiasson A, Bo K, Brubaker LP, DeLancey JO, Klarskov P, et al. The standardization of terminology of female pelvic organ prolapse and pelvic floor dysfunction. Am J Obstet Gynecol 1996;175:10–7.

The incidence of POP surgery is 1.5–1.8 surgeries per 1,000 women years (10, 11). There are approximately 300,000 POP surgeries each year in the United States (12).

Risk Factors

Risk factors for developing symptomatic POP include parity, vaginal delivery, age, obesity, connective tissue disorders, menopausal status, and chronic constipation (13–17). Modifiable risk factors (obesity and constipation) should be addressed in patients at wellness visits because improvement in these factors may reduce the risk of developing POP.

It is not clear if hysterectomy for non-POP conditions is a risk factor for developing POP. In a subanalysis of a cohort study from the United Kingdom, patients who underwent a hysterectomy had a 5% cumulative risk of undergoing prolapse surgery within the next 15 years (13). A more recent study found no increased risk of POP in women who underwent prior hysterectomy for non-POP indications (18).

Older studies reported that women who underwent primary POP surgery had an approximate 30–50% chance of needing a second prolapse surgery (19). More recent studies show a lower reoperation rate of approximately 6–30%, with most estimates consistent with the lower end of this range (19–22). This lower reoperation rate may reflect improvement in surgical technique as well as stratification of urinary incontinence as a separate risk in the outcomes data (19). Pelvic organ prolapse surgery that includes suspension of the vaginal apex is associated with a decreased reoperation rate (23). Risk factors for recurrent prolapse include age younger than 60 years for patients who underwent vaginal surgery for POP, obesity, and preoperative stage III or stage IV prolapse (24–26).

Clinical Considerations and Recommendations

▶ ***What is the recommended initial evaluation for a woman with suspected pelvic organ prolapse?***

The recommended initial evaluation for a woman with suspected POP includes a thorough history, assessment of symptom severity, physical examination, and goals for treatment. Symptom assessment is the most important part of the evaluation of a woman with POP.

History

In addition to a complete medical, surgical, obstetric, and gynecologic history, the nature of vaginal bulge symptoms and the degree of bother associated with the bulge should be recorded. Key information to elicit from the patient includes whether the protrusion is limiting physical activities or sexual function or becoming progressively worse or bothersome. Many women with POP on physical examination do not report symptoms of POP. Treatment is indicated only if prolapse is causing bothersome bulge and pressure symptoms, sexual dysfunction, lower urinary tract dysfunction, or defecatory dysfunction (27).

Lower urinary tract function should be assessed. This includes an evaluation for urine loss and type (stress or urgency urinary incontinence) and adequacy of bladder emptying. The relationship between urinary symptoms and prolapse can be inferred if voiding becomes more difficult when the effects of gravity are more pronounced, such as after long periods of standing (4). In addition, splinting (ie, the need to push on or support the bulging tissue) may be required to initiate or complete voiding.

Assessment of bowel function should be undertaken to determine if there is a history of straining with bowel movements, laxative use, fecal incontinence, and incomplete rectal emptying. The symptom of splinting often is correlated with the presence of a posterior compartment defect (eg, rectocele). Each patient should be assessed for symptoms of dyspareunia, coital incontinence (of urine or stool), and sexual dysfunction that is related to the prolapse.

Physical Examination

Physical examination should include an abdominal and pelvic examination to rule out pelvic masses. The external genitalia and vaginal epithelium should be evaluated for vaginal atrophy, skin irritation, or ulceration (27). Simply spreading the labia while examining the patient in a supine position can be helpful to assess the maximum descent of the prolapse. A detailed examination of the POP should be performed with a split speculum (ie, separate a bivalve speculum and use only the posterior blade to examine the apex and anterior vaginal wall, then turn the blade over and use it to hold the anterior wall while examining the postvaginal wall and perineal body as the patient performs the Valsalva maneuver, repetitive coughing, or both). Performance of a pelvic organ prolapse quantification (POP-Q) examination is recommended before treatment for the objective evaluation and documentation of the extent of prolapse (see *Is the pelvic organ prolapse quantification examination necessary before treatment for pelvic organ prolapse*?) If a patient's prolapse symptoms are not confirmed by the extent of prolapse observed during supine pelvic examination, repeating the pelvic examination in the standing position may reveal the greatest descent of POP.

Pelvic floor muscle tone should be assessed (27). It should be noted if the pelvic floor muscles can contract and relax volitionally. The strength of the contraction should be described as "absent," "weak," "normal," or "strong" (4).

▶ *Is additional testing beyond history and physical examination needed to evaluate women with pelvic organ prolapse?*

In general, no additional testing beyond a complete gynecologic, urologic, and defecatory history and physical examination is needed before treatment. However, if the prolapse is beyond the hymen or the patient has voiding symptoms, a postvoid residual urine volume should be recorded either with a catheter or ultrasonography (27). If there is urinary urgency or other lower urinary tract symptoms, minimum assessment involves a urinalysis, with culture and microscopy performed if indicated. Urodynamic testing may help inform patient counseling and may be considered if there is bothersome incontinence with stage II or greater prolapse or voiding dysfunction. If findings on initial assessment do not concur with symptoms, more specific imaging or referral to a specialist in urogynecologic care may be needed.

▶ *Is the pelvic organ prolapse quantification examination necessary before treatment of pelvic organ prolapse?*

A POP-Q examination is recommended before treatment of POP to objectively evaluate and document the extent of prolapse. Evaluation and documentation of the extent of the prolapse is important before treatment so that the surgeon has a preoperative comparator by which to measure postoperative anatomic success. The POP-Q system is the only validated method for objective measurement of prolapse in the three pelvic compartments: 1) anterior, 2) apical, and 3) posterior (Fig. 1) (28–30). The POP-Q system is recommended by the major national and international urogynecologic health organizations, including the American Urogynecologic Society, the Society of Gynecologic Surgeons, and the International Continence Society (31). In addition, POP-Q is used in most scientific publications on POP (32). Although the Baden–Walker system clinically describes prolapse findings, the POP-Q system is more precise and has been shown to be reproducible.

The POP-Q system does not use the terms "cystocele" and "rectocele" but instead uses terms for each prolapsed segment because the exact organ that lies behind the prolapsed vaginal epithelium may not be clear from the clinical examination. It incorporates measurements of the vaginal length, genital hiatus, and perineal body. The POP-Q measurements can be converted to stages based on the most severely prolapsed vaginal segment (Box 1) (28).

A validated examination allows for consistency in reporting and facilitates communication between gynecologic care providers. It is particularly important if a patient has a recurrent prolapse because it will allow a new gynecologic care provider to understand the patient's POP history. Outcomes can be evaluated only if pretreatment POP measurements are recorded accurately.

For patients desiring expectant management, documentation of the prolapse with the POP-Q allows an objective, validated, baseline measurement that can be referred to if symptoms change over time. Although recording a POP-Q examination is not necessary for these patients, it may be helpful to determine if there is an anatomic change over time.

▶ *Are effective nonsurgical treatments available for women with pelvic organ prolapse?*

For women with asymptomatic prolapse, education and reassurance are appropriate. Women may not realize that symptoms of voiding or defecatory dysfunction are related to prolapse, so education about how prolapse symptoms manifest can be helpful.

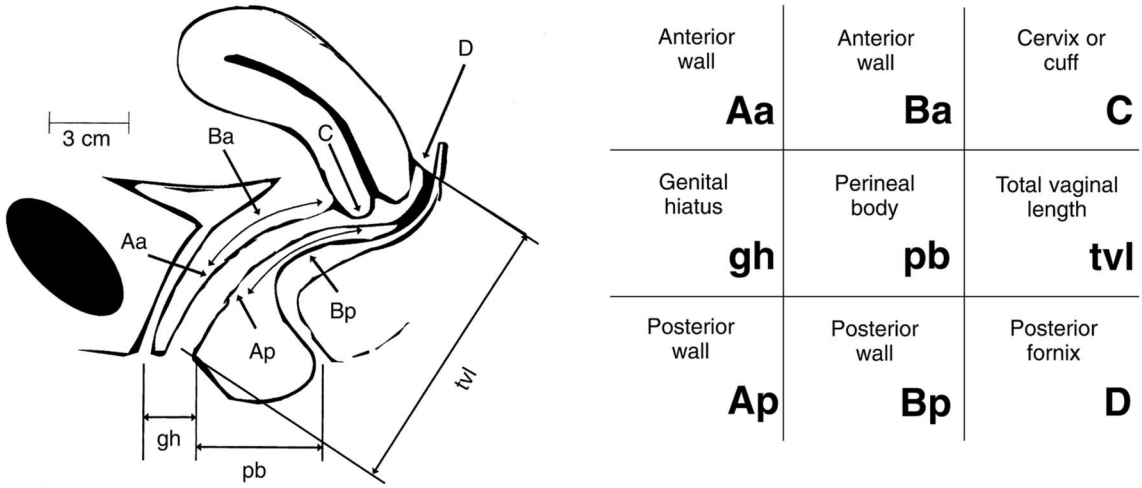

Figure 1. Pelvic Organ Prolapse Quantification System. Nine defined points measured in the midline and relative to the hymen assessed during maximal Valsalva except for TVL: Aa, 3 cm proximal to the external urethral meatus; Ba, most prolapsed portion of the anterior vaginal wall; C, leading edge of the cervix or vaginal cuff; gh, middle of the urethral meatus to the midline of the posterior hymen; pb, middle of the posterior hymen to the middle of the anal opening; tvl, maximum depth of the vagina with prolapse reduced; Ap, 3 cm proximal to the posterior hymen; Bp, most prolapsed portion of the posterior vaginal wall; D, posterior fornix in a woman who has a cervix. (Reprinted with permission from Bump RC, Mattiasson A, Bo K, Brubaker L, DeLancey J, Klarskov P, et al. The standardization of terminology of female pelvic organ prolapse and pelvic floor dysfunction. Am J Obstet Gynecol. 1996;175:10–17.)

Some symptoms related to pelvic organ prolapse may be managed with lifestyle modifications. For example, defecatory dysfunction may improve with fiber supplementation and use of an osmotic laxative (33). Sitting with feet elevated may decrease bulge symptoms. Pelvic muscle exercises, performed either independently or under professional supervision, may improve symptoms or slow the progression of POP (34, 35).

There is limited evidence for the treatment or prevention of POP with local or systemic estrogen (36). However, some clinicians believe that local estrogen may help with the vaginal irritation associated with POP.

Women considering treatment of POP should be offered a vaginal pessary as an alternative to surgery. A pessary should be considered for a woman with symptomatic POP who wishes to become pregnant in the future. A vaginal pessary is an effective nonsurgical treatment for women with POP, and up to 92% of women can be fitted successfully with a pessary (37). In one study protocol, a ring pessary was inserted first, followed by a Gellhorn pessary if the ring did not stay in place. Ring pessaries were used more successfully with stage II (100%) and stage III (71%) prolapse, and stage IV prolapse more frequently required Gellhorn pessaries (64%) (38). If possible, women should be taught to change their pessaries independently. If a woman is unable to remove and replace her pessary, regular follow-up (such as every 3–4 months) is necessary. Annual follow-up is recommended for patients who are able to maintain pessary hygiene on their own.

Pressure on the vaginal wall from the pessary may result in local devascularization or erosion in 2–9% of patients (39). Therapy should consist of removing the pessary for 2–4 weeks and local estrogen therapy. Resolution may occur without local estrogen therapy. If the problems persist, more frequent pessary changes or a different pessary may be required (39). Caregivers to patients with dementia should be made aware of the regular pessary changes needed to avoid complications. Although rare complications such as fistula can occur, pessary use is a low-risk intervention that can be offered to all women who are considering treatment of POP (40).

▶ *When is surgery indicated for the management of pelvic organ prolapse, and what are the primary approaches?*

Surgery is indicated for the treatment of POP in women who are bothered by their POP and have failed or declined nonsurgical treatments. There are various vaginal and abdominal surgical approaches for the treatment of POP (Table 1). Important considerations for deciding the type and route of surgery include the location and severity of prolapse, the nature of the symptoms (eg, presence of urinary, bowel, or sexual dysfunction), the patient's general health, patient preference, and the surgeon's expertise (41).

Table 1. Types of Pelvic Organ Prolapse Surgery

Surgical Technique	Aim	Indication
Abdominal sacral colpopexy	To correct upper vaginal prolapse	Most commonly used in women with recurrent cystocele, vault, or enterocele
Uterosacral ligament suspension	To correct upper vaginal prolapse	Performed at the time of hysterectomy or in patients with posthysterectomy vaginal vault prolapse
Sacrospinous fixation	To correct upper vaginal prolapse	Performed at the time of hysterectomy or in patients with posthysterectomy vaginal vault prolapse
Anterior vaginal repair (anterior colporrhaphy)	To correct anterior wall prolapse	May be used for the treatment of prolapse of the bladder or urethra (bladder, urethra, or both, herniates downward into the vagina)
Posterior vaginal repair (posterior colporrhaphy) and perineorrhaphy	To correct posterior wall prolapse	May be used for the treatment of rectocele (rectum bulges or herniates forward into the vagina), defects of the perineum, or both
Vaginal repair with synthetic mesh or biologic graft augmentation	To correct anterior wall prolapse, apical vaginal prolapse, or both	Depending on the specific defect, the mesh augmentation can either be anterior, apical, or both. This repair is not routinely recommended.

Adapted from Maher C, Feiner B, Baessler K, Christmann-Schmid C, Haya N, Marjoribanks J. Transvaginal mesh or grafts compared with native tissue repair for vaginal prolapse. Cochrane Database Syst Rev. 2016 Feb 9;2:CD012079.

▶ *Are vaginal surgical approaches effective for the management of pelvic organ prolapse?*

Vaginal hysterectomy and vaginal apex suspension with vaginal repair of anterior and posterior vaginal wall prolapse as needed are effective treatments for most women with uterovaginal and anterior and posterior vaginal wall prolapse (21, 22, 42, 43). Vaginal native tissue repairs are performed without the use of synthetic mesh or graft materials. These are relatively low-risk surgeries that may be considered as surgical options for most women with primary POP.

If a patient has uterine prolapse, vaginal hysterectomy alone is not adequate treatment. Vaginal apex suspension should be performed at the time of hysterectomy for uterine prolapse to reduce the risk of recurrent POP (23, 44). Vaginal apex suspension involves attachment of the vaginal apex to the uterosacral ligaments or sacrospinous ligaments. Uterosacral and sacrospinous ligament suspension for apical POP with native tissue are equally effective surgical treatments of POP, with comparable anatomic, functional, and adverse outcomes (21). In the Operations and Pelvic Muscle Training in the Management of Apical Support Loss trial, the 2-year follow-up surgical success rate was 64.5% for uterosacral ligament suspension compared with 63.1% for sacrospinous ligament fixation (adjusted odds ratio [OR], 1.1; 95% confidence interval [CI], 0.7–1.7) (21). The serious adverse event rate at 2-year follow-up was 16.5% for uterosacral ligament suspension compared with 16.7% for sacrospinous ligament fixation (adjusted OR, 0.9; 95% CI, 0.5–1.6) (21). Uterosacral ligament suspension can be performed by attaching the vaginal apex bilaterally to the ipsilateral uterosacral ligament or by attaching the vaginal apex to uterosacral ligament complex that is plicated in the midline (42, 43, 45). It is important that an adequate segment of uterosacral ligament is secured to the vagina. This often requires attachment to the midportion of the uterosacral ligament close to the ischial spine. Alternatively, the sacrospinous ligament can be used to support the vaginal apex. A unilateral right sacrospinous ligament fixation usually is used for the attachment point to avoid dissection around the colon (46).

Anterior colporrhaphy is an effective treatment for most anterior vaginal wall prolapse (47). Many women with anterior vaginal wall prolapse also have an apical prolapse (48). In these women, surgery should correct the apical prolapse and the anterior vaginal wall prolapse. Resupport of the vaginal apex concurrently with repair of the anterior vaginal wall defect reduces the risk of recurrent POP surgery (23). Paravaginal defects are lateral detachments of the vaginal wall from the fascial condensations over the levator ani muscles (49, 50). Diagnosis of paravaginal defects by physical examination is unreliable (51, 52). Moreover, if a paravaginal defect is suspected, there usually is apical loss of support (50). Apical support procedures may address most anterior vaginal wall defects, including paravaginal defects (53).

Posterior vaginal wall repair traditionally has been performed through a midline plication of the posterior vaginal wall fibromuscular connective tissue (54). The repair should be performed without placing tension on the levator ani muscles because this may lead to dyspareunia (55). Perineorrhaphy that results in reattachment of the perineal muscles to the rectovaginal septum can be performed as needed if a perineal defect is present. An alternative technique for performing posterior vaginal wall repair is site-specific repair, which involves dissection of the vaginal epithelium off the underlying fibromuscular connective tissue and repair of localized tissue defects with sutures. A finger often is placed in the rectum and directed anteriorly to identify various tissue defects of the posterior vaginal wall (56). Although a retrospective comparison of site-specific repair and midline colporrhaphy found that site-specific repair was associated with a higher rate of recurrence of a symptomatic bulge (11% versus 4%, $P=.02$) (57), a prospective study showed comparable outcomes for the two techniques (58).

▶ *When is abdominal sacrocolpopexy indicated for the management of pelvic organ prolapse?*

Abdominal sacrocolpopexy is a proven and effective surgery for the treatment of POP (20, 59). This procedure involves placement of a synthetic mesh or biologic graft from the apex of the vagina to the anterior longitudinal ligament of the sacrum. Women who may be candidates for abdominal sacrocolpopexy include those who have a shortened vaginal length, intra-abdominal pathology, or risk factors for recurrent POP (eg, age younger than 60 years, stage 3 or 4 prolapse, and body mass index greater than 26) (24–26). In women who are at increased risk of synthetic mesh-related complications (eg, chronic steroid use, current smoker), sacrocolpopexy with a biologic graft or alternatives to a sacrocolpopexy could be considered.

Studies evaluating abdominal sacrocolpopexy with biologic grafts show conflicting results. Abdominal sacrocolpopexy with porcine dermis xenograft had efficacy similar to that of abdominal sacrocolpopexy with synthetic polypropylene mesh. However, the porcine dermal xenograft used in this study is no longer available (60). In a study that evaluated the 5-year surgical outcomes of abdominal sacrocolpopexy among patients randomized to receive polypropylene mesh or cadaveric fascia lata, use of synthetic mesh resulted in better anatomic cure than use of cadaveric fascia lata grafts (93% [27 out of 29] versus 62% [18 out of 29], $P=.02$) (61).

Abdominal sacrocolpopexy with synthetic mesh has a lower risk of recurrent POP but is associated with more complications than vaginal apex repair with native tissue. Data from randomized controlled trials also show a significantly greater likelihood of anatomic success with mesh abdominal sacrocolpopexy compared with vaginal apex repair with native tissue (pooled OR, 2.04; 95% CI, 1.12–3.72) (62). Surgical complications that are more common after abdominal sacrocolpopexy with mesh include ileus or small-bowel obstruction (2.7% versus 0.2%, $P<.01$), thromboembolic phenomena (0.6% versus 0.1%, $P=.03$), and mesh or suture complications (4.2% versus 0.04%, $P<.01$) (62). In addition, sacrocolpopexy with mesh is associated with a significant reoperation rate due to mesh-related complications. Long-term (ie, 7-year) follow-up of participants of the Colpopexy and Urinary Reduction Efforts (CARE) trial found that the estimated rate of mesh complications (erosion into the vagina, visceral erosions, and sacral osteitis) was 10.5% (95% CI, 6.8–16.1), with a significant number of reoperations (20). Many of the CARE trial sacrocolpopexies, however, were performed with non-type 1 mesh, which may have increased the mesh complication rate. Because of complications attributed to multifilament and small-pore-size synthetic mesh, type 1 synthetic meshes (monofilament with large pore size) currently are used in the United States.

▶ *Do patients benefit from a minimally invasive approach to pelvic organ prolapse surgery?*

Sacrocolpopexy with or without supracervical hysterectomy or total hysterectomy can be performed laparoscopically with or without robotic assistance (63). Although open abdominal sacrocolpopexy is associated with shorter operative times (222 minutes versus 296 minutes; $P<.02$), minimally invasive sacrocolpopexy is associated with less blood loss (122 $\pm$ 146 mL versus 187 $\pm$ 142 mL; $P<.01$) and shorter hospitalization (1.3 $\pm$ 1 days versus 2.9 $\pm$ 1.6 days; $P<.01$) (64). Similar results were seen in a randomized controlled trial that compared open abdominal sacrocolpopexy with laparoscopic sacrocolpopexy, in which mean blood loss was significantly greater in the open arm (mean difference [MD] 184 mL; 95% CI, 96–272), and there were fewer inpatient days in the laparoscopic group (MD, 0.9 days; 95% CI, 0.1–1.7) (65).

Although robotic assistance shortens the learning curve for performing laparoscopic sacrocolpopexy and improves surgeon ergonomics (66–68), it has not been shown to improve short-term outcomes for patients (69–72). In two randomized controlled trials that compared robot-assisted sacrocolpopexy with laparoscopic sacrocolpopexy, operating time, postoperative pain, and cost were found to be significantly greater in the robot-assisted group (69, 72). The groups had similar anatomic and functional outcomes 6 months to 1 year after surgery, although the robotic experience of the surgeons was low at the start of the study, which may have affected the results (73). Overall, the current literature is too scant to adequately indicate

which minimally invasive approach should be recommended. Further comparative studies that assess long-term anatomic and functional outcomes and patient safety and that identify subgroups of patients who would benefit from a robotic approach are warranted (74).

▶ *Is posterior vaginal wall prolapse repair more effective with a transanal or transvaginal incision?*

Posterior vaginal wall prolapse repair is more effective when performed through a transvaginal incision than a transanal incision. Systematic review findings show that, compared with transanal incision, posterior vaginal repair results in fewer recurrent prolapse symptoms (relative risk [RR], 0.4; 95% CI, 0.2–1.0), lower recurrence on clinical examination (RR, 0.2; 95% CI, 0.1–0.6), and a smaller mean depth of rectocele on postoperative defecography (MD, –1.2 cm; 95% CI, –2.0 to –0.3) (75).

▶ *Are surgical approaches available to treat pelvic organ prolapse in women with medical comorbidities?*

Obliterative procedures—which narrow, shorten, or completely close the vagina—are effective for the treatment of POP and should be considered a first-line surgical treatment for women with significant medical comorbidities who do not desire future vaginal intercourse or vaginal preservation (76–79). Obliterative procedures have high reported rates of objective and subjective improvement of POP (98% and 90%, respectively) (80) and are associated with a low risk of recurrent POP (76, 80, 81). Because obliterative surgical procedures can be performed under local or regional anesthesia, these procedures may be especially beneficial for the treatment of POP in women with significant medical comorbidities that preclude general anesthesia or prolonged surgery, such as cardiac disease, chronic obstructive pulmonary disease, or thromboembolic disease. In addition, obliterative procedures for the treatment of POP are associated with low rates of complications, intensive care unit admissions, and mortality (6.8%, 2.8%, and 0.15%, respectively) (82). Patients undergoing obliterative procedures must be committed to no longer having vaginal sexual intercourse. In a multisite prospective study of older women (mean age 79 years) who underwent obliterative repair of POP, 95% of patients (125 out of 132) reported being satisfied or very satisfied with the results of the procedure 1 year after surgery (79). Patient regret also has been reported to be low. Among women interviewed more than 1 year after obliterative prolapse repair, only 9% (3 out of 32) reported they regretted having the procedure (81).

Common types of obliterative surgical repair of POP include a Le Fort-style partial colpocleisis and total colpectomy. Le Fort partial colpocleisis is performed when the uterus is preserved at the time of prolapse repair. This procedure involves denuding a strip of epithelium from the anterior and posterior vaginal walls and then suturing them together (83). This leaves lateral canals to drain the secretions from the cervix. Because the uterus is difficult to access postoperatively, normal results from cervical cytology and human papillomavirus testing and an endometrial evaluation usually are documented before surgery. For posthysterectomy vaginal prolapse, a colpectomy or tight anterior and posterior colporrhaphy creating a constricted vagina is a surgical option if a patient is amenable to an obliterative procedure. In total colpectomy procedures, the entire vaginal epithelium is denuded and sutures are used to invert the vagina (83). With any obliterative procedure, a suburethral plication or midurethral sling and a perineorrhaphy often are recommended to decrease the risk of postoperative stress urinary incontinence and recurrent posterior vaginal wall prolapse (80).

▶ *What can be recommended regarding currently available synthetic mesh and biologic graft materials for use in vaginal pelvic organ prolapse surgery?*

Availability of Transvaginal Synthetic Mesh

There are currently no available U.S. Food and Drug Administration (FDA)-approved transvaginal mesh products for the treatment of POP. Many transvaginal mesh products were removed from the market after the 2011 FDA announcement that identified serious safety and effectiveness concerns about the use of transvaginal mesh to treat POP (84). In April 2019, the FDA ordered the manufacturers of all remaining surgical mesh products indicated for the transvaginal repair of POP to stop selling and distributing their products in the United States (85). The FDA determined that the manufacturers' premarket approval applications—a requirement since the device's 2016 re-classification as "high risk" (86)—had failed to demonstrate an acceptable long-term benefit–risk profile for surgery with these devices compared with transvaginal native tissue prolapse repair. It is important to note that the FDA announcement applies only to mesh placed transvaginally to treat POP. The FDA order does NOT apply to transvaginal mesh for stress urinary incontinence or transabdominal mesh for POP repair.

The FDA advises that no intervention is needed for patients who received transvaginal mesh for the surgical repair of POP and are not experiencing any symptoms or complications (85). These patients should be counseled to continue with routine care and report any complications or

symptoms, including persistent vaginal bleeding or discharge, pelvic pain, or dyspareunia, to their gynecologic care provider. For more information, see Committee Opinion No. 694, *Management of Mesh and Graft Complications in Gynecologic Surgery* (87).

Although the 2019 FDA announcement stopped the sale of available transvaginal mesh POP repair products, some surgeons might still offer transvaginal mesh-augmented surgery for select patients with anterior and apical POP. Pelvic organ prolapse vaginal mesh repair should be limited to high-risk individuals in whom the benefit of mesh placement may justify the risk, such as individuals with recurrent prolapse (particularly of the anterior or apical compartments) or with medical comorbidities that preclude more invasive and lengthier open and endoscopic procedures. Before placement of synthetic mesh grafts in the anterior vaginal wall, patients should provide their informed consent after reviewing the benefits and risks of the procedure and discussing alternative repairs.

Vaginal Prolapse Repair With Transvaginal Mesh or Biologic Grafts

The use of synthetic mesh or biologic grafts in POP surgery is associated with unique complications not seen in POP repair with native tissue. A systematic review of seven randomized controlled trials that compared native tissue repair with synthetic mesh vaginal prolapse repair found that more women in the mesh group required repeat surgery for the combined outcome of prolapse, stress incontinence, or mesh exposure (RR, 2.40; 95% CI, 1.51–3.81) (41). The rate of mesh exposure was 12%, and 8% of women required repeat surgery for mesh exposure up to 3 years after the initial surgery (41). Systematic review findings show that vaginal repair of prolapse with biologic grafts (tissue from human cadaver or other species) results in similar rates of "awareness of prolapse" and reoperation for prolapse compared with repairs using native tissue (41). However, it is difficult to make an overall recommendation about the use of biologic grafts for vaginal prolapse repair because the available evidence is of low quality, and most of the biologic grafts that were used in studies to date are no longer available.

Posterior Vaginal Repair

The use of synthetic mesh or biologic grafts in transvaginal repair of posterior vaginal wall prolapse does not improve outcomes (41). In addition, there are increased complications (eg, mesh exposure) associated with placement of mesh through a posterior vaginal wall incision (54). In two randomized trials that compared native tissue with biologic graft material for the repair of posterior prolapse, the objective failure rate was significantly lower at the 1-year follow-up in the native tissue group (10% [10 out of 98]) as compared with the biologic graft group (21% [20 out of 93]) (RR, 0.47; 95% CI, 0.24–0.94), and the subjective failure rate was similar between the groups (RR, 1.09; 95% CI, 0.45–2.62) (58, 75, 88). There was no difference in the rate of postoperative dyspareunia between the groups (RR, 1.26; 95% CI, 0.59–2.68). Another trial that compared posterior biologic graft repair with traditional repair noted worse anatomic outcomes with posterior biologic graft repair than with traditional repair (46% versus 14%; $P=.02$) (19, 58). Thus, synthetic mesh or biologic grafts should not be placed routinely through posterior vaginal wall incisions to correct POP for primary repair of posterior vaginal wall prolapse.

Anterior Vaginal Repair

The use of biologic grafts in transvaginal repair of anterior vaginal wall prolapse provides minimal benefit compared with native tissue repair (89). Systematic review results indicate that native tissue and biologic graft-augmented anterior repair result in similar rates of prolapse awareness (RR, 0.98; 95% CI, 0.52–1.82) and risk of repeat surgery (RR, 1.02; 95% CI, 0.53–1.97) (89). Native tissue anterior repair appears to have an increased risk of anterior prolapse recurrence when compared with repair using any type of biologic graft (RR, 1.32; 95% CI, 1.06–1.65). However, subanalysis by biologic graft type showed no significant difference in recurrence risk between native tissue and porcine dermis graft (RR, 1.29; 95% CI, 0.98–1.70), which was the most commonly used graft among the included studies (89).

Compared with native tissue anterior repair, polypropylene mesh augmentation of anterior vaginal wall prolapse repair improves anatomic and some subjective outcomes but is associated with increased morbidity (89). Vaginally placed polypropylene mesh is associated with longer operating times and greater blood loss compared with native tissue anterior repair (89, 90). In addition, the use of vaginally placed polypropylene mesh is associated with an increased risk of repeat surgery for prolapse, stress urinary incontinence, and mesh exposure (composite outcome) (89).

▶ *Is special training required to perform pelvic organ prolapse procedures that use mesh or biologic grafts?*

Surgeons who perform POP surgery with biologic grafts or synthetic mesh grafts should have training specifically for these procedures and should be able to counsel patients regarding the risk–benefit ratio for the use of mesh compared with native tissue repair. There are unique risks and complications associated with the use of mesh in surgeries to treat POP. Special training regarding patient selection, anatomy, surgical technique, postoperative care, and management of complications is necessary for physicians

who perform POP surgery using mesh or biologic grafts (84, 90, 91). The American Urogynecologic Society has published guidelines for training and privileging for the performance of abdominal sacrocolpopexy and vaginal mesh prolapse surgery (92, 93).

▶ *Is it necessary to perform intraoperative cystoscopy during pelvic organ prolapse surgery?*

Routine intraoperative cystoscopy during POP surgery is recommended when the surgical procedure performed is associated with a significant risk of injury to the bladder or ureter. These procedures include suspension of the vaginal apex to the uterosacral ligaments, sacrocolpopexy, and anterior colporrhaphy and the placement of mesh in the anterior and apical compartments (94, 95).

Intraoperative cystoscopy is performed after completion of POP repair while the patient is still under anesthesia and should include a complete survey of the bladder and assessment of efflux of urine from the ureteral orifices. Identified issues such as no flow or reduced flow from the ureter or an injury to the bladder should be addressed intraoperatively. Delay in recognition of a urinary tract injury may lead to increased morbidity (96).

▶ *Are there effective pelvic organ prolapse surgical treatment methods available for women who prefer to avoid hysterectomy?*

Women who desire surgical treatment of POP may choose to avoid hysterectomy for a variety of reasons, including preservation of fertility, maintenance of body image, and beliefs about adverse effects on sexual function (97–99). Alternatives to hysterectomy for the surgical treatment of POP include hysteropexy (ie, uterine suspension) and Le Fort colpocleisis.

Hysteropexy

Hysteropexy is a viable alternative to hysterectomy in women with uterine prolapse, although there is less available evidence on safety and efficacy compared with hysterectomy (99). Hysteropexy may be performed through a vaginal incision by attaching the cervix to the sacrospinous ligament with sutures (100) or mesh (101). Hysteropexy also may be performed abdominally or laparoscopically by placing a mesh or biologic graft from the cervix to the anterior longitudinal ligament (99). Shortening the uterosacral ligaments laparoscopically with or without robotic assistance or by an abdominal incision also can be performed. A 2016 cohort study that compared laparoscopic sacral hysteropexy with vaginal mesh hysteropexy found that, at 1-year follow-up, the two procedures had similar efficacy and no significant differences in the rate of complications, blood loss, or length of hospitalization (101).

Benefits of hysteropexy compared with total hysterectomy include shorter operative time and a lower incidence of mesh erosion if mesh augmentation is used. In comparison, women with uterine prolapse who choose hysterectomy will have a lower risk of uterine and cervical cancer or any procedures that involve abnormalities of the cervix or uterus (eg, endometrial biopsy). They will not become pregnant and will not have uterine bleeding or pain.

Outcome data comparing hysterectomy with hysteropexy are not clear. In one study, vaginal hysterectomy for the treatment of stage II or greater POP was associated with a lower risk of recurrent prolapse than hysteropexy (100). However, in a randomized trial that compared sacrospinous hysteropexy with vaginal hysterectomy and uterosacral ligament vaginal vault suspension for stage 2 or greater POP, sacrospinous hysteropexy was found to be noninferior to vaginal hysterectomy (for anatomic recurrence of the apical compartment with bothersome bulge symptoms or repeat surgery for recurrent apical prolapse): sacrospinous hysteropexy 0% (n=0) versus vaginal hysterectomy 4.0% (n=4), a difference of −3.9% (95% CI, −8.6% to 0.79%) over 12 months (102). Longer-term follow-up on this cohort of women is needed. Another study that compared postoperative sexual function in women who underwent hysteropexy with women who underwent hysterectomy found no significant difference between the two groups (98). There is little information regarding pregnancy after uterine suspension (103).

Le Fort Colpocleisis

In women with POP who want to avoid hysterectomy or who have significant comorbidities and no longer desire vaginal coital function, a Le Fort colpocleisis is a therapeutic option. This is an effective treatment for POP with a high success rate and high patient satisfaction. However, patients should be counseled that this surgery is irreversible (77). For more information, see *Are surgical approaches available to treat pelvic organ prolapse in women with medical comorbidities*?)

▶ *Can the occurrence of stress urinary incontinence after surgery for pelvic organ prolapse be anticipated and avoided?*

All women with significant apical prolapse, anterior prolapse, or both should have a preoperative evaluation for occult stress urinary incontinence, with cough stress testing or urodynamic testing with the prolapse reduced (104). Some women will have a positive cough stress test result only when their POP is in the reduced position. Prolapse may obstruct the urethra or the urethra might kink from an anterior vaginal wall prolapse. This could mask stress urinary incontinence, which then may present after surgery. In

women with bothersome POP and current stress urinary incontinence symptoms, it is prudent to correct both disorders to reduce persistent or worsening stress incontinence after surgery. Because there is no single procedure that adequately treats POP and urinary incontinence, two procedures are done concomitantly. Thus, women with bothersome stress urinary incontinence who are undergoing POP surgery should consider having concomitant treatment for both disorders. The type of continence procedure often is selected based on the route of access for the prolapse repair (104).

Patients with POP but without stress urinary incontinence who are undergoing either abdominal or vaginal prolapse repair should be counseled that postoperative stress urinary incontinence is more likely without a concomitant continence procedure but that the risk of adverse effects is increased with an additional procedure (104). Burch colposuspension at the time of abdominal sacrocolpopexy and retropubic midurethral sling at the time of vaginal surgery for POP repair decrease the risk of postoperative stress urinary incontinence in women without preoperative stress urinary incontinence (104–106). In the CARE trial, women with no reported preoperative stress urinary incontinence who were undergoing open abdominal sacrocolpopexy for prolapse repair were randomized to receive concomitant Burch colposuspension or no continence procedure (105). Fewer women who underwent concomitant Burch colposuspension had postoperative stress incontinence compared with those who underwent sacrocolpopexy alone (34% versus 57%, $P<.001$). Similar results were found in the outcomes after the Vaginal Prolapse Repair and Midurethral Sling trial, which evaluated placement of a prophylactic midurethral sling at the time of vaginal prolapse surgery (106). Among the women who underwent prophylactic midurethral sling placement at the time of vaginal surgery, 24% developed stress urinary incontinence after surgery, compared with 49% in those who underwent only POP surgery.

In women undergoing vaginal POP surgery, the risks of complications from the stress urinary incontinence surgery should be weighed against the risk of postoperative stress urinary incontinence. Some practitioners favor a staged approach in which women undergo stress urinary incontinence surgery after POP surgery only if they develop stress urinary incontinence. For more information, see Practice Bulletin No. 155, *Urinary Incontinence in Women* (104).

▶ *What are the complications of pelvic organ prolapse surgery, and how are they managed?*

Complications after native tissue POP surgery include bleeding, infection (typically urinary tract) and voiding dysfunction (which usually is transient). Less common complications include rectovaginal or vesicovaginal fistula, ureteral injury, foreshortened vagina, or a restriction of the vaginal caliber (21, 75). In the Operations and Pelvic Muscle Training in the Management of Apical Support Loss trial, dyspareunia was noted in 16% of women 24 months after native tissue POP surgery (107). Changes in vaginal anatomy may lead to pelvic pain and pain with intercourse. Fistula and ureteral injury require prompt referral to specialists with expertise in managing these conditions. A short vagina or vaginal constriction after POP surgery often can be managed with vaginal estrogen and progressive dilators (108). If these management methods are not successful, referral to a specialist who is experienced with surgical correction of postoperative POP complications is recommended.

There are unique complications associated with synthetic mesh when they are used in POP surgery. These include mesh contracture and erosion into the vagina, urethra, bladder, and rectum. The rate of mesh erosion is approximately 12% after vaginal mesh prolapse surgery (41). When mesh is used for anterior vaginal wall prolapse repair, there is an 11% risk of mesh erosion, with 7% of these cases requiring surgical correction (89). The rate of dyspareunia is approximately 9% after vaginal mesh prolapse surgery (109). Multiple procedures often are required to manage mesh-related complications (110). Referral to an obstetrician–gynecologist with appropriate training and experience, such as a female pelvic medicine and reconstructive surgery specialist, is recommended for surgical treatment of prolapse mesh complications. For more information, see Committee Opinion No. 694, *Management of Mesh and Graft Complications in Gynecologic Surgery* (87).

▶ *How should recurrent pelvic organ prolapse be managed?*

Recurrence of POP is possible after any POP surgery. Recurrence rates between 6% and 30% have been reported (19). Women should be counseled about the risk of recurrence before undergoing POP surgery.

Women who present with recurrent POP should undergo counseling similar to that for women who present with primary POP. It is helpful to review the preoperative examination results and prior surgical reports. Many patients may choose not to undergo a repeat surgery. They may choose instead to monitor the prolapse or to use a pessary.

If a patient chooses to undergo surgery for recurrent vaginal apex prolapse, abdominal sacrocolpopexy, vaginal colpopexy with possible mesh or graft augmentation, or colpocleisis may be considered if the patient has failed a vaginal native tissue apical suspension. If the surgeon is not comfortable performing these procedures, referral of the patient to a surgeon who sub-specializes in pelvic reconstructive surgery and can offer these procedures is recommended.

Summary of Recommendations and Conclusions

The following recommendations and conclusions are based on good and consistent scientific evidence (Level A):

- Uterosacral and sacrospinous ligament suspension for apical POP with native tissue are equally effective surgical treatments of POP, with comparable anatomic, functional, and adverse outcomes.
- The use of synthetic mesh or biologic grafts in transvaginal repair of posterior vaginal wall prolapse does not improve outcomes.
- Compared with native tissue anterior repair, polypropylene mesh augmentation of anterior vaginal wall prolapse repair improves anatomic and some subjective outcomes but is associated with increased morbidity.

The following recommendations and conclusions are based on limited or inconsistent scientific evidence (Level B):

- Many women with POP on physical examination do not report symptoms of POP. Treatment is indicated only if prolapse is causing bothersome bulge and pressure symptoms, sexual dysfunction, lower urinary tract dysfunction, or defecatory dysfunction.
- Women considering treatment of POP should be offered a vaginal pessary as an alternative to surgery.
- Vaginal apex suspension should be performed at the time of hysterectomy for uterine prolapse to reduce the risk of recurrent POP.
- Abdominal sacrocolpopexy with synthetic mesh has a lower risk of recurrent POP but is associated with more complications than vaginal apex repair with native tissue.
- Obliterative procedures—which narrow, shorten, or completely close the vagina—are effective for the treatment of POP and should be considered a first-line surgical treatment for women with significant medical comorbidities who do not desire future vaginal intercourse or vaginal preservation.
- The use of synthetic mesh or biologic grafts in POP surgery is associated with unique complications not seen in POP repair with native tissue.
- Hysteropexy is a viable alternative to hysterectomy in women with uterine prolapse, although there is less available evidence on safety and efficacy compared with hysterectomy.

The following recommendations are based primarily on consensus and expert opinion (Level C):

- A POP-Q examination is recommended before treatment for the objective evaluation and documentation of the extent of prolapse.
- A pessary should be considered for a woman with symptomatic POP who wishes to become pregnant in the future.
- Pelvic organ prolapse vaginal mesh repair should be limited to high-risk individuals in whom the benefit of mesh placement may justify the risk, such as individuals with recurrent prolapse (particularly of the anterior or apical compartments) or with medical comorbidities that preclude more invasive and lengthier open and endoscopic procedures. Before placement of synthetic mesh grafts in the anterior vaginal wall, patients should provide their informed consent after reviewing the benefits and risks of the procedure and discussing alternative repairs.
- Surgeons who perform POP surgery with biologic grafts or synthetic mesh grafts should have training specifically for these procedures and should be able to counsel patients regarding the risk–benefit ratio for the use of mesh compared with native tissue repair.
- Routine intraoperative cystoscopy during POP surgery is recommended when the surgical procedure performed is associated with a significant risk of injury to the bladder or ureter. These procedures include suspension of the vaginal apex to the uterosacral ligaments, sacrocolpopexy, and anterior colporrhaphy and the placement of mesh in the anterior and apical compartments.
- All women with significant apical prolapse, anterior prolapse, or both should have a preoperative evaluation for occult stress urinary incontinence, with cough stress testing or urodynamic testing with the prolapse reduced.
- Patients with POP but without stress urinary incontinence who are undergoing either abdominal or vaginal prolapse repair should be counseled that postoperative stress urinary incontinence is more likely without a concomitant continence procedure but that the risk of adverse effects is increased with an additional procedure.

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The MEDLINE database, the Cochrane Library, and the American College of Obstetricians and Gynecologists' own internal resources and documents were used to conduct a literature search to locate relevant articles published between January 2000 and October 2016. The search was restricted to articles published in the English language. Priority was given to articles reporting results of original research, although review articles and commentaries also were consulted. Abstracts of research presented at symposia and scientific conferences were not considered adequate for inclusion in this document. Guidelines published by organizations or institutions such as the National Institutes of Health and the American College of Obstetricians and Gynecologists were reviewed, and additional studies were located by reviewing bibliographies of identified articles. When reliable research was not available, expert opinions from obstetrician–gynecologists were used.

Studies were reviewed and evaluated for quality according to the method outlined by the U.S. Preventive Services Task Force:

- I Evidence obtained from at least one properly designed randomized controlled trial.
- II-1 Evidence obtained from well-designed controlled trials without randomization.
- II-2 Evidence obtained from well-designed cohort or case–control analytic studies, preferably from more than one center or research group.
- II-3 Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments also could be regarded as this type of evidence.
- III Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

Based on the highest level of evidence found in the data, recommendations are provided and graded according to the following categories:

Level A—Recommendations are based on good and consistent scientific evidence.

Level B—Recommendations are based on limited or inconsistent scientific evidence.

Level C—Recommendations are based primarily on consensus and expert opinion.

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EXHIBIT 13

EXHIBIT 13

Physician Sexual Misconduct

Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct

Adopted as policy by the Federation of State Medical Boards
May 2020

Section 1: Introduction and Workgroup Charge

The relationship between a physician and patient is inherently imbalanced. The knowledge, skills and training statutorily required of all physicians puts them in a position of power in relation to the patient. The patient, in turn, often enters the therapeutic relationship from a position of vulnerability due to illness, suffering, and a need to divulge deeply personal information and subject themselves to intimate physical examination. This vulnerability is further heightened in light of the patient's trust in their physician, who has been granted the power to deliver care, prescribe needed treatment and refer for appropriate specialty consultation.

It is critical that physicians act in a manner that promotes mutual trust with patients to enable the delivery of quality health care. When there is a violation of that relationship through sexual misconduct, such behavior and actions can have a profound, enduring and traumatic impact on the individual being exploited, their family, the public at large, and the medical profession as a whole. Properly and effectively addressing sexual misconduct by physicians through sensible standards and expectations of professionalism, including preventive education, as well as through meaningful disciplinary action and law enforcement when required, is therefore a paradigmatic expression of self-regulation and its more modern iteration, shared regulation.

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 (hereafter referred to as "the Workgroup"), and charged its members 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 state 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 state 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.

In carrying out its charge, the Workgroup adopted a broad lens with which to scrutinize not only the current practices of state medical boards and other professional regulatory authorities in the United States and abroad, but also elements of professional culture within American medicine, including notions of professionalism, expectations related to reporting instances of misconduct or

impropriety, evolving public expectations of the medical profession, and the impact of trauma on survivors of sexual misconduct. In analyzing these issues, the Workgroup benefited tremendously from discussions with several of the FSMB's partner organizations and stakeholders that also have a role in addressing the issue of physician sexual misconduct. 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. This report has been enriched by these partners' valuable contributions.

A call for cultural change

The Workgroup acknowledged the importance of the environment and culture, from medical school to practice, for the development of and commitment to positive professional values and behaviors in medicine. In this regard, the Workgroup also acknowledged the existence of several highly problematic aspects of sexual misconduct in medical education and practice, many of which permeate the prevailing culture of medicine and self-regulation. The National Academies of Sciences report that organizational culture plays a primary role in enabling harassment and that sexually harassing behaviors are not typically isolated incidents.[1] Medical students and trainees who are subjected to environments in which harassment is accepted suffer not only as victims, but may also be undermined in their educational and professional attainment, resulting in loss of talent for the profession. To the extent that a culture that is permissive of sexual harassment results in perceived license to engage in such conduct oneself, patients are ultimately put at risk of dire consequences. Permissive environments could also reduce the likelihood that bystanders will feel responsibility to report misconduct.

Beyond the many instances, both reported and unreported, of sexual assault and boundary violations, concerns about sexual misconduct in medicine include various aspects of the investigative and adjudicatory processes designed to address them; the professional responsibility of health care practitioners to report suspected instances of sexual misconduct and patient harm; variation in state medical board policies and processes, as well as in state laws; transparency of state medical board processes and actions; a widespread need for education and training among medical regulators, board investigators, attorneys, and law enforcement personnel about trauma and how it might impact complainant accounts and the investigative process; and challenges posed for decisions about re-entry to practice and remediation.

This report summarizes these problematic elements so that they may be more widely appreciated, while offering potential solutions and strategies for state medical boards to consider for their

[1] National Academies of Sciences, Engineering, and Medicine. 2018. *Sexual Harassment of Women: Climate, Culture, and Consequences in Academic Sciences, Engineering, and Medicine*. Washington, DC: The National Academies Press. doi: https://doi.org/10.17226/24994.

jurisdictions. It aspires to provide best practice recommendations and highlight existing strategies and available tools to allow boards, including board members, executive directors, staff, and attorneys, to best protect the public while working within their established frameworks and resources. The report also advocates for an educational focus to change and improve culture, awareness, and behaviors across the continuum of medical education and practice, so as to improve care for and protection of patients.

Section 2: Principles

The analysis in this report is informed by the following principles:

- **Trust**: The physician-patient relationship is built upon trust, understood as a confident belief on the part of the patient in the moral character and competence of their physician.[2] In order to safeguard this trust, the physician must act and make treatment decisions that are in the best interests of the patient at all times.
- **Professionalism**: The avoidance of sexual relationships with patients has been a principle of professionalism since at least the time of Hippocrates. Professional expectations still dictate today that sexual contact or harassment of any sort between a physician and patient is unacceptable.
- **Fairness**: The principle of fairness applies to victims (also sometimes described as survivors) of sexual misconduct, who must be granted fair treatment throughout the regulatory process and be afforded opportunities to seek justice for wrongful conduct committed against them. Fairness also applies to physicians who are subjects of complaints in that they must be granted due process in investigative and adjudicatory processes; proportionality should be considered in disciplinary actions.
- **Transparency**: The actions and processes of state medical boards are designed in the public interest to regulate the medical profession and protect patients from harm. As such, the public has a right to information about these processes and the bases of regulatory decisions.

Section 3: Terminology:

Sexual Misconduct:

For the purposes of this report, physician sexual misconduct is understood as behavior that exploits the physician-patient relationship in a sexual way. Sexual behavior between a physician and a patient is never diagnostic or therapeutic. This behavior may be verbal or physical, can occur in person or virtually,[3] and may include expressions of thoughts and feelings or gestures that are of a sexual nature or that a patient or surrogate[4] may reasonably construe as sexual. Hereinafter, the term "patient" includes the patient and/or patient surrogate.

[2] Beauchamp T and Childress J., (2001) *Principles of Biomedical Ethics*, 5th ed., 34.
[3] Federation of State Medical Boards, *Social Media and Electronic Communication*, 2019.
[4] Surrogates are those individuals closely involved in patients' medical decision-making and care and include spouses or partners, parents, guardians, and/or other individuals involved in the care of and/or decision-making for the patient.

Physician sexual misconduct often takes place along a continuum of escalating severity. This continuum comprises a variety of behaviors, sometimes beginning with "grooming" behaviors which may not necessarily constitute misconduct on their own, but are precursors to other, more severe violations. Grooming behaviors may include gift-giving, special treatment, sharing of personal information or other acts or expressions that are meant to gain a patient's trust and acquiescence to subsequent abuse.[5] When the patient is a child, adolescent or teenager, the patient's parents may also be groomed to gauge whether an opportunity for sexual abuse exists.

More severe forms of misconduct include sexually inappropriate or improper gestures or language that are seductive, sexually suggestive, disrespectful of patient privacy, or sexually demeaning to a patient. These may not necessarily involve physical contact, but can have the effect of embarrassing, shaming, humiliating or demeaning the patient. Instances of such sexual impropriety can take place in person, online, by mail, by phone, and through texting.

Additional examples of sexual misconduct involve physical contact, such as performing an intimate examination on a patient with or without gloves and without clinical justification or explanation of its necessity, and without obtaining informed consent.

The severity of sexual misconduct increases when physical contact takes place between a physician and patient and is explicitly sexual or may be reasonably interpreted as sexual, even if initiated by the patient. So-called "romantic" behavior between a physician and a patient is never appropriate, regardless of the appearance of consent on the part of the patient. Such behavior would at least constitute grooming, depending on the nature of the behavior, if not actual sexual misconduct, and should be labeled as such.

The term "sexual assault" refers to any type of sexual activity or contact without consent (such as through physical force, threats of force, coercion, manipulation, imposition of power, etc., or circumstances where a person lacks the capacity to provide consent due to age or other circumstances) and may be used in investigations where there is a need to emphasize the severity of the misconduct and related trauma. Sexual assault is a criminal or civil violation and should typically be handled in concert with law enforcement. Sexual assault should be reported to law enforcement immediately, except in cases where reporting would contravene the wishes of an adult complainant and non-reporting in such an instance is permitted by applicable state law.

While the legal term "sexual boundary violation" is a way of denoting the breach of an imaginary line that exists between the doctor and patient or surrogate, and is commonly used in medical regulatory discussions, the members of the Workgroup felt that it was an overly broad term that may encompass everything from isolated instances of inappropriate communication to sexual misconduct and outright sexual assault. Thus, this report avoids the term in favor of more specific terms.

[5] American Academy of Pediatrics "Protecting Children from Sexual Abuse by Health Care Providers," Committee on Child Abuse and Neglect, 2010-2011, Published in *Pediatrics*, August 2011, Vol. 128, Issue 2.

Trauma:

For the purposes of this report, the definition of trauma provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) is used:

"Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."[6]

According to SAMHSA, "a program, organization, or system that is *trauma-informed* realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization."[7]

Patient:

A patient is understood as an individual with whom a physician is involved in a care and treatment capacity within a legally defined and professional physician-patient relationship.

Physician:

While this report primarily addresses physician licensees, the content and recommendations should be viewed as applying to all health professionals licensed by member boards of the FSMB, as well as other members of the health care team, including medical students.

Section 4: Patient Rights and Expectations for Professional Conduct in the Physician-Patient Encounter

Communication and Patient Education

Communication between a physician and patient should occur throughout any examination or procedure (provided the patient is not under general anesthetic during the procedure), including conveying the medical necessity, what the examination or procedure will involve, any discomfort the patient might experience, the benefits and risks, and any findings. This is especially important during the performance of an intimate examination. This not only lays out the parameters of the interaction for both parties; it may also help minimize the possibility that the patient will misinterpret the physician's actions.

[6] Substance Abuse and Mental Health Services Administration. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
[7] *Id*. Emphasis added.

The use of educational resources to educate patients about what is normal and expected during medical examinations and procedures is encouraged and should be provided by both physicians and state medical boards.

Informed Consent and Shared Decision-Making

The informed consent process can be a useful way of helping a patient understand the intimate nature of a proposed examination, as well as its medical necessity. The informed consent process should include, at a minimum, an explanation, discussion, and comparison of treatment options with the patient, including a discussion of any risks involved with proposed procedures; an assessment of the patient's values and preferences; arrival at a decision in partnership with the patient; and an evaluation of the patient's decision in partnership with the patient. This process must be documented in the patient's medical record.

Where possible, the consent process should take place well in advance of any procedure so that the patient has an opportunity to consider the proposed procedure in the absence of competing considerations about cancellation or rescheduling. Requiring decisions at the point of care puts patients at a disadvantage because they may not have time to consider what is being proposed and what it means for themselves and their values. However, it is recognized that obtaining consent well in advance is not always possible for urgent, emergency, or same-day procedures. The consent process should also include information about the effects of anaesthesia, including the possibility of amnesia, because these can be particularly problematic with respect to sexual misconduct. Use of understandable (lay, or common) language during the consent process is essential.

In instances where a patient is unable to provide consent to a pelvic or otherwise intimate examination due to the presence of anesthesia or for any other reason, an intimate examination should only be performed when it is medically necessary. Intimate examinations must never be performed for purely educational purposes when consent cannot be obtained.

Section 5: Complaints and the Duty to Report

In order for state medical boards to effectively address instances of sexual misconduct, they must have access to relevant information about licensees that have harmed or pose a significant risk of harming patients. The complaints process and physicians' professional duty to report instances of sexual misconduct are therefore central to a regulatory board's ability to protect patients.[8]

Complaints and Barriers to Complaints

It is essential for patients or their surrogates to be able to file complaints about their physicians to state medical boards in order that licensees who pose a threat to patients may be investigated and appropriate action taken. However, studies have estimated that sexual misconduct by physicians

[8] Additional reporting to entities other than state medical boards may also be warranted for purposes of patient protection, including law enforcement, hospital or medical staff administration, and medical school or residency program directors and supervisors.

is significantly under reported, and several challenges which may dissuade patients from filing complaints must be overcome.[9] These include distrust in the ability or willingness of institutions such as state medical boards, hospitals and other health care organizations to take action in instances of sexual misconduct; fear of abandonment or retaliation by the physician; societal or personal factors related to stigma, shame, embarrassment and not wanting to relive a traumatic event; a lack of awareness about the role of state medical boards and how to file complaints; or uncertainty that what has transpired is, indeed, unprofessional and unethical.

State medical boards can play an important role in providing clarity about the complaints process by providing information to the public about the process itself and how, why, and when to file a complaint. Recommended methods for optimizing the complaints process include:

- Providing the option to file complaints via multiple channels, including in writing, by telephone, email, or through online forms
- Making the process accessible to patients with information about filing complaints that is clearly posted on state medical board websites
- Ensuring that information about the complaints process is made available via translation for complainants who do not speak English

State medical boards, the FSMB and its partner organizations representing medical specialties whose members perform intimate examinations and procedures may also wish to provide education for patients on topics such as:

- The types of behavior that should be expected of physicians
- Types of behavior that might warrant a complaint
- What to do in the event that a physician's actions make a patient uncomfortable
- Circumstances that would warrant a report directly to law enforcement

State medical boards can also restore public trust and confidence in the complaints process by demonstrating swift and appropriate action on verified complaints.

The ability to file a complaint anonymously may be especially important in instances of sexual misconduct. The trauma and fear associated with sexual misconduct can pose barriers to legitimate complaints, especially when anonymity is not granted. While the ability of complainants to remain anonymous to the general public is recommended, complainant anonymity to the state medical board may not be possible.

State medical boards should address complaints related to sexual misconduct as quickly as possible for the benefit and protection of the complainant and other patients. Initial stages of investigations should be expedited to determine whether there is a high likelihood of imminent risk to the public, meriting steps to modify or cease practice while the investigation is completed.

[9] Dubois J, et al. Sexual Violation of Patients by Physicians: A Mixed-Methods, Exploratory Analysis of 101 Cases. *Sexual Abuse* 2019, Vol. 31(5) 503–523

State medical board staff and board investigators of administrative complaints are encouraged to communicate frequently with complainants throughout the complaint and investigative processes and to ask complainants about their preferred mode and frequency of communication, as well as their expectations from the process. Where possible, boards should consider having a patient liaison or navigator on staff who would be specially trained to provide one-on-one support to complainants and their families.

Duty to Report

In a complaint-based medical regulatory system, it is imperative that state medical boards have access to the information they require to effectively protect patients.[10] In addition to a robust complaints process, it is therefore essential that patients, physicians and everyone involved in healthcare speak up whenever something unusual, unsafe or inappropriate occurs. All members of the healthcare team, as well as institutions, including state medical boards, hospitals and private medical clinics also have a legal as well as an ethical duty to report instances of sexual misconduct and other serious patient safety issues and events. This duty extends beyond physician-patient encounters to reporting inappropriate behavior in interactions with other members of the healthcare team, and in the learning environment.

Early reporting of sexual misconduct is critical. This includes reporting of those forms of misconduct at the less egregious end of the spectrum that fall under potential grooming behaviors. Evidence indicates that less egregious violations that go unreported frequently lead to more egregious ones. Less egregious acts and grooming behaviors are almost always committed in private or after hours where they cannot be witnessed by parties external to the physician-patient encounter and therefore go unreported. Early reporting is therefore one of the only ways in which sexual misconduct with patients can be prevented from impacting more patients.

The ethical duty to report has proven insufficient in recent years, however, to provide the information state medical boards must have to stop or prevent licensees from engaging in sexual misconduct. There are likely several factors that inhibit reporting, including the corporatization of medical practice, which has led many institutions to deal with instances of misconduct internally. While corporatization increases accountability for many physicians and internal processes may be effective in addressing some types of sexual misconduct, it can also cause some institutions to neglect required reporting and the need for transparency. Physicians may also avoid reporting because of the moral distress and discomfort some physicians feel when asked to report their colleagues, and the impracticality of reporting where power dynamics exist and where stakes are high for reporters.

Thus, rather than relying on professional or ethical duties alone, alternative strategies and approaches should be considered. 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. An ability to publicize reasons for levying fines may also be helpful as the reputational risk to an institution could provide added incentives to report.

[10] Federation of State Medical Boards, *Position Statement on Duty to Report*, 2016.

Results of hospital and health system peer review processes should also be shared with state medical boards when sexual misconduct is involved. This type of conduct is fundamentally different from other types of peer review data related to performance and aimed at quality improvement and, while still relevant to medical practice, should be subject to different rules regarding reporting. Hospitals should also be required to report to state medical boards instances where employed physicians have been dismissed or are forced to resign due to concerns related to sexual misconduct.

Boards should have the authority to impose disciplinary action on licensees for failure to report. Where such authority does not currently exist, legislative change may be sought.[11] Language used in state laws describing when reporting is mandatory varies and can include "actual knowledge" of an event, "reasonable cause" to believe that an event occurred, "reasonable belief," "first-hand knowledge," and "reasonable probability" (as distinguished from "mere probability").[12] Despite the variance in language, the theme of reasonability runs throughout. If it is reasonable to believe that misconduct occurred, this should be reported to the state medical board and, in most instances, to law enforcement.

Reporting to Law Enforcement

There is variability in state laws that address when state medical boards are required to report instances of sexual misconduct to law enforcement. Despite this variability, best practices dictate that boards have a duty to report to law enforcement anytime they become aware of sexual misconduct or instances of criminal behavior. When reporting requirements are unclear, consultation with a board attorney is recommended, but boards are encouraged to err on the side of reporting. Protocols and consensus can also be established in collaboration with law enforcement to help clarify reporting requirements. This can also help to clarify circumstances where law enforcement should report instances of physician sexual misconduct to state medical boards.

In limited circumstances, boards may choose not to report to law enforcement. These may involve less egregious forms of sexual misconduct such as inappropriate speech or include circumstances where a complainant requests that law enforcement not be notified, as long as there is no law establishing a mandatory reporting requirement. Wishes of complainants should be respected in such circumstances, as victims may be at different stages of coming to terms with the trauma they've experienced. However, reporting to law enforcement must occur for any instance of child abuse, abuse of a minor, and abuse of a dependent adult, regardless of whether the complainant wants reporting to occur. In any instance where reporting sexual misconduct to law enforcement is considered, especially in instances where a decision is made *not* to report, a clear rationale for the board's decision should be documented. Boards can also facilitate the reporting process for patients by offering assistance or educational resources about the reporting process and relevant contact information.

[11] See, e.g., N.C. Gen. Stat. § 90-5.4
[12] Starr, Kristopher T Reporting a Physician Colleague for Unsafe Practice: What's the Law? *Nursing2019*: February 2016 - Volume 46 - Issue 2 - p 14

Cultivating Professionalism

Empowering physicians and physicians in training to report violations of professional standards is essential given the barriers posed by the hierarchical structure of most health care institutions.[13] Those in a position to observe and report sexual misconduct should be protected from retaliation and adverse consequences for medical school matriculation, training positions, careers or promotions. Cultivating positive behavior through role modelling and establishing clear guidance based on the values of the profession is the responsibility of multiple parties, not the state medical board alone. A broader notion of professionalism should be adopted that goes beyond expectations for acceptable conduct to include a duty to identify instances of risk or harm to patients, thereby making non-reporting professionally unacceptable. 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.

Unscrupulous, frivolous or vexatious reporting motivated by competition or personal animus is counterproductive to fulfilling this notion of professionalism and protecting the public, so should be met with disciplinary action. Processes for reporting and complaints should be normalized by making them a core component of medical professionalism, rather than a burdensome responsibility that befalls particular unfortunate individuals. This may help physicians feel less like investigators and more like responsible stewards of professional values. Those physicians and other individuals who do report in good faith should be protected from retaliation through whistleblower legislation and given the option to remain anonymous.

Section 6: Investigations

State Medical Board Authority

It is imperative that state medical boards have sufficient statutory authority to investigate complaints and any reported allegations of sexual misconduct. State medical boards should place a high priority on the investigation of complaints of sexual misconduct due to patient vulnerability unique to such cases. The purpose of the investigation is to determine whether the report can be substantiated in order to collect sufficient facts and information for the board to make an informed decision as to how to proceed. If the state medical board's investigation indicates a reasonable probability that the physician has engaged in sexual misconduct, the state medical board should exercise its authority to intervene and take appropriate action to ensure the protection of the patient and the public at large.

Each complaint should be investigated and judged on its own merits. Where permitted by state law, the investigation should include a review of previous complaints to identify any such patterns of behavior, including malpractice claims and settlements. In the event that such patterns are identified early in the investigation, or the physician has been the subject of sufficient previous complaints to suggest a high likelihood that the physician presents a risk to future

[13] Dubois J. et al. Preventing Egregious Ethical Violations in Medical Practice, Evidence-Informed Recommendations from a Multidisciplinary Working Group. *Journal of Medical Regulation* 2018, Vol.104(4), 23-31.

patients, or in the event of evidence supporting a single egregious misconduct event, the state medical board should have the authority to impose terms or limitations, including suspension, on the physician's license prior to the completion of the investigation.

The investigation of all complaints involving sexual misconduct should include interviews with the physician, complainant(s) and/or patient and/or patient surrogate. The investigation may include an interview with a current or subsequent treating practitioner of the patient and/or patient surrogate; colleagues, staff and other persons at the physician's office or worksite; and persons that the patient may have told of the misconduct. Physical evidence and police reports can also be valuable in providing a more complete understanding of events.

In many states, a complaint may not be filed against a physician for an activity that occurred beyond a certain time threshold in the past. There is a growing trend among state legislatures in recent years to extend or remove the statute of limitations in cases of rape, sexual assault and other forms of sexual misconduct. Given the impact that trauma can have on a victim of sexual misconduct, the length of time that it may take to understand that a violation has occurred, to come to terms with it, or be willing to relive the circumstances as part of the complaints process, the members of the Workgroup feel that no limit should be placed on the amount of time that can elapse between when an act of misconduct occurred and when a complaint can be filed.

Trauma-Informed Investigations

Because of the delicate nature of complaints of sexual misconduct and the potential trauma associated with it, state medical boards should have special procedures in place for interviewing and interacting with such complainants and adjudicating their cases. In cases involving trauma, emotions may not appear to match the circumstances of the complaint, seemingly salient details may be unreported or unknown to the complainant, and the description of events may not be recounted in linear fashion. Symptoms of trauma may therefore be falsely interpreted as signs of deception by board investigators or those adjudicating cases.

Professionals who are appropriately trained and certified in the area of sexual misconduct and victim trauma should conduct the state medical board's investigation and subsequent intervention whenever possible. Best practices in this area suggest that board members and staff should undergo specialized training in victim trauma. It is further recommended that all board staff who work with complainants in cases involving sexual misconduct undergo this training to develop an understanding of how complainants' accounts in cases involving trauma can differ from other types of cases. This can inform reasonable expectations on behalf of those investigating and adjudicating these cases and help eliminate biases. The FSMB and state medical boards should work to identify and ensure the availability of high-quality training in trauma and a trauma-informed approach to investigations. While a greater understanding of victim trauma is a priority, additional training in implicit bias related to gender, gender identity, race, and ethnicity would also help ensure fair and comfortable processes for victims.

Where state medical boards have access to investigators of different genders, boards should seek the complainant's preference regarding the gender of investigators and assign them accordingly. State medical boards should also allow inclusion of patient advocates in the interview process

and treat potential victims (survivors) with empathy, humanity, and in a manner that encourages healing. Questioning of both complainants and physicians should take the form of an information-gathering activity, not an aggressive cross-examination.

Section 7: Comprehensive Evaluation

State medical boards regularly use diagnostic evaluations for health professionals who may have a physical or mental impairment. Similarly, the use of diagnostic evaluations when handling a complaint regarding sexual misconduct provides significant information that may not otherwise be revealed during the initial phase of the investigation. A comprehensive evaluation may be valuable to the board's ability to assess future risk to patient safety.

A comprehensive evaluation is not meant to determine findings of fact. Rather, its purpose is to:

- assess and define the nature and scope of the physician's behavior,
- identify any contributing illness, impairment, or underlying conditions that may have predisposed the physician to engage in sexual misconduct or that might put future patients at risk,
- assist in determining whether a longstanding maladaptive pattern of inappropriate behavior exists, and
- make treatment recommendations if rehabilitative potential is established.

If its investigation reveals a high probability that sexual misconduct has occurred, the state medical board should have the authority to order an evaluation of the physician and the physician must be required to consent to the release to the board all information gathered as a result of the evaluation. The evaluation of the physician follows the investigation/intervention process but precedes a formal hearing.

The evaluation of a physician for sexual misconduct is complex and may require a multidisciplinary approach. Where appropriate, it should also include conclusions about fitness to practice.

Section 8: Hearings

Following investigation and evaluation (if appropriate), the state medical board should determine whether sufficient evidence exists to proceed with formal charges against the physician. In most jurisdictions, initiation of formal charges is public and will result in an administrative hearing unless the matter is settled.

Initiation of Charges

In assessing whether sufficient evidence exists to support a finding that sexual misconduct has occurred, corroboration of a patient's testimony should not be required. Although establishing a pattern of sexual misconduct may be significant, a single case is sufficient to proceed with a

formal hearing. State medical boards should have the authority to amend formal charges to include additional complainants identified prior to the conclusion of the hearing process.

Open vs Closed Hearings

If state medical boards are required, by statute, to conduct all hearings in public, including cases of sexual misconduct, many patients may be hesitant to come forward in a public forum and relate the factual details of what occurred. State medical boards should have the statutory authority to close the hearing during testimony which may reveal the identity of the patient. Where closing a hearing is not possible, great care should be taken to deidentify any personally identifying or sensitive information in transcripts and medical records. The decision to close the hearing, in part or in full, should be at the discretion of the board. Neither the physician nor the witness should control this decision. Boards should allow the patient the option of having support persons available during both open and closed hearings.

Patient Confidentiality

Complaints regarding sexual misconduct are highly sensitive. Therefore, enhanced attention must be given to protecting a patient's identity, including during board discussion, so that patients are not discouraged from coming forward with legitimate complaints against physicians. State medical boards should have statutory authority to ensure nondisclosure of the patient's identity to the public. This authority should include the ability to delete from final public orders any patient identifiable information.

Testimony

Sexual misconduct cases involve complex issues; therefore, state medical boards may consider the use of one or more expert witnesses to fully develop the issues in question and to define professional standards of care for the record. Additionally, the evaluating/treating physician or mental health care practitioners providing assessment and/or treatment to the respondent physician may be called as witnesses. The evaluating clinician may provide details of treatment, diagnosis and prognosis, especially the level of insight and change by the practitioner. Also, a current or subsequent treating practitioner of the patient, especially a mental health provider, may be called as a witness. All these witnesses may provide insight into factors that led to the alleged sexual misconduct, an opinion regarding the level of harm incurred by the patient, and describe the physician's rehabilitative potential and risk for recidivism.

Implicit Bias

In any case that comes before a state medical board, it is important for those responsible for adjudicating the case to be mindful of any personal bias that may impact their review and adjudication. Bias can be particularly strong where board members themselves have been victims of sexual assault or have been subject to previous accusations regarding sexual misconduct. Bias may even influence the decisions of state medical board members by virtue of their being

physicians themselves. Training about implicit bias is recommended for board members and staff in order to help identify implicit bias and mitigate the impact it may have on their work.[14]

Diverse representation on state medical boards in terms of gender, age, and ethnicity is important for ensuring balanced discussion and decisions. The inclusion of public members on state medical boards can also contribute to the reduction of bias in adjudication, while also amplifying the patient perspective through commitment to the priorities and interests of the public.[15] In order to ensure effective and meaningful participation from public members, appropriate orientation and education about their role should occur.

Section 9: Discipline

State medical boards have a broad range of disciplinary responses available to them that are designed to protect the public. Upon a finding of sexual misconduct, the board should take appropriate action and impose one or more sanctions reflecting the severity of the conduct and potential risk to patients. Essential elements of any board action include a list of mitigating and aggravating factors, an explanation of the violation in plain language, clear and understandable terms of the sanction, and an explanation of the consequences associated with non-compliance.

Findings of even a single case of sexual misconduct are often sufficiently egregious as to warrant revocation of a physician's medical license. Certain serious forms of unprofessional conduct should presumptively provide the basis for revocation of a license in order to protect the public. Misconduct in this class would include sexual assault, conduct amounting to crimes related to sex, regardless of whether charged or convicted, or egregious acts of a sexual nature. State medical boards should also consider revocation in instances where a physician has repeatedly committed lesser acts, especially following remedial efforts.

In a limited set of instances, state medical boards may find that mitigating circumstances do exist and, therefore, stay the revocation and institute terms and conditions of probation or other practice limitations. If a physician is permitted to remain in practice and gender- or age-based restrictions are used by state medical boards, consideration may also be given to coupling these restrictions with additional regulatory interventions such as education, monitoring or other forms of probation.

In determining an appropriate disciplinary response, the board should consider the factors listed in **Table 1**.

[14] Project Implicit, accessed November 13, 2019 at https://implicit harvard edu/implicit/
[15] Johnson DA, Arnhart KL, Chaudhry HJ, Johnson DH, McMahon GT, The Role and Value of Public Members in Health Care Regulatory Governance *Acad Med*, Vol. 94, No. 2 / February 2019

Table 1: Considerations in determining appropriate disciplinary response	
• Patient Harm[16] • Severity of impropriety or inappropriate behavior • Context within which impropriety occurred • Culpability of licensee • Psychotherapeutic relationship • Existence of a physician-patient relationship • Scope and depth of the physician-patient relationship • Inappropriate termination of physician-patient relationship	• Age and competence of patient • Vulnerability of patient • Number of times behavior occurred • Number of patients involved • Period of time relationship existed • Evaluation/assessment results • Prior professional misconduct/disciplinary history/malpractice • Recommendations of assessing/treating professional(s) and/or state physician health program • Risk of reoffending

Boards should not routinely consider romantic involvement, patient initiation or patient consent to be a legal defense. Sexual misconduct may still occur following the termination of a physician-patient relationship, especially in long-standing relationships or ones that involve a high degree of emotional dependence. Time elapsed between termination of the relationship is insufficient in many contexts to determine that sexual contact is permissible. Other factors that should be considered in assessing the permissibility of consensual sexual contact between consenting adults following the termination of a physician-patient relationship can include documentation of formal termination; transfer of the patient's care to another health care provider; the length of time of the professional relationship; the extent to which the patient has confided personal or private information to the physician; the nature of the patient's health problem; and the degree of emotional dependence and vulnerability.[17] Termination of a physician-patient relationship for the purposes of allowing sexual contact to occur is unacceptable and would still constitute sexual misconduct because of the trust, inherent power imbalance between a physician and patient, and patient vulnerability that exist leading up to, during and following the decision to terminate the relationship. Any consent to sexual or

[16] Broadly understood as inclusive of physical and emotional harm, resulting distrust in the medical system and avoidance of future medical treatment, and other related effects of trauma.
[17] Washington Medical Commission, *Guideline on Sexual Misconduct and Abuse*, 2017.

romantic activity provided by a patient within the context of a physician-patient relationship or immediately after its termination should be considered invalid.

Society's values and beliefs evolve, and some individuals may be slower to abandon long-held beliefs, even where these may be sexist or prejudiced in other ways. However, adherence to an outdated set of generational values that has since been found to be unacceptable is not a reason to overlook or excuse sexual misconduct.

The potential existence of a physician workforce shortage or maldistribution, or arguments related to particular restrictions being tantamount to taking a physician "out of work" should also not be used as reasons for leniency or for allowing patients to remain in harm's way. In cases involving sexual misconduct, it is simply not true that unsafe or high-risk care is better than no care at all. A single instance, let alone many instances, can cause an extremely high degree of damage to individuals and the communities in which they reside. However, staying true to the principle of proportionality also means considering the fact that some forms of discipline, including public notifications, generate significant shame upon the disciplined physician. This can compound the degree of severity of a disciplinary action and may be taken into consideration by state medical boards where less egregious forms of sexual impropriety are involved.

Temporary or Interim Measures:

In the event that a state medical board decides to remove a licensee from practice or limit the practice of a licensee as a temporary measure in order to reduce the risk of patient harm while an investigation takes place, there are several different interim measures that can be used. Common measures include an interim or summary suspension/cessation of practice, restrictions from seeing patients of a certain age or gender, restrictions from seeing patients altogether, or the mandatory use of a practice monitor (to be understood as distinct from a chaperone, as explained below) for all patient encounters.

The appropriateness of age and gender-based interim restrictions should be considered carefully before being imposed by state medical boards. Sexual misconduct often occurs for reasons related to power, rather than because of a sexual attraction to a particular gender or age group, thereby making these restrictions ineffective to protect patients in many cases.

Remediation

As discussed above, many forms of sexual misconduct and harmful actions that run against the core values of medicine should appropriately result in revocation of licensure. However, there may be some less egregious forms of sexual impropriety with mitigating circumstances for which a physician may be provided the option of participating in a program of remediation to be able to re-enter practice or have license limitations lifted following a review and elapse of an appropriate period of time.

The decision to allow a physician who has committed an act of sexual misconduct the opportunity to undergo a program of remediation with an end goal of potential license reinstatement is difficult for boards to make. Boards are therefore encouraged to draw from the

professional resources that already exist in making determinations about remediation potential and license reinstatement.

State medical boards should be mindful that not all physicians who have committed sexual misconduct are capable of remediation. Reinstatement and monitoring in such a context would therefore be inappropriate. For those who are considered for remediation, if at any point it becomes clear that the physician presents a risk of reoffending or otherwise harming patients, the remediation process should be abandoned, and reinstatement should not occur.

In determining whether remediation is feasible for a particular physician, state medical boards may wish to make use of a risk stratification methodology that considers the severity of actions committed, the mitigating and aggravating factors listed in section 9 above (Discipline), the character of the physician, including insight and remorse demonstrated, as well as an understanding of how their actions violated standards of professional ethics and state medical practice acts, and the perceived likelihood that they may reoffend. The consequences to patients and the general public of allowing a physician to engage in remediation and re-enter practice after a finding of sexual misconduct should be considered, including any erosion of the public trust in the medical profession and the role of state medical boards.

The goals of the remediation process should be clearly outlined, including expectations for acceptable performance on the part of the physician. The process of remediation should take place in-person (online or other forms of distance learning would not be sufficient), require full disclosure of and relate to the physician's offense(s) and be targeted to identified gaps in understanding of their particular vulnerabilities and other risks for committing sexual misconduct. As a condition of successful completion of a program of remediation, participants should be required to articulate not only *why* their actions were wrong, but also *how* they arrived at the point at which they were willing to commit them, and *how* they will guard against arriving at such a point again. For this to occur, assessment and remediation partners must be provided access to investigative information in order to properly tailor remedial education to the particular context in which the misconduct occurred. Finally, state medical boards should be mindful that remediation cannot typically be said to have "occurred" following successful completion of an educational course. Rather, a longitudinal mechanism must be established for maintaining the physician's engagement in a process of coming to terms with their misconduct and avoiding the circumstances that led to it. The longitudinal mechanism both demonstrates the physician's commitment to accountability and the effectiveness of a board's monitoring reach.

The members of the Workgroup acknowledge that shortcomings exist in the current evidence base regarding the effectiveness of remediation in instances of sexual misconduct. As noted elsewhere in this report, recidivism is exceedingly difficult to study well. Recommendations about the use of consistent terminology and improving the tracking of disciplined physicians will contribute to understanding what kinds of remedial interventions are most appropriate and effective in the context of sexual misconduct. Moreover, the Workgroup feels that further research is needed in several other areas, such as group learning experiences, instruction in victim empathy, remedial instruction with or without additional interventions, and identification of subgroups of offenders who may be at higher risk of reoffending.

License Reinstatement/Removal of License Restriction(s)

In the event of license revocation, suspension, or license restriction, any petition for reinstatement or removal of restriction should include the stipulation that a current assessment, and if recommended, successful completion of treatment, be required prior to the medical board's consideration to assure the physician is competent to practice safely. Such assessment may be obtained from the physician's treating professionals, state physician health program (PHP),[18] or from an approved evaluation team as necessary to provide the board with adequate information upon which to make a sound decision.

Transparency of board actions:

As state medical boards regulate the profession in the interest of the public, it is essential that evolving public values and needs are factored into decisions about what information is made publicly available. It has been made clear in academic publications and popular media, as well as through the #MeToo and TimesUp movements that the public increasingly values transparency regarding disciplinary actions imposed on physicians. It is likely that any action short of a complete revocation of licensure will draw scrutiny from the public and popular media. Such scrutiny can also be expected regarding decisions to reinstate a license or remove restrictions. The public availability of sufficient facts to justify a regulatory decision and link it to a licensee's behavior and the context in which it occurred can help state medical boards to explain and justify their decision.

The ability to disclose particular details of investigative findings and disciplinary actions is limited by state statute in many jurisdictions. State medical boards are encouraged to convey this fact to the public in order to protect the trust that patients have in boards, but also make efforts to achieve legislative change, allowing them to publicize information that is in the public interest. Where disclosure is possible, boards should select means for conveying information that will optimally reach patients. This should include making information available on state medical board websites and reporting to the FSMB Physician Data Center, thereby allowing for disciplinary alerts to be sent to other jurisdictions in which the physician holds a license and making information about disciplinary actions publicly available through FSMB's docinfo.org website, and the National Practitioner Data Bank. The use of private agreements or letters of warning in cases involving sexual misconduct is inappropriate because of the importance of disclosure for public protection and data sharing with other state medical boards or medical regulatory authorities from other jurisdictions.

Boards should also consider additional means of communicating, such as through mobile phone applications,[19] notices in newspapers and other publications. California[20] and Washington[21] both

[18] "A Physician Health Program (PHP) is a confidential resource for physicians, other licensed healthcare professionals, or those in training suffering from addictive, psychiatric, medical, behavioral or other potentially impairing conditions. PHPs coordinate effective detection, evaluation, treatment, and continuing care monitoring of physicians with these conditions." Source: Federation of State Physician Health Programs.
[19] The Medical Board of California has launched a new mobile application allowing patients to receive updates about their physician, including licensure status and practice location.
[20] CA Bus and Prof Code §1007 (2018)
[21] RCW 18.130.063

require that patients be notified of sexual misconduct license stipulations/restrictions at the time of making an appointment and that the patient verify this notification. Other boards have required licensees to obtain signatures from all patients in their care acknowledging their awareness of an adjudication for professional sexual misconduct. Boards may wish to consider whether these could be viable options in their states.

State medical boards are also encouraged 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. A label of "disruptive physician behavior" or even "boundary violation" is less helpful than the more specific label of "sexual misconduct." State medical boards and the FSMB should work together 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 state medical boards, while also enabling the tracking of trends, frequencies, recidivism and the impact of remedial measures.

Where particular actions on the part of the physician may not meet a threshold for disciplinary action, but might nonetheless constitute grooming or other concerning behaviors, state medical boards should consider ways in which to allow previously dismissed cases to be revisited during subsequent cases, such as through non-disciplinary letters of education or concern which remain on a licensee's record. The ability to revisit previous cases involving seemingly minor events can help identify patterns of behavior in a licensee and provide additional insight into whether a licensee poses a risk to future patients.

Section 10: Monitoring

Following a finding of sexual misconduct, if a license is not revoked or suspended, it is essential that a state medical board establish appropriate monitoring of the physician and their continued practice. Monitoring in the context of sexual misconduct occurs differently from monitoring substance use disorders and the resources available to boards differ from state to state. Many PHPs do not offer monitoring services for physicians who have faced disciplinary action because of sexual misconduct and even where such monitoring by a PHP is possible, it is typically only part of a way forward, rather than a solution on its own.[22]

For the purposes of this report, the members of the Workgroup understand the use of a *chaperone* as an informal arrangement of impartial observation, typically initiated by physicians themselves. A chaperone in this context is meant to protect the doctor in the event of a complaint, although their presence may also offer comfort to the patient.[23] The patient may request that the chaperone not be present for any portion of the clinical encounter. The American College of Obstetricians and Gynecologists (ACOG) has recently recommended that a chaperone be present for all breast, genital, and rectal examinations because of the profoundly negative

[22] Federation of State Physician Health Program Statement on Sexual Misconduct in the Medical Profession, May 2019.

[23] Paterson, R. Independent review of the use of chaperones to protect patients in Australia, Commissioned by the Medical Board of Australia and the Australian Health Practitioner Regulation Agency, February 2017.

effect of sexual misconduct on patients and the medical profession and the association between misconduct and the absence of a chaperone.[24]

The Workgroup supports ACOG's recommendation because of the potential added layer of protection that an impartial third party brings, while acknowledging that the use of board-mandated chaperones has been discontinued in some international jurisdictions and by particular state medical boards, because of a belief that they merely provide the illusion of safety and may therefore allow harmful behaviors to go unnoticed. There is risk of this occurring in instances where a chaperone is untrained or uninformed about their role, is an employee or colleague of the physician being monitored or does not adequately attend to their responsibilities. In order to distinguish a chaperone in a less formal arrangement with a physician from one mandated by a state medical board with established reporting requirements and formal training, the Workgroup recommends referring to the latter individual as a "practice monitor."

A *practice monitor* differs from a chaperone. We define a practice monitor as part of a formal monitoring arrangement mandated by a state medical board, required at all patient encounters, or all encounters with patients of a particular gender or age. The practice monitor's primary responsibility is to the state medical board and their presence in the clinical encounter is meant to provide protection to the patient through observation and reporting. Costs associated with employing a practice monitor are typically borne by the monitored physician, but practices may vary across states. The patient must be informed that the practice monitor's presence is required as part of a practice restriction. As the practice monitor is mandated for all clinical encounters, the patient may not request that the practice monitor not be present for any portion of the encounter. If a patient is uncomfortable with the presence of a practice monitor, they will need to seek care from a different physician. Patient supports (parents, family members, friends) may be present during examinations but do not replace, nor can they be used in lieu of a board mandated practice monitor.

While even this formal arrangement with a clearly defined role, training and direct reporting may have limitations, the practice monitor may be a useful option for boards in certain specific circumstances. In particular, in instances where there is insufficient evidence to remove a physician from practice altogether, but significant risk is believed to be present, the opportunity to mandate practice monitoring provides boards with an additional option, short of allowing a potentially risky physician to return to independent practice. As such, when practice monitors are implemented judiciously, the Workgroup believes that their use can enhance patient safety and should therefore be considered by state medical boards.

Practice monitors should only be used if the following conditions have been met:

- The practice monitor has undergone formal training about their role, including their primary responsibility and direct reporting relationship to the state medical board (as opposed to the physician being monitored).

[24] Sexual misconduct. ACOG Committee Opinion No. 796. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2020;135:e43–50.

- It is highly recommended that all practice monitors have clinical backgrounds. If they do not, their training must include sufficient content about clinical encounters so they can be knowledgeable about what is and is not appropriate as part of the monitored physician's clinical encounters with patients.
- The practice monitor should be approved by the state medical board and cannot be an employee or colleague of the monitored physician that may introduce bias or otherwise influence their abilities to serve as a practice monitor and report to the board or intervene when necessary. Pre-existing contacts of any sort are discouraged, but where a previously unknown contact is not available, the existing relationship should be disclosed. In some states, practice monitors are required to be active licensees of another health profession as it is felt that this reinforces their professional duty to report. When health professionals serve as practice monitors, they should not have any past disciplinary history.
- The practice monitor has been trained in safe and appropriate ways of intervening during a clinical encounter at any point where there is confidence of inappropriate behavior on the part of the physician, the terms of the monitoring agreement are not being followed, or a patient has been put at risk of harm.
- The practice monitor submits regular reports to the state medical board regarding the monitored physician's compliance with monitoring requirements and any additional stipulations made in a board order.
- Where possible, state medical boards should consider establishing a panel of different practice monitors that will rotate periodically among monitored physicians to ensure monitor availability and that a collegial relationship does not develop between a practice monitor and a monitored physician, unduly influencing the nature of the monitoring relationship.

Monitoring should be individualized and based on the findings of the multidisciplinary evaluation, and, as appropriate, subsequent treatment recommendations. If a diagnosis of contributory mental/emotional illness, addiction, or sexual disorder has been established, the monitoring of that physician should be the same as for any other mental impairment and state medical boards are encouraged to work closely with their state physician health program as a resource and support in monitoring. Conditions, which may also be used for other violations of the medical practice act, may be imposed upon the physician. Examples are listed in **Table 2**.

Table 2: Possible Conditions of Practice Following a Finding of Sexual Misconduct
• Supervision of the physician in the workplace by a supervisory physician • Requirement that practice monitors are always in attendance and sign the medical record attesting to their attendance during examination or other patient interactions as appropriate.[25] • Periodic on-site review by board investigator or physician health program staff if indicated. • Practice limitations as may be recommended by evaluator(s) and/or the state physicians health program. • Regular interviews with the board and/or state physician health program as required to assess status of probation. • Regular reports from a qualified and approved licensed practitioner, approved in advance by the board, conducting any recommended counseling or treatment. • Completion of a program in maintaining appropriate professional boundaries, which shall be approved in advance of registration by the board.

Section 11: Education

Education and training about professional boundaries in general and physician sexual misconduct in particular should be provided during medical school and residency, as well as throughout practice as part of a physician's efforts to remain current in their knowledge of professional expectations.

State Medical Board Members and Staff

State medical boards and the FSMB should take a proactive stance to educate physicians, board members and board staff about sexual misconduct and the effects of trauma. Members of state medical boards and those responsible for adjudicating cases involving sexual misconduct can also experience trauma. Education for dealing appropriately with traumatic elements of cases and finding appropriate help and resources would also be valuable for board members.

[25] Where a practice monitor does not have authority to make entries in a medical record, alternatives such as handwriting and scanning the attestation should be considered.

Medical Education and Training

Education and training should include information about professionalism and the core values of medicine; the nature of the physician-patient relationship, including the inherent power imbalance and the foundational role of trust; acceptable behavior in clinical encounters; and methods of reporting instances of sexual misconduct. For both medical schools and residency programs, this education and training should also include tracking assessment across the curriculum, identification of deficiencies in groups and individuals, remediation, and reassessment for correction, appropriate self-care, and the potential for developing psychiatric illness or addictive behaviors. Early identification of risk for sexual misconduct and unprofessionalism is central to public protection and maintaining public trust.

Physicians

For practicing physicians, because of lack of education or awareness, physicians may encounter situations in which they have unknowingly violated the medical practice act through boundary transgressions and violations. A reduction in the frequency of physician sexual misconduct may be achieved through education of physicians and the health care team. Engagement in accredited continuing medical education that addresses professionalism, appropriate and acceptable behavior, and methods for reporting sexual misconduct should be encouraged among physician licensees and other members of the healthcare team.

Resources should also be made available to physicians to help them develop better insight into their own behavior and its impact on others. These could include multi-source feedback and 360-degree assessments, and self-inventories with follow-up education based on the results. As with apology legislation, the use of these resources and the results from self-assessment or other forms of assistance should not be used against physicians. Such resources would likely be used more broadly if they came from specialty and professional societies, rather than from state medical boards alone.

Cooperation and Collaboration

State medical boards should develop cooperative relationships with state physician health programs, state medical associations, hospital medical staffs, other organized physician groups, and medical schools and training programs to provide physicians and medical students with educational information that promotes awareness of physician sexual misconduct. This information should include a definition of physician sexual misconduct, what constitutes appropriate physician-patient boundaries, how to identify and avoid common “grooming” behaviors such as adjusting appointment timing to facilitate time alone with a particular patient, contacting patients outside of clinical hours, or divulging personal information to a patient, and the potential consequences to both the patient and the physician when professional boundaries are not maintained. Physicians should be educated regarding the degree of harm patients experience as a result of sexual misconduct.

Patients

Education for patients is also essential so that they may be better informed about what to expect during a clinical encounter, what would constitute inappropriate behavior, and how to file a complaint with their state medical board. Information about boundary issues, including physician sexual misconduct, should be published in medical board newsletters and pamphlets. Media contacts should be developed to provide information to the public. Efforts should also be made by state medical boards and the FSMB to better educate the public about the existence and role of state medical boards.

Section 12: Summary of Recommendations

The goal of this report is to provide state medical boards with best practice recommendations for effectively addressing and preventing sexual misconduct with patients, surrogates and others by physicians, while highlighting key issues and existing approaches.

The recommendations in this section include specific requests of individual entities, as well as general ones that apply to multiple parties, including state medical boards, the FSMB and other relevant stakeholders. The Workgroup felt strongly that 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.

Culture:

1. Across the continuum from medical education to practice, continue to eliminate harassment and build culture that is supportive of professional behavior and does not tolerate harassment of any type.

Transparency:

2. State medical boards should ensure that sufficient information is publicly available (without breaching the privacy of complaints) to justify regulatory decisions and provide sufficient rationale to support them.

3. State medical boards should implement clear coding processes for board actions that provide accurate descriptions of behaviors underlying board disciplinary actions and clearly link licensee behaviors to disciplinary actions.

4. State medical boards and the FSMB should work together to develop consistent terminology for use in board actions that allows greater understanding for the public and the state medical boards, while also enabling the tracking of trends, frequencies, recidivism and the impact of remedial measures. These should support research and the early identification of risk to patients.

5. The means of conveying information to the public about medical regulatory processes, including professional expectations, reporting and complaints processes, and available resources should be carefully examined to ensure maximal reach and impact. Multiple communication modalities should be considered.

Complaints:

6. State medical boards are encouraged to provide easily accessible information, education and clear guidance about how to file a complaint to the state medical board, and why complaints are necessary for supporting effective regulation and safe patient care. The FSMB and its partner organizations representing medical specialties whose members perform intimate examinations and procedures should provide education to patients about the types of behavior that can be expected of physicians, what types of behavior might warrant a complaint, what to do in the event that actions on the part of a physician make a patient uncomfortable, and circumstances that would warrant a report to law enforcement.

7. State medical boards and board investigators of administrative complaints are encouraged to communicate frequently with complainants throughout the complaint and investigative process, according to the preferred mode and frequency of communication of the complainant.

8. Complaints related to sexual misconduct should be addressed as quickly as possible given their traumatic nature and to protect potential future victims.

9. State medical boards should have a specially trained patient liaison or navigator on staff who is capable of providing one-on-one support to complainants and their families.

Reporting:

10. Institutions should be required by statute to report instances of egregious conduct to state medical boards and be subject to fines levied by the state medical board, another appropriate regulatory agency or the state attorney general for failing to report.

11. Results of hospital and health system peer review processes should be shared with state medical boards when sexual misconduct is involved.

12. Hospitals should be required to report to state medical boards instances where employed physicians have been dismissed or are forced to resign due to concerns related to sexual misconduct.

13. 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.

14. Unscrupulous, frivolous or vexatious reporting motivated by competition should be met with disciplinary action.

15. Physicians and other individuals who report in good faith should be protected from retaliation and given the option to remain anonymous.

Investigations:

16. If the state medical board's investigation indicates a reasonable probability that the physician has engaged in sexual misconduct, the state medical board should exercise its authority to intervene and take appropriate action to ensure the protection of the patient and the public at large.

17. Where permitted by state law, investigations should include a review of previous complaints to identify any patterns of behavior, including malpractice claims and settlements.

18. State medical boards should have the authority to impose interim terms or limitations, including suspension, on a physician's license prior to the completion of an investigation.

19. Limits should not be placed on the length of time that can elapse between when an act of alleged physician sexual misconduct occurred and when a complaint can be filed.

20. Investigators should use trauma-informed procedures when interviewing and interacting with complainants alleging instances of sexual misconduct and adjudicating these cases.

21. State medical board members involved in sexual misconduct cases (either in investigation or adjudication) and all board staff who work with complainants in cases involving sexual misconduct should undergo training in the area of sexual misconduct, victim trauma, and implicit bias.

22. Where possible, boards should seek the complainant's preference regarding the gender of investigators and assign them accordingly.

23. State medical boards should also allow inclusion of patient advocates in the interview process.

24. The FSMB and state medical boards should work to identify and ensure the availability of high-quality training in sexual trauma and a trauma-informed approach to investigations.

Comprehensive Evaluation:

25. State medical boards should have the authority to order a comprehensive evaluation of physicians where investigation reveals a high probability that sexual misconduct has occurred.

Hearings:

26. State medical boards should have statutory authority to ensure nondisclosure of the patient's identity to the public, including by closing hearings in part or in full, and deleting any identifiable patient information from final public orders. Patient identity must also be protected during board discussion.

Discipline:

27. Certain serious forms of unprofessional conduct should presumptively provide the basis for revocation of a license in order to protect the public. Misconduct in this class would include sexual assault, conduct amounting to crimes related to sex, regardless of whether charged or convicted, or egregious acts of a sexual nature. State medical boards should also consider revocation in instances where a physician has repeatedly committed lesser acts, especially following remedial efforts.

28. Gender and age-based restrictions should only be used by boards where there is a high degree of confidence that the physician is not at risk of reoffending.

29. Practice monitors should only be used as a means of protecting patients if the conditions outlined in this report have been met, including appropriate training, reporting relationship to the state medical board and lack of pre-existing relationship with the monitored physician.

30. When considering remedial action after sexual misconduct, state medical boards should employ a risk stratification model that also factors in risk of erosion of public trust in the medical profession and medical regulation.

31. As part of remedial efforts, any partners in the assessment and remediation of physicians should be provided access to investigative information in order to properly tailor remedial education to the context in which the sexual misconduct occurred.

32. Following remedial activities, state medical boards should monitor physicians to ensure that they avoid being in circumstances similar to those in which they engaged in sexual misconduct.

33. State medical boards should consider ways in which to allow pertinent information from previously dismissed cases to be revisited during subsequent cases, such as through non-disciplinary letters of concern or education which remain on a licensee's record.

Education:

34. Education and training about professional boundaries and physician sexual misconduct should be provided during medical school and residency, as well as throughout practice as part of a physician's efforts to remain current in their knowledge of professional expectations. This should include education about how to proceed with basic as well as sensitive/intimate exams and the communication with the patients that is required as a component of these exams. This education should be informed by members of the public, as best possible.

35. State medical boards and the FSMB should provide education to physicians, board members and board staff about sexual misconduct and the effects of trauma. This should include resources to help physicians develop better insight into their own behavior and its impacts on others. Resources and materials should be developed in collaboration with state physician health programs, state medical associations, hospital medical staffs, other organized physician groups, and medical schools and training programs.

36. As stated in Recommendation #6 regarding complaints, state medical boards are encouraged to provide easily accessible information, education and clear guidance about how to file a complaint to the state medical board, and why complaints are necessary for supporting effective regulation and safe patient care. The FSMB and its partner organizations representing medical specialties whose members perform intimate examinations and procedures should provide education to patients about the types of behavior that can be expected of physicians, what types of behavior might warrant a complaint, what to do in the event that actions on the part of a physician make a patient uncomfortable, and circumstances that would warrant a report to law enforcement.

37. The FSMB, state medical boards, medical schools, residency programs, and medical specialty and professional societies should provide renewed education on professionalism and the promotion of professional culture. A coordinated approach facilitated by ongoing communication is recommended to ensure consistency of educational messaging and content.

38. The FSMB should facilitate the adoption and operationalization of the recommendations in this report by providing state medical boards with an abridged version of the report which highlights key points and associates them with resources, model legislation, and educational offerings.

Appendix A: Sample Resources

The following is a sample list of resources available to support greater understanding of sexual misconduct, sexual boundaries, the impacts of trauma, and implicit bias. The FSMB has not conducted an in-depth evaluation of individual resources, and inclusion herein does not indicate, nor is it to be interpreted as, an endorsement or guarantee of quality. Further, while some resources listed below are available free of charge, others are only accessible through purchase.

1. Sexual misconduct, sexual/personal/professional boundaries:
    - AMA: Code of Medical Ethics: Sexual Boundaries
        - Romantic or Sexual Relationships with Patients
        - Romantic or Sexual Relationships with Key Third Parties
        - Sexual Harassment in the Practice of Medicine
    - AMA: CME course: Boundaries for physicians
    - AAOS: Sexual Misconduct in the Physician-Patient Relationship
    - FSMB Directory of Physician Assessment and Remedial Education Programs
    - North Carolina Medical Board: Guidelines for Avoiding Misunderstandings During Patient Encounters and Physical Examinations
    - University of Vermont: Mandatory Reporters and CSAs (Sample Reporting Guidelines)
    - Vanderbilt University Medical Center: Online CME Course: Hazardous Affairs – Maintaining Professional Boundaries
    - Vanderbilt University Medical Center: Boundary Violations Index

2. Trauma-related resources:
    - SAMHSA: Concept of Trauma and Guidance for a Trauma-Informed Approach
    - National Institute for the Clinical Application of Behavioral Medicine: How Trauma Impacts Four Different Types of Memory
    - Frontiers in Psychiatry: Memory distortion for traumatic events: the role of mental imagery
    - Government of Canada, Department of Justice: The Impact of Trauma on Adult Sexual Assault Victims
    - National Institutes of Health: Trauma-Informed Medical Care: A CME Communication Training for Primary Care Providers
    - Western Massachusetts Training Consortium: Trauma Survivors in Medical and Dental Settings
    - American Academy of Pediatrics: Adverse Childhood Experiences and the Lifelong Consequences of Trauma
    - American Academy of Pediatrics: Protecting Physician Wellness: Working With Children Affected by Traumatic Events
    - Public Health Agency of Canada: Handbook on Sensitive Practice for Health Care Practitioners
    - Psychiatric Times: CME: Treating Complex Trauma Survivors
    - NHS Lanarkshire (Scotland): Trauma and the Brain (Video)
    - London Trauma Specialists: Brain Model of PTSD - Psychoeducation Video

3. Implicit bias:
    - AAMC: Online Seminar: The Science of Unconscious Bias and What To Do About it in the Search and Recruitment Process
    - AAMC: Proceedings of the Diversity and Inclusion Innovation Forum: Unconscious Bias in Academic Medicine
    - AAMC: Exploring Unconscious Bias in Academic Medicine (Video)
    - ASME Medical Education: Non-conscious bias in medical decision making: what can be done to reduce it?
    - APHA: Patient Race/Ethnicity and Quality of Patient–Physician Communication During Medical Visits
    - Institute for Healthcare Improvement: Achieving Health Equity: A Guide for Health Care Organizations
    - BMC Medical Education: Training to reduce LGBTQ-related bias among medical, nursing, and dental students and providers: a systematic review
    - American Psychological Association: CE - How does implicit bias by physicians affect patients' health care?
    - Joint Commission: Implicit bias in health care
    - Oregon Medical Board: Cultural Competency – A Practical Guide for Medical Professionals
    - StratisHealth: Implicit Bias in Health Care (Quiz)

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EXHIBIT 14

EXHIBIT 14

Part I - Special from Missouri Physicians Health Program

Sexual Misconduct by Professionals: A New Paradigm of Understanding

by Gregory E. Skipper, MD & Stephen Schenthal, MD

Illustrations

The following are but a few fictional examples drawn from compilations of real cases:

An overworked married pediatrician was attracted to a single mom in his practice. They became friendly and one day he offered to help if she ever needed anything fixed around the house. Eventually she called and asked him to come over to fix a leaky faucet. This started an affair that lasted several months. When his wife discovered the affair, he broke it off. The mother became angry, felt exploited, and retained an attorney.

Comment

It's important to realize that the family of patients can be considered patients too, especially in pediatrics, where the parents are considered patients along with their children.

A general surgeon kissed an employee, who was also his patient, when she came to him crying about a problem she was having. Word got out in the office and a formal complaint was made to the medical board.

Comment

Treating an employee, neighbor, or anyone else, means that the person then becomes a patient.

A family practitioner finally gave in to a seductive patient who brazenly seduced him.

Comment

Claiming that an affair was the patient's fault doesn't work. It's the doctor's sole responsibility to set limits and act professionally. If you are uncomfortable with a seductive patient, refer them.

Professional Sexual Misconduct

Betrayal and exploitation are among the most egregious of human offenses, and when they involve a health professional preying on a vulnerable patient, the most basic of ethical principles are violated. When the patient-physician relationship is exploited and Professional Sexual Misconduct (PSM) occurs, it is particularly problematic because it strikes at the core spirit of the profession. The breech of trust associated with PSM is damaging to the patient, the health professional and to the medical profession at large. It's damaging to the patient, who is exploited and may never trust a health professional again. It's damaging to health professionals, who often lose their reputations, find their finances plundered, licenses revoked, and in more than two dozen states, find themselves subject to criminal charges and imprisonment. Finally, it's damaging to the medical profession at large because of degradation in the perceived legitimacy of the profession each time this happens.

Unfortunately, claims of PSM are not rare. A confidential survey[1] found that 8% of physicians admitted committing some degree of PSM with one or more patients, and most physicians acknowledge they've been tempted. Despite this, there is a generalized denial in the health professions regarding the risks and/or existence of PSM and a taboo regarding discussing it. Even with the "sexual" nature of the offense, it turns out that health professionals who've committed PSM rarely have any type of sexual disorder. Very few are true sociopaths. Most of the time, in fact, these physicians simply lose good judgment and believe they've "fallen in love" with the patient. Most physicians who commit PSM do so in times of personal trauma or professional crisis, when judgment is diminished. Unresolved vulnerabilities may arise associated with overwork or professionally dissatisfaction. The turbulent times of midlife often trigger PSM. To flee the pain of parental death, a failing marriage or empty nest issues with the departure of children to college are times when physicians may "act out" inappropriately.

All this becomes more relevant by the fact that PSM is preventable. Educating physicians about good boundaries and helping them become more aware of their

vulnerabilities and risks and ways of setting up their practice to protect patients and themselves is critical. Not only is PSM preventable but doctors who commit PSM are usually treatable, and relapses are rare when good treatment and education occurs and precautions are taken.

Considering the very damaging real life consequences of PSM it is surprising how casually PSM is depicted on TV and in movies. The discordance between how professional boards and criminal agencies view PSM versus its media portrayal is troubling, and may contribute to the risk of PSM because it creates a false sense of acceptability for inappropriate relationships with patients. Additionally, there are many stories about relationships between doctors and their patients leading to successful marriage, without any apparent harm. These, however, are the exceptions. More typically, the patient eventually becomes aware of a sense of exploitation and becomes very angry. Not uncommon are cases in which a physician-patient marriage ends in divorce at which time the ex-spouse files a complaint and law suit... and wins. It's tragic that as terrible and devastating as PSM is, it is essentially a taboo subject; little or nothing is taught regarding PSM in medical schools, and it's rarely a subject for postgraduate training.

Physician sexual misconduct is behavior that exploits the physician-patient relationship in a sexual way, whether verbal or physical, or expressions of thoughts and feelings or gestures that are sexual or that reasonably may be construed by a patient as sexual.

To help prevent PSM it's important to have a basic understanding of boundary theory and the dynamics that underlie boundary violations, to develop vigilance for early warning signs of potential boundary problems with patients, and to gain insight into professional and personal vulnerabilities and risk factors. Excellent CME-based courses are available for further in-depth training.

PSM (synonymous with "sexual boundary violation") can be defined as any action of a sexual nature that oversteps or disregards ethical or legal limits of professional behavior. For our purposes, sexual refers to any erotic physical contact, and may also include sexual behavior involving language or gesture. Even the use of sexual humor or informal speech can be deemed misconduct. The somewhat vague concept of "boundary" is made more explicit by reference to professional ethical and legal norms.

Ethical prohibition against sexual relations with patients dates back at least as far as the Hippocratic Oath of ancient Greece. An abbreviated version of the passage states: "[I] will abstain from every voluntary act of mischief and corruption; and, further from the seduction of females or males, of free men or slaves." Most professional societies have a code of ethics which contains clear statements regarding what constitutes appropriate sexual boundaries. The major area in which these codes differ is regarding how long, if ever, it is necessary following termination of the patient-physician relationship before a relationship can be pursued. On the subject of where the lines are drawn inside the professional relationship, they are essentially identical.

The Federation of State Medical Boards, in a policy statement in 2007, clearly defines what it considers sexual boundaries, and states that disciplinary action should be taken against any physician who violates them. Here are some salient excerpts from that document:

"Physician sexual misconduct is behavior that exploits the physician-patient relationship in a sexual way. This behavior ... may be verbal or physical, and may include expressions of thoughts and feelings or gestures that are sexual or that reasonably may be construed by a patient as sexual. ...There are primarily two levels of sexual misconduct: sexual violation and sexual impropriety. Behavior listed in both levels may be the basis for disciplinary action by a state medical board ....Sexual violation may include physician-patient sex, whether or not initiated by the patient, and engaging in any conduct with a patient that is sexual or may be reasonably interpreted as sexual. Sexual impropriety may comprise behavior, gestures, or expressions that are seductive, sexually suggestive, or sexually demeaning to a patient."

The documents goes on to state, "Findings of sexual misconduct are often sufficiently egregious as to warrant revocation of a physician's medical license, although a lesser action may be considered for cases of sexual impropriety."

It is important to know that most acts of PSM occur following progressive problems with boundaries that precede the PSM. Often these steps are referred to as "boundary crossings," which may be initiated with the best of intentions, but progressively tumble down a "slippery slope" of professional destruction. While these precedent behaviors are not necessarily unethical in and of themselves, they are major warning signs. In order to prevent sexual boundary violations it is important to understand this progression and the precedent boundary disturbances. Sometimes these boundary disturbances are limited to one patient or one particular type of patient, and in

other cases they may characterize the clinician's general practice style. In the context of rehabilitation from sexual boundary violation(s), it is incumbent on the professional to address all of these boundary issues.

Precedent boundary problems can include time issues, such as extending the time of office visits (often by scheduling at the end of the day), conducting the visit during non-business hours or by extending the visit from the last appointment of the day into non-business hours (after the staff leave the office). Another category of precedent behaviors includes "concepts of place and space." For example, making home visits (except when clearly part of regular practice), meeting a patient at a social occasion or agreeing to share a meal with a patient at a restaurant. Another area, giving or receiving gifts, can be a problem if it tends to "deprofessionalize" the relationship, encourage romanticizing of the relationship or interferes with therapeutic aims. In general, it is a good idea to have an office policy that gifts from patients are not accepted (except to the office as a whole).

Physical contact is another area of concern. There are times in the course of clinical practice where touching the patient outside of a physical examination is accepted, such as a handshake at the beginning or end of an appointment, or the placing of a hand on the shoulder as a comforting gesture. Some practitioners also feel it is permissible to hug patients at times, though, depending on the characteristics of the patient, this can be very dangerous. Context is clearly important in determining to what extent a hug may be thought of in this way. Hugging can cause serious confusion in the professional relationship, be interpreted or experienced in a romantic way by the patient, and can lead to greater intimacy. An important adage to remember is that when it comes to boundaries, "perception is everything." The misinterpretation of a therapeutic hug as romantic may be impossible to defend.

Boundary issues involving money can precede PSM. Examples include lending or borrowing of money from patients, business activities with patients or even bartering in place of the standard fee. It's also important to be careful with language with patients. Using the title of doctor, for example, helps establish the professional relationship. The use of too familiar a tone of voice, the use of inappropriate colloquial language or the use of first names can be risky, especially in some settings. Wearing a white coat reenforces the professional image. Informal dress may convey the opposite. Finally, the issue of self-disclosure should be mentioned. While it is not uncommon for clinicians to occasionally share a story with a patient or to reveal selective aspects of their personal experience, the injudicious sharing of private information is clearly a boundary crossing, and interferes with the aim of the professional relationship. The disclosure of personal problems is virtually always inappropriate. Sharing by the doctor with the patient that he has an unethical attraction to them is highly inappropriate. This type of boundary crossing commonly precedes PSM.

Preexisting vulnerabilities afflicting the physician, such as psychiatric illness, alcohol and/or substance abuse disorder, paraphilias, personality disorder, mood disorder, sexual compulsivity or addiction and/or insufficient support, supervision, oversight or accountability make PSM more likely to occur. Other factors that can predispose the physician to PSM include marital/family problems, midlife or late midlife stage-of-life crisis and burnout. Similar preexisting vulnerabilities affecting a patient can also increase risk. Patients with histories of sexual abuse appear to be particularly vulnerable. It's important for every physician to know that PSM is unethical and can carry harsh consequences. Physicians should recognize inappropriate behaviors and not act inappropriately due to their emotional attractions to patients. Ultimately, it's best to refer the patient causing concerns to another physician. Before pursuing a relationship with a patient, contact your specialty society and/or the Missouri Board of Healing Arts for more guidelines to be sure it is ethical and safe. Consulting a good therapist prior to taking any action is also a good idea. We physicians are also ethically responsible to protect our colleagues. If we see red flags of an evolving boundary problem in another physician, we must consider an intervention. Stepping in can save a professional and protect a patient. Failing to follow these recommendations is very likely to be costly to everyone involved.

References

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Acknowledgment

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EXHIBIT 15

EXHIBIT 15

Code *of* Professional Ethics

of the American College of Obstetricians and Gynecologists

Obstetrician–gynecologists, as members of the medical profession, have ethical responsibilities not only to patients, but also to society, to other health professionals and to themselves. The following ethical foundations for professional activities in the field of obstetrics and gynecology are the supporting structures for the Code of Conduct. The Code implements many of these foundations in the form of rules of ethical conduct. Certain documents of the American College of Obstetricians and Gynecologists also provide additional ethical rules, including documents addressing the following issues: seeking and giving consultation, informed consent, sexual misconduct, patient testing, relationships with industry, commercial enterprises in medical practice, and expert testimony. Noncompliance with the Code, including the above-referenced documents, may affect an individual's initial or continuing Fellowship in the American College of Obstetricians and Gynecologists. These documents may be revised or replaced periodically, and Fellows should be knowledgeable about current information.

Ethical Foundations

I. The patient–physician relationship: The welfare of the patient (beneficence) is central to all considerations in the patient–physician relationship. Included in this relationship is the obligation of physicians to respect the rights of patients, colleagues, and other health professionals. The respect for the right of individual patients to make their own choices about their health care (*autonomy*) is fundamental. The principle of justice requires strict avoidance of discrimination on the basis of race, color, religion, national origin, sexual orientation, perceived gender, and any basis that would constitute illegal discrimination (justice).

II. Physician conduct and practice: The obstetrician–gynecologist must deal honestly with patients and colleagues (*veracity*). This includes not misrepresenting himself or herself through any form of communication in an untruthful, misleading, or deceptive manner. Furthermore, maintenance of medical competence through study, application, and enhancement of medical knowledge and skills is an obligation of practicing physicians. Any behavior that diminishes a physician's capability to practice, such as substance abuse, must be immediately addressed and rehabilitative services instituted. The physician should modify his or her practice until the diminished capacity has been restored to an acceptable standard to avoid harm to patients (*nonmaleficence*). All physicians are obligated to respond to evidence of questionable conduct or unethical behavior by other physicians through appropriate procedures established by the relevant organization.

III. Avoiding conflicts of interest: Potential conflicts of interest are inherent in the practice of medicine. Physicians are expected to recognize such situations and deal with them through public disclosure. Conflicts of interest should be resolved in accordance with the best interest of the patient, respecting a woman's autonomy to make health care decisions. The physician should be an advocate for the patient through public disclosure of conflicts of interest raised by health payer policies or hospital policies.

IV. Professional relations: The obstetrician–gynecologist should respect and cooperate with other physicians, nurses, and health care professionals.

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V. Societal responsibilities: The obstetrician–gynecologist has a continuing responsibility to society as a whole and should support and participate in activities that enhance the community. As a member of society, the obstetrician–gynecologist should respect the laws of that society. As professionals and members of medical societies, physicians are required to uphold the dignity and honor of the profession.

Code of Conduct

I. Patient–Physician Relationship

1. The patient–physician relationship is the central focus of all ethical concerns, and the welfare of the patient must form the basis of all medical judgments.
2. The obstetrician–gynecologist should serve as the patient's advocate and exercise all reasonable means to ensure that the most appropriate care is provided to the patient.
3. The patient–physician relationship has an ethical basis and is built on confidentiality, trust, and honesty. If no patient–physician relationship exists, a physician may refuse to provide care, except in emergencies. Once the patient–physician relationship exists, the obstetrician–gynecologist must adhere to all applicable legal or contractual constraints in dissolving the patient–physician relationship.
4. Sexual misconduct on the part of the obstetrician–gynecologist is an abuse of professional power and a violation of patient trust. Sexual contact or a romantic relationship between a physician and a current patient is always unethical.
5. The obstetrician–gynecologist has an obligation to obtain the informed consent of each patient. In obtaining informed consent for any course of medical or surgical treatment, the obstetrician–gynecologist must present to the patient, or to the person legally responsible for the patient, pertinent medical facts and recommendations consistent with good medical practice. Such information should be presented in reasonably understandable terms and include alternative modes of treatment and the objectives, risks, benefits, possible complications, and anticipated results of such treatment.
6. It is unethical to prescribe, provide, or seek compensation for therapies that are of no benefit to the patient.
7. The obstetrician–gynecologist must respect the rights and privacy of patients, colleagues, and others and safeguard patient information and confidences within the limits of the law. If during the process of providing information for consent it is known that results of a particular test or other information must be given to governmental authorities or other third parties, that must be explained to the patient.
8. The obstetrician–gynecologist must not discriminate against patients on the basis of race, color, religion, national origin, sexual orientation, perceived gender, and any basis that would constitute illegal discrimination.

II. Physician Conduct and Practice

1. The obstetrician–gynecologist should recognize the boundaries of his or her particular competencies and expertise and must provide only those services and use only those techniques for which he or she is qualified by education, training, and experience.
2. The obstetrician–gynecologist should participate in continuing medical education activities to maintain current scientific and professional knowledge relevant to the medical services he or she renders. The obstetrician–gynecologist should provide medical care involving new therapies or techniques only after undertaking appropriate training and study.

3. In emerging areas of medical treatment where recognized medical guidelines do not exist, the obstetrician–gynecologist should exercise careful judgment and take appropriate precautions to protect patient welfare.

4. The obstetrician–gynecologist must not publicize or represent himself or herself in any untruthful, misleading, or deceptive manner to patients, colleagues, other health care professionals, or the public.

5. The obstetrician–gynecologist who has reason to believe that he or she is infected with a bloodborne pathogen or other serious infectious agent that might be communicated to patients should voluntarily be tested for the protection of his or her patients. In making decisions about patient-care activities, a physician infected with such an agent should adhere to the fundamental professional obligation to avoid harm to patients.

6. The obstetrician–gynecologist should not practice medicine while impaired by alcohol, drugs, or physical or mental disability. The obstetrician–gynecologist who experiences substance abuse problems or who is physically or emotionally impaired should seek appropriate assistance to address these problems and must limit his or her practice until the impairment no longer affects the quality of patient care.

III. Conflicts of Interest

1. Potential conflicts of interest are inherent in the practice of medicine. Conflicts of interest should be resolved in accordance with the best interest of the patient, respecting a woman's autonomy to make health care decisions. If there is an actual or potential conflict of interest that could be reasonably construed to affect significantly the patient's care, the physician must disclose the conflict to the patient. The physician should seek consultation with colleagues or an institutional ethics committee to determine whether there is an actual or potential conflict of interest and how to address it.

2. Commercial promotions of medical products and services may generate bias unrelated to product merit, creating or appearing to create inappropriate undue influence. The obstetrician–gynecologist should be aware of this potential conflict of interest and offer medical advice that is as accurate, balanced, complete, and devoid of bias as possible.

3. The obstetrician–gynecologist should prescribe drugs, devices, and other treatments solely on the basis of medical considerations and patient needs, regardless of any direct or indirect interests in or benefit from a pharmaceutical firm or other supplier.

4. When the obstetrician–gynecologist receives anything of substantial value, including royalties, from companies in the health care industry, such as a manufacturer of pharmaceuticals and medical devices, this fact should be disclosed to patients and colleagues when material.

5. Financial and administrative constraints may create disincentives to treatment otherwise recommended by the obstetrician–gynecologist. Any pertinent constraints should be disclosed to the patient.

IV. Professional Relations

1. The obstetrician–gynecologist's relationships with other physicians, nurses, and health care professionals should reflect fairness, honesty, and integrity, sharing a mutual respect and concern for the patient.

2. The obstetrician–gynecologist should consult, refer, or cooperate with other physicians, health care professionals, and institutions to the extent necessary to serve the best interests of their patients.

V. Societal Responsibilities

1. The obstetrician–gynecologist should support and participate in those health care programs, practices, and activities that contribute positively, in a meaningful and cost-effective way, to the welfare of individual patients, the health care system, or the public good.

2. The obstetrician–gynecologist should respect all laws, uphold the dignity and honor of the profession, and accept the profession's self-imposed discipline. The professional competence and conduct of obstetrician–gynecologists are best examined by professional associations, hospital peer-review committees, and state medical and licensing boards. These groups deserve the full participation and cooperation of the obstetrician–gynecologist.

3. The obstetrician–gynecologist should strive to address through the appropriate procedures the status of those physicians who demonstrate questionable competence, impairment, or unethical or illegal behavior. In addition, the obstetrician–gynecologist should cooperate with appropriate authorities to prevent the continuation of such behavior.

4. The obstetrician–gynecologist must not knowingly offer testimony that is false. The obstetrician–gynecologist must testify only on matters about which he or she has knowledge and experience. The obstetrician–gynecologist must not knowingly misrepresent his or her credentials.

5. The obstetrician–gynecologist testifying as an expert witness must have knowledge and experience about the range of the standard of care and the available scientific evidence for the condition in question during the relevant time and must respond accurately to questions about the range of the standard of care and the available scientific evidence.

6. Before offering testimony, the obstetrician–gynecologist must thoroughly review the medical facts of the case and all available relevant information.

7. The obstetrician–gynecologist serving as an expert witness must accept neither disproportionate compensation nor compensation that is contingent upon the outcome of the litigation.

EXHIBIT 16

EXHIBIT 16

Richard W. Rafael, M.D.

[redacted]

[redacted]

[redacted]

[redacted]

Nevada Medical License #5289 August 10,1985-June 30, 2023

Nevada State Board of Pharmacy License expires 10-3-2024

SUMMARY OF EXPERIENCE

Private practice in Obstetrics and Gynecology, Reno Nevada
7/1/1986 - 12/31/2018

Residency in Obstetrics and Gynecology, Mount Sinai Hospital, Hartford, CT 7/1/1982 - 6/30/1986

Chief Resident — Department of Obstetrics and Gynecology, Mount Sinai Hospital Hartford, CT
1/30/1986 - 6/30/1986

Associated Clinical Professor, University of Nevada, School of Medicine, Reno, NV 1986-1991

Clinical Assistant Professor of Obstetrics, University of Nevada, Reno School of Medicine April 2019 – 2022

Diplomate of the American Board of Obstetrics and Gynecology
November 10,2000 through December 31, 2022

Fellow American College of Obstetrics and Gynecology Nevada Medical License #5289, Issued 8/10/1985 - current

Member ProAssurance Indemnity Claims Underwriting Committee, Quarterly Claims Review Proceedings Sept 19, 2013 – June 2020

Peer Review: Nevada State Board of Medical Examiners
3/12/20 – present and active

EDUCATION

1892 — 1986 Residency in Obstetrics and Gynecology, Mount Sinai Hospital, Hartford, Ct.

1978— 1982 St. George's University School of Medicine, Grenada, WI

1975 -1977 University of Nevada, Reno NV, B.S., Medical Sciences

1968-1972 University of California Santa Barbara, Goleta, CA, B.A., Political Sciences

1970— 1971 Institute of European Studies, Vienna, Austria, Comparative Government

CONTINUING MEDICAL EDUCATION

1. Boston University School of Medicine: Review and Update Course In Obstetrics and Gynecology, Cambridge, MA, 3/14/1984
2. Harvard Medical School: Reproductive Endocrinology, Advances in Gynecology, Cambridge, MA, 10/15/1984
3. Lasers in Obstetrics and Gynecology: S.U.N.Y., Upstate Virginia Beach, 08/1984
4. University of Connecticut and Yale University: Ella Grasso Memorial Lecture Series, Hartford, CT, 1984
5. Advanced-Colposcopy: American Society for Colposcopy and Cervical Pathology, 01/14/84
6. Johns Hopkins University, Emil Novak Memorial Course Baltimore, MD, 10/85
7. The American Fertility Society, Clinical Reproductive Endocrinology, Reno, NV 1987
8. Loss Prevention and Risk Management for Health Care Professionals, Nevada State Medical Association, Reno, NV 11/14/87
9. Osler Obstetrics and Gynecology Review Course, Osler Institute, San Francisco, CA 1987
10. The California Medical Association annual Session and Western Scientific Assembly, Reno, NV 03/9/88
11. Perinatology and Neonatology, University of California Irvine, 06/16/88
12. Clinical Workshop in Hysteroscopy Northern California Obstetrical and Gynecological Society, Sacramento, CA, 09/10/88
13. Clinical Obstetrics and Gynecology, review course, 1989
14. Changing Times in Obstetrics and Gynecology 1989
15. Osler Review Course Obstetrics, Gynecology, Pathology, Infertility, 1989
16. Loss Prevention for Physicians and Staff— 5 part series, Nevada Medical Liability, Reno, NV 1/20/89

17. Infertility Management in an Office Practice — Ultrasound Workshop, 9/29/89

18. Real time Ultrasound in Clinical Obstetrics 05/10 — 05/12/90

19. Comprehensive Review Course, University of California School of Medicine, 11/5 - 11/9/90

20. Clinical Care of Patients with Reproductive Failure, American Fertility Society, 06/10/91

21. Gynecological Update Applications of New Surgical Techniques and Medical Management, 10/1 — 10/3/92

22. 11th Annual Perinatal Medicine & Nursing Conference, Barbados, 10/30 — 11-6/93

23. Seventh Annual Techniques in Gynecologic Sur e , 11/10 — 11/12/94

24. American College of Obstetricians and Gynecologists, self-assessment program, PROLOG, 09/9/94

25. University of Chicago, Obstetrics and Gynecology Review Course, 09/9/95

26. American College of Obstetricians and Gynecologists, Reproductive Endocrinology and Infertility, 04/17/96

27. University California Davis Medical Center and School of Medicine, 8th Annual Ultrasound Update, 09/28 — 09/29/96

28. Washoe Medical Center, Hormone replacement therapy: Minimizing the Risks, 09/96

29. St. Paul Medical Services Risk Management in Ambulatory Care Seminar, 10/96

30. Washoe Medical Center How to Educate and Negotiate Managed Care Contracts, 12/96

31. Washoe Medical Center Medical Specialist and Managed Care, 12/96

32. Saint Mary's Regional Medical Center, OB/GYN M/M Conference, case presentation, 01/97

33. University of Colorado School of Medicine, Comprehensive Management of HIV Disease, 02/19/97

34. American College of Obstetricians and Gynecologists, PROLOG Gynecologic Oncology and Surgery, Third edition 02/26/97

35. Saint Mary's Regional Medical Center, OB/GYN Conference, Antibiotic Therapy in PPROM & M.S.A.F., The ABC's of STD's, 03/97

36. Saint Mary's Regional Medical Center, Quality Outcomes Management, 05/97

37. Practice Management Institute, Can Your Office Withstand an Audit, 06/17/97

38. University of California San Francisco, Essentials in Primary Care, 08/17 _08/22/97

39. University of California, San Francisco, OB-GYN, Histopathology Clinic, 10/13/97

40. Mayo School of Continuing Medical Education, Techniques in Advanced Laparoscopic and Gynecologic Surgery, 11/6 — 11/8-97

41. Washoe Medical Center Tumor Board, case presentation, 02/18/98

42. American College of Obstetricians and Gynecologists, Patient Management in the Office, 04/98

43. University of Chicago, Obstetrics and gynecology Review Course, 06/1 — 06/6/98

44. American Society for Clinical Laboratory Science, Give Your Clinic a Checkup,
05/14/99

45. St. Paul Medical Services Risk Management Seminar: Fraud and Abuse in
Medicare Billing, 05/99

46. Washoe Medical Center Women & Depression, 08/3/99

47. Washoe Medical Center, Bioethics: Death, Dignity, Caring, 09/21/99

48. Washoe Medical Center Type 2 Diabetes, 11/2/99

49. Washoe Medical Center, Non-Cardiac Chest Pain, 11/30/99

50. P.A.C.E., Negotiating Managed Care, 04/4/00

51. University of Wisconsin-Madison Medical School, Understanding Bladder Symptoms, 05/11/00

52. University of Chicago, Videotape, Obstetrics & Gynecology Review, 06/5 _06/10/00

53. American College of Obstetricians and Gynecologists, PROLOG, 07/27/00

54. Washoe County Medical Society, Managed Care Contracts — How to Negotiate and Maximize Reimbursement, 11/15/00

55. Health Science Center Clinical Issues in Women's Health for 21st Century, 10/13/01

56. Gynecare Thermachoice Il, Uterine Balloon Therapy System, Reno, NV 11/29/01

57. American College of Obstetricians and Gynecologists, PROLOG Obstetrics 4th Edition, 12/28/01

58. University California Davis Medical Center, Gynecare TVT Tension-Free Support for Incontinence, 02/13/02

59. University of Nevada School of Medicine, Clinical, Ethical, and Psychological Aspects of Non-Essential Medical Treatments, San Diego, CA, 05/3/02

60. Johns Hopkins University School of Medicine, Current Perspectives on HRT and Breast Health, 06/1/02

61. American College of Obstetricians and Gynecologists, PROLOG: Reproductive Endocrinology and Infertility, 4th edition, 08/21/02

62. Nevada Academy of Family Physicians, Washoe Medical Society, HIPAA Regulation Compliance, 09/12/02

63. University of Wisconsin, Patient Management Issues in Menopause, 11/20/02

64. American College of Obstetricians and Gynecologists, Patient Management in the office, 4th edition, 02/03/03

65. Domestic Violence, Ethics, Washoe Medical Center, 01/03

66. Washoe Health Systems, HIPAA-Bioethics, 02/24/03

67. American College of Obstetricians and Gynecologists, Coding Workshop, Module
1, 11, 07/25/03

68. University of Nevada School of Medicine, New Developments in the Diagnosis and Management of Heart Disease, 10/22/03

69. American College of Obstetricians and Gynecologists, Advances in Urogynecology, 11/03

70. American Association of Gynecologic Laparoscopists, Laparoscopy Workshop,

02/04

71. University of Nevada School of Medicine: Washoe Medical Center, Weapons of Mass Destruction (Medical ethics) 04/04

72. American Society for Reproductive Medicine, Advanced Gynecologic Surgery,
09/04

73. Nevada Academy of Family Physicians, Targeting Cholesterol in Heart Disease,
10/04

74. Bard PACE Preceptor Program, Preceptorship training in Acellular Collagen Matrix and Acellular Collagen Bio Mesh, 11/04

75. Global Congress of Gynecologic Endoscopy, AAGL appraisal of Surgical techniques for Pelvic Prolapse, 11/04

76. USS Women's Healthcare a division of Tyco Healthcare Group LP, Incontinence and Vaginal Prolapse Sling Surgery, 07/05

77. American College of Obstetricians and Gynecologists, PROLOG Gynecology and Surgery, 5th edition, 07/05

78. American College of Obstetricians and Gynecologists. PROLOG Gynecology Oncology and Critical Care, 01/06

79. American college of Obstetricians and Gynecologist. PROLOG Gynecologic Oncology and Critical Care, 04/06

80. Avaulta Biosynthetic and Ureters Trans obturator Urethral Support System, 05/16/06

81. University of Nevada School of Medicine, Current Issues of Medical Liability Risk Management, 10/06

82. Gynecare TVT Secure System Professional Education Program, 04/27/07

83. American College of Obstetricians and Gynecologists, PROLOG, Patient Management in the Office, 07/07

84. University of Nevada School of Medicine. Risk Management for Nevada Physicians, 11/07

85. Mayo Clinic World Robotics, Symposium in Gynecology, 02/08

86. University of Nevada School of Medicine, Risk Management for Nevada Physician – Improving Patient Care: Ethics, Communication and Litigation, 10/08

87. Boston Scientific — University of Nevada School of Medicine, Advances in Pelvic Floor Technology, 09/08

88. Saint Mary's Regional Medical Center, Cyber knife Stereotactic Radiosurgery, 01/09

89. Saint Mary's Regional Medical Center, Bio-Identical Hormone Replacement Therapy, 07/09

90. University of Nevada School of Medicine, Ethical Treatment of Patients: The Many Forms of Good Communication, 10/09

91. IND Insurance Exchange, Ethic, EMR's, and Elixirs 10/09

92. American College of Physicians Executives, 2009 PIM-Finance Express, 09/09

93. American College of Physicians Executives, 2009 PIM-Communication Express,
09/09

94. American College of Physicians Executives, 2009 PIM-Influence Express, 09/09

95. American College of Physicians Executives, 2009 PIM-Management Skills Express, 09/09

96. American College of Physicians Executives, 2009 PIM Marketing Express, 09/09

97. American College of Physicians Executives, 2009 PIM Negotiation Express, 09/09

98. American College of Physician Executives, IT change Management, 03/10

99. American College of Physicians Executives. Successful IT Change Mgmt., 04/10 100. Conceptus Inc., Physician Training for Essure, 08/10

101. American Board of Obstetrics and Gynecology, MOC Part Il-ABC exam, 10/10

102. The Christ Hospital, Pelvic Anatomy and Gynecologic Surgery Symposium, 12/10

103. Lifelong Health, Achieving Optimum Well-Being at Any Age, 04/11

104. American College of Physician Executives, Techniques of Financial Decision Making, 05/11

105. ACPE, Financial Decision Making , 06/11

106. ACOG, Antibiotics in Minor Gynecologic Procedures, 07/11 107.

ACOG, Informed consent, 07/11

108. ACOG, Gynecologic Oncology and Critical Care, 10/11

109. University of Nevada School of Medicine, Documents, Depositions, and Difficult Patients, 10/11

110. ACOG, 2012 Maintenance of Certification Part 11, 08/12

111. University of Nevada School of Medicine, Physician Risk Management Essentials
2012, Resources, Remedies, and Relationships, 10/12

112. ACOG, Prolog, Patient Management in the Office, 10/12

113. ACOG, Gynecologic Pelvic Ultrasound, 11/12 114. ACPE, Interact-

Health Law Express, 01/13

115. ACPE, Interact- Liabilities in HER Express, 01/13

116. American College of Physician Executives, Essentials of Health Law, 03/13

117. American College of Physician Executives, Liabilities in Electronic Health Record, 05/13

118. Renown Regional Medical Center, Osteoporosis Management of Fragility Fractures, 06/13

119. ACOG Prolog, Obstetrics 7th Edition, 07/13

120. ProAssurance Indemnity, Claims Review Proceeding —CUC, 09/13

121. Washoe County Medical Society and Nevada Academy of Family Physicians, What Physicians Need to Know About the ACA, 09/13

122. Advanced Practice Strategies, Inc., Informed Consent: A Medical Legal Case study, 09/13

123. ACOG, Maintenance of Certification 2013, 11/13 124. ProAssurance Indemnity, Claims Review Proceedings —CUC, 12/13, 2 AMAPRA CME Credits

125. ABOG, Maintenance of Certification 2014, 02/14

126. ACOG, Gynecology and Surgery 7th edition, 04/14

127. University of Chicago, 23rd Annual Advances in Urogynecology and Reconstructive Pelvic Surgery,16 AMA credits June 6-7, 2014

128. ProAssurance Indemnity, Claims review proceedings — CUC, 2.0 AMA PRA Category 1 credits 06/2014

129. American College of Physician Executives, Three Faces of Quality, 08/2014

130. Applied Medical, GelP01NT GYN Single Site/Reduced Workshop, 09/2014

131. ABOG,(MOC)Maintenance of Certification 2014, 25 AMA PRA credits 09/28/2014

132. Pelvic Anatomy and Gynecologic Surgery, 28 AMA CME December 4-6, 2014

133. Advances in Urogynecology and Reconstructive Pelvic Surgery, University of Chicago Pritzker School of Medicine, Northshore University Health Systems, June 4-6, 2015, 16 AMA CME

134. ABOG MOC Part II Article Review 25 AMA PRA Category Credits 12/31/2015

135. University of California Irvine School of Medicine Ethics for Professional, Honoring Choices 2 AMA PRA category 1 credits-Ethics 4/25/16

136. Marijuana Summit- What Healthcare Professionals, Law Enforcement Officers, Employers and Members of the Court Need to Know, May 11, 2016

137. MOC Part IV – Non surgical Therapies for Stress Urinary Incontinence 3 AMA PRA category 1 credits 8/25/16

138. ProAssurance Indemnity Claims Review Proceedings- CUC 2,o CME Credits Nov. 3, 2016

139. ProAssurance: The Anatomy of a Claim 2.0 AMA PRA Category 1 credits, Reno, NV. Nov 10, 2016

140. Diabetes Day for Primary Care Clinicians: Advances in Diabetes Care Feb 6, 2016, 4.50 AMA PRA Category 1 CME

141. ABOG MOC II MOC Requirements Article Review 25 AMA Category 1 AMA PRA credits 8/25/16

142. PROLOG, Female Pelvic Surgery and Reconstructive Surgery 14 AMA PRA Category 1 Credits 1/15/17

143. Annual Spring Conference on Women's Health 18 AMA PRA CME Credits, March 8-11, 2017

144. ProAssurance Indemnity 2.0 AMA PRA Category 1 credits June 29,2017, CUC meeting Las Vegas

145. American Association of Physician Leadership, Managing Physician Performance 24 AMA PRA Credits Category 1 credits, 8/6/17

146. ABOG Maintenance of Certification 2017, 28 AMA Category 1 CME Sept.15, 2017

147. The Risk of Poor Communication 1.75 AMA PRA Category 1 credits Relias Learning, ProAssurance1/10/18

148. Disclosure and Apology Module 1,2,3,4,5,6,7- 3.5 AMA PRA credits 1/13/18

149. Risk Management Basics: Protections and Pitfalls 2.00 AMA PRA CME 1/24/18

150. Disclosure of Unanticipated Outcomes 2 AMA PRA CME 0n 1/16/18

151. ProAssurance Indemnity, Claims review proceedings, February 15, 2018, 2 AMA PRA Category 1 CME credits

152. ABOG Maintenance of Certification 2018 (MOC) 28 AMA PRA CME Credits, Feb. 6, 2018

153. ACOG, Women's Healthcare 35 AMA PRA credits March 15, 2018

154. ProAssurance Indemnity, Claims Review Proceedings -2 AMA PRA credits June 21, 2018

155. ProAssurance Indemnity, Claims Review Proceedings - 2 credits September 13, 2018

156. Responsible and Effective Opioid Prescribing NetCE 3 AMA PRA Category 1 credits December 8, 2018

157. Suicide Prevention 2018, Kaiser Permanente, 6 AMA PRA Category 1 credits

158. American Red Cross-Adult First Aid/CPR/AED 2/16/18 date completed and valid for 2 years

138. Prolog, Gynecology and Surgery 8th edition, ACOG self-study, 25 credits May 31, 2019

139. Cleveland Clinic: Clinical Decisions: Management of Resistant Hypertension, AMA Category 1, 4/22/19 credit date 10/28/19

140. Cleveland Clinic: Clinical Decisions: Diabetes AMA Category 1 Credit date 10/28/19

141. Cleveland Clinic: Clinical Decisions: Urinary Incontinence in Women AMA Category 1 10/28/19

142. Cleveland Clinic: Clinical Decisions: Asthma, 10/29/19

143. ProAssurance Indemnity: Claims Review Proceedings-CUC, 2.0 AMMA PRA Category 1 credits, June 20, 2019

144. Medscape: Prediabetes Awareness in the Primary Care Setting, October 20,2019 0.25 AMA PRA Category 1 Credits

145. Cleveland Clinic: Clinical Decisions: Immunization in Immunocompromized Patients, AMA PRA Category 1, 10/31/19 Certificate 5048589

146. Cleveland Clinic: Clinical Decisions: Psoriasis, AMA PRA Category 1, 10/31/19 Certification number 5048565

147. Cleveland Clinic: Clinical Decisions: The Diagnosis and Evaluation of Hematuria in Adults, AMA PRA Category 1, 10/29/19 Certification 5046131

148. Cleveland Clinic: Clinical Decisions: Dermatology in Primary Care, AMA PRA Category 110/31/19 Certificate 5048264

149. Certificate of Completion: Intersections: Preventing Harassment and Sexual Violence, 7/16/19, University of Nevada Reno-UNR-NSHE, Ethics

150. Medscape: Pain Management and Opioids: Balancing Risks and Benefits, 3.5 AMA PRA category 1 credits, Jan 31, 2020

151. American Board Obstetrics and Gynecology Maintenance of Certification, 25 AMA PRA Category 1 Credits, American Board Certification Obstetrics and Gynecology valid through 12/31/21,

152. LDL-C, Cardiovascular risk, and Nonstatin Therapy: Identifying Patients and Improving Outcomes. Jan. 24, 2020.75 Category 1 AMA PRA

153. Certificate for Continuing Medical Education Credits 20 CME hours awarded, BME Case 18-18173, June 30, 2020.

154. Medscape: Omega-3s vs Pure EPA in Clinical Practice: What do CV Outcome Trials Tell Us? Jan 23,2020, 0.5 AMA PRA Category 1 Credits.

155. Medscape: Ring the Bell: Improving T2D Management With CVD, Jan. 21, 2020, 0.5 AMA PRA Category 1 Credits.

156. Basic Life Support Provider Jan.03,2020, BLS Provider, Recommended renewal Date Jan. 03, 2020, ACLS Medical Training completion.

157. Touro University of Nevada: Suicide: Identifying and Supporting People at Risk, 2 AMA PRA Category 1 credits June 4, 2020 – Jan 03, 2022

158. Nevada State Board of Medical Examiners BME Case # 17-17534 period. Peer review. 13 hours awarded July 1, 2019-June 30,2021 biennial period.

159. ProAssurance Indemnity: Claims Review Proceedings, Claims Underwriting Committee, Jan. 16, 2020, 2 AMA PRA Category 1 credits

160. Touro University Nevada: Opioid Law Prescribing Mandates, Opioid Use Disorder and Treatment, 2 AMA PRA Category Credits May 21, 2020.

161. University of Nevada, Reno School of Medicine Simulation Class: Safety in Maternity Care, Assisted vaginal Delivery, Vacuum Extraction, Postpartum Hemorrhage, Group Testing. Shared teaching of this class with Dr. McCarthy et al., June 19, 2020

162. University of Nevada, Reno School of Medicine Physical Examination MS 2 Students, "Evaluation of Overall Quality and thoroughness of building a History: HPI, PMH, Fam history, Social History, ROS, Meds., Allergies and thoroughness of Physical Exam. Communications skills.

163. Understanding Fetal Heart Rate Tracings, University of Nevada Ren, School of Medicine, Lecture for MS 3 students July 16, 2020.

164. Disease Management Clinical Decisions: Clinical Overview: Polycystic Ovarian Syndrome, AMA PRA 08/13/20, Cert. 5308016 0.75

165. Preventing Harassment and Discrimination, University of Nevada Reno, 9/29/20

166. Nevada State Board of Medical Examiners. BME Case # 18-18173,3/12/20, 20 CME credits

167. Nevada State Board of Medical Examiners, BME Case#18-18151, 16 CME Credits awarded 12/29/2020

168. Nevada State Board of Medical Examiners, BMW case #18-18159, 1/8/21, 17 CME credits awarded 1/8/2021

169. Nevada State Board of Medical Examiners 6/16/2021, BME case #20-19342, CME hours awarded: 20

170. Nevada Board of State Medical Examiners, BME Case #20-19593 CME hours awarded: 20 CME credits awarded.

171. Nevada Board of State Medical Examiners. BME Case #20-19417, CME 20 hours awarded 7/2/21

171. Medscape: Achieving Lipid Goals: Expert Cardiologist Perspectives on Strategies Beyond Statin Therapy, JANUARY 3, 2022. 0.5 ama PRA Category 1 Credits

172. Medscape: Novel Approaches to Postsurgical Analgesia: Getting a Head Start of Post-Op Pain, Jan. 3, 2022, 0.75 AMA PRA Category 1 Credits.

173. NetCE: Opioid Use Disorder, Course 96963, Opioid Use Disorder, 10 CME credits, Jan. 2022, recognized by Nevada State Board Medical Examiners

174. NetCE: Pneumonia, Course #94673, 10 CME Credits, recognized by BSBME, performed Jan 2022

175. NetCE Pancreatic Cancer, Course 90240, 10 CME awarded, recognized by Nevada State Board of Medical Examiners, performed Jan. 2022

176. Basic Life Support Certificate of Completion January 29, 2022, HCP-CPR (Adult/Child/Infant/Choking), Automated External Defibrillation/First Aid demonstrating proficiency in the subject by passing the examination in accordance with the Terms and Conditions of the National CPR Foundation. Valid for 2 years, course administered in accordance with the 2020 ECC/ILCOR and AHA guidelines. ID #4A2384

177. Nevada State Board of Medical Examiners BME Case Number 20-19786, CME hours awarded 20 (Twenty hours)date: 2/10/22

178. Nevada State Board of Medical Examiners BME Case #21-20708, 3/8/22

CME hours awarded 20.

179. American Board of Obstetrics and Gynecology 2022 Maintenance of Certification. 28 AMA PRA Category 1 Credits for completing 2022 MOC requirements.

180. Addressing the Diabetes and Obesity Pandemic, April 2, 2022, 6.50 HRS, Title NV CEA, University of Nevada Reno School of Medicine Certification. AMA PRA Category 1 Credits

181. Nevada State Board of Medical Examiners Peer Review BME Case Number 21-20043, 16.5 Category 1 CME hours.

182. Nevada State Board of Medical Examiners Peer Review 7/25/2022, BME Case # 21-20483, 17 credit hours Category 1 CME

183. Nevada State Board of Medical Examiners Peer Review 9/16,/2022,BME Case # 21-20464 20 CME Hours awarded Category 1

184. Nevada State Board of Medical Examiners Peer Review,9/28/22 BME Case Number 22-21253 during the July,2021-June 30,2023. CME hours awarded 20 hours Category 1 CME

185. Preventing Harassment and Discrimination for Higher Education: Module 1.Building Positive Workplace, Module 2. Developing Awareness and Recognizing Discrimination, Module 3.Cultivating Attitudes and Identifying Harassment, Module 4. Taking Action against Retaliation, Module 5.Building Supportive Communities, 6. Maintaining Positive Workplaces.

185. Nevada State Board of Medical Examiners BME Case#:21-20791, CME awarded 20 hours, Biennial period July 1, 2021-2023,

AWARDS

The Robert Hingson Humanitarian Award, St. George's University School of Medicine

Best Doctors Award — Gynecology, Top Doctors Chosen by Their Peers, Cleveland Monthly, March 2007

Best in Community Service, Renown Medical Center 2007

St. Mary’s Regional Medical Center Recognizes the Devotion You Provided for 35 years – Emeritus Staff Status

University of Nevada Reno School of Medicine, Office of Community Faculty "Thank you for sharing your knowledge and serving as a role model to support medical education" UNR Med Students

LITERARY ACCOMPLISHMENTS

The Influence of Weight in the Induction of Ovulation with Menotropins (HMG) and Human Chorionic Gonadotropin (HGG), Augusto Chong, M.D., Richard W. Rafael, M.D., Carol Forte, N.P.

PROFESSIONAL AFFILIATIONS: Past and Present

Diplomate of the American Board of Obstetrics and Gynecology
Dipolmate — December 2010

Fellow American College of Obstetrics and Gynecology

The American College of Obstetrics and Gynecology and Cervical Pathology

The Gynecological Laser Society

The Nevada State Medical Society
Task Force for Medical Liability Insurance, 1996-1997

Nevada State Medical Association Delegate 1997-1998, 2001, 2002

The Washoe County Medical Society
Board of Directors, January 1997 — December 1999, 2002
Vice President, January 2000 — December 2001
President, January 2001 — December 2001

Health Access Washoe County (H.A.W.C.), Board Member 2006, Board Member 2011 Financial Committee Member 2011, Search Committee Member 2012, Chairman of First Annual Fundraiser — HAWC Community Health Alliance 2012, Currently Community Health Alliance

IND — Insurance Co., Board Member 2007 to 2012, Subscribers Advisory Committee

ProAssurance 2013- 2019 Nevada Claims and Underwriting Committee- malpractice case review. Total 12 years in Peer Review Experience.

Clinical Assistant Professor of Obstetrics and Gynecology -

University of Nevada, Reno School of Medicine March 2019- present

Nevada State Board of Medical Examiners Peer Review – review malpractice cases

CLINICAL LECTURES

1. Hypertension in Pregnancy, 9/86, Medical Residents, Reno, NV
2. Diabetes in Pregnancy, 11/86, Medical Residents, Reno, NV
3. Evaluation and Management of I.U.G.R., 2/87, Reno, NV
4. Antenatal Fetal Monitoring, Churchill County Medical Society
5. Premature Onset of Labor, Nursing Staff, Washoe Medical Center, Reno, NV
6. Pelvic Inflammatory Disease, 3/88, Family Practice Residents, Reno, NV
7. Ectopic Pregnancy, 11/88, Family Practice Residents, Reno, NV
8. Gestational Diabetes, 12/99, Family Practice Residents, Reno, NV
9. Pelvic Organ Prolapse, 12/99, Family Practice Residents, Reno, NV
10. Ectopic Pregnancy 9/11/19 Morbidity and Mortality, UNR Family Practice Residents
11. Physical Diagnosis Female History and Physical 8/31/19 Student Outreach Clinic, UNR Medical Students
12. Vaginitis – 6/22/19 Student Outreach Clinic
13. Neuroanatomy – 6/10/19 review of Neuroanatomy Questions
14. Abnormal Uterine Bleeding – 5/18/19 SOC Clinic
15. Prevention and Screening for Cervical Cancer – 4/10/19 SOC Clinic
16. Safety in Obstetrics and Gynecology, Vacuum Extraction, Forceps Delivery, Postpartum Hemorrhage, Assisted Vaginal Delivery Workshop 6/19/2020, University of Nevada, Reno School of Medicine
17. Understanding Fetal Heart Rate Tracings, University of Nevada, Reno School of Medicine, July 16, 2020
18. Physical Diagnosis: History and Physical Examination, Medical Students, University of Nevada School of Medicine, July 17 and July 7/18/2020

Dr. Richard Rafael is a board certified Obstetrician and Gynecologist who has completed 32 years of private practice as a solo 0b/Gyn. He retired from private practice 12/31/18.

Dr. Rafael was President of the Washoe County Medical Society and served on the Board of Community Health Alliance, promoting access to care for the underserved. Dr. Rafael helped develop the major fund raising event for the Community Health Center. He was voted "Best Doctor" by his colleagues in 2007 and he was recognized by Renown Regional Medical Center as "Best in Community Service" for his work with Health Alliance.

Dr. Rafael was asked to join the IND Malpractice Insurance Board when Nevada was facing a crisis due to non-competition in malpractice insurance. IND grew and was acquired by ProAssurance, a global malpractice insurance company. He continues to contribute to the committee reviewing malpractice cases for the Western United States.

Dr. Rafael is currently working with the Student Outreach Clinic at University of Nevada, Reno School of Medicine and is a Clinical Assistant Professor of Obstetrics and Gynecology through the Department of Obstetrics and Gynecology.

Dr. Rafael is working with the Nevada State Board of Medical Examiners Peer Review and is responsible for reviewing records associated with Peer review of Obstetrical and Gynecology cases.

Dr. Rafael believes the needs of the patient comes first, and he seeks to treat all patients, students and professional staff with dignity and respect.

EXHIBIT 17

EXHIBIT 17

From: Johnna S. LaRue [redacted]
Sent: Monday, April 10, 2023 1:18 PM
To: Brandee Mooneyhan [redacted]
Subject: FW: [Marketing] Copies of Event Ads from Previous Years

Confirmed that Dr. Chambers only ever inquired in 2016 but never submitted any art or photos.

Thank you,

Johnna S. LaRue, CMBI
Deputy Chief of Investigations
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
(775) 324-9377 Phone
(775) 688-2553 Fax
jlarue@medboard.nv.gov
www.medboard.nv.gov

From: Beth Noonan [redacted]
Sent: Monday, April 10, 2023 1:16 PM
To: Johnna S. LaRue [redacted]
Subject: Re: [Marketing] Copies of Event Ads from Previous Years

Hi Johnna,

As previously stated he requested an ad for the 2016 AVN Expo but did not submit artwork for the advertisement.

Thanks,
Beth

Beth Noonan
Vice President
AVN Media Network
9400 Penfield Ave
Chatsworth, CA 91311

Phone: 818-671-3907
Mobile: 661-312-9533

Skype: avnbeth

On Mon, Apr 10, 2023 at 10:13 AM Johnna S. LaRue <jlarue@medboard.nv.gov> wrote:
Good Morning Ms. Noonan,

I am following up on the inquiry I made last year in regards to a physician and advertising with you company.

Can you please verify that George Chambers, MD or Chambers and Associates did not have any advertisements in any brochure or program of an award ceremony that your company is associated with?

Thank you,

Johnna S. LaRue, CMBI
Deputy Chief of Investigations
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
(775) 324-9377 Phone
(775) 688-2553 Fax
jlarue@medboard.nv.gov
www.medboard.nv.gov

From: Beth Noonan [redacted]
Sent: Friday, June 03, 2022 2:16 PM
To: Johnna S. LaRue [redacted]
Subject: Re: [Marketing] Copies of Event Ads from Previous Years

Yeah, that is what my records show.

Beth Noonan

Vice President
AVN Media Network
9400 Penfield Ave
Chatsworth, CA 91311
Phone: 818-671-3907
Mobile: 661-312-9533

Skype: avnbeth

On Fri, Jun 3, 2022 at 2:05 PM Johnna S. LaRue [redacted] wrote:
Is that the only time he has submitted for an ad?

Thank you,

Johnna S. LaRue, CMBI
Deputy Chief of Investigations
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
(775) 324-9377 Phone
(775) 688-2553 Fax
jlarue@medboard.nv.gov
www.medboard.nv.gov

From: Beth Noonan [redacted]
Sent: Friday, June 03, 2022 12:52 PM
To: Johnna S. LaRue [redacted]
Subject: Re: [Marketing] Copies of Event Ads from Previous Years

Hi Johnna,

It looks like he requested an ad for the 2016 AVN Expo but did not submit artwork for the advertisement.

Thanks,

Beth

Beth Noonan
Vice President
AVN Media Network
9400 Penfield Ave
Chatsworth, CA 91311
Phone: 818-671-3907
Mobile: 661-312-9533

Skype: avnbeth

On Fri, Jun 3, 2022 at 12:40 PM Johnna S. LaRue [redacted] > wrote:
Hi Beth,

Thank you for responding so quickly.

George Chambers, MD is the provider I am inquiring about.

Thank you,

Johnna S. LaRue, CMBI
Deputy Chief of Investigations
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
(775) 324-9377 Phone
(775) 688-2553 Fax
jlarue@medboard.nv.gov
www.medboard.nv.gov

From: Beth Noonan [redacted]>
Sent: Friday, June 03, 2022 12:39 PM
To: Johnna S. LaRue [redacted]>
Subject: Re: [Marketing] Copies of Event Ads from Previous Years

Hi Johnna,

To further assist you, please provide the name of the medical provider in question.

Thanks,

Beth

Beth Noonan
Vice President
AVN Media Network
9400 Penfield Ave
Chatsworth, CA 91311
Phone: 818-671-3907
Mobile: 661-312-9533

Skype: avnbeth

On Fri, Jun 3, 2022 at 12:20 PM AVN Media Network Inc. <support@avn.com> wrote:

Copies of Event Ads from Previous Years.

Name: Johnna LaRue
Email: jlarue@medboard.nv.gov
Company: Nevada State Board of Medical Examiners
Phone: 775-324-9377
Subject: Copies of Event Ads from Previous Years
Department: Marketing

Message:
I am looking for ads placed during events or in the magazine for a specific medical provider. Please contact me at the email or phone number above for more information as pertaining to my request.

Submitted on: 2022-06-03 19:20:06
IP Address: 167.154.72.236
User Agent: Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/102.0.5005.63 Safari/537.36

Block email | Block domain | Block ip

RESPONDENT'S EXHIBITS ADMITTED INTO EVIDENCE

EXHIBIT A

EXHIBIT A

GEORGE P. CHAMBERS, JR., M.D., F.A.C.O.G.

7220 SOUTH CIMARRON ROAD, SUITE 200
LAS VEGAS, NEVADA 89113
WEB: www.chambersobgynlv.com
PH: (702) 463-0800

EDUCATION

- 1998 to 2002 — **SUNY UPSTATE MEDICAL UNIVERSITY**
  Syracuse, New York 13210
  Obstetrics and Gynecology Residency Program
  • **Chief Resident, July 2001 to June 2002**
  • ***Alpha Omega Alpha* Honor Medical Society, Inducted 2000**

- 1994 to 1998 — **MEDICAL COLLEGE OF PENNSYLVANIA**
  Philadelphia, Pennsylvania 19129
  • **Doctor of Medicine, May 1998**

- 1992 to 1994 — **HAHNEMANN UNIVERSITY**
  Philadelphia, Pennsylvania 19102
  • **Graduate Studies in Biomedical Sciences**

- 1988 to 1992 — **AMERICAN UNIVERSITY**
  Washington, D.C. 20016
  • **Bachelor of Science in Chemistry, May 1992**

- 1987 to 1988 — **GEORGETOWN UNIVERSITY**
  Washington, D.C. 20057
  • **High School College Internship Program**

POST-RESIDENCY TRAINING

- 12/2013 — Certified, Sexual Health and Treament,
  The American Academy of Anti-Aging Medicine

- 11/2013 — Certificate of Completion,
  Female Genital Plastic/Cosmetic Surgery Masters Course,
  Preceptor: Michael P. Goodman, M.D., FACOG
  Davis, California 95616

BOARD CERTIFICATION

- 07/2008 — Fellow, American College of Obstetricians and Gynecologists

- 11/2007 — Diplomate, American Board of Obstetrics and Gynecology,
  Effective November 8, 2007 through December 31, 2021

EXPERIENCE

- 11/2009 to Present — Chambers & Associates OBGYN and Gynecological Surgery, PLLC, **Medical Director and Owner**, 7220 S. Cimarron Road, Suite 200, Las Vegas, Nevada 89113
- 04/2013 to 11/2018 — Women's Health Associates of Southern Nevada, **Laborist**, 9525 Hillwood Drive, Suite 130, Las Vegas, Nevada 89134
- 04/2011 to 03/2014
- 06/2007 to 07/2009
- 09/2003 to 06/2006

  Nevada Health Centers, Incorporated (Main Office)
  3325 Research Way, Carson City, Nevada 89706
  - **Hospitalist Ob/Gyn**, April 2011 to March 2014
  - **Hospitalist Ob/Gyn**, June 2007 to July 2009
  - **Attending Ob/Gyn**, September 2005 to June 2006
  - **Service Clinical Director**, September 2003 to August 2005
- 07/2006 to 10/2009 — Centennial Hills Ob/Gyn Associates, **Attending Ob/Gyn**, 1815 East Lake Mead Boulevard, Suite 314, North Las Vegas, Nevada 89030
- 05/2003 to 09/2003 — Women's Wellness OB/GYN, **Attending Ob/Gyn**, 10170 S. Eastern Avenue, Suite 160, Henderson, Nevada 89052

ACADEMIC APPOINTMENTS

- 2007 to 2020 — **Adjunct Assistant Professor** of Obstetrics and Gynecology, TOURO University Nevada College of Osteopathic Medicine, Henderson, Nevada 89014
- 2013 to 2015
  2005 to 2008

  Clinical Assistant Professor of Obstetrics and Gynecology
  University of Nevada School of Medicine
  Las Vegas, Nevada 89102
- 2006 to 2007 — **Adjunct Assistant Professor** of Obstetrics and Gynecology, TOURO University College of Osteopathic Medicine, Mare Island, Vallejo, California 94592

ACADEMIC HONORS AND AWARDS

- 2002 — Robert E.L. Nesbitt, M.D. Outstanding Resident in Ob/Gyn Award
- 2001 — Best Presentation by a Senior Resident Award
- 2000 to Present — *Alpha Omega Alpha* Honor Medical Society
- 1999 to 2001 — Best Ob/Gyn Resident-Student Teacher Award
- 1992 — National Organization of Black Chemists and Chemical Engineers Undergraduate Research Award
- 1992 — Distinguished Frederick Douglass Scholar Award
- 1988 to 1992 — Frederick Douglass Scholar (American University)

NON-ACADEMIC HONORS AND AWARDS

- 2020 — Recognized as one of Las Vegas "Top Doctors" in *Vegas Inc Healthcare Quarterly* magazine, vol. 29, 2020
- 2019 — Recognized as one of Las Vegas "Top Doctors" in *Vegas Inc Healthcare Quarterly* magazine, vol. 24, 2019
- 2019 — Recognized as one of Las Vegas "Top 100 Doctors & Dentists" in the Spring 2019 issue of *MYVEGAS* magazine
- 2018 — Recognized as one of Las Vegas "Top 100 Doctors & Dentists" in the Summer 2018 issue of *MYVEGAS* magazine
- 2018 — Recognized as one of Las Vegas "Top Doctors" in *Vegas Inc Healthcare Quarterly* magazine, vol. 20, 2018
- 2018 — Patient Choice Award, on vitals.com
- 2015 — Recognized as one of Las Vegas "Top Doctors" in *Vegas Inc Healthcare Quarterly* magazine, vol. 8, 2015
- 2014 — Recognized as a "Top 10 Doctor in City, Metro Area and State," on vitals.com
- 2011 — Recognized as one of Las Vegas "Top Doctors" in the Spring 2011 issue of *Las Vegas Life* magazine
- 2010 — Cited in the second edition of Who's Who In Black Las Vegas®
- 2009 to 2015 — Listed in *Guide to America's Top Obstetricians and Gynecologists*
- 2008 to 2015 — Patient Choice Award, on vital.com
- 2008 & 2010 — The Las Vegas Chamber of Commerce Customer Service Excellence Award
- 2007 — Recognized as one of Las Vegas "Top Doctors," in the June 2007 issue of *Las Vegas Life* magazine
- 2006 — Recognized as one of Las Vegas "210 Top Doctors," in the June 2006 issue of *Las Vegas Life* magazine
- 2005 to 2007 — National Health Service Corp Scholar

LICENSURE

- # 41471 — Colorado — (Inactivated by Dr. Chambers on 04/30/2017)
- # 10476 — Nevada — (Active & Unrestricted)
- # 228191 — New York — (Inactivated by Dr. Chambers on 08/11/2010)

PROFESSIONAL AFFILIATION

- 2009 to Present — American Congress of Obstetricians and Gynecologists
- 1998 to Present — American College of Obstetricians and Gynecologists
- 2012 to 2015 — National Society of Cosmetic Physicians
- 2012 to 2013 — The American Academy of Anti-Aging Medicine

PRESENTATIONS

- "Very-Low birth Weight Babies in Syracuse, New York," **9th Annual Chief and Senior OB/GYN Residents' Scientific Forum**," SUNY Upstate Medical University. Syracuse, New York; June 2002.

PRESENTATIONS (CONTINUED)

- "Uterine Atony at Caesarean Section," **Grand Rounds**, SUNY Upstate Medical University. Syracuse, New York; May 2002.

- "Abdominal Wall Defects: The Patient with the Massive Panniculus," **8th Annual Chief and Senior OB/GYN Residents' Scientific Forum**," SUNY Upstate Medical University. Syracuse, New York; June 2001.

- "Increasing Human Sexuality Awareness Through Youth Education," Generalist Physicians in Training 4th Annual Poster Session, **46th Annual Convention of the American Medical Student Association**, Arlington, Virginia; March 1996.

- "Synthesis and Characterization of 2,5-Dibutyl-1-oxa-cyclopentan-2-ol," Division of Industrial and Engineering Chemistry: Undergraduate Research in Washington, D.C. Area Universities, **204th American Chemical Society National Meeting**, Washington, D.C.; August 1992.

- "Synthesis and Characterization of 2,5-Dibutyl-1-oxa-cyclopentan-2-ol," Technical Sessions, **19th Annual National Conference of the National Organization of Black Chemists and Chemical Engineers**, New Orleans, Louisiana; April 1992.

PUBLICATION

- Chambers GP, Roscher NM, Yang L. "Synthesis and Characterization of 2,5-Dibutyl-1-oxa-cyclopentan-2-ol." In *Proceedings of the National Conference of the National Organization of Black Chemists and Chemical Engineers*. Held in New Orleans, Louisiana, April 20-24, 1992, vol 19. Washington, D.C.: NOBCChE, 1992.

EXHIBIT B

EXHIBIT B

CERTIFICATE OF COMPLETION

This certificate is awarded to

George P. Chambers, Jr., M.D., FACOG

For Successfully Completing the
Female Genital Plastic/Cosmetic Surgery Masters Course: 16 hours

Awarded By Dr. Michael P. Goodman

22 November 2013
Date

EXHIBIT C

EXHIBIT C

The American Academy of Anti-Aging Medicine

Upon the recommendation of the Executive Board, and after
successfully completing all of the certificate requirements
The Board has conferred upon

George Chambers, MD

a certificate in

Sexual Health and Treatment

and is entitled to all the rights and honors thereto appertaining, given at the Offices
of the American Academy of Anti-Aging Medicine, Chicago, Illinois
This fourteenth day of December, two thousand and fourteen

Robert M. Goldman, MD, Ph.D, DO, FAASP
The Chairman of The American Academy of Anti-Aging Medicine

Jennifer Landa, MD
Director, Anti-Aging and Regenerative Medicine Fellowship

Ronald M. Klatz, MD, DO
The President of The American Academy of Anti-Aging Medicine

Sexual Health and Treatment

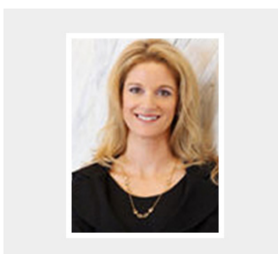
Certification Description:

The Sexual Health Certification provides comprehensive education to practitioners in the diagnosis, evaluation and treatment of sexual health disorders in men and women.

There is a dual emphasis on learning evidence based scientific literature in the area of sexual health, and learning clinical practice protocols, and practices to allow participants to treat patients with the most up to date and comprehensive treatment tools. The teachings combine didactic learning as well as participatory and lab learning within four online modules.

After completion of the 4 modules, the participant will be considered a Certified Sexual Health Clinician. The modules are lively, engaging and informative providing the participant with the essential knowledge and skills needed to be able to comprehensively care for patients who have sexual health challenges.

Director Of The Sexual Health Certification:



Jennifer Landa, MD, Ob/Gyn specializes in helping women and men balance their hormones, restore their energy, and replenish their sex lives. At the heart of her practice is the belief that maintaining one's health is hard work and she encourages her patients to make lifestyle changes that will result in increased health.

Dr. Landa's focused, energetic, and straightforward style comes across well when she speaks in front of groups and on camera. She lectures nationally on preventive medicine and has appeared on national and local television. Dr. Landa just completed her first book with co-author Virginia Hopkins. Their book, The Sex Drive Solution for Women, is a no-nonsense approach to many of the sex drive issues that Dr. Landa addresses with her patients every day.

Module A: Female Sexual Health

Online Certification - Sexual Health **Only: $1,800** ADD TO CART (/cart;cart,add_to_cart,sh_online_module_1,1.html)

Sexual Health and Treatment - Module A

Course Description:

Chambers 007

The first of the four module series will introduce and cover many essential issues in female sexual health. Treatment protocols that are both evidence based and clinically relevant will be given throughout the lectures. The vulvar anatomy and disorders of the vulva will be covered thoroughly including the evaluation and treatment of such disorders by an expert in the field of vulvovaginal disorders and treatments for vaginal dryness from a Harvard gynecologist that includes everything from the conventional to the Ayurvedic.

Selected Topics:

- Overview of female sexual dysfunction
- Women's sexual health–anatomical concerns
- Causes and treatment of dyspareunia
- Treatment of vulvar/vaginal atrophy
- Perform diagnostic evaluations on patients with FSD
- Be familiar with surgical treatment of sexual dysfunction
- Understand adrenal function as it affects sex drive and how to address in patients
- Be familiar with newer modalities including orgasmic meditation and certain tantric principles and techniques
- Prescribe novel tools, methods, and various sexual aids for patients to boost sex drive

Module B: Male Sexual Health, Gay and Transgender Therapy

Online Certification - Sexual Health
Sexual Health and Treatment - Module B

Only: $1,800

ADD TO CART (/cart;cart,add_to_cart,sh_online_module_2,1.html)

Course Description:

Sexual Health Module B will cover all aspects of male sexual health, encompassing evaluation and treatment of male sexual dysfunction, including a comprehensive look at male hormone therapy, through discussion of testosterone therapy, treatment of premature ejaculation, and sexuality treatment for the LGBT population.

Selected Topics:

- Evaluation and Hormonal Treatment of Male Sexual Dysfunction
- Erectile Dysfunction - Advanced Therapeutics
- Transgender Hormone Therapy Protocol
- Oxytocin Use in Male Sexual Function
- Comprehensive Look at Male Hormone Therapy
- Discussion of Testosterone Pellet Therapy, Oxytocin and Treatment of Premature Ejaculation Therapies for Erectile Dysfunction
- Treatment of Sexual Dysfunction after Prostate Cancer
- Sexuality in the Lesbian, Gay and Transgender communities will be discussed extensively including sexual function, dysfunction and special considerations in treating these populations

Module C: Impact of Medical and Psychological Conditions on Sexuality

MedEd Library (https://tarsus.geniussis.com/Registration.aspx) CONTACT US (/contact-us.html) CART (/cart.html) MY ACCOUNT (/my-account.html)

MENU

Online Certification - Sexual Health
Sexual Health and Treatment - Module C

(/) **Only: $1,800**

ADD TO CART (/cart;cart,add_to_cart,sh_online_module_3,1.html)

Chambers 008

Course Description:

This module will focus on various physical and emotional issues which result in sexual dysfunction. Treatment modalities will be discussed with focus on breast cancer patients and uro-gynecologic issues. Examples and discussion will be reviewed to gain an understanding on identifying and/or properly referring patients with psychologic aspect of sexual dysfunction.

Selected Topics:

- Discuss sexual problems and issues that may result as a consequence of various medical conditions and their management
- Understand and treat sexual problems of patients with breast cancer
- Identify and possibly treat or make proper referral for uro-gynecologic issues leading to sexual dysfunction
- Understand various paraphilia and unusual sexual practices and evaluation and treatment of patients with concerns in these areas
- Identify and treat and/or proper referral of patient with psychologic aspects of sexual dysfunction

Module D: Hormones and sexual dysfunction plus sex and pregnancy (prenatal, pregnant and post-partum)

Online Certification - Sexual Health
Sexual Health and Treatment - Module D

Only: $1,800

ADD TO CART (/cart;cart,add_to_cart,sh_online_module_4,1.html)

Course Description:

This module with focus on advanced endocrinology in the male patient. Male sexuality, late-life hypogonadism, benign prostatic hyperplasia, lower urinary tract symptoms, prostate cancer and the use of hormonal therapies, nutrition and the aging male, osteoporosis in men and sarcopenia will all be subjects of discussion in this module. The male athlete will also be a focus of this very interesting course.

Selected Topics:

- Understand treatment of sexual dysfunction with oxytocin
- Be able to identify and treat adrenal dysfunction leading to sexual dysfunction
- Learn about pellet therapy, indications, dosing and benefits
- Know how hormones besides estrogen and progesterone play a role in sexual dysfunction and how to address these issues
- Understand improvement of prenatal status, fertility, postpartum sexuality and contraception

Chambers 009

Learn More

Learn More

A4M Membership

(/a4m-membership.html)

Learn More

(/)

The **American Academy of Anti-Aging Medicine** (A4M) is dedicated to the advancement of healthcare technologies and transformations that can combat chronic diseases associated with aging. A4M offers continuing medical education, activities, and training through its advanced education entity **Metabolic Medical Institute** (MMI).

A division of Tarsus Medical owned by Tarsus Group

(https://www.tarsusmedicalgroup.com/)

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EXHIBIT D

EXHIBIT D

IMNE | Institute for Medical and Nursing Education

Certifies that

George P. Chambers Jr, MD

has participated in the educational activity titled

National Society of Cosmetic Physicians
7th Annual Congress on Aesthetic Vaginal Surgery
October 20-21, 2012

at The Cosmopolitan of Las Vegas in Las Vegas, NV

and is awarded 16 AMA PRA Category 1 Credits ™

Steve Weinman, RN
Executive Director

11/01/12

150 West End Avenue | Somerville, NJ 08876 | USA | +1 609 936 7015 (Phone) | +1 609 207 7032 (Fax)| www.IMNE.com

SOUTH COAST
UROGYNECOLOGY
THE ALINSOD INSTITUTE FOR
AESTHETIC VAGINAL SURGERY

AND

NATIONAL SOCIETY
OF
COSMETIC PHYSICIANS

7th Annual Congress On Aesthetic Vaginal Surgery

CAVS 2012

OCTOBER 20-21, 2012
The Cosmopolitan
Las Vegas, Nevada

RED M ALINSOD, M.D., FACOG, FACS, ACGE
Program Director and Chairman
www.urogyn.org

AL SOCIETY
OF
PHYSICIANS

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WELCOME LETTER FROM THE CHAIRMAN

Dear Friends and Colleagues, Welcome to CAVS 2012!

Once more I am thrilled to bring to you this year's 7th Annual Congress on Aesthetic Vaginal Surgery, CAVS 2012. We continue to grow as a supportive and professional association of surgeons whose goals are totally committed to our patient's safety and well-being. Thank you for joining us again this year as we learn from experts from around the United States and the world. It is wonderful to be back in Las Vegas to enjoy the thrills of the vibrant city and to rekindle friendships. CAVS is the first and longest running CME conference in the world on Aesthetic Vaginal Surgery and continues to be the "Grand Daddy" of them all. Thank you for your loyalty and desire for learning. Our goal is to live up and surpass your expectations. It has been an amazing seven years of growth as we see societies focusing on Aesthetic Vaginal Surgery arising from countries all over the globe from numerous European countries, Brazil, Korea, China, and others. We welcome our sister societies with open arms. We support organizations that educate and promote safety in the care of women. This year, we intend to raise this support and awareness to a higher level with opportunities offered to our attendees to give of their talents and time in the compassionate service for genitally harmed women.

As in past meetings, our focus is pinpoint sharp on labial and vaginal surgery and what it takes to perform these safely, beautifully, and with care. I would like to thank our renowned experts, across the nation and abroad, who have graciously accepted to share their knowledge with us. The preliminary agenda attached gives an outline of topics to be discussed and presented. CAVS 2012 will be the place to hear and learn of new ideas and new techniques in Aesthetic Vaginal Surgery and to expand on those already established. We will keep you on the cutting edge.

I would love to meet each and every one of you and start a long friendship. Please feel free to contact me for further information and details.

Warmest regards,

Red Alinsod, MD, FACOG, FACS, ACGE
Program Director and Chairman, CAVS 2012
red@urogyn.org
www.urogyn.org
www.pelvicsurgeon.com
949-499-5311 Office
949-499-5312 Fax

Day 1, Saturday, October 20, 2012
Symposium on Aesthetic Labial Surgeries
Program Chairman: Red Alinsod, MD

07:00 – 08:00 Breakfast, On-Site Registration

08:00 – 08:10 L0: Welcome
NSOCP and CAVS: From Evolution to Revolution
Red Alinsod, MD

08:10 – 08:45 Keynote Address
L1: New and Evolving Treatments for
Female Sexual Dysfunction
Jennifer Berman, MD (35 min)

Medical management and treatment of female sexual function complaints is becoming more mainstream and gradually evolving as more clinical and basic science studies are dedicated to solving this problem. Aside from hormone replacement therapy, medical management of female sexual function complaints still remains in the experimental phases and requires "off label" use. The goal of this talk is to educate health care professionals that not all female sexual complaints are psychological/emotionally based and that there are possible medical treatment options available. Attendees should gain a general understanding of female sexual function complaints, the etiologies that are medically based, as well as a comfort level with the treatment options available. Studies are currently in progress assessing the effects of vasoactive substances, adrenal and gonadal hormones and pituitary activating hormones, as well as other neuromodulators on the female sexual response. Aside from hormone replacement therapy, all medications discussed in this talk, other than over the counter products, are not FDA approved for use in women, are still in phases of clinical trials, however, some can be prescribed off label.

Literature about vag. aesthetics
- grace@cosmeticphysicians.org
- Michaelgordon2350@gmail.com
- [illegible]

08:45 – 09:05 L2: The Ev
Michael G
This presentation will revie
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1) Reasons women give f
(AVS).
2) Psychological, sexual,
requesting AVS.
3) Outcome studies of AV

The goal of this lecture is t
reviewed medical literatur
Excluded are all "opinion p
theoretical editorializing.

Suggestions will be made f
answers to audience queri
protocol and coordination

"...Only the facts, Mam..!"

09:05 – 09:25 L3: Body I
Otto Placil
Issues of abnormal body ir
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09:25 – 09:45 L4: The G-
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09:45 – 10:05 L5: Labia M
Bernard S
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Results: "Satisfied" cosme
Conclusions: The aesthetic
evolving and continuously
results are based on indivi
the technique itself!

- about vag. aesthetics
cosmeticphysicians.org
...250@gynmd.com

08:45 – 09:05 L2: The Evolution of AVS: A Literature Review
Michael Goodman, MD (20 min)
This presentation will review the peer-reviewed medical literature to date in the following areas:

1) Reasons women give for requesting aesthetic vulvovaginal surgery (AVS).
2) Psychological, sexual, and body image makeup of women requesting AVS.
3) Outcome studies of AVS.

The goal of this lecture is to familiarize attendees with the sum of peer-reviewed medical literature involving the areas outlined above. Excluded are all "opinion pieces," anecdotal information, and theoretical editorializing.

Suggestions will be made for areas of useful potential study with answers to audience queries regarding the mechanics of writing a study protocol and coordination a publishable study.

"...Only the facts, Mam..!"

09:05 – 09:25 L3: Body Image and AVS
Otto Placik, MD (20 min)
Issues of abnormal body image, real and imagined, are discussed to help the surgeon analyze patient reasons for requesting surgery and to help set achievable end points and expectations

09:25 – 09:45 L4: The G-Spot: Science and Fiction
Gul Zikria, MD (20 min)
Since the term was coined in the early 1980s. The G Spot has been a concept that has intrigued the lay public. It has also been a boon for sexologists and therapists publications and practices. In the 1990s it reemerged as a marketing term as G Spot Amplification by Dr. David Matlock. Whereby the area called the G Spot was bulked up with collagen. Despite the lack of scientific evidence, the public influenced by lay press and marketing gimmicks, is demanding this procedure as a panacea for their sexual enhancement. In this lecture I will be discussing the Myth and science of the G Spot.

09:45 – 10:05 L5: Labia Minora Plasty Techniques: A Review
Bernard Stern, MD (20 min)
Background: Once uncommon and rarely asked for surgery, now enormous demand by women from all walks of life.
Methods: Sculpted linear resection, deepitheliazation, Modified V-wedge, and Z-plasty techniques.
Results: "Satisfied" cosmetic result initially 91.6%
Conclusions: The aesthetic and functional results achieved by these evolving and continuously refined techniques, are remarkable. The results are based on individual surgeons skills at "his" technique, not the technique itself!

"Colpoperineoplasty"

- Use 4-0, 5-0, 6-0 sutures

13:55 – 14:10 L15: Surgical Management of the Camel Toe
Red Alinsod, MD (15 Min)
A modification of a standard Vulvectomy, Labia Majora Plasty, is presented for the purpose of reducing the discomfort, sagging and looseness of the Labia Majora in an aesthetically pleasing and elegant manner. The first long term results of this technique is presented performed over seven years.

14:10 – 14:45 **Panel Q&A, Break & Exhibits**

14:45 – 14:55 L16: The Unified Approach to Labiaplasty: Minora/Majora/Hood Combined Surgery
Red Alinsod, MD (10 Min)
An advanced technique is presented that combines labiaplasty of the minora, majora, and clitoral hood as a unified whole. This radical labiaplasty technique allows for one single layered closure per side. This technique is used in a select subset of patients who request maximum comfort and elimination of the labia minora. (video presentation)

14:55 - 15:10 L17: Herpes Outbreaks Complicating Aesthetic Vaginal Procedures
Bernard Stern, MD (15 Min)
Although herpetic outbreaks have been well documented in Cosmetic Surgery literature (almost exclusively though in relation to cosmetic facial procedures mostly laser and/or TCA peals), there is nothing in Aesthetic Vaginal Surgery literature addressing this problem. Preventive pre/intra/and post operative treatment with Acyclovir or Valtrex has become commonplace for these procedures. Having had 3 outbreaks in the previous year's cosmetic vaginal procedures, no patient of which admitted to previous exposure to the virus, one with a significant sequellae, preventive prophylactic treatment is now being suggested.

15:10 – 15:25 L18: Medical Photography and Videography for Idiots
Red Alinsod, MD (15 Min)
A medical practice is often judged by the quality of its photographs. It is imperative in a cosmetic practice to know how to take advantage of today's technologies in photography. Medical photography can be low cost and simple when basic tenets are followed. Medical photography can be used for medical documentation, medico-legal protection, marketing, advertising, staff training, and patient education. This presentation focuses on the typical types of photography done for an aesthetic vaginal surgery practice.

If ZP patient doesn't allow pre-op photo, politely ask her to see another surgeon.

If for short zoom, need these lens:
- 24-70 mm or longer
- Macro [100 mm F2.8 for close ups] lens

III Positions for pre-op + post-op photos.
- Sides (45°, 90°, 180°)
- Front lying in stirrups
- Patient view from above looking downward
- Front view standing.
- Rear view standing
- Rear view on hands & knees
- Rear view lying on abdomen
- Make sure patients understands these poses

Alinsod's course cost?
VS
Goodman's course cost?

15:25 – 15:50 L19: Relations
Subtlety (25 M
Monique Ram
It's not about the tools it's abo
will cover the elements of a
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15:50 – 16:05 L20: Searc
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18:30 – 22:00 **Welco**
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FACULTY LISTING

RED M. ALINSOD, MD, FACOG, ACGE LAGUNA BEACH, CA
South Coast Urogynecology and The Laguna Laser Center
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Phone: (949) 499-5311 Fax: (949) 499-5312
Email: red@urogyn.org
Website: www.urogyn.org, www.pelvicsurgeon.com

Dr. Alinsod graduated from Loma Linda University School of Medicine in 1986 and completed his OB/GYN residence from Loma Linda University Medical Center in 1990. His focus is in pelvic and vaginal surgery. He was the first Rutledge Fellow at MD Anderson Cancer and Tumor Institute and was also accepted to Yale's Gynecologic Oncology fellowship. While heading the Gynecological Services at George Air Force Base, California, and Nellis Air Force Base, Nevada. Dr. Alinsod concentrated on benign gynecology, urogynecology and pelvic surgery. During his 12-year military career, he trained extensively in vaginal surgery, hysteroscopic, and advanced laparoscopic surgery. He became a fellow of The Accreditation Council of Gynecologic Endoscopy in 1995, Certificate #20, the first surgeon to achieve this distinction in Nevada. He is one of the first surgeons in the United States to perform and teach the "trans-obturator tape" incontinence sling, Anterior IVS sling, and Posterior IVS vaginal suspension. He has taught pelvic reconstructive surgery for various companies (AMS, BARD, Boston Scientific, Tyco, Caldera Medical, Coloplast/Mpathy Medical) over the past 15 years and knows of the products and technologies that relate to incontinence and pelvic reconstructive surgery, specifically mesh augmented repairs. Dr. Alinsod was the first surgeon to attach biologic and polypropylene mesh to the Posterior IVS device and use it for posterior compartment repair along with apical vault suspension now copied by many companies. He invented a vaginal approach to uterine suspension using standard sling material and mesh suspension kits in 1997. He owns several patents including the one for the Lone Star APS Retractor System and the "Sling with Bladder Support" from which came systems such as Perigee, Avaulta A, Prolift A, and Ascend A. Most recently, he was awarded the patent for a surgical stand and stray for pelvic/vaginal/colorectal/urologic surgery. Dr. Alinsod is the primary designer and inventor of Caldera Medical's Ascend Pelvic Floor Mesh device and also the designer of Coloplast/Mpathy Medical's shaped Restorelle Mesh. He is the inventor of the LoneStar APS Vaginal Retractor System, APS Draping System, Alinsod UroGyn Scissors/Pickups/Table, APS Balloon Catheter Pain Pump System, and Alinsod Labiaplasty Pain Catheters. Dr. Alinsod continues to be active in surgical teaching and product design and development as it relates to vaginal and pelvic surgery.

After a ten-year career in Los Angeles working for a very busy medium sized multi-specialty group, Dr. Alinsod decided to try a solo urogynecologic practice. In 2004, he was recruited by South Coast Medical Center in Laguna Beach, California, to develop the Women's Center and head up the Urogynecology services. Today, he is the director and owner of South Coast Urogynecology and the Alinsod Institute for Aesthetic Vaginal Surgery. He developed the first CME approved course in AVS and founded CAVS 7 years ago to educate surgeons on AVS, provide a medium for the exchange of ideas, and to protect the health of patients.

He is very active in presenting talks locally and nationally and in teaching physicians the art and science of incontinence/pelvic reconstructive surgery and aesthetic gynecology. He has presented talks in AVS for The American Academy of Cosmetic Surgeons, International Society of Cosmetogynecologists, National Society of Cosmetic Physicians, American Association of Gynecologic Laparoscopists, and he was the first Honorary Chairman of Brazil's aesthetic Gynecology Symposium, 2009. Recently, Red has presented his vaginal mesh clinical study at the IUGA meeting in Brisbane, WS-AUA in Hawaii and AUGS in Chicago. Before the year ends he will be presenting at AAGL in Las Vegas, in Warsaw, Poland and in China. He continues his world class teaching program in both pelvic reconstructive surgery and aesthetic vaginal surgery in Laguna Beach.

FACULTY LISTING

JUAN CARLOS DIAZCADENA, MD — PHOENIX, AZ

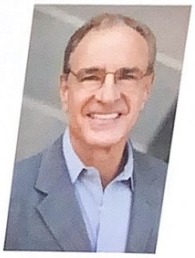
6036 N 19TH Ave, Ste 301, Phoenix, Arizona 85015
Phone: (602) 710-2040
Email: cdiazcadena@cox.net
Website:

Dr. Diazcadena graduated from Universidad Nueva Granada Military School of Medicine and Health sciences, Bogota Colombia in 1986. He completed his Family Practice residency at the University of Minnesota in 1995 and completed his OB/GYN residency at Good Samaritan Regional Medical Center in Phoenix, Arizona in 1998.

Dr. Diazcadena is a sole practitioner in Phoenix, AZ. He is currently the Department chair of OB/GYN for Phoenix Baptist Hospital and Director/President of Clinica Central, a non-profit organization directed to proving healthcare for uninsured women and women in need.

His caring and focus is on the individual's overall health and well-being. The goal of his practice is to provide the best and most current medical management on urogynecology with minimally invasive surgery including robotic surgery, pelvic reconstruction and cosmetic gynecology.

MICHAEL GOODMAN, MD, CMP, CCD — DAVIS, CA



"Caring For Women Wellness Center"
635 Anderson Road, Suite 12B, Davis, California 95616
Phone: (530) 753-2787
Email: info@drmichaelgoodman.com
Website: www.drmichaelgoodman.com

Stanford University trained in obstetrics and gynecology, Dr. Michael Goodman began his practice in rural Mendocino County, California in 1972, where he was one of the early pioneers of Family-Centered Maternity Care. In the early 1980s his interest turned to the new area of advanced operative laparoscopy. He became one of the first credentialed Advanced Operative Laparoscopists, and taught, wrote, and lectured on the subject, as well as functioning as a peer reviewer for the Journal of the American Association of Gynecologic Laparoscopists (now called the Journal of Minimally Invasive Surgery.)

Beginning in the mid- '90s, Dr. Goodman developed an interest in integrative, menopausal and sexual medicine, as well as female genital plastic and cosmetic surgery. After moving to Davis, CA in 2000 he became certified as a Clinical Bone Densiometrist and Certified Menopause Practitioner. After additional training, he incorporated a long- time interest in Sexual Medicine into his practice. His present practice in Davis, California specializes in difficult gynecologic issues, peri-menopausal medicine, health and vitality enhancement, male and female sexuality issues, bone densiometry, pelvic ultrasound and vulvovaginal aesthetic surgery. He has been an invited guest at numerous seminars on these subjects, and has appeared as an invited guest many times on area network TV and talk radio. His six citations in peer-reviewed scientific literature on the subject of female genital plastic/cosmetic surgery are by far the most internationally of any researcher.

Dr. Goodman is the proud father of four children, ages 13 to 39, and enjoys exercising, tennis, gardening, music and writing. He is the author of two popular books on menopause, and many peer-reviewed articles on female genital plastic surgery, genital aesthetics and sexuality/body image, hormone therapy, advanced operative laparoscopy, and family-centered maternity care.

EXHIBIT E

EXHIBIT E

MEDICAL RECORDS

This exhibit contains personal medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310.

EXHIBIT F

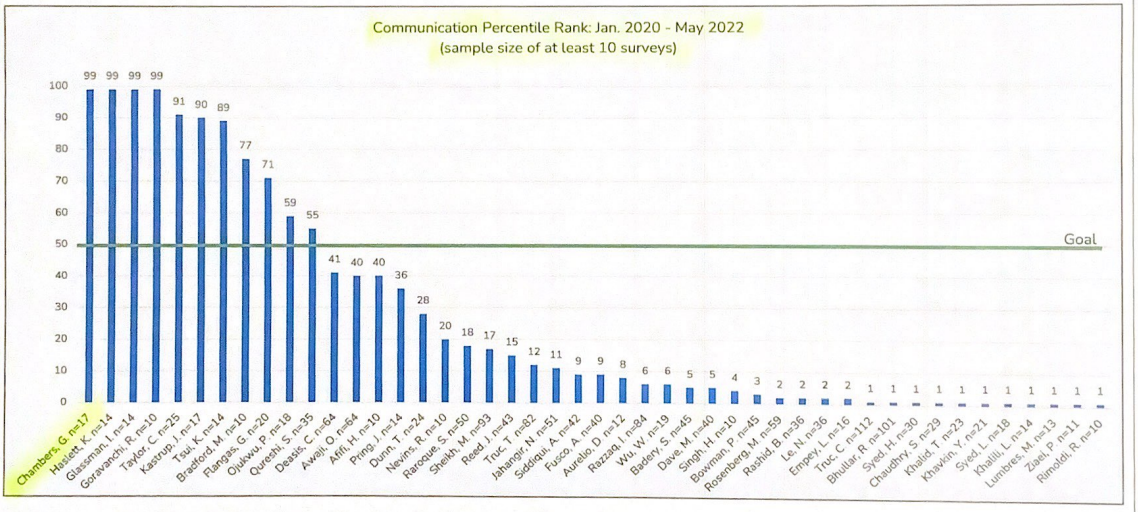
EXHIBIT F

Physician Communication

Patients are asked three questions about their physicians' communication on the HCAHPS survey

1. How often did doctors **explain** things in a way you could **understand**?
2. " " " " **listen carefully** to you?
3. " " " " treat you with **courtesy and respect?**

Press Ganey compares raw scores to generate a national percentile ranking, seen below



Behaviors that improve communication with patients

- Use layman's terms
- Use the whiteboard
- Sit while speaking with patients
- Round with the nurse
- Eliminate medical jargon
- Ask patient to teach-back instructions
- Reflective listening
- Use simple explanations
- Demonstrate empathy
- Give patients your business card
- Explain information multiple times

SPRING VALLEY HOSPITAL MEDICAL CENTER

Chambers 024

EXHIBIT G

EXHIBIT G

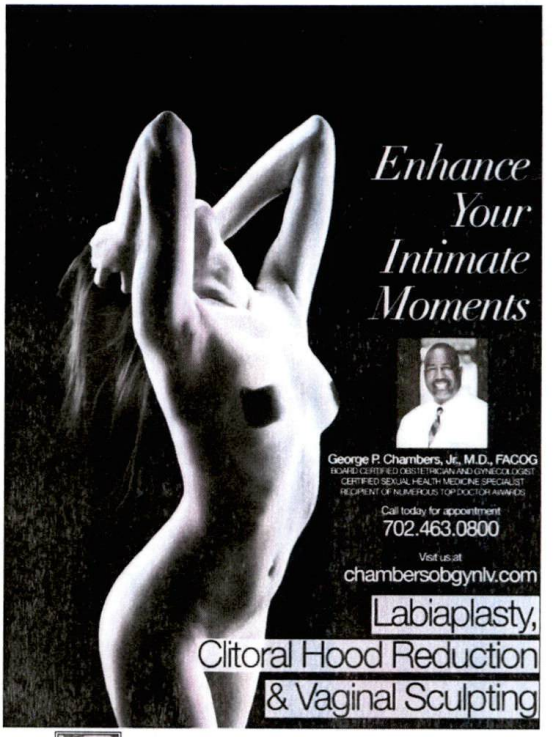

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EXHIBIT H

EXHIBIT H

MEDICAL RECORDS

This exhibit contains personal medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310.

EXHIBIT I

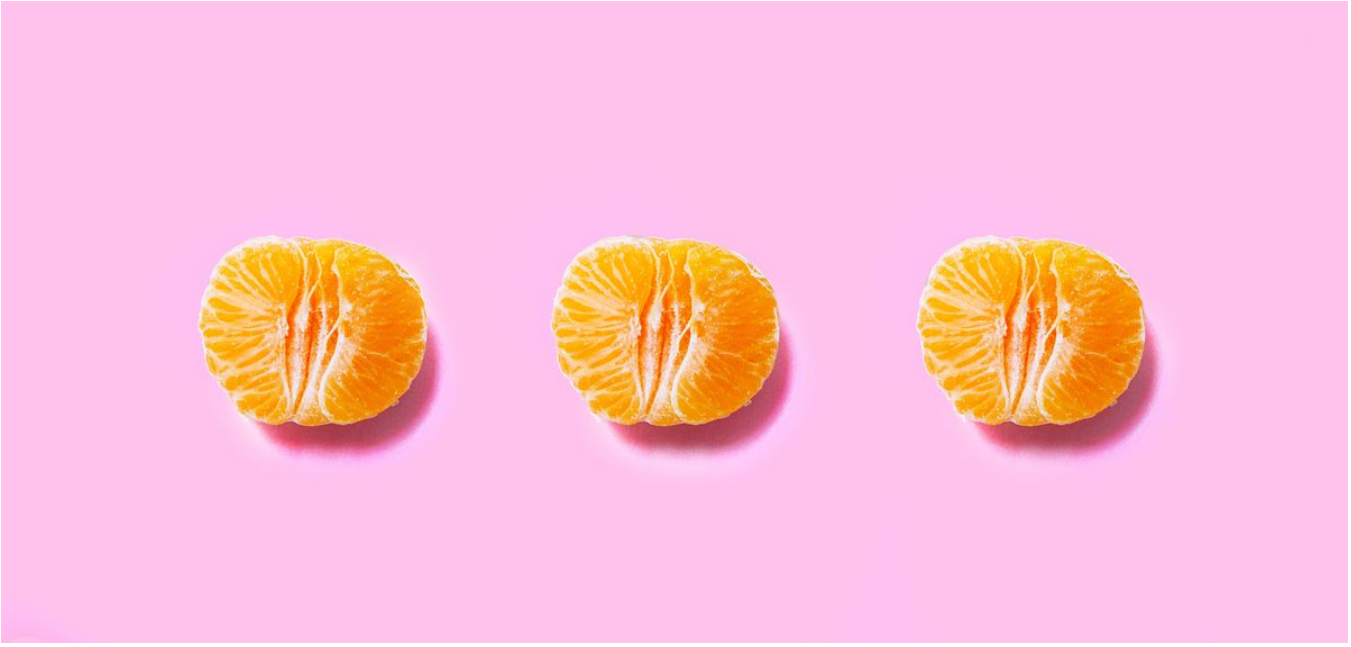
EXHIBIT I

Health

What Exactly Is A Designer Vagina? What To Know About Labiaplasty

Basically, it's a surgical vulva makeover.

BY **MARA SANTILLI** PUBLISHED: FEB 15, 2020



GETTY IMAGES

If celebs have taught us anything in recent years, it's that the vulva and vagina aren't off-limits when it comes to cosmetic treatments. From the Kardashian sisters' openness about getting laser vaginal rejuvenation to Sharon Osborne talking about her vaginal tightening procedure, it's clear that beautification treatments below the belt are becoming commonplace. And the trend is growing among non-celebrities too. In fact, when it comes to labiaplasty (aka "designer vagina" surgery, which involves altering the labia), there was a 53 percent increase in procedures from 2013 to 2018 in the U.S., according to the American Society for Aesthetic Plastic Surgery.

This growing trend might be due to an increase in awareness and conversation about vaginal health, suggests Juliana Hansen, MD, professor of surgery and division chief of plastic and reconstructive surgery at Oregon Health and Science University School of Medicine. “For many generations, vaginal health has been considered taboo, and procedures and options for care for female genitalia weren’t available,” Dr. Hansen says.

The number of labiaplasty procedures increased 53 percent in the U.S. between 2013 and 2018.

Regardless of the the exact reason behind the trend, vaginal health, and plastic surgery in and around the vaginal area, are getting more attention than ever before. Here, everything you need to know about labiaplasty and other common vaginal cosmetic procedures.

MORE FROM WOMEN'S HEALTH
Everything to Know About Your Menstrual Cycle

What is labiaplasty?

WATCH: Everything to Know About Your Menstrual Cycle

Labiaplasty is mostly an aesthetic procedure, but it could also be functional (more on the reasons women have it done below). In most cases, the surgery alters the labia minora, or the inner lips of the vagina, Dr. Hansen explains, but it could be tailored to alter the labia majora, or outer lips, as well. Basically, the plastic surgeon shortens the labia to remove excess tissue, which might be bothering the patient for aesthetic or functional reasons, e.g., it gets in the way during sex or exercise.

Labiaplasty is different from a vaginoplasty, which is a surgical procedure for vaginal tightening, Dr. Hansen explains. Certain patients may have this done because of pelvic-floor issues, such as incontinence, after multiple childbirths, she says. But, it's also often done to help increase vaginal tightness for sexual pleasure purposes. However, "there is not a ton of evidence that [vaginoplasty] procedures work well," Dr. Hansen says, "and there may be potential for causing chronic pain and harm."

Labiaplasty involves shortening the labia to remove excess tissue, which might be bothering someone due to aesthetic or functional reasons.

There are also non-surgical vaginal rejuvenation treatments, which fall into the "designer vagina" trend but are totally different than labiaplasty. “These include lasers to stimulate the mucosa, or inner lining, of the vagina, and LED light treatments that supposedly stimulate the vagina to produce more tissue,” Dr. Hansen says. However, she warns that most of these treatments are not FDA-approved or scientifically proven to increase vaginal tightness or reduce dryness.

Surgeries for transgender women are generally completely separate from labiaplasty procedures and vaginal rejuvenation procedures as well. Gender confirmation surgeries often involve creating a vulva for a male-to-female transgender patient, but typically the new vulva then needs to be dilated and stretched to function properly, Dr. Hansen says—which is

labiaplasty procedures.

Why would someone get a labiaplasty?

There are a few reasons for undergoing a labiaplasty procedure, but most of them involve aesthetics as opposed to medical necessity:

- **Dissatisfaction with the labia’s appearance**: This is the number-one reason women tend to have labiaplasty done. They might experience embarrassment or lack of confidence in how their labia look, especially during sex. In many women, the labia minora hang lower—which is completely normal!—but doesn't match the very narrow beauty standards women see in media, Dr. Hansen says.
- **Discomfort with long labia:** Having larger or longer labia could actually cause functional problems for some patients. This could include discomfort riding a bike or wearing underwear or a thong, or excess moisture coming from the vagina.
- **Pain during sex:** Dissatisfaction with the appearance of the labia may affect a patient’s confidence in the bedroom—but having enlarged or longer labia could also get in the way during sex, potentially causing a painful, or at the very least, uncomfortable experience. “Just by reducing the size of the labia, sexual function might be improved, if anything, because you’re not as worried about the tissue getting pulled or stretched during intercourse,” Dr. Hansen says.
- **Cancers or pre-cancerous conditions:** One medical reason for a labia reconstruction might involve having to remove part of the labia that contains cancer cells in the vaginal area. “Cancers or pre-cancerous conditions that can grow there might require excisions,” Dr. Hansen says.

What are the risks of labiaplasty?

Like any medical procedure, labiaplasty doesn't come 100 percent risk-free. Possible complications include wound separation and scarring. Some researchers have also raised concerns about possible loss of sexual

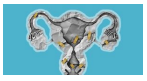
sensation as a result of labiaplasty, as well as an increased risk of trauma to the perineal area during vaginal delivery, though all of these risks need to be researched further.

What are the steps of a labiaplasty procedure?

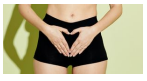
Getting labiaplasty starts with a consultation with a plastic surgeon. This is a discussion of what the problem with the vulva is, pre-operation. The doctor has to see the same issue that the patient sees with their labia, says Dr. Hansen. If there isn't a good surgical solution, which would involve shortening or reconstructing the labia, then the surgeon won't recommend surgery to the patient, Dr. Hansen notes.

The procedure itself is always surgical, but it can be done in-office, under local anesthesia in a clinic, or can be done under general anesthesia in a hospital, Dr. Hansen says. During the operation, the surgeon will reduce the size and length of the labia minora, and make a stitch line. It takes some time to heal, so she recommends two to three weeks of resting and icing the area, and keeping it clean.

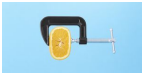
RELATED STORIES



'I Had Vaginal Reconstruction Surgery'



12 Reasons Your Vagina Hurts So Damn Much



Can Your Vagina Be Too Tight For Sex?

"We also recommend that patients avoid activities that will traumatize or stretch out the stitch line for about six weeks to three months," Dr. Hansen says (so it might involve getting creative with your typical sexual activity).

Patients tend to agree that the surgery goes quickly (it typically only takes about an hour), but the healing process is long. "Post operation was

extremely painful, as I expected. I took a lot of pain medicine and avoiding being on my feet at all costs for at least a week. It hurt badly when I walked for about seven days, and I felt a burning pain which was worse during urination," wrote one patient in a review of her experience with the procedure at Labiaplasty Boston in Boston, Massachusetts. "You should make sure you have at least a week off if you plan on getting this done. However, this procedure was well worth the pain."

(You can check out real before-and-after images from the Labiaplasty Center of NYC here—but, warning, they are *NSFW.*)

How much does labiaplasty cost?

These are typically considered elective cosmetic surgeries, Dr. Hansen says, so it would be difficult to get it covered by any insurance company, even if you could argue that the procedure might be medically beneficial (such as in the case of pain during sex or reconstruction after the removal of cancerous cells).

Are labiaplasty procedures off-limits for anyone?

Generally speaking, if the surgeon doesn't see a valid reason for performing labiaplasty on a patient, they won't. Other than that, patients who have other medical conditions, especially those that might affect healing, would not be good candidates, Dr. Hansen says. If you have other medical conditions, it's best to consult your primary care physician first before seeing a plastic surgeon.

Also, the procedure is a no-go for pregnant women, because giving birth would affect healing. "A natural childbirth would impact that area, and women might tear their stitch line or need an episiotomy after birth," Dr. Hansen says, so most surgeons would never recommend that.

The bottom line: Labiaplasty may help if you feel that your labia are interfere with your ability to function sexually or cause pain or discomfort. But keep in mind that it's normal for vulvas and vaginas to come in all shapes and sizes—so only take the medical risk if *you* want to.

MARA SANTILLI

Mara is a freelance writer and editor specializing in culture, politics, wellness, and the intersection between them, whose print and digital work has appeared in Marie Claire, Women's Health, Cosmopolitan, Airbnb Mag, Prevention, and more. She's a Fordham

University graduate who also has a degree in Italian Studies, so naturally she's always daydreaming about focaccia.

EXHIBIT J

EXHIBIT J

Guidelines for the Standardization of Genital Photography

Natalie R Joumblat, BS, Jimmy Chim, MD, Priscila Gisselle Aguirre Sanchez, MD, Edgar Bedolla, MD, Christopher J Salgado, MD

Special Topic

Guidelines for the Standardization of Genital Photography

Aesthetic Surgery Journal
2018, Vol 38(10) 1124–1130

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Natalie R. Joumblat, BS; Jimmy Chim, MD; Priscila Gisselle Aguirre Sanchez, MD; Edgar Bedolla, MD; and Christopher J. Salgado, MD

Abstract

Plastic surgery relies on photography for both clinical practice and research. The Photographic Standards in Plastic Surgery laid the foundation for standardized photography in plastic surgery. Despite these advancements, the current literature lacks guidelines for genital photography, thus resulting in a discordance of documentation. The authors propose photographic standards for the male and female genitalia to establish homogeneity in which information can be accurately exchanged. All medical photographs include a sky-blue background, proper lighting, removal of distractors, consistent camera framing, and standard camera angles. We propose the following guidelines to standardize genital photography. In the anterior upright position, feet are shoulder-width apart, and arms are placed posteriorly. The frame is bounded superiorly by the xiphoid-umbilicus midpoint and inferiorly by the patella. For circumferential documentation, frontal 180 degree capture via 45 degree intervals is often sufficient. Images in standard lithotomy position should be captured at both parallel and 45 degrees above the horizontal. Images of the phallus should include both the flaccid and erect states. Despite the increasing incidence of genital procedures, there lacks a standardized methodology in which to document the genitalia, resulting in a substantial heterogeneity in the current literature. Our standardized techniques for genital photography set forth to establish a uniform language that promotes more effective communication with both the patient as well as with colleagues. The proposed photography guidelines provide optimal visualization and standard documentation of the genitalia, allowing for accurate education, meaningful collaborations, and advancement in genital surgery.

Editorial Decision date: January 15, 2018; online publish-ahead-of-print February 6, 2018.

In medicine, photography enables objective analysis of results by using validated scoring methods based on visual assessments. Especially in plastic surgery, a visually oriented specialty, photography plays an extremely important role in both clinical practice and research.[1] Clinically, photographs are used for preoperative planning, intraoperative visual referencing, postoperative documenting, and assessing surgical outcome.[1-3] In addition, photographs can be utilized in patient education to clearly communicate the surgical plan as well as provide pre- and postoperative comparisons.[2] In research, photography is used in presentations and publications to demonstrate an objective analysis of applied techniques and outcomes.[1,2] From a legal standpoint, photography should be an integral part of the patient's record as it could support the defense of the surgeon in the event of litigation.[2]

From the Division of Plastic, Reconstructive, Aesthetic and Transgender Surgery, University of Miami Hospital, University of Miami Miller School of Medicine, Miami, FL

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Consistency is crucial in medical photography. Standardized photography reduces variables that can produce false postoperative comparisons as well as provides reliable reproducibility for valid photographic results in academic research.[1] Studies show that minor deviations from accepted standards decreases the clinical value of the photography, thus reducing its validity in medicolegal litigation, surgical planning, and communication amongst surgeons.[2,4-6]

In order to ensure accurate comparisons amongst colleagues, the American Society of Plastic Surgeons and the Plastic Surgery Educational Foundation issued Photographic Standards in Plastic Surgery[7] in 1991. This publication standardized photography of the face, ears, mouth, breasts, abdomen, hips/thighs, calves/feet, forearm, hands, and fingers.[6,7] Despite the increasing incidence of genital procedures, there is a paucity of literature that establishes photographic standards for the genitalia. We utilize our experience in genital surgery and photography to propose standard techniques that best capture the genital anatomy in a uniform manner.

GENERAL TECHNIQUES FOR PHOTOGRAPHIC STANDARDIZATION

The following generic guidelines, applicable to all medical photography, are based on review of the medical literature in addition to our own personal experience. The proposed criteria include uniform background, lighting, camera positioning, patient preparation and positioning, and photo editing.[1,3,8]

Photography Background

The standard background color in medical photography is sky blue, converted to 18% gray Kodak standard in grayscale, because it is a medium tone that contrasts with most skin colors.[9] Most camera meters are calibrated to make everything medium toned, thus having a medium toned background to lock in an exposure reading that produces color tones closest to reality. By the same token, if the camera is metered to a background lighter than sky blue, the photo will be darker, and the converse holds true as well.[9] In the clinic, this can be achieved through a handheld drape, a window shade, a roll of seamless backdrop paper, or a painted wall.[10] In the operating room, sterile blue towels may be used.[9]

Photographic Lighting

In a studio setting, optimal illumination may be achieved by placing two lights anterior, one light posterior, and one light superior of the patient being photographed.[8,11] The two anterior lights are best placed 90° apart so that each lamp is 45° with respect to the patient, one on the left side, and the other on the right.[8,11] The posterior light is best placed 30 to 60 cm from the background to minimize shadows being cast onto the background.[8,11] Strub et al described a similar symmetric multilight source positioning, but found it inferior to asymmetric lighting when photographing the nose.[12] Asymmetric lighting increases contrast and shadowing, thus enhancing 3-dimensionality and detail rendition, both important in surgical planning of rhinoplasties.[12] In genital photography, symmetric lighting is preferred, as it minimizes the shadows casted on the patient and thus reduces its distorting effect on the patient's form.[11] When selecting the light source's bulb, color temperature must be considered. "Cold" light (≥6000 K) is preferred to "warm" light (≤3500 K), as it does not produce a soft yellow glow that "warm" light does, but rather a blueish-white quality, equivalent to the high noon sun, that produces the best representation of true color.[11,13] In the clinic and in the operating room, frontal lamps in optimal positioning can be impractical. When relying on a camera's flash for lighting, special attention should be paid to positioning the camera parallel to the area of interest in order to minimize shadows.[6,11] In the operating room (OR), we turn away the adjustable lights for two reasons. First, OR lights can vary in color temperature, distance, and angle, which can alter the color, magnification, and shadowing of the subject Second, modern sensors are unable to detect the difference in intensity between the OR and ambient lighting. The camera's automatic settings have shown to produce the truest color in the setting of mixed lighting.[1]

Camera Positioning

To standardize magnification, the lens should be kept at a constant level and distance from the patient. When positioning the camera, anatomic landmarks and a tripod may assist with consistent distances and angles.[8,10,11] The camera should be placed at the height of the desired anatomic region and placed at a distance where the appropriate bounds and magnification are achieved, thus avoiding the need for zoom.[11] When possible, zoom should be avoided as it may distort the patient to look wider and adds another variable to the operator, making consistency more difficult to achieve. In cases where desired magnification cannot be accomplished mechanically, zoom may be utilized, but when doing so, the subject at hand must remain in the frame's center in order to preserve the photograph's focal point.[11] When photographing an area 8 cm or less, place a ruler in at least one of the photographs to provide a frame of reference for true size.[11]

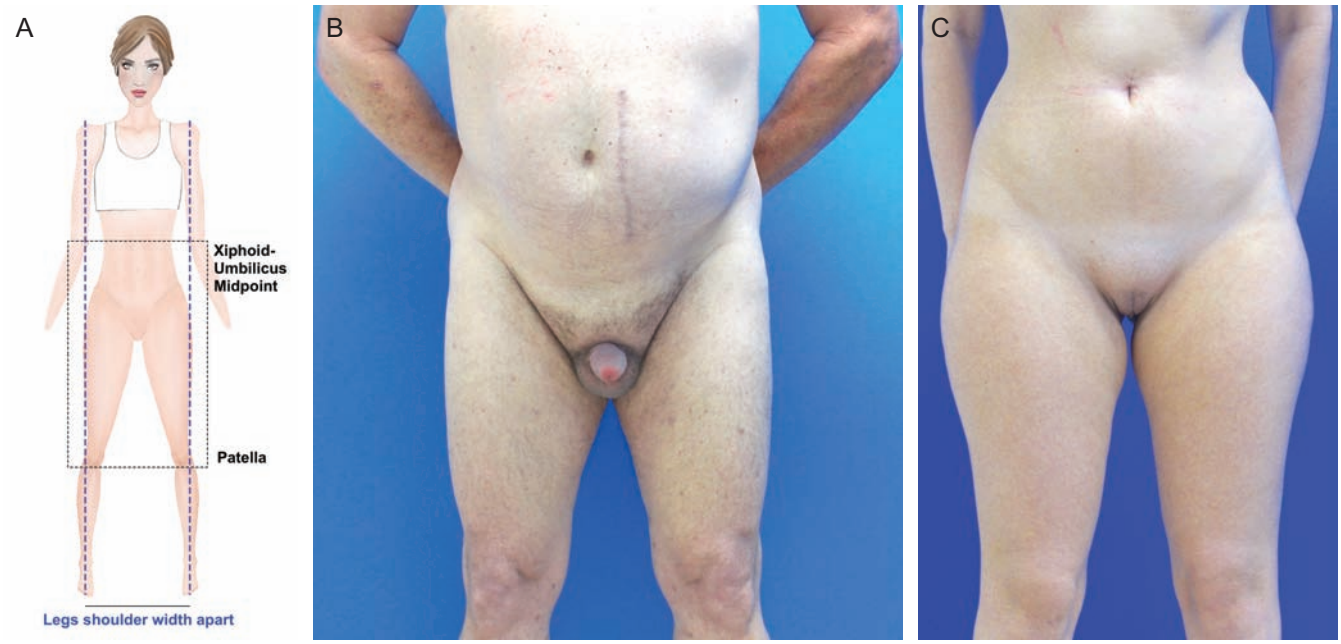

Figure 1. (A) Schematic illustration of a patient standing with legs shoulder width apart and the bounds for framing when taking a photograph of a patient's genitalia in the antero-posterior (AP) view (courtesy of Priscila Sanchez, MD). (B) AP standardized view of a 53-year-old man's external genitalia with a diagnosis of a hidden penis. (C) AP standardized view of a 26-year-old woman's external genitalia who presents with lichen sclerosis (not visible in this view).

Patient Preparation and Positioning

In medical photography, unobscured visualization of the area of interest is achieved through eliminating distractors, including the patient's clothing, gown, undergarments, jewelry, glasses, piercings, and makeup.[3,7,8,10,11] Position the patient approximately 3 feet in front of the background to minimalize distracting shadows.[14] At this position, the patient will angle themselves to assume the 5 standard views: one AP (0°), two oblique (±45°), and two lateral (±90°).

Photo Editing

If photographs are not standardized at the time of capture, editing software may be utilized to zoom and crop in order to uniformize magnification, allowing for more accurate side-by-side comparisons.[9,11] While photo editing is a useful tool, anytime an image is digitally manipulated, the authenticity is compromised. Thus, the photographic techniques describe should not be replaced by postproduction editing, and the attention to detail should be placed at the time of capture.[11]

SPECIFIC TECHNIQUES FOR PHOTOGRAPHIC STANDARDIZATION OF THE GENITALIA

With the senior author's extensive experience in performing and documenting varied genital procedures, we propose the following guidelines to standardize genital photography (C.J.S.). For the anterior-posterior image, we found that an upright standing position with the feet at shoulder-width apart is a readily acquired position for most patients in the clinical setting (Figure 1). This allows not only expeditious acquisition of the standard position, but also adequate and natural spacing between the lower extremities, thus permitting evaluation of the genital appearance in situ. Framing of the patient is somewhat arbitrary, and the authors found that the image should at least capture the xiphoid-umbilicus midpoint superiorly and the entire patella inferiorly. For the remarkably endowed male genitalia, adjustments in the framing may be made at the clinician's discretion. The lens should be positioned in level with the mons to allow for direct focus of the genital region in relation to the abdomen and lower extremities.

Arm positioning has little effect on the positioning of the genitalia, but the upper extremities can impede visualization, especially in the lateral views. The authors recommend that the patient's arms and hands hang slightly posteriorly at the sides to allow for complete capture of protuberant or retracted genitalia (Figure 2). In the female patient, lateral and oblique views do not typically reveal useful information and the anterior upright and lithotomy views suffice in most instances. A unilateral upper extremity should be utilized for retraction to capture ventral views of the penis and visualization of the scrotum.

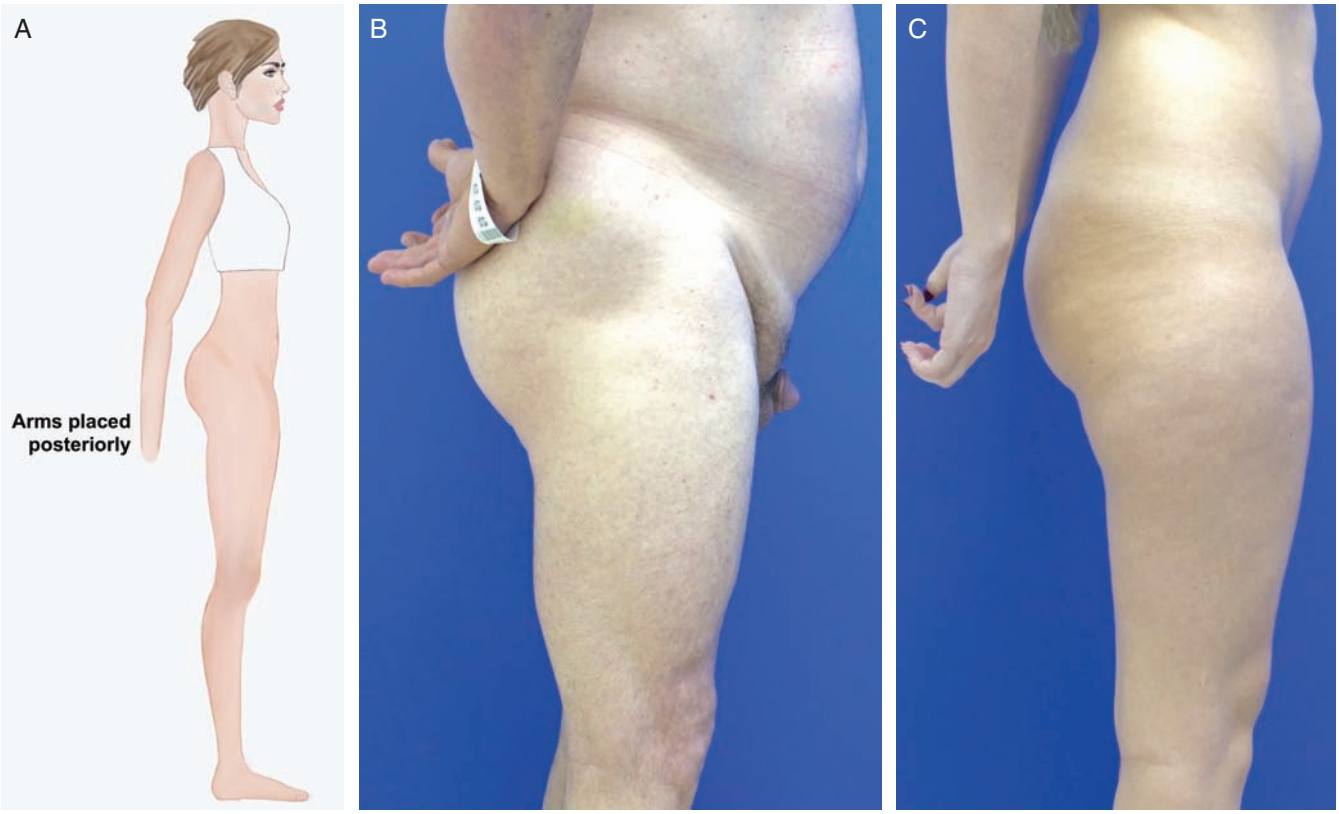

Figure 2. (A) Schematic illustration of a patient standing with arms placed posteriorly in the lateral view (courtesy of Priscila Sanchez, MD). (B) Lateral view of a 53-year-old man's external genitalia with arms placed posteriorly. (C) Lateral view of a 26-year-old woman's external genitalia with arms placed posteriorly.

In regards to differing angles of imaging, we found that frontal 180 degree capture via 45 degree intervals is often sufficient (Figure 3). Circumferential documentation can be utilized as well if further body contouring procedures are being considered. Thus 5 images should be documented for the frontal 180 degree photographs and 8 images would result from a full 360-degree circumferential series.

Lithotomy views were also found to be critical in the documentation of genital photography. These views assist in examination, objective diagnosis, and operative planning. To achieve standard lithotomy position in the clinic and in the operating room, the hips should be flexed 80 to 100° from the torso with the thighs abducted approximately 30 to 40° from the midline (Figure 4). Stirrups should support the legs at a position roughly parallel to the trunk.[15] OR lighting, as previously mentioned, is limited. Turning off the adjustable overhead lights and positioning the camera parallel to the genital's plane is simplest technique for easily reproducible, least distorted photographs in the setting of minimal equipment. For framing, the horizontal axis should include midthigh, and the vertical axis should include the entire genitalia and inferior border of the buttocks.

We found that that the genital images should be captured on a level parallel and in line with trunk as well as 45 degrees above the horizontal axis. These 2 views allow for evaluation of the mons, clitoris, clitoral hood, and labial tissues in females, and the ventral penis and scrotum in males. Retraction of specific anatomic regions of the genitalia or the surrounding skin is often necessary by the patient or the clinician to expose key aspects of the exam. In the female patient, retraction of the clitoral hood and labial tissues exposes key aspects including the introital characteristics, labial length, interstices, and genital wounds/scars. In cases of labia minora hypertrophy, it is important to document the length of the labia minora from base to distal edge, to facilitate acquisition of insurance coverage for the operation. In the male patient, retraction of the foreskin and elevation of the scrotal skin exposes the glans penis and perineal region, respectively. Photography of the male phallus should be done in both the flaccid and erect state. In the office, the erect length can be approximated by applying outward traction to the penis and measuring from the phallus base to the most distal tip of the glans.[16] Otherwise, we accept the patient providing photographic documentation of their truly erect penis obtained in the privacy of their own home. The latter

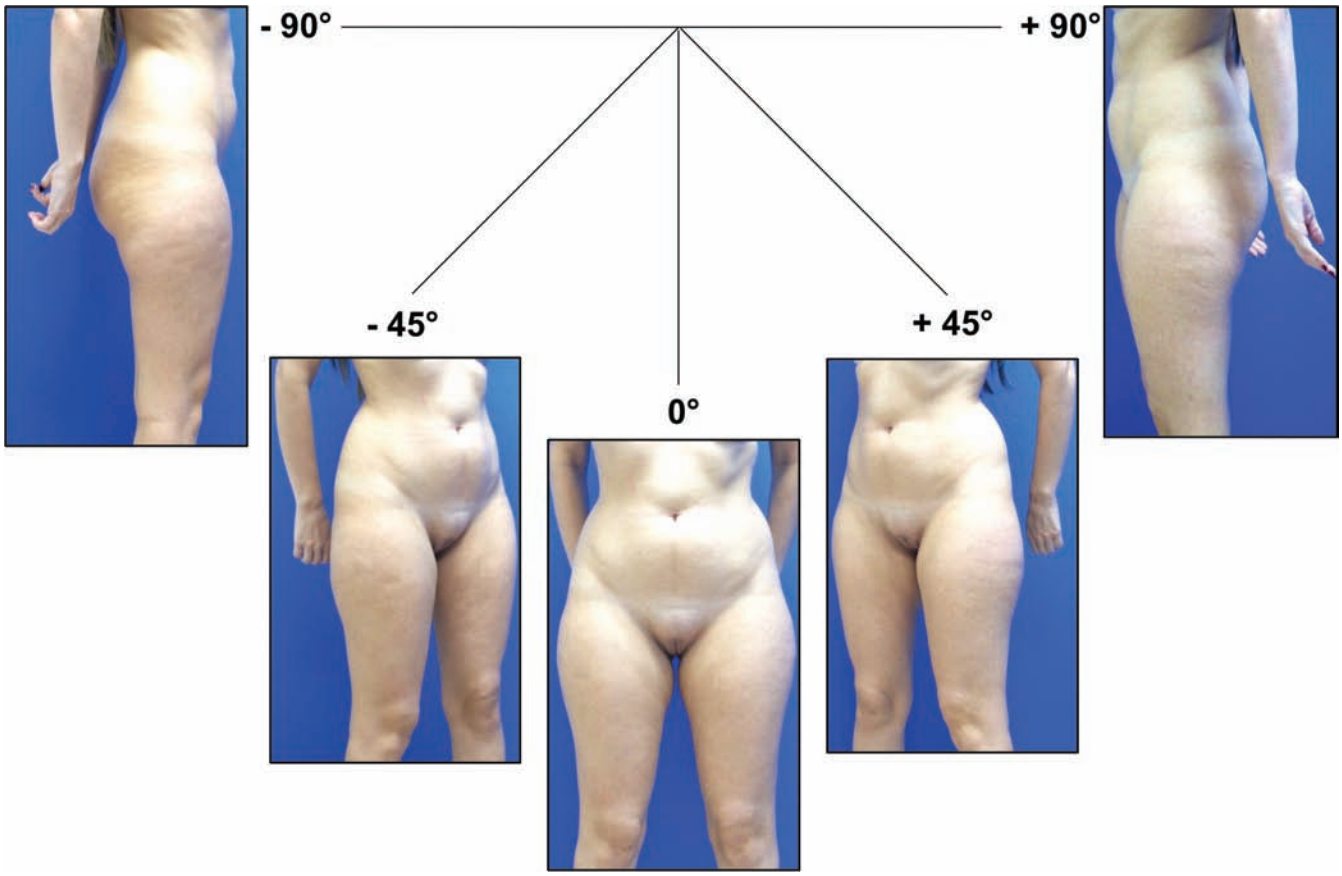

Figure 3. A 26-year-old woman positioned at −90°, −45°, 0°, +45°, and +90° (courtesy of Natalie Joumblat).

may prove more useful in circumstances where the phallus appears as a micropenis in the flaccid state, and only in the truly erect state does it become of normal length (5.5 to 6 inches), in addition to Peyronie's disease evaluation.

In cases of excessive body and genital hair we ask our patients to depilate these areas. Often, abundant hair not only conceals potential pathology, but obscures a clear view of the genital anatomy, thus compromising the operative plan.

DISCUSSION

Surgery of the genitalia, especially aesthetic procedures, has grown exponentially since the early 2000s, with some of the most popular procedures including the labiaplasty, vaginal rejuvenation, labia majora resection, mons lift, clitoral hood reduction, and volume augmentation of the mons pubis and labia majora.[17] According to the American Society for Aesthetic Plastic Surgery's Cosmetic Surgery National Data Bank Statistics, vaginal rejuvenation procedures increased by 12.5% between 2007[18] and 2013,[19] and labiaplasty procedures increased by 43% between 2014[20] and 2016.[21] Despite the increasing incidence of genital procedures, the current literature does not include any clear guidelines for photography of the male and female genitalia.[7,15] As a consequence, genital photography is substantially varying, as evidenced in peer-reviewed literature as well as national and international meetings.

With a busy practice caring for patients with aesthetic and functional problems of the genitalia, the authors believe that genital photographic standards are vital in communication with both the patient as well as with colleagues. Uniformity in pre- and postoperative photography minimizes distractors and allows surgeons to more effectively educate the patient on their surgical outcomes.[22] Reproducible guidelines enable surgeons to standardize genital photography, thus generating a homogenous language in which meaningful comparisons can be made, multicenter studies performed, and further advancement in genital surgery achieved.

CONCLUSION

The proposed photography guidelines provide optimal visualization and standard documentation of the genitalia, allowing for accurate education, meaningful collaborations, and advancement in genital surgery.

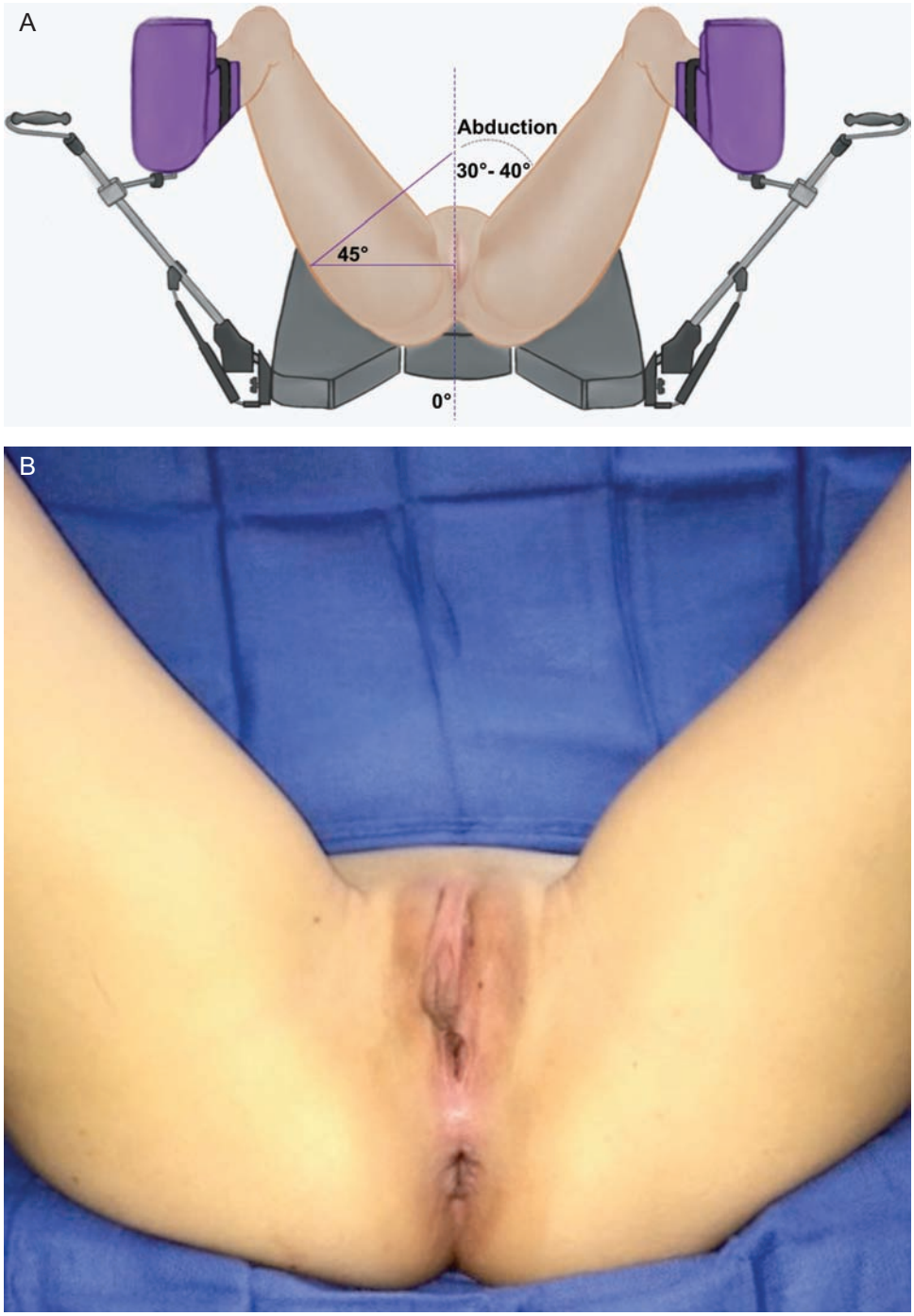

Figure 4. (A) Schematic illustration of a patient in standard lithotomy position (courtesy of Priscila Sanchez, MD). Hips are flexed 80 to 100°. Thighs are abducted 30 to 40° from midline. Capture images at 0° and 45° above the horizontal axis. (B) A 32-year-old woman in standard lithotomy position captured in the operating room with surgical blue towels as the background. Hips are flexed at 90° and legs are abducted 40° from the midline. Image is captured at 0° from the horizontal axis, an additional image should be captured at 45° above the horizontal (not shown).

Disclosures

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