HB3515

101ST GENERAL ASSEMBLY

State of Illinois

2019 and 2020

HB3515

by Rep. Thomas Morrison

SYNOPSIS AS INTRODUCED:

New Act
225 ILCS 60/22 from Ch. 111, par. 4400-22

Creates the Youth Health Protection Act. Provides that a medical doctor shall not prescribe, provide, administer, or deliver puberty-suppressing drugs or cross-sex hormones and shall not perform surgical orchiectomy or castration, urethroplasty, vaginoplasty, mastectomy, phalloplasty, or metoidioplasty on biologically healthy and anatomically normal persons under the age of 18 for the purpose of treating the subjective, internal psychological condition of gender dysphoria or gender discordance. Provides that any efforts to modify the anatomy, physiology, or biochemistry of a biologically healthy person under the age of 18 who experiences gender dysphoria or gender discordance shall be considered unprofessional conduct and shall be subject to discipline by the licensing entity or disciplinary review board. Provides that no medical doctor or mental health provider shall refer any person under the age of 18 to any medical doctor for chemical or surgical interventions to treat gender dysphoria or gender discordance. Contains definitions, a statement of purpose, and legislative findings. Amends the Medical Practice Act of 1987 to make related changes.

LRB101 11160 CPF 56398 b

A BILL FOR

1 AN ACT concerning regulation.

2 **Be it enacted by the People of the State of Illinois,**
3 **represented in the General Assembly:**

4 Section 1. Short title. This Act may be cited as the Youth
5 Health Protection Act.

6 Section 5. Legislative findings. The General Assembly
7 finds and declares the following:
8 (1) At birth, doctors identify the sex of babies. They do
9 not assign them a "gender."
10 (2) Being biologically male or biologically female is not a
11 disorder, illness, deficiency, shortcoming, or error.
12 Scientists and other medical professionals have recognized
13 that biological sex is a neutral, objective, and immutable fact
14 of human nature.
15 (3) Puberty is not a disease or a disorder.
16 (4) There is no conclusive, research-based evidence
17 proving that if there is incongruence between one's objective
18 and immutable biological sex (and its attendant healthy and
19 normally functioning anatomy and physiology) and one's
20 subjective, internal sense of being male or female that the
21 problem resides in the body rather than the mind.
22 (5) The May 19, 2014 issue of the highly respected Hayes
23 Directory reports that the practice of using hormones and

1 surgery to treat gender dysphoria in adults is based on "very
2 low quality of evidence" and goes on to discuss the "serious
3 limitations to the evidence" in great detail. It reports
4 further that the use of hormones and surgery to treat gender
5 dysphoria in children and adolescents has no evidence base.

6 (6) Health risks and complications of puberty suppression:
7 The use of puberty-suppression medications for the treatment of
8 gender-dysphoric minors is "off-label." The health risks
9 include the arrest of bone growth, a decrease in bone
10 accretion, the prevention of sex-steroid-dependent
11 organization and maturation of the adolescent brain, and the
12 inhibition of fertility by preventing the development of
13 gonadal tissue and mature gametes for the duration of
14 treatment.

15 (7) Self-fulfilling nature of puberty suppression: "There
16 is an obvious self-fulfilling nature to encouraging a young boy
17 with [gender dysphoria] to socially impersonate a girl and then
18 institute pubertal suppression. Given the well-established
19 phenomenon of neuroplasticity, the repeated behavior of
20 impersonating a girl alters the structure and function of the
21 boy's brain in some way-potentially in a way that will make
22 identity alignment with his biologic sex less likely. This,
23 together with the suppression of puberty that prevents further
24 endogenous masculinization of his brain, causes him to remain a
25 gender non-conforming prepubertal boy disguised as a
26 prepubertal girl."

(8) Cross-sex hormones risks and effects: The use of cross-sex hormones for the treatment of gender dysphoria in minors is "off-label," and long-term risks are unknown.

Sterility and voice changes are permanent for both men and women.

An interagency statement published by the World Health Organization states that "sterilization should only be provided with the full, free and informed consent of the individual" and that "sterilization refers not just to interventions where the intention is to limit fertility ... but also to situations where loss of fertility is a secondary outcome. ... Sterilization without full, free and informed consent has been variously described by international, regional and national human rights bodies as an involuntary, coercive and/or forced practice, and as a violation of fundamental human rights, including the right to health, the right to information, the right to privacy."

Since parents or guardians must provide consent for hormonal interventions, and since parents and guardians are not being made aware of the experimental nature of the off-label use of hormones for the treatment of gender dysphoria or of the fact that most children with gender dysphoria outgrow it by late adolescence if otherwise supported through natural puberty, parents and guardians are unable to provide fully informed consent.

Breast tissue growth in men who take estrogen is permanent.

"Male"-pattern baldness and body and facial hair growth in women who take testosterone are permanent.

For biologically healthy men who take estrogen to treat their subjective, internal feelings about their sex, there is an "increased risk of liver disease, increased risk of blood clots, (risk of death or permanent damage), increased risk of diabetes and of headaches/migraines heart disease, increased risk of gallstones, may be increased risk of noncancerous [tumor] of pituitary gland."

For biologically healthy women who take testosterone to treat their subjective, internal feelings about their sex, there is an increased risk of heart disease, stroke, diabetes, breast cancer, ovarian cancer, and uterine cancer. Taking testosterone can have a "destabilizing effect" on "bipolar disorder, schizoaffective disorder, and schizophrenia."

(9) The Christian Medical and Dental Associations "[believe] that prescribing hormonal treatments to children or adolescents to disrupt normal sexual development for the purpose of gender reassignment is ethically impermissible, whether requested by the child or the parent."

(10) The Catholic Medical Association "urges health care professionals to adhere to genetic science and sexual complementarity over ideology in the treatment of gender dysphoria (GD) in children. This includes especially avoiding puberty suppression and the use of cross-sex hormones in children with GD. One's sex is not a social construct, but an

1 unchangeable biological reality."
2 (11) Surgery (e.g., mastectomy and orchiectomy) is
3 irreversible.
4 (12) Teen brain: Neuroscientist, Professor of Neurology at
5 the University of Pennsylvania, and author of The Teenage
6 Brain, Dr. Frances Jensen, explains that:
7 Teenagers do have frontal lobes, which are the seat of our
8 executive, adult-like functioning like impulse control,
9 judgment and empathy. But the frontal lobes haven't been
10 connected with fast-acting connections yet. ...
11 But there is another part of the brain that is fully active
12 in adolescents, and that's the limbic system. And that is the
13 seat of risk, reward, impulsivity, sexual behavior and emotion.
14 So they are built to be novelty-seeking at this point in
15 their lives.
16 (13) Suicide rate: The oft-cited suicide rate of 41% for
17 those who identify as "trans" is based on an erroneous
18 understanding of a study by the Williams Institute, an
19 understanding that ignores the acknowledged and serious
20 limitations of the study.
21 (14) There is no evidence that surgery or chemical
22 disruption of normal, natural, and healthy development or
23 processes reduces the incidence of suicide.
24 (15) Dr. J. Michael Bailey, Professor of Psychology at
25 Northwestern University, and Dr. Raymond Blanchard, former
26 psychologist in the Adult Gender Identity Clinic of Toronto's

Centre for Addiction and Mental Health (CAMH) from 1980-1995 and the Head of CAMH's Clinical Sexology Services from 1995-2010, have written the following:

(a) Children (most commonly, adolescents) who threaten to commit suicide rarely do so, although they are more likely to kill themselves than children who do not threaten suicide.

(b) Mental health problems, including suicide, are associated with some forms of gender dysphoria. But suicide is rare even among gender dysphoric persons.

(c) There is no persuasive evidence that gender transition reduces gender dysphoric children's likelihood of suicide.

(d) The idea that mental health problems, including suicidality, are caused by gender dysphoria rather than the other way around (i.e., mental health and personality issues cause a vulnerability to experience gender dysphoria) is currently popular and politically correct. It is, however, unproven and as likely to be false as true.

(16) There is no phenomenon of women trapped in men's bodies or vice versa, or of men having women's brains or vice versa: Science has not proven that the brains of transgender individuals are "wired differently" than others with the same biological sex. In other words, there is no conclusive evidence of a "female brain" being contained in a male body or vice versa. In fact, it is impossible for an opposite sexed brain to

1 be "trapped" in the wrong body. Every brain cell of a male
2 fetus has a Y chromosome; female fetal brains do not. This
3 makes their brains forever intrinsically different.
4 Additionally, at 8 weeks gestation, male fetuses have every
5 cell of their body, including every brain cell, bathed by a
6 testosterone surge secreted by their testes. Female fetuses
7 lack testes; none of their cells, including their brain cells,
8 experience this endogenous testosterone surge. [Reyes FI,
9 Winter JS, Faiman C. "Studies on human sexual development Fetal
10 gonadal and adrenal sex steroids"; J Clin Endocrinol Metab.
11 1973 Jul; 37(1):74-8; Lombardo, M. "Fetal Testosterone
12 Influences Sexually Dimorphic Gray Matter in the Human Brain";
13 The Journal of Neuroscience, 11 January 2012, 32(2); Campano,
14 A. [ed]. Geneva Foundation for Medical Education and Research:
15 human sexual differentiation (2016).]
16 (17) Brain-sex theories: "[C]urrent studies on
17 associations between brain structure and transgender identity
18 are small, methodologically limited, inconclusive, and
19 sometimes contradictory. Even if they were more
20 methodologically reliable, they would be insufficient to
21 demonstrate that brain structure is a cause, rather than an
22 effect, of the gender-identity behavior. They would likewise
23 lack predictive power, the real challenge for any theory in
24 science."
25 (18) Desistance: The best research to date suggests that
26 without social or medical "transition" most (60-90%)

gender-dysphoric children will come to accept their biological sex after passing naturally through puberty. While "12-27% of 'gender variant' children persist in gender dysphoria; that percentage rises to 40% amongst those who visit gender clinics." Research shows that desistance rates rise significantly among those who are given puberty-blockers and "gender-affirmative psychotherapy," thus suggesting that such interventions lead minors "to commit more strongly to sex reassignment than they might have if they had received a different diagnosis or a different course of treatment."

(19) The American College of Pediatricians confirms what "detransitioners" assert: There are many possible post-natal, environmental causes for gender dysphoria:

Family and peer relationships, one's school and neighborhood, the experience of any form of abuse, media exposure, chronic illness, war, and natural disasters are all examples of environmental factors that impact an individual's emotional, social, and psychological development.

(20) Autism: "Mounting evidence over the last decade points to increased rates of autism spectrum disorders (ASD) and autism traits among children and adults with gender dysphoria, or incongruence between a person's experienced or expressed gender and the gender assigned to them at birth. ... It is possible that some of the psychological characteristics common in children with ASD-including cognitive deficits, tendencies toward obsessive preoccupations, or difficulties learning from

1 other people-complicate the formation of gender identity."
2 (21) A study published in May 2018 "further confirmed a
3 possible association between ASD and the wish to be of the
4 opposite gender by establishing increased endorsement of this
5 wish in adolescents and adults with ASD compared to the general
6 population controls."
7 (22) "Rapid-onset gender dysphoria" (ROGD): Dr. J. Michael
8 Bailey, Professor of Psychology at Northwestern University,
9 and Dr. Raymond Blanchard, former psychologist in the Adult
10 Gender Identity Clinic of Toronto's Centre for Addiction and
11 Mental Health (CAMH) from 1980-1995 and the Head of CAMH's
12 Clinical Sexology Services from 1995-2010, explain the
13 phenomenon of ROGD:
14 The typical case of ROGD involves an adolescent or young
15 adult female whose social world outside the family glorifies
16 transgender phenomena and exaggerates their prevalence.
17 Furthermore, it likely includes a heavy dose of internet
18 involvement. The adolescent female acquires the conviction
19 that she is transgender. (Not uncommonly, others in her peer
20 group acquire the same conviction.) These peer groups
21 encouraged each other to believe that all unhappiness, anxiety,
22 and life problems are likely due to their being transgender,
23 and that gender transition is the only solution. Subsequently,
24 there may be a rush towards gender transition. ... We believe
25 that ROGD is a socially contagious phenomenon in which a young
26 person-typically a natal female-comes to believe that she has a

1 condition that she does not have. ROGD is not about discovering
2 gender dysphoria that was there all along; rather, it is about
3 falsely coming to believe that one's problems have been due to
4 gender dysphoria previously hidden (from the self and others).
5 Let us be clear: People with ROGD do have a kind of gender
6 dysphoria, but it is gender dysphoria due to persuasion of
7 those especially vulnerable to a false idea.
8 (23) Brown University Researcher, Dr. Lisa Littman,
9 conducted a survey of parents whose children developed Rapid
10 Onset Gender Dysphoria. Littman wrote that the "worsening of
11 mental well-being and parent-child relationships and behaviors
12 that isolate [adolescents and young adults] from their parents,
13 families, non-transgender friends and mainstream sources of
14 information are particularly concerning. More research is
15 needed to better understand this phenomenon, its implications
16 and scope."
17 (24) The number of children "being referred for
18 transitioning treatment" in England has increased 4,400% for
19 girls and 1,250% for boys, which has resulted in calls from
20 members of Parliament for an investigation.
21 (25) Body Integrity Identity Disorder (BIID) shares in
22 common several features with gender dysphoria. BIID is a
23 condition in which "[s]ufferers from BIID experience a mismatch
24 between their physically healthy body and the body with which
25 they identify. They identify as disabled. They often desire a
26 specific amputation to achieve the disabled body they want." As

1 with some cases of gender dysphoria, scientists say there is
2 evidence for neurological involvement as a cause of the
3 experience of BIID, and yet physicians largely oppose elective
4 amputations of healthy anatomical parts:

5 According to the principle of nonmaleficence physicians
6 must not perform amputations without a medical indication
7 because amputations bear great risks and often have severe
8 consequences besides the disability ... for example,
9 infections [or] thromboses. Even though some physicians
10 perform harmful surgeries as breast enlargement surgeries,
11 this cannot justify surgeries that are even more harmful. Even
12 if amputations would be a possible therapy for BIID, they would
13 be risky experimental therapies that could be justified only if
14 they promised lifesaving or the cure of severe diseases and if
15 an alternative therapy would not be available. At least the
16 first condition is not fulfilled in the case of BIID, and
17 probably the second is not fulfilled either. Above all, an
18 amputation causes an irreversible damage that could not be
19 healed, even if the patient's body image would be restored
20 spontaneously or through a new therapy. ... But since all
21 psychiatrists who have investigated BIID patients found that
22 the amputation desire is either obsessive or based on a
23 monothematic delusion, and since neurological studies support
24 the hypothesis of a brain disorder (which is also supported by
25 the most influential advocates of elective amputations),
26 elective amputations have to be regarded as severe bodily

1 injuries of patients.
2 (26) The American College of Pediatricians (ACPeds), "a
3 national medical association of licensed physicians and
4 healthcare professionals who specialize in the care of infants,
5 children, and adolescents" that split from the American Academy
6 of Pediatrics because of its politicization of the practice of
7 medicine, describes puberty-suppression, cross-sex hormone,
8 and surgeries variously referred to as sex-change, sex
9 reassignment, gender reassignment and gender confirmation
10 surgeries as child abuse."
11 (27) Dr. Lisa Simons, pediatrician at Robert H. Lurie
12 Children's Hospital of Chicago, stated in a PBS Frontline
13 documentary that "'The bottom line is we don't really know how
14 sex hormones impact any adolescent's brain development.' ...
15 What's lacking, she said, are specific studies that look at the
16 neurocognitive effects of puberty blockers."
17 (28) Dr. Kenneth Zucker, one of the world's leading
18 authorities on gender dysphoria, states that:
19 "Identity is a process. It is complicated. It takes a long
20 period of time ... to know who a child really is. ... There are
21 different pathways that can lead to gender dysphoria. ... It's
22 an intellectual and clinical mistake to think that there's one
23 single cause that explains all gender dysphoria. ... Just
24 because little kids say something doesn't necessarily mean that
25 you accept it, or that it's true, or that it's in the best
26 interest of the child. ... Little kids can present with extreme

1 gender dysphoria, but that doesn't mean they're all going to
2 grow up to continue to have gender dysphoria.
3 (29) Dr. Eric Vilain, a geneticist at UCLA who specializes
4 in sexual development and sex differences in the brain, says
5 the studies on twins are mixed and that, on the whole, "there
6 is no evidence of a biological influence on transsexualism
7 yet."
8 (30) Sheila Jeffreys, lesbian feminist scholar, warns
9 against the "transgendering" of children: "Those who do not
10 conform to correct gender stereotypes are being sterilized and
11 they're being sterilized as children."
12 (31) Heather Brunskell-Evans Heather, social theorist,
13 philosopher, and Senior Research Fellow at King's College,
14 London, UK, and Michele Moore, Professor of Inclusive Education
15 and Editor-in-Chief of the world-leading journal Disability &
16 Society, critique the "transgender" ideology:
17 [O]ur central contention is that transgender children
18 don't exist. Although we argue that 'the transgender child' is
19 a fabrication, we do not disavow that some children and
20 adolescents experience gender dysphoria and that concerned and
21 loving parents will do anything to alleviate their children's
22 distress. It is because of children's bodily discomfort that we
23 argue it is important families and support services are
24 informed by appropriate models for understanding gender. Our
25 analysis of transgenderism demonstrates it is a new phenomenon,
26 since dissatisfaction with assigned gender takes different

forms in different historical contexts. The 'transgender child' is a relatively new historical figure, brought into being by a coalition of pressure groups, political activists and knowledge makers. ... Bizarrely, in transgender theory, biology is said to be a social construct but gender is regarded as an inherent property located 'somewhere' in the brain or soul or other undefined area of the body. We reverse these propositions with the concept that it is gender, not biology, which is a social construct. From our theoretical perspective, the sexed body is material and biological, and gender is the externally imposed set of norms that prescribe and proscribe desirable [behaviors] for children. Our objection to transgenderism is that it confines children to traditional views about gender.

(32) Stephanie Davies-Arias, writer, communication skills expert, and pediatric transition critic, writes that "changing your sex to match your 'gender identity' reinforces the very stereotypes which [transgender organizations] claim to be challenging ... as, in increasing numbers, boys who love princess culture become 'girls' and short-haired football-loving girls become 'boys'. Promoted as a 'progressive' social justice movement based on 'accepting difference', transgender ideology in fact takes that difference and stamps it out. It says that the sexist stereotypes of 'gender' are the true distinction between boys and girls and biological sex is an illusion."

(33) Sex-change regret/De-transitioning: Increasing numbers of young men and women experience "sex-change regret" and are "detransitioning." Unfortunately, some effects of "medical transitions" are irreversible. A BBC documentary titled "Luke" includes a young biological woman who regrets taking cross-sex hormones and having a double mastectomy at age 20 and shares her experience.

Section 10. Purpose. The purpose of this Act is to protect gender-dysphoric, gender-discordant, and gender-non-conforming minors or minors who experience rapid onset gender dysphoria from medical procedures or the off-label use of chemicals that have not been studied for these purposes and that permanently alter anatomy, biochemistry, or physiology.

The State has a moral duty and legal right to step in and regulate medical practices that are found in violation of the principles that inhere in the Nuremberg Code, including the principle that experiments should be based on previous knowledge (e.g., an expectation derived from animal experiments) that justifies the experiment.

Section 15. Definitions. As used in this Act:

"Biological sex" means a person's objective, immutable biological sex, which may be understood according to the following: In biology, an organism is male or female if it is structured to perform one of the respective roles in

1 reproduction. This definition does not require any arbitrary
2 measurable or quantifiable physical characteristics or
3 behaviors; it requires understanding the reproductive system
4 and the reproduction process. Different animals have different
5 reproductive systems, but sexual reproduction occurs when the
6 sex cells from the male and female of the species come together
7 to form newly fertilized embryos. It is these reproductive
8 roles that provide the conceptual basis for the differentiation
9 of animals into the biological categories of male and female.
10 There is no other widely accepted biological classification for
11 the sexes.
12 "Desistance" means the tendency for gender dysphoria to
13 resolve itself as a child gets older and older.
14 "Detransition" means the process by which someone who has
15 been identifying as the opposite sex, presenting himself or
16 herself as the opposite sex, taking cross-sex hormones, and may
17 or may not have had surgery rejects his or her "trans" identity
18 and accepts his or her objective, immutable biological sex.
19 "Gender" means the psychological, behavioral, social, and
20 cultural aspects of being male or female.
21 "Gender dysphoria" means one's persistent discomfort with
22 his or her sex or sense of inappropriateness in the gender role
23 of that sex.
24 "Gender identity" means one's sense of oneself as male,
25 female, or transgender. "Gender identity" also means one's
26 innermost concept of self as male, female, a blend of both male

1 and female, or neither male nor female.

2 Section 20. Prohibition on treatment of persons under the
3 age of 18 for gender dysphoria or gender discordance.
4 (a) A medical doctor shall not prescribe, provide,
5 administer, or deliver puberty-suppressing drugs or cross-sex
6 hormones and shall not perform surgical orchiectomy or
7 castration, urethroplasty, vaginoplasty, mastectomy,
8 phalloplasty, or metoidioplasty on biologically healthy and
9 anatomically normal persons under the age of 18 for the purpose
10 of treating the subjective, internal psychological condition
11 of gender dysphoria or gender discordance.
12 (b) Any efforts to modify the anatomy, physiology, or
13 biochemistry of a biologically healthy person under the age of
14 18 who experiences gender dysphoria or gender discordance shall
15 be considered unprofessional conduct and shall be subject to
16 discipline by the licensing entity or disciplinary review board
17 with competent jurisdiction.
18 (c) No medical doctor or mental health provider shall refer
19 any person under the age of 18 to any medical doctor for
20 chemical or surgical interventions to treat gender dysphoria or
21 gender discordance.

22 Section 90. The Medical Practice Act of 1987 is amended by
23 changing Section 22 as follows:

1 (225 ILCS 60/22) (from Ch. 111, par. 4400-22)
2 (Section scheduled to be repealed on December 31, 2019)
3 Sec. 22. Disciplinary action.
4 (A) The Department may revoke, suspend, place on probation,
5 reprimand, refuse to issue or renew, or take any other
6 disciplinary or non-disciplinary action as the Department may
7 deem proper with regard to the license or permit of any person
8 issued under this Act, including imposing fines not to exceed
9 $10,000 for each violation, upon any of the following grounds:
10 (1) Performance of an elective abortion in any place,
11 locale, facility, or institution other than:
12 (a) a facility licensed pursuant to the Ambulatory
13 Surgical Treatment Center Act;
14 (b) an institution licensed under the Hospital
15 Licensing Act;
16 (c) an ambulatory surgical treatment center or
17 hospitalization or care facility maintained by the
18 State or any agency thereof, where such department or
19 agency has authority under law to establish and enforce
20 standards for the ambulatory surgical treatment
21 centers, hospitalization, or care facilities under its
22 management and control;
23 (d) ambulatory surgical treatment centers,
24 hospitalization or care facilities maintained by the
25 Federal Government; or
26 (e) ambulatory surgical treatment centers,

1 hospitalization or care facilities maintained by any
2 university or college established under the laws of
3 this State and supported principally by public funds
4 raised by taxation.
5 (2) Performance of an abortion procedure in a willful
6 and wanton manner on a woman who was not pregnant at the
7 time the abortion procedure was performed.
8 (3) A plea of guilty or nolo contendere, finding of
9 guilt, jury verdict, or entry of judgment or sentencing,
10 including, but not limited to, convictions, preceding
11 sentences of supervision, conditional discharge, or first
12 offender probation, under the laws of any jurisdiction of
13 the United States of any crime that is a felony.
14 (4) Gross negligence in practice under this Act.
15 (5) Engaging in dishonorable, unethical or
16 unprofessional conduct of a character likely to deceive,
17 defraud or harm the public.
18 (6) Obtaining any fee by fraud, deceit, or
19 misrepresentation.
20 (7) Habitual or excessive use or abuse of drugs defined
21 in law as controlled substances, of alcohol, or of any
22 other substances which results in the inability to practice
23 with reasonable judgment, skill or safety.
24 (8) Practicing under a false or, except as provided by
25 law, an assumed name.
26 (9) Fraud or misrepresentation in applying for, or

1 procuring, a license under this Act or in connection with
2 applying for renewal of a license under this Act.
3 (10) Making a false or misleading statement regarding
4 their skill or the efficacy or value of the medicine,
5 treatment, or remedy prescribed by them at their direction
6 in the treatment of any disease or other condition of the
7 body or mind.
8 (11) Allowing another person or organization to use
9 their license, procured under this Act, to practice.
10 (12) Adverse action taken by another state or
11 jurisdiction against a license or other authorization to
12 practice as a medical doctor, doctor of osteopathy, doctor
13 of osteopathic medicine or doctor of chiropractic, a
14 certified copy of the record of the action taken by the
15 other state or jurisdiction being prima facie evidence
16 thereof. This includes any adverse action taken by a State
17 or federal agency that prohibits a medical doctor, doctor
18 of osteopathy, doctor of osteopathic medicine, or doctor of
19 chiropractic from providing services to the agency's
20 participants.
21 (13) Violation of any provision of this Act or of the
22 Medical Practice Act prior to the repeal of that Act, or
23 violation of the rules, or a final administrative action of
24 the Secretary, after consideration of the recommendation
25 of the Disciplinary Board.
26 (14) Violation of the prohibition against fee

splitting in Section 22.2 of this Act.

(15) A finding by the Disciplinary Board that the registrant after having his or her license placed on probationary status or subjected to conditions or restrictions violated the terms of the probation or failed to comply with such terms or conditions.

(16) Abandonment of a patient.

(17) Prescribing, selling, administering, distributing, giving or self-administering any drug classified as a controlled substance (designated product) or narcotic for other than medically accepted therapeutic purposes.

(18) Promotion of the sale of drugs, devices, appliances or goods provided for a patient in such manner as to exploit the patient for financial gain of the physician.

(19) Offering, undertaking or agreeing to cure or treat disease by a secret method, procedure, treatment or medicine, or the treating, operating or prescribing for any human condition by a method, means or procedure which the licensee refuses to divulge upon demand of the Department.

(20) Immoral conduct in the commission of any act including, but not limited to, commission of an act of sexual misconduct related to the licensee's practice.

(21) Willfully making or filing false records or reports in his or her practice as a physician, including,

1 but not limited to, false records to support claims against
2 the medical assistance program of the Department of
3 Healthcare and Family Services (formerly Department of
4 Public Aid) under the Illinois Public Aid Code.

5 (22) Willful omission to file or record, or willfully
6 impeding the filing or recording, or inducing another
7 person to omit to file or record, medical reports as
8 required by law, or willfully failing to report an instance
9 of suspected abuse or neglect as required by law.

10 (23) Being named as a perpetrator in an indicated
11 report by the Department of Children and Family Services
12 under the Abused and Neglected Child Reporting Act, and
13 upon proof by clear and convincing evidence that the
14 licensee has caused a child to be an abused child or
15 neglected child as defined in the Abused and Neglected
16 Child Reporting Act.

17 (24) Solicitation of professional patronage by any
18 corporation, agents or persons, or profiting from those
19 representing themselves to be agents of the licensee.

20 (25) Gross and willful and continued overcharging for
21 professional services, including filing false statements
22 for collection of fees for which services are not rendered,
23 including, but not limited to, filing such false statements
24 for collection of monies for services not rendered from the
25 medical assistance program of the Department of Healthcare
26 and Family Services (formerly Department of Public Aid)

1 under the Illinois Public Aid Code.
2 (26) A pattern of practice or other behavior which
3 demonstrates incapacity or incompetence to practice under
4 this Act.
5 (27) Mental illness or disability which results in the
6 inability to practice under this Act with reasonable
7 judgment, skill or safety.
8 (28) Physical illness, including, but not limited to,
9 deterioration through the aging process, or loss of motor
10 skill which results in a physician's inability to practice
11 under this Act with reasonable judgment, skill or safety.
12 (29) Cheating on or attempt to subvert the licensing
13 examinations administered under this Act.
14 (30) Willfully or negligently violating the
15 confidentiality between physician and patient except as
16 required by law.
17 (31) The use of any false, fraudulent, or deceptive
18 statement in any document connected with practice under
19 this Act.
20 (32) Aiding and abetting an individual not licensed
21 under this Act in the practice of a profession licensed
22 under this Act.
23 (33) Violating state or federal laws or regulations
24 relating to controlled substances, legend drugs, or
25 ephedra as defined in the Ephedra Prohibition Act.
26 (34) Failure to report to the Department any adverse

final action taken against them by another licensing jurisdiction (any other state or any territory of the United States or any foreign state or country), by any peer review body, by any health care institution, by any professional society or association related to practice under this Act, by any governmental agency, by any law enforcement agency, or by any court for acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this Section.

(35) Failure to report to the Department surrender of a license or authorization to practice as a medical doctor, a doctor of osteopathy, a doctor of osteopathic medicine, or doctor of chiropractic in another state or jurisdiction, or surrender of membership on any medical staff or in any medical or professional association or society, while under disciplinary investigation by any of those authorities or bodies, for acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this Section.

(36) Failure to report to the Department any adverse judgment, settlement, or award arising from a liability claim related to acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this Section.

(37) Failure to provide copies of medical records as required by law.

1 (38) Failure to furnish the Department, its
2 investigators or representatives, relevant information,
3 legally requested by the Department after consultation
4 with the Chief Medical Coordinator or the Deputy Medical
5 Coordinator.
6 (39) Violating the Health Care Worker Self-Referral
7 Act.
8 (40) Willful failure to provide notice when notice is
9 required under the Parental Notice of Abortion Act of 1995.
10 (41) Failure to establish and maintain records of
11 patient care and treatment as required by this law.
12 (42) Entering into an excessive number of written
13 collaborative agreements with licensed advanced practice
14 registered nurses resulting in an inability to adequately
15 collaborate.
16 (43) Repeated failure to adequately collaborate with a
17 licensed advanced practice registered nurse.
18 (44) Violating the Compassionate Use of Medical
19 Cannabis Pilot Program Act.
20 (45) Entering into an excessive number of written
21 collaborative agreements with licensed prescribing
22 psychologists resulting in an inability to adequately
23 collaborate.
24 (46) Repeated failure to adequately collaborate with a
25 licensed prescribing psychologist.
26 (47) Willfully failing to report an instance of

1 suspected abuse, neglect, financial exploitation, or
2 self-neglect of an eligible adult as defined in and
3 required by the Adult Protective Services Act.

4 (48) Being named as an abuser in a verified report by
5 the Department on Aging under the Adult Protective Services
6 Act, and upon proof by clear and convincing evidence that
7 the licensee abused, neglected, or financially exploited
8 an eligible adult as defined in the Adult Protective
9 Services Act.

10 (49) Entering into an excessive number of written
11 collaborative agreements with licensed physician
12 assistants resulting in an inability to adequately
13 collaborate.

14 (50) Repeated failure to adequately collaborate with a
15 physician assistant.

16 <u>(51) Violating the Youth Health Protection Act.</u>

17 Except for actions involving the ground numbered (26), all
18 proceedings to suspend, revoke, place on probationary status,
19 or take any other disciplinary action as the Department may
20 deem proper, with regard to a license on any of the foregoing
21 grounds, must be commenced within 5 years next after receipt by
22 the Department of a complaint alleging the commission of or
23 notice of the conviction order for any of the acts described
24 herein. Except for the grounds numbered (8), (9), (26), and
25 (29), no action shall be commenced more than 10 years after the
26 date of the incident or act alleged to have violated this

1 Section. For actions involving the ground numbered (26), a
2 pattern of practice or other behavior includes all incidents
3 alleged to be part of the pattern of practice or other behavior
4 that occurred, or a report pursuant to Section 23 of this Act
5 received, within the 10-year period preceding the filing of the
6 complaint. In the event of the settlement of any claim or cause
7 of action in favor of the claimant or the reduction to final
8 judgment of any civil action in favor of the plaintiff, such
9 claim, cause of action or civil action being grounded on the
10 allegation that a person licensed under this Act was negligent
11 in providing care, the Department shall have an additional
12 period of 2 years from the date of notification to the
13 Department under Section 23 of this Act of such settlement or
14 final judgment in which to investigate and commence formal
15 disciplinary proceedings under Section 36 of this Act, except
16 as otherwise provided by law. The time during which the holder
17 of the license was outside the State of Illinois shall not be
18 included within any period of time limiting the commencement of
19 disciplinary action by the Department.

20 The entry of an order or judgment by any circuit court
21 establishing that any person holding a license under this Act
22 is a person in need of mental treatment operates as a
23 suspension of that license. That person may resume their
24 practice only upon the entry of a Departmental order based upon
25 a finding by the Disciplinary Board that they have been
26 determined to be recovered from mental illness by the court and

1 upon the Disciplinary Board's recommendation that they be
2 permitted to resume their practice.
3 The Department may refuse to issue or take disciplinary
4 action concerning the license of any person who fails to file a
5 return, or to pay the tax, penalty or interest shown in a filed
6 return, or to pay any final assessment of tax, penalty or
7 interest, as required by any tax Act administered by the
8 Illinois Department of Revenue, until such time as the
9 requirements of any such tax Act are satisfied as determined by
10 the Illinois Department of Revenue.
11 The Department, upon the recommendation of the
12 Disciplinary Board, shall adopt rules which set forth standards
13 to be used in determining:
14 (a) when a person will be deemed sufficiently
15 rehabilitated to warrant the public trust;
16 (b) what constitutes dishonorable, unethical or
17 unprofessional conduct of a character likely to deceive,
18 defraud, or harm the public;
19 (c) what constitutes immoral conduct in the commission
20 of any act, including, but not limited to, commission of an
21 act of sexual misconduct related to the licensee's
22 practice; and
23 (d) what constitutes gross negligence in the practice
24 of medicine.
25 However, no such rule shall be admissible into evidence in
26 any civil action except for review of a licensing or other

disciplinary action under this Act.

In enforcing this Section, the Disciplinary Board or the Licensing Board, upon a showing of a possible violation, may compel, in the case of the Disciplinary Board, any individual who is licensed to practice under this Act or holds a permit to practice under this Act, or, in the case of the Licensing Board, any individual who has applied for licensure or a permit pursuant to this Act, to submit to a mental or physical examination and evaluation, or both, which may include a substance abuse or sexual offender evaluation, as required by the Licensing Board or Disciplinary Board and at the expense of the Department. The Disciplinary Board or Licensing Board shall specifically designate the examining physician licensed to practice medicine in all of its branches or, if applicable, the multidisciplinary team involved in providing the mental or physical examination and evaluation, or both. The multidisciplinary team shall be led by a physician licensed to practice medicine in all of its branches and may consist of one or more or a combination of physicians licensed to practice medicine in all of its branches, licensed chiropractic physicians, licensed clinical psychologists, licensed clinical social workers, licensed clinical professional counselors, and other professional and administrative staff. Any examining physician or member of the multidisciplinary team may require any person ordered to submit to an examination and evaluation pursuant to this Section to submit to any additional

1 supplemental testing deemed necessary to complete any
2 examination or evaluation process, including, but not limited
3 to, blood testing, urinalysis, psychological testing, or
4 neuropsychological testing. The Disciplinary Board, the
5 Licensing Board, or the Department may order the examining
6 physician or any member of the multidisciplinary team to
7 provide to the Department, the Disciplinary Board, or the
8 Licensing Board any and all records, including business
9 records, that relate to the examination and evaluation,
10 including any supplemental testing performed. The Disciplinary
11 Board, the Licensing Board, or the Department may order the
12 examining physician or any member of the multidisciplinary team
13 to present testimony concerning this examination and
14 evaluation of the licensee, permit holder, or applicant,
15 including testimony concerning any supplemental testing or
16 documents relating to the examination and evaluation. No
17 information, report, record, or other documents in any way
18 related to the examination and evaluation shall be excluded by
19 reason of any common law or statutory privilege relating to
20 communication between the licensee, permit holder, or
21 applicant and the examining physician or any member of the
22 multidisciplinary team. No authorization is necessary from the
23 licensee, permit holder, or applicant ordered to undergo an
24 evaluation and examination for the examining physician or any
25 member of the multidisciplinary team to provide information,
26 reports, records, or other documents or to provide any

1 testimony regarding the examination and evaluation. The
2 individual to be examined may have, at his or her own expense,
3 another physician of his or her choice present during all
4 aspects of the examination. Failure of any individual to submit
5 to mental or physical examination and evaluation, or both, when
6 directed, shall result in an automatic suspension, without
7 hearing, until such time as the individual submits to the
8 examination. If the Disciplinary Board or Licensing Board finds
9 a physician unable to practice following an examination and
10 evaluation because of the reasons set forth in this Section,
11 the Disciplinary Board or Licensing Board shall require such
12 physician to submit to care, counseling, or treatment by
13 physicians, or other health care professionals, approved or
14 designated by the Disciplinary Board, as a condition for
15 issued, continued, reinstated, or renewed licensure to
16 practice. Any physician, whose license was granted pursuant to
17 Sections 9, 17, or 19 of this Act, or, continued, reinstated,
18 renewed, disciplined or supervised, subject to such terms,
19 conditions or restrictions who shall fail to comply with such
20 terms, conditions or restrictions, or to complete a required
21 program of care, counseling, or treatment, as determined by the
22 Chief Medical Coordinator or Deputy Medical Coordinators,
23 shall be referred to the Secretary for a determination as to
24 whether the licensee shall have their license suspended
25 immediately, pending a hearing by the Disciplinary Board. In
26 instances in which the Secretary immediately suspends a license

1 under this Section, a hearing upon such person's license must
2 be convened by the Disciplinary Board within 15 days after such
3 suspension and completed without appreciable delay. The
4 Disciplinary Board shall have the authority to review the
5 subject physician's record of treatment and counseling
6 regarding the impairment, to the extent permitted by applicable
7 federal statutes and regulations safeguarding the
8 confidentiality of medical records.

9 An individual licensed under this Act, affected under this
10 Section, shall be afforded an opportunity to demonstrate to the
11 Disciplinary Board that they can resume practice in compliance
12 with acceptable and prevailing standards under the provisions
13 of their license.

14 The Department may promulgate rules for the imposition of
15 fines in disciplinary cases, not to exceed $10,000 for each
16 violation of this Act. Fines may be imposed in conjunction with
17 other forms of disciplinary action, but shall not be the
18 exclusive disposition of any disciplinary action arising out of
19 conduct resulting in death or injury to a patient. Any funds
20 collected from such fines shall be deposited in the Illinois
21 State Medical Disciplinary Fund.

22 All fines imposed under this Section shall be paid within
23 60 days after the effective date of the order imposing the fine
24 or in accordance with the terms set forth in the order imposing
25 the fine.

26 (B) The Department shall revoke the license or permit

1 issued under this Act to practice medicine or a chiropractic
2 physician who has been convicted a second time of committing
3 any felony under the Illinois Controlled Substances Act or the
4 Methamphetamine Control and Community Protection Act, or who
5 has been convicted a second time of committing a Class 1 felony
6 under Sections 8A-3 and 8A-6 of the Illinois Public Aid Code. A
7 person whose license or permit is revoked under this subsection
8 B shall be prohibited from practicing medicine or treating
9 human ailments without the use of drugs and without operative
10 surgery.
11 (C) The Department shall not revoke, suspend, place on
12 probation, reprimand, refuse to issue or renew, or take any
13 other disciplinary or non-disciplinary action against the
14 license or permit issued under this Act to practice medicine to
15 a physician:
16 (1) based solely upon the recommendation of the
17 physician to an eligible patient regarding, or
18 prescription for, or treatment with, an investigational
19 drug, biological product, or device; or
20 (2) for experimental treatment for Lyme disease or
21 other tick-borne diseases, including, but not limited to,
22 the prescription of or treatment with long-term
23 antibiotics.
24 (D) The Disciplinary Board shall recommend to the
25 Department civil penalties and any other appropriate
26 discipline in disciplinary cases when the Board finds that a

1 physician willfully performed an abortion with actual
2 knowledge that the person upon whom the abortion has been
3 performed is a minor or an incompetent person without notice as
4 required under the Parental Notice of Abortion Act of 1995.
5 Upon the Board's recommendation, the Department shall impose,
6 for the first violation, a civil penalty of $1,000 and for a
7 second or subsequent violation, a civil penalty of $5,000.
8 (Source: P.A. 99-270, eff. 1-1-16; 99-933, eff. 1-27-17;
9 100-429, eff. 8-25-17; 100-513, eff. 1-1-18; 100-605, eff.
10 1-1-19; 100-863, eff. 8-14-18; 100-1137, eff. 1-1-19; revised
11 12-19-18.)