Introduction

This article reports on the recommendations developed by a multidisciplinary working group that was convened to address the problem of egregious ethical violations in medicine. By egregious violations, we mean clear violations of codes of medical ethics and law that directly harm patients. The working group meeting followed four years of research on cases of violations led by a team at Washington University School of Medicine (WUSM) with funding from the National Institute of Aging (NIA). Detailed methods and findings from the background studies are reported elsewhere.1-3

Background

Codes of medical ethics and professionalism commit physicians to acting in accord with core values of medicine, including care for patients, altruism, competence, compassion, and respect for patient autonomy.4,5 Such values support the relationships needed to meet the goals of medicine — healing, prevention of disease, and palliation of pain and suffering.6 While it is challenging to live up to these ethical ideals in all patient encounters,7 egregious ethical violations appear to be relatively rare. Such violations are naturally hidden events. When they become apparent, disciplinary actions provide some of the most trustworthy prevalence data: approximately five in 1,000 physicians are disciplined by a state medical board per year, and only 1.1 in 1,000 receive severe disciplinary action involving license revocation, suspension or surrender.8-10

While rare, the rate of severe disciplinary actions against physicians is nevertheless similar to the rate of new diagnoses of breast cancer each year (1.3 in 1,000) and much more common than new diagnoses of HIV (0.14 in 1,000)—both of which are widely recognized as urgent challenges for medicine and public health.21 Moreover, most egregious
violations are never reported to state medical boards,\textsuperscript{2,3,12,13} and when they are reported, some boards infrequently take action against a physician’s license.\textsuperscript{9,14} Thus, such violations — while uncommon — are undoubtedly far more prevalent than current databases such as the National Practitioners Database (NPDB) indicate.

As noted, the working group was particularly concerned with a subset of the causes of disciplinary action by boards: egregious violations of medical ethics such as sexual abuse of patients, criminal or negligent prescribing of opioids, or performing unnecessary surgeries for profit.\textsuperscript{15} The WUSM team focused on these three behaviors because they not only contradict the core values of medicine, but also directly harm patients. Additionally, prior research by the team indicated that these forms of wrongdoing were sufficiently frequent to accrue at least 75 cases in each area of wrongdoing, which was necessary for purposes of statistical modeling.\textsuperscript{16}

The recent case of Larry Nassar, a physician who practiced sports medicine, illustrates many of the dynamics commonly found by the WUSM research team in such cases. Across more than 20 years, Nassar sexually molested more than 265 girls (as young as six years of age) and young adult women.\textsuperscript{17-19} In a lawsuit filed in April 2017, a woman claimed that Nassar had sexually assaulted her while he was still in medical school in 1992.\textsuperscript{17} Additionally, he was convicted of receiving and possessing child pornography\textsuperscript{20} and charged with practicing without a license in Texas\textsuperscript{21} and obstruction-of-justice for destroying and concealing evidence.\textsuperscript{20} While Nassar completed a residency and fellowship, we found no evidence that he was board certified.\textsuperscript{18} It has been reported that he was almost dismissed from medical school after two semesters because he failed biochemistry twice.\textsuperscript{22} In at least eight instances, his victims reported his behavior to someone in leadership, who failed to report the behavior to the state medical board.\textsuperscript{18} When law enforcement was first notified, Nassar managed to distort his actions and present them as within the standard of care. No witnesses were involved to dispute his claims.\textsuperscript{18} In repeated instances, Nassar sexually assaulted his victims when their parents were in the room, demonstrating not only his boldness but also the trust that patients and others have that a physician will only perform medically-appropriate actions according to the standard of care.\textsuperscript{20}

The recent extended investigative report “Doctors and Sex Abuse” by the Atlanta Journal-Constitution illustrates the damage that such violations pose to the reputation of medicine, particularly when ongoing abuse is permitted to continue through oversight failures.\textsuperscript{13,23-25} Within the current social climate in the United States, characterized by a growing awareness and intolerance of sexual harassment, it is particularly appropriate for the field of medicine to take actions to identify, appropriately respond to, and prevent such egregious violations of medical ethics. However, we believe it is most appropriate to view the problem of sexual abuse of patients as one species within a larger genus: egregious ethical violations that directly harm patients. Prescribing opioids for profit to those with known substance user disorders\textsuperscript{26-28} or performing unnecessary invasive procedures for profit, such as spinal fusion surgeries or cardiac catheterizations,\textsuperscript{29,31} cause patients psychological, physical, and financial harm, and in some cases death.\textsuperscript{32}

Many features of the Nassar case are common across different kinds of egregious ethical violations: The violations were committed by a male, repeated, and selfishly motivated; oversight was lax or absent; and individuals who learned about the violations failed to take decisive action.\textsuperscript{1,3,33} Accordingly, many of the actions that need to be taken to identify cases sooner and respond decisively are the same across different kinds of violations.

To address this matter, the authors convened as a working group on October 2 and 3, 2017.
The working group consisted of four PhD-level investigators from the research team with backgrounds in social science research and bioethics, and nine external experts. Experts included a patient advocate, a health lawyer, legal counsel for a state medical board, and physicians from the Association of American Medical Colleges (AAMC), Accreditation Council for Graduate Medical Education, American Medical Association Council on Ethical and Judicial Affairs, the Federation of State Medical Board’s (FSMB) Journal of Medical Regulation, the Academy for Professionalism in Health Care, and the Physician Assessment and Clinical Education Program. All members agreed that they did not speak on behalf of any institutions or programs. However, members were selected in light of their expertise, which often derived from relevant experience in such settings.

Prior to convening the working group meeting, WUSM research team members conducted a systematic review of the literature on legal and disciplinary actions in medicine. Structured search terms were developed with research librarians from the Washington University Schools of Law and Medicine. Searches were conducted using Lexis-Nexis and PubMed from 2007 onwards. The team examined 2,386 records from Lexis-Nexis and 5,176 records from PubMed. Relevant papers were summarized for working group members in three categories: empirical studies, recommendations from legal scholars, and general background information.

The working group meeting opened with four sessions: a general overview of disciplinary actions, and three sessions on specific forms of violations — namely, sexual abuse of patients, negligent or criminal prescribing of opioids, and the performance of unnecessary (fraudulent) invasive procedures. Two subgroups were formed: one focused on education and remediation, and one focused on policy and oversight. Each session adopted a similar format:

- Presentation of data from the literature review and the WUSM study team’s project
- Subgroup evaluation of recommendations offered in the published literature and generation of new recommendations
- Plenary discussion of all recommendations

Recommendations were then revised based on plenary group discussions and post-meeting review of a draft document.

The group set the goals of offering recommendations that would prevent the majority of instances of egregious ethical violations and, when such violations did occur, help oversight programs to identify them sooner and take the steps necessary to ensure they are not repeated. The consensus of the group was that each of the recommendations offered is worth pursuing. By “pursuing” we mean there is reason to believe a recommendation will be effective in fostering the goals of the project, while recognizing that any recommendation will require closer examination and adaptation by policymakers and stakeholders to ensure that they are feasible and balance obligations. To use an analogy from architecture, we offer a schematic design rather than a blueprint with technical specifications.

**Recommendations**

We recommend pursuing the following actions to prevent and appropriately respond to egregious ethical violations in medicine.

1. **Recruit Trainees, Physicians and Staff Who Embrace the Positive, Core Values of Medicine**

Medical schools and medical centers must seek trainees at all levels (medical students, residents, fellows), attending physicians, and staff who demonstrate a commitment to core values in medicine such as caring for persons, altruism, competence, compassion, and respect for patient autonomy. It is controversial and of questionable efficacy to prospectively screen medical students, residents, fellows and staff using personality testing aimed at identifying deficits. Focusing on commitment to positive values may be more fruitful in advancing the mission of medicine. A growing body of literature has defined the positive values and traits associated with medical professionalism, While assessment lags behind, there is a consensus that assessing professionalism requires a multi-model approach, which might include the use of standardized patients.
validated tests using realistic vignettes, multi-source or 360° surveys, or direct observation of behaviors.

2. Educate Leaders to Create a Culture of Professional Integrity
Many of the problems observed in medicine are reflected within the broader cultures in which physicians work. Changing national and institutional cultures in ways that demonstrate respect for all persons will support professional behavior. Leaders need to be particularly sensitive to their role in enforcing policies and supporting interventions to end serious wrongdoing by physicians. Far too often, cases of egregious ethical violations are ignored, covered up or even enabled by leaders. To combat problems of cynicism and inaction, medical students, residents, nurses and others who are often in the best position to observe and report wrongdoing must be empowered to do so. Further, as they may feel particularly vulnerable to retaliation, they must be protected. A culture of professional integrity can protect patients and whistleblowers more than current laws. To accomplish this goal, leaders must investigate credible complaints in a timely manner that balances concerns for privacy with the need for transparency. Leaders must not tolerate behavior that threatens patient safety or creates a hostile workplace. Leaders in medicine must be selected for their character, experience, and abilities, and be provided with formal training to ensure that they have the skills needed to lead effectively with integrity. We recommend that leadership programs for physicians incorporate sessions focused on rationales and strategies for responding effectively to allegations of egregious wrongdoing. These sessions might be led by individuals with expertise in organizational psychology and human resources.

3. Provide Feedback to Physicians
Studies indicate that physicians often make positive changes to behavior when provided with objective data comparing them to peers or with 360° (multisource) feedback from diverse colleagues. The following three examples illustrate ways of providing feedback from diverse stakeholders. First, institutions can conduct physician evaluations using multisource feedback from a large number of individuals, including patients, caregivers, family members, supervisors, physician peers, allied health co-workers, and trainees. Such feedback can support positive behavior change while protecting evaluator identities. Second, prescription drug monitoring programs (PDMPs) can be used not only to track patterns of “drug-seeking patients” but also to provide feedback to physicians on their prescribing patterns vis-à-vis peers within their specialty. Third, medical consultants can be encouraged to provide feedback to referring physicians and vice versa. This would increase the perception of peer oversight, which may also be protective against egregious ethical violations.

4. Increase Oversight by Physician Peers and Colleagues
Oversight may include feedback, but implies a more systematic approach to observation, including establishing a sense of being observed. Some data indicate that peer oversight and group practices may be protective against serious practice violations. We offer three examples of the kind of oversight that could be provided more consistently by building on existing systems. First, medical societies can require peer review of cases involving invasive or risky procedures. We recommend that all persons who conduct risky invasive procedures participate in registries sponsored by medical societies. Second, many settings, such as solo medical practices, make ongoing peer-review by highly qualified physicians difficult. However, by utilizing electronic medical records it is possible to provide peer review at a distance. Peer reviewers might be incentivized by offering CME credits for participating in auditing processes. Third, chaperones should be provided by default when an intimate examination is medically indicated. Chaperones should be absent only at a patient’s request. These requirements must be enforced. In some cases, following harmful deviations from standards of care, we recommend that physicians lose the right to practice in the absence of peers.
5. Track Wrongdoing and Consequences
Tracking wrongdoing is essential to protecting patients by providing data to inform decisions of disciplinary committees, patients who seek information on their physicians, and researchers who seek to understand professional violations. Tracking consequences enables transparent evaluation by state medical boards and other disciplinary bodies. Several steps can be taken to improve the quality of tracking. We recommend that the NPDB guidelines require that state medical boards and reporting institutions provide descriptions of the facts of a case, thus enabling trained NPDB staff to code appropriately. Appropriate coding will avoid the use of uninformative categories such as “other” and “not applicable”—the most common codes used at present, when codes are assigned. To permit identification of links between specific forms of wrongdoing and the disciplinary actions taken, we recommend connecting NPDB data to state medical board data. We recommend the creation of a national tracking system to track serious disciplinary actions against individuals through medical school, graduate medical education, and medical practice to facilitate rapid response to wrongdoing. Such a database—because it might track more minor violations and even accusations—might be highly confidential and accessible only to those who are investigating or adjudicating cases. Negligent reporting, credentialing, privileging and failure to report physicians under disciplinary scrutiny by institutions should be recognized as causes of action when patients are unnecessarily harmed by a physician with a history of professional violations. Institutions should be protected from legal liability when sharing information in good faith with other institutions regarding a physician’s past performance. We encourage establishing a system whereby private insurers could share with the Centers for Medicare and Medicaid Services information about physician billing patterns to enable earlier detection of fraudulent or illegal behaviors by expanding the pool of available data. Either a national PDMP should be established or states must be able to query neighboring states’ PDMPs without increasing the administrative burden (e.g., by using a single log-in portal).

6. Foster the Establishment of More Uniform and Transparent Actions by State Medical Boards
Currently, tremendous variation exists in how state medical boards respond to instances of serious wrongdoing. In some states, physicians commonly return to practice following severe disciplinary action for egregious professional violations. We encourage the FSMB to provide leadership by sharing best practices across state medical boards and publishing examples of sensible and effective model statutes. We recommend that boards publish their disciplinary actions on publicly available websites. While some boards do this already, many do not, or the data they publish are vague and incomplete.

7. Across All Career Stages, Permanently Remove Individuals from Medicine Following Egregious Violations or a Persistent Failure to Serve the Goals of Medicine
Individuals who demonstrate disregard for the well-being of others, a lack of remorse for harming others, and illegal behaviors do not act in accordance with the core values of medicine and pose a significant threat to patients. From the first day of medical school through medical practice, patterns of behavior that run contrary to the goals of medicine should be monitored and treated in the same manner as gross incompetence. The response should be both rapid and fair for the protection of patients and physicians. Medical boards should have and exercise the authority to permanently revoke or suspend medical licenses for first-time egregious offenses that run counter to the core values of medicine (e.g., rape or risky...
unnecessary invasive procedures done for profit) or for repeated lesser offenses following remediation efforts. Medical schools and institutions sponsoring residencies and fellowships should exercise their authority to dismiss medical students, residents, and fellows on the same grounds.

8. Partner with Law Enforcement in Appropriate Ways

Given different standards of evidence and procedures, administrative review of cases (e.g., of sexual abuse) by state medical boards may provide less stressful approaches to investigation and adjudication for patients who have been victimized, compared to criminal investigations. Boards typically also have the authority to remove a physician from medical practice more swiftly than criminal systems. Nevertheless, the protection offered to the public by administrative review and action may fall short of that provided by criminal prosecution. Boards should routinely ask patient victims (e.g., victims of sexual abuse) whether they want to work with law enforcement to pursue criminal charges.

Patients’ wishes not to pursue such charges should be respected. Boards should be mindful of their obligation to work with law enforcement in cases involving mandatory reporting. We encourage law enforcement to provide boards with highly trained liaisons to support investigations involving all relevant criminal activities, including unnecessary invasive procedures and sexual abuse, in ways similar to the support provided for investigating inappropriate opioid prescriptions and false claims.

9. Provide Patients with Educational Materials to Inform Expectations and Choices

Patients must not shoulder the burden of ensuring competent and professional service from physicians. However, it is appropriate to empower patients by providing information to inform reasonable expectations. For example, it would be appropriate to provide patients with written information on the use of chaperones for intimate examinations and how a well woman exam or a sports physical is appropriately conducted. Patients should be provided with information, such as American Board of Internal Medicine’s Choosing Wisely brochures, that describe when invasive procedures are indicated, as well as the right to request a second opinion, particularly if patients have any reservations about the medical necessity of procedures. Vulnerable patients should have access to patient advocates and consent monitors when considering invasive or risky procedures.

10. Conduct Basic Research to Understand the Factors that Lead to Egregious Ethical Violations

Very little data exist that help to explain how and why egregious ethical violations occur in medical practice. Effective prevention and remediation efforts will require access to detailed data on cases and novel analytic approaches to identify causal factors. We recommend that state medical boards and the NPDB partner with researchers to identify data points to collect when investigating and reporting cases and eliminate the use of vague descriptions of the reasons for disciplinary action such as “not applicable” and “other.”

Some studies have found rates of board certification among wrongdoers to be significantly lower than those of the general U.S. physician population. However, no data identify the specific factors associated with board certification that might be protective of integrity in medicine. Accordingly, at this time, we recommended further research to understand the specific elements of post-graduate training that may enhance competence and professionalism in medicine.

While the vast majority of male physicians are never sanctioned by a state medical board, the overwhelming majority of physicians who commit egregious ethical violations are male. The impact of increased gender diversity on overall professionalism in medicine is worthy of study, including gender diversity in positions of leadership within medical centers and healthcare institutions.

It is important to conduct research aimed at identifying barriers and facilitators to implementing reforms, and to track and evaluate progress in implementing reforms.

It is appropriate for agencies and institutions that support research on health care — including the National Institutes of Health and the Agency for Healthcare Research and Quality — and institutions that are directly responsible for oversight of medical practice — including the FSMB, the Joint Commission, and all health care systems — to support research on these topics.

While these 10 recommendations focus on the field of medicine, we acknowledge that protecting patients requires that all health care professionals abide by high standards. We encourage medical societies and health care institutions to work with state medical boards and allied health-credentialing boards to consider the steps necessary to prevent
and appropriately respond to egregious ethical violations by all health care professionals.

Conclusions

The responsibility for reducing egregious ethical violations belongs to the field of medicine and health care leadership. Patients, medical students, and nurses may observe egregious ethical violations. However, patients may not want to relive trauma when they have been victimized, and medical students, nurses and junior colleagues may fear retaliation and career harm if they act as whistleblowers. This is particularly true in institutional cultures that are tolerant of wrongdoing or unprofessional behavior. None of the recommendations we offer depend upon increased action from vulnerable groups, though some of them support such action, for example, when patients who were victimized wish to cooperate with law enforcement.

While the vast majority of physicians are committed to the well-being of their patients and behave with professional integrity, a small minority repeatedly commit egregious ethical violations. We embrace the goals of making such violations significantly less frequent and, when they do occur, identifying them sooner and taking the steps necessary to ensure they are not repeated. The 10 recommendations offered by our working group provide a schematic design to meet these goals. Implementation of these recommendations will require the commitment of specific groups following debate and refinement of the recommendations. Above we recommended specific actions for the FSMB, namely, that it “provide leadership by sharing best practices across state medical boards,” publish “examples of sensible and effective model statutes” (e.g., rules for mandatory reporting, whistle-blower protection, mandatory revocation, and public reporting), and support collaborative research aimed at understanding predictors of egregious violations and barriers and facilitators to implementing reforms.

While full implementation of appropriate measures will take time and study, we believe it is urgent to take visible actions to acknowledge and address the problem at hand.

Financial Support and Conflicting Interests: This research was supported by grants from the National Institute of Aging (1R01AG043527) and National Center for Advancing Translational Sciences (UL1TR000448). The authors have no relevant financial conflicts of interest to disclose.

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