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Protecting the profession: lessons from the recent physician scandals

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Abstract: Sexual abuse scandals in recent years have eroded some of the trust that is foundational for the physician–patient relationship. A closer analysis of some of these stories of abuse from the standpoint of medical professionalism, primarily utilizing the example of Larry Nassar, DO, yields potential ways in which instances of abuse may be reduced or eliminated. The goal of this paper is to elicit lessons that can be learned from these tragic sequences of events so that physicians, healthcare institutions, physician practices, medical boards, and even patients themselves can introduce measures that help prevent future stories like these.

It may seem like the #MeToo movement is a thing of the past; and, in many respects, it's true that the hashtag and news stories about the sexual misconduct of high-profile figures rarely reach the national media these days. However, in an essay titled “The Big #MeToo Moment for Doctors is Finally Here” in the *New York Times* recently, Helen Ouyang, MD, MPH, argues that the movement is still alive in the healthcare world. She notes, “Now the edifice may finally be cracking: the #MeToo movement is picking up pace in the medical profession. Though it's been slow going and long delayed, survivors may see justice dealt, and other offenses could be prevented” [1]. Tom Beauchamp [2], who played a large role in founding contemporary bioethics, recently noted that case studies are important for the progress of bioethics, and that scandals play a leading role. What follows is an in-depth review of some recent scandals from the perspective of bioethics, in the hope that it will facilitate lessons that can be learned and help prevent such scandals

in the future – protecting both patients and the medical profession itself.

The story of the fall of Larry Nassar, DO, serves as an archetype for the instances of abuse, enablement, and lack of oversight in healthcare that are all too visible in the media today. A close look at his victims' stories and the stories of those who surrounded him can be helpful in reexamining how the legal and moral standards of professionalism, which are there to protect patients from abuse, can instead protect abusers when they are not followed or enforced. The goal of this paper is to elicit lessons that can be learned from this tragic sequence of events, so that physicians, healthcare institutions, physician practices, and even patients themselves can help prevent future stories like these.

On January 24, 2018, Dr. Larry Nassar, was sentenced to 40–175 years in prison for multiple sex crimes, in addition to the 60 years that he had already been sentenced for child pornography. He had been a successful athletic trainer and sports medicine physician, eventually becoming the National Medical Coordinator for USA Gymnastics (USAG), attending the Olympics in Atlanta, Sydney, and Beijing with the gymnastics teams. He also worked for Michigan State University (MSU), where he received his Doctor of Osteopathic Medicine (DO) degree, as an Assistant and then an Associate Professor.

The storm surrounding Larry Nassar began when an investigative report was published by IndyStar on August 4, 2016 that accused USAG of failing to report or follow-up on claims of sexual abuse of its athletes [3]. Former USAG athlete Rachel Denhollander sent an email to IndyStar claiming she was abused “by Larry Nassar, the team doctor for USAG.” Following interviews with Denhollander, another gymnast, and Nassar himself, and the filing of a civil lawsuit against Nassar by another one of the gymnasts, IndyStar published another story on September 12, 2016 [4]. In that story, IndyStar stated that USAG had learned of “athlete concerns” in the summer of 2015, and “relieved Dr. Nassar of his duties.” Nassar continued to serve as a team physician for Twistars Gymnastics Club in Michigan and to work at Michigan State's College of Osteopathic Medicine until the university received the criminal complaint on August 30, 2016.

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The scale of his abuse is truly staggering: according to an article in *MSU Today* on May 16, 2018, there were “332 survivors ...” [5]. The duration is also shocking. The allegations of abuse predate the Ingham County Circuit Court lawsuit that eventually led to Nassar’s conviction and sentencing by *at least* 2 decades. A female in a federal lawsuit claimed that Nassar assaulted her in 1992 [6]. According to the 2016 lawsuit, one gymnast claims Nassar began abusing her in 1994. Additionally, a parent at the Twistars Gymnastics Club told the gym’s owner, former Olympic gymnastics team coach John Geddert, about abuse by Nassar in 1997, “alleging sexual abuse, assault, and molestation, according to a federal lawsuit” [7]. Geddert took no action at the time, and he continued to employ and support Nassar even beyond his indictment in the civil case in the fall of 2016. USAG had started an investigation into abuse by Nassar in the summer of 2015, which only resulted in him being quietly relieved of his duties with no punitive actions being taken. In the wake of Nassar’s trial, multiple individuals associated with MSU, USAG, and other organizations have since resigned [8].

The question on most minds is: how could this have happened? In the case of Nassar, he took advantage of many factors that put physicians in a position in which they can exploit the vulnerabilities and trust of patients. His abuse was hidden under the pretext of physical examinations and osteopathic manual manipulation (OMM), telling patients, family members, coaches, and other physicians that his actions were a normal part of medical care. Nassar’s patients had multiple vulnerabilities that compounded their susceptibility to abuse. They were not only patients, but also minors, students, and athletes. Nassar knew these vulnerabilities well, and he excelled at maintaining patient trust and compliance despite the brazenness of his abuse.

Nassar’s abuse and subsequent prosecution is not a unique story, but it is one among many that can be associated with the recent #MeToo movement. Since the lawsuit and media coverage of the Nassar scandal, over 200 women at the University of Southern California (USC) have accused a former student health clinic gynecologist, George Tyndall, MD, of abuse during examination or treatment [9]. Tyndall was found by an investigation to have violated USC’s sexual harassment policy, and he was given the option to resign with a severance package or be terminated, and Tyndall resigned. USC did not report him to the Medical Board of California, but later admitted, “In hindsight, while not legally obligated, USC now believes it should have filed a consumer complaint with the Medical Board earlier in 2017 when Tyndall resigned” [10]. Tyndall resigned on June 30, 2017, and then he renewed his medical license in January of 2018. Tyndall was eventually arrested on felony charges on June 25, 2019, and he was found dead in his home on October 5,

2023, prior to facing a criminal trial [11]. Meanwhile, USC has agreed to pay more than \$1.1 billion in settlements with former patients [12].

Robert Hadden, MD, a former OB/GYN physician at Columbia University and NewYork-Presbyterian Hospital, was convicted in January of 2023 on four counts of enticing and inducing victims to travel interstate to engage in unlawful sexual activity. An article in ProPublica published on September 12, 2023 argued at length, with lots of evidence introduced at various civil and legal trials, that Columbia University knew about his sexual abuse (226 victims to date have settled with Columbia University for \$236 million dollars) and either did nothing about it or actively hindered efforts to prosecute him [13].

It is important to note that this kind of abuse is not just limited to females, minors, or athletes. Over 100 male student-athletes at The Ohio State University have accused Richard H. Strauss, MD, a former (now deceased) team physician and professor, of sexual abuse during routine physicals and injury examinations [14, 15].

Nor is this kind of abuse just limited to physicians associated with academic medical centers, as noted in a recent examination of 101 cases of sexual violations by DuBois et al [16]. In that study, 94.1 % of the cases were nonacademic (physicians in private practice), and the other frequent case characteristics were: male (100 %); age greater than 39 (92.1 %); the patients were always examined alone with the physician (85.1 %); and involved cases of repeated abuse of multiple victims (96 %). They caution, however, drawing necessary conditions from these common conditions. “In the vast majority of physician encounters that involve these traits, no sexual assault occurs. Thus, these are best understood as risk factors for sexual assault, particularly when combined, rather than sufficient conditions” [16]. Before we examine some lessons that can be gleaned from these examples, we want to briefly review the underlying moral prohibitions against sexual misconduct.

Professional standards

Standards of conduct

The sexual abuse perpetrated by Nassar, and of which Tyndall, Haddon, and Strauss are also convicted/accused, is prohibited on many levels. Legally, state laws proscribe sexual assault and battery. Institutions like MSU and USC, like every federally funded education program or activity, have policies that specify inappropriate actions that violate Title IX of the Federal Education Amendments Act of 1972 (e.g., the sexual harassment policy that Tyndall allegedly

violated at USC). These inappropriate actions also violate common principles of medical ethics and standards of conduct annunciated by most professional organizations and associations for physicians. These principles and standards of professionalism and ethics are the moral framework for this article.

Professional standards and the basic principles of ethics in healthcare derive from the fiduciary nature of the relationship between a physician and patient. The patient (the beneficiary) places his/her trust in a physician out of a position of vulnerability and need, expecting the physician (the fiduciary) to act in his/her best interests [17]. A physician agrees to maintain the fiduciary role because they are a member of the profession, and the profession as a whole decided in its infancy that its interactions with patients to be this kind of relationship rather than a business or contractual one [17]. The Charter of Medical Professionalism frames this relationship in terms of a contract with society, stating, “*Professionalism is the basis of medicine’s contract with society*. This demands placing the interests of patients above those of the physician, setting and maintaining standards of competence and integrity, and providing expert advice to society on matters of health” [18].

If the physician assents to this cooperative, fiduciary relationship, certain responsibilities follow. In a typical relationship, the patient is an autonomous individual with established legal and moral rights to make decisions for themselves. The physician must respect the autonomy of the patient and not only allow, but also enable, them to make decisions. Because the patient puts their trust in the physician, the physician is responsible for being worthy of that trust, meaning faithfully acting in the best interests of the patient instead of one’s own interests. Tom Beauchamp and James Childress [19], the ethicists who originally identified the four common foundational principles of medical ethics, categorize this idea in the ethical principles of *beneficence* and *nonmaleficence*. The principle of beneficence states that a physician should actively promote the interests of a patient (or improve their well-being), and nonmaleficence states that a physician should not harm, or when possible, prevent harm to a patient.

Applied to the actions of Larry Nassar in the context of the physician–patient relationship that he had with the gymnasts and athletes he treated, we can see that he had a responsibility to avoid harming them, and to act beneficently toward them. Although the legitimate treatments he performed on them may have been beneficial to their health, the illegitimate touching of a sexual nature he did to them was not for their benefit, but his. These prurient actions were not only nonbeneficial for these athletes, but also were harmful in a variety of ways.

Rachel V. Rose, JD, a Texas lawyer, bioethics teacher, and victim of sexual assault, says this about sexual misconduct by physicians: “It has very traumatic effects. You’re in with a professional or person you are supposed to trust. Whether you are a child or adult, anytime that trust is violated, it’s absolutely going to cause, in most people, long-lasting effects” [20]. Rhonda Freeman, PhD, in an article for *Psychology Today*, concurs: “Betrayal, violation of trust, and remembrance of the inappropriate acts can leave abuse survivors with trauma-related symptoms. Conditions such as posttraumatic stress disorder (PTSD), anxiety, depression, complex PTSD, eating disorders, substance abuse, alcohol dependence, or a disordered personality (i.e., borderline personality) are not uncommon after abuse” [21]. The emotional testimonies of Rachel Denhollander and the other females that came forward to speak against Nassar are powerful testimonies to the deleterious effects of his abuse, and abuse in general.

Informed consent

Another of the fundamental principles identified by Beauchamp and Childress [19] is the principle of *autonomy*, or respect for the autonomy of other people. One implication of this principle is “acknowledging the moral right of every individual to choose and follow his or her own plan of life and actions” [22]. In the context of medical ethics, this refers to the right of individuals to make decisions about their own healthcare, or to provide consent to examinations and treatments. The requirement that physicians must obtain informed consent from patients prior to medical interventions is well established in the United States.

Based on the testimonies of his victims, Nassar did not provide enough information to his patients for them to be able to distinguish between legitimate treatment procedures and the illegitimate sexual touching to which he subjected them. In his case, we can surmise that the lack of information was intentional, a necessary step in the deception played upon his victims. This deception also played a part in protecting him from the scrutiny of other physicians and colleagues, because we can see in hindsight from the reports on the results of the Title IX investigation from 2014: “In the spring of 2014, Nassar was briefly suspended while the school’s Title IX department investigated a complaint by a student who alleged he’d sexually abused her, but was reinstated after a panel of medical experts, all of whom had close ties to the sports doctor, said there was nothing sexual about Nassar’s treatments. He continued to see – and, according to police reports, continued to abuse – patients at MSU despite remaining under criminal investigation for the same allegation that sparked the Title IX probe” [23].

The process of informed consent is not just the patient's opportunity to evaluate risks among treatment options, but it is also a part of the physician–patient encounter that protects and facilitates a patient's right to self-determination. The 1982 Report of the President's Commission in part recognizes informed consent as a protection for patients: "Self-determination as a shield is valued for the freedom from outside control it is intended to provide. It manifests the wish to be an instrument of one's own and 'not of other men's acts of will'" [24].

A proper and thorough process of informed consent between a physician and patient provides the patient with an opportunity: (1) to fully understand the nature of the treatment options; and (2) to accept a treatment option based on rational reasons or reject any treatment options that they are not comfortable with (or is subjectively judged to be antagonistic to their best interests).

One positive aspect of this trend is the move toward patient-centered understanding and values in the consent process. The practical effect of the patient-centered shift is that it provides the patient with justification to request more information, in some situations beyond what a reasonable physician might think to disclose, in order to make an intelligent decision with which they are fully satisfied. When informed consent becomes routine in the physician–patient relationship, and the decision is the result of a shared decision-making process, it empowers the patient and helps to prevent coercion and abuse. Relating back to the Nassar and Tyndall cases, if a robust informed consent process and standard practice of shared decision-making were present when those athletes were considering treatments that might involve touching of sensitive areas, they (or their parents) might have felt more empowered to refuse those treatments, or request alternatives.

Patient advocacy

The ability to prevent coercion and abuse does lie to some extent with the patient themselves, or the patient's proxy. Patients and surrogates should ask their physician to explain the need for a treatment or the details of how a treatment is implemented if they do not understand. The principle of respect for autonomy, universal in professional codes of ethics and in the medical ethics literature, grounds a patient's justification for accepting or refusing treatment according to the patient's own choice.

Regardless of how well-established it is, the patient's ability to choose remains potential until actuated by the patient themselves. This is in no way to blame victims for their abuse. Forces such as vulnerabilities and the imbalance in the physician–patient relationship are reasons why patients may never

realize their autonomous potential. Much of the onus, however, is on physicians to enable patients to make their own choices, and to minimize the power imbalance in the relationship. One step that physicians can take to help patients actuate their autonomy is to involve them continuously in the physician–patient relationship and informed consent process. Stephanie Tillman, a certified nurse midwife, gives an excellent example in her guest editorial: "In midwifery school, I was trained to discuss transferring power prior to starting any external or invasive gynecologic care (e.g., "This exam is in your control, you can stop me at any time for any reason, please let me know if there's any pain and I'll change what I'm doing"), what will happen before an examination even starts (e.g., "I'll use a swab to collect a sample and then insert the speculum"), utilize language throughout the examination to continue to ensure understanding and give opportunities for questions or reclamation of consent (e.g., "You'll feel my hand on your leg and then on the outside"), check in throughout the procedure (e.g., "Tell me if you're feeling any pain"), and then afterward (e.g., "Tell me if there's anything I can do next time to make that exam more comfortable") [25].

The point to be learned is that patients can help protect themselves from abuse by educating themselves and demanding that physicians educate them on the treatments and therapies involved in their care. Patients should enter the therapeutic relationship expecting a partnership with the physician in which both of them are fully engaged in making decisions. Physicians, because of the fiduciary nature of the relationship and inherent power imbalance, have more responsibility for establishing this cooperative partnership with patients. If the relationship exists for the benefit of the patient, this shared decision-making model appears to be the ideal: "Patients who collaborate with their physicians to reach a shared healthcare decision have greater trust in the doctor–patient relationship, cooperate more fully to implement the shared decision, and express greater satisfaction with their healthcare" [26].

Conclusions

A review of the news reports related to the recent physician misconduct cases can provide us with a good deal of information about how these particular physicians sexually assaulted multiple patients over long periods of time. It can also give us information about the medical context and environment that enabled them to get away with it for such a long time, and insight into how these physicians exploited the healthcare system to abuse their patients. A review of the literature on medical professionalism and clinical ethics provides us with a structural framework of the

physician–patient relationship from which we can analyze the behavior of these physicians, and by extension, the behavior of other physicians. Together, we can utilize these analyses to generate some recommendations that may help prevent similar cases in the future.

First, an improved informed consent process between a provider and patient can empower patients to distinguish between legitimate and illegitimate evaluations and treatments. At a minimum, a patient should be confident enough to ask a physician to stop an examination or treatment that becomes uncomfortable or threatening. Patients should participate in shared decision-making with physicians and demand enough information from physicians to fully understand the techniques of the examination and treatment to which they will be subjected. The ethical and legal guidelines for optimal informed consent exist and are known by most physicians; however, in practice, they are often subverted or neglected due to time or other constraints. Any instance in which the informed consent process is less than robust is one that is more prone to misunderstanding and coercion.

Second, patients can be less susceptible to unwanted interventions and examinations if they are more involved in the decisions about their care. As we have just discussed, a better-informed consent process improves the physician–patient relationship and can enlighten patients regarding the nature and purpose of their care. When decisions are shared by the patient and provider, patients are in a better position to decline unwanted examinations and treatments. Patients who educate themselves on the proposed examinations and treatments, either by self-learning or by asking for more information from the physician, are better able to recognize when a physician crosses a particular boundary. Physicians have a responsibility to reduce the power imbalance inherent in the relationship by empowering patients to be involved in the decisions, or to make decisions for themselves.

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