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ORDER OF THE SUPREME COURT OF THE STATE OF NEVADA DENYING PETITION FOR REVIEW (SEPTEMBER 24, 2021)

IN THE SUPREME COURT
OF THE STATE OF NEVADA

DOUGLAS NORBERG,

Appellant,

v.

NEVADA CENTER FOR DERMATOLOGY; ASHLEY VAZEEN; AND DR. BILLIE CASSE,

Respondents.

No. 82083

Before: HARDESTY, C.J., PRAGUIRRE, J., STIGLICH, J., CADISH, J., SILVER, J., PICKERING, J., HERNDON, J.

Review denied. NRAP 40B.

It is so ORDERED.[1]

[1] To the extent appellant seeks to amend and supplement the amendment to the petition for review, the request is granted. All documents submitted in support of the petition for review have been considered.

/s/ Hardesty
C.J.

/s/ Praguirre
J.

/s/ Stiglich
J.

/s/ Cadish
J.

/s/ Silver
J.

/s/ Pickering
J.

/s/ Herndon
J.

cc: Hon. Egan K. Walker, District Judge
Douglas Norberg
Lemons, Grundy & Eisenberg
Washoe District Court Clerk

ORDER OF THE COURT OF APPEALS OF THE STATE OF NEVADA DENYING MOTION TO PUBLISH (SEPTEMBER 22, 2021)

IN THE COURT OF APPEALS
OF THE STATE OF NEVADA

DOUGLAS NORBERG,

Appellant,

v.

NEVADA CENTER FOR DERMATOLOGY; ASHLEY VAZEEN; AND DR. BILLIE CASSE,

Respondents.

No. 82083-COA

Before: GIBBONS, C.J., TAO, J., BULLA, J.

This court entered an order affirming the district court's order of dismissal in this matter on July 16, 2021. Respondents thereafter filed a motion requesting that this court reissue the order as a published opinion. Having considered the motion, we conclude that publication is not warranted. NRAP 36(c)(1), (f)(4). Accordingly, we deny the motion.

It is so ORDERED.

/s/ C.J.Gibbons

/s/ J. Tao /s/ J. Bulla

ORDER OF AFFIRMANCE OF THE COURT OF APPEALS OF THE STATE OF NEVADA (JULY 16, 2021)

IN THE COURT OF APPEALS
OF THE STATE OF NEVADA

DOUGLAS NORBERG,

Appellant,

v.

NEVADA CENTER FOR DERMATOLOGY; ASHLEY VAZEEN; AND DR. BILLIE CASSE,

Respondents.

No. 82083-COA

Before: GIBBONS, C.J., TAO, J., BULLA, J.

Douglas Norberg appeals from a district court order dismissing a complaint in a tort action. Second Judicial District Court, Washoe County; Egan K. Walker, Judge.

Norberg filed a complaint against respondents Nevada Center for Dermatology (NCD),[1] Ashley

[1] There are no allegations in the complaint specifically pertaining to NCD beyond the fact that it employed the other two respondents, but Norberg contends that NCD is liable for their conduct under the doctrine of respondeat superior. In light of our disposition, we need not address this issue.

Vazeen, and Dr. Billie Casse, asserting claims for intrusion upon seclusion and violation of NRS 449A.112. In relevant part, Norberg alleged that Vazeen, a nurse practitioner employed by NCD, intentionally invaded his privacy by allowing her medical assistant and Dr. Casse to observe while she conducted a full-body examination of Norberg's skin. Norberg alleged that Vazeen did not obtain his consent or inform him of the reason for the two other women's presence, that they were not directly involved with his care, and that their presence caused him "to start having a sexual response," which resulted in "humiliation, embarrassment, pain and anguish."

Respondents moved to dismiss Norberg's complaint on grounds that his claims actually sounded in medical malpractice and that he failed to file his complaint with the requisite expert affidavit or within the relevant one-year limitations period. They also argued that Norberg failed to state a claim for intrusion upon seclusion, that NRS 449A.112 does not provide a private right of action, and that, even if it does, Norberg nevertheless failed to state a claim for its violation. The district court agreed on all counts and, over Norberg's opposition, dismissed the complaint with prejudice and without leave to amend. This appeal followed.

As a preliminary matter, we note that the district court, in reaching its decision, considered documents related to Norberg's visit to NCD that the parties attached to their respective motion and opposition, which the court concluded it was entitled to do without treating the motion as one for summary judgment on grounds that "(1) the complaint refer[red] to the document[s]; (2) the document[s] [were] central to the

plaintiff's claim; and (3) no party question[ed] the authenticity of the document[s]." *Baxter v. Dignity Health*, 131 Nev. 759, 764, 357 P.3d 927, 930 (2015) (internal quotation marks omitted) (providing that a court may consider documents not attached to the complaint when ruling on a motion to dismiss—without treating it as a motion for summary judgment—if the documents satisfy these requirements); *see* NRCP 12(d) ("If, on a motion under Rule 12(b)(5) . . . , matters outside the pleadings are presented to and not excluded by the court, the motion must be treated as one for summary judgment under Rule 56."). Although Norberg does not challenge the district court's decision on this point, we nevertheless note that Norberg's complaint did not actually refer to or rely on any of these documents. Rather, the complaint referenced the events of the visit itself, and we are not persuaded that the holding in *Baxter*, which primarily concerned documents incorporated into pleadings by reference, *id.*, applies to the circumstances at issue here. Accordingly, in resolving this appeal, we treat the district court's order as having granted summary judgment in favor of respondents. *See* NRCP 12(d); *Witherow v. State, Bd. of Parole Comm'rs*, 123 Nev. 305, 307-08, 167 P.3d 408, 409 (2007) ("[I]f the district court considers matters outside of the pleadings, this court reviews the dismissal order as though it were an order granting summary judgment.").

This court reviews a district court's order granting summary judgment de novo. *Wood v. Safeway, Inc.*, 121. Nev. 724, 729, 121 P.3d 1026, 1029 (2005). Summary judgment is proper if the pleadings and all other evidence on file demonstrate that no genuine dispute of material fact exists and that the moving party is

entitled to judgment as a matter of law. *Id.* When deciding a summary judgment motion, all evidence must be viewed in a light most favorable to the non-moving party. *Id.* General allegations and conclusory statements do not create genuine disputes of fact. *Id.* at 731, 121 P.3d at 1030-31.

On appeal, Norberg contends that his claims did not sound in medical malpractice, that he stated viable claims for intrusion upon seclusion and violation of NRS 449A.112, and that, alternatively, he should have been granted leave to amend his complaint. Because we conclude that Norberg's claim for intrusion upon seclusion—even assuming it is not entirely dependent upon allegations of medical malpractice—fails as a matter of law, we address that issue first.

To recover for invasion of privacy based on intrusion upon seclusion, the plaintiff must show: "1) an intentional intrusion (physical or otherwise); 2) on the solitude or seclusion of another; 3) that would be highly offensive to a reasonable person." *PETA v. Bobby Berosini, Ltd.*, 111 Nev. 615, 630, 895 P.2d 1269, 1279 (1995), *overruled on other grounds by City of Las Vegas Downtown Redev. Agency v. Hecht*, 113 Nev. 644, 650, 940 P.2d 134, 138 (1997). The plaintiff must demonstrate that he "had an actual expectation of seclusion or solitude and that that expectation was objectively reasonable." *Id.* at 631, 895 P.2d at 1279. With respect to the offensiveness element, "[w]hile what is 'highly offensive to a reasonable person' suggests a standard upon which a jury would properly be instructed, there is a preliminary determination of 'offensiveness' which must be made by the court in discerning the existence of a cause of action for intrusion." *Id.* at 634, 895 P.2d at 1281 (internal quotation marks omitted).

In making such a determination, the court should consider "the degree of intrusion, the context, conduct and circumstances surrounding the intrusion as well as the intruder's motives and objectives, the setting into which [s]he intrudes, and the expectations of those whose privacy is invaded." *Id.* at 634, 895 P.2d at 1282 (internal quotation marks omitted).

We agree with the district court that Norberg's claim for intrusion upon seclusion fails as a matter of law. First, under the circumstances presented here, we question the extent to which respondents intentionally intruded upon Norberg in such a way as to contravene a reasonable expectation of privacy. *Compare id.* at 635, 895 P.2d at 1282 (identifying "a hospital room" as a "place traditionally associated with a legitimate expectation of privacy"), *with Sanchez-Scott v. Alza Pharm.*, 103 Cal. Rptr. 2d 410, 418 (Ct. App. 2001) (recognizing that a "patient knows and expects that [medical personnel] enter and leave [medical spaces] in accordance with the medical needs of the patient"). Regardless, considering the circumstances in light of the *PETA* factors, the alleged intrusion does not rise to the level of offensiveness required for liability to attach. *See PETA*, 111 Nev. at 634, 895 P.2d at 1282; Restatement (Second) of Torts § 652B cmt. d (Am. Law Inst. 1977) ("There is . . . no liability unless the interference with the plaintiff's seclusion is a substantial one, of a kind that would be highly offensive to the ordinary reasonable man, as the result of conduct to which the reasonable man would strongly object.").

Considering the degree of intrusion, *PETA,* 111 Nev. at 634, 895 P.2d at 1282, we agree with Norberg that the type of examination conducted here—where a patient is disrobed—exposes what is normally a

private space. *See* Restatement (Second) of Torts § 652B cmt. c ("Even in a public place, however, there may be some matters about the plaintiff, such as his underwear or lack of it, that are not exhibited to the public gaze. . . ."). But we must consider the sensitivity of the situation in tandem with the overarching context, including respondents' conduct, motives, and objectives, the setting, and Norberg's expectations. *PETA*, 111 Nev. at 634, 895 P.2d at 1282. And the undisputed context here was that Norberg had returned to NOD following an initial examination by Vazeen—for which the medical assistant had been present and acted as a scribe—that Norberg believed was inadequate. Because of this, Vazeen conducted a second examination with the medical assistant again serving as a scribe, and she brought in Dr. Casse to supervise, which Norberg concedes was reasonable in light of the alleged inadequacy of the first exam.[2] Moreover, Norberg conceded below that he was expecting the medical assistant to be present at the second exam, that he was aware of NCD's policy of having such a

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[2] Despite acknowledging the reasonableness of supervision by Dr. Casse in light of the circumstances, Norberg contends that the doctor was not actually supervising Vazeen and was instead merely watching her conduct the examination. But Norberg fails to cogently argue this distinction, as a commonly understood meaning of the word "supervise" is to merely "oversee." *Supervise, Merriam-Webster Online Dictionary*, https://www.merriam-webster.com/dictionary/supervise (last visited July 13, 2021); *see Edwards v. Emperor's Garden Rest.*, 122 Nev. 317, 330 n.38, 130 P.3d 1280, 1288 n.38 (2006) (providing that the appellate courts need not consider claims unsupported by cogent argument). And it does not follow that a supervising physician is not truly supervising until she intervenes, as one may readily imagine a scenario in which the supervisee conducts herself appropriately, thereby obviating the need for intervention.

party present, and that he implicitly consented to the same by showing up for the second exam.

Perhaps most importantly, although Norberg summarily contends that neither the medical assistant nor Dr. Casse were directly involved in his care, the record reveals no other purpose for their presence and shows that they were, in fact, acting in furtherance of his treatment, and Norberg does not point to any evidence or even allege that respondents acted with any motive or purpose beyond that limited scope. *See id.* at 635, 895 P.2d at 1282 (providing that "[m]any courts, and Professor Prosser, have found the inquiry into motive or purpose to be dispositive of th[e] [offensiveness] element of the tort," and acknowledging that a doctor's conduct may be intrusive where she is "not seeking to further the patient's treatment"). In the absence of any motive or purpose for intruding upon Norberg's privacy in an objectionable manner—even assuming that he is correct that Dr. Casse observed the examination without his consent—Norberg cannot show that the conduct complained of rose to the requisite level of offensiveness. *See id.* Accordingly, Norberg failed to demonstrate a genuine dispute of material fact as to his claim for intrusion upon seclusion, and the district court appropriately granted summary judgment in favor of respondents on that claim. *See Wood*, 121 Nev. at 729, 121 P.3d at 1029.

Despite the foregoing, Norberg contends that respondents still should have obtained his express consent and/or explained the reasons for both the medical assistant and Dr. Casse's presence, and he further contends that neither woman's presence during the examination was necessary and that they were

not actually providing him medical care. But these arguments concern the scope of Norberg's consent to the skin examination, as well as the standard of care for medical providers conducting such procedures, which are issues of medical malpractice requiring supportive expert testimony.[3] *See* NRS 41A.071 (requiring the district court to dismiss an action for medical malpractice without prejudice if it is filed without the requisite expert affidavit); *Humboldt Gen. Hosp. v. Sixth Judicial Dist. Court*, 132 Nev. 544, 550-51, 376 P.3d 167, 172 (2016) (providing that, "where general consent is provided for a particular treatment or procedure, and a question arises regarding whether the scope of that consent was exceeded, an expert medical affidavit is necessary");[4] *see also Szymborski*

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[3] To the extent Norberg contends that these are matters of common knowledge and experience, *see Estate of Curtis v. S. Las Vegas Med. Inv'rs, LLC*, 136 Nev., Adv. Op. 39, 466 P.3d 1263, 1268 (2020) (holding that there is an "extremely narrow" and "rare" exception to the expert-affidavit requirement in situations of obvious negligence not involving professional judgment), we disagree. The alleged conduct at issue in this case was not so obviously deficient as to remove it entirely from the bounds of professional judgment. *See id.* And Norberg's argument on this point is belied by his own briefing both below and on appeal, which is rife with references to outside materials, anecdotes, and medical authorities evidencing what he believes to be the appropriate standard of care in the medical profession under circumstances like those at issue here.

[4] Citing *Humboldt*, Norberg contends that he did not provide any consent at all for the medical assistant or Dr. Casse to be present and that his claim therefore does not implicate medical malpractice. *See* 132 Nev. at 550, 376 P.3d at 172 ("[W]here a plaintiff claims not to have consented at all to the treatment or procedure performed by a physician or hospital, we conclude that such an allegation constitutes a battery claim and thus does

v. Spring Mountain Treatment Ctr., 133 Nev. 638, 642, 403 P.3d 1280, 1284 (2017) (providing that "[a]llegations of breach of duty involving medical judgment, diagnosis, or treatment indicate that a claim is for medical malpractice," as expert testimony is required to determine the reasonableness of the providers' actions in such cases).

Accordingly, to the extent the district court determined that Norberg's claim for intrusion upon seclusion—at least in part—sounded in medical malpractice, we affirm summary judgment on that claim on grounds that Norberg failed to file his complaint with the requisite expert affidavit. *See* NRS 41A.071; *Szymborski*, 133 Nev. at 643, 403 P.3d at 1285 ("Our case law declares that a medical malpractice claim filed without an expert affidavit is void *ab initio*." (internal quotation marks omitted)); *see also Estate of Curtis*, 136 Nev., Adv. Op. 39, 466 P.3d at 1270 (affirming summary judgment where the plaintiffs failed to file the complaint with the requisite expert affidavit). Likewise, because Norberg concedes on appeal that he failed to file his claim within the requisite one-year limitations period for medical malpractice, we affirm summary judgment on statute-of-limitations grounds. *See* NRS 41A.097(2) (providing

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not invoke NRS 41A.071's medical expert affidavit requirement." (emphasis added)). But the *Humboldt* court was referring to situations where no consent is given for the specific "treatment or procedure performed," not situations like those at issue here where a patient gives consent for the treatment or procedure itself, but not for each individual involved in administering it. *Id.* And Norberg does not allege any lack of consent to the skin examination itself; rather, he challenges the scope of the consent he provided for that procedure, which is a matter requiring an expert affidavit. *See id.* at 550-51, 376 P.3d at 172.

that a plaintiff must file a claim for medical malpractice within three years from the date of injury or one year from the date he discovered the injury, whichever occurs first).

Turning to Norberg's claim for violation of NRS 449A.112—a statute that does not specifically set forth a remedy for its violation—he concedes on appeal that he is unaware of any authority in support of the notion that the statute provides a private right of action, and the only authority addressing this issue that we found in our own research summarily concluded it does not. *See Yates v. NaphCare*, No. 2:12-cv-01865-JCM-VCF, 2013 WL 4519349, at *2 (D. Nev. Aug. 23, 2013) (concluding that the identical prior version of the statute, then codified as NRS 449.720, "create[d] no private right of action"). And our supreme court has generally held that "when no clear statutory language authorizes a private right of action, one may be implied [only] if the Legislature so intended." *Neville v. Eighth Judicial Dist. Court*, 133 Nev. 777, 781, 406 P.3d 499, 502-03 (2017) ("Without legislative intent to create a private judicial remedy, a cause of action does not exist and courts may not create one, no matter how desirable that might be as a policy matter, or how compatible with the statute." (internal quotation marks omitted)). But the only argument Norberg advances on appeal in support of recognizing a private right of action under the statute is that if this court declines to do so, there will be no remedy for its violation. He thus fails to meaningfully address the overarching question of whether the Nevada Legislature intended to create a private right of action under NRS 449A.112 or the factors that guide this court in making such a deter-

mination: "(1) whether the plaintiffs are of the class for whose special benefit the statute was enacted; (2) whether the legislative history indicates any intention to create or deny a private remedy; and (3) whether implying such a remedy is consistent with the underlying purposes of the legislative scheme." *Neville*, 133 Nev. at 781, 406 P.3d at 502-03 (alteration and internal quotation marks omitted). Accordingly, we need not reach this issue.[5] *See Edwards*, 122 Nev. at 330 n.38, 130 P.3d at 1288 n.38.

Insofar as Norberg relies on NRS 449A.112(1)(a) (providing that patients have the right to "[r]eceive considerate and respectful care), and 449A.112(2) ("The patient must consent to the presence of any person who is not directly involved with the patient's care during any examination, consultation or treatment."), as establishing a duty of care under a theory of either negligence per se or garden-variety negligence, the claim still falls short; we are not persuaded that such theories escape the heightened procedural

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[5] To the extent Norberg relies on the New York case of *Chanko v. American Broadcasting Companies, Inc.*, in arguing that this court should allow him to proceed with his statutory claim, we note that the Court of Appeals in that case allowed the plaintiffs to proceed with their claim for breach of physician-patient confidentiality, a privilege created by statute. *See* 49 N.E.3d 1171, 1173-77 (N.Y. 2016) (providing that such a claim involves "disclosure of . . . confidential information to a person not connected with the patient's medical treatment"). But Norberg conceded below that respondents did not disclose any confidential information to third parties and that he was not suing under such a theory. And he fails to explain how the analysis set forth in *Chanko*—a New York decision interpreting New York law—sheds any light on the question of whether our legislature intended to provide a private right of action under NRS 449A.112. *See Edwards*, 122 Nev. at 330 n.38, 130 P.3d at 1288 n.38.

requirements applicable to claims for medical malpractice.[6] *See Szymborski*, 133 Nev. at 646-47, 403 P.3d at 1287-88 (evaluating whether a particular regulatory provision "invoke[d] medical judgment" sufficient to implicate medical malpractice under a theory of negligence per se); *Smith v. Cotter*, 107 Nev. 267, 271-74, 810 P.2d 1204, 1207-08 (1991) (analyzing whether the plaintiff presented sufficient expert testimony at trial to demonstrate that the defendant doctor committed medical malpractice by violating NRS 449.710, a patients' rights provision akin to NRS 449A.112 that was likewise later recodified in NRS Chapter 449A). We therefore affirm summary judgment on this claim for the same reasons discussed above. *See* NRS 41A.071, .097(2).

Finally, Norberg argues in the alternative that he should have been permitted to amend his complaint to add the medical assistant as a defendant. Specifically, he claims that she is not a medical professional and that adding her would therefore allow him to circumvent Nevada's medical malpractice statutes. But it does not appear from the record that Norberg raised this issue or otherwise requested this relief below, and he has therefore waived it. *See Old Aztec Mine, Inc. v. Brown*, 97 Nev. 49, 52, 623 P.2d 981, 983

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[6] Although it is arguable that what constitutes "considerate and respectful care" under NRS 449A.112(1)(a) might in some cases fall within the common-knowledge exception to the expert-affidavit requirement, *see Estate of Curtis*, 136 Nev., Adv. Op. 39, 466 P.3d at 1268, we note that what is "considerate" or "respectful" in the unique context of medical practice may often diverge from the common understanding of those terms among laymen. And here, as above, we are not persuaded that respondents' alleged conduct was so obviously inconsiderate or disrespectful as to obviate the need for an expert perspective. *See id.*

(1981) ("A point not urged in the trial court . . . is deemed to have been waived and will not be considered on appeal."); *cf. Woodstock v. Whitaker*, 62 Nev. 224, 230, 146 P.2d 779, 781 (1944) ("[N]ot having requested the court for permission to amend, the appellant will be deemed to have elected to stand on his [pleading] as originally filed.").

Based on the foregoing, we

ORDER the judgment of the district court AFFIRMED.[7]

/s/ Gibbons
Chief Justice

/s/ Tao
Judge

/s/ Bulla
Judge

cc: Hon. Egan K. Walker, District Judge
Douglas Norberg
Lemons, Grundy & Eisenberg
Washoe District Court Clerk

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[7] Insofar as Norberg raises arguments that are not specifically addressed in this order, we have considered the same and conclude that they either do not present a basis for relief or need not be reached given the disposition of this appeal.

ORDER OF THE SECOND JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA GRANTING MOTION TO DISMISS (OCTOBER 20, 2020)

IN THE SECOND JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA IN AND FOR THE COUNTY OF WASHOE

DOUGLAS NORBERG,

Plaintiff,

v.

NEVADA CENTER FOR DERMATOLOGY, ASHLEY VAZEEN AND DR. BILLIE CASSE,

Defendants.

Case No.: CV20-01218

Dept. No. 7

Before: Egan K. WALKER, District Judge.

Before the Court is Defendants Nevada Center for Dermatology, Ashley Vazeen, APRN, NP-C, and Billie Cassé, D.O.'s *Motion to Dismiss on behalf of all Defendants for Failure to State a Claim Upon which Relief may be Granted*, filed on August 19, 2020 by their counsel of record, Lemons, Grundy & Eisenberg. Plaintiff Douglas Norberg, appearing in proper person, filed an opposing brief titled *Reply to Motion to*

Dismiss on September 3, 2020, and an *Addendum to Reply to Motion to Dismiss* on September 4, 2020. On September 10, 2020, Defendants filed a *Reply in Support of Defendants' Motion to Dismiss for Failure to State a Claim Upon Which Relief may be Granted* and submitted the matter to the Court for decision.

The Court, having examined the record and documents on file and being fully advised in the premises, hereby finds and orders as follows:

Background

Plaintiff Norberg's Complaint alleges that on December 11, 2018, he underwent a "full body skin exam," at Nevada Center for Dermatology performed by Ashley Vazeen, an advanced practice registered nurse employed by Nevada Center for Dermatology. Plaintiff alleges that during that medical encounter, Billie Cassé, D.O., and a medical assistant, also employed by Nevada Center for Dermatology, entered the examination room without his consent to "witness" the completion of plaintiff's full body skin examination. *Complaint*, p. 1, ¶ I. Plaintiff contends that the presence of Dr. Cassé and the medical assistant/scribe caused him to "start having a sexual response during which time the only thing that plaintiff could think about was 'please don't have an erection' resulting in humiliation, embarrassment, pain and anguish." *Complaint*, p. 2, ¶ V. The Complaint identifies no other damages.

The Complaint was filed on August 6, 2020, and asserts claims for invasion of privacy/intrusion upon seclusion and breach of statutory duty to protect patient privacy based on NRS 449A.112(2) based on the December 11, 2018 medical encounter.

Defendants, all of whom are providers of health care, filed a motion to dismiss this action asserting that the Complaint sounds in professional negligence but was not supported by an expert affidavit as required by NRS 41A.071, and that this action is time barred because it was filed after the expiration of the statute of limitations of NRS 41A.097. Defendants contend that Plaintiff's assertion of claims labeled as invasion of privacy did not alter the nature of the action, the gravamen of which is professional negligence, which required compliance with NRS Chapter 41A. Defendants further contend that even if the case was determined not to be a professional negligence action and thus not subject to the mandates of NRS Chapter 41A, dismissal is nevertheless required because the Complaint fails to allege sufficient facts to state a claim for common law invasion of privacy/ intrusion upon seclusion, fails to state a cognizable claim under NRS 449A.112(2), and fails to assert any allegations against Nevada Center for Dermatology.

Plaintiff's opposition brief does not refute that the Complaint was filed without an affidavit or that this action was filed more than a year after the accrual of Plaintiff's cause of action. Instead, Plaintiff contends that NRS 41A.071 and NRS 41A.097 are inapplicable because he has asserted the intentional tort of invasion of privacy to which NRS 41A.071 does not apply, and he has alleged a violation of NRS 449A.112. Regarding the absence of allegations against Nevada Center for Dermatology, Plaintiff refers to the doctrine of *respondeat superior* without analysis.

In their reply, Defendants emphasize that the gravamen of this action is for professional negligence because Plaintiff's claims are based on conduct that

occurred in the course of a professional medical relationship and his claims raise questions of medical judgment beyond the common knowledge and experience of jurors. Therefore, Plaintiff was required to comply with NRS 41A.071 and NRS 41A.097 but failed to do so. Defendants alternatively contend that Plaintiff's Complaint fails to state a claim for common law invasion or privacy/intrusion upon seclusion and fails to state a cognizable claim under NRS 449A.112(2).

The parties' briefing establishes that Plaintiff had previously been a patient at Nevada Center for Dermatology and had undergone physical examinations by APRN Vazeen in the presence of the medical assistant, who is also a scribe for APRN Vazeen, to which Plaintiff did not object. It is also undisputed that Dr. Cassé is a physician at Nevada Center for Dermatology who provides supervision to APRN Vazeen. Plaintiff acknowledges that Dr. Cassé's presence as a supervising physician was reasonable and "agree[s] that it was reasonable to bring in a supervisor when the completeness of Nurse Vazeen's previous examination was questioned." *See, e.g., Opposition*, pp. 5-6.

LEGAL STANDARD FOR MOTION TO DISMISS UNDER NRCP 12(B)(5)

A complaint should be dismissed under NRCP 12(b)(5) "only if it appears beyond a doubt" that the plaintiff is entitled to no relief under any set of facts that could be proved in support of the claim. *Buzz Stew, LLC v. City of North Las Vegas*, 124 Nev. 224, 228, 181 P.3d 670, 672 (2008); *Blackjack Bonding v. City of Las Vegas Municipal Court*, 116 Nev. 1213, 1217, 14 P.3d 1275, 1278 (2000). In analyzing the merits of a motion to dismiss under NRS 12(b)(5), the

Court accepts all factual allegations as true and draws all inferences in favor of the plaintiff. *Buzz Stew, LLC*, 124 Nev. at 228, 181 P.3d at 672. The Court need not, however, blindly accept conclusory allegations, unwarranted factual deductions or unreasonable inferences. *See Sprewell v. Golden State Warriors*, 266 F.3d 979, 988 (9th Cir. 2001). Nor is the court required to accept as true allegations contradicted by the exhibits attached to the complaint. *Id.* 'Dismissal is proper where the allegations are insufficient to establish the elements of a claim for relief." *Stockmeier v. Nevada Dep't of Corr. Psychological Review Panel*, 124 Nev. 313, 316, 183 P.3d 133, 135 (2008) (internal citation omitted).

A plaintiff cannot cure the defects in a complaint by attaching exhibits or by asserting new allegations in his opposition. *See Broam v. Bogan*, 320 F.3d 1023, 1026 n. 2 (9th Cir. 2003) ("In determining the propriety of a Rule 12(b)(6) dismissal, a court may not look beyond the complaint to a plaintiff's moving papers, such as a memorandum in opposition to a defendant's motion to dismiss.") (citation omitted). The Court may consider documents outside the pleadings in reviewing a motion to dismiss without converting the motion to one for summary judgment if the Complaint refers to the document, the document is central to plaintiff's claim, and no party questions the authenticity of the document. *Baxter v. Dignity Health*, 131 Nev. 759, 764, 357 P.3d 927, 930 (2015) [citations omitted].

Here, the Complaint refers to the December 11, 2018 visit, which is central to plaintiff's claims. *See Complaint*, ¶ 1. Both parties have included excerpts of the medical records referenced in the Complaint, which the Court has considered.

ANALYSIS UNDER NRS CHAPTER 41A

Defendants moved to dismiss the Complaint under NRS 41A.071 and NRS 41A.097 contending that Plaintiff's failure to include an affidavit by a medical expert warrants dismissal of the Complaint and that his claims are barred by the one-year statute of limitations applicable to professional negligence actions.

Plaintiff contends that his claims are "privacy" claims and intentional torts to which NRS 41A is inapplicable. The Court disagrees.

In *Estate of Curtis v. South Las Vegas Medical Investors, LLC*, 136 Nev. Adv. Op., 39, 466 P.3d 1263 (2020), the Nevada Supreme Court wrote:

> [A] court must ask two fundamental questions in determining whether a claim sounds in ordinary negligence or [professional negligence]: (1) whether the claim pertains to an action that occurred within the course of a professional relationship; and (2) whether the claim raises questions of medical judgment beyond the realm of common knowledge and experience. If both these questions are answered in the affirmative, the action is subject to the procedural and substantive requirements that govern [professional negligence] actions.

466 P.3d at 1269 (alterations in original), quoting *Bryant v. Oakpointe Villa Nursing Ctr., Inc.*, 684 N.W.2d 864, 871 (Mich. 2004). Similarly, in *Szymborski v. Spring Mountain Treatment Center*, 133 Nev. 638, 403 P.3d 1280 (2017), the Court instructs:

> Allegations of breach of duty involving medical judgment, diagnosis, or treatment indicate that a claim is for medical malpractice. [Citations omitted.] By extension, if the jury can only evaluate the plaintiff's claims after presentation of the standards of care by a medical expert, then it is a medical malpractice claim. [Citations omitted.] If, on the other hand, the reasonableness of the health care provider's actions can be evaluated by jurors on the basis of their common knowledge and experience, then the claim is likely based in ordinary negligence. [Citation omitted.]

Szymborski, 133 Nev. at 641-42, 403 P.3d at 1284, citing, *inter alia, Humboldt Gen. Hosp. v. Sixth Judicial Dist. Court*, 132 Nev. 544, 376 P.3d 167 (2016) (reasoning that a medical expert affidavit was required in an action asserting battery where the scope of a patient's informed consent was at issue, because medical expert testimony would be necessary to determine the reasonableness of the health care provider's actions).

Here, although Plaintiff has pleaded claims for "invasion of privacy" and "breach of statutory duty to protect patient privacy," the gravamen of his claims are for professional negligence and thus required compliance with NRS 41A.071. Plaintiff Norberg's claim pertains to an action that occurred within the course of a professional relationship. Plaintiff's Complaint alleges that he underwent a full body skin exam at Nevada Center for Dermatology by Nurse Practitioner Vazeen, at which her medical assistant and physician supervisor were present. *Complaint*, p. 1.

In his Complaint, plaintiff identifies himself as a patient, and alleges that he "did not receive 'considerate and respectful care.'" *Complaint*, p. 3.

Notwithstanding Plaintiff's assertion that Dr. Cassé and the medical assistant were not directly involved in his care, the Complaint alleges that Dr. Cassé owed him—a patient—a duty to protect his rights *as a patient*, to collaborate with other health care professionals, and to render "considerate and respectful care." *Complaint*, pp. 2-3. Moreover, the medical record reflects that Nurse Practitioner Vazeen was rendering medical services in collaboration with Dr. Cassé, her supervising physician. Such collaboration is permitted by Nevada law. *See, e.g.*, NAC 630.490 (physician collaboration with advanced practice registered nurse).

Further, this action challenges the defendants' medical judgment. Plaintiff's Complaint is critical of the collaborative medical decisions by health care providers in rendering treatment consisting of a "full body skin exam" of the Plaintiff. The examination was performed by APRN Vazeen at Plaintiff's insistence and in collaboration with Dr. Cassé because Plaintiff questioned the adequacy of a previous examination of his genitalia performed by APRN Vazeen.

Whether the presence of the medical assistant/scribe and the supervising physician of a nurse practitioner to collaborate in the medical evaluation of Plaintiff constituted a breach of the standard of care requires specialized knowledge and is not within the common knowledge of jurors. Expert testimony will be required to determine whether having a medical assistant/scribe present during a patient examination and asking the supervising physician to assess

the patient is medically reasonable and in conformity with applicable standards of care. Indeed, Plaintiff's Complaint invokes standards applicable to the nursing profession and the medical profession. *See Complaint*, p. 2, ¶ VII and p. 3, Whether the standards of the nursing and medical associations have been breached will require expert testimony as well.

The applicability of NRS 41A.071 does not depend on the label the plaintiff has placed on a claim, but on the nature of the claim. Despite the labels Plaintiff has applied to his claims, the Complaint asserts a professional negligence action, for which Plaintiff must establish a breach of the standard of care through expert testimony. *See* NRS 41A.100. Therefore, Plaintiff was required to comply with NRS 41A.071.

Similarly unpersuasive is Plaintiff's contention that his privacy claims do not fall within the ambit of NRS Chapter 41A because they are intentional torts. Plaintiff's assertion is unsupported by legal authority and contradicted by Nevada law. *See, e.g., Humboldt Gen. Hosp. v. Sixth Judicial Dist. Court*, 132 Nev. 544, 376 P.3d 167 (2016), in which the plaintiff asserted a claim for the intentional tort of battery and thus argued she was not required to comply with NRS 41A.071. The Nevada Supreme Court determined that the battery claim was actually a claim for professional negligence based on lack of informed consent, requiring compliance with NRS 41A.071. *See also Schwarts v. University Medical Center of So. Nevada*, Docket Nos. 77554 and 77666, 460 P.3d 25, 2020 WL 1531401 (Nev., Mar. 26, 2020) (unpublished disposition) (holding that an expert affidavit was required to support plaintiff's civil conspiracy claim which alleged that the health care providers conspired to falsify the patient's

medical records to conceal the cause of death because proof of the civil conspiracy claim required plaintiff to prove that the health care provider's actions fell below the relevant standard of medical care).

Here, Plaintiff cannot prove his privacy claims until he first proves that the Defendants breached the applicable standards of care with regard to their medical decisions and judgment in connection with his examination. This is evident from Plaintiff's opposition brief in which he acknowledges being told it was "the standard of care across medical specialties" to have medical assistants "and sometimes other professionals in the exam room." *Opposition*, p. 12. Plaintiff contrary assertion that "it is usual practice in medicine to obtain consent before bringing in third parties to observe a patient's modestly sensitive examination" [*Opposition*, p. 14, lines 357-359] actually buttresses the conclusion that expert testimony will be required to prove his privacy claims. This is true because what constitutes the "usual practice in medicine" implicates the standard of care which must be established by expert testimony. *See* NRS 41A.015; NRS 41A.100(1). In other words, proof of what constitutes the "usual practice in medicine" regarding obtaining consent for the presence of other medical professionals during an examination will require medical expert testimony. *See, e.g., Bronneke v. Rutherford*, 120 Nev. 230, 237, 89 P.3d 40, 45 (2004) (a physician's duty to disclose is measured by a professional standard, which the plaintiff must establish with expert testimony concerning the customary disclosure practice of physicians or what a reasonable physician would disclose under the circumstances).

Because the "usual practice" of medicine in connection with what is appropriate during a patient examination is not within the common knowledge of jurors, this action sounds in professional negligence. *See Estate of Curtis*, 466 P.3d at 1269; *see also Szymborski*, 133 Nev. at 641, 403 P.3d at 1284, *citing, Humboldt Gen. Hosp.*, 132 Nev. at 550-51, 376 P.3d at 172 (if the jury can only evaluate the plaintiff's claims after presentation of the standards of care by a medical expert, then it is a medical malpractice case."). Accordingly, Plaintiff's Complaint is subject to the affidavit requirement of NRS 41A.071. The foregoing analysis also applies to the claim against Nevada Center for Dermatology, against whom no allegations are asserted. *See Estate of Curtis*, 466 P.3d at 1269-70 (where allegations underlying negligent hiring, supervision and training claims are inextricably linked to professional negligence, the claim is categorized as vicarious liability rather than an independent tort, for which an expert affidavit is required). Plaintiff provides no cogent argument in opposition to Nevada Center for Dermatology's motion in this regard. Having failed to provide the required affidavit, this Court must dismiss Plaintiff's Complaint without prejudice and without leave to amend. NRS 41A.071, *Washoe Med. Center*, *supra.*

Statute of Limitations under NRS 41A.097

Having determined that Plaintiff's Complaint sounds in professional negligence, the Court further finds that this action is governed by the statute of limitations of NRS 41A.097. Where, as here, the statute of limitations defense appears from the face of the Complaint, and the Complaint does not allege that the limitations period was tolled, a motion to

dismiss pursuant to NRCP 12(b)(5) is proper. *See Manville v. Manville*, 79 Nev. 487, 387 P.2d 661 (1963), *superseded by rule on other grounds by NC-DSH, Inc. v. Garner*, 125 Nev. 647, 218 P.3d 853 (2009); *see also Bemis v. Estate of Bemis*, 114 Nev. 1021, 1024, 967 P.2d 437, 439 (1998) (the court may dismiss a complaint for failure to state a claim upon which relief may be granted if the action is barred by the statute of limitations). While the appropriate accrual date for the statute of limitations is generally a question of fact, the question is one of law when the facts are uncontroverted. *Winn v. Sunrise Hosp. & Medical Center*, 128 Nev. 246, 252, 277 P.3d 458, 462 (2012); *Libby v. District Court*, 130 Nev. 359, 366, 325 P.3d 1276, 1280-81 (2014). This is such a case.

The face of the Complaint in this action demonstrates that NRS 41A.097(2)'s one-year period elapsed before this action was filed on August 6, 2020. The Complaint alleges that the medical treatment at issue occurred on December 11, 2018. *Complaint*, p. 1, ¶ 1. The Complaint then alleges that the complained-of medical services that involved the presence of female health care professionals in the examination room caused him to experience a sexual response resulting in his "humiliation, embarrassment, pain and anguish." *Complaint*, p. 2, ¶ V. No other damages are alleged. In short, the treatment about which plaintiff complains occurred on December 11, *2018*, at which time he allegedly suffered the "damage" of which he was clearly aware at the time of the visit. As such, he was on inquiry notice of his cause of action. *See Massey v. Litton*, 99 Nev. 723, 728, 669 P.2d 248, 252 (1983) (a plaintiff "discovers" his injury "when he knows or, through the use of reasonable

diligence, should have known of facts that would put a reasonable person on inquiry notice of his cause of action.").

Consequently, Plaintiff was required to file this action within a year after the December 2018 examination at issue. Plaintiff did not file this action until more than six months after the one-year statute of limitations expired. Neither his Complaint nor his Opposition allege tolling or otherwise justify Plaintiff's failure to file within the limitations period. Therefore, dismissal with prejudice is warranted based on the bar of the statute of limitations.

ANALYSIS UNDER COMMON LAW AND NRS 449A.112(2)

If Taken as True, the Allegations in Plaintiff's First Cause of Action are Insufficient to State a Claim for Intrusion Upon Seclusion

The Court finds that dismissal of Plaintiff's First Claim for Relief for invasion of privacy/intrusion upon seclusion is also warranted under common law principles because the Complaint contains insufficient facts to establish the essential elements of this common law claim. *See Stockmeier*, 124 Nev. at 316, 183 P.3d at 135 (dismissal is proper where the allegations are insufficient to establish the elements of a claim for relief.").

The privacy tort of intrusion upon seclusion consists of the following elements: (1) an intentional intrusion; (2) on plaintiff's solitude or seclusion; (3) that would be highly offensive to a reasonable person. *See PETA v. Berosini*, 111 Nev. 615, 630, 895 P.2d 1269, 1279 (1995), *overruled on other grounds by City*

of Las Vegas Downtown Redev. Agency v. Hecht, 113 Nev. 644, 650, 940 P.2d 134, 138 (1997). The rationale for the tort of intrusion is "that one should be protected against intrusion by others into one's private 'space' or private affairs." *Id.* The tort is "grounded in a plaintiff's objective expectation of privacy." *Franchise Tax Board of Cal. v. Hyatt*, 130 Nev. 662, 683, *vacated and remanded on other grounds in Franchise Tax Board of Cal. v. Hyatt*, 136 S.Ct. 1277 (2016), citing *Berosini*, 111 Nev. at 630, 631, 895 P.2d at 1279 (recognizing that the plaintiff must actually expect solitude or seclusion, and that plaintiff's expectation of privacy must be objectively reasonable). The Nevada Supreme Court has noted that "the question of what kinds of conduct will be regarded as a 'highly offensive" intrusion is largely a matter of social conventions and expectations." *Berosini*, 111 Nev. at 634, 895 P.2d at 1281 (citing J. Thomas McCarthy, the Right of Publicity and Privacy, § 5.10(A)(2)). The Court provided the following guidance for courts considering what is "highly offensive" to discern whether the elements of the tort have been met:

> "While what is 'highly offensive to a reasonable person' suggests a standard upon which a jury would properly be instructed, there is a preliminary determination of 'offensiveness' which must be made by the court in discerning the existence of a cause of action for intrusion." [Citations omitted.] A court considering whether a particular action is "highly offensive" should consider the following factors: "the degree of intrusion, the context, conduct and circumstances surrounding the intrusion as well as the intruder's

> motives and objectives, the setting into which he intrudes, and the expectations of those whose privacy is invaded." [Citation omitted.]

Berosini, 111 Nev. at 634, 895 P.2d at 1281-82 (citations omitted).

Here, Plaintiff's Complaint contains insufficient facts to state a claim for intrusion upon seclusion against Defendant. Plaintiff does not establish an intentional intrusion by any of the Defendants upon his solitude or seclusion, much less one that is "highly offensive" as defined in *Berosini*. This claim is brought in the context of a medical examination involving three medical professionals involved in Plaintiff's care. Plaintiff's "modesty" does not equate to a "highly offensive" intrusion by his examining nurse or the health care team in the context of a examination room of a medical facility.

The Complaint also fails to allege sufficient facts showing that the presence of the nurse, medical assistant and supervising physician was unreasonable. To the contrary, Plaintiff admits that the presence of the medical assistant was expected and did not bother him. *Opposition*, p. 6. He also acknowledges that Dr. Cassé's presence as a supervising physician was reasonable. He "agree[s] that it was reasonable to bring in a supervisor when the completeness of Nurse Vazeen's previous examination was questioned." *Opposition*, p. 5, lines 104-105. He goes on to state: "it is an entirely plausible reason for Dr. Cassé to be present." *Id.*, lines 124-125. These admissions are discordant with the rationale for the tort of intrusion, which is "that one should be protected against intrusion by others into one's private 'space' or private affairs." *Berosini*, 111 Nev. at 630, 895 P.2d at 1279.

Plaintiff's admissions demonstrate that he cannot prove that the presence of Dr. Cassé and APRN Vazeen's medical assistant during the medical examination was an intrusion on his seclusion, much less one that was "highly offensive to a reasonable person." Thus, even accepting the allegations in the Complaint as true, the Court finds that Plaintiff's allegations are insufficient to establish the essential elements of this tort, requiring its dismissal for failure to state a claim for relief for invasion of privacy.

If Taken as true, the Allegations in Plaintiff's Second Claim are Insufficient to State a Claim for Breach of Statutory Duty to Protect Patient Privacy

Defendants contend that dismissal of the Second Claim for Relief is warranted because there is no private right of action under NRS 449A.112(2) and because Plaintiff has not alleged sufficient facts to establish a violation of the statute by Defendants in any event because there was no unnecessary disclosure of confidential medical information and all Defendants were medical professionals who were directly involved in Plaintiff's medical care. *Motion*, pp. 14-16.

Plaintiff's opposition brief is unclear whether he is conceding there is no private right of action under NRS 449A.112(2) and/or whether his claim should be considered under a negligence per se theory. Plaintiff states that he considered suing under a negligence per se theory, but he did not do so because "Nurse Vazeen was not negligent and negligence per se requires a violation of a safety law." *Opposition*, p. 9.

NRS 449A.112(2) is in the Patient Rights section of NRS 449A and provides as follows:

> 2. Except as otherwise provided in NRS 108.640, 239.0115, 439.538, 442.300 to 442.330, inclusive, and 449A.103, and chapter 629 of NRS, discussions of the care of a patient, consultation with other persons concerning the patient, examinations or treatments, and all communications and records concerning the patient are confidential. The patient must consent to the presence of any person who is not directly involved with the patient's care during any examination, consultation or treatment.

Defendants assert that NRS 449A.112(2) is the state counterpart to the Health Insurance Portability and Accountability Act (HIPAA), as they both seek to protect health information from unnecessary disclosure. *See Webb v. Smart Document Sols., LLC*, 449 F.3d 1078, 1084 (9th Cir. 2007) (by enacting HIPAA, Congress recognized "the importance of protecting the privacy of health information."). As such, like HIPAA, NRS 449A.112 does not provide a private right of action for a purported violation of its provisions. *See Webb*, 449 F.3d at 1081 (stating that HIPAA provides no private right of action); *Yates v. NaphCare*, No. 2:12-cv-01865-JCM-VCF, 2013 WL 4519349, *2 (D. Nev. Aug. 23, 2013) (ruling that HIPAA and state-law provisions, including NRS 449.720, create no private right of action). Plaintiff's opposition provides no cogent argument to the contrary.

The Court agrees with Defendants' analysis. The Court further notes that unlike other sections of NRS Chapter 449A, there is no provision in the Patient Rights section of NRS 449A that provides a remedy for an alleged violation of its provisions. *See* NRS

449A.100 through NRS 449A.124; *compare* NRS 449A .254, *et seq.* Because no private right of action exists under NRS 449A.112(2), Plaintiff's second claim for the alleged violation of the statute is not legally cognizable and thus may be dismissed on that basis alone. *See, e.g., Morrison v. Quest Diagnostics, Inc.*, 139 F.Supp.3d 1182, 1189 (D. Nev. 2015) (court dismissed HIPAA claim with prejudice "because private citizens are not entitled to sue in court for violations of HIPAA statute").

Even if a private right of action existed for a violation of NRS 449A.112(2), the Complaint fails to state a claim for relief because the Complaint does not demonstrate that any Defendant failed to protect Plaintiffs privacy or otherwise violated the statute by disclosing confidential information. Plaintiff's Complaint is devoid of any allegation that any Defendant disclosed confidential information.

The Complaint also lacks sufficient facts showing that any Defendant violated NRS 449A.112(2). The only persons alleged to have been present during Plaintiff's examination were the medical professionals involved in his care. The record describes the purpose of the health care professionals' presence during the examination, namely, to provide medical supervision (physician) and to serve as a scribe (medical assistant). Plaintiff agrees "it was reasonable to bring in a supervisor when the completeness of Nurse Vazeen's previous examination was questioned." *Opposition*, p. 5, lines 104-105. Under the circumstances, it was entirely reasonable for Defendant Vazeen to have her supervising physician present, which Plaintiff admits. In fact, he acknowledges that Dr. Cassé's presence was "entirely plausible." *Opposition*, p. 5, lines 124-125.

In addition, Dr. Cassé's presence during the exam was legal and ethical. *See* NAC 630.490 and AMA Code of Ethics Opinion 3.1.1. In addition, Plaintiff admits he knew the medical assistant would be present as she had been present during prior examinations, and her presence did not bother him. *Opposition*, p. 6.

Based upon the record before the Court, the Court finds that the presence of the supervising physician and scribe during Plaintiff's December 18, 2018 examination did not violate NRS 449A.112(2). Because the Defendant health care professionals were all directly involved in Plaintiff's care during the full body examination, his explicit consent was not required under NRS 449A.112(2). Accordingly, the Court finds that Plaintiff has failed to allege a cognizable claim under NRS 449A.112(2) and thus dismisses Plaintiff's Second Claim for alleged breach of statutory duty to protect patient privacy.

In conclusion, after examining the allegations in Plaintiff's Complaint, the briefing of the parties and based upon the applicable law, and good cause appearing,

IT IS HEREBY ORDERED that Defendants' *Motion to Dismiss for Failure to State a Claim Upon Which Relief May be Granted* is hereby GRANTED. This action is hereby DISMISSED with prejudice and without leave to amend.

IT IS SO ORDERED.

/s/ Hon. Egan K. Walker
District Judge

DATED October 20, 2020

RELEVANT STATUTORY TEXT AND PROCEDURAL RULE

NRS 41A.071. Dismissal of action filed without affidavit of medical expert.

If an action for professional negligence is filed in the district court, the district court shall dismiss the action, without prejudice, if the action is filed without an affidavit that:

1. Supports the allegations contained in the action;
2. Is submitted by a medical expert who practices or has practiced in an area that is substantially similar to the type of practice engaged in at the time of the alleged professional negligence;
3. Identifies by name, or describes by conduct, each provider of health care who is alleged to be negligent; and
4. Sets forth factually a specific act or acts of alleged negligence separately as to each defendant in simple, concise and direct terms.

NRS 449A.112. Specific rights: Care; refusal of treatment and experimentation; privacy; notice of appointments and need for care; confidentiality of information concerning patient.

1. Every patient of a medical facility or facility for the dependent has the right to:

(a) Receive considerate and respectful care.

(b) Refuse treatment to the extent permitted by law and to be informed of the consequences of that refusal.

(c) Refuse to participate in any medical experiments conducted at the facility.

(d) Retain his or her privacy concerning the patient's program of medical care.

(e) Have any reasonable request for services reasonably satisfied by the facility considering its ability to do so.

(f) Receive continuous care from the facility. The patient must be informed:

(1) Of the patient's appointments for treatment and the names of the persons available at the facility for those treatments; and

(2) By his or her physician or an authorized representative of the physician, of the patient's need for continuing care.

2. Except as otherwise provided in NRS 108.640, 239.0115, 439.538, 442.300 to 442.330, inclusive, and 449A.103 and chapter 629 of NRS, discussions of the care of a patient, consultation with other persons concerning the patient, examinations or treatments, and all communications and records concerning the patient are confidential. The patient must consent to the presence of any person who is not directly involved with the patient's care during any examination, consultation or treatment.

Nev. R. App. P. 36
Entry of Judgment

(a) Entry. The filing of the court's decision or order constitutes entry of the judgment. The clerk shall file the judgment after receiving it from the court. If a judgment is rendered without an opinion, the clerk shall enter the judgment following instruction from the court.

(b) Notice. On the date when judgment is entered, the clerk shall mail to all parties a copy of the opinion, if any, or of the order entering judgment, if no opinion was written.

(c) Form of Decision. The Supreme Court and Court of Appeals decide cases by either published or unpublished disposition. (1) A published disposition is an opinion designated for publication in the *Nevada Reports*. The Supreme Court or Court of Appeals will decide a case by published opinion if it: (A) Presents an issue of first impression; (B) Alters, modifies, or significantly clarifies a rule of law previously announced by either the Supreme Court or the Court of Appeals; or (C) Involves an issue of public importance that has application beyond the parties. (2) An unpublished disposition, while publicly available, does not establish mandatory precedent except in a subsequent stage of a case in which the unpublished disposition was entered, in a related case, or in any case for purposes of issue or claim preclusion or to establish law of the case. (3) A party may cite for its persuasive value, if any, an unpublished disposition issued by the Supreme Court on or after January 1, 2016. When citing such an unpublished disposition, the party must cite an electronic database, if available,

and the docket number and date filed in the Supreme Court (with the notation "unpublished disposition"). A party citing such an unpublished disposition must serve a copy of it on any party not represented by counsel. Except to establish issue or claim preclusion or law of the case as permitted by subsection (2), unpublished dispositions issued by the Court of Appeals may not be cited in any Nevada court for any purpose.

(d) Duplicate Order or Opinion. (1) The justices of the Supreme Court, judges of the Court of Appeals, or district judges designated by the governor to serve on the Supreme Court or Court of Appeals for a specific case, if they are physically present within the State of Nevada, may sign duplicate copies of any order or opinion. If duplicate copies of an order or opinion are signed by the various members of the Supreme Court or Court of Appeals, the justices or judges signing the duplicate copies shall date their signatures on duplicate copies and shall immediately inform the clerk of the court that the duplicate copies are signed. The clerk of the court shall then note on the appropriate signature line of the original order or opinion that the absent justices or judges have signed duplicate copies of the order or opinion under this Rule. When possible, a facsimile of each signed duplicate copy of the order or opinion shall also be transmitted immediately to the clerk of the court. The duplicate copies of the order or opinion containing the original signatures of the justices or judges shall be sent by the fastest means available to the clerk of the Supreme Court, who shall place those duplicates in the court's file. (2) The clerk shall file an order or opinion that is signed in duplicate under

this Rule upon receiving notice from the absent justices or judges that they have signed the duplicate copies. The order or opinion shall be effective for all purposes when the clerk receives notice under this Rule that the requisite number of signatures have been obtained and files the order or opinion. An order or opinion that is signed under this Rule shall contain a notice to the parties that it was signed under this Rule.

(e) Reversal, Modification; Certified Copy of Opinion to Lower Court. Where a judgment is reversed or modified, a certified copy of the opinion or other disposition shall be transmitted with the remittitur to the court below.

(f) Motion to Reissue an Order as an Opinion. A motion to reissue an unpublished disposition or order as an opinion to be published in the *Nevada Reports* may be made under the provisions of this subsection by any interested person. With respect to the form of such motions, the provisions of Rule 27(d) apply; in all other respects, such motions must comply with the following: **(1) Time to File**. Such a motion shall be filed within 14 days after the filing of the order. Parties may not stipulate to extend this time period, and any motion to extend this time period must be filed before the expiration of the 14-day deadline. **(2) Response**. No response to such a motion shall be filed unless requested by the court. **(3) Contents**. Such a motion must be based on one or more of the criteria for publication set forth in Rule 36(c)(1)(A)-(C). The motion must state concisely and specifically on which criteria it is based and set forth argument in support of such contention. If filed by or on behalf of a nonparty, the motion must also identify the

movant and his or her interest in obtaining publication. **(4) Decision**. The granting or denial of a motion to publish is entrusted to the sound discretion of the panel that issued the disposition. Publication is disfavored if revisions to the text of the unpublished disposition will result in discussion of additional issues not included in the original decision.

CODE OF MEDICAL ETHICS, SECTIONS 3.11 AND 3.12

Code of Medical Ethics Opinion 3.1.1 Privacy in Health Care

Protecting information gathered in association with the care of the patient is a core value in health care. However, respecting patient privacy in other forms is also fundamental, as an expression of respect for patient autonomy and a prerequisite for trust.

Patient privacy encompasses a number of aspects, including personal space (physical privacy), personal data (informational privacy), personal choices including cultural and religious affiliations (decisional privacy), and personal relationships with family members and other intimates (associational privacy).

Physicians must seek to protect patient privacy in all settings to the greatest extent possible and should:

1. Minimize intrusion on privacy when the patient's privacy must be balanced against other factors.
2. Inform the patient when there has been a significant infringement on privacy of which the patient would otherwise not be aware.
3. Be mindful that individual patients may have special concerns about privacy in any or all of these areas.

Code of Medical Ethics Opinion 3.1.2
Patient Privacy & Outside Observers to the Clinical Encounter

Individuals legitimately present during patient-physician encounters include those directly involved in the patient's care, and can include other members of the health care team or employees of pharmaceutical or medical device companies when they are present to provide technical assistance, in keeping with ethics guidance.

When individuals who are not involved in providing care seek to observe patient-physician encounters, e.g., for educational purposes, physicians should safeguard patient privacy by permitting such observers to be present during a clinical encounter only when:

(a) The patient has explicitly agreed to the presence of the observer(s). Outside observers should not be permitted when the patient lacks decision-making capacity, except in rare circumstances and with the consent of the parent, legal guardian, or authorized decision maker.

(b) The presence of the observer will not compromise care.

(c) The observer understands and has agreed to adhere to standards of medical privacy and confidentiality.

Under no circumstances should physicians accept payment from outside observers to allow those observers to be present during a clinical encounter.

NORBERG LETTER TO NEVADA CENTER FOR DERMATOLOGY (MARCH 5, 2019)

1075 Mercedes Drive
Sparks, Nevada 89441
March 5, 2019

Ashley Vazeen
Nevada Center for Dermatology
650 Sierra Rose Drive, Suite A
Reno, Nevada 89511

Dear Ms. Vazeen:

Last year after I complained that I had had an incomplete full body skin exam you brought in Dr. Casse' for the follow up examination in addition to your assistant. There were two women watching while I was on the examining table naked from the waist down. It made me extremely uncomfortable! I had successfully ignored the presence of one extra female, I couldn't ignore two! I had an audience! The whole time I was telling myself "don't embarrass yourself, don't get an erection". It definitely helped that you introduced Dr. Casse' beforehand. It enabled me to think, "these women are medical professionals, they have a reason to be here, they are not here for the view. Dr. Casse' just watched, she did not participate in the examination. Her presence was not for the benefit of the patient! Dr. Casse' was either supervising you or you were conducting a lesson. I was a teaching tool. Whatever the reason was for Dr. Casse's presence I hope it served a useful purpose.

I am perfectly at ease being examined by a solitary female examiner. I know what she is thinking. She is

thinking about doing her job. I do not know what an assistant is thinking. I don't even know why she is there. She seems to be there just to watch! Male patients universally detest third parties[1] [2]-but they won't complain! They will tough it out because it is unmanly to admit to weakness-but you may never see that patient again.[1] You might want to introduce your assistant and tell the patient why the she is there. Your male patients or for that matter any patient will accept the presence of a third party better if the patient knows the reason for a third party's presence.

My wife is a nurse who teaches CNA's. At the end of their training CNA students are required to work with real patients. When introducing students to real patients in intimate situations, it is unwise to ask permission. The patient will usually refuse. My

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[1] Are Male Patients Uncomfortable with Female Doctors, Athena Insight "However, chaperons (sic) can make patients more uncomfortable—male patients in particular are overwhelmingly opposed to any third party in the room, particularly a female assistant—and most assistants are female." (emphasis not supplied)

[2] Patient Modesty—Sensitive Issues for Men, Health Unlocked "Then the NP pulled the drape completely off me, and I was exposed to both women from waist to ankles. I was so shocked and embarrassed I literally couldn't speak—the NP hadn't said anything beforehand about bringing in a witness, never explained why it was necessary, and never asked my permission for it (which I certainly would not have given). Before this encounter, I had never even heard of "chaperones," and had never been undressed in a doctor's office for anyone but that doctor. The whole encounter left me feeling insulted, disrespected, and humiliated; I had trouble sleeping and focussing (sic) at my job, and ended up seeing a therapist for a few months."

wife doesn't give the patient a chance to refuse. She says, "My name is nurse Norberg and this is so and so who will assist me." Medical education sometimes requires the use of real patients.[3] I just never expected that I would be that patient.

I finished my career as a teacher. If anyone should cooperate in education, I should! It is not a question of modesty. I am only concerned about avoiding an embarrassing physical reaction. I have a simple request. If you need me as a teaching tool again please tell me before the examination. I care only to know the reason because it will make it easier to relax. I will always assist with education!

During the examination you covered me with a drape. I did not object at the time because it would not have been understood and just would have made things worse. I hate draping. In fact, I hate anything that makes no logical sense. There is always a case to be made for simplicity and efficiency. I think draping is ineffective, counterproductive and inconsistent. Genitals have to be exposed to be examined. Draping genitals and then removing the drape just highlights the patient's nudity. Medical professionals are unanimous that they are indifferent to patient nudity. If so, why not treat patients accordingly? 1

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[3] I watched a television program once on "ghost surgeries". It was about people who hire prominent surgeons to do relatively simple surgeries to later find out that the surgeon they hired actually did not do the surgery. It was done by a surgical resident under supervision. The TV program was highly critical of the practice. I do not agree! If surgical residents do not have patients to operate on, how are you going to train new surgeons? Patients simply have to accept the fact that sometimes medical education requires live human guinea pigs!

have nothing to be ashamed of and I do not want to be treated as though I should. Draping is a palliative. It pretends to do something it actually fails at!

In summary, if you need a patient for medical education, I will be honored to cooperate, but please inform me beforehand.

Yours truly,

Douglas Norberg

NEVADA CENTER FOR DERMATOLOGY
LETTER TO NORBERG
(MARCH 8, 2019)

Mr. Douglas Norberg
1075 Mercedes Drive
Sparks, NV 89441

Re: Response to your letter

Dear Mr. Norberg,

Ashley Vazeen, APN forwarded your letter to me regarding your office visit and concerns you had regarding the presence of Dr. Casse' and a medical assistant in the room while you were examined. I understand your issue of privacy, particularly in regards to the full skin exam, which can be difficult for some people, particularly when there are other medical professionals in the room. You did mention that sometimes students are in the room and it is appropriate to ask patients if it is ok to have them present, however, in your case there were no students and thus you were not asked for permission. Dr. Casse' is a Board Certified dermatologist, and it is routine to have a medical assistant present as well to assist in procedures and to scribe.

Given the lengthy letter you sent, your negative experience here was significant enough to warrant this response. First, we regret that you had this experience, but our policy is to have medical assistants and sometimes other professionals in the exam room. This is not unusual and is the standard of care across medical specialties. Having said that, you may be more comfortable seeing a male dermatologist and we would be happy to recommend and/or refer you to

one in town since there are many good ones. If you choose to continue being seen here, you will no longer see Ashley. Instead, you will see Dr. Lamerson, and I will be in the room to assist. Although I am the Practice Administrator, I have also filled in as a Medical Assistant, and since I'm male, this might alleviate some of your discomfort. Hopefully, that will resolve the issues you have in the future.

Please let me know if you would like recommendations of male dermatologists in town or if you have any questions.

Sincerely,

/s/ Kenji Sax, PhD
Practice Administrator

NORBERG LETTER TO NEVADA STATE BOARD OF NURSING (JULY 26, 2019)

1075 Mercedes Drive
Sparks, Nevada 89441
March 5, 2019

Nevada State Board of Nursing
5011 Meadowood Mall Way, #300
Reno, NV 89502

Dear Board:

1075 Mercedes Drive

Sparks, Nevada 89441

July 26, 2019

Nevada State Board of Nursing

5011 Meadowood Mall Way, #300

Reno, NV 89502

Dear Board:

For several months I had a couple of skin problems in my pubic hair. I thought they would heal but they didn't. When I remembered that one of the symptoms of cancer is a sore that does not heal, I made an appointment with the Nevada Center for Dermatology. When the appointment came, Nurse Practitioner Ashley Vazeen, came in with a medical assistant. I noted the presence of the medical assistant and decided to ignore her. My two skin problems were dealt with and eventually healed. At the end of the examination Nurse Vazeen said, "I want to give you a full body skin examination." I had never heard

of such a thing but since I was 73 at the time and spent a lot of time in the sun playing golf, I agreed. The examination was scheduled for December 10, 2019. In the meantime, I researched a full body skin examination on line. All of the articles emphasized that the patient "get naked" so that "every square centimeter" of skin could be examined.

When the examination came Nurse Vazeen asked me if there was anything new. I responded that I had little black spots all over my scrotum. She examined me and correctly diagnosed the problem as Angiokeratoma of Fordyce, a benign condition. She then proceeded to do the full body skin examination. During the examination I heard the door to the examining room open. When I looked up Dr. Lamerson was talking to Nurse Vazeen. The conversation was about my examination. I vividly remember giving Dr. Lamerson my "what the hell are you doing here look". The conversation was very brief, less than 5 minutes, and she left.

When I got home, I realized that I had not taken off my underpants. The skin examination had been incomplete. I would either have to change dermatology clinics or give the Nevada Center for Dermatology another chance. The next day I was scheduled for a couple of spots on my face to be frozen so I mentioned that my examination the previous day had been incomplete. Nurse Vazeen left with her medical assistant. About 10 minutes later they came back with an additional woman. Nurse Vazeen introduced her as Dr. Casse'. The examination took place with me on the examination table naked from the waist down and two women sitting at my feet just watching. The rest of the story can be found in the letters.

I should digress to mention that Nurse Vazeen's conduct was always professional. She cured me of a skin condition, she correctly diagnosed another and she completed the full body skin examination when I asked her to. I have no complaint against either the quality or propriety of her medical care.

I am writing to you to ask for an interpretation of NRS § 449A.112 (2) which reads as follows in part: "The patient must consent to the presence of any person who is not directly involved with the patient's care during any examination, consultation or treatment." It is evident to me that both Drs. Lamerson and Casse' visitations were supervisory. I had explicitly consented to Nurse Vazeen's examination of me and implicitly her medical assistant. I never consented to anyone else. What I would like to know is whether NRS § 449A.112 (2) or other treatment principles require that consent be gained before witnessing an examination. I will tell you freely that had they asked me I would have consented. I will always fell honored to contribute to someone's medical education. Despite the fact that I felt I had been humiliated in the examination I was not angry. These are women and probably did not realize what they had inflicted upon me. I felt that I should inform them. I thought they would be grateful or at least polite. I expected an answer like, "We are sorry for the embarrassment we inflicted upon you, of course we will advise you why if we bring in a third party to witness your examination.

What egregiously peeves me is not my treatment but the insulting letters where I was told to find another provider! I may be immodest but I am definitely sensitive to being disrespected. Was I within my

rights as a patient to ask to be told in advance why third parties are being brought into watch my examination? Should my consent have been obtained before Dr. Casse' was brought in to witness my examination? The Nevada Center for Dermatology will doubtless claim that Dr. Casse' was directly involved with the patient's care. I do not agree! Dr. Casse' said nothing and did not budge off her seat! The caregiver is "directly" involved but a supervisor is "supervising"!

It is more questionable that a medical assistant is "directly involved". A medical assistant is not treating, she is "assisting". She assists the medical professional with perfunctory matters but does not engage in treatment. My medical assistant was never involved in any way with my treatment. Male general practitioners use female assistants for routine exams of female patients but never for males! In no case was I ever examined by a male doctor with a female present. No doctor, male or female, uses male assistants when examining female patients-ever! If male doctors do not use female assistants while examining male patients, should female doctors? It is one thing to be examined by a female medical professional who is just doing her job. It is quite another to being examined while someone of another gender is just sitting there watching. I am not modest so the presence of a single female medical assistant didn't really bother me much. However, some men are modest and they have as much right to be modest as women.[1] [2] [3] [4]

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[1] Why Men Patients are Forced to Man Up in the Medical Setting

[2] Chaperones in the Exam Room–Who Gets to Decide

Using patients for education is common in teaching hospitals. There should be ample precedent. If teaching hospitals are required to obtain consent, so should doctors' offices.

I do not request any disciplinary action. My request is simply that the Nevada Center for Dermatology be informed of proper protocols for informing patients when third parties are present and obtaining consent for the use of chaperones. If such protocols do not exist, they should be developed and promulgated. Modesty is an important issue for patients, please give this complaint the attention it deserves. You also might want to correlate with the State Board of Osteopathic Medicine and Medical Examiners' Board.

Yours truly,

Douglas Norberg

Encl: Letter to Vazeen December 11,2018
Letter to Vazeen March 5,2019
Letter from the Nevada Center for Dermatology, March 8,2019
Letter to Vazeen April 3, 2019
Letter from the Nevada Center for Dermatology April 9, 2019
Letter to Lamerson April 29, 2019
Letter from Lamerson May 6, 2019
Letter to Lamerson May 9, 2019
Letter from Lamerson May 13, 2019
Letter to Lamerson May 20, 2019

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[3] *See* Patient Modesty–What not to Do-YouTube

[4] *See* Patient Modesty–the Right Way–YouTube

ARTICLE:
SENSITIVE ISSUES FOR MEN PATIENT MODESTY

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modestguy
2 years ago 26 Replies

Given that the home page for this website prominently mentions the well-known male tendency to avoid medical treatment, I was extremely surprised that my search on the terms "modesty" and "privacy" yielded no results. There's a growing awareness that one of the major reasons men stay away from health care providers is the fact that their needs for modesty and bodily privacy are seldom respected. There is no such thing as a male mammographer, but the vast majority of scrotal ultrasounds are performed by female technicians. It's unthinkable for a female patient to end up undressed in a room with a male doctor and a male assistant. But the reverse happens all the time: more and more female physicians and NP's are bringing in so-called "chaperones" when performing intimate examinations and procedures on their male patients, and those chaperones are almost always female. Usually, men in these situations say nothing about their feelings of embarrassment, exposure, anger, and/or humiliation—but when they do, their responses are usually dismissed. Not always, but far more often than not: "You don't have anything we haven't seen before." "We don't have modesty here." "Do you have a problem with women?

Since my goal is to initiate some discussion of this topic here, I'll share an "ambush" experience of my own. I've posted about this on other blogs, so if you

follow the subject already you may have seen this before.

I'd been seeing a female NP for 5-6 years so thought I had a good working relationship with her. Then I had my first "intimate" exam with her—regarding a mass I'd noticed on one of my testicles. After the initial discussion, she left while I undressed, lay down on the exam table, and covered myself with a drape as she instructed. But when she opened the door again, one of the intake nurses (also female) was right behind her. Without a word to me, they positioned themselves directly across from each other at my hips. Then the NP pulled the drape completely off me, and I was exposed to both women from waist to ankles. I was so shocked and embarrassed I literally couldn't speak—the NP hadn't said anything beforehand about bringing in a witness, never explained why it was necessary, and never asked my permission for it (which I certainly would not have given). Before this encounter, I had never even heard of "chaperones," and had never been undressed in a doctor's office for anyone but that doctor. The whole encounter left me feeling insulted, disrespected, and humiliated; I had trouble sleeping and focussing [sic] at my job, and ended up seeing a therapist for a few months.

As mentioned, I have discussed this encounter on other websites, so I'm not necessarily seeking feedback for myself. I would be interested in hearing about similar experiences from other men, and how you responded to them. The more visible this issue becomes, the more likely things are to change.

ACHA GUIDELINES:
BEST PRACTICES FOR SENSITIVE EXAMS

ACHA Guidelines
Best Practices for Sensitive Exams

The American College Health Association (ACHA) recommends every institution have a policy regarding sensitive medical exams to protect patients' safety and minimize risk associated with the performance of these exams. It is ACHA's recommendation that, as part of institutional policy, a chaperone be provided for every sensitive medical examination and procedure.

The purpose of this guideline is to provide recommendations for a consistent and safe environment for care on college campuses. The recommendations on policy development promote respect for patient dignity and the professional nature of a sensitive medical examination or procedure. Maintaining and fostering a culture of responsibility and mutual accountability, providing education for both providers and patients, and appropriately responding to suspected unprofessional or unsafe behavior is paramount to the college health and wellness mission.

Introduction

ACHA is committed to promoting best practices that provide optimal care for all students. As part of this continued effort, the guidelines that follow will intentionally outline practices, procedures, and policies for sensitive exams. ACHA encourages institutions of higher education to not only adopt the following guidelines, but to also consider the entire student experience, beginning with how we create safety in

our clinics and how we build rapport with the patients we serve.

Best practices indicate that we should approach our work through a trauma-informed lens. Trauma-informed approaches emphasize physical, psychological, and emotional safety for both patients and providers. This fosters a sense of safety, control, and empowerment for diverse patient populations.

In addition to providing trauma-informed care, ACHA recommends being sensitive to the creation of an inclusive environment to serve a diverse patient population. To achieve inclusivity, we recommend intentional design and regular review of campus health center intake and medical history forms, cultural sensitivity training for providers and other clinic staff, and patient educational materials and signage that better ensure physical, psychological, and emotional safety.

Despite recommendations regarding use of chaperones for sensitive examinations from the American Medical Association (AMA), the American College of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics (AAP), the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), the General Medical Council (GMC) in the United Kingdom, and the states of Georgia* and Ohio,† many organizations do not have a standard.

There is a lack of policy, consistency in policy, and implementation of policy in part due to a lack of

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* Official Code of Georgia Annotated 360-3-02(12)

† Ohio Administrative Code 4731-26-01

evidence regarding impact on patient experience or care outcomes. AAP recommends that a chaperone be mandatory for all adolescent genital, rectal, and breast exams, and AWHONN has since 2001 maintained a position statement supporting patient opt-out of chaperone presence during the sensitive exam. The AMA and ACOG Committee on Ethics endorse offering a chaperone for all sensitive exams (opt-in), as does the British GMC with the AMA stating in their Code of Ethics Opinion 1.2.4 that physicians should adopt and communicate a policy offering chaperones (opt-in) for all patient care, not limited to sensitive exams.

To date, most college health organizations with a chaperone policy have adopted opt-out policies. Several schools offer opt-in policies, and others have policies specifying that a chaperone is mandatory for male-identifying providers when the patient is assigned female at birth or female-identified. Some schools have mandatory policies for all sensitive examinations that do not permit patients to opt out unless there is a clinical emergency and a chaperone is not available.

Much of the research on chaperone policy centers on provider compliance, documentation, and satisfaction with use of chaperones, with a few surveying patient attitudes regarding chaperones, and none exploring patients' experiences with chaperones or impact on outcomes.

The intent of this document is to provide guidance to ensure best practices around sensitive exams. Given the lack of consistent recommendations from other major organizations on chaperoning for sensitive exams and a paucity of data on outcomes and patient satisfaction with chaperoning, ACHA has created these guidelines to promote patient safety and mitigate

risk. We recognize that schools are differently resourced, which may necessitate increased collaboration with campus and community partners to develop creative solutions in order to provide optimal care for all students.

Institutions must keep in mind their obligation to protect the safety of their students regardless of how they meet student health care needs. Many schools have separate training facilities for athletes and may outsource specific specialized care (i.e., physical therapy, gynecological care). Contracts for institutional and non-institutional providers should include the protocols for sensitive exams to ensure consistent adherence to protections and ethical practices. The outsourcing of specialized care does not negate the institution's obligation to protect patients, and contracts for outsourced care should include expectations of compliance with the institution's chaperone policy.

In keeping with best practices, when creating a chaperone policy consideration must be given to the power differential between patient and provider, as well as chaperone and provider. The power differential between patient and provider and provider and chaperone informs who may serve as a chaperone. It is important to understand the inherent vulnerability of our patients when they are seeking care, as well as the potential vulnerability of the chaperone. This vulnerability encompasses the reliance on providers' professionalism and expertise, ethical practice, and a chaperone's ability to provide input that might change the course of an exam without fear of retaliation.

Because the provider has the power to make and influence decisions and is involved in sensitive touch,

chaperones play a critical role by offering a sense of safety and balance of power. Due to the heightened vulnerability during sensitive exams, chaperones play an integral role in protecting both patient and provider and better ensuring there is no abuse of power by the provider. SAMHSA's tenets of trauma-informed care should be utilized by both chaperone and provider. Trauma-informed care honors patient voice, agency, control and choice. It is important to note that providers are often unaware of a patient's prior experiences; therefore, adopting the tenants of trauma-informed care are crucial to avoid potential re-traumatization.

Chaperones should be able to freely provide critical input during an exam based on the needs of the patient, as well as feedback after an exam without coercion, fear of retaliation, or reprimand. Therefore, organizationally, chaperones should not report directly to the provider, or to the direct supervisor of the provider when possible. The chaperone should also not be subject to academic evaluation; therefore, it is not recommended that medical students or other health care trainees serve as chaperones.[15] A clear protocol for documentation and complaints should be outlined as part of the policy with consideration to organizational power structures that might deter critical feedback, risking ethical standards of care.

Core Principles for Policy Development

All institutions that provide sensitive exams should have a written policy that includes:

- Definition of Sensitive Exam, Near Sensitive Exam, and Chaperone

- Use of Chaperones
- Chaperone Training
- Provider and Staff Training
- Patient Education
- Reporting of Non-Compliance and Complaints
- Risk Management Related to Investigation of Complaints

Definition of Sensitive Exams, Near Sensitive Exams, and Chaperone

A sensitive exam or procedure includes, but is not limited to, an exam, evaluation, palpation, physical therapy for, placement of instruments in, or exposure of:

- Genitalia
- Rectum
- Breast

A patient's personal and cultural experiences may broaden their own definition of a sensitive exam or procedure. Some patients may include in their definition of a sensitive exam an examination or procedure that involves partial exposure or palpation of body parts near sensitive areas (e.g., exposure of undergarments, palpation of the groin or buttocks, or auscultation near the breast), and a chaperone should be offered.

A chaperone is a trained person who acts as a support and witness for a patient and a provider during a sensitive exam or procedure. If properly trained to do so, they may also assist the provider with equipment

and specimen handling. However, these responsibilities should not detract from their ability to support and witness important aspects of the examination. A chaperone is utilized to help protect and enhance the patient's comfort, safety, security, and dignity during a sensitive exam or procedure. The chaperone may be a provider or a trained staff member. Whenever possible the patient should be allowed to request the gender of the chaperone. A family member or support person may be present during a sensitive exam or procedure if it is the expressed desire of the patient but cannot serve as a chaperone.

We have chosen to use the word "chaperone" for the purposes of this document primarily due to its specific use in policies, guidance from major organizations and literature around the topic of the sensitive exam. However, we understand there may be a negative connotation surrounding the term chaperone, which may imply that someone needs to be supervised or cannot be trusted to act with integrity. In addition, students may view the term as out-of-date and creating a culture of distrust. Some institutions have used different terminology in their policies and patient education materials such as clinical attendant or assistant. We support individual institutions' choice to use the terminology that is most accepted on their campus for their policy development and educational resources. Again, for the purposes of this document and to avoid confusion, we will continue to use the word chaperone within this document.

Types of Chaperone Policies

There are three recognized options for a chaperone policy—opt-out, opt-in, and mandatory. ACHA recom-

mends an opt-out policy for all sensitive exams and supports institutions who endorse a mandatory chaperone policy for sensitive exams to mitigate risk.

> Opt-out policy is one in which a chaperone is planned and provided for at every sensitive exam or procedure and available for any exam upon patient or provider request. A patient has a right to decline a chaperone after being provided adequate education that explains the nature of the sensitive exam and the role of the chaperone.
>
> Opt-in policy is one in which a chaperone is offered and available upon the request of the patient. Institutions should provide patient education regarding the option of a chaperone and the nature of the sensitive examination. Signage alone as patient education is insufficient. A power differential during a medical encounter may exist, making it uncomfortable for the patient to request the additional support of a chaperone. For this reason, opt-in policies are discouraged for sensitive examinations.
>
> Mandatory policy is one in which a chaperone must be present during a sensitive exam or the exam will not be performed. Institutions that adopt a mandatory policy should not allow their policy to impede emergency care. While this may provide the greatest institutional protection, patient autonomy and agency may be negatively impacted.

An institution's policy regarding sensitive medical exams may contain elements from each of these types

of policies. While ACHA recommends an opt-out policy in most situations, there may be circumstances that necessitate a mandatory chaperone. For example, any patient who is defined by state law as a minor requiring parental consent, who is sedated, or who lacks the capacity to provide informed consent at the time of care requires a chaperone and cannot decline. Opt-in policies may be more appropriate for consideration for exams near sensitive areas (i.e., near-sensitive exams).

While policies should respect the patient's ability to decline a chaperone, policies should also allow a provider to retain the right to not perform the examination and refer that patient to another health professional or clinic if they are not comfortable completing the sensitive exam without a chaperone.

All policies should include:

- Patient education
- Chaperone and provider training
- Documentation of chaperone use or declination of use
- Reporting of non-compliance or complaints
- Investigation of complaints or allegations of misconduct.
- Consent for photographs that may be taken during a sensitive exam
- Supervision structure for chaperones independent of clinical providers

A core component of policy development includes reporting responsibilities regarding violations of the

policy, as well as concerns for inappropriate exams. The chaperone and patient should be educated and empowered with a clear understanding of how to report concerns. Similarly, all staff should be aware of and have a mechanism for reporting violations of the policy.

Implementation of Policies

Chaperone Training

A key component to the successful implementation of a chaperone policy is the training of staff who will chaperone sensitive exams. Depending on the type of staff employed for this function, they may have little experience observing or assisting with the sensitive exam. It is crucial to outline expectations of the chaperone, as well as key components of the exam, procedures, and steps performed by the provider during the sensitive exam.

In the clinical setting, there is often a perceived power differential or hierarchy between the provider and support staff or assistants. Chaperones may feel uncertain or concerned about intervening during an inappropriate exam or reporting potential misconduct. Training of both chaperone and provider should review expectations for each role, improve communication between the team, suggest neutral terms for intervention in the case of patient distress or chaperone discomfort, and set expectations for provider behavior and procedure. A portion of the training for the chaperone must include how to report unprofessional conduct during the medical exam or concerns about violation of the chaperone policy.

Training should occur at hire or when someone is designated as a chaperone and renewed regularly with knowledge/skill competency to include cultural sensitivity and trauma-informed practices. Below are key components of the role to be included in chaperone training:

- Ensuring patient comfort during exam
- Ensuring patient dignity with privacy for dressing/undressing and appropriate gown or drape
- Informing patient that chaperone will be present if a sensitive exam is performed or for any other exam as requested by the patient or provider
- Documenting chaperone presence during exam or declination of chaperone by patient
- Positioning of chaperone during exam to visualize point of contact of exam or procedure
- Assisting other staff with dressing/undressing and toileting before or after examination. Two staff, one of which is a chaperone, should be provided to patients who require such assistance.
- Reviewing how chaperone may intervene or stop an exam if they are concerned about patient distress or inappropriate steps during the exam
- Reviewing reporting mechanisms for concerns or non-compliance with policy

Provider Training

Training providers on sensitive exams is another key component to providing patients with a safe care environment. With the inclusion of chaperones for sensitive and near-sensitive exams, training should be given to all providers performing such exams including, but not limited to, physicians, residents, fellows, advanced practice providers, nurses, imaging technologists, physical therapists, and athletic trainers.

Training should include respecting a patient's decision to refuse a chaperone while also acknowledging a provider's right to refer that patient to another health professional or clinic if the provider is not comfortable completing the sensitive exam without a chaperone. Providers should not consider parents and other untrained individuals as proper chaperones for sensitive exams. While it is important to have chaperones present during the sensitive exam, providers should minimize the amount of sensitive information asked and shared in front of the chaperone to protect patient confidentiality.

Training should occur at hire and renewed regularly with knowledge/skill competency to include cultural sensitivity and trauma-informed practices. Below are key components to be included in provider training:

- Proper communication with patient about why the sensitive exam is needed
- Proper communication before and during sensitive exams to explain what to expect from the exam and what will happen during the exam

- Documentation of patient education provided
- Documentation if patient declines any part of exam
- Documentation of chaperone presence or declination of chaperone use
- Chaperone communication to signal the need to pause exam due to obscured view or patient discomfort
- Documentation of consent when taking photographs of sensitive areas
- Two staff, one of which is a chaperone, should be provided to patients who need assistance with dressing/undressing or toileting before or after an exam.

Patient Education

Patients are understandably vulnerable during a medical examination, particularly during a sensitive exam. Understanding what to expect throughout the visit—from questions about the patient's history to the components of the physical exam—is critical to empower patients. Prior to the exam, it is important to educate the patient as to why the examination is needed, what the exam entails, the purpose and availability of a chaperone, and importantly, the patient's ability to decline or stop any portion of the exam. Patient education may be provided using a variety of educational resources or materials including chaperone or provider explanation, in-room posted or written materials, and web-based written information or videos.

Best practice recommendations should include:

- Provision of materials outlining the components of a sensitive exam, the role of a chaperone, and how to report concerns about inappropriate exams or violations of the policy
- Expectation that a chaperone will be present for a sensitive medical exam and available for any other exam upon patient request
- Ability of a patient to request the gender of a chaperone
- Verbal explanation of the planned examination by a provider
- Education on the patient's right to request further clarity on the exam, express discomfort, or to terminate an exam at any point
- Provision of adequate privacy to undress/dress with appropriate gowns/drapes to afford patient dignity

Reporting of Non-Compliance or Violation of Policy

As mentioned above, chaperone and provider training and patient education should include information on the processes for reporting violations of policy. All reports and complaints should be evaluated by a process developed by each institution to ensure a timely investigation, quality assurance, and quality improvement. Chaperone policies should include processes for reporting concerns of suspected non-compliance and policy violations by patients, chaperones, clinic staff, and providers. Because of power differentials inherent in clinical care and

resultant disincentives for reporting, reporting lines of authority should be distinct from employment and clinical supervisory hierarchy. To minimize disincentives for patient reporting, multiple processes should be developed and included in patient education materials at each visit, including an anonymous reporting option.

Risk Management

Instances of alleged misconduct by providers may place organizations at considerable reputational or financial risk. These polices should be reviewed and approved by the institutional general counsel, and for those institutions affiliated with academic medical centers, the procedural and response policies of both organizations should be closely aligned.

The presence of a chaperone may provide some protection to providers against unfounded allegations of improper behavior. Consistent with this objective, the institutional guidelines should include provisions for addressing instances when the provider is uncomfortable with a patient request for no chaperone.

All providers should be adequately educated about the policies and expectations related to the use of chaperones during medical examinations. Organizations should include within their policies guidelines for the appropriate response to reports of noncompliance with the guidelines and must investigate allegations of suspected unprofessional behavior by providers. Institutions must be cognizant of state law, especially those concerning minors.

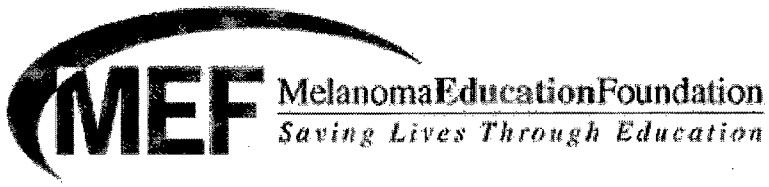
- Timely investigations of suspected inappropriate behavior should be conducted by an

impartial external office (e.g., Title IX, campus law enforcement, medical ethics review board).

- Results of external investigations should be reviewed by institutional general counsel or a human resources team and should be shared with the governing body of the organization for corrective action as indicated.
- Organizations should retain objective and subjective comments received regarding provider interactions with patients (e.g., patient comments, patient satisfaction survey data), which may be useful as part of investigations in demonstrating patterns of behavior.
- Understanding that being the subject of an investigation may be a traumatic experience, institutional support resources should be made available to providers or chaperones during the course of an investigation.

[. . .]

MELANOMA EDUCATION FOUNDATION:
FINDING MELANOMA EARLY
THE DREADED SKIN EXAM



Note: The following was written by Ken, a 37-year-old from New York, as an example of how one man got past his fear and embarrassment of undergoing a skin exam.

> What I was worried about was the embarrassment related to having someone carefully examining every square inch of my body.

I became aware of the threat of skin cancer a few years ago when friends of our family lost a son to the disease. As a result, my mother insisted that I get a skin examination. However, I wasn't really worried about skin cancer. I wasn't worried about the virtually painless biopsy, either. What I was worried about was the embarrassment related to having someone carefully examining every square inch of my body. To make matters worse, the dermatologist to which I was referred was a woman, and the idea of having a female doctor look at my entire male body made me even more nervous.

So, with fear and trepidation, I made an appointment. At the visit, she biopsied a suspicious mole found in the middle of my back, which, thankfully, was found to be non-cancerous. To be honest, I couldn't

quite bring myself to have her look everywhere at that first visit. I opted to keep my underwear on, which still allowed her to look at the sun-exposed areas of my skin. In our sun-worshipping culture, it's recommended that people get skin exams annually. So, when I recently noticed some new moles and blotches on my back and shoulders, and remembered that I hadn't been examined in a few years, I made another appointment.

I was still a little nervous when I showed up at the doctor's office early one morning for this latest appointment. The nurse led me into the exam room and handed me a gown to put on. She said that I could leave my underwear on, but I said that I'd like the doctor to look "there," too, because it's highly recommended you have your entire body examined; melanomas can appear in areas that are never exposed to the sun. She responded that it would be fine to remove my underwear if I'm comfortable with that, and left the room. I undressed and put on the gown. A few minutes later, my doctor came in and her congenial—yet very professional—manner began to put me at ease. She asked what my concerns were, and I told her about the new marks on my back. Then it was time for the exam.

It's highly recommended you have your entire body examined; melanomas can appear in areas that are never exposed to the sun.

First, she had me sit on the exam table. She looked carefully at my back and arms and assured me that the marks were just normal ones caused by sun exposure. She then lowered the gown to my waist and looked over my chest and abdomen. (At

this point I slipped my arms out of the gown to make a subsequent part of the exam go more smoothly, which I'll explain shortly.) Finding nothing wrong there, she had me stand up so she could look at my buttocks and the backs of my legs as I held my gown in front of me—probably a good idea since I was facing the door, and one never knows when a nurse could open the door to talk to the doctor!

The next area to be examined was the front of my body below the waist. This was the part that I had always feared, but this time, my modesty wasn't holding me back. She had me turn around, and since I had already slipped my arms out of the gown, it was easy for me to just set it aside on the exam table. This is entirely optional; it's fine to leave the gown on and just have the doctor lift it to continue the exam. As I stood there wearing nothing but my wedding ring, she examined my hips and thighs as well as my groin area. Now, this part is always dicey for men because it's easy to feel very self-conscious and have a uniquely male physical reaction, but this is very common and nothing to be embarrassed about. Anyway, the doctor carefully pushed my private parts to each side in order to get a complete view of the skin surface in that area. I can assure you that doctors know how to do this in a manner which does not cause any uncomfortable sensation. Remember, it's all in a day's work for a doctor accustomed to doing these exams.

Remember, it's all in a day's work for a doctor accustomed to doing these exams.

She continued the exam, focusing on the lower parts of my legs. We then began discussing the treat-

ment of a wart on my right knee. We stood there for a few moments as she finished explaining how to treat the wart, and then I realized that she had picked up my gown and was holding it out for me. By this time I had already forgotten I was naked! I put the gown back on, and she had me sit on the exam table again. She finished the exam by carefully examining my feet, including the area between each of the toes. We discussed a couple of other concerns, talked about our kids, and then the exam was finished. I felt a great sense of triumph that I had finally conquered all of my anxieties about being naked in front of a female doctor, and in the future will be far less nervous about it. In fact, I don't think I even blushed!

I wrote this to keep others from being nervous and inhibited about having their skin examined. Skin cancer is a growing concern in the United States. It's estimated that [192,310] people will be diagnosed with melanoma in [2019]. One of the main reasons people refuse to get these exams is embarrassment. Please do not let that stop you! You don't have to go to a doctor of the opposite sex, but on the other hand, many people, including myself, actually feel more comfortable doing that. Don't put it off! If I—a modest, conservative white male—can have this done, anyone can. Check your modesty at the door of the exam room and have a doctor check your skin.