

Predatory Medicine: Concealed Economies of Sexual Violence and Racial Capitalism

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Abstract

This article addresses the extensive sexual violence against women by physicians in the United States. I focus on the case of George Tyndall, a physician in California who sexually and racially violated hundreds of students at the University of Southern California for decades. Through an STS Black feminist lens, I argue that sexually predatory behavior by gynecologists is an invisible outcome of systemic mechanisms operationalized within healthcare and its institutional networks. I propose an analytic, predatory medicine, to examine the broad layers of intimidation and abuse of power, sociohistorical and over time, that conceal these complaints and cases to protect institutional power and its racist masculinist domination. I survey a diverse scope of sources such as film, legal documents, policy reports, and journalism.

Keywords

sexual violence, gynecology, intimidation, predatory, racial capitalism

Introduction

Sexual violence by physicians against patients, primarily women, is a silent plague in the United States. According to the *Atlanta Journal-Constitution* (AJC), between 1999 and 2015, 3,100 physicians were accused of sexual violations. Among these, 2,400 physicians received sanctions for sexual infractions directed at patients (Teegardin et al. 2016). The thousands of sexually violated patients are mostly women (cisgender and queer) but also include cisgender men and the members of

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the queer and trans community.¹ Among the victims who sought healthcare in private offices, hospitals and clinics, and university student health services are women of varying ages, sexual, gender, ethnic, and racial identities, and class statuses. Moreover, many sexual assault and abuse cases by physicians remain undetected and unreported because most “patient-victims” do not report sexual violations (DuBois et al. 2019, 504; Teegardin et al. 2016).²

The extensive history of sexual abuse cases in medicine presents an enormous landscape of abuse of power in medical authority. Convicted perpetrator gynecologists in the US include Robert Hadden, Peter LaFuria, Nikita Levy, and Brian Finkel. These physicians have been found guilty of criminal acts such as sexual abuse, rape, sexual assault, harassment, and voyeurism during examinations of their female patients. Aside from the sensationalized cases of sexual misconduct in sports by physicians such as Larry Nassar, only limited literature has paid attention to sexual violence in healthcare, specifically gynecology. However, the George Tyndall case reframes “medical criminality” and forces us to dig into how systems of power protect medical privilege (DuBois et al. 2019, 504).

The George Tyndall case is the most recent large-scale scandal to gain public visibility and legal attention. The late George Tyndall, a former gynecologist working for the University of Southern California’s (USC) student health services, was first accused in 1991 by a student of sexual misconduct.³ According to the *AJC*, USC initiated a query into sexual misconduct in 2006. However, Tyndall continued to work in the health services clinic despite ongoing reports by patients and staff to the administration. In 2016 a nurse complained to the USC rape crisis office about Tyndall’s behavior after years of reporting to the administration without recourse, and only then he was put on paid leave. In March 2018 the *Los Angeles Times* exposed the Tyndall case at USC following a lead from a unanimous source in February 2018 (see Los Angeles Times Staff 2019). Immediately after that, the *Los Angeles Times* retained over twenty anonymous reports. By 2021 seven hundred women—primarily students—had accused Tyndall of sexual assault.⁴

The *Los Angeles Times* investigation ruptured the long-standing silence about what became the most extensive legal case of sexual violence committed by a gynecologist against female patients in the US. One indication of the severity of this massive human tragedy and steep institutional culpability is the federal class-action lawsuit, which dispersed \$1.1 billion in settlements to about 17,000 former patients of Tyndall becoming the largest sex abuse payout in education history.⁵ USC’s recent efforts to show transparency and compliance with victims and the public include website disclosures of documents about evaluating all complaints over time. This institutional public response displays institutional accountability, responsibility, and solutions for women seeking justice. However, USC’s public response to the *Los Angeles Times* reporting and the subsequent flooding of

complaints and legal cases is an aftermath reaction that underscores protection of its prestige and institutional power on the world stage.

The term *predatory* is jarring when we think about the intimate relationship between physicians and patients during pelvic examinations. To be predatory is to exhibit a particular mode of lurking in plain or hidden sight to prey on patient vulnerability. Physicians who sexually violate women's bodies within medical spaces are rightly labeled predators. One woman, Erin Vance, whom an Oregon physician sexually assaulted while under anesthesia, told the *AJC*, "I mean, I couldn't move. I was completely at the mercy of whoever was there, and it turned out that the person who was there was a serial predator" (Teegardin et al. 2016). Vance uses the term *predator* to indicate why a physician would assault twelve patients (Norder 2016b). While many patient-victims like Vance have used the term *predator* to describe their sexual assailants, the public, including the media, also employ the term. I associate *predator* with the systems of power and systemic logics that abuse, neglect, surveil, and do not protect women who experience sexual violence by physicians. Gynecologists who commit sexual violence against patients are part of a broader medical and sociohistorical landscape of violence, or what I refer to as predatory medicine.

Predatory medicine is an anti-racist feminist analytic to address rape culture in the medical industry, particularly in gynecology; for looking at how institutions create conditions that allow for this pattern of behavior to exist and proliferate; and for examining the impact that the medicalization and institutionalization of rape culture have on women and girls. Feminist scholars must show how systemic power—from medical practice design to legal structures—enables the dominant forces of rape culture and neglect in healthcare. In this article, I categorize these behaviors and systems as sexual violence to visualize its hidden landscapes and economies (Ceelen et al. 2019). I articulate how the clinic and clinical practice in gynecology are vectors that mask the predatory behaviors and logics that abuse medical power. I argue that sexual predation of gynecologists is a hidden landscape and economy of sexual violence routinized systemically over time by racial capitalistic institutions.

My main argument is rooted in three key issues about the gynecology clinic and clinical practice: how medical knowledge and practice intimidate patients and mask predatory behavior and sexual violence; how institutional power contributes to the predatory logics of protecting medical authority and thereby continually shaping the clinic as a predatory space; and the critical significance of understanding slavery, post-slavery, and racial capitalism as the pillars for how predatory function in modern-day sexual violence in gynecology. My main goal is to examine how in the George Tyndall case exemplifies how the pelvic exam becomes a site of predation to routinize intimidation. USC's response over time is important to think about a landscape of economy of sexual violence and how

systemic predation is a function of protecting racist masculinist domination within clinical spaces and barrier to reporting complaints.

I analyze diverse sources through an anti-racist feminist lens such as public documents, digital materials, media reports, and public discourses. We do not always need verification from violated women to examine the systems of power that cause trauma. My Black feminist politics legitimizes their experiences with an understanding that their trauma is deep and their fear of disbelief after public exposure is surreal. I contextualize the voices of violated women to offer a purview of the systemic power within the established legal evidence. I trace and diagnose systemic and cultural dilemmas through materials circulating in the public sphere through legal documents, journalistic investigations, public videos, and media reports. Lastly, I analyze the short documentary film *Breach of Trust* (2019), directed by former UCS graduate student Mishal Mahmud, that sheds light upon the intimate and wider issues addressed in this article.

Theorizing Predatory Medicine

Feminists bring critical insights about the intersection of race, gender, and power in medicine to expand the notion of predatory medicine and interrogate racial and sexual violence in gynecology. Feminist science and technology studies (STS) has documented the complexities of the pelvic exam and the role of gynecology as a site of differential power in the making of gender, sex, and sexuality (Kapsalis 1997; Klein 2010; Harding 1987; Martin 1987, 1991; McGregor 1998; Mulla 2014). Emily Martin's book *The Woman in the Body: A Cultural Analysis of Reproduction* (1987) contemplates how gynecological exams and interactions disembodiment and fragment women's sense of self within power relations and in contact with medical instruments such as the pelvic speculum. Martin demonstrated the value of women's knowledge production about oppressive spaces and their resistance through an agentic self. Similarly, Terri Kapsalis's work in *Public Privates: Performing Gynecology From Both Ends of the Speculum* explores the pelvic exam as a performative practice that enacts and produces differential power transforming women from "person to pelvic" (1997, 11). Kapsalis made critical arguments about the repeatable nature of gynecology as a performance of specific roles and scripts to show that gynecology itself can be reproduced for the public in various ways, including theatrically (9). Furthermore, Kapsalis asserts that "gynecology makes female bodies" to emphasize that through gynecology's performative practices, the female body and sexuality is reconfigured (6). Women are medical subjects of the pelvic exam and vehicles for producing the ideal patient who participates in the erasures and anonymity of their femaleness.

James M. Henslin and Mae A. Biggs's (1971) framing of a sociology of the vaginal examination informed the work of many STS feminists, such as Kapsalis and myself. Henslin and Biggs argue that through the "desexualization of the vaginal examination," the patient is depersonalized at various stages (1971, 136). During

the interaction of the pelvic exam, the patient performs being an object or “nonperson,” a stage they call “person as pelvic” (135–36). Gynecology, as performative on both sides, is then a critical lens by which to interrogate the sexual predatory manipulation of the pelvic exam and the performative acts of enduring such violence or moving through an exam with confusion about the trespass of sexual boundaries.

Kelly Underman’s *Feeling Medicine: How the Pelvic Exam Shapes Medical Training* moves us in a different direction to reconsider how the pelvic exam is a “two-pronged navigation of feelings” for patients and physicians raising questions about the “embodied experiences of sensations for both” (2020, 3). Underman argues that the teaching and learning of the pelvic exams offers renewed terrain for physicians to address their uncomfortable feelings that too often lead to a disconnection to patients during the pelvic exam. She explores how the use of guided teaching assistants is an affective tool for “upholding the cultural, political, economic interests of the medical profession—and the forms of resistance possible” (4). While Underman’s argument that the pedagogical use of guided teaching assistants for pelvic exams has shifted the experience of medical training to allow for a more subjective experience for medical students, Underman’s work further confirms that gynecology *is performative*, as Kapsalis and Henslin and Biggs argue.

Henslin and Biggs, Kapsalis, and Underman established an intellectual trajectory about the clinical mechanics of the pelvic exam, how the patient is situated in the process, the social world of gynecology, and the power relation between physician and patient. Feminists in STS must deepen their address of the sociohistorical hauntings that systematize how institutional power reinforces the abuse of medical privilege, such as the persistent unethical conduct of medical students who have long practiced the pelvic exam on unconscious patients under the supervision of physicians. Perry Hendricks and Samantha Seybold argue that the “unauthorized pelvic examinations (UPEs) are sexual assault” (2022, 368). UPEs signal predatory intent in which medical professionals prey on unconscious vulnerable patients to conduct unauthorized pelvic examinations. UPEs as sexual assault is yet another way to see that any nonconsensual sexual behaviors toward *conscious* patients during or amidst a pelvic examination is sexual assault. Patients expect a pelvic examination for professional medical purposes and not for the personal pleasure of clinicians. UPEs are symptomatic of the vestiges of violence, racism, and objectification of female bodies that reinforce the predatory nature of sexual violence in gynecology. Kapsalis, Henslin and Biggs, and Hendricks and Seybold all support the misogynist and racist hauntings in the examination room that advanced gynecology over time.

Gynecology was built upon unseeing women, especially Black women, from the waist up. Black feminists have long addressed the sociohistorical predation of

racial science, clinical practices, and its afterlife of slavery (Cooper Owens 2017; D. Davis 2018, 2019; Falu 2023; Hammonds 2004; Morgan 2004; Mullings 2002; Roberts 1997). The history of slavery and medicine in the US and across the transatlantic territories reveals how abuse of power and the rise of medicine were institutionalized to exert predatory practices targeting Black women with reproductive medicine experimentation and sexual violence. Doctors and slaveholders during the nineteenth century in the US exerted control over enslaved women's bodies and health—particularly their reproductive health—forging the ways that “medical practices became entwined with the cause of slavery's continuance” (Schwartz 2006, 4; Cooper Owens 2017; Morgan 2004). The formation of medical training, practice, and knowledge is intricately tied to doctors' opportunistic quests to serve slaveholders' understanding that their success with plantation production depended upon the health of enslaved Black people. In these circumstances, the predatory gaze of medical practice was subsequently predicated upon opportunities to practice upon enslaved Black women. The medical predatory effect is evident in how enslaved Black women avoided, if possible, having medical doctors summoned for their reproductive needs (Schwartz 2006, 145). Given these histories, Moya Bailey and Whitney Peoples propose a Black feminist health sciences studies approach that engages research of Black women's health through “social justice science” practices rooted in Black feminist STS traditions (2017, 2).

Black feminists have also emphasized how systemic power is embedded within reproduction and reproductive medicine (Cooper Owens 2017; D. Davis 2019; Morgan 2004) and sexual violence (Collins 2010; A. Davis 1978). The entanglement of sexual violence and medicine deeply compounded the making of such a predatory business in the name of medical science. Deirdre Cooper Owens (2017) reminds us how doctors during the nineteenth century benefited from the sexual violence experienced by enslaved women during slavery. Doctors benefited from obstetric practices from pregnancies from rape, whether by enslavers and other white men or by forced sex with other enslaved Black men, to increase the numbers of enslaved people for labor. Doctors profited from repetitive surgical procedures on enslaved women with surgically repaired obstetric fistulas that did not fully heal due to repetitive sexual violence (Cooper Owens 2017, 32–33). The predatory nature of systemic power and racial and gender domination in medicine harped upon the social conditions of enslaved Black women to advance medical practice and knowledge. Sociohistorical cases of sexual violence by doctors against Black women are also silenced, such as the story of Harriet Jacobs, who experienced sexual violence at the hands of her enslaver who was a physician. These sociohistorical histories are the roots of sexual violence as an economy for reproductive labor.

Racism and sexual violence are predatory systems. STS Black feminist scholars pay attention to how predatory systems in medicine are conquering forces for

capitalist gains, to protect power, and to silence vulnerable patients; these are the high stakes of predatory medicine. For example, slave hospitals were sites of “corporeal of geographic containment” for the ways white male doctors “moved black patients and body parts across a terrain that only they controlled” (Cooper Owens 2017, 8; Camp 2004). Medical discourses mobilized scientific racism and gender control through medical narratives based on racist experimentation. Medical journals were also sites of violent containment of enslaved Black women’s narratives. Many nineteenth-century medical publications do not document the names of individual patients or racially identify the enslaved Black women discussed in those publications when describing certain medical conditions. These past medical practices contributed to an exploitative medical system for capitalism and slavery.

Alys Eve Weinbaum’s notion of slave episteme helps me think about how it “was brewed up in the context of the Atlantic slavery as a thought system that produces material effects over time” (2019, 1). I agree with Weinbaum that the slave episteme not only enabled the gender and racial exploitation of reproductive slavery within its time, but it also continues into the present in contemporary cultural production (2). Weinbaum’s argument about contemporary reproductive cultures and politics expose “the epistemic conditions that will, if left uninterrogated and unchecked, continue to enable slavery’s reproductive afterlife” (2) squarely informs how predatory medicine functions as a framework. Predatory medicine is a manifestation of the slavery episteme. There is an unseen relationship between slavery, reproduction, and capitalism with the plight of sexual violence in medicine today and over time.

A few public health scholars (AbuDagga, Carome et al. 2019; AbuDagga, Wolfe et al. 2016; DuBois et al. 2019) have argued that there are ethical implications to having the medical profession take a stricter course of action against sexual abuse of patients by medical professionals. However, these debates about sexual abuse do not address a larger landscape of sexual violence as the central force within the medical system. Disciplinary categories such as sexual misconduct, sexual abuse, and sexual violations are applied to investigate the systemic problems of sexual assault in medicine within the existing scholarship and policy briefs. Nevertheless, we must be cautious about how these terms mask the power mechanisms of predatory medicine. For example, the Federation of State Medical Board (FSMB) policy statement, dated 2006, titled “Addressing Sexual Boundaries: Guidelines for State Medical Boards,” defines physician misconduct as “behavior that exploits the physician-patient relationship in a sexual way” (15). The nine-page policy statement sets guidelines for how medical boards should define and investigate sexual misconduct by focusing on scrutiny, surveillance, and disciplinary action toward physicians. In 2020 the FSMB workgroup on physician sexual misconduct readopted the 2006 report and published another thirty-one-page report and recommendations titled *Physician Sexual Misconduct*, which called for a “cultural

change” of “environment and culture, from medical school to practice, for the development of and commitment to positive professional values and behaviors in medicine” (2020, 2).⁶ The reports address physicians’ behavior and disciplinary outcomes. By suggesting that cultural change is imperative, their message signals a problem more extensive than the state of professional values and ethical behavior, such as an entrenched culture of “secrecy” about sexual misconduct in medicine (DuBois et al. 2019, 519). A crystalizing sign of sexual violence as a structural problem is the pervasive institutional silencing that shapes a culture of secrecy spawning forms of intimidation, specifically with the clinical space.

George Tyndall Case: The Clinic and Intimidation

Intimidation permeates all corners of the healthcare industry (Lamontagne 2010). Professor of nursing Clare Lamontagne argues about healthcare that the “cultural acceptance of intimidation may blind us to its pervasiveness, resulting in the subtle and continuation victimization of those who are most vulnerable to its effect” (2010, 55). The George Tyndall case is a chilling example of the hidden pervasive effect of intimidation within a clinical space. Tyndall’s sex crimes at the student health center expose the vulnerability of patient-student identities. A key factor is that young college students are often seeing a gynecologist for the first time and may not be familiar with the procedures of the pelvic exam. The lack of experience makes the pelvic exam and interaction with the doctor an intimidating event. In this section, I think critically about how the breach of trust between doctor and patient is more than a medical professional broken boundary but rather the manipulation of vulnerabilities. I discuss how intimidation shapes the predatory forces in gynecology and how such forces are masked within medical practice and healthcare in general. For this analysis, I focus on the George Tyndall case and the testimonial short film *Breach of Trust* (2019).

Many college students seek student health services for gynecological exams for many reasons, such as STI evaluation, pregnancy testing, or if sexually assaulted by another college student (Mozingo et. al. 2023). The student health services on college campus are integral to the university experience for students. Students are not detached from their college identities and anxieties to perform and keep up with the demands of college life. The George Tyndall case mirrors how student health clinics shadow institutional responsibility to transition students with their first-time gynecological experiences. Yet they are the shadowboxes of institutional power, gender domination, racial capitalism, and the horrors of sexual violence.

In *Breach of Trust*, a young former student, Brennan Heil, reports needing an STI checkup after sexual assault on campus. She was encouraged to go the gynecologist at the student health center. She described her encounter with Tyndall as creepy and flirty. Tyndall asked her if she had had a pelvic exam before, and she only remembers having some testing when she was nine years old. Tyndall responded, “It’s not your

first rodeo.” In *Breach of Trust*, Brennan describes the sexual violence as “taking his hands and massaging me inside, even my clitoris.” Brennan reported that the chaperone, who was far from the table and witness to the scene, walked away. Students trust that their first gynecological visit at a student health clinic will be safe because the university ought to have their best interests in mind, as student consumers and young adults away from home. A nurse chaperone who “walks away” from the scene only worsens the mistrust. Furthermore, the film affirms that students did not feel safe with USC administration given its unresponsiveness to their complaints. Sexual violation by a doctor employed by the university deepens the fear of not being believed by the administration.

Most doctors are aware that their differential medical positionality—with their foreign medical language and experience—intimidates patients. The “white coat effect,” a concept coined by Thomas Pickering (Pickering et al. 2002) to describe how fear and nervousness manifest as in high blood pressure upon arrival to the doctor’s office, is a long-standing illustration of the effects of medical intimidation. While the white coat effect is argued to impact anyone regardless of race, gender, or class, it is rooted in the sociohistorical violence of medicine, slavery, racism, and anti-Blackness (Jones 2002). The professional boundaries between doctors and patients have long been crossed through incomprehensible intimidating language and practices, all leading to abuse of power whether racist, gender-non-affirming care, or sexual violence. Intimidation manipulates the ways that sexual boundaries are violated and masked by routine medical practices in space and time.

Similarly to the white coat effect, the pelvic speculum causes anxiety, pain, and discomfort, as research and public opinion remind us (Taylor et al. 2017, S2349). Most gynecologists know that patients confront these challenges during the pelvic exam, including emotional trauma related to genital or sexual trauma (Huber et al. 2009, 795; Taylor et al. 2017, S2353). Despite the extensive redesigning of the vaginal speculum over centuries—with size and material variations such as plastic and pediatric specula—to improve patients’ experiences, many physicians believe that the traditional vaginal speculum is good enough (Rossmann 2008, 49). However, these industrial redesigns of vaginal speculums do not get us closer to eradicating the sexual violence of patients by physicians.

Predatory medicine addresses the power relations that intrude as sexual violence within medical spaces. Women’s experiences of gender-based violence in gynecology are not subtly consensual. Women’s experiences of gender-based violence in gynecology are not subtly consensual. Neither should women be positioned as misinterpreting their medical experiences, particularly in the case of the USC students’ first or second time with a gynecologist, as *Breach of Trust* shows. Medical professional organizations have attempted to give a roadmap for how a physician crosses sexual boundaries with a patient. For example, FSMB

defines a “severe” form of misconduct to include “sexually inappropriate or improper gestures or language that are seductive, sexually suggestive, disrespectful of patient privacy, or sexually demeaning to a patient” (2020, 4). Sexual violence by a physician is recognizable to patients when the behavior blatantly crosses a sexual or physical boundary. The routine pelvic examination and medical language too often mask the crossing of sexual boundaries. FSMB frames sexual misconduct as “physical contact, such as performing an intimate examination on a patient with or without gloves, without clinical justification or explanation of its necessity, and without obtaining informed consent” (4). Suppose a physician does not wear gloves during a pelvic examination, as in Tyndall’s case. Students recognize that practice as inappropriate, but the ambiguity paralyzes patients, putting them at risk of sexual violence. The FSMB statements are insufficient roadmaps to abolish the ambiguity of “physical contact” and what constitutes a “routine” pelvic exam and medical interaction.

Another USC student in *Breach of Trust* stated that Tyndall requested to photograph her vagina as part of research during the examination. The student felt extremely uncomfortable with the request but assumed that it was safe for research purposes. Tyndall’s fetish with voyeuristic photography was incidentally discovered during a search of his office to remove smelling rotten fruits. The USC administration found many photographs of female private parts. Predators mask and manipulate for sexual pleasure the pelvic exam with disguising voyeuristic photographing of woman’s vaginas. The USC student had just delivered a baby and had consented to the pelvic exam, but she was trapped by intimidation. Imagine the confusion for first timers to the pelvic exam to differentiate medical practice and sex crime when asked to be photographed for research purposes.

The US is fraught with many cases of inappropriate photographing, especially on unconscious women patients.⁷ The State of Florida mandate gynecologists in government-funded clinics to ask patients to read and sign a consent form for the pelvic exam. I was asked to complete such form as a patient in 2020. It was a new form that my gynecologist had not implemented during my prior visits. The State of Florida reactionary policy was a result of major lawsuit against a surgeon taking voyeuristic photographs of unconscious patients. I recall asking my woman gynecologist about sexual abuse cases by gynecologists and if the pelvic exam consent form was preventative response. She was surprised to hear about this nation-wide problem and was only abiding to the consent form policy for Florida state clinics. The consent form briefly explained what to expect by defining the pelvic examination and the body part to be examined, alongside risks and complication associated with it such as bleeding, discomfort, and infection. How would such a form help the public become informed about other risks, such as sexual abuse?

Intimidation makes sexual violation permissible to predators under the illusion that patients do not detect a sexual violation if the medical examination blurs it. Many women become paralyzed when they sense being touched inappropriately during the pelvic or breast exam. These reports exemplify an unspoken intimate intimidation for sexual exploitation. Medical intimidation by patients teaches us about the unseen web of norms and ideologies that filter down into the medical space and subsequently enable sexual violence to continue unaddressed by intervention and accountability. The Tyndall legal cases convey that patients feel something wrong and inappropriate is happening to them during the examination. As noted within the film and other sources, the fondling, vaginal penetration without gloves, and photographing became fused and blurred by uncertainty of the “standard medical procedures”. Women know and can feel when something is a violation. The next section examines how the complaint and reporting in Tyndall’s case is a window into these predatory dynamics.

Institutional Intimidation and Complaint Reporting

The reporting of sexual violence complaints is yet another intimidating factor for any patient, specifically college students and BIPOC students. Students’ fear of being discredited when filing a sexual assault complaint against a physician on a university campus contributes to their sense of security and safety (or lack thereof) as students and patients (Ceelen et al 2019; Tarzia et al. 2018). In *Breach of Trust*, a visiting student for the summer from Duke University, Kay Zhang, said that “there is no such thing as who is the more victimized victim.” Kay is referring to the confusion experienced during the pelvic exam and the difficulty of recognizing sexual violation. She states in the film that “it is hard to explain the level of uncomfortableness” and questions whether she would be “categorized as a victim” given her “worse experience.” Kay’s introspection moves us to grapple with the next level of vulnerability after being assaulted—that is the vulnerability that institutional power preys upon to sanitize “criminal activity” to defend its privilege and capital. The word *uncomfortableness* carries emotional thinking about what constitutes sexual violation during a gynecological visit and pelvic examination alongside whether one is recognizable as a “victim.” However, a USC student in the film recognized sexual violation when she recalled how Tyndall “rammed” the speculum into her. Therefore, Kay’s reflection about whether any victim is more or less a victim than the next person illuminates how sexual predation is manipulated through the pelvic exam and reinforced by the institutional irresponsibility to address these crimes.

USC’s response over time helps us to think about a landscape of economy of sexual violence and how systemic predation is a function of protecting racist masculinist domination within clinical spaces. USC’s past failures to appropriately respond to the reported complaints during Tyndall’s tenure exemplify how institutions have built intimidation into their power structures. The structural intimidation ripples fear across patient-victims and medical staff such as nurses

and administrative personnel in proximity to the predator. For example, Cindy Gilbert, a former nurse and whistleblower from the USC student health services clinic, in *Breach of Trust* recounts the USC administration's silence on Tyndall's behavior.⁸ She acknowledges that patients complained about "consistently inappropriate comments and inappropriate behavior and exams." Cindy's witnessing of student complaints highlights how the medical staff are often first responders to bring the complaints to the higher administration. Ordinarily, patients may not trust the clinic medical staff if they believe that they will protect the doctor or their jobs, as in the nurse who walked away from Brennan Heil's scene. Students are more likely to hope that the student health staff will protect their rights as students.

Former nurse Cindy is a key witness and advocate who helps us critique the layers of intimidation entrenched within institutions such as the university. Cindy alerted the university administration about the complaints and was told that "they [staff] should not talk to anyone about it." She says, "We could not go to HR or even equity and diversity office." She could only go to management, who "did not do anything." The medical staff also embody and carry the fear and frustration caused by the university's intimidating tactics and behavior. Such institutional neglect toward medical staff is perceived by students. The silencing and dismissal of the medical staff brave enough to report is intimidation to invisibilize the dilemmas. According to the film and media, Cindy eventually reported Tyndall to the rape crisis center, at which time (2016) Tyndall was put on paid leave. Unfortunately, Cindy resigned in 2017 from the health center after experiencing what she and other coworkers describe as "retaliation for speaking out against Tyndall." Retaliatory and punitive tactics maintain the economy of sexual violence. If silenced, alarms that may threaten student enrollment and financial support will not ring.

Institutional intimidation is forged through what Sara Ahmed calls "institutional mechanics" (2021, 6). Ahmed emphasizes that making complaints of sexual violence at universities teaches us how institutions work (25). Complaints are the mirrors of how institutional power works. Ahmed explores how complaints, for example, are stopped or blocked by the "doors" that teach us about power. I interpret these doors as the institutional mechanics encompassing the people, procedures, policies, logics, and all influential forces of power. These institutional mechanics control how doors open and close to hear complaints and how complainants experience their complaint-making process. This institutional control is predatory in the sense that it lurks for the most vulnerable people to exploit or dispose. USC's punitive tactics and dismissal of the reports of sexual violence by Tyndall is a dramatic immense phenomenon. Tyndall was put on *paid* leave only after Cindy reported the issues to the rape crisis center in 2016. However, it is not until 2018 after the *Los Angeles Times* ruptures the institutional silence that hundreds of people come forward with sexual violence complaints.

The intent of intimidation is to subdue a person so firmly that they cannot retaliate. If the *Los Angeles Times* had not pursued an anonymous tip, hundreds of women would have been silenced and forgotten about for an undetermined time alongside the hidden depths of institutional trauma.

Dr. Dana Loewy, who was a graduate student in 1995, recounts in the film how Tyndall “shoved several fingers into her, and when she shrieked, he commented ‘Don’t make such a fuss,’” in addition to other sexual comments. She shared the experience with another doctor at the clinic who responded with a nonverbal reaction of embarrassment and “looked away.” Dr. Loewy said that, based on the woman doctor’s reaction, she must have known about Tyndall’s reputation. This doctor’s reaction exemplifies how doctors also embody institutional intimidation. The choice to not acknowledge Dr. Loewy’s experience and pursue a call-to-action points to how institutional intimidation silences actors who have influence. Unfortunately, we know that the woman doctor was not the only medical staff to “look away,” as did the nurse in Brennan’s story. Helplessness is a sign and symptom of predation. We want more Cindys in the world with the courage to defend “students’ rights to have people take their concerns seriously,” as she states in the film. But institutions promote helplessness by ignoring complaints and punishing staff who report.

In Tyndall’s case, the eventual rush and publicity of complaint reporting and testimonies weakened the walls of institutional intimidation. STS feminist inquiry into how complaint reporting is entangled within a politics of intimidation is critical for examining the magnitude of silencing hundreds of people associated with one single sexual predator and institution. Again, Ahmed’s notion of institutional mechanics helpful here: the “path of a complaint, where a complaint goes, how far it goes,” she writes, “teaches us something about how institutions work” (2021, 6). Understanding how healthcare, whether at a university or hospital, depends upon institutional tactics are used to stall or ignore complaints of sexual violation by patients to protect power. Ahmed guides us to think about the possibilities of resistance through complaint reporting and how “frustration can be a feminist record” and “complaint can be a feminist pedagogy” (7). The frustration of confronting power through examining the paths of complaint and reporting is a feminist pedagogical exercise if we dig into how power works on multiple scales, specifically sexual violence in medicine. Institutional power in healthcare protects a wide range of situations, from physicians or institutional reputations to avoiding lawsuits and media attention.

The *AJC* has conducted an extensive investigation into the myriad ways that power is protected when this dilemma is confronted—including how hospitals or physician employers ignore complaints or push resignations instead of reporting physicians to medical boards or law enforcement (Ernsthausen 2016; Norder 2016a; DuBois et al. 2019; Teegardin and Norder 2019). The persistent challenges

of inadequate documentation and transparency of sexual violence cases in medicine manifest institutional mechanics (DuBois et al. 2019, 504). Handling complaints and sexual violence cases without care and justice is a deep, invisible problem. The FSMB 2020 report emphasized a comprehensive process to file, investigate, and handle with care and sensitivity complaints alongside a “duty to report” all complaints to the medical boards. The FSMB acknowledges that low complaint reporting is due to several reasons associated with “distrust in the ability or willingness of institutions such as state medical boards, hospitals and other healthcare organizations to take action in instances of sexual misconduct and fear of abandonment or retaliation by the physician” (2020, 7). The weaponizing of distrust, fear, humiliation, and uncertainty crystalizes intimidation. The FSMB remind us that building public trust is predicated upon eradicating the vast web of intimidation. The FSMB charges that **because** the “ethical duty to report is insufficient” (8), alternative strategies to ensure that state medical boards are aware of all complaints and cases **are necessary**, and signal the entrenched systemic issues that I refer to as predatory medicine precisely because of public mistrust and unawareness. For example, many physicians accused of sexual violence or who lost their medical licenses in one state have been able to relocate to another state to practice medicine with relicensing, according to *AJC* reporting (Norder 2016b). The relocation of medical practices by sexual predators is only one of many systemic manifestations of predatory systems that professional organizations or state government agencies have yet to control or abolish.

Predatory Medicine: A Black Feminist Path Forward

As a Black feminist health science studies scholar, I take seriously the critical significance of slavery, post-slavery, and racial capitalism as the pillars for how predatory behavior, logics, and systemic power function in modern-day sexual violence in gynecology. Black feminist activist Tarana Burke coined the hashtag #MeToo in 2007, which only many years later became a vehicle for women to mobilize an international movement against sexual violence and rape culture. Tarana’s hashtag #MeToo was a call to action to pay greater attention to sexual violence against Black women. However, an anti-racist approach to the #MeToo movement was lost (Jones 2018).

What does an anti-racist and anti-heteropatriarchal approach to the abolish of sexual violence in gynecology require of us? A critical first step is to acknowledge that all women regardless of race, gender, sexuality, and class are subject (some more than others) to how racial capitalism benefits from maintaining sexual violence and rape culture in gynecology. Destin Jenkins and Justin Leroy remind us that “to think with racial capitalism is to rethink the past, present, and futures of capitalism” (2021, 10). Jenkins and Leroy emphasize that racial capitalism “is also a methodological practice—a way of seeing—that asks practitioners to question the structuring idioms, themes, and subjects in the study of capitalism in

the present” (10). If racial capitalism is a method or “way of seeing,” it must become an analytic to interrogate sexual violence in gynecology. The sociohistorical trajectories of medicine, gynecology in particular, must be our first reminder that reproductive healthcare is driven by a racial calculus that reinforces the power dynamics within its capitalist, racist system.

Black feminists remind us that the fields of gynecology and obstetrics were built upon a racial calculus that not only objectifies Black bodies but mobilizes those power dynamics to also exploit vulnerable ethnic groups (Cooper Owens 2017; D. Davis 2018). The surgical experimentation by gynecologist Dr. James Marion Sims upon enslaved Black women Anarcha, Betsy, Lucy, and many others is a classic sociohistorical example of how gynecology institutionalized intimidation and capitalized upon vulnerable Black people (Cooper Owens 2017; McGregor 1998; Skloot 2011). Furthermore, Cooper Owens’s historical account of gynecology includes the ways that Irish women in New York were subjects of gynecological surgery experimentation during the nineteenth century (2017, 4). I agree, then, that racial capitalism is a method to see how the structural violence within institutions built upon the exploitation and violence against vulnerable Black and ethnic groups will impact *any person* preyed upon, regardless of race and ethnicity.

The Tyndall case evidences that race and ethnicity played a critical role in sustaining the silence. *Breach of Trust*, as well as public legal documents, remind us that many students who sought medical services at the student health services were international students, specifically of Asian descent. USC’s large Asian and international student population is another exploitable vulnerability for a predator. I concur with Professor Jane Junn, who, in the film, states that “the vulnerability of international students, [for] whom [a] gynecology visit is likely their first time, don’t know what to say and would not know how to object.” Students would certainly be afraid to object against Tyndall, who also made racial comments as plaintiffs reported in legal documents of court proceedings.⁹¹⁰ Former students in the film spoke out against USC’s protective interests to raise capital over addressing their complaints. Students questioned the value of their worth to the university.

I am deeply concerned that many patient-victims within these predatory landscapes of sexual violence are BIPOC. I strongly suspect that many patient-victims in the case of George Tyndall were Latinx and Black. Even in the case of former physician Robert Hadden at Columbia Presbyterian Hospital in New York City, we can anticipate that some, if not all, patients who were sexually violated were Latinx and Black. These racial and ethnic demographics would make sense based on the neighborhoods that these institutions serve. As Professor Junn also noted in the film, “non-white patient victims are far more vulnerable and likely not report.” The low reporting of sexual violence complaints among accused physicians across the US is likely due to the majority being BIPOC patient-victims.

The absence of a racial measurement of the demographics of patient-victims throughout the US and globally is racial capitalism at its best. The racial history of sexual violence, reproduction, and medicine is central to uprooting the systemic and structural violence. It is critical to know whether patients are racially targeted to further understand how institutions exploit social vulnerabilities to protect physicians with sexually predatory behavior.

Predatory medicine puts racial capitalism at the center of the sexual violence without overlooking the impact upon white women. After all, racism and misogyny are intertwined forces. Jenkins and Leroy state that racial capitalism “suggests a future-oriented political analysis that cautions against either a ‘race first’ or a ‘class first’ approach toward social justice” (2021, 10). Jenkins and Leroy help us understand that healthcare and universities are capitalist ventures that have long exploited and benefit from racialization and racial difference. The institutional colorblindness of healthcare and universities obscures the vulnerability of BIPOC students and patients to sexual violence. Institutional racist colorblindness is rooted in intimidation that at its baseline infrastructure is whiteness and patriarchal logic and systems that deny the existence of medical racism.

We remember the silenced story of Ruby McCollum, the Black Floridian woman who murdered Dr. Clifford Leroy Adams in his clinic in 1952, that shocked the world (Evans 2006). The story is known for Ruby being coerced to have sex many times during an era when Florida exercised paramour rights, which assumed that white men had the right to Black women for sexual pleasure.¹⁰ Ruby’s story remind us that the silencing of these issues is not new. The complex entanglement of medical economies, racial capitalism, and rape culture that sanctions predatory violence against women raises profound implications of healthcare as a sexual economy of violence (Varman et al. 2018). Abolishing sexual violence in medicine is a reproductive political project that requires new scopes of reproductive politics (Ginsburg and Rapp 1991, 1995). To abolish sexual violence in gynecology, in the US and globally, we need a rigorous systems analysis that centers racism and gender violence.

Notes

¹ This article does not discuss the experiences of queer women or LGBTQ+ community impacted by sexual violences by physicians. However, it does not discount that there may be queer or nonbinary or trans among this invisible demographic of patients abused by physicians.

² DuBois et al. use the term “patient-victims” (2019, 504). While I would prefer not to refer to women as victims, I use the term throughout to refer to patients who experienced sexual violence by physicians.

³ George Tyndall died on October 4, 2023, at age seventy-seven in California. He was set to stand trial in 2024. He likely died of natural causes with heart disease and type II diabetes contributing to his death, according to the County of Los Angeles Department of Medical Examiner (2024).

⁴ This number count was reported across various media outlets, including *Los Angeles Times*, *The Guardian*, and *New York Times*.

⁵ The settlement decision was widely reported. See, for example, Hamilton and Ryan 2021.

⁶ In 2021 FSMB published a second short recommendation report titled "State Medical Board Recommendations for Stronger Approaches to Sexual Misconduct by Physicians" adopted from 2020 report (King et al. 2021).

⁷ The male nurse in Colorado is the largest case; 700,000 photographs of unconscious or drugged patients were found on the nurse's cellphone in 2022 (List 2022).

⁸ In 2020 Dawn Wooten, a Black nurse, publicly reported unconsented hysterectomies and other neglectful care at the ICE detention center in Georgia (Treisman 2020). Wooten bravely forged ahead with her revelations, which eventually led to the detention center's closing. However, she suffered extensive alienation in the process. To date, she has subsequently experienced difficulties securing employment. Indeed, the repercussions she has faced also point to the violence of systemic intimidation. These are the carceral and punitive stakes of women whistleblowers, as in Cindy's case.

⁹ There are many public media reports and legal proceedings documenting the racial misconduct, harassment, and racist behavior by Tyndall of his patients; see Lieff Cabraser Heinmann & Bernstein, n.d.

¹⁰ For more on the paramour rights in Florida exposed by the Ruby McCollum case see Hartford, n.d.

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