Report of Investigation into the Circumstances That Allowed Robert Hadden to Abuse Patients

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SIDLEY

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EXECUTIVE SUMMARY

Throughout his approximately 25-year tenure as an obstetrician and gynecologist at Columbia University and NewYork-Presbyterian Hospital ("NYP," together with Columbia, the "Institutions"), Robert Hadden sexually assaulted patients who came to him for care. He did so while cloaked in the trust and respectability attendant to his profession and the prestige conferred by a thriving practice associated with two preeminent Institutions.

Hadden's conduct as a sexual predator has been publicly and conclusively established, and he is serving 20 years in federal prison. But questions have remained regarding how he was able to commit his crimes for decades at Columbia and NYP. This public report (the "Report") examines the factors that contributed to allowing that abuse to occur and to continue for such a prolonged period of time.

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Hadden's abuse of patients at Columbia and NYP ended more than 13 years ago. It was a patient who precipitated that end. On a Friday afternoon in 2012, a month after having given birth, the patient saw Hadden for a postpartum visit at Columbia's East 60th Street medical office. Under the guise of an examination, Hadden sexually assaulted her. She left Hadden's office as quickly as she could and promptly called the police.

Two officers of the New York City Police Department responded to the patient's call. Upon hearing her report of what Hadden had done, the officers went directly to Hadden's office and placed him under arrest. Hadden was released later that night without having been charged with a crime, subject to a continuing investigation by the Manhattan District Attorney's Office.

The medical and administrative leadership of both Columbia and NYP—after incorrectly concluding that this was the first time a patient had accused Hadden of sexual misconduct—

allowed Hadden to return to work the following Tuesday. The sole condition imposed was that Hadden adhere to the Institutions' policies, particularly the chaperone policy—a policy that Hadden's own account had already made clear he violated when examining the patient who called the police. Hadden resumed seeing patients on the Tuesday following his Friday arrest. Multiple patients who saw Hadden after he returned to work have reported that he sexually abused them during that time.

After five weeks, Hadden—who had continuously avoided requests by Columbia to interview him about the events leading to his arrest—took a month of vacation and sick days, citing the stress of the post-arrest scrutiny. While he was on leave, Columbia informed him that due to his refusal to be interviewed, he could not return to seeing patients. He did not return, but he remained on paid and unpaid medical leave from Columbia for nearly two years.

Meaningful punishment for Hadden's crimes did not occur for nine more years. Spurred by publicity surrounding a lawsuit filed by the patient who called the police, other survivors came forward to describe the abuse that Hadden had inflicted on them. Their accounts initially resulted in a prosecution by the Manhattan District Attorney's Office. That case ended when Hadden pleaded guilty in 2016 to charges of forcible touching and committing a criminal sexual act, resulting in the surrender of his medical license but no prison time. However, in 2020, the United States Attorney's Office for the Southern District of New York charged Hadden with federal offenses related to his abuse of patients. Hadden was tried and convicted in January 2023 and, six months later, was sentenced to serve 20 years in federal prison. He remains there today.

Following Hadden's federal conviction and sentence—amid demands from survivors, elected officials, medical students, and others for accountability by the Institutions where Hadden worked—Columbia announced in November 2023 that it would undertake a multi-pronged effort

to "address past abuses of Robert Hadden and support survivors." As one aspect of that plan, Columbia and NYP commissioned a team at Sidley Austin LLP (the "Investigation Team") to conduct this investigation (the "Investigation"), and in particular to "thoroughly examine the circumstances that allowed Hadden's abuse to continue, establish a process for survivors and others with knowledge of Hadden's abuse to share their stories, and issue public findings."

This Report sets forth our factual findings and conclusions from that Investigation.

I. The Investigation's Scope and Methodology

By the time the Investigation Team was engaged, the fact of Hadden's decades as a sexual predator was well established, and the Investigation did not focus on Hadden's guilt. Instead, our work focused on examining the circumstances at Columbia and NYP that allowed Hadden's abuse of patients to continue for as long as it did, and, based on what we learned, formulating recommendations to help guard against anything like that abuse happening again. Consistent with that scope, our mandate did not extend to events that occurred after Hadden stopped seeing patients in 2012. And while some reporting of survivors' accounts of Hadden's sexual abuse is intertwined with our work, we have limited our descriptions of the harm that Hadden inflicted to what is necessary to accurately portray Hadden's abuse and to inform the Investigation's focus on factors that allowed the abuse to occur and to persist.

We spoke with more than 120 witnesses. Approximately half of these witnesses were survivors, whose willingness to relive these events through their accounts was critical to our work. The same is true of the many survivors with whom we did not speak directly, but who have provided accounts to courts and journalists; this Report relies on them as well.

Beyond survivors, we interviewed more than 60 current or former employees of Columbia and NYP, including physicians, nurses, medical assistants, administrative staff, administrative supervisors, and physician and non-physician leaders at each Institution. All current employees of

the Institutions spoke with us when requested, as did many former employees. Some former employees and other witnesses declined to speak with us, did not respond to our requests, or could not be located. Hadden declined to speak with us.

We also reviewed more than 120,000 documents. We reviewed documents from both Columbia and NYP, including personnel files, contemporaneous notes and communications, policies and procedures, patient records, governance documents, and electronic communications drawn from the accounts of approximately 50 individuals, among other records. In addition, we reviewed documents from external sources, including information disclosed during Hadden's state and federal prosecutions and the civil actions filed against Hadden and the Institutions.

Finally, we consulted with experts to inform our work. In order to conduct our Investigation in a trauma-informed and survivor-centered manner, we consulted with the Rape Abuse & Incest National Network about trauma-informed investigation techniques, the approach to our interviews, and our eventual recommendations. We also consulted with Dr. Louise Perkins King, MD, JD, an Assistant Professor of Obstetrics, Gynecology and Reproductive Biology at Harvard Medical School, a practicing OB/GYN physician, and the former Chair of the Ethics Committee for the American College of Obstetricians and Gynecologists.

II. Hadden's Abuse

Certain aspects of Hadden's abuse were factors in allowing it to occur and persist for as long as it did. Among other things, Hadden engaged in grooming behaviors and abused patients in vulnerable circumstances, making it more difficult for patients to report him. He also misled patients with excuses and diagnoses that purportedly justified his conduct, and he manipulated the Institutions' chaperone system—which otherwise might have helped to detect or deter his crimes—by scheduling and engaging in examinations when no chaperone was present.

Notwithstanding Hadden's efforts, some patients did report his abuse. Indeed, our Investigation revealed that Hadden's arrest was not the first time that patients or staff had complained about his inappropriate sexual conduct with patients. In Chapter 4, we discuss numerous reports that patients and staff describe having made about Hadden's abusive or, at minimum, deeply questionable behavior over the years. We focus in particular on five complaints about Hadden's conduct that were escalated to physician leadership and how they were resolved. The last of these—the one that led to Hadden's arrest, but did not prevent his prompt return to work—is afforded particular attention in Chapters 5 and 6.

III. Factors that Permitted Hadden's Abuse of Patients to Occur and Continue

We formed three core conclusions from our Investigation about the factors that permitted Hadden's abuse to occur and to persist for so long.

First, the Institutions did not effectively make use of chaperoning—namely, assigning a staff member to observe sensitive examinations or procedures and report on misconduct—which has come to be recognized as a key safeguard to deter or discourage sexual misconduct by physicians. During the early years of Hadden's career, staff might be present during examinations and procedures to assist a doctor, but chaperones were not required. In 2007, a policy was instituted mandating the presence of chaperones for certain examinations; but the chaperone program was understaffed, and the policy was not enforced in any systematic way. Further, chaperones were not trained about what, specifically, they should be alert to, or about where or how to effectively report potential signs of abuse. Moreover, they worked in a hierarchical professional environment in which they worried about being believed—or even retaliated against—if they raised questions about a doctor. These weaknesses in chaperone staffing, training, policies, and enforcement undermined the effectiveness of chaperoning as a means to prevent and detect conduct like Hadden's.

Second, there were a variety of obstacles to patient—and even staff—reporting of physician misconduct at both Institutions; and at Columbia, there was no complaint-reporting policy to facilitate patient reporting of complaints about physicians' conduct. Some of the impediments to reporting arose from Hadden's own conduct, including his crafting of a positive image that facilitated his abuse, and his abuse of particularly vulnerable patients who might be less likely to report him. But other phenomena at the Institutions also discouraged reporting, like a hierarchical professional culture that left staff wary of raising issues about doctors, and the prestige of the Institutions that affected the willingness of patients to come forward. In the face of these obstacles, Columbia had no policies to govern the receipt, recording, and resolution of patient complaints about physician misconduct at its outpatient facilities.[1] Thus, for abuse that occurred in a Columbia-run office—as much of Hadden's abuse did—patients had no obvious place to make a report. Many patients who did make reports told whichever Columbia employee they could find, including receptionists, medical assistants, or other doctors. Those individuals were not trained in how to handle complaints of misconduct, particularly ones against a prominent member of their Institution. These obstacles hindered Columbia's ability to receive and address patients' complaints and reduced the opportunity for the Institution to identify and act on information about Hadden's abuse.

Third, and finally, the Institutions failed to respond effectively to the reports of misconduct that they did receive. Despite the obstacles to reporting, several reports about Hadden's abuse did reach physician leaders over the years. Decisionmakers resolved the complaints *ad hoc* in an

[1] Throughout this Report, discussions of "complaints" or "reports" about a physician refer to those that are about physician misconduct, not those that are about wait times, billing issues, or other administrative matters. We note that some NYP policies draw a distinction between "grievances" and "complaints." For ease of comprehension, we refer to a report of physician misconduct as a "complaint."

environment in which deference to physicians like Hadden was the cultural norm. The decision to permit Hadden to return to work after his arrest exemplifies this problem. In addition, neither Institution had effective policies or procedures to maintain records of complaints about physician misconduct in a per-physician manner that would allow patterns of misconduct by a physician to emerge. Almost none of the prior reports of Hadden's misconduct, even when documented, were placed in his Columbia personnel or NYP credentialing files. So, when Hadden was arrested after 25 years of abuse, individuals at Columbia and NYP deciding how to respond to that arrest incorrectly believed based on a review of Hadden's files that Hadden had a clean record.

IV. Institutional Changes and Commitments

In keeping with our mandate not just to examine the circumstances that allowed Hadden's abuse of patients to occur and continue, but also to make recommendations to ensure Columbia and NYP have policies and procedures in place to guard against anything similar reoccurring, this Report also describes the changes that the Institutions have made since Hadden stopped seeing patients, as well as commitments the Institutions are making in connection with the issuance of this Report.

Even before this Investigation, the Institutions had made a number of changes that address factors we have since identified as permitting Hadden's sexual predation to occur and continue. For example, both Institutions now have implemented materially identical policies that guide employees on the "prompt reporting, escalation, and investigation requirements related to sexual misconduct allegations" involving patients. Those policies create reporting channels for sexual misconduct complaints, govern the Institutions' initial response to and escalation of such reports, and dictate how they will be investigated, assessed, recorded, and maintained. The Institutions have also each implemented more rigorous chaperone policies.

Nevertheless, with the benefit of what we have learned from the Investigation, we believe there remain opportunities for improvements in empowering and supporting patients; strengthening the chaperone role; strengthening the culture of reporting and addressing factors that chill reporting; ensuring effective information sharing, investigation, and recordkeeping regarding sexual misconduct allegations; and ensuring oversight and continual improvement, all with the goal of preventing sexual misconduct. With that in mind, we have made recommendations to the Institutions; and, as set forth in the Report, the Institutions have committed to concrete steps in furtherance of all of the aims above.

V. Structure of the Report

The structure of the Report itself is as follows:

Part One of the Report consists of two chapters that provide background. **Chapter 1** describes the origin of the Investigation and our methodology in conducting it. **Chapter 2** provides background on the Institutions, on Hadden, and on the nature of OB/GYN care generally.

Part Two of the Report consists of four chapters that present factual findings about the circumstances surrounding Hadden's abuse. **Chapter 3** describes Hadden's abuse and identifies methods that Hadden employed to carry it out. **Chapter 4** catalogues contemporaneous reports and red flags about Hadden's conduct, including those that were escalated to physician leadership. **Chapter 5** describes the circumstances of Hadden's arrest in 2012. **Chapter 6** details the decision to permit Hadden to return to work after his arrest, and the circumstances of his eventual termination.

Part Three of the Report consists of three chapters that reflect our analysis and conclusions about the factors that contributed to allowing Hadden's abuse of patients to occur and continue. **Chapter 7** focuses on factors that undermined the efficacy of chaperoning as a mechanism to prevent and detect Hadden's wrongdoing. **Chapter 8** focuses on factors that discouraged reporting

of Hadden's abuse by patients and staff. **Chapter 9** focuses on factors that contributed to the Institutions' failure to act to protect patients in the face of reports that were made about Hadden's misconduct.

Part Four of the Report consists of **Chapter 10**, which itemizes improvements the Institutions have made since 2012 that address factors that permitted Hadden's abuse, as well as further improvements the Institutions have committed to make in connection with the issuance of this Report.

PART I
BACKGROUND

This Report examines the circumstances and behavior that allowed Hadden's exploitation of patients to persist for so many years. In this Part of the Report, we set out background relevant to our findings and conclusions.

In **Chapter 1**, we describe the origins and scope of the Investigation and the process that we employed to perform our work.

In **Chapter 2**, we describe the interrelationship between Columbia University and NewYork-Presbyterian Hospital, which, though not uncommon at academic medical centers, involves overlapping roles and responsibilities that are material to our analysis. In particular, Hadden and other physicians within Columbia's medical school were concurrently employed by Columbia and credentialed by NYP, and they regularly saw patients both at facilities operated by Columbia and at facilities operated by NYP. We also discuss the nature of the practice of obstetrics and gynecology.

CHAPTER 1
THE INVESTIGATION

I. Origins and Scope

After decades of sexually abusing patients, Robert Hadden is now serving a 20-year sentence in federal prison. That sentence was imposed in July 2023 after a jury in federal court in Manhattan found him guilty of multiple offenses based on his sexual abuse of patients. This federal conviction followed nearly a decade of complaints and civil lawsuits brought by survivors, as well as a previous sexual assault case brought by the Manhattan District Attorney's Office, which Hadden resolved in 2016 by pleading guilty to a subset of the crimes charged. As part of his guilty plea in that case, Hadden specifically admitted under oath to "oral sexual conduct against a patient for no valid medical purpose" and to forcible touching of a patient for the purpose of gratifying his own sexual desires.[2]

While Hadden's conduct as a sexual predator has been well and publicly established, questions have remained regarding how Hadden was able to commit these acts repeatedly, over 25 years, in the very spaces where patients came to be treated and cared for. In the aftermath of Hadden's July 2023 federal conviction, criticism of Columbia University and NewYork-Presbyterian Hospital for their conduct in connection with Hadden's abuse mounted. Additional survivors of Hadden's abuse filed lawsuits against Columbia, NYP, Hadden, and others. In October 2023, elected officials and survivors of sexual abuse led a demonstration at Columbia calling for accountability. Medical students protested that month during the inauguration of

[2] As a result of his guilty plea in the case brought by the Manhattan District Attorney's Office, Hadden was added to a sex offender registry and surrendered his medical license, but received no sentence of imprisonment.

Columbia's new President, Minouche Shafik, calling on Columbia to identify all patients who saw Hadden and notify them of his conviction and to commission an independent investigation.

The demand to notify former patients of Hadden's conviction was of particular significance because late 2023 was the closing of an important legal window for adult survivors of sexual abuse in New York. New York's Adult Survivors Act, signed into law on May 24, 2022, had created a "one-year lookback window" during which survivors of sexual abuse could "sue their abusers regardless of when the abuse occurred," i.e., regardless of otherwise applicable statutes of limitations.[3] But to take advantage of this revival of potential claims, survivors were required to file suit by November 23, 2023.

On November 13, 2023, Columbia announced a plan "to address past abuses of Robert Hadden and support survivors."[4] The announced plan involved several components, including:

- the creation of a $100 million survivors' settlement fund;
- notification to nearly 6,500 individuals who had seen Hadden for medical care of the crimes for which Hadden had been convicted and sentenced and of their rights under the Adult Survivors Act;
- the launch of a center for patient safety; and
- the initiation of engagement with outside experts to review quality and patient safety programs, policies, and procedures.

As part of the plan, Columbia, along with NYP, also commissioned a team at Sidley Austin LLP to conduct this Investigation, the scope of which would be to "thoroughly examine the

[3] Press Release, *Governor Hochul Signs Adult Survivors Act*, N.Y. STATE GOVERNOR (May 24, 2022), https://www.governor.ny.gov/news/governor-hochul-signs-adult-survivors-act.

[4] *Columbia University and CUIMC Announce Multi-Pronged Plan To Address Past Abuses of Robert Hadden and Support Survivors*, COLUMBIA UNIVERSITY IRVING MEDICAL CENTER (Nov. 13, 2023), https://www.cuimc.columbia.edu/rebuilding-trust/news-updates/columbia-university-and-cuimc-announce-multi-pronged-plan-address-past-abuses-robert-hadden-and-support-survivors.

circumstances that allowed Hadden's abuse to continue, establish a process for survivors and others with knowledge of Hadden's abuse to share their stories, and issue public findings."[5]

In mid-November 2023, Columbia sent the promised letter to almost 6,500 patients who had seen Hadden for medical care, notifying them of Hadden's convictions and of the various components of the planned response. The letter also explained how to contact the Investigation Team by phone or email, should any patient choose to do so. Columbia simultaneously made the same information available on a public website.[6]

To facilitate the Investigation, Columbia and NYP each formed a special committee of its own Board of Trustees. Each Institution's Special Committee comprises independent and disinterested members of that Institution's Board who did not serve as trustees at the time Hadden was seeing patients.

Consistent with the original announcement of the Investigation, the Investigation Team's mandate was to examine thoroughly the circumstances that allowed Hadden's abuse of patients to continue for as long as it did, to make recommendations to ensure Columbia and NYP have the policies and procedures in place to guard against this kind of misconduct ever happening again, and to issue this public Report of findings and conclusions. The mandate did not extend to events that occurred after Hadden stopped seeing patients, such as the Institutions' involvement in any civil litigations or criminal prosecutions. And while it necessarily included consideration of Hadden's sexual abuse of patients, that conduct was well established prior to the initiation of the

[5] We would like to thank the entire team of lawyers and staff at Sidley for their hard work and dedication in conducting the Investigation and preparing this Report. Sidley partners Matthew Podolsky, Holly Gregory, and Melissa Colón-Bosolet, and associates Tyler Domino, Rachel McKenzie, and former associate Mallika Balachandran, among others, made important contributions to that work.

[6] *Rebuilding Trust*, COLUMBIA UNIVERSITY IRVING MEDICAL CENTER (updated Feb. 27, 2026), https://www.cuimc.columbia.edu/rebuilding-trust.

Investigation, so we have limited our discussion of that abuse to what is necessary to portray it accurately and to inform the Investigation's focus—namely, identifying the factors that allowed that abuse to occur and to go on for as long as it did.

II. Methods and Approach

The scope of the Investigation was broad, requiring a thorough examination of events, institutional policies and practices, and conduct that spanned more than 25 years. That review entailed careful analysis of relevant documents and interviews of individuals with knowledge of events across that period. During the Investigation, we reviewed more than 120,000 documents drawn from a collection of millions, spoke with more than 120 witnesses, and consulted with two expert sources. The subsections below detail relevant aspects of how we conducted the Investigation.

A. Survivor Interviews and Accounts

At the center of the Investigation are the people who were harmed by Hadden's abuse. The Investigation Team's intention has been to ensure that these survivors[7] were empowered to participate in the Investigation in whatever form and to whatever extent they chose. From the outset, the Investigation Team strove to conduct the Investigation in a trauma-informed and survivor-centered manner. To that end, the Investigation Team consulted with the Rape Abuse & Incest National Network ("RAINN") about trauma-informed investigation techniques, the approach to our interviews, and our eventual recommendations.[8] Everyone on the Investigation

[7] In this Report we refer to the patients who saw Hadden for medical care both as "patients" and as "survivors." We understand and respect that some people who have experienced harm prefer one term over the other. We have used both terms, as we understand those preferences are not uniform.

[8] An overview of RAINN and its work is attached as Appendix A.

Team who interviewed survivors participated in a training led by RAINN to reinforce the Investigation Team's understanding of survivor-centered considerations.

Out of respect for their privacy and in keeping with our efforts to conduct a trauma-informed investigation, the Investigation Team did not initiate communications directly with survivors, but we did establish mechanisms for survivors who wished to contact us. The Investigation Team established a dedicated email address and toll-free telephone hotline for individuals who wished to speak with us. Columbia shared that number and email address with almost 6,500 former patients who saw Hadden for medical care in the November 2023 letter informing them of the Investigation. That information was made available on a public website about the Investigation and remained available throughout the course of this Investigation. The Investigation Team also spoke with counsel for certain survivors, and we contacted prosecutors who conducted the criminal trial against Hadden in order to inquire into whether there were witnesses (and their counsel) from that trial who would like to meet with us. When the Investigation Team spoke with survivors, we did so in whatever format each survivor identified as most comfortable.

Through these mechanisms, the Investigation Team spoke with dozens of survivors. In total, more than 100 individuals contacted us, primarily through the toll-free telephone hotline or email address. Some individuals who contacted the Investigation Team did so only to pose questions or requests, but more than 60 survivors chose to share their experiences as patients. The vast majority of patients we spoke with asked that we not use their names in this Report, and we have not named any patients here. The Investigation Team also reviewed the accounts of hundreds of survivors who publicly described their experiences in court proceedings, court filings, or the media.

While we have not included all of the details that these survivors shared, we appreciate and learned from each account. Many survivors described how difficult it was to relive the experiences they shared, but they did so to have their voices heard, to shed light on Hadden's abuse, and to help bring about meaningful change. The Investigation Team is grateful to all of the survivors who have shared their experiences, including those who spoke with us, and the Investigation Team respects the decision of those survivors who decided not to do so.

B. Institutional Sources

Both Columbia and NYP provided the Investigation Team with broad access to relevant documents and witnesses, as set forth below. Within the scope of our Investigation, we had the freedom to pursue all avenues of inquiry, and we were not denied any information or interviews that we requested from either Institution.[9]

1. Institutional Documents

The Investigation Team requested and reviewed documents from both Columbia and NYP. In order to identify factors that permitted Hadden's conduct to occur and continue, we requested documents related to events across Hadden's 25-year career at both Institutions. These records were stored in different systems, many of which, as discussed in this Report, have changed over time or were not organized in a systematic and easily searchable manner. In searching for records of patient complaints, for example, the Institutions searched across a variety of possible repositories of information, including archived records.

The Institutions' search for records was time-consuming and sometimes iterative, as additional potential data sources were identified, but ultimately the Institutions were able to

[9] We have not included privileged material in this Report, and nothing in this Report is intended to waive any applicable privilege, including but not limited to the attorney-client privilege and work-product protection.

respond to our requests and we were able to review a large volume of documents. In total, we reviewed more than 120,000 documents drawn from a collection of millions, including personnel and credentialing files maintained by the Institutions, contemporaneous notes and communications (including emails), policies and procedures, patient records, and governance documents, among other things.

As for emails specifically, the Investigation Team reviewed communications drawn from the email data of approximately 50 individuals. The monthly volume of Columbia emails for the relevant period of Hadden's tenure—which ended more than a decade ago—varied in ways that suggest that some emails from that period no longer exist. The Investigation Team interviewed Columbia's Chief Information Security Officer in order to determine whether additional data could be recovered or a forensic investigation could be undertaken, but the necessary data and hardware no longer exist. Columbia migrated its email systems to a new cloud environment between 2018 and 2020, and the previous email servers were decommissioned. No log files exist from the prior platform, and individual users' computers have been replaced several times since then. As a result, the servers, system files, and end-user computers that existed between 2011 and 2014 no longer exist, and the data that we understand would be needed by a forensic analyst no longer exists.

While it may be that not every email from that period still exists, by searching the email boxes of dozens of custodians, many of whom were in dialogue with each other about events during the relevant periods, we were able to review a substantial email record.

2. Institutional Witnesses

Aided by what we learned from the documents, the Investigation Team interviewed more than 60 current or former employees of Columbia and NYP, some of them more than once. Those employees hold or held a wide variety of positions, including as physicians, nurses, medical assistants, administrative staff, administrative supervisors, and physician and non-physician

leaders of each Institution. Among others, the Investigation Team spoke with Dr. John Evanko, former Chief of the Columbia Division of General Obstetrics and Gynecology ("General OB/GYN Division"); Dr. Rogerio Lobo, former Chair of the Department of Obstetrics and Gynecology at Columbia ("OB/GYN Department") and Chief of Service for Obstetrics and Gynecology at NYP; Dr. Mary D'Alton, current Chair of the OB/GYN Department and Chief of Service for Obstetrics and Gynecology at NYP; Dr. Lee Goldman, former Dean of Columbia's Vagelos College of Physicians and Surgeons (Columbia's medical school); Lee Bollinger, former President of Columbia University; Dr. Richard Liebowitz, former Chief Medical Officer of NYP; Dr. Robert Kelly, former President of NYP; and Dr. Steven Corwin, former Chief Executive Officer of NYP.

All current employees of Columbia and NYP who were asked to participate in an interview did so. Many former employees also spoke with the Investigation Team, but some declined to speak with us. Some witnesses did not respond to our requests or could not be located. Hadden himself declined (through his attorney) to speak with us.

C. Other Documents

The Investigation Team also reviewed many documents from external sources. Those documents included information publicly disclosed during Hadden's state and federal prosecutions and the civil actions filed against him and the Institutions.

D. Expert Assistance

In addition to RAINN, whose role is described above, the Investigation Team consulted with Dr. Louise Perkins King, MD, JD.[10] Dr. King is an Assistant Professor of Obstetrics, Gynecology and Reproductive Biology at Harvard Medical School; the Associate Director of Ethics at Brigham and Women's Hospital; and the Director of Research and the Associate

[10] Dr. King's curriculum vitae is attached as Appendix B.

Fellowship Program Director in the Minimally Invasive Gynecologic Surgery Division at Brigham and Women's Hospital. Dr. King has served as the Chair of the Committee on Ethics for the American College of Obstetricians and Gynecologists, was a member of the AMA Journal of Ethics, and is a member of the Harvard Medical School Center for Bioethics. Dr. King provided the Investigation Team with expertise grounded in her experience as a medical ethicist and as a practicing obstetrician and gynecologist. She also provided insight from her personal experience as a survivor of sexual assault.

E. Challenges

This Investigation had certain limitations and faced certain challenges. Notably, Hadden's tenure at the Institutions spanned 25 years, and it ended over a decade ago. The span of time at issue, and the passage of time since, affected the information available to the Investigation Team and the ease with which that information could be gathered. In several instances, electronic systems where relevant information had once been stored had changed, sometimes more than once, increasing the difficulty of gathering those records and sometimes making it impossible.

The passage of time also affected the availability of witnesses and their recollections of the events at issue. There has been significant turnover in personnel at both Columbia and NYP; and while many former employees were willing to speak with us, that was not uniformly the case. Other important witnesses were unavailable because of health issues or because they had passed away by the time of our work.

While these challenges necessarily impacted our work, we are confident that we were able to gather and assess evidence sufficient to make the findings and conclusions set forth in this Report.

CHAPTER 2
FACTUAL BACKGROUND

I. Columbia University and NewYork-Presbyterian Hospital

For his entire career, from 1987 until 2012, Robert Hadden was a practicing obstetrician and gynecologist at one of New York City's major medical centers, now known as Columbia University Irving Medical Center ("CUIMC").[11] Like many academic medical centers, which combine the training of doctors with patient care, CUIMC in practice operates through a partnership between two separate entities: Columbia University and NYP.[12]

Columbia, a private research university located in upper Manhattan, runs the medical school associated with CUIMC. Columbia also operates clinics and doctors' offices where the faculty of its medical school sees patients. NYP is an academic healthcare system that operates its own hospitals, clinics, and doctors' offices in New York City, including on the CUIMC campus. NYP's facilities at CUIMC, including the hospital named NewYork-Presbyterian/CUIMC, are staffed by physicians who are Columbia faculty with "clinical privileges," permitting them to see their patients at NYP locations, as well as by residents—junior physicians who have recently graduated from medical school without a faculty appointment—who are hired directly by NYP.

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[11] CUIMC refers separately to both (a) a physical medical campus in northern Manhattan and (b) a clinical, research, and educational enterprise that houses four of Columbia's professional colleges and schools: the Vagelos College of Physicians and Surgeons, which is the medical school; the College of Dental Medicine; the School of Nursing; and the Mailman School of Public Health. To avoid confusion, we use the term "CUIMC" to refer to the physical medical campus, and we use terms like "Columbia" and "the medical school" to refer to Columbia University.

[12] NYP was created in 1998 by the merger of The Presbyterian Hospital, which was staffed by physicians affiliated with Columbia University and its medical school, and The New York Hospital, which was staffed by physicians affiliated with Cornell University and its medical school. Although NYP continues to operate facilities staffed by Cornell faculty, this Report concerns only NYP's operations staffed by Columbia faculty. Moreover, although certain events discussed in this Report occurred prior to the merger, for ease of comprehension, this Report refers generally to NYP and its predecessor entities as "NYP."

At the times relevant to this Report, therefore, Columbia-employed physicians like Hadden could see patients at both Columbia-run facilities and at NYP-run facilities. Columbia was responsible for employing physician faculty and for operating its outpatient facilities, while NYP was responsible for the daily running of NYP hospital locations, including how faculty members employed by Columbia functioned within those hospital locations. In light of this structure, Columbia and NYP had separate policy systems, which changed over time. Columbia and NYP had overlapping responsibility, however, for the physicians who practiced at both Institutions, and certain physicians simultaneously held leadership roles at both Institutions.

As for Hadden himself, after graduating from New York Medical College, Hadden was hired in 1987 by The Presbyterian Hospital (a predecessor to NYP) as a resident in the Obstetrics and Gynecology ("OB/GYN") Department. He became chief resident of the OB/GYN Department in 1990 and completed his residency in 1991. Hadden then was hired to be an Assistant Clinical Professor of Obstetrics and Gynecology in the Columbia OB/GYN Department. Hadden began seeing patients at Columbia offices and was granted admitting privileges at NYP, allowing him to admit and see patients there. Hadden maintained his clinical practice at Columbia and NYP from 1991 until he took leave in 2012 as a result of the events described in this Report.

II. Obstetric and Gynecologic Care

OB/GYN physicians practice in the fields of obstetrics and gynecology and have specialized training in women's health care. Gynecology involves care of the female reproductive system. Obstetrics involves treating and caring for patients during pregnancy, childbirth, and the postpartum period.

A. Gynecology

Patients visit their gynecologist as needed, and depending on the patient's needs, these visits can involve sensitive examinations of the breasts and the pelvic region. A patient may

undress completely except for a gown. A patient undergoing a pelvic examination is in a vulnerable position, typically lying on an examination table, with the patient's hips at the edge of the table and the patient's feet in stirrups. In addition to physical examinations, gynecology visits may involve intimate questions about sexual history, concerns like pain or discomfort during sex, and other issues involving the patient's reproductive system that many people find uncomfortable to discuss. Gynecologic examinations require the patient's informed consent, and patients have the right to decline any examination and to decline to answer any question.[13]

B. Obstetrics

Obstetric care often involves regular appointments with an OB/GYN physician from confirmation of pregnancy until a baby is born. Absent issues that require more frequent visits, obstetric care can involve monthly appointments early in pregnancy, progressing to bi-weekly appointments and eventually weekly appointments towards the end of pregnancy. For a typical, low-risk pregnancy, a patient may have a dozen or more appointments in the approximately nine-month span prior to giving birth. Obstetric examinations too require the patient's informed consent, and patients have the right to decline any examination and to decline to answer any question.[14]

C. Chaperones

Since at least August 2007, the American College of Obstetricians and Gynecologists ("ACOG") has recommended that a chaperone—that is, a third person, such as a medical assistant, who attends and observes a patient interaction—be available upon request for gynecologic

[13] *See* ACOG, Committee Opinion No. 819: Informed Consent and Shared Decision Making in Obstetrics and Gynecology (Feb. 2021), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/02/informed-consent-and-shared-decision-making-in-obstetrics-and-gynecology.

[14] *See id.*

exams.[15] "Chaperones can provide reassurance to the patient about the professional context and content of the examination and the intention of the physician," ACOG explained then, and can also "offer witness to the actual events taking place should there be any misunderstanding."[16] At Columbia, a formal chaperone policy was distributed in January 2007 that was intended to apply to Columbia doctors at all locations. That policy went further than ACOG's recommendation: It provided that "[a]ll healthcare providers, male and female, are required to have a chaperone present when performing an internal pelvic or transvaginal ultrasound examination." Nonetheless, the practices regarding the use of chaperones at both Columbia and NYP were inconsistent and faced significant challenges, both before and after the institution of this policy. These practices, as well as the relevance and role of chaperones, are discussed in detail in Chapter 7.

D. Hadden's OB/GYN Practice

Like many OB/GYN physicians, Hadden practiced as part of a practice group made up of multiple physicians, each of whom had their own patients, but each of whom also covered for each other, including for deliveries. That practice group was itself part of the larger Division of General Obstetrics and Gynecology at Columbia, which was one division within the Department of Obstetrics and Gynecology. The General OB/GYN Division was led by a Division Chief, who then reported to the Department Chair, who oversaw the entire OB/GYN Department. For certain of the events relevant to this Report, the General OB/GYN Division Chief was Dr. Richard Levine (1991–2005)[17] or Dr. John Evanko (2006–2012), and the OB/GYN Department Chair was either Dr. Harold Fox (1993–1994), Dr. Rogerio Lobo (1995–2003), or Dr. Mary D'Alton (2004–

[15] ACOG, Committee Opinion No. 373: Sexual Misconduct (Aug. 2007) (superseded by Opinion No. 796).

[16] *Id.*

[17] During that period, Dr. Levine's position was sometimes referred to as Practice Leader.

present). The Department Chair both supervised the Department of Obstetrics and Gynecology at Columbia and served as Chief of Service at NYP, overseeing the Columbia-affiliated OB/GYN practice with responsibility for managing related hospital programs at NYP. Also relevant to some events detailed in this Report is the OB/GYN Department Administrator, who was the non-physician leader of the department who oversaw the administrative staff and managed financial matters. The Department Administrator reported directly to the Department Chair.

Like many OB/GYN physicians, Hadden saw patients at multiple locations. Hadden saw patients who came in for annual examinations at offices run by Columbia, or, at certain times, clinics run by NYP. When delivering babies or undertaking procedures that required in-patient treatment, Hadden would see patients at NYP. During the course of his time at Columbia and NYP, Hadden saw patients at private offices run by Columbia in Manhattan, including on East 60th Street, at a clinic on 168th Street, and at the Herbert Irving Pavilion on the CUIMC campus. These Columbia locations were managed by a site manager, who coordinated schedules, managed the medical assistants, and responded to patient needs and complaints, among other things. Hadden also saw patients at locations run by NYP, including the main hospital on the CUIMC campus and a clinic in Washington Heights. Because patients saw Hadden at multiple locations and on multiple occasions over the course of years, and because these events happened many years ago, it is sometimes difficult to establish with certainty where some of Hadden's conduct occurred.

PART II
HADDEN'S ABUSE

In this Part of the Report, we describe the nature and methods of Hadden's abuse, the complaints and red flags that the Institutions received about it at the time, and the Institutions' contemporaneous responses to those reports.

In **Chapter 3**, we describe Hadden's abuse, the harm it caused, and the techniques Hadden used to evade detection and apprehension. Among other things, Hadden engaged in grooming behaviors and abused patients in vulnerable circumstances, which made it more difficult for patients to report him. He also misled patients with excuses and diagnoses that purportedly justified his conduct. And he manipulated the chaperone system—which otherwise might have helped to detect or deter his crimes—by scheduling and engaging in examinations when no chaperone was present.

In **Chapter 4**, we first consider complaints about Hadden that patients and staff describe having been made while he was still seeing patients. We then focus on five specific complaints that were escalated to individuals in positions of leadership or authority at Columbia or NYP, with attention to how they were handled. Finally, we discuss the Institutions' practices concerning written records of patient complaints.

In **Chapter 5**, we describe the events surrounding the patient complaint about Hadden's abuse that was most widely disseminated among institutional leadership: the 2012 complaint in which a patient reported Hadden to the police, resulting in Hadden's arrest.

In **Chapter 6**, we discuss the Institutions' reaction to that 2012 complaint and arrest, specifically, their decision to let Hadden return to work four days later without significant investigation. We also describe the consequences of Hadden's return to work, including his continued abuse and exploitation of patients, his eventual termination, and subsequent criminal and civil litigation.

CHAPTER 3
HADDEN'S ABUSE OF PATIENTS AND ITS IMPACT

Hadden abused patients throughout his 25-year career, from the beginning of his practice through the five-week period in 2012 that followed his arrest. Patients have shared their experiences of that abuse with the Investigation Team, in court proceedings and filings, and with the media. They have done so, they explained, to shed light on Hadden's abuse, to have their voices heard, and to help bring about meaningful change.

In this chapter, we describe that abuse and identify methods that Hadden employed to carry it out. The patient accounts in this chapter are not an exhaustive catalogue, given the extent and duration of Hadden's abuse, but instead are examples intended to reflect the nature of the conduct Hadden engaged in. Many patients suffered more than one kind of abuse, and readers should be aware that some of the descriptions below are graphic.

We did not find it necessary to investigate the details of any particular account of abuse. It is well established that sexual assaults are significantly underreported,[18] not overreported. According to a recent study in the Journal of Patient-Centered Research and Reviews, the same is true in medicine, as only 5–10% of victims are estimated to report abuse by physicians.[19] Many of the accounts by patients or colleagues of Hadden's abuse, moreover, corroborate each other in that they describe conduct during physical examinations, comments by Hadden, patterns of touching, or approaches to avoiding the presence of chaperones that are similar to each other. Finally, and importantly, Hadden pleaded guilty in state court to committing both a criminal sexual act in the

[18] Cameron Kimble, *Sexual Assault Remains Dramatically Underreported*, BRENNAN CENTER FOR JUSTICE (Oct. 4, 2018), https://www.brennancenter.org/our-work/analysis-opinion/sexual-assault-remains-dramatically-underreported.

[19] Tristan McIntosh et al., *Responding to Sexual Abuse in Health Care: Development of a Guide for Patients*, 9 J. PATIENT-CENTERED RSCH. & REVS. 117 (2022), https://pmc.ncbi.nlm.nih.gov/articles/PMC9022717/.

third degree and forcible touching, and he was convicted after a trial in federal court of multiple counts of enticing women to travel in interstate commerce in order to sexually assault them. The judge in that federal prosecution found that the testimony at trial alone had demonstrated that there were up to 154 women who were harmed by Hadden. Many other patients who saw Hadden and reported abuse in other venues did not participate in those proceedings, making the true number higher. In sum, there is no reasonable doubt that Hadden engaged in widespread sexual abuse of patients.

I. Hadden's Abuse of Patients

Hadden abused patients in a wide variety of ways, including massaging and groping their breasts, pinching and twisting their nipples, digitally penetrating their vaginas, attempting to sexually stimulate them by rubbing their vaginas, touching their clitorises, and licking their vaginas. He did all of this under the guise of providing medical care.

According to patients, Hadden's abuse often began with grooming behaviors that earned the patient's trust. He would also ask intrusive sexual questions that were not connected to any medical concerns that patients had expressed. He inquired, for example, into the sexual positions patients used and into their sexual satisfaction and gave unsolicited advice on those topics. Hadden gave one patient unsolicited advice about oral sex. He asked another patient questions about whether she would participate in anal sex and whether she used dildos or sex toys. With another patient, he gestured at different sexual positions while providing graphic sexual advice. These kinds of conversations, patients later realized, were for Hadden's own sexual satisfaction, not in service of their own medical care.

Along with intrusive questions, Hadden made non-medical remarks about patients' bodies. He told one patient her breasts were beautiful and another patient that she could be a swimsuit

model. He made crude comments about the negative effect of another patient's weight on her sexual activity.

Hadden also engaged in purported medical care that was wholly unrelated to the obstetric and gynecologic care that patients sought. He suggested to many patients, for example, that he perform a mole check or a scoliosis check during their office visit, sometimes with an explanation that he could save the patient money by doing so. Patients initially interpreted this as generosity, because it spared them the time and expense of an additional appointment. In connection with those purported "checks," however, Hadden directed patients to stand and bend over in a way that left them fully exposed, sometimes without any gown at all.

Hadden also exploited the intimate examinations that characterize OB/GYN care. Appropriate obstetric and gynecologic care frequently includes examinations of the breasts and genital area. Given the inherent sensitivity of those examinations, professional practice guidelines dating back to at least 2007 dictate that they be conducted with "only the necessary amount of physical contact required to obtain data for diagnosis and treatment."[20] Hadden instead prolonged those examinations, repeated them over and over, and carried them out in a sexual, rather than clinical, way.

Hadden frequently conducted sexualized breast examinations, for example. A patient at Hadden's criminal trial testified that during her pregnancies she saw Hadden for monthly examinations and that Hadden's breast examinations at each visit "lasted several minutes," during which he used both hands, without gloves, to cup her breasts and squeeze her nipples—a frequency and manner inconsistent with the standard of care outlined by an expert at that trial. Another patient

[20] ACOG, Committee Opinion No. 373: Sexual Misconduct (Aug. 2007) (superseded by Opinion No. 796).

described the experience of Hadden's breast exams to the court as "a very prolonged, ungloved massage." Two other patient witnesses in court proceedings recognized the sexual nature of Hadden's breast examinations when they either "felt [Hadden's] erected penis against [the patient's] leg" or looked down and saw that Hadden had an erection while conducting the examination.

Hadden similarly exploited pelvic examinations. He engineered repeated examinations, for example by directing a teenage patient to return whenever her three-month sample packs of birth control ran out. Each time she returned Hadden conducted another pelvic examination, resulting in approximately four examinations (rather than the more typical one) per year, during each of which he rubbed her clitoris with his fingers before inserting them into her vagina. Additional patients reported that Hadden touched them in a sexual manner during pelvic examinations, including by using his fingers to stimulate them or to digitally penetrate them in a sexual manner. A patient testifying at Hadden's criminal trial explained that he inserted his fingers in and out of her vagina for what felt "like a lifetime" in a motion that was as if "he was trying to masturbate" the patient. A nurse at the same trial similarly testified about the "sexual" way in which Hadden, during a pelvic examination, ran his fingers several times up and down a patient's labia before inserting them.

Multiple patients also report that Hadden licked them or touched them with his mouth or tongue during pelvic examinations. A patient who testified at Hadden's trial, for example, described a visit during which Hadden first conducted a pelvic examination with a nurse present. After the nurse left the room, while the patient was still in the same position, Hadden told the patient he needed to check something, and she then felt him lick her vagina several times, up and down. A second patient testified that Hadden would conduct vaginal examinations with a nurse

present at the beginning, but then the nurse would leave, and at one such examination she felt Hadden lick her vagina. Other patients had similar experiences.

Hadden also caused significant pain during his examinations, as patients explain. One patient described a dilation check during pregnancy that lifted her off the table in pain and was unlike anything she experienced when seeing another doctor. Another patient described a pelvic examination that left her bleeding, crying, and in extreme pain afterward. A third described Hadden to a court as a "sadist," explaining that very shortly before she gave birth, Hadden conducted an examination with such force and in a manner that was so physically painful that she could barely walk.

If a patient resisted his abuse, Hadden pushed past that resistance, with the benefit of his authority as a doctor, in a manner that suggested nothing was wrong. One patient was in the hospital, having just delivered, and Hadden said he would do a breast examination and check to see if her milk had come in. She indicated she did not need the examination, but in a movement that happened very quickly, he nevertheless conducted the breast exam. Another patient underwent a pelvic examination during an office visit during which Hadden rubbed her clitoris, making her very uncomfortable, and she sat right up, reflecting her alarm. Rather than stopping, Hadden told her to lie back down because he was not finished. A third patient told the federal court that she had questioned Hadden multiple times during an abusive examination but reported that he "always had a quick reply" that left her feeling ashamed and confused about what had been done to her.

Some incidents of Hadden's abuse took place even with a chaperone present. A patient who wrote a detailed letter in 1994 to Dr. Harold Fox (the OB/GYN Department Chair) describing her abuse explained that the nurse in the room was turned around and seemed to be deliberately

avoiding observing the examination. Several other survivors similarly recall that they were abused while a chaperone was in the room either turned around, turning away, or looking alarmed.

II. Enduring Effects of Hadden's Abuse

Hadden's abuse has impacted patients in ways that endure long after his examinations ended. For many, it resurfaces unbidden during moments of their everyday lives, and more recently they have relived it when participating in court proceedings and interviews, reading about his misconduct in the news, or seeing his face pictured in various places after events came to light. Many who were unsure of what was happening or confused in the moment have described the trauma of realizing later what had happened to them. They have explained that the now-public nature of Hadden's abuse adds another layer of difficulty, because they fear people knowing or imagining what happened to them.

Patients report experiencing a continuing sense of powerlessness and fear. Some thought they were the only ones Hadden harmed or worried that they did something to cause the abuse. Others blame themselves, asking why they froze during the abuse rather than speaking up.[21] Some describe guilt that they did not report Hadden and that others were abused after them. Some patients do not trust themselves because they did not recognize Hadden's grooming and abusive conduct, and they no longer trust others either.

Fear continues to invade these patients' experiences with medical care. Some delay or avoid gynecologic care, and others describe delaying all medical care to the detriment of their health. Many no longer trust doctors. Some express fear that their children, especially their

[21] Freezing is a recognized neurological response to sexual abuse. *See* RAINN, *Fight, Flight, Freeze, & Fawn: Understanding Survival Responses* (updated Aug. 8, 2025), https://rainn.org/mental-health-therapy-support-after-sexual-violence/fight-flight-freeze-and-fawn-understanding-survival-responses/.

daughters, will be abused by a doctor as well. And their fear is not limited to medical settings. Many report that their intimate and familial relationships have suffered. Some are unable to tell a partner what they experienced, while others experience difficulties with sexual intimacy. Several report that the abuse contributed to a divorce. For some, the trauma destroyed their desire to have more children. Patients report seeking therapy and dealing with medical conditions such as post-traumatic stress disorder, anxiety, depression, disordered eating, nightmares, and insomnia after Hadden's abuse. Many patients believe Hadden's abuse will affect them for the rest of their lives.

III. Hadden's Methods of Abuse

Hadden employed a number of techniques that facilitated his abuse and helped him avoid detection. He groomed patients, earning their trust and surprising and confusing them when he betrayed it. He often abused particularly vulnerable patients. He supplied diagnoses that purportedly justified his conduct. And, finally, he took steps to ensure that third parties were not present to observe some incidents of his abuse.

A. Grooming Behavior

Hadden carefully cultivated patients' trust, and then he exploited that trust to abuse them. While his medical practice was noticeably busy, Hadden was solicitous and seemingly generous with his time; he "had a gift," one patient later told a court, for "making himself personable and disarming." After he conducted physical examinations in an examination room, he talked with patients in his office, which was decorated with pictures of his family and his dogs that seemed to tell a story of a family man. He shared stories about his own life with patients, whether about his wife, his disabled son, or his daughter's ballet experiences. He spoke with patients at length, in contrast to their experience with some other doctors, and he became known as a doctor who cared. Patients describe the effect these efforts had; they felt that Hadden was approachable, that they had a bond with him, and that he was a friend.

When Hadden then escalated his conduct by asking intrusive questions, or groping their breasts, or touching their vaginas in a sexual way, patients felt not only violated but also confused, because they trusted him. That confusion made patients more vulnerable to abuse, because they struggled to believe it was happening. One patient explained to the court that "[f]or years I struggled thinking that what he did to me was not true but rather something that I misunderstood." Another patient explained to the court that, more than ten years later, she was "still processing how [she] misjudged [her] situation." Hadden used this confusion to his advantage; as one patient later explained to the court, he "relied on shock and reinforced the uncertainty and disbelief he knew patients felt by normalizing his actions."

B. Abusing Patients with Particular Vulnerabilities

Hadden frequently abused patients who were in vulnerable positions, increasing the inherent power differential between Hadden and any patient, and decreasing the likelihood that patients would report his conduct. Many patients seeing obstetricians and gynecologists are vulnerable simply by virtue of their need for care. Some are deeply concerned about their own health, others are worried about the health of a pregnancy. Multiple patients have explained that they returned to Hadden only out of concern for the health of their unborn children. Hadden, however, often abused patients with additional vulnerabilities, whether because of youth and inexperience, or isolation by virtue of upbringing, financial issues, or language barriers.

Many of Hadden's victims were young and inexperienced with gynecologic care. One patient told a court that Hadden "became [her] doctor as a young woman," "at a time when [she] had no idea what happens when you see a [g]ynecologist." Another patient who began seeing Hadden as a teenager—and was subjected to frequent pelvic examinations, inappropriate comments, and sexual touching—did not realize until much later that these were not typical

examinations or comments. Only when she went to another doctor did she realize what an appropriate examination entailed.

Another patient Hadden targeted was 18 years old and facing a language barrier when Hadden assisted in her emergency delivery. She has reported that during her labor Hadden touched her, sometimes without gloves, in ways that made her feel uncomfortable, as though he was attempting to arouse her sexually. She requested another doctor but was not provided one, and Hadden delivered her child.

A third patient encountered Hadden in 1988 when she was a teenager. She was recovering from surgery at NYP to remove a cyst from her bile duct when Hadden assaulted her. She explained that he waited until her parents and other medical staff were no longer in the room to purportedly show her how to conduct a breast exam, even though her hospital stay was unrelated to any issue with her breasts. He fondled and squeezed her breasts for a prolonged period, and she understood based on his actions that the examinations were not done for medical purposes. She recalls being terrified.

Other patients describe having been abused by Hadden at times when they were vulnerable for other reasons. One patient had just moved to New York, knew no one in the city, and was from a conservative religious background, with no experience with gynecology until her first pregnancy. Hadden assaulted her during her obstetric appointments, but because of a prior pregnancy loss, she continued to see him because she was concerned for the health of her unborn child. Another patient was assaulted with a chaperone in the room and did not want to return to the practice, but felt she had to return for the sake of her unborn child. Hadden also abused at least one patient who was in a very fragile economic situation; the patient had no housing and was living in her car. Hadden conducted a pelvic examination with such force and in such a manner that the patient was in pain

for weeks afterward. When it came to reporting, however, the patient worried about whether anyone would believe her account over Hadden's.

C. Providing Diagnoses as Purported Justification for Abuse

Hadden also provided a variety of diagnoses as purported justifications for the frequency or manner of his examinations, including diagnoses other physicians later refuted. Hadden diagnosed one patient with a latex allergy, for example, and then used his bare hands for pelvic exams. After leaving Hadden's practice, that patient saw an allergist who confirmed that she had no latex allergy, and conducting pelvic exams without gloves, as an expert in Hadden's criminal trial testified, falls below the standard of care.

Many patients reported being told that they had an inverted, tilted, or upside down uterus, a potentially legitimate diagnosis, which Hadden nevertheless used as a rationale for conducting additional exams or engaging in other inappropriate conduct. For one such patient, Hadden proceeded to use his fingers to "demonstrate" that certain sexual positions would be painful. She asked him to stop, but he did the same thing at her next appointment. For another, Hadden used his hands to examine the patient and purported to manually "move" her tilted uterus by moving his fingers up and down. Years later, a different OB/GYN confirmed for this patient that she did not have a "tilted" uterus. For a third patient, Hadden told her that they should act out sex positions due to her inverted uterus. She immediately left the office and the practice.

D. Avoiding Chaperones

Hadden also carried out his abuse by avoiding people who might witness what he was doing. Practices regarding the presence of chaperones during intimate examinations changed significantly over the 25-year course of Hadden's career, as discussed more fully in Chapter 7. When Hadden first began to see patients, no formal policy required the presence of chaperones and individual physicians' practices varied; after 2007, chaperones were required during certain

intimate examinations but adherence was inconsistent, including because of staffing shortages. Regardless of the formal guidance in place, Hadden took steps to avoid the presence of chaperones in at least two ways.

1. Second Examinations Without a Chaperone

Hadden frequently contrived to conduct a second, unchaperoned examination within a single visit in order to abuse patients. On these occasions, Hadden conducted an initial examination with a nurse, medical assistant, or other chaperone present. Pretending to conclude, he waited for the chaperone to leave before telling the patient that he had "forgotten" to check something and needed to examine them again. Then, unchaperoned, he abused the patient.

A former nurse's aide at NYP testified at Hadden's federal criminal trial that she observed this tactic as early as the late 1980s or early 1990s. Sometime between 1988 and 1991, she assisted Hadden with a Pap smear and left the room when she thought the examination was over. Realizing she forgot her stethoscope, she reentered the room and witnessed Hadden with one hand moving in the patient's vagina, the other on the patient's knee, his eyes closed and directed upwards, and his face red. The nurse's aide stepped out of the room again, closed the door, and then knocked on the door, more loudly this time. When she re-entered, the curtain was closed, covering Hadden and the patient from her view, and she heard Hadden washing his hands.

Other patients report similar experiences. A patient testified at Hadden's trial that during her appointment in approximately 2010, Hadden conducted a typical examination with a nurse present, but, after the nurse left, he told the patient to "stay there." The patient stayed on the examination table because she thought Hadden had found something wrong, but then Hadden abused her, running his fingers from her clitoris to the end of her vagina and "thrusting" his fingers into her vagina. During the visit that ultimately resulted in his arrest, Hadden followed the same

pattern. He conducted an examination with a chaperone present, and then, after the chaperone left, he purported to check one more thing and licked the patient's vagina.

2. Patients Scheduled Outside Business Hours

A second way in which Hadden saw patients without anyone else present was by scheduling appointments at times when there were no chaperones available, like the early morning hours or after the end of the workday. These off-hours visits were sometimes framed as accommodations for busy patients, including patients who also worked at Columbia or NYP. A medical assistant might learn of an early morning visit only by coming in when the office first opened to find specimens Hadden had already collected before the office opened for the day. A site manager told Hadden to stop seeing patients outside of office hours, because it created liability concerns, but it is unclear what effect this admonition had. While one medical assistant remembers that he stopped seeing patients at off-hours at some point, another medical assistant recalls that Hadden's practice in this regard did not change.

CHAPTER 4
COMPLAINTS AND RED FLAGS

Over the years that Hadden practiced, patients and other employees reported concerns about his conduct to staff, physicians, and leadership. Near the end of his tenure, one patient reported him to the police. Patients spoke with medical assistants or other staff during their visits, or shared concerns about Hadden when they returned for later appointments with other physicians. Employees spoke with their colleagues. One patient even wrote a detailed letter about her experience to the Chair of the OB/GYN Department. Some of these reports prompted attention from physician leadership, but none of them resulted in a restriction on Hadden's access to patients. Instead, Hadden's access to patients ended when he chose to go on leave in August 2012 from his reported stress following his arrest and was thereafter prohibited from returning because he refused to let Columbia interview him about the events underlying the arrest.

Patients and employees of the Institutions have shared the details of these reports with the Investigation Team, in court proceedings and filings, and with journalists. The reports took different forms and many occurred long ago. Given the passage of time, the information now available about each event varies. For some of the reports described below, we know only the patient's or employee's account of what took place. In other cases, though, there is more than one person with relevant information or there are documents that reflect the report at the time it was made, including in instances in which reports were addressed to or escalated to physician leadership.

In Section I, we discuss a broader group of reports about Hadden's conduct that patients and employees (including some people who were both) describe having been made. For many of these reports, there is limited information available. In Section II, we focus on five complaints about Hadden's conduct that were escalated to physician leadership at Columbia, all but one of

which are also reflected in contemporaneous documents. We address in greater detail in the following chapter the fifth of these complaints to reach physician leadership—the 2012 incident in which a patient reported Hadden to the police, which was the principal catalyst for the end of Hadden's practice and his eventual prosecution. Finally, in Section III, we describe the Institutions' systems for recordkeeping of patient complaints.

I. Accounts of Patient Complaints Not Escalated to Leadership

Below are accounts shared by patients and employees of contemporaneous reports that were made about Hadden's conduct. This section does not include every report that has been described in litigation, the press, or conversations with the Investigation Team. Because this Investigation concerns the circumstances that allowed Hadden's conduct to continue while he was seeing patients, this section also does not include the additional reports that were made after Hadden stopped seeing patients and his conduct became more widely known.

During Hadden's tenure, according to patients, staff, and physicians at the Institutions, complaints about Hadden's conduct were made in the following instances:

- A patient who saw Hadden as a minor in the late 1980s subsequently described in a civil complaint that, during the visit, Hadden insisted on conducting a vaginal examination and then smelled her after she told him she was menstruating. She complained to staff about Hadden's conduct, but she says she was "brushed off."

- A patient who saw Hadden from 1989 through 1990 subsequently described in a civil complaint that Hadden abused her while still in his residency at NYP by inflicting pain during a pelvic examination. After she told him that he was hurting her, he did the same thing again, which caused her to jump down from the examination table. The patient reported Hadden's conduct to a receptionist, who directed her to someone she understood was a patient relations coordinator. That person said she would look into the incident and get back to the patient. The patient recounted that she did not hear anything further.

- A patient who saw Hadden at a clinic in 1992 when she was a pregnant teenager was, according to public reporting, subjected to a "very rough" examination during which Hadden refused to stop when she said he was hurting her. A week after her appointment, the patient returned to the clinic to report the assault to a receptionist, who gave her a phone number. The patient called the phone number several times,

eventually reaching someone, and explained that a doctor in the clinic had made her uncomfortable. She was transferred around but was unable to get anyone in a position of authority to speak to her directly.

- A Columbia employee who saw Hadden for care at the Herbert Irving Pavilion beginning in the mid-1990s recalls that Hadden asked her to come in for repeated examinations, including breast examinations that were only a month apart and pelvic examinations that felt very frequent. During the breast examinations, Hadden repeatedly commented about the size of her breasts, which made the patient uncomfortable. The patient complained about Hadden's conduct to a friend who worked with Hadden as a medical assistant. The medical assistant responded that there could not have been any misconduct because the patient was not Hadden's "type." The medical assistant told the patient that Hadden liked women who were tall, skinny, and blonde. For her part, the medical assistant does not recall receiving any complaints about sexual misconduct involving Hadden, but she does remember that Hadden was known around that office to have a "type," namely tall blondes.

- A former medical assistant who saw Hadden in approximately 1995 or 1996 for abdominal pain subsequently told the Manhattan District Attorney's Office about the experience. She said that Hadden initially conducted a pelvic examination with a nurse present, but that after the nurse left, Hadden conducted an abdominal examination while standing at the patient's side, during which she felt his erect penis against her. The patient reacted by getting up and leaving. As she left the office, she recalls telling a receptionist that Hadden was "a pervert."

- A patient who saw Hadden between 1996 and 1997 subsequently described in a civil complaint that Hadden abused her by, among other things, making belittling comments about her body and touching her clitoris. She reported Hadden's behavior to someone she understood was a patient advocate, who took her information. The patient stated that she never received a response.

- A patient who saw Hadden in October 2004 described in a civil complaint that she reported to a receptionist after an appointment that Hadden had behaved inappropriately. The receptionist gave her a pen and paper so that she could report her experience. She did so, but did not receive a response.

- According to public reporting, a patient who saw Hadden around 2004 or 2005 reported to another doctor in Hadden's practice—the doctor who had initially referred the patient to Hadden—that Hadden had been "really inappropriate" with her and had made her "extremely uncomfortable" during her appointment. She explained that the physician dismissed her concerns. After giving birth, she stopped going to Columbia altogether.

- A patient who saw Hadden in the mid-2000s subsequently told the Manhattan District Attorney's Office and journalists that Hadden asked invasive questions about her sexual preferences and preferred sexual positions. She explained that, during a pelvic examination, he touched her clitoris with his finger. She said that

she told two other physicians in the practice that she did not want Hadden delivering her unborn child.

- A patient who saw Hadden in approximately 2006 described in a civil complaint that Hadden conducted a two-handed breast examination during which he massaged and fondled her breasts while staring at her face and chest. She reported to staff that Hadden made her "extremely uncomfortable" and that she did not want to be seen by him again.

- A patient who saw Hadden in 2006 described in a civil complaint that Hadden assaulted her by conducting examinations without gloves and, during a dilation check at NYP, examining her so aggressively that she grabbed his hand and told him to stop because he was hurting her. She reported her experience to another physician in Hadden's practice, but did not report it to NYP.

- A patient of another doctor in Hadden's practice recalls having seen Hadden in approximately 2008 for one visit during her pregnancy. She recalls that Hadden conducted a breast examination in a way that seemed inappropriate. She raised the issue with her regular obstetrician, and there is some evidence that she did so at her next visit. Her regular obstetrician, who has since left the Institutions, declined to speak with the Investigation Team.

- A patient who saw Hadden from approximately 2007 to 2011 subsequently described in a civil complaint that Hadden abused her during appointments throughout that period. In the patient's last appointment, Hadden instructed her to roll over onto her stomach and touched her inappropriately. On her way out, she reported what happened to the front desk at Hadden's office. She recalls that Hadden subsequently called her and asked her what she believed had happened.

- A doctor in Hadden's practice recalls a patient complaining to her that Hadden was weird or made her uncomfortable. The doctor recalls viewing the report as difficult to evaluate and that it would have needed to be more explicit to act on.

- Another doctor in Hadden's practice recalls that, a few years before Hadden's arrest, one of the doctor's patients saw Hadden because the doctor was on vacation. The doctor recalls that the patient subsequently reported to him that Hadden made the patient uncomfortable. The doctor recalls viewing the patient's complaint as vague and not knowing what to do with it.

- A medical assistant who worked with Hadden recalls that, near the end of Hadden's tenure at the Institutions, a patient reported to her that the patient was concerned that Hadden had touched her in an inappropriate way and had lingered too long while examining her vaginal area. The medical assistant recalls responding to the patient that, if the patient felt that way, she should tell someone (even though the patient had just done so).

In addition to these specific reports about Hadden's behavior, there were also more general discussions about Hadden among his coworkers that suggest some awareness that he had inappropriate contact with patients. For example, a medical assistant at Columbia recalls hearing whispering among the nurses about Hadden's behavior and the way he touched patients, and also among coworkers who did not like the way he performed examinations. And as mentioned above, a medical assistant recalls that there was discussion among the staff at one of Hadden's offices about Hadden's "type" and the fact that he would spend more time with women who looked a certain way. The medical assistant recalls that if Hadden went into his conference room with a tall, blonde patient, Hadden's receptionist might remark that the medical assistant need not hurry because Hadden spent considerably more time with those patients. While these conversations were not specific, taken together they indicate some level of awareness or discomfort with the appropriateness of Hadden's behavior.

II. Complaints Escalated to Leadership

In addition to the reports above, there were at least five reports about Hadden's conduct during office visits at Columbia that were addressed to, or escalated to, physician leadership there. While the reported incidents occurred in Columbia offices, some physicians who served as leaders of Columbia departments also held leadership roles at NYP, at least after the merger in 1998. Chairs of the Columbia OB/GYN Department—Dr. Rogerio Lobo (1995–2003) and Dr. Mary D'Alton (2004–present)—serve as the Chief of Service for OB/GYN at NYP. By virtue of this structure of dual leadership roles, the reports of misconduct that were known by the Department Chair at Columbia were likewise known by the Service Chief at NYP, because the same individual simultaneously held those leadership positions at each Institution.

A. Patient Letter Sent to Dr. Fox (Department Chair) in 1994

In 1994, a patient wrote a letter to Dr. Harold Fox, who was the Acting Chair of the OB/GYN Department at Columbia, in which she reported complaints she had about Hadden's conduct during an examination. She sent a copy of the letter to "Risk Management – Columbia-Presbyterian Medical Center." In her letter, the patient reported that she had seen Hadden in 1993 and had a breast examination so prolonged that she asked Hadden whether something was wrong. Hadden also conducted a painful Pap smear, and a pelvic examination during which he ran his fingers up and down the patient's labia saying he was "lubricating the outside." In her letter, the patient described the examination in detail, including the fact that it left her "feeling violated." She also explained that a third person in the room, whom she identified as a nurse, had her back "half turned" during the breast examination and, after assisting with a Pap smear, turned away again during the examination.

Dr. Fox responded to the patient by letter, telling her that he would speak to Hadden and would follow up on her concerns. Although Dr. Fox's counsel did not respond to our request to speak with Dr. Fox directly, according to public reporting, after receiving the patient's letter, Dr. Fox spoke with an unspecified medical assistant about the patient's concerns and the medical assistant reported nothing inappropriate to him. The patient's letter had made clear, however, that for periods of the examination, the nurse or medical assistant had been facing away from Hadden and the patient. Apart from Dr. Fox's letter promising to follow up, the patient never heard again from Dr. Fox or from Columbia and she concluded that she was not being taken seriously.

There is no evidence that the patient's detailed letter was maintained in Hadden's departmental file, or any other file, within the Institutions. As described in Chapter 9, there is evidence that Dr. Fox's response letter—but not the patient's original complaint—was contained in Hadden's departmental file.

B. Patient Complaint Escalated to Dr. Levine (Practice Leader) in the 1990s

At some point in the 1990s, Hadden subjected a patient to a breast examination that was sufficiently extended and uncomfortable that it caused her to switch physicians. The patient reported to her new physician why she had switched doctors, and that physician in turn recalls walking down the hall to share the patient's account with Dr. Richard Levine, the senior physician in the group, believing that he was a person with authority in the department to do something about it. There is no indication, however, of what steps, if any, Dr. Levine took in response to this complaint, and no documents have been identified that reflect either the complaint or its resolution. There may be no documentation because, as the physician later recalled, the patient declined to report the complaint further when the physician suggested doing so. Dr. Levine passed away in 2020 and so could not be interviewed by the Investigation Team.

C. Inappropriate Computer Use Escalated to Dr. Lobo (Department Chair) in 2000

An episode of sexual misconduct by Hadden that did not involve a patient came to the attention of physician leadership in June 2000. That month, an information technology employee for the OB/GYN Department reported to Department Chair Dr. Rogerio Lobo that it appeared Hadden had viewed pornography on a computer at Columbia's East 60th Street office. Dr. Lobo spoke with Hadden, who denied having viewed the pornography, but Dr. Lobo recalls that he probably did not believe Hadden's denial because Dr. Lobo believes the IT employee would not have brought it to his attention if it did not occur. Dr. Lobo told Hadden that work computers should not be used for that purpose. Dr. Lobo then wrote a "note to the file," included it in Hadden's departmental file, and considered that the end of the matter. The note memorialized allegations of "inappropriate use of the computer during normal work hours," Dr. Lobo's discussion with Hadden, and Hadden's denial. Dr. Lobo does not recall why he used the language

"inappropriate use of a computer" rather than "pornography," but Dr. Lobo understood the incident to have involved pornography. Others in the Department also heard about the incident and recall that it involved pornography.

D. Patient Complaint Escalated to Dr. Evanko (Division Chief) in 2008

In 2008, a patient reported to a site manager in the OB/GYN Department that Hadden had made inappropriate comments about her body during an office visit. The site manager took notes of the patient's concerns and emailed them to herself. She also escalated the patient's concerns to the Department Administrator. The Department Administrator does not remember what steps she took in response but believes she would have communicated the complaint to Dr. Mary D'Alton, the Chair of the OB/GYN Department, with whom she had a close working relationship. Dr. D'Alton does not recall knowing about such a complaint at the time. A few days later, according to a contemporaneous email, the site manager spoke about the patient's complaint with Dr. John Evanko, who was the General OB/GYN Division Chief. Ultimately, neither the site manager, the Department Administrator, nor Dr. Evanko recall how this incident was addressed. Indeed, Dr. Evanko and the Department Administrator have no recollection of the incident.

E. Patient Report to the Police in 2012

In 2012, a patient saw Hadden for a postpartum visit, during which he licked her vagina after a chaperone had left the room. The patient promptly reported Hadden to the New York City Police Department. Hadden was arrested in his office the same day, and the incident was escalated to leadership throughout both Institutions. Because this report was the primary catalyst for the end of Hadden's practice and his eventual prosecution, Chapters 5 and 6 discuss the report and its aftermath in greater detail.

III. Patient Complaint Recordkeeping

Other than the correspondence about the complaint to Dr. Fox in 1994, Dr. Lobo's 2000 note to the file regarding inappropriate computer use, the 2008 emails memorializing that a complaint about Hadden's sexualized statements during an examination was escalated to Dr. Evanko, and documentation surrounding Hadden's arrest in 2012, there appears to be no contemporaneous documentation reflecting any of the other reports about Hadden's misconduct. It is unclear, however, whether any records that might have been created in connection with such reports would necessarily have made their way into either Institution's files, or could be located now if they had.

With respect to Columbia, the current Chief Quality Officer recalls that when she arrived at Columbia in March 2012 (then as Quality Director), there was no system in place for compiling and tracking complaints. Consistent with that recollection, the Investigation Team has discovered no evidence that Columbia had a policy establishing any process for handling or resolving patient complaints until September 2012, after Hadden had stopped seeing patients.[22] Moreover, many doctors and staff practicing at Columbia have no recollection of receiving guidance about how they were to handle patient complaints during Hadden's tenure.

NYP, for its part, had a department throughout Hadden's tenure, now known as the Patient Services Administration, devoted to addressing patient concerns, and that department did keep organized records. But the passage of time and changes in systems make it difficult to identify older patient complaints today. For nearly two decades of Hadden's tenure, for example, NYP's

[22] Starting shortly after the current Chief Quality Officer arrived at Columbia in March 2012, Columbia set up a spreadsheet system to handle complaints, particularly those that were considered serious or sensitive, but that system was only in place for a few months before Hadden went on leave and it did not include all complaints.

patient complaint records were kept on paper, organized by year and patient last name, and accordingly were and are difficult to search for complaints about a particular physician (although searches were conducted). Other records are digital, but the digital systems have changed several times before the current system and did not carry over older complaints wholesale.[23]

Separate and apart from how they treated patient complaints generally, the Institutions do maintain personnel and other files about physicians, including about Hadden. Specifically, across the two Institutions, at least the following three types of files exist for each physician: a Faculty Affairs file maintained by Columbia; a departmental file maintained by the OB/GYN Department; and a credentialing file maintained by NYP as part of NYP's credentialing process. But those files do not seem to have been considered a required end-point or repository for patient complaints. Thus, of the four reports above about Hadden's behavior for which contemporaneous documentation is known to exist, only Dr. Fox's brief reply to the 1994 patient complaint (but not the patient's complaint itself) and Dr. Lobo's 2000 note to the file about Hadden's inappropriate computer usage made their way into any of the three files the Institutions maintained about Hadden, specifically, into his departmental file. None of the three files contains the 1994 patient complaint letter to which Dr. Fox was responding or anything about the 2008 patient complaint that contemporaneous emails reflect was escalated to Dr. Evanko.

In sum, while both Institutions have searched their files for complaints about Hadden, there appear to be scant records of the numerous complaints described above. The absence of such records is unsurprising in light of the age of the complaints in question, the lack of any policy or

[23] Columbia and NYP searched for patient complaints related to Hadden in both electronic and archived paper files. At the Investigation Team's request, they carried out additional record searches, including for complaints described above. Neither Institution discovered written records of patient complaints about Hadden's sexual misconduct while he was seeing patients beyond those discussed in this chapter.

guidance for maintaining records of patient complaints at Columbia during Hadden's tenure, and the recordkeeping systems at NYP.

CHAPTER 5
HADDEN'S ARREST

In 2012, a patient reported to the New York City Police Department that she had been assaulted by Hadden during a postpartum appointment earlier that afternoon. That same day, the police went to Hadden's office and took him into custody, setting into motion the events that would ultimately end Hadden's practice and lead to his criminal prosecution.

I. A Patient's Call to the Police

On a Friday afternoon in the summer of 2012, a patient who had seen Hadden throughout her pregnancy returned to Columbia's East 60th Street office for a routine postpartum examination by Hadden after having given birth a month earlier. A medical assistant was in the room for most of the examination, including while Hadden conducted a breast and pelvic examination. When the examination appeared to be over, the medical assistant entered some things in the computer and left. At that point, Hadden asked the patient to lay back down so he could take another look. He pulled a sheet over her legs, dipped his head down, and licked her clitoris, causing her to jump up. Hadden then started making small talk, while purporting to conduct a second breast exam. When Hadden left the room to let the patient get dressed, she made a distraught call to her partner from the room's en suite bathroom. The patient's partner encouraged her to call the police.

Once dressed, the patient headed directly to the elevator in an effort to exit the building quickly. But Hadden followed her and pressured her to return to his office. There, he continued to make small talk until she was able to escape by faking a phone call with her nanny as an excuse to leave. Hadden nonetheless walked with her to reception and instructed her to make another appointment. The patient disregarded the instruction and left. Once outside, she met her partner, who had rushed over, and they went home together.

That afternoon, the patient called Hadden's office and reached a supervisory nurse. Per that nurse's roughly contemporaneous notes, the patient began the call "hysterically crying" and "unable to speak," leading her partner to take the phone and confirm that they were speaking with a nurse before placing the patient back on the line. Referring to the medical assistant who had left the room just before the abuse, the patient said that she wanted "to get the nurse[']s name that was in the room with her because [her partner] wants [her] to call the police to have on record what happened to [her] when the nurse left the room."

Placing them on hold, the supervisory nurse communicated the situation to the site manager and asked for permission to provide the patient with the medical assistant's name. The site manager, in turn, called the Department Administrator and obtained permission to tell the patient the medical assistant's name. With that authorization, the supervisory nurse provided the medical assistant's name and asked if there was anything else she could do. The patient said no and ended the call.

Immediately following the call, the site manager spoke individually with the medical assistant, Hadden, and the receptionist. The medical assistant reported nothing unusual, telling the site manager that she had been in the examination room while Hadden performed a pelvic examination and that she left after the examination ended while the patient was sitting up in her gown talking to Hadden. For his part, Hadden told the site manager that the patient had complained of pain after the medical assistant left, so he told her to lie back down for another examination. But as soon as he touched the area, according to Hadden, the patient ended this subsequent examination by saying "that's enough." Hadden said that he told the patient to get dressed and come see him in his office, but instead he encountered her moments later in the hallway and thought she was behaving strangely. He said that he walked her to the check-out area to schedule

a follow-up with the receptionist and left her there. The site manager then spoke to the receptionist, who told her that the patient had been acting strangely, had her hands in the air, said something to the effect of "I've got to go," and walked out without scheduling the requested follow-up.

The site manager next received a call from Dr. John Evanko, Chief of the General OB/GYN Division at Columbia. Dr. Evanko suggested to the site manager, and then to Hadden, that Hadden should try to call the patient. Hadden did so, leaving her a message in which he said that he heard she was upset, asked her to call him back or return to the office so they could talk, and said that he was, himself, "very upset." The Department Administrator separately called the patient and left a message seeking to discuss what had happened.

II. Hadden's Arrest and Release

While this was happening at Columbia's East 60th Street office, the patient called the police. In response, two NYPD officers came to her apartment, where the patient described the assault to them. Based on her account, the officers went to Hadden's office to arrest him, arriving at the East 60th Street office late in the afternoon.

Upon the officers' arrival, the Department Administrator immediately called Dr. Mary D'Alton, Chair of the OB/GYN Department, to tell her about the situation, prompting Dr. D'Alton to rush over. When Dr. D'Alton arrived, she met Hadden in a consultation room at the back of the practice and asked him what was going on. Dr. D'Alton recalls that Hadden told her that during a postpartum examination, after the chaperone left, the patient asked him to check an episiotomy (an incision made during childbirth), which looked fine to him. Dr. D'Alton recalled noting to herself at the time that guidelines would have required a chaperone to be present for that examination. During her conversation with Hadden, one of the officers entered the room and explained that a patient had alleged that Hadden licked her during an appointment. Dr. D'Alton recalls that Hadden looked stunned and denied the accusation.

The officers arrested Hadden and took him to a police station for questioning. Dr. D'Alton and the site manager went to the station as well. This was the first time in Dr. D'Alton's experience that the police had ever interacted with the practice at all, much less arrested one of its doctors. Her immediate view, however, was that the patient must have been mistaken because examinations entail an array of sensations and what the patient was accusing Hadden of having done was inconceivable.

An administrator at Columbia has reported that Dr. D'Alton shared effectively that view with her during the evening of Hadden's arrest. Specifically, in later recounting the events of that day to reporters, the administrator said that after she began notifying various senior Columbia administrators about the arrest, she received an "angry" call from Dr. D'Alton, who told her that "this was just a crazy patient" and asked her why she was "spreading this around." Dr. D'Alton has publicly denied making these comments, saying that she "did not downplay the seriousness of the matter, and . . . did not denigrate the patient."

Word of Hadden's arrest quickly spread to the highest levels of Columbia and NYP. Among others, the following senior executives of the two Institutions were told of the arrest that evening: Lee Bollinger, President of Columbia University; Dr. Steven Corwin, Chief Executive Officer of NYP; Dr. Robert Kelly, President of NYP; Dr. Lee Goldman, Columbia's Dean of the Vagelos College of Physicians and Surgeons (Columbia's medical school); Dr. Richard Liebowitz, NYP's Chief Medical Officer; Maxine Frank, NYP's Chief Legal Officer; and Jane Booth, Columbia's General Counsel.

The Boards of each Institution received informal notification of the arrest. President Bollinger forwarded along the email that had notified him of Hadden's arrest to William Campbell,

who was Chair of the Columbia Board of Trustees. Dr. Liebowitz called Arthur Hedge, the Quality Chair for the NYP Board of Trustees. Both trustees have since passed away.

Dr. Liebowitz recalls from his call with Hedge that Hedge instructed that evening that Hadden should not be allowed into the hospital and that a fast but thorough investigation should be done. But Dr. Liebowitz's memory of the conversation is not firm. His memory also includes that Hadden was, indeed, suspended from NYP per Hedge's supposed instruction, and that is incorrect; Hadden was not suspended. Apart from Dr. Liebowitz's tentative recollection of the conversation, we have identified no other evidence that Hedge gave the instruction that Hadden should be suspended pending an investigation.

The communications between the various leaders of the two Institutions on the evening of Hadden's arrest consistently reflected concern for Hadden and skepticism about the validity of the accusations. Dean Goldman recalls speaking with Dr. D'Alton and that she immediately defended Hadden, saying that Hadden had an impeccable reputation, which Dean Goldman credited because he trusted Dr. D'Alton's judgment. President Bollinger recalls that when he was notified of Hadden's arrest, he was told in substance that Dr. D'Alton had full confidence in Hadden. On the NYP side, Dr. Liebowitz recalls speaking directly with Dr. D'Alton, and that she expressed disbelief at the accusation against Hadden. And Dr. Kelly recalls being told—apparently by Dr. Evanko—that Hadden was considered to be a good guy and that the allegation could not be true. Dr. D'Alton also spoke with Brian Noonan, the Vice President of Claims and Litigation Management within NYP's legal department, and Jane Booth, Columbia's General Counsel.

At around 8 p.m., Dr. D'Alton reported from the police station that an attorney sent by Columbia had arrived and was with Hadden. Dr. D'Alton remained at the police station—where

she waited with Hadden's family and was in regular communication with Booth—until Hadden was released around midnight.

Hadden was not charged prior to his release, and throughout the evening there was uncertainty whether he had officially been "arrested" at all. At least at the outset, Dr. D'Alton believed that Hadden had not been arrested and had simply been asked to go to the police station to be questioned. Similarly, Andria Castellanos (a Senior Vice President for NYP) told Dr. Kelly in an email later that evening, after Hadden had arrived at the police station, that it was "[s]till not clear if [Hadden] is being arrested."

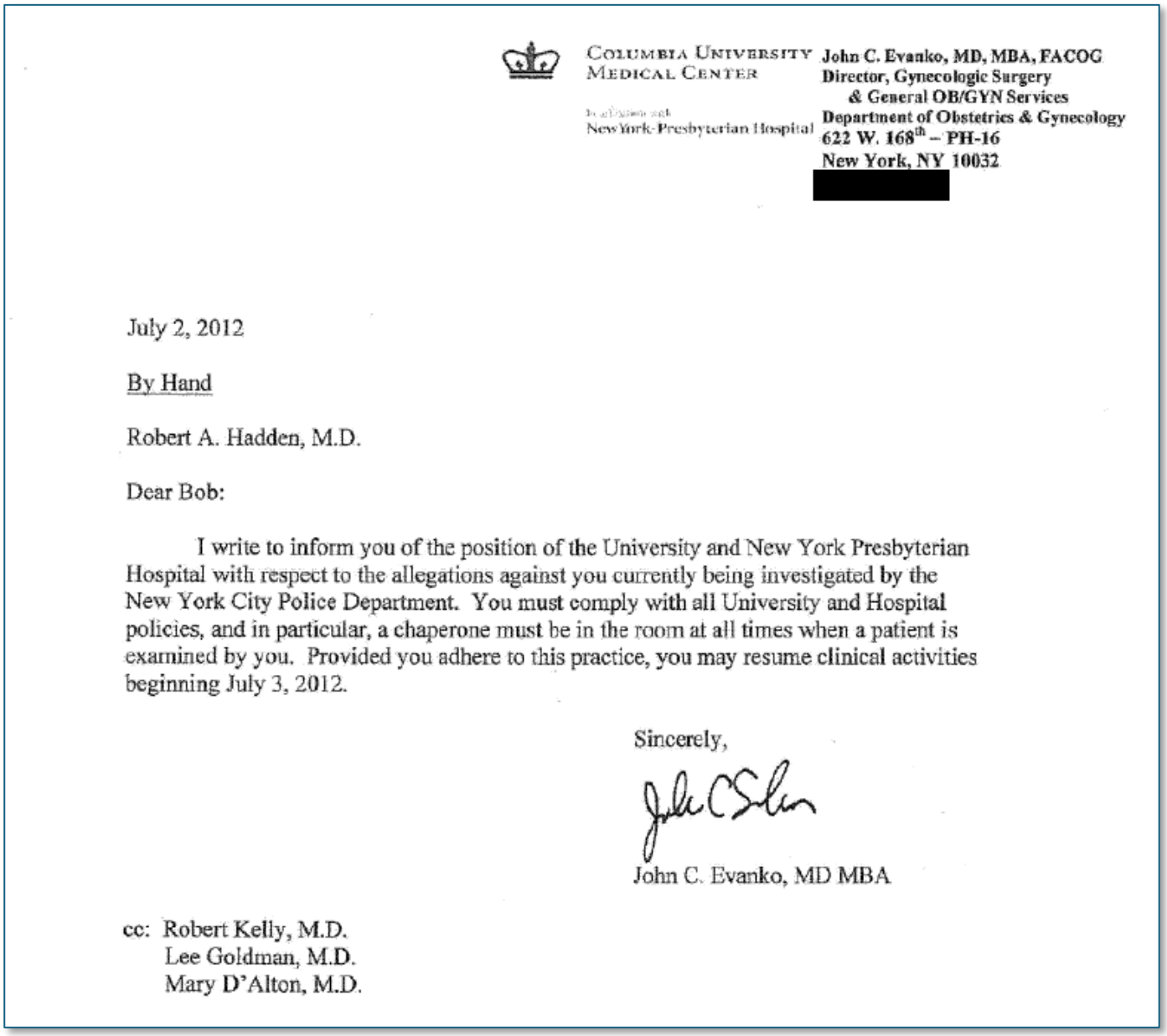
Whatever the official label, however, for Hadden's trip to the police station and subsequent departure uncharged, it was communicated to various senior executives at each of the Institutions that law enforcement's investigation into the event would continue. For example, when Dr. Evanko informed Castellanos and Dr. Kelly at the end of the night that Hadden "was just released," he added that there were "no charges" but that the police would "continue to investigate." Other senior administrators at NYP were similarly aware that the investigation would continue, as were senior Columbia administrators and Dr. D'Alton.

On Saturday afternoon, Hadden expressed his appreciation to Dr. D'Alton for her assistance the prior evening, emailing her: "Again, words can not express my gratitude for all your support." She responded: "[P]lease it is my pleasure to be able to [do] anything."

CHAPTER 6
HADDEN'S RETURN TO WORK AND AFTERMATH

I. Hadden's Return to Work

Four days after Hadden's arrest, he was permitted to return to work, provided he adhere to the policy requiring that chaperones be present during his examinations. A letter informing him of that condition was delivered to Hadden on Monday, and he returned to work on Tuesday.



COLUMBIA UNIVERSITY MEDICAL CENTER
New York-Presbyterian Hospital

John C. Evanko, MD, MBA, FACOG
Director, Gynecologic Surgery
& General OB/GYN Services
Department of Obstetrics & Gynecology
622 W. 168th – PH-16
New York, NY 10032
[redacted]

July 2, 2012

By Hand

Robert A. Hadden, M.D.

Dear Bob:

I write to inform you of the position of the University and New York Presbyterian Hospital with respect to the allegations against you currently being investigated by the New York City Police Department. You must comply with all University and Hospital policies, and in particular, a chaperone must be in the room at all times when a patient is examined by you. Provided you adhere to this practice, you may resume clinical activities beginning July 3, 2012.

Sincerely,

John C. Evanko, MD MBA

cc: Robert Kelly, M.D.
Lee Goldman, M.D.
Mary D'Alton, M.D.

The conversations about how to handle Hadden's potential return to work began at least as early as the Saturday morning after his arrest and primarily involved Columbia leadership, including Dr. Lee Goldman (Dean of Columbia's medical school), Dr. Mary D'Alton (Chair of the OB/GYN Department), and Dr. John Evanko (Chief of the General OB/GYN Division). These leaders also consulted repeatedly with Columbia's in-house lawyers, Jane Booth and Patricia Catapano, who in turn consulted repeatedly with Columbia's outside counsel.[24]

Individuals at NYP also learned of Hadden's arrest on Friday and were in communication that evening with NYP's Chief Legal Officer, Maxine Frank. Senior administrators at NYP recall concluding that the decision about whether Hadden should return to work belonged principally to Columbia. Dr. Robert Kelly (President of NYP), for example, recalls a general feeling among NYP leadership that Columbia was dealing with the issue because it involved a Columbia doctor in a Columbia space. And Dr. Steven Corwin (CEO of NYP) recalls that the decision belonged to Columbia and that he viewed NYP as going along with it. Columbia officials, for the most part, recall having viewed it as a joint decision. Consistent with that view, the letter Dr. Evanko signed notifying Hadden of the condition of his return explained that it was informing Hadden of "the position of the University and New York Presbyterian Hospital."

Although the witnesses' recollections of the conversations on the Saturday and Sunday following Hadden's arrest are not perfectly consistent, it is clear that there were a large number of conversations that weekend about Hadden's return to work. None of those conversations, however, appears to have involved a debate about whether Hadden would return to see patients. The Investigation Team is not aware of any evidence, beyond Dr. Liebowitz's individual recollection

[24] We have not included privileged material in this Report, and nothing in the Report is intended to waive any applicable privilege, including but not limited to the attorney-client privilege and work product protection.

about a conversation with Arthur Hedge (described in Chapter 5), that anyone advocated for Hadden to be placed on leave or otherwise not return to work. At NYP, Dr. Corwin recalls that at the time Hadden was arrested, NYP did not have a procedure to place a physician on temporary leave pending an investigation, and he has no recollection of any discussion surrounding Hadden's suspension that weekend. He believes that had there been a discussion of placing Hadden on leave at that time, there would be a record of it, because potentially placing Hadden on leave would have been significant. Dean Goldman recalls that no one suggested that Hadden should not return to work. The focus of the weekend, he recalls, was not whether to keep Hadden from returning but, rather, how to ensure guardrails were in place while more information was being gathered.

Moreover, no significant investigation into Hadden's conduct was performed over that weekend or prior to permitting Hadden to return to work. On the evening of the arrest and over the weekend, Columbia and NYP administrators asked Dr. Evanko and Dr. D'Alton their views of Hadden. But over that weekend, no one had yet reviewed Hadden's files. There also had only been a brief conversation with the medical assistant, who in any event was not in the room for the events at issue, and no one had interviewed the other doctors, medical assistants, or other professionals who worked with Hadden during his career. No one at the Institutions had interviewed Hadden about the incident either, beyond the receipt of his brief denials on Friday afternoon, nor had anyone insisted that he be interviewed before he could return to work. In fact, even after returning to seeing patients, Hadden rescheduled and resisted his own interview for weeks, and it never took place.

In addition, although Dr. D'Alton knew the full scope of the allegation—that Hadden had licked a patient's vagina—other decisionmakers recalled being uninformed as to the full nature of the allegation at the time they made their decision. For example, Dean Goldman recalls

understanding that there was inappropriate behavior or touching, but not knowing the details or whether anyone else was present in the room.

Senior administrators recall placing great weight on Dr. D'Alton's assurances that she had known Hadden for a long period of time, that there had been no prior complaints against him, that he was of high character, and that it was inconceivable that he had done what the patient had alleged. For example, President Bollinger recalls that Dr. D'Alton expressed full confidence in Hadden, which he found meaningful because he felt Dr. D'Alton was exceptional and would never allow misconduct in her department. Dean Goldman likewise recalls that Dr. D'Alton reached out to him soon after the arrest, expressing her shock and saying that Hadden had an impeccable reputation. Dean Goldman recalls that this was meaningful to him because he, too, trusted Dr. D'Alton's judgment and believed she had a history of selecting the right personnel.

Dr. D'Alton's own recollection of the decision to permit Hadden to return to work is not inconsistent with these accounts, although she recalls relying on other leaders involved too. She recalled that the decision was made in light of: Hadden's denial of the allegations; the fact that the allegations were otherwise not known to be true; and her understanding that Hadden not only had no previous record of misconduct and no prior complaints, but had an excellent track record.

Columbia's outside counsel—herself a former sex crimes prosecutor at the Manhattan District Attorney's Office—recalls that, at some point on Sunday of that weekend, she reached out to the chief of that office's sex crimes unit, whom she knew well. Outside counsel recalls that, during that conversation, the chief of the sex crimes unit confirmed that Hadden's arrest had been voided.[25] She recalls that the chief of the sex crimes unit also confirmed that the investigation was

[25] The term "voided arrest" refers to a situation in which the District Attorney's Office does not immediately file charges, despite the initial arrest.

ongoing. Outside counsel also recalls that she informed the chief of the sex crimes unit that Columbia was considering allowing Hadden to return to work on the condition of being chaperoned, and she recalls that she asked whether the District Attorney's Office had any concerns. Outside counsel recalls that the chief of the sex crimes unit raised no affirmative objection, and she believed that if the chief of the sex crimes unit had a concern about Hadden returning to work she would have said so. We understand that this conversation was not memorialized, and the former chief of the sex crimes unit declined to speak with us.

Dr. D'Alton recalls that she reviewed Hadden's departmental file on Monday morning. She recalls seeing in the departmental file the 2000 "note to the file" stating that her predecessor as OB/GYN Department Chair, Dr. Rogerio Lobo, had "discuss[ed] allegations that [Hadden] was involved in the inappropriate use of the computer during normal work hours," but she does not recall seeing the letter from her other predecessor, Dr. Harold Fox, responding to the detailed 1994 patient complaint about Hadden's inappropriate conduct during an examination. Catapano (a lawyer in Columbia's legal department) likewise recalls going to the OB/GYN Department on Monday and reviewing Hadden's departmental file. The Director of Patient Services at NYP also recalls looking for prior complaints against Hadden at some point and determining that none existed.

Also on Monday, Columbia's outside counsel conducted a telephonic interview of the medical assistant who had been present for the first part of the examination that led to Hadden's arrest. But that medical assistant was not Hadden's regular medical assistant—she had merely been covering for Hadden's regular medical assistant on that day—and Hadden had already conceded to Dr. D'Alton that he had performed the examination at issue after the medical assistant had left the room. No one interviewed other medical assistants before letting Hadden return to work.

By Monday afternoon, the proposed letter to Hadden regarding his return to seeing patients was in final form. The letter—included in full form above, signed by Dr. Evanko, and copied to Dr. Kelly, Dean Goldman, and Dr. D'Alton—stated that "the position of the University and New York Presbyterian Hospital" was that Hadden could "resume clinical activities" the following day, provided that he "comply with all University and Hospital policies, and in particular, [that] a chaperone must be in the room at all times when" Hadden examined a patient.

It was determined that Dr. Evanko should present the letter to Hadden in person to convey its seriousness, so on Monday afternoon Dr. Evanko met with Hadden and delivered the letter. During that meeting, Dr. Evanko discussed the specifics of the letter and endeavored to convey the seriousness of its contents to Hadden. Also on Monday, Dr. Evanko discussed the letter with the site manager of the Columbia office at Herbert Irving Pavilion on the CUIMC campus, directing her to make sure that a chaperone would be available to be with Hadden at all times. The OB/GYN Department Administrator recalls similarly telling that site manager that Hadden was not to be alone with a patient after his arrest.

Hadden resumed seeing patients the next day.

II. Hadden's Continued Abuse

Hadden's first day back at work after his arrest was Tuesday, July 3, 2012. Over the next five weeks, Hadden continued seeing patients and continued his abuse. During that time, chaperones were instructed to accompany Hadden during examinations. At least one medical assistant was instructed by her supervisor not to leave Hadden unsupervised in an examination room with any patient, at any time. In addition, the site manager of the East 60th Street office recalls a greater focus on chaperones within the department more generally. While the preexisting chaperone policy was reemphasized, including to medical assistants, and Dr. Evanko recalls

checking in with staff, ultimate responsibility for Hadden's compliance with the policy appears to have rested with Hadden.

Multiple patients have subsequently reported that Hadden assaulted them during the five weeks when he saw patients after his arrest. One patient provided an account, in proceedings before the federal court in which Hadden was convicted, of an assault that occurred on July 3, 2012, Hadden's first day back at work, during an examination she recalls being unchaperoned. In her written statement to the court, she expressed her shock that Hadden was permitted to return to his office just four days after his arrest, given the information that was known to management. Another survivor explained to the Manhattan District Attorney's Office that, on July 31, 2012, Hadden forcibly pulled her pants and underwear down while he talked about the appearance and shape of her body. Hadden thereafter "cupp[ed]and manhandl[ed]" her buttocks, hips, and vagina and, without wearing gloves, put his fingers in her vagina. She reported to the District Attorney's Office that no chaperone was in the room during that encounter. A third patient similarly told the federal judge overseeing Hadden's criminal trial that she was assaulted by Hadden a "couple of weeks [after] he was allowed to come back to work." A fourth patient has filed a civil complaint alleging that, in July 2012, Hadden performed a vaginal examination with such force that her membranes broke and she went into labor. Then, at a subsequent appointment in August 2012, Hadden pulled, tugged, and squeezed her nipples until breast milk was expressed.

During the five weeks when Hadden practiced following his arrest, appointment records show that he saw more than 350 patients. While they do not specify the date of abuse, more than 20 of these patients have filed civil complaints alleging that Hadden abused them.

III. Hadden's Refusal to Be Interviewed and Leave of Absence

By the morning after his arrest, Columbia's in-house counsel's office, consistent with Columbia's practice and the apparently general disbelief that Hadden had done what he was

accused of, took steps to arrange a criminal defense attorney for Hadden. By the end of the weekend, Hadden had selected one of two attorneys proposed by Columbia's outside counsel. His attorney's fees would be paid by Columbia.

Columbia's outside counsel thereafter requested that Hadden sit for an interview with Columbia—to be conducted by outside counsel and others—about the allegations underlying the arrest. But, at the same time that Hadden continued to see (and abuse) patients over these five weeks, he and his counsel repeatedly avoided allowing Columbia to interview him about the incident that led to his arrest. Columbia's outside counsel requested that Hadden's interview be scheduled for July 23, 2012. Hadden's attorney agreed to the interview but responded that Hadden was unavailable until July 26, 2012, and the interview was scheduled for that day. Then, on July 25, 2012, Hadden's attorney requested that the interview be delayed due to a medical issue with a member of her family. On August 6, with no new date having yet been selected, Hadden's attorney informed Columbia's outside counsel that she wanted to put off rescheduling the interview until the results of a DNA test being conducted by law enforcement were returned.

The next day, Tuesday, August 7, 2012, proved to be the last day on which Hadden saw patients at either of the Institutions. On Friday, August 10, 2012, with no notice, Hadden prospectively called in sick for a two-week period, to be followed by a two-week vacation. Hadden informed Dr. Evanko that he would be out as the result of stress.

Despite Hadden being out, Columbia's outside counsel reiterated Columbia's request to interview Hadden, and his attorney continued to decline. In light of that refusal, on August 17, 2012, Columbia's outside counsel sent a letter to Hadden's attorney on Columbia's behalf, copied directly to Hadden at his home address, informing Hadden that if he "refuse[d] to consent to . . .

an interview, that refusal may affect his employment status with Columbia University and Columbia's willingness to continue to pay his legal fees."

Approximately one week later, on August 23, 2012, after having consulted with Booth and Catapano (who in turn had consulted with outside counsel), Dean Goldman made the decision that, in light of Hadden's refusal to cooperate, Columbia should cease paying Hadden's legal fees and suspend or terminate him. Accordingly, that same day, Columbia's outside counsel sent another letter to Hadden's attorney, stating:

> In view of Dr. Hadden's refusal to cooperate with the University in its investigation of this matter, the University will not permit him to return to patient care duties on September 4 after his current vacation. The University will also discontinue support of his legal expenses after August 22, 2012.
>
> If Dr. Hadden wishes to apply for a leave without pay, he should write to his Chair, Dr. Mary D'Alton, or if he feels that he cannot continue patient care responsibilities for medical reasons, he should apply for a medical leave. To do so, he should contact [the Department Administrator]. If Dr. Hadden does not voluntarily absent himself from work, the matter will be referred to the New York Presbyterian Hospital Medical Board.

By August 31, 2012, Hadden had at least informally requested a 60-day medical leave. On September 26, 2012, Hadden's request for medical leave was granted, effective September 4 through November 1, 2012. Under provisions of Columbia's Faculty Handbook, Hadden was entitled to up to six months of medical leave with salary.

The August 23rd letter to Hadden's attorney stated that if Hadden did not absent himself from work, the matter would be referred to the NYP Hospital Medical Board. Hadden did absent himself, and he was not brought before the Medical Board. Had there been a referral to the Medical Board, it could have involved an investigation of the allegations against Hadden and discipline by the Board. Further, under New York's Public Health laws, a suspension, restriction, or termination

of employment or privileges by a hospital would have triggered reporting to New York State regulatory bodies.

IV. Hadden's Non-Renewal and Extended Medical Leave

Hadden's employment at Columbia, and his privileges at NYP, continued during this period. On August 9, 2012, the day before he first called in sick, NYP granted Hadden his biennial reappointment, with admitting privileges, through June 30, 2014. The process leading to that reappointment had begun before his arrest, but there is no indication in the letter conveying the reappointment or elsewhere that consideration was given to halting the process in light of the accusation that he had sexually assaulted a patient and had been arrested.

Hadden remained on paid medical leave until December 2012, when Columbia notified him it was declining to reappoint him to Columbia's medical faculty upon the expiration of his existing appointment on June 30, 2013. Accordingly, on December 20, 2012, Dr. D'Alton wrote Hadden the following letter informing him that his employment would expire either on June 30, 2013, or—since Columbia's policy was not to terminate employees while they were on medical disability leave—on whatever date thereafter Hadden ceased to be medically disabled:

> I regret to inform you that your appointment as Assistant Clinical Professor of Obstetrics and Gynecology in the Department of Obstetrics and Gynecology will not be renewed beyond June 30, 2013.
>
> It is noted that you are currently on a medical disability leave from Columbia University. Your appointment as an Assistant Clinical Professor will continue until June 30, 2013 or until a physician indicates that you are medically able to return to work, whichever is later.
>
> We deeply appreciate the skill and care with which you have served the Department of Obstetrics and Gynecology.

Following this notification, Hadden's paid medical leave was further extended multiple times until March 3, 2013. Hadden was to be placed on unpaid medical leave from Columbia

starting March 4, 2013, but he applied for and was granted long-term disability instead. On April 24, 2013, Columbia sent a letter to former patients of Hadden notifying them that Hadden had "closed his private practice at Columbia University Medical Center," and offering those patients the opportunity to switch to another physician in the practice. As of June 4, 2013, Hadden's privileges at NYP were terminated.

Hadden remained on long-term disability until early June 2014. Finally, on June 11, 2014, Dr. D'Alton wrote Hadden a letter advising him that he had been deemed medically fit to return to work and, as a result, his appointment was being terminated effective immediately pursuant to the terms of her December 20, 2012 letter. She also advised Hadden that he was eligible to retire from Columbia and could contact the Benefits Department with questions about that process.

V. Legal Aftermath

A. Prosecution by the Manhattan District Attorney's Office (2012–2016)

Shortly after Hadden's arrest in June 2012, the Manhattan District Attorney's Office began investigating the allegations made by the patient who had reported him to the police. In June 2014, after further survivors came forward, the District Attorney's Office indicted Hadden and charged him with five felonies and four misdemeanors, including forcible touching, criminal sex acts, and sexual abuse against six individuals. The District Attorney's Office later filed a pre-trial motion seeking the court's permission to offer evidence at trial of assaults it said Hadden had committed against 19 other survivors. In February 2016, Hadden pleaded guilty to a subset of the crimes charged: committing a criminal sexual act in the third degree (a felony); and forcible touching (a misdemeanor). In doing so, Hadden specifically admitted to oral sexual conduct against the patient who reported him to the police and the forcible sexual touching of another survivor. He agreed to surrender his New York State medical license and not to seek licensure in any other jurisdiction. In exchange, the District Attorney's Office agreed not to prosecute Hadden for any similar crimes

known to the District Attorney's Office as of February 22, 2016. Hadden was sentenced to "zero days" time served and a one-year conditional discharge, and he was prohibited from practicing medicine.

B. Prosecution by the United States Attorney's Office (2020–2023)

In September 2020, eight months after a survivor appeared on CNN to recount the abuse she suffered from Hadden, a federal grand jury in the Southern District of New York indicted Hadden, charging him with the federal offense of inducing patients to travel across state lines so that he could sexually abuse them.

Hadden was tried by the United States Attorney's Office in federal court in January 2023. Over the course of two weeks, nineteen witnesses testified, including the four survivors underlying the four counts submitted to the jury, four other survivors, two expert witnesses, a doctor who worked with Hadden, and two OB/GYN nurses. The jury found Hadden guilty on four counts of enticement and inducement to travel to engage in illegal sex acts. Hadden was sentenced to 20 years in prison, where he remains today.

C. Civil Suits Against Hadden, the Institutions, and Other Individuals

Since Hadden's arrest in June 2012, over 70 civil complaints related to Hadden's abuse, involving approximately 900 unique plaintiffs, have been filed in New York state and federal court. These complaints were filed both on behalf of individuals and putative classes of survivors. Some of the survivors filed complaints in their own names, while others chose to proceed under pseudonyms.

Between April 2013 and the January 2020 CNN interview, eight civil lawsuits related to Hadden's abuse were filed in New York state court and federal court. Between that interview and Hadden's federal sentencing on July 25, 2023, another dozen civil lawsuits were filed in New York state court. Since Hadden's sentencing, approximately 50 additional civil complaints involving

hundreds of survivors have been filed in New York state court. Columbia and NYP have paid in the aggregate more than $1 billion in connection with settlements with survivors.

PART III
FACTORS THAT PERMITTED HADDEN'S ABUSE OF PATIENTS TO OCCUR AND CONTINUE

For 25 years, Hadden engaged in widespread and repeated abuse of patients. He did so in office and hospital settings, with others present and when he was alone with patients. He did so despite reports of his behavior to physicians, staff, and leadership. In this Part of the Report, we analyze factors that contributed to allowing Hadden's abuse to occur and to continue for as long as it did. Some of these factors were specific to Hadden, while others related to the Institutions where he worked and their policies, procedures, and culture.

In **Chapter 7**, we consider factors that undermined the efficacy of chaperoning as a mechanism to prevent and detect Hadden's wrongdoing. In particular, we observe that no policy mandated chaperones before 2007, and that the policy that was implemented in 2007 failed to achieve its intended goals. That is because chaperones were not trained to effectively detect and report sexual abuse and because the program was under-resourced and not enforced.

In **Chapter 8**, we consider factors that presented obstacles to patient and staff reporting of physician misconduct. Some of the impediments arose from Hadden's own conduct: He crafted a positive image and reputation that discouraged patients from reporting him, and he abused vulnerable patients who were less likely to report him. He also benefited from the effect that the prestige and power of Columbia University and NYP had in dissuading patients from making complaints, and from a hierarchical culture within the Institutions that made staff wary of reporting a doctor. Columbia did not implement a complaint-reporting system that could have offset these obstacles; at the time, Columbia lacked policies for how its outpatient facilities should receive, handle, and maintain records of patient complaints.

In **Chapter 9**, we consider the failure of the Institutions to respond effectively to reports and complaints they received about Hadden's misconduct. Columbia in particular lacked coherent recordkeeping systems to track reports and complaints, which otherwise might have allowed supervisors or leaders to recognize an ongoing problem. It also lacked an effective system for resolving patient complaints, which resulted in *ad hoc* decisionmaking in an environment in which deference to physicians like Hadden was the cultural norm. And NYP's physician recredentialing processes, which putatively included consideration of complaints, did not effectively incorporate reports of physician misconduct, in significant part due to recordkeeping failures.

CHAPTER 7
FACTORS RELATING TO CHAPERONES AND DETECTION OF WRONGDOING

Sexual assault committed under the guise of medical care in the privacy of a doctor's office or hospital room can be difficult to detect and prevent. But, as the American College of Obstetricians and Gynecologists ("ACOG") has observed, a third party or "chaperone" in an examination can serve as a witness for potential misconduct and "deter or discourage sexual misconduct by physicians."[26] In fact, since 2007, Columbia physicians practicing at either Columbia or NYP facilities have been required to have a chaperone present for certain OB/GYN examinations. Even after this requirement was instituted, however, at least during Hadden's tenure, chaperones were often not available because of staffing challenges, and it appears that chaperones did not receive training that would have helped them identify, guard against, and report problematic conduct. Even when chaperones were available, Hadden was able to evade them, in part because there was no systematic mechanism for monitoring or enforcing compliance with the policy that required their presence. The changing approach to chaperones, the failure to train on and enforce the chaperone policy, and Hadden's evasion of chaperones undermined the ability of chaperones to detect and prevent Hadden's abuse.

I. The Chaperone Policy Evolved Over Time

For most of Hadden's career, from 1987 until January 2007, neither Columbia nor NYP had a formal policy that required chaperones in OB/GYN examinations. Indeed, ACOG—which appears to have begun recommending the availability of chaperones in August 2007—recognized at the time that "[l]ocal practices and expectations differ[ed] with regard to the use of chaperones"

[26] ACOG, Committee Opinion No. 796: Sexual Misconduct (Jan. 2020) (superseding Opinion No. 373), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/01/sexual-misconduct.

at that time.[27] Nonetheless, even though not required, a third party was often present during some examinations. A doctor conducting a pelvic examination, for example, might have the assistance of a nurse or a medical assistant to hand them instruments and gloves or process a specimen for testing. But for this period, the presence of that nurse or medical assistant was at the doctor's discretion.

During this pre-policy period, individual practices of physicians at the Institutions with respect to chaperones—and the understanding of physicians and staff concerning when chaperoning was appropriate—varied widely. Some male physicians, in particular, made it their practice not to examine a patient without a chaperone. One female physician in the general OB/GYN practice similarly understood that male doctors would have generally tried to have a chaperone for exams, but female doctors would not. One administrator, on the other hand, understood that sometimes patients could decide if they wanted a chaperone to be present. And a former nursing supervisor recalled that, in the 1990s, only those physicians with the busiest practices, who therefore needed help to keep their days moving, were assigned medical assistants. This practice dovetailed with another nurse's recollection that the chaperone role was most frequently discussed during the pre-2007 period as providing assistance to the doctor, rather than chaperoning the patient. It is clear that many examinations during the pre-2007 period were not chaperoned at all.

A mandatory chaperone policy was instituted in 2007 for certain OB/GYN examinations. On its face, the 2007 Chaperone Policy was a "New York Presbyterian Hospital Division of Obstetrics Perinatal Practice Guidelines" policy, that made reference to "Labor and Delivery," a

[27] ACOG, Committee Opinion No. 373: Sexual Misconduct (Aug. 2007) (superseded by Opinion No. 796).

ward of the hospital. Other evidence indicates, notwithstanding the content of the document, that the Chaperone Policy may have been a Columbia policy rather than an NYP policy. A December 11, 2007 memorandum regarding the Chaperone Policy authored by Dr. Mary D'Alton and the Department Administrator refers to the policy as "[t]he Department's policy" and was distributed to "[a]ll practicing physicians and staff at East 60th Street and Irving 4," which were two Columbia office locations.

In any event, the Columbia physician who served as Director of Quality Assurance and reviewed the 2007 Policy before it was issued recalls that, regardless of which Institution formally promulgated the policy, the intention was that all Columbia OB/GYN doctors were required to adhere to it at any location where they were seeing patients. Dr. D'Alton—whose position as the Columbia OB/GYN Department Chair simultaneously made her NYP's OB/GYN Service Chief—likewise recalls that the policy was intended to apply to Columbia OB/GYN physicians everywhere. Indeed, the memorandum in December that year stressed that "[i]t is imperative that all practices at all sites adhere to this [chaperone] policy," and, similarly, an email reminder sent to staff at both Columbia and NYP at the end of 2007 directed that "for PAP and other invasive exams, there MUST BE A CHAPERONE IN THE ROOM."

Even after the implementation of the policy in 2007, however, the role of a chaperone was sometimes framed in terms that emphasized assistance to the doctor, maintaining appropriate records, or providing a witness to defend the physician against false accusations. For example, in a 2008 email, Dr. John Evanko, who was the Chief of the Division of General Obstetrics and Gynecology, expressed concerns to the Department Administrator about the chaperone policy and the risk that it might pose to doctors as written:

> I was also concerned about the language regarding males. I would not want to be a young female in the clinic with two males possibly

> a male med student learning in the room performing pelvic exams on me. I think it exposes the two males to risk because I do not think two males falsely accused of inappropriate behavior will be able to defend themselves to the same degree a male could with a female chaperone present. I think the policy as written puts the patient in the position of having to speak up or relies on the common sense of the docs. I think the policy could have covered this angle better.

This framing of the role of a chaperone as protecting the physician may not have given sufficient emphasis to the importance of being vigilant witnesses and deterrents to physician misconduct.

II. Chaperone Shortages Undermined the Efficacy of the Chaperone Policy

In practice, chaperones were not always available to fulfill the requirements of the policy. While not a universal experience, many doctors recall that staffing levels and the availability of medical assistants to chaperone were ongoing challenges. In outpatient settings, this condition may in part have resulted from the range of responsibilities performed by the medical assistants, who were often also called upon to serve as chaperones. In addition to serving as chaperones, medical assistants' duties included cleaning and preparing examination rooms, obtaining information from the patient, and processing specimens. Moreover, doctors often used multiple examination rooms to see patients on the same day, which could leave a single medical assistant responsible for two or three rooms. The result was that while the medical assistant cleaned the room after an examination of a patient, the doctor might already have moved on to performing another examination of a different patient in another room. In this structure, as one physician recalls, one medical assistant per doctor was not enough and staffing shortages could make it physically impossible for medical assistants to perform all of the tasks expected of them. As a physician recalls, in a busy practice, there was a tension between efficiency and chaperoning that forced a choice between waiting to see patients or proceeding to see them without a chaperone.

In March 2008, shortly after the policy was announced, Dr. Evanko described in an email a meeting at NYP's Allen Hospital, in which application of the chaperone policy to NYP's Ambulatory Care Network ("ACN"), a network of outpatient facilities, was discussed. Dr. Evanko pointed out that the policy did not "appreciate the realities of ACN," and that while he "wholeheartedly agree[d] with the intent of the policy, the docs often do not have readily available [medical assistants] and now they will be confronted with seeing patients or breaking policy."

Staffing levels were doubled at some point to two medical assistants per doctor, but there are indications that the availability of chaperones continued to be a challenge for some time. In November 2012, years after the policy was instituted and months after Hadden's arrest, one of Hadden's physician colleagues wrote to Columbia department administrators that she had "repeatedly requested chaperones to no avail" and that while she agreed with the policy, she only had "a chaperone about 20% of the time."

III. Insufficient Chaperone Training Undermined the Efficacy of the Chaperone Policy

Even when a chaperone was present, monitoring a physician's conduct was not an easy task, since the medical assistants who chaperoned played so many roles simultaneously: readying rooms and performing other tasks that facilitated the visit, assisting the doctor performing the examination, and serving as a chaperone for the patient. It was also a delicate task, since the medical assistants were observing, and potentially reporting, the behavior of doctors, who were generally viewed as ranking above the medical assistants in the overall medical hierarchy.

There is little evidence that, even when required to be present as chaperones, any training medical assistants received prepared them for these complexities in the chaperone role. Medical assistants were expected to arrive at Columbia with some basic knowledge or education about how to be a medical assistant, and they shadowed more senior medical assistants or nurses in their department as part of the onboarding process. We are aware of no trainings, however, that

addressed the kinds of behaviors that chaperones should watch for or view as red flags during OB/GYN examinations.

As a result, chaperones likely did not observe some of Hadden's conduct, and may not have recognized it as troubling if they did see it. Indeed, several survivors reported that during their visits with Hadden, the medical assistant in the room looked down or turned away from what Hadden was doing. Consistent with these reports, a medical assistant who worked regularly with Hadden recalled that during examinations she did not look directly at patients; she recalled that patients did not like it when someone stared during an examination and the medical assistant considered it a privacy issue for the patients. Instead, she stood nearby in the room, and assisted Hadden with instruments, but she might or might not have been able to see the vaginal examinations he conducted of patients. And at least one nurse at NYP recalls behavior by Hadden that she found odd or strange, but that appears not to have registered as a warning sign, such as comments by Hadden about the length of patients' pubic hair. Targeted chaperone trainings, had they existed, would have provided a mechanism to communicate the patient protection role of chaperones and to encourage medical assistants to report physicians if there were concerns about their conduct.

The chaperone role was inherently challenging, to the extent it could require medical assistants to report the conduct of doctors. They worked with those doctors every day, and developed relationships with them; even an administrator who recalls believing that medical assistants would come forward with significant issues also saw that those working relationships would make doing so awkward for the medical assistants. In addition, doctors ranked above medical assistants in the hierarchy at Columbia. As set forth in more detail in Chapter 8, some medical assistants and nurses believed that any complaints that they raised about doctors would

not be heard because of that hierarchy, and some worried that it was the reporters, not the doctors, who would suffer consequences. Targeted chaperone trainings also would have presented an opportunity to address these concerns, to emphasize the importance of this role in protecting patients, and to empower potential reporters to take this difficult action when it was called for.

IV. Lack of Enforcement Undermined the Efficacy of the Chaperone Policy

Even after the chaperone policy was put in place, there was little in the way of monitoring or enforcing compliance with the policy during Hadden's tenure, or consequences when it was violated. Physicians were expected to comply with the policy, and that expectation was communicated. A site manager recalls that she tried to ensure that each physician had a medical assistant, and she recalls that a lead medical assistant was responsible for reporting any violations of the policy. But physicians and medical assistants recall no system—like the one used today requiring a patient's chart to reflect the presence of a chaperone—that was in place when Hadden saw patients to monitor or enforce compliance with the chaperone policy. As discussed below, Hadden was able to evade the chaperone policy repeatedly and without apparent consequence.

V. Hadden Conducted Unchaperoned Examinations

Even when chaperones were required and available, Hadden avoided having them present when he was with patients. As explained in Chapter 3, he scheduled patients before or after normal office hours, for example. While some patients and staff understood this practice to be an accommodation to busy patients, it meant that there were no chaperones available when those appointments occurred. Notably, however, "special scheduling" and "seeing a patient outside normal office hours" were listed as "early indications" of potential "inappropriate behavior" by

ACOG in its 2007 guidance on sexual misconduct.[28] Two staff members recall that, at some point, a site manager asked Hadden to stop this practice because it created safety or liability issues. One medical assistant recalls that Hadden did stop seeing patients before or after normal business hours after a time, but another medical assistant recalls that Hadden did not change his behavior in response to the site manager's comment. This medical assistant would in some instances discover that Hadden had seen a patient early in the morning only when she found a specimen from the examination waiting for her to process.

Even when medical assistants were in the office, Hadden evaded them. As one medical assistant who was also a survivor told a court, Hadden would wait outside examination rooms until she was distracted and could not chaperone, and only then enter patient rooms. Hadden also repeatedly evaded chaperoning by conducting a patient's examination in the presence of a chaperone, then ending that examination and allowing (or instructing) the chaperone to leave, only to re-initiate a second examination without the chaperone present by telling the patient that he had "forgotten" something, or that he had to check one more thing. With the chaperone then gone, Hadden abused the patient.

An early example of this conduct was the subject of testimony during Hadden's criminal trial. A former nurse's aide stated that, in the late 1980s or early 1990s, she observed Hadden abuse a patient after assisting him with an annual examination including a Pap smear. After the Pap smear, the nurse's aide left the room to deliver the specimen to a different location and moved on to calling her next patient in a different room when she realized she had left her stethoscope behind. She returned to the room where Hadden and the original patient were, and when she stepped inside,

[28] ACOG, Committee Opinion No. 373: Sexual Misconduct (Aug. 2007) (superseded by Opinion No. 796).

she saw Hadden, red-faced, looking up, moving his right arm between the patient's legs, and she thought he was doing something in her vagina. The nurse's aide testified that the scene did not look right and that she stepped back out of the room and knocked more loudly before entering again.

Multiple patients have reported similar experiences, including the patient who contacted the police in 2012. At a postpartum appointment, Hadden examined her with a chaperone present and told her things looked fine, after which the chaperone left the room. Hadden then told her that he had forgotten to check something and that she should return to the examination table. At that point, he assaulted her, leading her to call the NYPD the same afternoon.

There is no evidence that Hadden faced consequences for evading the chaperone requirement. Patients say they were examined without chaperones, medical assistants were aware Hadden saw patients without chaperones, and a site manager in fact spoke to him about seeing patients before and after hours when chaperones were not available. And in 2012, when Dr. D'Alton arrived at the East 60th Street office on the day that Hadden was arrested and heard what had happened, Dr. D'Alton immediately realized that Hadden had violated the chaperone policy. Yet when he returned to work, he was instructed by letter to comply with applicable policies, including the chaperone policy. But there was no mention in that letter of the fact that he had already violated that policy, and there is no evidence that his violation caused particular concern about the efficacy of a chaperone as an effective safeguard when he returned.

* * *

Without an effective, systematic way to ensure the presence of a third-party chaperone during his examinations, Hadden was able repeatedly and over years to avoid witnesses to his conduct and to nullify any deterrent effect chaperones might have had. And even when a chaperone

was present, Hadden was able to take advantage of a lack of specific training and his authority to decrease the likelihood that the presence of a chaperone would result in detection or reporting of his misconduct.

CHAPTER 8
FACTORS THAT DISCOURAGED REPORTS OF MISCONDUCT

Although many survivors made efforts to register complaints about Hadden's conduct, patient reporting faced substantial challenges. Some of those challenges came from Hadden himself, and others from cultural or societal sources. But a significant barrier was the lack of structure regarding clear reporting channels and opportunities, and the absence of policies designed to account for natural obstacles to reporting of physician misconduct.

I. Hadden's Image as a Warm and Popular Doctor Discouraged Reporting

As noted in Chapter 3, Hadden cultivated an image as a warm and caring physician, which not only enabled his abuse but also helped protect him. He was known by patients and colleagues for his seeming warmth, for the amount of time he spent with patients, and for what seemed to be his popularity with patients. Many patients trusted him to listen to their concerns when other physicians could be dismissive.

Hadden's image brought new patients to him, since he was sometimes recommended in part based on how popular he was believed to be with existing patients. It also protected him by confusing patients whom he abused about what had actually happened to them. When patients were uncomfortable during their appointments with Hadden, at least some mistrusted their own experiences because Hadden had appeared to be so kind. They ended up doubting themselves and the notion that Hadden would harm them.

Staff at the Institutions also considered Hadden's reputation when deciding whether to speak up. One medical assistant, for example, heard whispers that Hadden was inappropriate with patients and even received expressions of discomfort directly from patients, but she was hesitant to believe the worst and report him. Among other things, this medical assistant found it significant that many patients who saw Hadden had returned to him for so many years and that other patients

and staff saw him and referred family members to him. Another medical assistant who worked with Hadden was herself abused when she saw him as a patient. Yet, as she later told a court in a written submission, she "questioned who was going to believe [her]" and worried that she had "no proof" and would "be humiliated or ridiculed by [her] peers" if she reported Hadden. As set forth in more detail in Chapters 5 and 6, the perception that Hadden was well-liked by patients who saw him and had never been a source of problems played an important role when decisionmakers assessed the allegations resulting in Hadden's arrest in 2012 and his denial that he had sexually assaulted a patient.

II. Patient Vulnerability Made Reporting More Challenging

Hadden abused vulnerable patients, and that vulnerability acted in some circumstances as an obstacle to reporting his abuse. All patients who see an OB/GYN physician are vulnerable to some extent, in part because of the power dynamic inherent in every doctor-patient relationship and in part because of the particular nature of OB/GYN care. The American College of Obstetricians and Gynecologists recognizes this challenge, explaining that the practice of obstetrics and gynecology "includes interaction in times of intense emotion and vulnerability for patients and . . . sensitive physical examinations and . . . disclosure of private information."[29]

In light of those sensitive subjects and examinations, some patients were reluctant to raise concerns about their examinations, even with the family or friends to whom they might ordinarily turn. Some patients were also uncertain about what was appropriate or inappropriate for OB/GYN care; patients expressed confusion about the propriety of Hadden's questions about their sexual

[29] ACOG, Committee Opinion No. 796: Sexual Misconduct (Jan. 2020) (superseding Opinion No. 373), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/01/sexual-misconduct.

activity, the proper parameters of a pelvic or breast examination, and the circumstances under which a rectal examination would be appropriate.

Many patients described particularly heightened concerns during pregnancy. Even when they had questions about Hadden's examinations, some patients pushed those reservations out of their minds because they were focused on ensuring the health of their unborn children. As one survivor put it in a written statement provided to a court, Hadden "had power over me by holding the health and wellbeing of my first unborn child in his hands. And he knew it." Another survivor, who had lost a previous pregnancy, said that her fear that something would be wrong with her unborn child drove her to continue attending appointments with him.

Beyond the inherent vulnerability of this group of patients, Hadden abused many patients who were particularly vulnerable in other ways. He repeatedly abused patients who were young and did not know what an OB/GYN visit should entail or did not have experience with other OB/GYN doctors to compare with Hadden's examinations. When one survivor saw Hadden at a young age, Hadden gave her a three-month supply of birth control with instructions to return when the pills ran out, then conducted a pelvic examination on each return visit, four times each year. This survivor did not know these exams were out of the ordinary because Hadden was her first gynecologist.

Finally, Hadden abused at least one patient who was in a very fragile economic situation; the patient had no housing and was living in her car. Hadden conducted a pelvic examination with such force and in such a manner that the patient was in pain for weeks afterward. When it came to reporting, however, the patient worried about whether anyone would believe her account over Hadden's.

III. The Prestige and Importance of Columbia and NYP Discouraged Reporting

Hadden's affiliation with Columbia University and NYP, and the status and importance of those Institutions to many patients, also affected patients' willingness to report his conduct, in at least two ways. First, many patients had difficulty believing a doctor at such prestigious and trusted Institutions would do anything so inappropriate. "I trusted the institution that trusted this doctor," one patient explained in a court submission. "[B]y being a patient at the famed Columbia University," another survivor said to the same court, she trusted that she was "receiving the best and most thorough care available for [her] and [her] unborn children" and that "Hadden was being screened, supervised and governed to provide that 'best' care." As a result, patients doubted their own experiences, and that doubt was an obstacle to reporting his abuse. "I was at one of the best hospitals in the country" and "never questioned whether they employed the best doctors," one patient explained to the court. "I just assumed it was a 'me' problem."

The special importance of Columbia University, in particular, deterred reporting in a second way. Many patients had significant ties to Columbia that extended beyond having Hadden as their doctor. They were students, employees, or had family associated with Columbia, and they hesitated to do anything that could endanger those important ties. One survivor worked at Columbia and feared that reporting Hadden would jeopardize her plan to get a degree from Columbia. Other survivors reported long, sometimes multi-generational, family histories that were intertwined with Columbia; they had enormous loyalty to the Institution and feared putting their family association with Columbia at risk, or hurting family members who had devoted themselves to Columbia. Finally, survivors who were employed by Columbia expressed fear that they would be disbelieved if they attempted to report Hadden's conduct and worried complaining would threaten their own employment and careers.

IV. A Hierarchical Institutional Culture Made Staff Wary of Reporting Hadden

Medicine is a hierarchical profession. In that hierarchy, physicians are widely viewed as ranking above non-physician staff like nurses, medical assistants, or administrative staff. Both a nurse at NYP and an administrator at Columbia, for example, recall physicians as occupying an exalted or god-like status. A senior staff member at Columbia likewise recalls Columbia struggling with deference to powerful figures, especially male physicians on the faculty. The nurse, the administrator, and the senior staff member all attributed this culture to some degree to the fact that physicians attracted patients and generated income. A physician in another Columbia department who saw Hadden as a patient, and whom he abused, likewise recalls a focus on billing and bringing in money for doctors at Columbia that was significant enough that the physician believes it skewed matters at Columbia. Some of these employees also noticed that the hierarchy at Columbia placed men at the top. Both the nurse and the physician who was also a patient recalled Columbia being an old boys' club; the nurse harbored questions about whether women would be believed; and the senior staffer had the sense that successful male physicians could do no wrong at Columbia.

Physicians and leadership at both Institutions acknowledge that a hierarchical culture existed, though they generally also view some hierarchy as necessary in the profession and believe that the culture has improved in the time since the events in this Report transpired. In any hierarchy, there can be fear of reporting superiors, and that was true at Columbia and NYP. Some physicians and administrative leaders at Columbia and NYP nevertheless believe that input from physician and non-physician colleagues was welcomed and encouraged. Dr. Mary D'Alton, the Chair of the Columbia OB/GYN Department and Chief of Service at NYP, recalls repeatedly encouraging people in the Department to make her aware of problems so that she could address them. Dr. John Evanko, who was Chief of the Division of General OB/GYN where Hadden practiced, believes that staff in fact felt comfortable talking with physicians in leadership and therefore would have

no problem raising complaints. An administrator who served as a site manager similarly believed that medical assistants would feel comfortable coming forward to report a physician, at least for something serious, despite the awkwardness of doing so. In fact, some physicians and staff did feel that they had a supervisor or other resource to whom they could escalate issues of concern that came up.

Many non-physician staff, however, felt differently. They believed that for a non-physician to speak up about a physician's conduct would be pointless, because either the reporter would not be believed or, even if the reporter were believed, action would not be taken against a doctor. A medical assistant who worked with Hadden, for example, was abused by him when she saw him as a patient. Yet, as she later told a court, when she thought about what she could do in response, she "questioned who was going to believe [her]." A nurse at NYP testified that she witnessed Hadden repeatedly abusing patients by conducting pelvic examinations in a manner that "seemed sexual," and left her "in shock" and wondering "what the hell" he was doing. She never made a formal report to NYP, though, because, as she testified at his criminal trial, "historically, there has always been a hierarchy between physicians and nurses, and [she] felt that [she] didn't have a voice." She thought nothing would happen to Hadden even if she did make a report.

Another non-physician who worked with Hadden was abused when she saw him for her own care. She did not report him because he was a doctor, and she believed he would be viewed as above her (and therefore presumably more credible) because of his title. She did not feel it was a comfortable environment for reporting, and when she had seen others report complaints she believed nothing had been done in response. Some physicians recognized this dynamic: One physician in the OB/GYN Department at the time believes that, before Hadden's arrest, medical

assistants would not have felt empowered to speak up about something that happened in an examination because of this hierarchy.

In addition to feeling that it would be pointless, non-physician staff feared retaliation if they reported a doctor. The Institutions lack current records confirming whether either had an applicable policy barring retaliation for reporting misconduct by a physician during much of Hadden's tenure. Beginning at least as early as 2010, Columbia did have a University-wide Administrative Code of Conduct, which instructed administrative officers to report activity that "may be illegal, unethical or otherwise troubling" and stated that "[t]he University prohibits retaliation against individuals who report or seek guidance on possible ethical or compliance issues in good faith." Columbia also had a non-retaliation policy beginning in 2003. Although Columbia was not able to locate a copy of the 2003 version of the policy, the 2009 version expressly prohibited retaliation against individuals only for registering complaints relating to the misuse of patient information under confidentiality laws such as HIPAA. On its face, it did not prohibit retaliation for any other types of complaints or reports. It is not clear whether Columbia had a non-retaliation policy specifically targeted at protecting medical staff who made reports of physician misconduct.[30]

NYP, for its part, had a general non-retaliation policy at least as early as 2004. That policy stated that "[e]mployees are protected from retaliation in any form and by anyone connected with NYP for reporting issues and concerns in good faith and on a timely basis." Similarly, compliance trainings for employees (from 2010 and 2011) describe the non-retaliation policy at the time as "assur[ing] all employees about their protection from any and all retaliation, when they come

[30] Columbia did have non-retaliation policies related to reports of sexual harassment targeted at students, faculty, and employees.

forward to report a potential compliance concern in good faith," and stating that "[r]etaliation, even by a physician, for reporting a potential compliance problem will not be tolerated."

In any event, it is clear that staff at Columbia and NYP remained concerned that reporting would result in adverse consequences, large or small, for the person reporting. For example, a medical assistant whom Hadden abused did not report his conduct because she did not want the animosity and problems she anticipated a report would bring, and she feared losing her job. Another medical assistant recalls believing that people were aware of Hadden's behavior but understood that no one wanted to be the whistleblower because she believed whistleblowers generally suffered consequences. A third medical assistant who was also a patient and whom Hadden abused worried that she would get fired or be ridiculed by her peers if she reported what Hadden had done to her. A nurse who worked at NYP believed that if she had been abused by Hadden—which she had not—she never would have reported it because doing so would have caused people to turn on her and try to find fault with her job performance. Even at the time of the Investigation Team's work in 2024 and 2025, by which time Columbia and NYP had long since implemented applicable non-retaliation policies, survivors who were affiliated with Columbia or NYP asked to speak in confidence and expressed concern about professional consequences if their names were connected to reports of the experiences they shared.

Patients also understood Hadden's status as a doctor and took it into account when considering reporting. Many were afraid that their accounts would not be believed. One patient thought that no one would credit an account of this kind of assault by a doctor. In a court submission, another patient, who was abused in the early 1990s, put it bluntly: "No one believed the victim in 1993." The immediate reaction to Hadden's arrest suggests that this skeptical attitude toward patient complaints continued into 2012.

The behavior of chaperones could reinforce these concerns in the minds of patients. One patient explained that when a chaperone was present during an exam, but did not say or do anything about Hadden's behavior, she concluded that the chaperone was not going to take the patient's side against a doctor.

V. At Columbia, the Lack of Clear Reporting Channels, and the Absence of Policies Governing Patient Complaints, Discouraged Reporting

During Hadden's tenure, Columbia lacked overarching policies for its outpatient facilities to govern recording and reporting patient complaints about a physician or to establish clear reporting channels for patients to raise their concerns.[31] Although it is possible that the passage of time has limited the available information, there is no evidence that any such policies existed until after Hadden's arrest. The lack of clear channels for patient complaints meant that, rather than compensating for the challenges patients experienced when contemplating making a report of physician misconduct, Columbia's policies—or lack thereof—formed an additional barrier to reporting.[32]

At least some patients never reported their complaints at all because they were unsure where to bring their concerns about Hadden. One former patient explained that Hadden had engaged her in sexual conversation about masturbation and other topics unrelated to her reason for a visit, all while his hand was on her leg or knee. She knew immediately that something was wrong and never went back to see him again. After the visit, she talked to friends but did not know whom

[31] For a period toward the end of Hadden's tenure and after, some information about overall patient satisfaction was solicited through an outside service called Press Ganey, which surveys patients about their experience. Department leadership, however, found the survey results did not provide a good measure of patient experience, in part because the survey was cumbersome to complete.

[32] As discussed in Chapter 9, NYP did have an applicable patient complaint system, though the lack of systematic record storage and information sharing limited the ultimate utility of that system with respect to discerning and preventing physician misconduct.

to tell at Hadden's office. She believes that if she had known whom to speak with about it, someone could have looked into what had happened and might have discovered Hadden's conduct. Even patients affiliated with the Institutions were unaware of reporting channels. A survivor who worked in the OB/GYN Department saw Hadden in the early 2000s, when he administered a breast examination that made her uncomfortable and asked intrusive questions about sexual positions. She did not know to whom to speak and recalls how difficult it was to report that kind of behavior.

As set forth in Chapter 4, many patients have indicated that they reported their complaints to medical assistants or to check-out staff as they left their appointments. Others raised their concerns with different physicians at subsequent appointments. There is no evidence that any policy existed during Hadden's tenure that guided physicians and staff on how to handle these complaints, on what information should be requested from a patient and memorialized, or on when a complaint should be escalated and to whom. Moreover, physicians in Hadden's department recall no training about how to make a record of a complaint received about a patient's office visit, or how to handle such a complaint, although many believe they would have told their division chief.

In practice, attempts by patients to complain about Hadden were met with a wide variety of responses. Some complaints, as discussed in Chapter 4, were memorialized and escalated to leadership. In other cases, however, physicians fielded a complaint but judged it too vague to merit action. Medical assistants sometimes heard a patient's concerns but dismissed or did not address them. One patient expressed concern to her friend, who was a medical assistant in one of the offices where Hadden worked, and the medical assistant dismissed that concern by telling the patient that the patient was not Hadden's type. In another situation, a patient told a different medical assistant about a concern that Hadden had conducted an inappropriate examination, and the medical assistant responded that if the patient felt that way, the patient should tell someone (even though

the patient had just done that). One patient who described complaining to a receptionist was given a number to call and did so, but explains that she was transferred and ultimately unable to speak with anyone in a position of authority. Another patient reported that she was given a paper and pen to record her complaint. In none of these examples does it appear that patients were directed to a system ready to receive and act upon their concerns.

CHAPTER 9
FACTORS RELATING TO INSTITUTIONAL RESPONSES TO REPORTS AND WARNINGS

Despite the obstacles that discouraged reporting of Hadden's misconduct, discussed in Chapter 8, some patients did report complaints about Hadden over his 25-year tenure, including, most dramatically, the complaint to the police that led to Hadden's arrest. Indeed, there is evidence that five complaints about Hadden's sexual misconduct reached physician leaders at the Institutions. In four of those cases, documentary evidence confirms that complaints reached supervisors: when a patient sent a letter to the Chair of the OB/GYN Department in 1994; when a patient's detailed account of inappropriate sexualized comments was escalated to the Division Chief in 2008; when a patient called the police and Hadden was arrested in 2012; and, while not a complaint by a patient, when an OB/GYN Department Chair was alerted in 2000 to Hadden's alleged use of a work computer to view pornography. Yet neither the complaints made by patients nor even the ones that documents confirm were elevated to supervisors caused the Institutions to intercede and stop Hadden's abuse.

In this chapter we consider the failure of the Institutions to respond effectively to reports and complaints they received about Hadden's misconduct. Columbia in particular lacked coherent recordkeeping systems to track reports and complaints, which otherwise might have allowed supervisors or leaders to recognize an ongoing problem. It also lacked an effective system for resolving patient complaints, which resulted in *ad hoc* decisionmaking in an environment in which deference to physicians like Hadden was the cultural norm. And NYP's physician recredentialing processes, which putatively included consideration of complaints, did not effectively incorporate reports of physician misconduct in significant part due to recordkeeping failures. These factors contributed to the institutional failure to act to protect patients from Hadden despite these reports of abuse.

I. Patient Complaints Were Not Stored in a Systematic and Accessible Manner and Columbia Lacked a Policy for Addressing Patient Complaints

A significant factor in the Institutions' failure to act to protect patients from Hadden, despite reports of his misconduct, was the lack of a coherent, centralized recordkeeping system for such reports within and across the Institutions, and the absence of a system for acting upon and resolving patient complaints at Columbia. By the time of the complaint to police in 2012, there had been a number of prior reports of misconduct by Hadden, but those reports were either absent altogether from available records or reflected only in ways that obscured the scope of what had been alleged. As a result, the true substance of prior allegations about Hadden was either unknown to decisionmakers or able to be perceived as involving isolated, immaterial events.

NYP and Columbia each handled their own records of complaints about physicians. The Institutions operated independently, and we are unaware of any system through which either Institution could access or search records of the other Institution in order to understand what historical complaints might have been received against one of its doctors by that other Institution. Had better procedures existed and been followed—particularly at Columbia—it seems likely that more complaints about Hadden would have been captured and a discernible pattern might have emerged.

A. NYP's Patient Complaint Systems

Within NYP, the mechanism for patients to submit complaints has generally been robust and well-identified. NYP has a dedicated Patient Services department that is responsible for receiving and acting upon such complaints. It receives complaints from patients and handles everything from concerns about doctors to reports of physical injuries suffered within the hospital. Nevertheless, not all complaints—including complaints about alleged misconduct by medical

personnel—made their way into the Patient Services system. In some instances, complaints were handled informally, or staff did not think to make a referral when they should have.

Despite the robustness of NYP's mechanisms for receiving complaints from patients, its systems for recording those complaints in a way that would allow for useful lookbacks—e.g., to search for a pattern of complaints against a particular medical provider—were inconsistent. There were numerous systems that changed over time. From at least 1990 to 1996, patient complaints were kept as physical paper records in the Patient Relations office, organized by the complaining patient's name rather than the subject of the complaint. In 1996, NYP shifted to an electronic documentation system, but this system was abandoned in or about 2001 due to technical difficulties. For the next 11 years, until 2011, NYP reverted to paper files. Since 2011, near the end of Hadden's tenure, NYP has used a system that stores patient complaints electronically on a closed system on which NYP's Patient Services creates entries. This system allows users to perform searches for complaints about any employee, including physicians and staff, but would not include some complaints from prior eras because they were not transferred wholesale into the new system.

B. Columbia's Patient Complaint Systems

During Hadden's tenure, Columbia lacked a structured system, with associated policies, for receiving, recording, resolving, and maintaining patient complaints.

As discussed above in Chapter 8, there was not an obvious, dedicated place to make a complaint, so individuals with concerns about medical personnel found their way to, among other places, various University-wide complaint departments that were not designed to deal with patient complaints. For example—although we have seen nothing about this related to Hadden specifically—there is evidence that some people with complaints about medical personnel registered those complaints with Columbia's Office of Equal Opportunity and Affirmative Action,

which existed to handle complaints by members of the Columbia community against faculty and staff, not patient complaints about medical care. Separately, a few individuals appear to have complained to a "compliance hotline" that Columbia established in 2006, which largely addressed issues like billing rather than complaints relating to patient care. In some instances, it appears that patients with complaints about their treatment at Columbia's outpatient facilities registered their complaints instead with NYP's Patient Services department (which forwarded at least some of those back to Columbia, but it is unclear if they did so in all cases or what happened with those complaints). No systematic recordkeeping process existed to ensure that patient complaints lodged in these various places would be consolidated in any centrally accessible file.

Without clear guidance on where to go, numerous patients with complaints about Hadden (as described in Chapter 4) made those complaints directly to a medical or administrative employee of the OB/GYN facility where they were treated. One example involved a patient's complaint in 2008 that, during an examination, Hadden made comments about her body that made her feel violated. As described more fully in Chapter 4, that patient did not make the complaint through any established channel, but instead to the site manager of the medical practice, who escalated it to the Department Administrator by email. The site manager told the Department Administrator that she also escalated the complaint to Dr. John Evanko, who was the Chief of the General OB/GYN Division. But that *ad hoc* process produced no formal record of the complaint or its resolution. The only written record appears to be the emails in the site manager's and Department Administrator's email accounts.

Other survivors have similarly reported making complaints of misconduct about Hadden directly to medical or administrative staff where they were treated. We did not discover any written records of those complaints, which may indicate that they were never formally recorded anywhere.

And beyond the complaints of misconduct against Hadden that survivors describe having made, there may well have been others over the years about which we are unaware entirely. No systematic recordkeeping process existed to ensure that such complaints would be consolidated or maintained in any centrally accessible file associated with the subject of the complaint.

Beyond the lack of a dedicated system for receiving and recording patient complaints about physician misconduct, there also appear to have been no clear system at Columbia for investigating, tracking, and resolving patient complaints against doctors during Hadden's tenure. As a general matter, employees have little recollection of specific reporting requirements or whether mechanisms existed to compile and track complaints. Staff likewise have little recollection of having received any training on patient complaints or recordkeeping.

Although the lack of a centralized effort by Columbia to track patient complaints persisted throughout virtually all of Hadden's career, Columbia did begin taking steps to implement such a system at the end of Hadden's career and has subsequently improved those systems. Specifically, in early 2012 (i.e., months before Hadden's arrest), a newly hired Director of Quality at Columbia began to track patient complaints in spreadsheets, although it was recognized that those spreadsheets were not capturing all patient complaints. Eventually, Columbia set aside the spreadsheet system and implemented a more robust event-reporting structure, discussed in Chapter 10.

C. Multiplication of Doctor Files Across the Institutions

Patient complaints—to the extent they were recorded—were generally stored by patient name rather than by the subject of the complaint. But even if a patient complaint or other disciplinary note about a doctor made its way into that doctor's file, there was no single doctor's file maintained across the two Institutions, and no settled practice or understanding about where reports of physician misconduct should be stored for later review. For example, Dr. Evanko—

Hadden's direct supervisor—believed that it was the credentialing file that was meant to be the repository of such reports. But others apparently believed differently. The sole patient-complaint-related documents that the Investigation Team found in any of Hadden's files—the letter response from Dr. Harold Fox (former Acting Chair of the Columbia OB/GYN Department) in 1994 to the patient who raised "concerns regarding the care provided by Dr. Robert Hadden" and the note to the file from Dr. Rogerio Lobo (former Chair of the Columbia OB/GYN Department) regarding Hadden's inappropriate use of a computer—were found only in Hadden's departmental file, not his credentialing file. And, indeed, despite Dr. Evanko's suggestion that the credentialing file was the appropriate repository for complaint-related documents, Dr. Evanko—who was Chief of the General OB/GYN Division—does not appear to have caused a record to be placed in Hadden's credentialing file relating to either the complaint elevated to him in 2008 or even the complaint that led to Hadden's arrest in 2012.

D. Recordkeeping Weaknesses Contributed to Hadden's Ability to Continue his Abuse

A better system of collecting and storing complaints against providers might have contributed to earlier discovery of Hadden's abuse. Reports of sexual abuse by Hadden were made to the Institutions at various times over the years, both orally and in writing. But the Institutions failed to see the pattern of abuse at least in part because knowledge of prior complaints was confined, at best, to the memories of whatever personnel were involved in that particular complaint—personnel who might no longer be employed whenever the next event occurred. Nor was there any file that decisionmakers at the Institutions could reliably have gone to for the purpose of reviewing all prior complaints against Hadden. Each complaint existed as an isolated event, known to some employee of the Institutions at some moment in time, but often not recorded, and, when recorded, not added systematically to any repository.

The detrimental impact of this failure of recordkeeping appears most clearly in the Institutions' response to Hadden's arrest in June 2012. In making the decision to allow Hadden to continue seeing patients, the decisionmakers relied before reviewing Hadden's files on the anecdotal (but incorrect) assurances of Hadden's supervisors—Dr. Mary D'Alton and Dr. Evanko—that Hadden had not previously been the subject of any complaints. Then, on the Monday after Hadden's arrest—after the decision had been made to let him continue seeing patients, but before he had begun doing so—Dr. D'Alton and Patricia Catapano (an attorney in Columbia's legal department) each recall reviewing Hadden's physical departmental file. Yet at this critical juncture, when the history of complaints against Hadden was front and center for decisionmakers in deciding how to respond to his arrest, there is no evidence that any of the prior patient complaints against Hadden were in his file to be reviewed.

For example, there is no evidence that the detailed 1994 letter to Dr. Fox complaining about Hadden's inappropriate physical examination was in Hadden's departmental file, or any other file, within the Institutions. There is evidence that Hadden's departmental file contained Dr. Fox's short letter response to the patient acknowledging receipt of her "concerns . . . regarding the care provided by Dr. Robert Hadden" and promising to follow up, but the response was vague, with no description of her "concerns."

The same is true of the 2008 complaint by a patient that Hadden had behaved inappropriately during an examination, including by making comments about her body that made her feel violated. That complaint was made orally to the site manager, but then written up and escalated by email to the Department Administrator, and then escalated orally to Dr. Evanko. While the email trail memorializing the patient's complaint still exists, the complaint was never recorded in Hadden's departmental file, so neither Dr. D'Alton nor Catapano could see it in their

review of the file in 2012 after Hadden's arrest. And although Dr. Evanko may have been personally aware of the complaint in 2008, it is not clear that he recalled it in 2012 when Hadden was arrested, and in any event, he did not raise it.

The only other complaint against Hadden that appears to have been documented and placed in Hadden's departmental file by the time of his arrest in 2012 was the complaint that Hadden had used an office computer to view pornography. But even that was written up in a sanitized fashion, memorializing only that there were allegations that Hadden "was involved in inappropriate use of the computer during normal work hours," that he "denied such use," and that he was "doing well professionally and [was] not having any problems." Dr. D'Alton recalls seeing the memo during her review of Hadden's departmental file and recalls having had a conversation with Dr. Lobo about it at some point thereafter, although she does not recall when. Dr. Lobo's recollection is that nobody consulted him during the period following Hadden's arrest. Regardless, Dr. D'Alton recalls being unable to form a conclusion about the event described in the memo and she recalls that she did not raise it with others at the time because it did not involve patient care.

Thus, the absence of a system for recording and collecting complaints against physicians was a factor in the failure to act to protect patients from Hadden despite these reports of abuse. Had such a system existed, a pattern might have been detected even before Hadden's arrest. And a well-maintained collection of prior complaints in an easily identifiable and accessible file at the time of Hadden's arrest could have disabused decisionmakers of the incorrect notion that Hadden had not been the subject of prior complaints. That awareness could have led to a different decision about permitting him to continue seeing patients for the period after his arrest. As detailed in Chapter 6, multiple women who saw Hadden during the five weeks in which he saw patients after his arrest have subsequently reported that Hadden assaulted them.

II. There Was Confusion Between the Institutions Concerning Responsibility for General Risk Management at Columbia's Outpatient Facilities

Another possible factor in the Institutions' failure to act to protect patients from Hadden despite various reports of inappropriate conduct by Hadden over the years was confusion between the two Institutions concerning responsibility for general, non-litigation-related risk management and compliance for the outpatient facilities administered by Columbia.[33] Columbia leaders seem to have believed that responsibility had been delegated to NYP, while leaders at NYP viewed their role as a limited one, extending only to issues involving actual or likely litigation.

Within NYP, risk management was a function performed by NYP's general counsel's office and was often described as being divided into two sub-components. One sub-component of risk management was the management of lawsuits and pre-litigation complaints likely to ripen into litigation, including potential and actual medical malpractice claims. The other sub-component of risk management at NYP covered issues that were not immediately likely to result in litigation, such as complaints of physician misconduct, issues involving problematic patients, and promulgating policies relating to staff behavior.

At some point, the Institutions agreed that NYP, for a fee, would assume responsibility for performing risk management for Columbia in connection with incidents at Columbia outpatient facilities. Recollections at the two Institutions differ as to what "risk management" functions NYP took on for Columbia. Columbia officials recall believing that NYP had assumed responsibility not just for litigation-related risk management involving outpatient facilities, but also for at least some portion of the more general risk management function, which would include the quality of clinical care at outpatient facilities. For its part, NYP officials understood that NYP had agreed to

[33] This section refers to risk management in the nature of compliance. The Institutions' procedures for reducing the risk of medical errors are not the subject of this Report and are not addressed here.

handle the litigation-related risk management function for Columbia (including pre-litigation complaints that deemed likely to ripen into litigation), but NYP officials do not recall NYP having agreed to handle risk management for Columbia more generally, nor do they recall understanding that officials at Columbia believed otherwise. There is no indication that the Institutions were aware of this confusion during Hadden's tenure, i.e., that they each believed the other was responsible for general risk management at Columbia outpatient facilities, including as it related to physicians' care of patients.

It is not possible to determine whether or the extent to which this apparent confusion could have contributed to Hadden's ability to persist in his abuse. At minimum, a situation in which Columbia officials believed incorrectly that NYP was providing general risk management in connection with the outpatient facilities may mean that nobody was thinking systemically about managing or mitigating risks—including the risk of physician misconduct—at Columbia's outpatient facilities, whether proactively or in response to particular incidents. That, in turn, may have increased the risk that physician misconduct like Hadden's would go unidentified and unaddressed.

III. Physician Evaluation Processes Did Not Include Meaningful Review of Misconduct Complaints

During the entirety of Hadden's career, NYP required physicians to undergo a process of review and recredentialing to its medical staff every two years to maintain their admitting privileges at NYP. While the forms used in this process changed over time, in general the physician's supervisor was asked to approve an applicant "upon the satisfactory review," as one application form described it, of patient complaints and compliments, professional liability activities, and other factors. Functionally, however, this process acted as no check on Hadden over time. Although there were complaints against Hadden, including ones that were known to his

supervisors, there is no evidence that any complaint against Hadden was considered or documented in his recredentialing process. Nor does there appear to have been another regularly conducted review of Hadden by NYP or Columbia that included consideration of patient complaints against him. This lack of regularly conducted reviews that included the gathering and meaningful consideration of patient complaints was another factor in the failure to act to protect patients from Hadden.

A. NYP's Semiannual Practice Review and Biennial Recredentialing Processes

Physicians hired by Columbia University had to apply for admitting privileges at NYP. The credentialing process at NYP was administered by the hospital's Medical Staff Office ("MSO"), which reviewed and verified the applicant's academic and professional qualifications before determining whether to grant the applicant NYP admitting privileges.

The credentialing process would start after a physician had received an offer of employment from Columbia. The physician would then submit an application to NYP detailing his or her qualifications, experience, and any history of malpractice or misconduct, among other things. Each applicant would also submit three references. Credentialing analysts in the MSO would verify and supplement this information by running various checks, reviewing clinical competency and evaluations, and making inquiries of other hospitals. If no concerns were identified, the application would be approved by the Service Chief/Department Chair and all application materials would be sent to the Director of the MSO and the Vice President of Medical and Professional Affairs. The application would eventually be reviewed by the Board of Trustees' Credentialing Committee for final approval.

Following initial appointment, the Service Chief/Department Chair was responsible for conducting regular, ongoing reviews of the physician. In particular, every six months, the Service Chief/Department Chair was required to attest to the physician's performance in an Ongoing

Professional Practice Evaluation ("OPPE"). The 2012 OPPE form stated that the physician's "appointment/reappointment is contingent upon the satisfactory review" of six expressly identified "data elements," one of which is "Patient Complaints and Compliments." Below those six data elements was a certification that—although somewhat garbled—at minimum represented that the signers "have reviewed the above provider specific data for this applicant," and have "compare[d] this applicant to similarly privileged clinicians . . . in order to determine if there are any issues or trends related" to their competency to practice.[34] That certification was then signed by the Division Chief and the Service Chief, who, from 2006 to 2012, were Dr. Evanko and Dr. D'Alton. Beginning as early as late 2011, a third signature from the Quality Assurance Director was also required. Certain OPPE forms reviewed during the Investigation included an additional page for itemizing the number of incidents for that physician in certain categories, including a category for patient complaints.

In addition to the OPPE process, every two years (that is, every four OPPEs), each credentialed physician had to be recredentialed. The process would begin six months before the expiration of the physician's appointment with the physician resubmitting details of his or her credentials and professional activities to the MSO. A credentialing analyst at NYP would review those materials and the physician's credentialing file more generally, focusing on any recent

[34] The garbled language of the certification may have represented an effort to take the language of the requirement that an OPPE be completed every six months and turn it into a certification that the requirement had been complied with. It read as follows:

> I have reviewed the above provider specific data for this applicant review the above provider-specific data for each clinician and compare this applicant to similarly privileged clinicians every six months in order to determine if there are any issues or trends related to competencies required to perform the delineated privileges or quality of care provided by this applicant. I acknowledge that the above provider-specific data has been considered as part of the approval process for this applicant.

updates to the file. By at least as early as 2011, credentialing analysts also reviewed any patient concerns or complaints concerning the physician that were recorded in NYP's patient complaint database. Ultimately, as with the initial credentialing decision, applications for renewal of recredentialing had to be approved by the Board of Trustees' Credentialing Committee.

B. NYP's Recredentialing Process Did Not Involve Consideration of Known Complaints Against Hadden

Hadden was initially credentialed in 1992 and thereafter reappointed every two years between 1994 and 2014. Despite multiple documented complaints against Hadden that reached his supervisors, there is no written reference in Hadden's multi-decade credentialing file to any patient complaint against Hadden, nor any written indication that a particular patient complaint against Hadden was ever considered during the OPPE or recredentialing process.

For example, although Dr. Fox received and responded to a patient's detailed complaint about Hadden in June 1994, he does not appear to have ensured that a copy of the letter made it into Hadden's credentialing file for consideration during the recredentialing process. To the contrary, Hadden was recredentialed for two years on August 2, 1994, and the file contains no mention of patient complaints.

The same is true of the patient complaint about Hadden made in or around October 2008 to the site manager for Hadden's practice group. Although that complaint was elevated to Dr. Evanko, the OPPE signed by Dr. Evanko and Dr. D'Alton covering the period from July 1, 2008 to December 31, 2008 expressly states Hadden received no complaints during that period, and there is no indication this complaint was considered as part of Hadden's next biennial reappointment.

Even Hadden's arrest was not included in his credentialing file. Hadden was arrested on June 29, 2012, and the arrest was widely known by NYP and Columbia officials. But on August

9, 2012—more than a month after the arrest and while Hadden was refusing to be interviewed about the circumstances that precipitated it—Hadden's biennial reappointment was granted for the period from July 1, 2012 through June 30, 2014. Although an OPPE should have been in the file covering the period from January 1, 2012 through June 30, 2012, and could have referenced the allegations or arrest, there was no such OPPE. The OPPE covering that period was not signed by Dr. Evanko and Dr. D'Alton until March 2013, and it did not indicate anything about the arrest or the complaint underlying it.

In sum, the OPPE and biennial credentialing processes, although nominally intended to include consideration of patient complaints against the relevant physician, were not conducted that way in practice. There is no indication that any of the known patient complaints against Hadden were considered during either process.

IV. A Culture of Deference to Physicians and the Absence of Effective Policies for Resolving Patient Complaints Hindered Scrutiny of Physician Conduct

As discussed in Chapter 8, employees at various levels of the Institutions recall a hierarchical culture at the Institutions. In addition to the negative pressure such a culture could place on reporting of physician misconduct by nurses, medical assistants, and staff, it could also result in deference by physicians and leadership to their colleagues in the running of their practices, including in handling complaints directed against them. This culture of deference to physicians was another factor in the failure to act to protect patients from Hadden.

As an initial matter, it appears, at least at Columbia, that departments were siloed, operating with relative autonomy and, even within the OB/GYN practice, with individual physicians focused on managing their own patients. Evidence also suggests that individual physicians were likely to trust and defer to each other in their practices. One nurse recalls that the combination of physicians' status at the top of the medical hierarchy and the premium they put on collegial relations with each

other left the impression that physicians were unlikely to meaningfully hold each other accountable for misconduct. Dr. Robert Kelly, former President of NYP (and physician), likewise recalls a culture among physicians of being uncomfortable reporting misconduct by fellow physicians. A former senior staff person at Columbia recalls that senior physicians were rarely challenged. Even when they engaged in inappropriate behavior, like seriously mistreating staff, their conduct was tolerated or addressed without formal consequence. And more generally, at least some physicians, including those in leadership at both Columbia and NYP, simply could not believe that a doctor would engage in abuse and exploitation of the sort that Hadden did.

Consistent with this culture, physicians and administrators were often predisposed to deal with complaints about physicians deferentially, potentially resulting in missed signals that could have cut through the secrecy behind which Hadden operated. One example involves the earliest written complaint whose existence can be clearly established, the 1994 patient letter. Although there is no way to know with certainty because neither Dr. Fox nor Hadden spoke with the Investigation Team, it appears that Dr. Fox—Hadden's supervisor—may have handled the serious written complaint that a patient made to him about Hadden in part by passing it along to Hadden, himself, to review and consider. That could explain why the letter does not appear to have been retained in any institutional file—e.g., Hadden's personnel files or his credentialing paperwork—but was produced by Hadden himself in civil litigation years later. It is also consistent with the apparent lack of any consequences for Hadden and the fact that Dr. Fox never substantively responded to the patient.

Another potential example of the notion that doctors were predisposed to act deferentially with respect to accusations against other doctors is the report made in 2000 that Hadden had used a work computer to view pornography. Dr. Lobo (then the Department Chair) did make a record

of the incident, but he wrote his memo to Hadden's file in a way that did not mention that the allegation involved pornography. He also commented that Hadden was "doing well professionally and is not having any problems." The anodyne statement allowed others, years later, to put this record aside as irrelevant when contemplating whether to allow Hadden to return to work after his arrest.

In any event, the clearest example of doctors showing deference to other doctors in the face of allegations of misconduct comes from the weekend when Hadden was arrested. On that occasion, Dr. D'Alton quickly presumed that the patient's allegations could not be true and must be the result of a misunderstanding. None of the other decisionmakers appear to have disagreed with that presumption either, despite the absence of a significant investigation. Instead, they relied in significant part on Hadden's denial, Dr. D'Alton's vouching for him, and the extraordinary nature of the allegation.

Doctors' skepticism of complaints against other doctors may also be seen in how some physicians apparently thought about and failed to adhere to the chaperone policy, as described in Chapter 7. From the beginning, the value of having chaperones present was discussed at least in part as a mechanism to protect doctors from presumptively false claims of abuse, not as a mechanism to protect patients from actual abuse. Even after Hadden's arrest, the chaperone policy was at times discussed explicitly in terms of ensuring doctors were protected from allegations by patients.

Moreover, the lack of defined policies at Columbia for intake, recording, and resolution of patient complaints necessarily resulted in *ad hoc* decisionmaking by individual actors, who were inclined to trust or at least defer to the judgment and discretion of physicians over complaints by patients. Staff and doctors who received complaints from patients about Hadden reported them

along or not based on their own personal determination. Similarly, supervisors who received complaints dealt with them *ad hoc* based on their personal determination. Policies at Columbia and NYP today provide specific direction for how complaints of sexual abuse by physicians or staff are to be reported, investigated, resolved, and maintained. But those policies did not exist during Hadden's tenure.

Clear policies could have mitigated several of the issues that likely contributed to Hadden's ability to persist in his abuse. For example, it appears that a culture of professional collegiality and deference among doctors discouraged staff from reporting Hadden's behavior to other physicians, and the same culture may have influenced doctors' impressions that certain complaints were too vague to merit further action. An explicit policy that mandated not only reporting, but also specific procedures for investigating and resolving complaints, could have decreased reliance upon individual and immediate judgments about the credibility or character of an accused physician.

Such a policy would have had strong grounding in both the law and medical ethics. New York law requires physicians and other medical professionals to report information "which reasonably appears to show" professional misconduct—including suspected physical or verbal abuse of patients—to the State Board for Professional Medical Conduct.[35] Guidance from the New York State Health Department's Office of Professional Medical Conduct makes clear that licensed health professionals are required by law to report colleagues suspected of misconduct, and that "[f]ailure to report suspected instances of misconduct is, in itself, misconduct."[36] Both the

[35] N.Y. Pub. Health Law § 230(11)(a). The version of this law effective from November 3, 2008 to March 31, 2013 contains functionally equivalent or identical language.

[36] N.Y. State Dep't of Health, *Understanding New York's Medical Conduct Program – Physician Discipline* (rev. March 2016), https://www.health.ny.gov/publications/1445/.

American Medical Association[37] and the American College of Obstetricians and Gynecologists[38] similarly encourage physicians to report unethical behavior by their colleagues, including the abuse of patients.

Beyond encouraging reporting, to the extent a culture of collegiality prompted leaders to handle reports of alleged misconduct by Hadden with undue deference, a policy that mandated specific procedures for investigating and resolving complaints against doctors—including by requiring that multiple decisionmakers be involved—could have ensured more rigorous and neutral consideration of the merits of those complaints. To the extent that the complaints about Hadden that were escalated within the Institutions were handled unilaterally by the individual supervisor who received the complaint, that had the effect of siloing information about Hadden's alleged misconduct. That compartmentalization, again, made it less likely that the pattern of complaints about Hadden could be identified.

The evidence suggests that the absence of sufficient policies to routinize complaint processing and investigations of physician misconduct permitted the individual impressions of physicians and leadership to displace objective, evidence-based decisionmaking. There is no doubt that Hadden's conduct was nearly unthinkable to his colleagues and superiors. But because there was a tendency to credit and trust physicians, and a failure to engage in effective process-based

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[37] AMA, *Principles of Medical Ethics*, Principle II (revised June 2001) ("A physician shall . . . strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities."), https://code-medical-ethics.ama-assn.org/principles. A substantively similar principle governed from 1980 to 2001.

[38] ACOG, *Code of Professional Ethics*, Ethical Foundation II (Dec. 2018) ("All physicians are obligated to respond to evidence of questionable conduct or unethical behavior by other physicians through appropriate procedures established by the relevant organization."), https://www.acog.org/-/media/project/acog/acogorg/files/pdfs/acog-policies/code-of-professional-ethics-of-the-american-college-of-obstetricians-and-gynecologists.pdf; *see also* ACOG, *Sexual Misconduct Statement of Policy* (Feb. 2019, amended 2023).

responses to patient concerns, Hadden was able to evade detection, monitoring, and investigation at multiple junctures in his career, allowing his misconduct to persist.

* * *

Together, the factors above, including Columbia's lack of effective recordkeeping systems to track reports and complaints, which otherwise might have allowed supervisors or leaders to recognize an ongoing problem; its lack of an effective system for resolving patient complaints, which resulted in *ad hoc* decisionmaking in an environment of deference to physicians like Hadden; and NYP's physician recredentialing processes, which did not effectively incorporate reports of physician misconduct, contributed to the institutional failure to act to protect patients from Hadden despite reports of abuse.

PART IV
INSTITUTIONAL CHANGES AND COMMITMENTS

In addition to examining the circumstances that allowed Hadden's abuse to continue for as long as it did, the Investigation Team was charged with making recommendations to ensure that Columbia and NYP have policies and procedures to guard against something like Hadden's abuse recurring. In Part III, we discussed factors that contributed to allowing that abuse to occur and to continue, including gaps in institutional policies and weaknesses in institutional culture that together contributed to Hadden's ability to carry out his abuse and to evade detection and intervention.

In this Part of the Report, we explain how, in the years since Hadden stopped seeing patients, both Columbia and NYP have made significant improvements to their systems, addressing many of the weaknesses identified in this Report. An understanding of those changes was necessary for the Investigation Team to formulate the recommendations we provided to the Institutions after conducting the Investigation and is necessary for readers to consider the commitments that Columbia and NYP have made to the future improvements described below.

In **Chapter 10**, we first summarize the current state of relevant policies and procedures, and their implementation in practice, reflecting changes since the time of Hadden's conduct. We then set forth new commitments that the Institutions have made to further enhance these policies in light of this Report.

CHAPTER 10
INSTITUTIONAL CHANGES AND COMMITMENTS

In addition to examining the circumstances that allowed Hadden's abuse to continue for as long as it did, the Investigation Team was charged with making recommendations to ensure that Columbia and NYP have policies and procedures in place that will guard against anything like Hadden's abuse happening again. In Part III, we outlined factors that contributed to allowing that abuse to occur and to continue, including gaps in institutional policies and weaknesses in institutional culture that contributed to Hadden's ability to carry out his abuse and to evade detection and intervention.

In the years since Hadden stopped seeing patients, both Columbia and NYP have made significant improvements to their policies and procedures that address many of the weaknesses identified in this Report. An understanding of those changes was necessary for the Investigation Team to formulate the recommendations we provided to the Institutions after conducting the Investigation and is necessary for readers to consider the commitments that Columbia and NYP have made to the future improvements described below.

There has been substantial positive change at both Institutions, but with the benefit of the information gathered during the Investigation, we believe there remain opportunities for improvement in the areas of empowering and supporting patients; strengthening the chaperone role; strengthening the culture of reporting and addressing factors that chill reporting; ensuring effective information sharing, investigation, and recordkeeping regarding sexual misconduct allegations; and ensuring oversight and continual improvement. With that in mind, we have made recommendations to the Institutions, and the Institutions have committed to a variety of additional measures, as set forth below.

In this chapter, we first provide an overview of the Institutions' current, relevant policies and procedures and then describe the new commitments that the Institutions have made to further enhance these policies in light of the findings contained in this Report.

I. Current Institutional Policies and Procedures

A. Institutional Policies About Sexual Misconduct Involving a Patient

In 2023, with assistance from Praesidium, an external consultant that specializes in advice relating to the prevention of sexual abuse, Columbia[39] and NYP each separately implemented coordinated policies titled "Allegation of Sexual Misconduct Involving a Patient." The policies, which were later updated in 2025, largely mirror each other and seek to guide employees on the "prompt reporting, escalation, and investigation requirements related to sexual misconduct allegations." Sexual misconduct is broadly defined in each policy as "any behavior of a sexual nature that exploits the inherent power imbalance between healthcare providers . . . [and] patients," including boundary violations,[40] inappropriate behavior, overt sexual behaviors, and sexual offenses. Each Institution outlines in its respective policy the reporting obligations of employees and the process to be followed when a report of sexual misconduct is received. That process and its current application are summarized below.

1. Reporting Channels

Patients, medical personnel, and staff may make reports of sexual misconduct through multiple reporting channels at Columbia and NYP. At Columbia, OB/GYN patients now receive automated text messages inviting them to report any concerns after patient visits, including after

[39] The entity that generally instituted these policies is ColumbiaDoctors, which is the faculty practice organization that runs the practices of Columbia physicians and whose CEO is a dean at Columbia. For ease of comprehension, however, we continue to refer simply to "Columbia."

[40] Boundary violations are defined as patterns of actions that "blur, disregard, or breach the professional boundaries between . . . staff or clinicians and patients."

visits with sensitive examinations. Patients and others can also make reports to Columbia's Patient Safety Hotline by phone, email, or an online form that includes an option to submit anonymously. Doctors and staff are directed by Columbia's policy to enter reports directly into Columbia's centralized safety incident reporting system, "SafetyZone," or to escalate them to someone who will do so. SafetyZone allows for complaints to be made anonymously. Doctors and staff also may lodge complaints by phone or email with Columbia's Compliance Hotline, including anonymously if desired.

At NYP, patients can make reports of misconduct through the Patient Services Administration. Information about reporting concerns is provided to patients in NYP's Patient Rights and Responsibilities document online and at hospital locations. Medical personnel and staff are directed by NYP's policy to make reports directly into "KEEPSAFE," which is NYP's centralized incident report system where employees may make reports, including anonymously, and to escalate the matter for reporting to the Patient Services Administration.

NYP's Compliance Hotline also has the capability of receiving complaints from patients, staff, or others, including by phone or through a web-based interface with an anonymous option.

2. Reporting, Escalation, and Information Sharing Between the Institutions

All personnel employed by the Institutions are obligated to report any incident of actual or suspected sexual misconduct "promptly" (Columbia) or "immediately" (NYP), and to record the complaint—or escalate it to a person who has the ability to record it—in either SafetyZone (Columbia) or KEEPSAFE (NYP).

When a report of potential sexual misconduct is recorded in SafetyZone at Columbia, the Sexual Misconduct Allegation Response Team ("SMART") is responsible for responding. The SMART team, comprised of members of Columbia's and ColumbiaDoctors' leadership, provides

notification of the complaint to the Chair and Administrator of the relevant department, and to the Division Chief, if applicable.[41]

When a report of potential sexual misconduct is recorded in KEEPSAFE at NYP, Patient Services at NYP is responsible for notifying the NYP Review Committee and other members of the NYP leadership team. The Review Committee is chaired by NYP's Director of State and Federal Investigations, a position currently filled by the former Deputy Chief of the Intimate Partner & Sexual Violence Bureau of the Manhattan District Attorney's Office, and includes NYP's Vice President and Chief Medical Officer for Medical and Professional Affairs, who oversees NYP's credentialing and recredentialing processes.[42] This committee is responsible for reviewing the allegation in the first instance. Although not noted in the policy, the Director of State and Federal Investigations at NYP is currently assisted by two former NYPD Special Victims Unit officers who serve as investigators.

Under each policy, the respective Institution notifies leadership at the other Institution about the complaint when the provider who is alleged to have engaged in misconduct is associated with both Columbia and NYP.

3. Preliminary Assessment

When an allegation of sexual misconduct is reported under either the Columbia or NYP policy, the respective Institution performs a preliminary assessment to determine if the allegation

[41] The SMART team comprises the following: the Office of the General Counsel; the Chief Executive Officer from 61st Street Service Corporation, as applicable; the Chief Executive Officer, Chief Operating Officer, Chief Medical Officer, and Chief Quality Officer from ColumbiaDoctors; and the Senior Vice Dean for Clinical Affairs and the Vice Dean of Academic or Faculty Affairs from Vagelos College of Physicians and Surgeons.

[42] The Review Committee also includes the following or their designee: NYP's Chief Respect Officer; Vice President, Patient Services and Patient Experiences; and Vice President, Security.

is "reasonably credible."[43] If the allegation is reported to Columbia, the SMART team should immediately initiate the preliminary assessment and complete its preliminary assessment as expeditiously as possible with the goal of completing the assessment within three business days. If the allegation is reported to NYP, the Review Committee should initiate the preliminary assessment immediately following notification and make all efforts to complete its preliminary assessment within 24 hours or as expeditiously as possible. While the preliminary assessment is ongoing, each policy provides for interim measures in the interest of patient safety, such as removing the provider who is alleged to have engaged in misconduct from duty, removing the provider from patient care, or reassigning the provider from the involved patient. If the allegation is found to be reasonably credible, the provider alleged to have committed misconduct is placed off duty.

4. Investigation and Disposition of a Complaint

After establishing that a report is reasonably credible, either SMART or the Review Committee (depending on where the report originated) performs additional investigative steps. Immediately upon receipt of "any report" (Columbia) or "a credible report" (NYP) of possible sexual misconduct, relevant evidence, including video footage and access records for the involved locations, must be preserved. Investigative steps taken at each Institution include searching databases and files for previous allegations or findings against the subject, including querying the other Institution for any such information in its files, interviews of staff and witnesses, and an interview of the patient if the patient is willing. At Columbia, the interview of the patient must be performed by someone who is trained in trauma-informed care, while NYP's written policy states

[43] The term "reasonably credible" is not defined and no written guidance is provided to decisionmakers.

"[a]ll efforts" will be made to have the interview conducted in a trauma-informed manner in a setting "designed to promote sensitivity and patient privacy." When the subject of a complaint is affiliated with both Institutions, the Institutions' policies require consultation with each other, but Columbia and NYP each maintain the authority to make their own findings and to take their own actions.

Upon completion of the investigation, the Columbia SMART team communicates its findings and recommendations to the Department Chair, the Division Chief, if applicable, and other individuals depending on the location of the incident; if the allegations are substantiated, the SMART team will also communicate its findings and recommendations to the Dean and the President of Columbia. Likewise, the NYP Review Committee reports its findings and recommendations to a Notification Group of hospital leadership that includes the Chief Medical Officer, Chief Operating Officer, and General Counsel of NYP. In addition, the NYP Review Committee prepares a closing memorandum to be included in the credentialing or employment file for the subject of the allegation. The SMART team or the Review Committee, as applicable, informs the patient in writing as to the outcome of the investigation.

5. Recordkeeping

At Columbia, evidence, including photographs, video surveillance, and written statements (including email and texts, among other things), as well as the letter to the patient containing the final determination resulting from the investigation, are preserved and retained "as determined by SMART" in SafetyZone. Access to those historical records is limited to a small group because of the sensitivity of the material. The Columbia policy includes an additional commitment that documents related to an investigation will not be destroyed. At NYP, evidence, including photographs, video surveillance, written statements, and any grievance response, gathered during an investigation is preserved by the Security Department, the Respect Office, departmental

leadership, the Patient Services Administration, and the Review Committee, "as appropriate." Neither Institution can access or search the other Institution's database.

6. Training

The Institutions require annual training with respect to their respective sexual misconduct polices, and participation is electronically recorded and audited. Columbia's training materials reiterate the content of the policy, including the duty to report and the investigative process, and list examples of behavior that require reporting under the policy. NYP's training provides a similar reiteration of the policy and requires an attestation that the participant completed the training.

B. Chaperone Policies

1. Columbia

Columbia's current chaperone policy, last updated in 2023, provides guidance on the use of medical chaperones during examinations and medical procedures across all Columbia practices. Individual Columbia departments may also impose their own more stringent policies, and the Department of Obstetrics and Gynecology's policy on "Medical Chaperones for Obstetric and Gynecologic Examinations," last updated in 2024, imposes additional chaperoning requirements for OB/GYN appointments.

For OB/GYN appointments, the departmental policy requires the presence of a chaperone during any examination or procedure involving the breast, genital, or rectal areas. The use of a chaperone must be recorded by the clinician in the patient's electronic health record. Certified medical assistants, licensed practical nurses, and registered nurses are expected to serve as chaperones as part of their job functions. The policy states that every effort should be made to provide a patient with a chaperone of the patient's preferred gender. In the Department of Obstetrics and Gynecology, no faculty or staff member (including temporary employees) who

interacts with patients may begin work before completing departmental chaperone training, and all existing employees must thereafter attest to the policy on an annual basis.

In addition to the broader Columbia chaperone policy itself, which covers basic information, Columbia provides more detailed guidance in its training, most recently updated in 2025, and in the Department of Obstetrics and Gynecology's departmental training protocol, most recently updated in November 2024.[44] Columbia's chaperone training provides staff with an overview of the policy, best practices, examples of procedures requiring a chaperone, roles and responsibilities of a chaperone, and how to document chaperone compliance. Both the 2024 OB/GYN training protocol and the Columbia-wide training detail the role of a chaperone, which includes a duty to observe all actions of the healthcare provider and to remain present for the entirety of an examination, while also providing assistance to the healthcare provider. These training materials also describe chaperones' responsibility to familiarize themselves with the components of a professional sensitive examination and identify variances in standard practice. The best practices guidance for such sensitive examinations states that they should be performed with the "least amount of physical contact," that gloves must be worn at all times when hands could come in contact with blood or bodily fluids, and that the clinician should explain to the patient what to expect during the examination and the purpose of the chaperone.

The Columbia-wide chaperone policy and the 2025 Columbia-wide training specifically direct the physician, upon conclusion of an examination, to ask the patient if there are any other concerns and, if there are none, to verbalize the end of the examination. The Columbia-wide

[44] The training protocol is a three-page document distributed via email to faculty, fellows, residents, and staff who interact with patients, regardless of whether they will serve as a chaperone, for review at time of hire and annually. It is also posted on the OB/GYN Department's intranet site.

chaperone policy also notes, however, that a clinician may conduct the non-examination portion of the visit after the patient is dressed or has been provided privacy with an appropriate gown or other coverage. OB/GYN chaperones have expressed concern about leaving the room when a patient is merely gowned, and at least one chaperone has raised this issue with the Department.

The Columbia-wide chaperone policy directs chaperones to immediately escalate to their supervisor any inappropriate physician interaction or conduct or any complaint received from a patient and/or family, and to create a record in SafetyZone. Columbia's chaperone training also requires chaperones to report immediately to their supervisor, without fear of retaliation, if they witness inappropriate behaviors or comments during an examination, and directs escalation in accordance with the sexual misconduct policy, including submitting an event in SafetyZone. The trainings are not interactive, and do not include hypothetical examples, but they do include the definitions of sexual misconduct in a manner consistent with Columbia's sexual misconduct policy.

2. NYP

NYP's current chaperone policy, last updated in 2023, provides a description of the use of a chaperone and how a physician should perform a chaperoned examination. Much of the information is identical to that contained in Columbia's chaperone training. The policy applies to physicians in all clinical settings, including telemedicine and home visits. The policy's stated purpose is "to provide guidance on the use of medical chaperones and to promote patient safety, dignity, and comfort" during examinations, treatments, and procedures. Pursuant to the policy, all vaginal and pelvic examinations and intravaginal examinations and procedures including ultrasound require the presence of a chaperone. Other treatments, including those involving external genitalia, breasts, and the rectum require the physician to offer the patient the option of having a chaperone present. For all other examinations, treatments, and procedures, a medical

chaperone will be present if the patient requests one. The use of a chaperone must be "clearly communicated to the patient" before the examination, treatment, or procedure. Healthcare providers must document the name of the chaperone in the patient's electronic health record, and must similarly document that a patient declined a chaperone. The policy states that every effort should be made to provide a patient with a chaperone of the patient's preferred gender.

The policy requires, "if appropriate," that written information be available to the patient that clearly states why and how a procedure is to be performed. The policy also directs the healthcare providers to "drape" the patient to minimize exposure during the examination, to perform examinations with the "least amount of physical contact required for adequate diagnosis and treatment," and to keep dialogue medically relevant and avoid unnecessary personal comments. Finally, before completing the examination, the policy requires the healthcare provider to elicit any final physical concerns from the patient before "clearly communicating to the patient that the examination will be concluded." If the patient has no final physical concerns, the healthcare provider is directed to clearly communicate the end of the examination. NYP's chaperone policy also notes that a clinician may conduct the non-examination portion of the visit after the patient is dressed or has been provided privacy with an appropriate gown or other coverage.

Under this policy, all personnel, including members of the healthcare team who serve as chaperones, receive training in privacy and confidentiality, protecting the interests and well-being of patients, verifying the content of clinical conversations and physical examinations, and reporting concerns. In addition, the policy directs chaperones to "immediately escalate" to their supervisor any inappropriate physician interaction or conduct or any complaint received from a patient or family member, and to create a record of the incident in KEEPSAFE.

NYP's training provides an overview of the policy and largely mirrors Columbia's training, including describing best practices, examples of procedures requiring a chaperone, roles and responsibilities of a chaperone, how to record a complaint, and directing employees who have concerns about potential sexual misconduct to escalate those concerns in accordance with NYP's "Allegation of Sexual Misconduct Involving a Patient" policy. NYP's chaperone training also requires chaperones to report immediately to their supervisor if they witness inappropriate behaviors or comments during an examination, and directs escalation in accordance with the sexual misconduct policy. Like Columbia, NYP's training describes the chaperone's duties, which include a duty "to observe all actions of the healthcare provider and to remain present for the entirety of an examination," while also providing assistance to the healthcare provider. This training also describes chaperones' responsibility "to familiarize [themselves] with the components of a professional sensitive examination and identify variances from standard practice." The best practices guidance for such sensitive examinations states that they should be performed with the "least amount of physical contact," that "[g]loves must be worn at all times when hands could come in contact with blood or bodily fluids," and that the clinician should explain to the patient what to expect before each step of the examination and the purpose of the chaperone. The training is not interactive and does not include hypothetical examples.

3. Patient Education

Both Institutions provide patients with a notice of their right to a medical chaperone, which patients sign before their appointments. OB/GYN patients can access a "What to Expect at Your OB/GYN Appointment" document through a QR code posted in examination rooms, or by going to the relevant Institution's website. That document describes physical examinations that may occur during the appointment as well as the chaperone policy.

C. Non-Retaliation Policy

Both Columbia and NYP have general non-retaliation policies in place prohibiting retaliatory action against individuals who raise concerns. In 2018, Columbia developed a non-retaliation policy prohibiting members of the Columbia community "from retaliating against any person . . . who files a compliance report, cooperates with a compliance investigation, or seeks guidance on compliance concerns in good faith." The policy outlines resources to assist with policy interpretation and designates a compliance hotline for anonymous reporting.

NYP's non-retaliation policy, last revised March 2024, prohibits "intimidation, harassment or retaliation against any individual" who reports suspected violations of the law or NYP policy, or who cooperates in a compliance investigation. NYP commits in this policy to creating a culture in which employees feel "empowered to express problems, concerns or opinions without fear of retaliation." Under the policy, NYP employees have an "affirmative duty" to report issues or concerns and to participate in investigations. Failure to report or participate in an investigation may result in discipline, including termination. Under the policy, reports of retaliation will be investigated by the Office of Corporate Compliance.

Columbia's and NYP's trainings on their sexual misconduct and chaperone policies also include statements that staff members can act without fear of retaliation, although this is not reflected in the corresponding policies.

II. New Tools for Promoting Patient Safety

In addition to the policies described above, the Institutions have also begun to implement risk management tools developed at the Vanderbilt University Center for Patient and Professional Advocacy, which provides services aimed at promoting professional behavior and identifying provider behavior that undermines a culture of safety and respect. The Institutions are deploying two Vanderbilt tools: the Patient Advocacy Reporting System ("PARS") and the Coworker

Observation Reporting System ("CORS"). These tools incorporate data about both patient and coworker concerns, and compare that data to national data from peer institutions in order to identify professionalism or patient safety concerns.

When the tools indicate a professionalism concern about an individual provider, a committee comprised of leadership from both Columbia and NYP is notified and convenes to determine an appropriate response, up to and including a formal investigation or disciplinary process. When a provider is flagged in this manner, both Columbia and NYP receive a spreadsheet that contains all relevant reports about the provider from all reporting channels at both Institutions so that both Institutions see the full scope of concerns.

III. The Institutions' Future Commitments

As discussed in Chapters 7, 8, and 9, this Report identifies a number of policy, practice, and cultural factors that contributed to Hadden's continued abuse of patients for more than two decades. In particular, the Investigation Team found that weaknesses in chaperone policies and training, as well as limited resources and support for chaperones, undermined the ability of chaperones to detect and deter misconduct. We found that reporting systems for patient complaints, particularly at Columbia, did not sufficiently enable reports or address barriers to patient reporting. We found that insufficient procedures for tracking and considering patient complaints at both Institutions, and for resolving patient complaints at Columbia, particularly in the context of a culture highly deferential to physicians, hindered the Institutions' ability to respond effectively to reports of physician misconduct and to detect patterns of misconduct over time. Finally, we found that the Institutions failed to respond appropriately to the reports of misconduct that they did

receive, in part because they did not adequately maintain complaints about physician misconduct in a per-physician way that would allow patterns of misconduct to emerge.[45]

As set forth above, both Institutions have made significant changes to their policies and practices since Hadden last saw patients more than 13 years ago, and many other changes are underway. Nevertheless, with the benefit of what we have learned from the Investigation, we believe there remain opportunities for improvements in empowering and supporting patients; strengthening the chaperone role; strengthening the culture of reporting and addressing factors that chill reporting; ensuring effective information sharing, investigation, and recordkeeping regarding sexual misconduct allegations; and ensuring oversight and continual improvement, all with the goal of effectively preventing sexual misconduct.

With that in mind, we have made recommendations to the Institutions, and, as set forth below, the Institutions have committed to the following concrete steps in furtherance of all of the aims above.

A. Empowering and Supporting Patients

1. The Institutions will provide the "What to Expect at Your OB/GYN Appointment" document to patients in advance of appointments to allow time for patients to review the explanation of what an appropriate examination includes before an appointment begins, including electronically (by email or through Epic) in advance of an appointment or by hard copy at check-in or via mail.

2. The Institutions will provide patients with information concerning the various avenues to report complaints or concerns, and how to raise those concerns confidentially, including by providing additional detail in the "What to Expect at Your OB/GYN Appointment" document.

[45] In the course of conducting this Investigation, we also identified the possibility that certain records no longer exist, as noted in Chapter 1. Each Institution's sexual misconduct policy now mandates that, "[i]mmediately upon receipt of any report" (Columbia) or "[i]mmediately upon receipt of a credible report" (NYP), the relevant team shall "identify and take steps to preserve and maintain all relevant evidence including, but not limited to, video surveillance footage and access records for the involved location(s)."

3. The Institutions will review their sexual misconduct policies to ensure that they make clear that supportive resources will be offered to patients during any investigation, provided that the provision of such resources is consistent with the patient's wishes.

4. The Institutions will implement enhanced medical chaperone trainings that:

    - Incorporate further direction to chaperones to proceed in a trauma-informed manner;

    - Incorporate direction to inform patients of any expected discomfort and their right to pause the examination or procedure at any time; and

    - Include training on how to identify signs of distress in patients and examples of what those signs may look like, including how those signs may appear for sexual assault survivors.

B. Strengthening the Chaperone Role

1. The Institutions will review their medical chaperone trainings to ensure that the trainings are more interactive and scenario-based, including by incorporating concrete examples of sexual misconduct.

2. The Institutions will ensure that the chaperone policies clarify when the duties of a chaperone end.

3. As set forth above, the Institutions will implement enhanced medical chaperone trainings that incorporate direction to proceed in a trauma-informed manner, including informing patients of the right to pause an examination, and provide detail on identifying signs of distress in patients, including how those signs may appear for sexual assault survivors.

C. Strengthening the Culture of Reporting and Addressing Potential Chilling Factors

1. The Institutions will ensure that, with respect to their sexual misconduct policies:

    - Policy language with respect to mandatory reporting is strengthened;

    - Further confidentiality assurances are incorporated to help facilitate reporting, particularly in the case of an employee reporting potential misconduct involving a colleague; and

    - Policies make clear that alternative means of reporting are available when escalation to a particular individual, including a supervisor, causes discomfort.

2. The Institutions will update their sexual misconduct and chaperone policies and trainings to:

    - Make clear that individuals have the ability to report anonymously;
    - Strengthen the language regarding mandatory reporting;
    - Incorporate additional content with respect to the responsibilities of personnel in supervisory roles to report and escalate complaints; and
    - Make clear that failure to report an allegation of sexual misconduct involving a patient, like the underlying conduct in violation of the sexual misconduct policies, could result in discipline up to and including termination.

3. The Institutions will incorporate non-retaliation language (now in other, broader non-retaliation policies) into their sexual misconduct policies to encourage reporting by employees, and will provide examples of retaliatory conduct that is prohibited.

D. Ensuring Effective Information Sharing, Investigation, and Recordkeeping Regarding Sexual Misconduct Allegations

1. The Institutions will explore mechanisms for efficiently identifying all reporting regarding a given provider at either Institution, including the potential use of the CORS and PARS tools described above to do so.

2. The Institutions will provide additional guidance on making preliminary determinations about "reasonably credible" allegations of sexual misconduct to ensure consistency, including by identifying examples of factors to be considered by the SMART team or Review Committee making those determinations.

3. The Institutions will incorporate a non-exhaustive list of factors for when an external investigator should be considered to conduct an investigation, including in cases that are particularly complex, serious in nature, require specialized expertise, involve high-level staff, or when internal impartiality may be doubted.

4. The Institutions will identify in their sexual misconduct policies specific individuals (by title) at each Institution who will lead investigations into allegations of sexual misconduct and be responsible for ensuring that each of the investigative steps set forth in the policies have taken place.

5. The Institutions will revise their sexual misconduct policies to clarify that the information that must be maintained by the investigative teams includes information related to all allegations, information gathered during the investigation, and the disposition of each investigation.

6. The Institutions will revise their sexual misconduct policies to clarify that all relevant evidence, including email, when applicable, must be preserved and retained.

E. Ensuring Process Oversight and Continual Improvement

1. The Institutions will identify a mechanism, whether through SafetyZone and KEEPSAFE or an additional technology, to generate regular reports in aggregate form that include the number of sexual misconduct complaints, the disposition of any investigations, and the discipline imposed, in order to monitor the effectiveness of the Institutions' sexual misconduct policies over time.

2. The Institutions will implement additional oversight by their respective Boards of Trustees of the sexual misconduct and chaperone policies, including:

    - Establishing a process identifying when and how the Boards are informed of serious issues; and

    - Establishing a process in which the Boards are trained regarding their oversight-related responsibilities, including with respect to reviewing disciplinary decisions made by senior management to ensure consistency and appropriate follow-up.

3. The Institutions will continue to review their sexual misconduct policies at least annually, and more frequently, as needed.

CONCLUSION

We have conducted a thorough investigation that included more than 120 interviews of both survivors and current and former employees of Columbia and NYP. The Investigation Team has reviewed more than 120,000 documents. Based on that Investigation, we have identified a number of factors that contributed to the circumstances that allowed Hadden's abuse to occur and to persist. We found that the Institutions did not effectively make use of chaperoning, which has come to be recognized as a key safeguard to deter or discourage sexual misconduct by physicians. Weaknesses in chaperone staffing, training, policies, and enforcement undermined the effectiveness of chaperoning as a means to prevent and detect Hadden's conduct. We also found that there were a variety of obstacles to patient and staff reporting of physician misconduct at both Institutions, and at Columbia there was no complaint-reporting policy that would sufficiently enable patient reporting of complaints about physicians' conduct. This omission hindered Columbia's ability to receive and address patients' complaints, and reduced the opportunity for the Institution to identify and act on information about Hadden's abuse. Finally, we found that the Institutions failed to respond effectively to the reports of misconduct that they did receive. Despite the obstacles to reporting, several reports about Hadden's abuse did reach physician leaders over the years. Yet decisionmakers resolved the complaints *ad hoc* in an environment in which deference to physicians like Hadden was the cultural norm, and without systems of records that would effectively identify patterns of physician misconduct.

The Institutions have already made significant changes to their policies and practices since Hadden last saw patients more than 13 years ago. With the benefit of what we have learned from the Investigation, we believe there remain opportunities for improvements in empowering and supporting patients; strengthening the chaperone role; strengthening the culture of reporting and addressing factors that chill reporting; ensuring effective information sharing, investigation, and

recordkeeping regarding sexual misconduct allegations; and ensuring oversight and continual improvement, all with the goal of effectively preventing sexual misconduct. We have made recommendations to the Institutions, and they have committed to concrete steps in furtherance of all of these goals. It is hoped that those steps will help to guard against anything like Hadden's abuse ever happening again.

APPENDIX A

As the nation's largest anti-sexual violence organization and operator of the National Sexual Assault Hotline, RAINN's mission is to stop sexual violence by supporting survivors, holding perpetrators accountable, and creating safer communities. RAINN's victim service programs have helped more than 5 million people since 1994 by providing confidential, trauma-informed, 24/7 support services to survivors and their loved ones. RAINN advocates at the federal and state level for legislation that prevents harm, protects victims, and ensures perpetrators are held accountable, including advocating for reforming statutes of limitations and expanding access to crucial sexual assault medical care. RAINN also partners with the media and entertainment industries, colleges and universities, law enforcement and other organizations to raise awareness of sexual violence and its impact on survivors.

RAINN Consulting Group helps workplaces and institutions prevent sexual harassment, sexual assault, child sexual abuse, and other forms of sexual misconduct by building trauma-informed, survivor-centered systems that work. RAINN Consulting Group's multidisciplinary team provides subject matter expertise through services, including tailored training and education, organizational assessments, policy and protocol review and development, and client-branded crisis and reporting hotlines, to help organizations strengthen their prevention and response to sexual misconduct. Their work has supported a range of types of organizations such as government agencies, non-profits, schools, and large commercial clients across a variety of industries, including higher education, healthcare, technology, athletics, and entertainment. RAINN Consulting Group's work is based on rigorous research and best practices and is grounded in a survivor-sensitive and trauma-informed approach.

APPENDIX B

Louise Perkins King, MD, JD, FACOG
Curriculum Vitae

Education

08/1992	BA	French Literature	University of Colorado, Boulder
07/1996	Juris Doctorate *cum laude*		Tulane University School of Law New Orleans, LA
6/2006	MD	Distinction in Research	University of Texas Southwestern Medical School, Dallas, TX

Postdoctoral Training

7/06-6/10	Residency	Obstetrics and Gynecology	Parkland Memorial Hospital, Dallas TX, St Paul University Hospital, University of Texas Southwestern Medical School
7/10-6/12	Fellow AAGL/ASRM	Obstetrics and Gynecology Minimally Invasive Gynecologic Surgery	Center for Minimally Invasive and Robotic Surgery; Stanford University Hospital, Palo Alto, CA

Faculty Academic Appointments

2012-2014	Instructor	Obstetrics, Gynecology and Reproductive Biology	Harvard Medical School
2014-	Assistant Professor	Obstetrics, Gynecology and Reproductive Biology	Harvard Medical School
2016-	Adjunct Faculty	Petrie Flom Center for Health Law Policy, Biotechnology and Bioethics	Harvard Law School

Appointments at Hospitals/Affiliated Institutions

2012-2020	Physician/Surgeon	Obstetrics and Gynecology	BIDMC
2012-2020	Physician/Surgeon	Obstetrics and Gynecology	BIDMC Needham
2020-	GYN Staff Attending	Obstetrics and Gynecology	Brigham and Women's Hospital

Other Professional Positions

1994-1995	Assistant Director	Tulane Legal Assistance, Tulane University Law School
1995	Law Clerk	California Supreme Court, Staff of Justice Joyce Kennard
1995-1996	Law Clerk	Louisiana 4th Circuit Court of Appeals, Staff of Justice Moon Landrieu

1996-1998	Briefing Attorney	Louisiana Supreme Court
1998-2002	Lawyer	Dallas Bar Association, Volunteer Attorney Program and Children's Justice Project
1999-2000	Research Assistant	UT Southwestern Department of Internal Medicine, Cardiology Division
2000-2002	Research Coordinator	Donald W. Reynolds Center for Cardiovascular Research, UT Southwestern Department of Internal Medicine, Division of Cardiology
2003-2004	Research Fellow	Doris Duke Clinical Research Fellowship, UT Southwestern Department of Internal Medicine, Division of Cardiology
2015-	Consultant	Boston IVF Ethics Committee

Major Administrative Leadership Positions

Local

2026 -	Associate Director of Ethics	Brigham and Women's Hospital
2015 -	Director	Center for Bioethics; Harvard Medical School 2014-2015 Faculty member
2015-	Course Director and Designer	Reproductive Bioethics, Center for Bioethics; Harvard Medical School
2017	Conference Organizer	Center for Bioethics Annual Conference, Harvard Medical School
2018-2019	Associate Director	Fellowship in Minimally Invasive Gynecologic Surgery, BIDMC (fellowship discontinued)
2019	Conference Organizer	BIDMC Ethics Consult Service Conference

Committee Service

Local

2004-2010	Member	Parkland Ethics Committee, Parkland Memorial Hospital, Dallas, TX
2010-2012	Member	Stanford Ethics Committee, Stanford University Hospital, Palo Alto, CA
2012	Member	Operating Room Committee for HIPPAA compliant storage of images from new video technologies, BIDMC
2012-	Member	Quality Assurance Committee, Obstetrics and Gynecology, BIDMC
2013	Member	"Faculty Hours" Operating Room Committee , BIDMC Developed policy for safe use of light cord in laparoscopic surgery

2013-	Member	Gynecology Leadership Committee, BIDMC		
		2013-2014	Member	Subgroup Developed policy for and type of screen in pre-op between OB/GYN and anesthesia
		2014	Member	OB/GYN Subgroup crafting DG17 Policy
		2014-2015	Member	Subgroup to develop total laparoscopic hysterectomy pathways
2014-	Member	Community Ethics Committee, Harvard Hospitals		
2015-	Member	Ethics Program, Harvard Pilgrim Health Care		
2017-2018	Member	Critical Thinking Working Group, BIDMC		
2017-2020	Member	Ethics Advisory Committee		
2017	Member	Search Committee, Faculty recruitment for Urogyn Division, BIDMC		
2018-2020	Member	Ethics Liaison, BIDMC		
2018-2020	Member	Perioperative Throughput Task Force, East Campus, BIDMC		
2021-	Member	Behavioral Health, Endocrinology, Urology (BE-U) Program, Disorders and Differences in Sex Development Advisory Committee, Boston Children's Hospital Ethics Committee		
2021	Member	Ethics Committee, Brigham and Women's Hospital		

Professional Societies

2000-	**American Medical Association (AMA)**			
	2016- 2025	Member	Editorial Board, AMA Journal of Ethics	
2000-	**American Society for Bioethics and Humanities (ASBH)**			
2008-	**American College of Obstetricians and Gynecologists (ACOG)**			
	2008-2010	Member	Committee on Practice Bulletins	
	2012-2016	Member	Committee on Professional Liability	
	2016-2019	Member	Committee on Patient Safety and QA	
	2017	Editor	Recorded talk on safety, reliability and ethics in the surgical environment	
	2017	Editorial support	Casebook for medical students on errors and disruptive behaviors in surgical setting	
	2019	Member	Ethics Committee	
	2021-2025	Vice Chair	Ethics Committee	
2012-	**Massachusetts Chapter American College of Obstetricians and Gynecologists**			
	2012	Member	Legislative Committee	
	2014	Panel Coordinator	District 1 Junior Fellows Day	
	2014-2016	Young Member	District 1 Advisory Board	
	2018-	**Secretary/Treasurer**		
2010-	**American Society of Reproductive Medicine (ASRM)**			

2010	**American Association of Gynecologic Laparoscopists (AAGL)**		
	2017-2018	Member	Committee on Ethics
	2019-	**Chair**	Committee in Ethic
	2020	**Chair**	JMIGS Publication Ethics Committee
2012-	**Society for Laparoscopic Surgeons (SLS)**		
	2017-	Board Member	
2014-	**Boston Obstetrical Society (Fellow)**		

Editorial Activities

Ad hoc reviewer

Journal of Minimally Invasive Gynecologic Surgery
Journal of the Society of Laparoscopic Surgeons
Fertility and Sterility
Hastings Center Report

Other Editorial Roles

2008	Theme Editor	Medical Care for U.S. Immigrants. Virtual Mentor, American Medical Association Journal of Ethics. April 2008, Volume 10, Number 4: 191-194. http://virtualmentor.ama-assn.org/
2013,2017	Assistant to Editors	Nezhat's Operative Gynecologic Laparoscopy and Hysteroscopy, 4th edition
2016-2025	Editorial Board	AMA Journal of Ethics
2016-2017	Co-editor	Supplemental edition of Hastings Center Report
2019	Editor	Case Book on Reproductive Bioethics in process - Springer

Honors and Prizes

2002	Honorable Mention; Martin Luther King Scholarship	UT Southwestern Medical School	Community Service
2007	Chairman's Award	UTSMS Residency Obstetrics and Gynecology	Outstanding Intern
2010	Outstanding Resident in Ambulatory Gynecology	UTSMS Residency Obstetrics and Gynecology	

Report of Funded and Unfunded Projects

Funding Information

Past

2015-2017	OvaScience Ethics Committee Ethicist, Member of Ethics Committee *Evaluation of ethics of various policies for publicly traded reproductive medicine company. Three major products all of which sought to use mitochrondrial transfer to improve oocyte health.*
2018-2019	Eleanor and Miles Shore Fellowship Program for Scholars in Medicine; PI *Study of surgical volume in gynecologic surgery and relation to ethical requirements around informed consent; survey studies conducted nationally. Reporting of results ongoing.*
2019-2020	Radcliffe Accelerator Grant PI/ Coordinator of Meeting Support for two-day seminar to discuss ethical issues surrounding transfer of genetically anomalous embryos.

Current Unfunded Projects

2019- Resubmitted for 2021	Bacillus Calmette–Guerin (BCG) vaccine to treat endometriosis Co-PI We plan to use a live vaccine to reset the immune system in endometriosis patients.

Report of Local Teaching and Training

Teaching of Students in Courses

Prior to Harvard Appointment

2005	GYN Pelvic Exam	2-3 hours course taught 6 times UT Southwestern Medical Center
2005	Anatomy tutor 1st year medical students	6 hours / week fall semester UT Southwestern Medical Center
2005	Ethics and Genetics 1st year medical students	3 hours / week UT Southwestern Medical Center
2007-2010	Race, Genetics, and Ethics 1st year medical students	2 hour lecture each year UTSWMC Ethics in Science and Medicine

After Harvard Appointment

2013-	Practice of Medicine (POM)	HMS Longwood Campus
2013-	Professional Development 1 Ethics – Truth Telling and Confidentiality	1.5 hour lecture BIDMC
2014-2019	Boot Camp Faculty	2 hours per year
	Essentials of the Profession 1 (codirected with [Name omitted])	2 hours for each class BIDMC

	Covid Case and Introduction Informed Consent Deciding for Others History and Ethics of Research (1.5 hours) Rationing and Futility Reproductive Ethics Ethics of Disparities Ethics at End of Life 1st and 3rd year medical students	
	Essentials of the Profession 2: Moral Distress and Futility The Physician as Double Agent Disclosure and Apology After Medical Error and Adverse Events Ethics at the End of Life 2: Physician Assisted Suicide and Euthanasia Professional Obligations during a Pandemic (previously ethics in global health) – 2 hours Ethics of Access to Reproductive Health Services Conflicts of Interest: Identification and Prevention	Each 2 hour course taught twice in Spring and in Fall
2015-2019	Reproductive Bioethics	
2018-	Teaching Fellow – Fundamentals - MBE	
2015-	Center for Bioethics Clinical Bioethics Course - MBE	Regular lecture on reproductive bioethics yearly
2017-	Center for Bioethics – Lecturer for Clinical Ethics - MBE	3 hour lecture on reproductive bioethics to master's students
2018-	Center for Bioethics – Lecturer for Fellowship in Bioethics	3 hour lecture on reproductive bioethics to fellowship students

Formal Teaching of Residents, Clinical Fellows and Research Fellows (post-docs)

2012-2020	Didactics	BIDMC OBGYN residents 6 hours over course of year
2013-2020	Yearly Didactics	BIDMC REI Fellows 2-4 hours yearly – including ethics
2017	Gynecologic "SIM Olympics"	BIDMC 3 hour course for residents

Clinical Supervisory and Training Responsibilities

2005	Trainer for gynecologic pelvic exam	Southwestern Medical Center 2-3 hour course, taught 6 times
2012-2020	Teaching in OR OB/GYN residents in BIDMC OR	BIDMC 8-20 hours weekly
2012-2020	Teaching in OR of Reproductive Endocrinology and Infertility Fellows	BIDMC Needham OR 8-12 hours monthly
2013-2020	Preceptor, Obstetrics and Gynecology Resident practice	Range 0-12 hours per week 2013 -2020 BIDMC 2020- BWH Continuity Clinic
2013-2020	Preceptor, Obstetrics and Gynecology Resident practice	Range 0-12 hours per week BIDMCs 2013 -2020 Continuity Clinic 2020- BWH

Formally Mentored Harvard Medical and Graduate Students:

2010-2014	[Name omitted] – Stanford Medical School Class of 2014; Residency/Fellowship Anesthesia Children's Boston 2020/Clinical Assistant Professor Stanford Department of Anesthesiology I supervised [Name omitted] on several research projects during my fellowship at Stanford. He assisted us in creating databases of our surgical cases. I mentored him throughout his medical school years and kept in touch during his residency.
2014-2015	[Name omitted] – I supervised [Name omitted] efforts in research as a medical student. She is now and OBGYN resident at BWH.
2015-2017	[Name omitted] – Master's of Bioethics Mentee; Joint with PhD in Religion and Society, Tenure-Track Assistant Professor in Religious Studies/Bioethics (co-appointment in both departments) at University of Puget Sound, Tacoma, WA. I supervised [Name omitted] as a master's candidate and assisted with her Capstone.
2015-2016	[Name omitted] – Master's of Bioethics Mentee I supervised [Name omitted] as a Master's student and assisted with her Capstone.
2016-2017	[Name omitted] – Master's of Bioethics Mentee I supervised [Name omitted] as a Master's student and assisted with her Capstone. Now an accredited specialist in personal injury law
2016-2017	[Name omitted] – Master's of Bioethics Mentee. I supervised [Name omitted] as a Master's student and assisted with her Capstone, currently working at Journal of Law and Biosciences as an editor.
2016-2017	[Name omitted] – Master's of Bioethics/Capstone Mentee. I supervised [Name omitted] as a Master's student and assisted with her Capstone. Currently Senior Director at SOPHIA GENETICS.

2016-2017 [Name omitted] – BIDMC ethics program
I supervised [Name omitted] in her work at post grad philosophy work BIDMC and we wrote one paper together. Community engagement at Hebrew Senior Life.

2017- [Name omitted] – Harvard College student, Senior analyst at clear view healthcare partners soon to enter medical school
I supervised [Name omitted] as a Harvard history student and assisted with her thesis. She will soon enter medical school.

2017-2019 [Name omitted] – HMS student – AMA JOE monthly online discussion forum
Resident in Pediatric Neurology at Stanford
I supervised Dr [Name omitted] in his work with campus group devoted to ethics.

2017-present [Name omitted] – Master's of Bioethics
I supervised [Name omitted] as a Master's student and assisted with her Capstone.
She is now an OBGYN resident in Canada.

2017-2018 [Name omitted] – Master's of Bioethics Mentee
I supervised [Name omitted] as a Master's student and assisted with her Capstone.
She hopes to enter medical school.

2017-2018 [Name omitted] – Master's of Bioethics Mentee, Researcher at Olivares Navarrete Lab
I supervised [Name omitted] as a Master's student and assisted with her Capstone.

2018-2019 [Name omitted] – Master's of Bioethics/Capstone Mentee
I supervised [Name omitted] as a Master's student and assisted with her Capstone
OBGYN resident Toronto. We recently submitted a paper together for publication

2018-2019 [Name omitted] – Master's of Bioethics Mentee, Attorney at Bradley Healthcare practice group
I supervised [Name omitted] as a Master's student and assisted with her Capstone.

2018-2019 [Name omitted] – Master's of Bioethics Mentee, EVP at Walkers and Turner
I supervised [Name omitted] as a Master's student and assisted with her Capstone.

2018-2019 [Name omitted] – Master's of Bioethics Mentee, Research Assistant at Baylor College of Medicine
I supervised [Name omitted] as a Master's student and assisted with her Capstone.

2019-2020 [Name omitted] – Master's of Bioethics Mentee, Senior Policy Analyst at Health Canada
I supervised [Name omitted] as a Master's student and assisted with her Capstone.

2019- 2020 [Name omitted] – Master's of Bioethics Mentee, Current Master's student
I supervised [Name omitted] as a Master's student and assisted with her Capstone.

2019 [Name omitted] – MD candidate scholarship project
Obstetrics and gynecology resident at NYU Langone health
I supervised [Name omitted] as a Master's student and assisted with her Capstone
We wrote a published paper together

2019 [Name omitted] – Master's of Bioethics/Capstone Mentee, medical student at UC Irvine in the program for medical education for the Latino community
I supervised [Name omitted] as a Master's student and assisted with her Capstone.

2018-2019	[Name omitted] – Master's Public Health, Second thesis advisor I supervised [Name omitted] for her Master's thesis on abortion and amici briefs to Supreme Court.
2018-2020	[Name omitted] – Former Master's of Bioethics student, PhD candidate OHSU I supervised [Name omitted] as a Master's student and we have a paper in press together.
2020-2021	[Name omitted] – Current Master's student
2020-2021	[Name omitted] – Current Master's student – HMS medical student to start 2021
2020-2021	[Name omitted] – Current Master's student
2020-2021	[Name omitted] – Current Master's student
2020-2021	[Name omitted] – Current Master's student

2010-2014	[Name omitted] **MD / Assistant Professor Anesthesiology, Stanford**, **CA** Supervised on various research projects at Stanford Medical School, recently matched to Combined Anesthesia/Pediatric program at Harvard
2013-2014	[Name omitted] **MD, MPH / Assistant Professor**, **OB/GYN, Vanderbilt University Medical Center** Supervised through work on projects and through match process
2013-2014	[Name omitted] **MD / OB/GYN Mount Auburn Hospital, Cambridge, MA** Mentoring for residency program
2014-2015	[Name omitted]**, MD / Fellow Female Pelvic Medicine, Cleveland Clinic, Cleveland, OH** Supervised on projects related to OSATS testing for suturing skills and ACOG District 1 activities
2015-2016	[Name omitted] **MD/ OBGYN George Washington Faculty Associates** Mentored writing a chapter on ectopic pregnancy

Formal Teaching of Peers (e.g., CME and other continuing education courses)

2013	Advancing Robotic Surgical Skills in Gynecology CME	1 talk, afternoon of hands-on training BIDMC
2013	Uterine Fibroids BIDMC lunch lecture, primary care/nursing staff	1 talk BIDMC
2013	Contraceptives Update for primary care staff	1 talk BIDMC
2015	Needham perioperative talks	2 talks BID Needham

Local Invited Presentations

2004	Lecture	*Health Insurance and Cardiac Transplantation* Parkland Memorial Hospital, Dallas, TX
2004	Lecture	*Cardiac Amyloid and V122I Mutant Transthyretin in African Americans: Results from Dallas Heart Study* Donald W. Reynolds Clinical Cardiovascular Research Center, Dallas, TX: Works in Progress series
2011	Grand Rounds	Safe Laparoscopic Entry Department of OB/GYN, Kaiser, Santa Clara, CA
2012	Reading	Non-Fiction Reading "Stick," Pegasus Physicians of Stanford (CA) cold reading of my non-fiction piece to audience
2014	Grand Rounds	*Uterine Morcellation* BIDMC Needham
2015	Invited Speaker	*Debate on Abortion* Harvard Law School Federalist Society
2016	Invited Speaker	The Limits to Consumerism in Health Care Harvard Law School/Petrie Flom
2016	Lecture	Fraiman Lecture on Medical Ethics, Cambridge Health Alliance. Cambridge, MA
2017	Grand Rounds	*Pelvic Pain*
2017	Grand Rounds	*Reproductive Bioethics* Sponsored REI Nurses Village Pharmacy
2018	Grand Rounds	Reproductive Bioethics Mass General Hospital. Boston, MA
2019	Lecture	*Birth Rights and Wrongs* Harvard Law School/Petrie Flom

Report of Regional, National and International Invited Teaching and Presentations

No presentations below were sponsored by 3rd parties/outside entities

Invited Presentations and Courses

2017	Lecture	*Ethics in ART* New England Fertility Society Annual . Location

National

2004 African Americans have an increased prevalence of heart failure: the Dallas Heart Study / oral

	presentation to large national audience Doris Duke Clinical Research Fellowship Yearly Conference, Asilomar, CA
2011	AAGL (American Association of Gynecologic Laparoscopists) Moderator Section of Plenary Session Annual Meeting Hollywood Florida
2011	Annual Meeting on Laparoscopic, Robotic & Vaginal Hysterectomy with Comprehensive Hands-on Workshop on Laparoscopic Suturing & Knot-Tying with Simulation in New York, Simulation Preceptor
2011	SLS (Society of Laparoscopic Surgeons) Moderator Section of Plenary Session Annual Meeting Los Angeles California
2013	Social Media; Ambulatory Surgery Centers 20th Annual Future Trends in Minimally Invasive Gynecologic Surgery Conference (http://www.holycrosshealth.org/gate)
2014	Harvard Clinical Bioethics Course – Core Case in Obstetrics and Gynecology Boston, MA
2015	AAGL Annual Meeting "Overview of Contract Law for Surgeons" Invited presentation
2016	Harvard Center for Bioethics – Social Justice Conference – Fairness in Access to ART
2016	AAGL Boot Camp
2016	AAGL Annual Meeting – trainer for morcellation techniques
2016	SLS Annual Meeting– Ethics in Surgical Consent Process
2016-2018	HMS 4 credit course in Reproductive Bioethics
2017	New England Fertility Society Annual Meeting – Ethics in ART
2017	ACOG National Meeting – Ethics in OBGYN
2017	Harvard Clinical Bioethics Course – Basics of Reproductive Bioethics
2017	Hastings/Harvard Fellowship – Reproductive Bioethics
2018	Harvard Clinical Bioethics Course – Basics of Reproductive Bioethics
2018	Hastings/Harvard Fellowship – Reproductive Bioethics
2018	HMS Master's Bioethics – clinical reproductive bioethics
2019-	HMS 2 credit course in Reproductive Bioethics
2019	NIH (NCI) Gynecology and Women's Health: Benign Conditions and Cancer Workshop
2019	Harvard Clinical Bioethics Course – Basics of Reproductive Bioethics; Surgical Ethics; Genetics (3 lectures)
2019	Hastings/Harvard Fellowship – Reproductive Bioethics
2019	HMS Master's Bioethics – clinical reproductive bioethics
2019	Adolescent Gynecology Course – Ethics in Pediatric and Adolescent Gynecology
2020	Petrie Flom – Forum – June Medical

National

2004	Lecture	*African Americans Have an Increased Prevalence of Heart Failure: The Dallas Heart Study*
	Presentation	Doris Duke Clinical Research Fellowship Yearly Conference, Asilomar, CA
2011	Moderator	Section of Plenary AAGL (American Association of Gynecologic Laparoscopists) Annual Meeting. Hollywood, FL
2011	Workshop, Simulation Preceptor	*Laparoscopic Suturing & Knot-Tying with Simulation* Laparoscopic, Robotic and Vaginal Hysterectomy with Comprehensive Hands-on in New York, Annual Meeting

2011	Moderator	Section of Plenary Session, SLS (Society of Laparoscopic Surgeons), Annual Meeting Los Angeles CA
2013	Lecture	*Ambulatory Surgery Centers* 20th Annual Future Trends in Minimally Invasive Gynecologic Surgery Conference (http://www.holycrosshealth.org/gate)
2014		Harvard Clinical Bioethics Course – Core Case in Obstetrics and Gynecology Boston, MA
2015	Invited Presentation	*Overview of Contract Law for Surgeons* AAGL American Association of Gynecologic Laparoscopists Annual Meeting.
2016	Lecture	*Fairness in Access to ART* Social Justice Conference, Harvard Center for Bioethics
2016	Trainer	*Boot Camp* *Morcellation Techniques* AAGL American Association of Gynecologic Laparoscopists Annual Meeting
2016	Lecture	*Ethics in Surgical Consent Process* SLS (Society of Laparoscopic Surgeons) Annual Meeting
2016-2018		HMS 4 credit course in Reproductive Bioethics
2017		*Ethics in Ob/GYN* ACOG American College of Obstetrics and Gynecology National Meeting
2017		Harvard Clinical Bioethics Course – Basics of Reproductive Bioethics
2017		Hastings/Harvard Fellowship – Reproductive Bioethics
2018		Harvard Clinical Bioethics Course – Basics of Reproductive Bioethics
2018		Hastings/Harvard Fellowship – Reproductive Bioethics
2018		HMS Master's Bioethics – clinical reproductive bioethics
2019-		HMS 2 credit course in Reproductive Bioethics
2019		NIH (NCI) Gynecology and Women's Health: Benign Conditions and Cancer Workshop
2019		Harvard Clinical Bioethics Course – Basics of Reproductive Bioethics; Surgical Ethics; Genetics (3 lectures)
2019		Hastings/Harvard Fellowship – Reproductive Bioethics

2019	HMS Master's Bioethics – clinical reproductive bioethics
2019	*Ethics in Pediatric and Adolescent Gynecology* Adolescent Gynecology Course
2020	Petrie Flom – Forum – June Medical

International

2014	AAGL Annual Meeting "Roundtable:" What to do if you are sued
2014	AAGL Annual Meeting Co-Course Director: Surgical Misadventures (discussion of surgical risk management and liability issues in minimally invasive gynecologic surgery) ASRM ABOG Foundation Ken Ryan Ethics Symposium – Invited Plenary – Ethics of Egg
2017	Freezing
2018	SLS Ethics in Surgery – SLS Annual Meeting
2019	ASBH Elective Oocyte Cryopreservation for Women Under 30: a Help or a Hindrance to Autonomy? (Panel)
2019	ASBH Surgical Bioethics (Panel)
2019	ASRM Advertising in Elective Oocyte Cryopreservation – Critique

2014	Roundtable Discussion	*What to Do If You Are Sued* Surgical Misadventures (Co Course Director) AAGL American Association of Gynecologic Laparoscopists Annual Meeting
2017	Invited Plenary	*Ethics of Egg Freezing* ASRM (American Society for Reproductive Medicine) ABOG Foundation Ken Ryan Ethics Symposium.
2018	Lecture	*Ethics in Surgery* SLS (Society of Laparoscopic Surgeons) Annual Meeting
2019	Panel	*Elective Oocyte Cryopreservation for Women Under 30: A Help or a Hindrance to Autonomy?*
	Panel	*Surgical Bioethics* American Society for Bioethics and Humanities (ASBH) Conference
2019	Lecture	*Advertising in Elective Oocyte Cryopreservation – Critique* ASRM (American Society for Reproductive Medicine)

<u>Report of Clinical Activities and Innovations</u>

Current Licensure and Certification

2012	Massachusetts Medical License 251835

2013 Board Certified, American Board Obstetrics and Gynecology

Practice Activities Minimally Invasive Gynecologic Surgery

2012-	Minimally invasive gynecologic surgery	BIDMC / BIDMC Needham	80%

Clinical Innovations

Report of Education of Patients and Service to the Community

Activities

2017-	Mentor	Winsor High School – served as mentor to senior interested in health profession [none of my children attend this school]
2018		Career Day – Cathedral High School, Boston MA

Educational Material for Patients and the Lay Community

Books, monographs, articles and presentations in other media

2000-2001	Presentation	"Scare them Straight" program for first offenders in juvenile justice system Lecture Series, County of Dallas Probation Department

Educational material or curricula developed for non-professional students

2003	Contributor	*Essays That Worked for Medical Schools: 40 Essays from Successful Applications to the Nation's Top Medical Schools* Baer, Jones; Ballantine Books, New York, 2003
2006-2010	Author	*Intern to Intern Guide UTSW Residency* Used for residents at UT Southwestern Medical Center, Parkland Memorial Hospital, Dallas, TX

Report of Scholarship

Peer Reviewed Publications in print or other media

Research Investigations

1. Sharma N, Rutherford JD, Grayston JT, **King LP**, Jialal I, Andrews TC. Association between C-reactive protein, anti-Chlamydia pneumoniae antibodies, and vascular function in healthy adults. American Journal of Cardiology 87(1): 119-21, 2001.

2. Estep JD, Mehta SK, Uddin F, **King L**, Toto KH, Nelson LL, Dries DL, Yancy CW, Drazner MH. Beta-blocker therapy in patients with heart failure in the urban setting: moving beyond clinical trials. American Heart Journal 148(6): 958-63, 2004.

3. Markham DW, Dries DL, **King LP**, Leonard D, Yancy CW, Peshock RM, Willett D, Cooper RS, Drazner MH. Blacks and whites have a similar prevalence of reduced left ventricular ejection fraction in the general population: The Dallas Heart Study (DHS). American Heart Journal 155(5): 876-82, 2008.

4. Thibodeau JT, Rao MP, Gupta C, Ayers CR, Gupta S, Mammen PP, Markham DW, Mishkin JD, Patel PC, **King LP**, Drazner MH. Health insurance as a requirement to undergo cardiac transplantation: a national survey of transplant program practices. Transplant Proc. 2013 Jan-Feb;45(1):360-3

5. Hur HC, **King LP**, Klebanoff MJ, Hur C, Ricciotti HA Fibroid morcellation: a shared clinical decision tool for mode of hysterectomy. Eur J Obstet Gynecol Reprod Biol. 2015 Dec;195:122-7.

6. Franconeri A, Fang J, Carney B, Justaniah A, Miller L, Hur HC, **King LP**, Alammari R, Faintuch S, Mortele KJ, Brook OR. Structured vs narrative reporting of pelvic MRI for fibroids: clarify and impact on treatment planning. Eur Radiol. 2018 Jul;28(7):3009-3017.

7. Jaramillo-Cardoso A, Shenoy-Bhangle A, Garces-Descovich A, Glickman J, **King L**, Mortele KJ. Pelvic MRI in the diagnosis and staging of pelvic endometriosis: added value of structured reporting and expertise. *Abdom Radiol (NY)*. 2020;45(6):1623-1636. doi:10.1007/s00261-019-02199-6

8. Alammari RA, Jorgensen EM, Modest AM, Chu J, **King LP**, Awtrey CS. Impact of prior hysterectomy on surgical outcomes for laparoscopic adnexal surgery. Surg Endosc. 2019 Sep 3. doi: 10.1007/s00464-019-07083-4.

Other Peer Reviewed

Reviews, Case Reports or series, descriptions of new methods or theories of full length proceedings of meetings

1. **King LP**, Siminoff LA, Meyer DM, Yancy CW, Ring WS, Mayo TW, Drazner MH. Health insurance and cardiac transplantation: A call for reform. Journal of American College of Cardiology 45(9): 1388-91, 2005.

2. **King LP**. Sex selection for nonmedical reasons. Virtual Mentor American Medical Association Journal of Ethics 9(6): 405-469, 2007.

3. **King LP**. Why we can't turn our backs. Virtual Mentor American Medical Association Journal of Ethics. 10(4): 191-194, 2008.

4. **King LP**, Wendel, G. Laborist staffing requires special attention. Virtual Mentor American Medical Association Journal of Ethics 10(12): 792-796, 2008.

5. **King LP**, Miller, DS. Gynecologic oncology group trials in uterine corpus malignancies: Recent progress. Journal Gynecologic Oncology 19(4): 218-222, 2008.

6. **King LP**. Educating patients as medicine goes green. Virtual Mentor American Medical Association Journal of Ethics 11: 427-433, 2009.

7. **King LP**, Miller DS. Recent progress: gynecologic oncology group trials in uterine corpus tumors. Rev Recent Clin Trials 2009;4:70-4.

8. Nezhat C, Cho J, **King LP**, Hajhosseini B, Nezhat F. Laparoscopic management of adnexal masses. Obstet Gynecol Clin North Am 2011;38:663-76.

9. Nezhat C, Gomaa M, Hajhosseini B, **King LP**. Robotic-assisted laparoscopic treatment of bowel, bladder and ureteral endometriosis. Journal of the Society of Laparoendoscopic Surgeons 2011; 15(3); 387-92.

10. Nezhat C, Hajhosseini B, **King LP**. Laparoscopic management of bowel endometriosis: A study of one hundred and ninety-three cases with special reference to predictors of severe disease and recurrence. JSLS 2011 Jul-Sep;15(3):387-92

11. Nezhat C, **King L**, Paka C, Odegaard J, Beygui R. Bilateral thoracic endometriosis affecting the lung and diaphragm - Case report. JSLS. 2012 Jan-Mar;16(1):140-2.

12. **King LP,** Hajhosseini B, Gomaa MM. Pioneers in laparoscopic colon surgery. J Am Coll Surg. 2011 Mar;212(3):423-4. doi: 10.1016/j.jamcollsurg.2010.11.007.

13. Nezhat C, Modest AM, **King LP**. The role of the robot in treating urinary tract endometriosis. Curr Opin Obstet Gynecol. 2013 Aug;25(4):308-11.

14. **King LP**, Nezhat C Perils and promise in big data Fertil Steril 2015 Jun;103(6):142

15. Nezhat C, Falik R, McKinney S, **King, LP** Pathophysiology and management of urinary tract endometriosis Nat Rev Urol 2017 Jun; 14(6): 359-72

16. Mapes M, O'Brien B, **King LP** How should clinicians counsel a woman with a strong family history of early-onset alzheimer's disease about her pregnancy? AMA JOE AMA J Ethics. 2017 Jul 1;19(7):663-674.

17. **King, LP**, Zacharias R, Johnston J Autonomy in tension: *Reproduction, Technology, and Justice* Hastings Center Report Hastings Cent Rep. 2017 Dec;47 Suppl 3:S2-S5.

18. **King LP** Should clinicians set limits on reproductive autonomy? Hastings Center Report Hastings Cent Rep. 2017 Dec;47 Suppl 3:S50-S56

19. **King LP**, Penzias A. Fostering discussion when teaching abortion and other morally and spiritually charged topics. AMA J Ethics. 2018 Jul 1;20(7):E637-642.

20. Brennan L, Milad MP, **King LP**. The morcellation "debate" and the FDA 510(k) Process-A call for further reform. Obstet Gynecol Surv. 2019;74(12):679-692. doi:10.1097/OGX.0000000000000733

21. **King LP** A reluctant critic: Why gynecologic surgery needs reform. Hastings Cent Rep. 2019 May;49(3):10-13. doi: 10.1002/hast.1001.

22. Bayefsky MJ, DeCherney AH, **King LP**. Respecting autonomy-a call for truth in commercial advertising for planned oocyte cryopreservation. *Fertil Steril*. 2020;113(4):743-744.

23. Glaser LM, Brennan L, **King LP**, Milad MP. Surgeon volume in benign gynecologic surgery: A review of outcomes, impact on training, and ethical contexts. J Minim Invasive Gynecol. 2018 Sep 19. pii: S1553-4650(18)31245-7.

24. Watson KL, **King LP**. Double discrimination, the pay gap in gynecologic surgery, and its association with quality of care. Obstet Gynecol. 2021 Apr 1;137(4):657-661.

25. House KB, Kelley S, Sontag DN, **King LP,** Ending restraint of incarcerated individuals giving birth AMA J Ethics. 2021;23(4):E364-368.

Non -Peer Reviewed Publications in print or other media

Proceedings of Meetings or other non-peer reviewed research
Reviews, Chapters Monographs and Editorials

1. Stowe Locke Teti, Christy Cummings, **Louise P. King**, Cynthia C. Coleman, Kayla Tabari and Christine Mitchell. Should new mothers with Covid-19 be separated from their newborns? https://www.thehastingscenter.org/why-new-mothers-with-covid-19-should-not-be-separated-from-their-newborns/

2. **Louise P King**, Lena Dunham's Lesson for Doctors https://www.thehastingscenter.org/lena-dunhams-lesson-doctors/

3. **Louise P King,** #MedBikini and Social Media Peer Review https://blog.petrieflom.law.harvard.edu/2020/07/31/medbikini-social-media-peer-review/

4. Jonathan M. Marron, **Louise P. King**, and Paul C. McLean Ethical Duties of Health Care Providers and the Public in the Time of COVID-19 https://blog.petrieflom.law.harvard.edu/2020/04/16/ethical-duties-health-care-providers-covid19/

5. **Louise P King**, Preventing Access to Abortion is Prima Facie an "Undue Burden" https://blog.petrieflom.law.harvard.edu/2020/07/16/preventing-access-abortion-undue-burden/

6. **King LP** It's the End of Sex as We Know it and I Feel a Little Nervous Hastings Center Report, 2017 47: 42–43

Books, Textbooks

1. **King LP**. Endometrial cancer in now what? Ob/Gyn Patient Encounters. Rajiv Gala ed. Lippincott Williams and Wilkins. 2009.

2. Nezhat C, Veeraswamy A, **King LP**. The Place of the Surgical Robot for Expert Laparoscopists. In: Wetter P, ed. Prevention and Management. 3 ed. Miami, Fl: Society of Laparoendoscopic Surgeons; 2011.

3. Nezhat C, Lewis M, **King LP**. Laparoscopic vessel sealing devices. In: Wetter P, ed. Prevention and Management. 3 ed. Miami, Fl: Society of Laparoendoscopic Surgeons; 2011.

4. Nezhat C, Nezhat C, Nezhat F, Ferland R, Lewis M, **King LP**. Laparoscopic access. In: Wetter P, ed. Prevention and Management 3ed. Miami, FL: Society of Laparoendoscopic Surgeons; 2011.

5. Kopelman D, **King LP**, Nezhat C. Intestinal endometriosis. In: Wetter P, ed. Prevention and Management. 3 ed. Miami, Fl: Society of Laparoendoscopic Surgeons; 2011.

6. Kopelman, **King LP**, Nezhat Laparoscopic management of intestinal endometriosis in Nezhat's Operative Gynecologic Laparoscopy and Hysteroscopy 4th ed. Cambridge University Press 2013

7. Nezhat, **King LP** et al Laparoscopic management of adnexal masses in Nezhat's Operative Gynecologic Laparoscopy and Hysteroscopy 4th ed. Cambridge University Press 2013

8. **King LP** et. al. Safe laparoscopic access in Nezhat's Operative Gynecologic Laparoscopy and Hysteroscopy 4th ed. Cambridge University Press 2013

9. **King LP** et al Non tubal ectopic pregnancies: Diagnosis and management in Management and Therapy of Early Pregnancy Complications. Springer 2016

10. **King LP** et. al. safe laparoscopic access in Nezhat's Operative Gynecologic Laparoscopy and Hysteroscopy 5th ed. In press

11. **King LP** et. al. Operative hysteroscopy in Nezhat's Operative Gynecologic Laparoscopy and Hysteroscopy 5th ed. In press

12. **King LP** et al Uterine Fibroids Taylor and Francis 2019

13. **King LP** et al Pelvic Pain in Scientific American Obstetrics and Gynecology 2018

Letters to Editor

1. Drazner, MH, **King LP**. Letter to the Editor: Economic . Journal of American Medical Association 299(2): 2512, 2008.

Professional Educational Materials or Reports, in print or other media

King LP "ACOG is you" https://www.acog.org/About-ACOG/ACOG-Departments/Junior-Fellows/ACOG-We-Are-You-Video?IsMobileSet=false

King LP ASRM Webinar Planned oocyte Cryopreservation: Medical, ethical and social considerations https://www.asrm.org/resources/videos/ethics-webinars/webinars/ethics-webinar-planned-oocyte-cryopreservation/

Clinical Guidelines and Reports

ACOG Committee Opinion 583, Committee on Professional Liability, Predispute Voluntary Binding Arbitration; Lead Author (http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Professional_Liability/Predispute_Voluntary_Binding_Arbitration)

ACOG Committee Opinion, Committee on Professional Liability, Social Media; Lead Author (within group of 3 authors)

AAGL, Essentials in Minimally Invasive Gynecologic Surgery, Chapter on Safe Laparoscopic Access in Gynecologic Surgery; Complications in Laparoscopic Gynecologic Surgery, Lead Author (within group of six authors)

ACOG Policy Statement on Innovation (first author - 2016)

ACOG online materials related to appropriate professional behavior and consequences of poor professional behavior (One of five authors – 2016)

Abstracts, Poster Presentations and Exhibits Presented at Professional Meetings

Thesis

African American Ethnicity and Cardiovascular Disease: Selected Issues. Thesis in support of MD with distinction in research. Mentor Mark S. Drazner MD

Narrative Report

During my time at HMS, BIDMC and now BWH, I have merged my unique skill sets in law, mediation, ethics, medicine and surgery to become a national leader in reproductive health and justice.

My specific area of clinical expertise which provides a unifying theme for my academic activities and achievements is *Clinical Expertise, Innovation and Ethics in Minimally Invasive Gynecologic Surgery with a focus in Reproductive Bioethics.*

I am currently a member of the Department of Obstetrics and Gynecology, Division of Minimally Invasive Gynecologic Surgery. I spend the majority of my time providing care to the local and regional community, addressing complex gynecologic medical and surgical issues. Eighty percent of my time is spent in providing clinical care; roughly half that clinical time I am also teaching and supervising a medical student, resident, or fellow. My remaining time is divided between classroom teaching, creating academic material, mentoring, clinical research and scholarship.

I am an innovator in evaluating and developing models of care in Advanced Gynecologic Surgery that focus on quality and justice. One exemplary publication in this regard is Pathophysiology and management of urinary tract endometriosis. I have developed multiple curricula and workshops for our residents, fellows, medical students and masters' level students. I have published widely on safety in laparoscopic surgery and have worked to create protocols addressing safety and liability issues in the operating room at BIDMC (prior to a move to BWH) and on a national level through my work with ACOG and AAGL. I serve as Director of Research in my division and Associate Program Director for our fellowship.

Since my promotion to Assistant Professor, a large part of my teaching and writing has focused on ethical issues that arise in reproductive health. One exemplary set of publications in this area is a supplement to

the Hastings Center Report found at https://www.thehastingscenter.org/publications-resources/special-reports-2/just-reproduction-reimagining-autonomy-reproductive-medicine/. I am the Director of Reproductive Bioethics at the Center for Bioethics and consult with all HMS affiliated REI groups. In that role I mentor 1-2 students per year, created and run a popular course on reproductive ethics and give a well-received yearly lecture on the same topic to the master's and fellowship students. I co-direct the first year HMS ethics course and in that role worked collaboratively with local and national leaders to change the curriculum at HMS around abortion and reproductive justice to ensure inclusion of varied viewpoints while encouraging a focus on disparities. I received a Radcliffe Accelerator Grant focusing on issues related to genetics, selection in assisted reproduction and disability which has resulted in a recent submitted publication and various ongoing projects and collaborations.

I serve on multiple committees and boards, in our hospital, locally, and nationally, working on legislative and bioethical issues. I am the chair of AAGL's ethics committees and previously served as Vice-Chair of ACOG's ethics committee. I served on the Board of the AMA Journal of Ethics. I recently published a piece in the Green Journal discussing sex and gender discrimination and am drafting legislation with collaborators nationally to address equity issues in gynecologic surgery. I hope to make lasting change in women's health during my career, not only in my direct interactions with my patients and in my teaching, but also in my broader work through legislative efforts and bioethics scholarship.

I believe my record supports one or more Significant Supporting Activities: Administration and Institutional Service Metrics for my leadership roles in national and local ethics committees as well as my direction of various educational efforts; Education of Patients and Service to the Community Metrics for various podcasts and outreach efforts including legislation in conjunction with patient advocacy groups; and Special Merit in Education Metrics for my role in leading educational efforts in ethics at HMS.

In sum, as an attorney, a surgeon and a bioethicist I have demonstrated a commitment to service, teaching, and research. I will continue to pursue projects demonstrating academic excellence and intellectual honesty.