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A Feminist Analysis of Pelvic Exam Violence

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A FEMINIST ANALYSIS OF PELVIC EXAM VIOLENCE

A Thesis

Presented In

Partial Fulfillment of the
Requirements for the Degree of

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BY

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Introduction

“I remember feeling pain and confusion, like, ‘Is this a nightmare?...I was very sleepy and sedated. My next memory is looking over and he was bagging the swabs he had collected without my permission.”¹ These are the words of Ashley Weitz, who received a pelvic exam against her wishes while anesthetized in 2007. Weitz checked into the emergency room for extreme nausea, and after being anesthetized, she woke up to find her doctor examining her genitals and collecting bacterial swabs—after she had declined an exam while conscious. Weitz would later testify in 2019 in support of legislation in Utah requiring informed consent for pelvic exams performed by medical students and doctors, garnering increased media attention to this issue.

When we discuss pelvic examination, we typically center conversations around women’s health and gynecology, linking pelvic exams with well-being and health maintenance. However, examination is not always in the interest of the individual being inspected; sometimes, it is violation. Former U.S. Olympic gymnastics team physician Larry Nassar dominated headlines in 2016, after his decades of sexual abuse against athletes and others was brought to national attention, with hundreds of victims eventually coming forward.² Nassar committed many kinds of horrific violent acts, including digitally

¹ Emma Goldberg, “She Didn’t Want a Pelvic Exam. She Received One Anyway,” *The New York Times*, February 17th, 2020.

² Marlene Lenthang, “How USA Gymnastics Has Changed Since the Larry Nassar Scandal,” *ABC NEWS*, July 26th, 2021.

penetrating the vaginas of many young girls and women.³ Although multiple complaints had been lodged against Nassar over several decades, no significant actions were ever taken by Michigan State University, where Nassar was employed, nor by USA Gymnastics, empowering him to continue violently traumatizing many.⁴ In another abuse scandal in 2019, University of Southern California's gynecologist George Tyndall was reported to have abused hundreds of students, including committing pelvic exam abuse. Similarly, allegations had been made for many years, but no action was taken.⁵ After his arrest, public outrage, and a subsequent lawsuit, USC agreed to a settlement with the victims, worth over a billion dollars.⁶ However, once these scandals entered the mainstream national consciousness, there was little question as to whether or not Nassar or Tyndall did anything wrong. Their behavior was easily labeled as assault and abusive. It was quickly recognizable and nameable as a form of violence. Medical institutions nor physicians were rushing to defend these men's behavior. Startlingly, these strong attitudes against abuse are not consistent. In many states, it is acceptable practice for unconscious patients to have their vulvas, vaginas, cervixes, and uteruses examined without their consent.⁷ Even though informed consent is not secured, this type of pelvic exam violence is not ubiquitously labeled as assault. To this day, many physicians and institutions defend the practice as a normal, non-problematic phenomenon.

³ Dwight Adams, "Victims Share What Larry Nassar Did to Them under the Guise of Medical Treatment," *The Indianapolis Star*, May 24th, 2018.

⁴ Marlene Lenthang, "USA Gymnastics."

⁵ Stefanie Dazio, "USC Agrees to \$852m Settlement with More than 700 Women Who Alleged Sexual Abuse by Former Campus Gynecologist," *USA Today*, March 26, 2021.

⁶ Matt Hamilton and Harriet Ryan, "For USC Women, Largest-Ever Sex Abuse Payout Leaves Bitterness, Vast Disparities," *Los Angeles Times*. May 2, 2021.

⁷ "Legislative Action: States Banning Unauthorized Pelvic Exams." *The Epstein Health Law and Policy Program*, September 4th, 2021.

Pelvic exam violence exists within the broader issue of gynecological violence. Anaiz Zamora and Greta Rico as “a form of violence with many varied expressions, from unnecessary procedures, the pathologization of physiological processes, medical misinformation and maltreatment, aggressive practices that provoke harm and injuries, and even inappropriate and violating comments.”⁸ Other forms of gynecological violence include exams or procedures performed without the patient’s informed consent. The issue of gynecological violence is adjacent to obstetric violence, terminology that comes from Latin American movements to understand and end the medical violence pregnant individuals face during pregnancy and labor and delivery, including forced episiotomies, coerced caesarian sections, verbal abuse, and more.⁹

In this thesis, I examine the specific gynecological violence issue of nonconsensual pelvic exams performed on unconscious patients, often performed for the purpose of training medical students. This practice generally entails a woman being put under anesthesia for a surgery that doesn’t necessitate a pelvic exam, however, during the exam a medical student, or multiple, will use her body to practice conducting a pelvic exam. Nonconsensual pelvic exams must be understood as violence, violence that is as unacceptable as the more commonly understood abuses committed by Nassar and Tyndall. Popular notions of violence often necessitate aggressive physical actions that injure the body or sexually-motivated, uninvited touch of private body parts. Therefore, it may not be intuitive to label nonconsensual pelvic exams as sexual assault because they do not appear to be conducted in the pursuit of sexual pleasure or with the goal of exerting power over

⁸ Anaiz Zamora and Greta Rico, “I Felt Raped’: Breaking the Silence around Gynecological Violence,” *Women’s Media Center*, December 21, 2020.

⁹ Elizabeth Kukura, “Obstetric Violence,” *Georgetown Law Journal* 106, no. 3 (March 2018): 721.

patients, but are often for educational purposes. However, focusing on the intention behind these exams skews a clear view of the behavior—individuals inserting their fingers into patients’ vaginas while they are unconscious without consent. The impact of this action can be as damaging as any other form of sexual assault. This issue is not abstract—it is embodied. One woman who experienced a nonconsensual exam shares, “I started having panic attacks trying to figure out what had happened...I have a history of sexual abuse, and it brought up bad memories.”¹⁰ Weitz similarly describes her assault as “traumatizing” and that it “changed the way that [she] sought and received medical care.”¹¹ Doctors are constructed as individuals with the knowledge and sense of responsibility to determine when it is appropriate to touch their patients’ bodies, and this construction has the power to obfuscate what should be clear violations of consent and bodily autonomy. The potential impacts of nonconsensual pelvic exams are clear and must be respected as the potential ramifications of sexual assault.

In more than half of the country, this practice is perfectly legal.¹² Because it is most often medical students conducting these nonconsensual exams, they most often occur at teaching hospitals, whose patients are disproportionately low-income women and/or women of color.¹³ In this thesis project, I seek to better understand some of the causes and responses to this issue. My research questions are (1) What are the attitudes within medical and gynecological communities toward pelvic exam violence?; (2) What are the main points

¹⁰ Goldberg, “Pelvic Exam.”

¹¹ Hannah Harris Green, “Med Students Are Doing Vaginal Exams on Unconscious, Nonconsenting Patients,” *Vice News*, June 26th, 2019.

¹² “Legislative Action: States Banning Unauthorized Pelvic Exams.”

¹³ Goldberg, “Pelvic Exam.”

of controversy within medical discourse about nonconsensual pelvic exams?; (3) What kinds of legal responses are being pursued to prevent this issue?

Context & Significance

The so-called “father” of gynecology, Marion J. Sims, developed the field of gynecology by performing inhumane, cruel experiments on enslaved Black women. Sims also developed the speculum, which Kelly Underman, a sociology professor whose work explores the role of pelvic exams in medical training, describes as, “a material tool for expanding biopolitical control over certain kinds of bodies.”¹⁴ The modern field of American gynecology is built on these colonial legacies, including the devaluation of consent. Sims exploited enslaved Black women’s bodies because they “did not have to be recruited, persuaded, and cajoled to endure pain and indignity; they could not refuse.”¹⁵ He used his power over others’ bodies to gain information and benefit his own career. During unconscious pelvic exams today, the agency of patients is sacrificed in the name of increased convenience and economic efficiency for medical institutions. To be clear, I am not equating the abuse that patients suffer today with the torture experienced by enslaved women. Rather, I seek to reveal how current attitudes of entitlement to AFAB bodies and justifications for violence against them are legacies from the colonial underpinnings of the field.

Patient consent can be violated in a multitude of ways, typically in ways that benefit doctors. In 2010, Rebecca Skloot published her first book, *The Immortal Life of Henrietta*

¹⁴ Kelly Underman, *Feeling Medicine: How the Pelvic Exam Shapes Medical Training*, (NYU Press, 2020), 29.

¹⁵ Harriet A Washington, *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present* (Doubleday, 2006), 129.

Lacks, which told the story of how a thirty-one-year-old working-class Black woman named Henrietta Lacks sought treatment for her cervical cancer at Johns Hopkins hospital in 1951.¹⁶ At the time, Johns Hopkins was one of the only hospitals willing to treat low-income Black Americans. A gynecologist working there performed a biopsy on Lacks and sent her cells over to a research center without Lacks' consent. Researchers found that Lacks' cells were unique in how they continuously multiplied, rather than dying off like others'. Lacks' cells, eventually termed HeLa cells, would be considered a radical discovery, used in thousands of other studies and medical developments. Neither Lacks nor her family were ever notified, were ever given the opportunity to consent, and never saw any of the incredible profits that researchers had gained from their research and commercialization of Lacks' cells.¹⁷ Skloot's book brought attention to Lacks' story and the decades-long efforts of Lacks' family to achieve justice. Furthermore, Lacks' story has inspired more conversation around consent and justice, particularly racial justice. For example, in 2017 there were policy efforts to revise research participant protections to include mandatory consent for biological specimens taken from individuals before they are researched.¹⁸ While these efforts were not successful, they reflect conversation that is slowly growing within medical research communities. Although these conversations are about research, their relevance is found in how they shift scientific values to include consent and respect for autonomy, even in the process of knowledge-building. My thesis translates these conversations to the realm of pelvic exams.

¹⁶ Rebecca Skloot, *The Immortal Life of Henrietta Lacks*, (Crown, 2010).

¹⁷ "Henrietta Lacks: Science Must Right a Historical Wrong," *Nature*, September 1st, 2020.

¹⁸ *Ibid.*

Medical anthropologist Paul Farmer has highlighted the issue of doctors and medical institutions prioritizing cost-effectiveness over equity and health. Farmer writes in his book, *Pathologies of Power: Health, Human Rights, and the New War on the Poor*, “Rights violations are, rather, symptoms of deeper pathologies of power and are linked intimately to the social conditions that so often determine who will suffer abuse and who will be shielded from harm.”¹⁹ Although Farmer is not addressing gynecological violence specifically, his analysis of power and vulnerability in terms of violation is important to understand how pelvic exam violence is a systemic failure that leaves most victims without any realistic form of recourse.

Moreover, gynecology does not just exist as a site of harm for people in the United States, and the resistance isn’t limited to the U.S. either. Gynecological violence is also prevalent issue in France, and during the #metoo movement, many individuals began to share their stories of harm in gynecological or obstetric settings, using the hashtag #PayeTonUtérus in 2014.²⁰ The issue was confirmed to be systemic in a government ordered report on this issue, published in 2018. Many are organizing against this type of violence. One organization demanding government action to prevent the issue is Stop Violences Obstétricales et Gynécologiques (StopVOG), however the French government has done little to combat the issue since the report was issued.²¹ Additionally, many women in Mexico are currently fighting gynecological violence, with the government receiving over

¹⁹ Paul Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor*, (University of California Press, 2004), 7.

²⁰ Lara Bullens, “‘Too Little’ Done to Combat Obstetric and Gynecological Violence Against Women” *France24*, November 21st, 2021.

²¹ *Ibid.*

3000 complaints between 2003 and 2017.²² Some women are turning to feminist midwives and midwifery houses for better care.²³

There is ongoing conversation around gynecological violence and consent, though academic discussion is relatively limited. Many physicians deny that the practice of nonconsensual pelvic exams exists at all, however, the limited research about the topic suggests otherwise.²⁴ This issue has received bursts of attention throughout the last several decades, often spurred by an individual coming forward to share their story. The first flow of attention occurred in the 1980s, with one study surveying 69 women and finding that all wanted to be asked for permission, leading the researchers to suggest that vaginal examinations only be performed with consent.²⁵ The next influx of attention, resulting in much more attention than the prior flow, occurred in the early 2000's, largely due to two major studies. The first, "The Ethics of Intimate Examinations: Teaching Tomorrow's Doctors," by medical student Yvette Coldicott, medical sociology lecturer Catherine Pope, and medical clinical dean Clive Roberts, was conducted in the United Kingdom and found that out of 704 examinations, written consent had been obtained in only 24% and neither oral or written consent were obtained in another 24%. The study also revealed that it was not uncommon for multiple students to examine one patient.²⁶ The other was titled "Don't Ask, Don't Tell: A Change in Medical Student Attitudes After Obstetrics/Gynecology

²² Anaiz Zamora and Greta Rico, "Gynecological Violence."

²³ Ibid.

²⁴ Phoebe Friesen, "Educational Exams on Anesthetized Women: Why Consent Matters," *Bioethics*, (April 2018), 303.

²⁵ J. Bibby, N. Boyd, C. W. E. Redman, D. M. Luesley, "Consent For Vaginal Examination By Students On Anaesthetised Patients," *The Lancet*, (November 12th, 1988): 1150.

²⁶ Yvette Coldicott, Catherine Pope, and Clive Roberts, "The Ethics of Intimate Examinations: Teaching Tomorrow's Doctors," *British Medical Journal*, (January 11th, 2003), 98.

Clerkships Toward Seeking Consent for Pelvic Examinations on an Anesthetized Patient” and was written by Peter Ubel MD, Christopher Jepsen PhD, and Ari Silver-Isenstadt MD. This study was based in the United States and surveyed medical students’ attitudes toward consent for pelvic examination, finding that students who had completed an obstetrics/gynecology clerkship rated consent as less important than those who had not.²⁷ These studies generated media attention and incited several other articles written about the topic, and California was the first state to ban this practice with legislation in 2003.²⁸ These studies also led medical associations, such as the American College of Gynecologists, to create statements condemning the practice. However, attention eventually died down and by the beginning of 2019, only five states had bans in place. The most recent surge in attention was in 2019, due to Ashley Weitz’s testimony and the Utah ban. After Utah’s ban, eleven more states followed suit in 2019, four in 2020, and five in 2022.²⁹

Theoretical Frameworks

Pelvic exam abuse is a reproductive justice issue. The term reproductive justice was coined in the 1990’s by Black feminists and it describes the movement to end reproductive oppression.³⁰ Although reproductive justice originally was focused on the right to abortion, the right to have children, and the right to raise children in safe environments, it has

²⁷ Peter Ubel, Christopher Jepsen, and Ari Silver-Isenstadt, “Don’t Ask, Don’t Tell: A Change in Medical Student Attitudes After Obstetrics/Gynecology Clerkships Toward Seeking Consent for Pelvic Examinations on an Anesthetized Patient,” *American Journal of Obstetrics and Gynecology*, (February 1st, 2003), 577.

²⁸ “Legislative Action: States Banning Unauthorized Pelvic Exams.”

²⁹ Ibid.

³⁰ Loretta Ross, Lynn Roberts, Erika Derkas, Whitney Peoples, and Pamela Bridgewater, *Radical Reproductive Justice: Foundations, Theory, Practice, Critique*, (Feminist Press, 2017), 14.

expanded to include advocacy against additional forms of reproductive injustices, including advocacy for the right and access to make decisions about one's gender, sexuality, relationships, and bodies.³¹ In *Radical Reproductive Justice: Foundations, Theory, Practice, and Critique*, activists Loretta Ross, Lynn Roberts, Erika Derkas, Whitney Peoples, and Pamela Bridgewater describe reproductive justice as the unity of three frameworks, explaining,

There are three main frameworks for fighting reproductive injustices: reproductive health that deals with healthcare service delivery for individuals; reproductive rights that address the legal regime through the US Constitution, such as ending abortion restrictions and maintaining access to contraceptives; and reproductive justice that focuses on organizing resistance and movement building using global human rights standards.³²

A reproductive justice framework is central to this issue because of its fundamental emphasis on freedom and autonomy. Ross has recently described how reproductive justice is constantly evolving to include more facets of gender-based reproductive-related issues,³³ and includes the right to be free from medical reproductive harm. I argue that pelvic exam violence should be conceptualized through reproductive justice lens because it is encompassed under both the tenet of reproductive health and the broader value of bodily sovereignty. Additionally, violence to the reproductive organs can be both physically and mentally traumatic, impeding an individuals' relationship to their reproductive system, and ultimately their ability to exercise complete reproductive agency. My application of the reproductive justice framework seeks mandatory consent in gynecological practices and

³¹ Loretta Ross, Lynn Roberts, Erika Derkas, Whitney Peoples, and Pamela Bridgewater, *Radical Reproductive Justice*, 18.

³² Loretta Ross, Lynn Roberts, Erika Derkas, Whitney Peoples, and Pamela Bridgewater, *Radical Reproductive Justice*, 20.

³³ Loretta Ross, "Reproductive Justice As a Human Right", recorded October 27th, 2021 at Northwestern University, video, 20:24.

teaching methods, with the intention of preventing reproductive and psychological trauma for individuals assigned female at birth. Therefore, throughout this thesis, I work from a reproductive justice framework as an analytical and evaluative tool to critique approaches seeking to prevent gynecological abuse.

I am inspired by other feminists and scholars critiquing medical institutions. My understanding of consent in medical environments has grown from Intersex justice activism surrounding the issue of Intersex infants and children undergoing medically unnecessary surgeries to better fit the biological sex binary. Intersex justice frameworks prioritize questioning medical authority and its institutional undermining of consent for the individual in the name of medical expertise.³⁴ Intersex activist Pidgeon Pagonis advocates for doctors to transform their understanding of consent and care to be patient-centered and autonomy-focused when operating on Intersex infants and treating Intersex individuals,³⁵ which is also relevant in gynecological care. Individuals have come forward to share their stories of harm during and after these exams, and their experiences must be centered—over the “professional” opinions of doctors—when it comes to deciding proper consent protocols for pelvic exams.

Exam abuse also frequently occurs in prisons. In Angela Davis’s book, *Are Prisons Obsolete?*, she discusses how sexual abuse routinized in women’s prisons through practices such as strip searches and body cavity searches, in addition to other forms sexual coercion and assault by guards and officers. To further illustrate her point, Davis quotes Australian lawyer and activist Amanda George as stating,

³⁴ Pidgeon Pagonis, “9 Damaging Lies Doctors Told Me When I Was Growing Up Intersex,” *Everyday Feminism*, November 30th, 2015.

³⁵ *Ibid.*

At the same time as the state deplors "unlawful" sexual assaults by its employees, it actually uses sexual assault as a means of control. In Victoria, prison and police officers are vested with the power and responsibility to do acts which, if done outside of work hours, would be crimes of sexual assault. If a person does not "consent" to being stripped naked by these officers, force can lawfully be used to do it...³⁶

Although Davis's work focuses on exams as violence within prisons, and I focus on the pelvic exam violence that occurs in gynecological office, her work is central to deconstructing pelvic exam violence. Abolitionist theory and reproductive justice are intertwined in many instances. For example, the discussion in Davis's book can be applied to gynecologists abusing unconscious people or manipulating conscious people during their exams. If the individual wasn't wearing doctors' clothing and/or was in a different location than their office, it would be considered sexual assault. But because doctors are considered to be medical "experts", they are allowed authority over other people's bodies, including intimate violations.

Linda Tuhiwai Smith's work relates well to this concept. She writes in her book, *Decolonizing Methodologies: Research and Indigenous Peoples*, "Once it was accepted that humans had the capacity to reason and to attain this potential through education, through a systematic form of organizing knowledge, then it became possible to debate these ideas in rational and 'scientific' ways."³⁷ Since science is often viewed as infallible and objective, I use her work to critique the prevalent masculinist understanding of AFAB anatomy and

³⁶ Angela Davis, *Are Prisons Obsolete?* (Seven Stories Press, 2003), 82.

³⁷ Linda Tuhiwai-Smith, *Decolonizing Methodologies: Research and Indigenous Peoples*, (Zed Books 1999), 62.

personhood and accepted teaching methods, which are rooted in colonialism, sexism, racism, ableism, etc. In addition, I combine Smith's critique with Assistant Professor in the Biomedical Ethics Unit at McGill University Phoebe Friesen's work to question the positioning of physicians within Western medicine as all-knowing experts on AFAB anatomy and pleasure. Friesen writes in her article, "Educational Pelvic Exams on Anesthetized Women: Why Consent Matters", that in "exchange for many years of hard work that transforms physicians into the sole bearers of a special body of knowledge and skills[...]physicians are granted this power, and those seeking care are granted a space in which they can be at their most vulnerable."³⁸ The norms of harm for pelvic exams are symptomatic of a flawed medical system in which doctors are constructed as omniscient entities, as Friesen has explicated. The position of the expert over a dehumanized body is traceable to the origins of gynecology. Long-standing attitudes toward AFAB bodies as not in need of respect and thoughtful care creates an environment of hostility towards those who dissent and allows doctors to dismiss concerns for bodily autonomy and patient-centered care.

I am also greatly influenced by Kimberlé Crenshaw. In her article, "Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color", Crenshaw writes, "Where systems of race, gender, and class domination converge... strategies based solely on the experiences of women who do not share the same class or race backgrounds will be of limited help to women who because of race and class face different obstacles."³⁹ I use her concept of intersectionality when detailing how pelvic exam violence

³⁸ Phoebe Friesen, "Educational Exams on Anesthetized Women," 304.

³⁹ Kimberlé Crenshaw, "Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color," *Stanford Law Review*, (1991), 1246.

disproportionately impacts low-income individuals and people of color. Additionally, I use the intersectionality framework to critique whether or not legal solutions to the issue, such as increased regulations on pelvic exams, are inclusive of all people affected by gynecological violence, or if they leave certain populations marginalized. This concept is crucial for analyzing how effective proposed responses to this issue are and who they help.

Dean Spade's work on the limitations of legal activism provides a strong framework for understanding and critiquing legal approaches to reproductive rights activism. In "Rethinking Transphobia and Power—Beyond a Rights Framework", Spade writes that effective activism must explore "other ways that power and control operate allows us to see which vectors are addressed and accounted for by legal equality claims and which are not...in social movements that work for transformation beyond the limits of law."⁴⁰ Spade's work provides a useful framework for evaluating rights-based activism because it emphasizes the necessity of dismantling social systems and structures that create the conditions for oppression to happen. While policy-based advocacy can be crucial, its effects are typically limited. Furthermore, policy advocacy surrounding reproductive rights is based in the right to privacy, rather than a human rights framework that truly values autonomy and health.⁴¹ It does not ensure that everyone will be able to use those rights, nor does it dismantle the structures and cultural beliefs that lead to the oppression of women, trans, intersex, and nonbinary people. This concept will inform my interpretation of different organizations' work. Spade goes on to write,

⁴⁰ Dean Spade, "Rethinking Transphobia and Power—beyond a Rights Framework," in *Normal Life: Administrative Violence, Critical Trans Politics, and the Limits of the Law*, (Duke University Press, 2015), 101-137.

⁴¹ "Roe vs. Wade," Oyez.

“The myth of legal equality in the United States is supported by the narrative that US laws used to exclude people on the basis of race and gender but now they do not. Supposedly, all is now fair and equal. However, our nation itself was built by the establishment of property and labor regulation that created and utilized racial and gender categories from the beginning.”⁴²

I value Spade’s critique of the myth of legal equality because it encourages further examination of not only how laws are implemented unequally, but also about how they function within broader, unequal systems. Furthermore, Spade’s framework pairs well with Crenshaw’s intersectionality framework to understand how policy affects people differently by the different social positions of marginalization and privilege that they hold, complicating and deepening my analysis and evaluations.

Methodology

My research process is qualitative. My understanding of qualitative inquiry is influenced by Lynn Butler-Kisber. Butler-Kisber summarizes, “the strengths of a qualitative study are the focus on situations and/or experiences of people, the inductive/emergent nature of the work, and the emphasis on words instead of numbers.”⁴³ I conduct a feminist critical discourse analysis (FMCD), described by Michelle M. Lazar in *Feminist Critical Discourse Analysis: Gender, Power and Ideology in Discourse*, as being concerned with “critiquing discourses which sustain a patriarchal social order: that is, relations of power that systematically privilege men as a social group and disadvantage, exclude and disempower

⁴² Dean Spade, “Transphobia,” 116.

⁴³ Lynn Butler-Kisber, “Getting Started In Qualitative Inquiry,” in *Qualitative Inquiry: Thematic, Narrative, and Arts-Based Perspectives*, (London Sage, 2010), 3.

women as a social group. One of the aims is to show that social practices on the whole, far from being neutral, are in fact gendered in this way.”⁴⁴ I qualitatively analyze the language used in thirty-five journal articles written about pelvic exam violence, collected from journals of medicine and nursing. The FCDA method allows me to derive the implications of the language used in different literature and how it upholds or resists patriarchy, racism, and violence. I also use the FCDA method when examining the wording of petitions, legislation, and other written legal advocacy to discern how effectively they address the issue. I plan to analyze petitions on Change.org, testimony in front of state legislature, and material put out by legal advocates and organizations.

I draw from Foucault’s ideas about how social power is produced through discourse to demonstrate how the language used in medical journal articles reflects and perpetuates power and entitlement over bodies assigned female at birth. As Foucault describes in *Power/Knowledge*, “There can be no possible exercise of power without a certain economy of discourses of truth which operates through and on the basis of this association. We are subjected to the production of truth through power and we cannot exercise power except through the production of truth.”⁴⁵ Foucault theory of social power will allow me to explicate how the word choice of medical researchers and doctors perpetuates harmful and stigmatizing beliefs about AFAB anatomy and creates environments where violence against AFAB individuals is normalized. I am also inspired by how Chela Sandoval interprets Foucault’s theory of discourse and social power within a cultural studies framework.

⁴⁴ Michelle M. Lazar, *Feminist Critical Discourse Analysis: Gender, Power and Ideology in Discourse*, (Palgrave Macmillan, 2005), 5.

⁴⁵ Michel Foucault, *Power / Knowledge: Selected Interviews and Other Writings*, (Harvester Wheatsheaf, 1980), 93.

Sandoval writes about how a cultural studies approach is committed to an oppositional consciousness, which, “is aligned with Foucault’s concept of power, which emphasizes the figure of the very *possibility* of positioning power itself. This possibility depends on constant rearrangement in relation to a whole paradigm...that requires the perpetual reformatting of consciousness, and practice.”⁴⁶ I incorporate a cultural studies approach in my critique of the masculinist understanding of AFAB anatomy that is evident in the journal articles I analyze. I also incorporate this approach when studying community-based responses to gynecological violence, such as an artistic project showcasing women’s stories of violence they experienced by their gynecologists.

This project is rooted in feminism and I intend to contribute to feminist debates surrounding reproductive justice and bodily autonomy. Additionally, I contribute to conversation on resisting the medicalization of AFAB bodies and the harm inflicted upon them by colonial institutions. My work supports the argument for patient-centered care and supplements the reasoning behind alternative methods of care. Ultimately, I imagine a system of health care that centers autonomy and agency, even and especially in situations where individuals voluntarily provide their bodies to professionalized figures, effectively shifting the dynamics of power from medical expert and object of study, to institutionally-educated care-provider and experientially-educated care-receiver.

Medical Discourse Surrounding Exams Under Anesthesia (EUAs)

⁴⁶ Chela Sandoval, “On Cultural Studies: An Apartheid of Theoretical Domains,” in *Methodology of the Oppressed*, (University of Minnesota Press, 2000), 76.

The discourse within medical communities surrounding nonconsensual EUAs is in a state of tension. It is focused on nonconsensual EUAs that occur at teaching hospitals for the purpose of medical training and education and some individuals favor and justify the practice, whereas others argue against it, each for a variety of reasons.

In this chapter, I select the most common points of debate and analyze how the discourse both perpetuates and resists the racism, misogyny, and other types of hegemonic dynamics within gynecology. The concept of consent is central to each argument, with the main points of discordance surrounding implicit/assumed consent versus informed/explicit consent. I argue that the arguments in favor of nonconsensual EUAs uphold medical paternalism, patriarchy, and racism, however, I also argue that the discourse arguing against the practice both upholds and challenges dominant power structures. I am a proponent of explicit consent practices prior to conducting EUAs, still, I believe it is imperative to critique how doctors and students are arguing for consent. The rationale, even when arguing in favor of consent, matters almost as much as the position, as the logic used by those in favor of consent can, and in many cases does, continue to perpetuate harmful dominant medical paradigms. These debates are largely happening in the vacuum of medical schools and hospitals, institutions that have historically been exclusive and white male-dominated.⁴⁷ Although this has changed, particularly in the fields of obstetrics and gynecology, as will be apparent in my analysis, this vacuum still broadly lacks the incorporation of reproductive justice values in a medical context, including patient autonomy and the right of patients to be informed about and determine their care experiences.

⁴⁷ Lyndra Vassar, "How medical specialties vary by gender," *American Medical Association*, February 18th, 2015.

Utilitarian vs. Kantian Ethical Frameworks

Underpinning all the arguments surrounding nonconsensual EUAs are two ethical frameworks: Utilitarianism and Kantianism. Individuals who defend nonconsensual EUAs are operating according to a Utilitarian ethic. As Coldicott explains, “Utilitarianism considers whether more people benefit from an action than are harmed by it. Harm to one individual (the patient) may be sanctioned if it is for the benefit of the larger group (other patients).”⁴⁸ In contrast, articles that critique the practice of nonconsensual EUAs operate using a Kantian framework. Coldicott details, “Kant’s categorical imperative provides a counter position. Humanity should be seen as an ‘end in itself, never merely as a means’...Using any one person as a ‘means to an end’—for example, using patients as teaching ‘aids—is unacceptable.”⁴⁹ In this section, I delineate how a Utilitarian framework promotes problematic attitudes of entitlement toward patients’ bodies, whereas a Kantian framework inspires a more patient-centered approach, yet still does not challenge the power dynamics of assigning the ultimate authority of deciding what constitutes harm to doctors, rather than patients. Due to these inadequacies, I propose that a human rights framework should guide gynecological care, as it is compatible with reproductive justice and most undermines hegemonic structures within healthcare.

Utilitarianism is present in the beliefs of those who argue that EUAs are a necessary practice because they prepare future doctors with more experience.⁵⁰ In this context, a

⁴⁸ Yvette Coldicott, Catherine Pope, and Clive Roberts, “The Ethics of Intimate Examinations,” 98.

⁴⁹ *Ibid.*,

⁵⁰ H Draper, J Ives, J Parle, N Ross, “Medical Education and Patients’ Responsibilities Back to the Future?” *Journal of Medical Ethics*, (2008), 116.; Eli Adashi, “Teaching Pelvic,” 733.

utilitarian framework prioritizes viewing patients as teaching tools over viewing patients as individuals whose full autonomy must be respected and whose individual needs should be deeply valued. Patients are conceptualized in terms of their usefulness, based on what they can provide to the profession. In one article, two doctors endorse a statement by ACOG, quoting, “The patient should be encouraged to participate in the teaching process to contribute her fair share to the development of a new generation of health care providers...”⁵¹ Although this article supports clear consent practices for EUAs, the phrase “fair share” is indicative of Utilitarian values. This phrase implies that there is a moral obligation for patients to provide their bodies as practice opportunities for medical students, supporting the belief that teaching medical students, potentially benefitting many future patients, is more important than maximizing an individual patient’s comfort. In addition to treating patients as teaching tools, this application of the Utilitarian framework fosters limited understanding and respect for full recognition of patient autonomy, which is likely to harm future patients, not just benefit them through more experienced doctors as some claim.

The utilitarian approach to nonconsensual EUAs reflects a striking level of entitlement to patients’ bodies and a concerning assumption on the behalf of providers to know what is best for patients. The utilitarian framework leads to the moralized expectation that patients will altruistically participate in invasive exams, rationalizing that all who use the medical system should share the tasks of teaching, so all can reap the benefits of doctors with as much experience as possible. The article, “Medical Education and Patients’ Responsibilities: Back to the Future?”, based in the UK, argues,

⁵¹ Carey York-Best and Jeffrey Ecker, “A Teachable Moment,” 742.

a new and more explicit agreement is needed, in which the default should be that all patients are willing to help in the education of medical students, while we ensure that all such students are already competent in simulation before first practising upon real patients. The days have long gone when it was considered acceptable to teach medical students...to do vaginal examinations on unconsenting anaesthetised women (although recent evidence suggests that this practice still continues¹²). While these practices may seem repugnant to us now, they did allow student doctors to familiarise themselves with procedures early on in their careers, arguably building competency and producing well-trained junior doctors.⁵²

To suggest that the default patient response should be allowing medical students to examine them upholds the dominant norms of entitlement to patients' bodies. In contrast, a feminist understanding of consent would not include having expectations of another person allowing someone to insert their fingers into one's vagina. Additionally, by simultaneously stating that nonconsensual pelvic exams are no longer acceptable, while acknowledging evidence that this practice still occurs, the authors construct their arguments without fully acknowledging the scope of the issue of consent for teaching-oriented pelvic exams. It reflects a dissonance and a lack of commitment to investigate why those nonconsensual exams still occur. It is constructing the issue in a way that deflects how the same attitudes that perpetuate that nonconsensual exams under anesthesia are also present within discussion that sets an expectation for patients to allow medical students to conduct pelvic exams on them for practice.

The article rationalizes having an expectation of patient participation in order to prevent some patients from being "free riders" by refusing to be used for teaching, while still

⁵² H Draper, J Ives, J Parle, N Ross, "Medical Education," 116.

experiencing the benefits of competent doctors who have practiced on others during their education. The label, “free-rider” suggests selfishness, entitlement, and a lack of consideration for others. To equate patient refusal to partake in students’ training to being a free-rider serves to demonize patients who exercise their autonomy in a way that inconveniences medical institutions, discouraging doctors from encouraging patients freely exercise their agency when deciding if they are okay with a medical student examining them. Although the authors state that those who refuse should be treated with respect and grace, their suggested “agreement” model still reflects an attitude of entitlement to patients’ bodies that is steeped within the foundation of gynecology.

This application of the Utilitarian framework especially harms trauma survivors, as it functions through the assumption that individuals with trauma who are unwilling to add any difficulties to their pelvic exam experiences inherently cost medical students of some level of preparedness to work with patients like them in the future, implying that their participation would benefit a greater number of people. The authors re-iterate that participation should not be obligatory, acknowledging that,

a woman who has been raped might find it more difficult to agree to additional vaginal examinations or to vaginal examinations by inexperienced practitioners. Of course, one might counterargue that, if we as individuals wish to be treated well when at our most vulnerable...then it is even more important that medical students and other trainees are at least present at such moments; the alternative is that their first real experience is also their first learning experience. Perhaps this is why so many patients report poor communication skills in such circumstances.⁵³

⁵³ H Draper, J Ives, J Parle, N Ross, “Medical Education,” 118.

By suggesting that patient experiences of poor doctor communication may be due to a lack of experiences with vulnerable patients, and therefore it is important for students to be present in the exam of a particularly vulnerable and traumatized patient, the authors shift the emotional responsibility and labor involved with trauma-informed care onto the traumatized patients. Learning by experience is not the only, or even necessarily most effective method of learning to work with vulnerable individuals. Medical students should not have their first learning experience when working with the patient—it should come long before. Suggesting that the only alternative to adding potentially unnecessarily stressful exams to patients' visits is for doctors to have their first learning experience be their first "real" experience diminishes any additional efforts or options that could be built into medical school curriculums and upholds a lack of expectations of initiative on the parts of instructors. Rather than placing the onus on patients who have been a victim of rape or other traumas, alternatives that could truly challenge entitlement to patients' bodies could include more instruction should be considered. These authors may endorse explicit consent, but it is these same attitudes of entitlement that create the conditions that allow for breaches of consent and normalize nonconsensual actions.

On the other side of this debate, the Kantian framework necessitates judging whether an act is morally good according to a decided ethical code rather than if it will lead to a so-called greater good, and it is explicitly clear in a handful of articles arguing against nonconsensual EUAs, and is implicitly present in all of them. In contrast to the utilitarian framework, the Kantian framework is used to argue for consent practices as an ethical behavioral practice, without necessarily taking into account the perceived benefits of nonconsensual EUAs. Although the Kantian framework does not necessarily prescribe

specific ethical values, patients are understood as an “end,” not as a means or a pathway to achieve another goal. They must be treated as individual cases, where each individual aspect of their treatment must be morally justified.

In favor of informed and explicit consent for EUAs, Doctor Stephanie Schniederjan challenges existing Utilitarian frameworks by incorporating the Kantian directive of attention to individual experiences. She writes about the sense of violation that a lack of consent can leave patients experiencing, and argues, “To create an environment of greater respect for patient autonomy and dignity, it is increasingly recognized that we must cultivate among medical professionals a heightened sensitivity to sociocultural issues-particularly in the realm of women's health.”⁵⁴ By citing harms that could occur and arguing for informed and explicit consent, Schniederjan urges doctors to place more emphasis on the need to respect individual patients. She argues for a stronger ethic that takes into account attention to social dynamics of power, which undermines the idea of sacrificing women’s autonomy to prepare medical students.

In contrast to the implications of the utilitarian framework, Trauma-informed care is clearly grounded in a Kantian ethical framework, as it considers and prioritizes the individual experiences and related needs of each patient individually, as evidenced by the article’s declaration that specific consent for each patient is a trauma-informed care practice. Promoting Kantian ethical frameworks upheaves the status quo of exploitation in medical education and research by centering the needs of the individual above any assumed potential benefits of knowledge production. The article, “Consent for Pelvic Examinations Under Anesthesia by Medical Students: Historical Arguments And Steps Forward,”

⁵⁴ Stephanie Schniederjan, “Ethics Versus Education,” 387.

suggests that “Trauma-informed care is an evidence-based framework that is guided by the assumption that individuals are more likely than not to have experienced trauma. Obtaining specific consent...is practicing trauma-informed care to both understand the impact of trauma and avoid re-traumatizing patients.”⁵⁵ In this context, Kant’s categorical imperative necessitates doctors adopting an ethical value of presuming that, and treating all patients, with a level of care and mindfulness appropriate for individuals who have experienced trauma, regardless of whether they have or not. The practice of asking for consent, therefore, would be consistent, rather than dependent on the context or other factors.

These two frameworks will be apparent throughout the rest of the analysis, as they underlie several arguments about nonconsensual EUAs made by both advocates for and against the practice. Although a Kantian framework is an important step away from viewing patients’ bodies as tools for teaching, it does not truly center the perspective of the individual being examined. The doctors are still the actors creating the ethical code to be followed, providing them with the power to define and measure harm that they perpetrate. This does not necessarily guarantee certain rights or standards of treatment to patients.

In place of these two frameworks, a human rights framework should be centered. Both a theoretical and practical framework, a human rights approach originates from a belief in “inherent human dignity”⁵⁶ and contains many principles that serve both patients and providers, and are legally recognized. A human rights framework address some of the limitations to a Kantian framework by stipulating specific values to structure patient care. A

⁵⁵ Hannah Cundall, Sally MacPhedran, and Kavita Shah Arora, “Consent for Pelvic Examinations Under Anesthesia by Medical Students: Historical Arguments And Steps Forward,” *Obstetrics & Gynecology*, (2019), 1300.

⁵⁶ Tamar Ezer and Jonathan Cohen, “Human Rights in Patient Care: A Theoretical and Practical Framework,” *Health and Human Rights*, (December 2013), 7.

human rights approach in patient care that “takes individual rights to information, privacy, and bodily integrity seriously and treats all people as equals’ transforms ‘government approaches to the physician-patient relationship’.”⁵⁷ This framework is most compatible with a reproductive justice framework, as both operate according to core principles of patient autonomy and integrity, and it offers deeper systemic change in the power dynamics between doctors and patients.

Lawyers Ezer and Cohen advocate for a human rights approach in patient care as compared to a patients’ rights approach, due to the fact that a patients’ rights framework stems from a consumer framework, in which rights are not granted to patients “because they are human, but rather because they are recipients of a transaction. In this way, consumer rights stem from principles of neoliberal economic theory and more closely resemble contractual rights. They do not have the ‘inherent,’ ‘unalienable,’ or ‘universal’ qualities of human rights.”⁵⁸ This approach offers deeper systemic change in the power dynamics between doctors and patients. Although a Kantian framework also prevents viewing patients as teaching tools, it does not prescribe specific moral or ethical values. By turning to a Kantian framework and neglecting to include the language or framework of human rights, the doctors advocating against nonconsensual EUAs still place the power of developing an ethical code within medical institutions. A human rights framework specifically outlines unalienable rights that must be upheld for patients, including a right to bodily integrity, a right to liberty and security of person, and a right to freedom from degrading treatment, all of which are directly incompatible with nonconsensual EUAs.

⁵⁷ Jonathan Mann, Sophia Gruskin, Michael Grodin, and George Annas, *Health and human rights: A reader*, (New York: Routledge, 1999), p. 281.

⁵⁸ Tamar Ezer and Jonathan Cohen, “Human Rights in Patient Care,” 7.

EUAs as “standard procedure” & Potential Harm

In this section, I explore one of the most common points of contention within the discourse: whether or not the understanding of nonconsensual EUAs as routine practice meant that specific consent was unnecessary. I examine how the use of normality is used by doctors to uncritically continue harmful practices and I critique how doctors position themselves as “objective” experts about the body who are above cultural associations and feelings toward intimate body parts. I also analyze the reasons provided by medical advocates against this practice, critiquing some for perpetuating top-down approaches to understanding consent. I demonstrate how many of the points made on both sides of this argument continue to privilege doctors’ perspectives on harm over those of patients, reflecting a reluctance to trust and allow patients to determine what is harmful to them. In contrast, I identify some advocates as subverting paternalism by turning to a patient-centered approach by valuing patient opinions on consent prior to EUAs.

The notion of routineness and regularity was frequently cited as a reason for which this practice does not need to change, implying that because the practice is considered normal, it must not be flawed or requiring of more critical thought. Regularity not only referred to the commonality of the practice, but also referred to the attitude that a pelvic examination conducted by a medical student is no different from any other examination, such as an ophthalmologist examining a patient’s eye.⁵⁹ Doctor Jennifer Goedken even compared the view of a doctor examining pelvic anatomy to a plumber viewing “a sink or drainpipes.”⁶⁰ Unlike an eye or drainpipes, the vagina, cervix, and uterus have been socially

⁵⁹ Nikhil Kaushik, “What Examination is Not Intimate?” *British Medical Journal*, (2003), 1326.

⁶⁰ Jennifer Goedken, “Pelvic Examinations Under Anesthesia: An Important Teaching Tool,” *Journal of Health Care Law & Policy*, (2005), 236.

constructed as private body parts that are also connected with sexuality. By decontextualizing the vagina, cervix, and uterus as any other body parts or objects of attention rather than intimate body parts, these doctors minimize the depth of harm that can occur when these body parts are touched and looked at by strangers without permission. This language categorizes doctors as separate entities from everyday people, who are above cultural associations and personal meanings that many people ascribe to their bodies.

In addition to framing nonconsensual EUAs as standard, many justifications of this practice framed the exams as “minor”, thus minimizing their potentially devastating impacts on patients. For example, one student explained that a typical justification of this practice places it on the same level as many other “minor” activities during surgery, such as closing an incision or cutting stitches, both of which non-controversially do not require consent.⁶¹ Another student was quoted as subscribing to this mentality, stating, “I have assisted in a hydrocoele (I held a small retractor and cut sutures); I gained valuable experience and did no harm...Informed consent is important, and I try to obtain it whenever possible, but let's not go too far.”⁶² Describing EUAs as minor similarly decontextualizes the intimacy of genitals as being attached to a person who likely considered them private or personal parts of themselves. Furthermore, citing normality as a reason to continue a harmful practice reflects a lack of commitment to improving medical care to best serve patients in the name of continuity. One anesthetist explicitly advocated against allowing cultural understandings of certain body parts to influence examinations,

⁶¹ Shawn Barnes, “Practicing Pelvic Examinations by Medical Students on Women Under Anesthesia: Why Not Ask First?” *Obstetrics and Gynecology*, (2012), 942.

⁶² Aneel Bhangu, “Consent Is Crucial But Don’t Go Too Far, For Students’ And Patients’ Sakes,” *British Medical Journal*, (2003), 1326.

providing the example that, “breasts are not considered ‘intimate’ parts in many places of the world.”⁶³ By decontextualizing breasts from the relevant cultural contexts, the anesthetist attempts to prove that body parts that are culturally-coded as private should not be treated with any more care or consideration than any other body part, an argument that rests on the idea that if an attitude or feeling is specifically culturally-based rather than a universal or a supposedly objective truth, it is not valid or deserving of doctors’ concerns. This upholds dominant medical paradigms of doctors’ beliefs mattering more than their patients and reinforces the notion that doctors are above cultural beliefs and sensitivity.

Some even expressed hostility toward the idea of explicit consent, dismissing the idea that consent could be important for something considered so minor. Ophthalmologist Nikhil Kaushik described an article suggesting informed consent forms as “another attempt to justify the obsession with political correctness.”⁶⁴ To describe consent as political correctness reflects a lack of value for a patient’s right to make decisions for their own body and a severe lack of recognition for the potential harm that inspecting someone’s vagina without permission can cause. Akin to Kaushik, Doctor Elizabeth Frayn states in response to Coldicott’s article, “As someone who regularly carries out breast, vaginal, and rectal examinations on patients, I found myself irritated by...the paper”, thinking it made “ethical mountains out of everyday molehills.”⁶⁵ Frayn reasons, “After all, compared to a dilatation and curettage or a vaginal hysterectomy, internal examinations are not particularly traumatic.”⁶⁶ Frayn suggests that being experienced with intimate examinations eliminates

⁶³ Roger Kneebone, “Reply From the Editor,” *British Medical Journal*, (2003), 1327.

⁶⁴ Nikhil Kaushik, “What Examination is Not Intimate?” 1326.

⁶⁵ Elizabeth Frayn, “Ethical Mountains of Everyday Molehills,” *British Medical Journal*, (2003).

⁶⁶ *Ibid.*

the need to ask for consent, removing agency for the patient in the name of expertise-granted authority. She also operates with a narrow definition of trauma, implying that the physical invasiveness of a procedure is the most important consideration, and it is acceptable to dismiss emotional and mental trauma associated with less invasive procedures.

The pushback to the argument that nonconsensual EUAs are simply routine practice that does not require explicit consent included referencing the American College of Obstetricians and Gynecologists (ACOG), the Association of Professors of Gynecology and Obstetrics (APGO), and the American Medical Association (AMA) as having released statements explicitly condemning the practice.⁶⁷ The statement by ACOG was released in 2007 and re-affirmed in 2020, and recommends, “Pelvic examinations on an anesthetized woman that offer her no personal benefit and are performed solely for teaching purposes should be performed only with her specific informed consent obtained before her surgery.”⁶⁸ A 2019 APGO’s statement also affirms explicit consent for EUAs conducted for teaching purposes, and was supported by the AAMC and endorsed by ACOG.⁶⁹ Using these statements reaffirms institutional authority on an issue that should be driven by patient opinion and victim testimony. Although it is important, and valuable, that these organizations have statements recommending explicit consent, this strategy also carries the danger of reinforcing a top-down approach to reforming norms around consent. To

⁶⁷ Shawn Barnes, “Pelvic Examinations.”; Eli Adashi, “Teaching Pelvic Examinations Under Anesthesia Without Patient Consent,” *Journal of the American Medical Association*, (February 26th, 2019), 733.

⁶⁸ “Professional Responsibilities in Obstetric-Gynecologic Medical Education and Training,” *The American College of Obstetricians and Gynecologists*, August 11th, 2011.

⁶⁹ “APGO Statement on Teaching Pelvic Exams to Medical Students,” *Association of Professors of Gynecology and Obstetrics*, (2019).

demonstrate this danger, attention must be paid to the fact that before their 2007 statement, the American College of Gynecologists and Obstetricians stated that “patients have ‘an obligation to participate in the teaching process.’”⁷⁰ Deferring to an institution like ACOG because they now happen to have the correct position sets a dangerous precedent for future situations regarding patient autonomy. By using these guidelines as a reason for why the practice is flawed, the authors simultaneously affirmed the all-knowingness of these medical associations while using the associations’ authority to dispel the doctors’ own presumptions of norms within their field. It is true that referencing these statements refutes the idea that doctors, even considering their expertise, are not unquestionably entitled to patients’ pelvises, with this idea coming from officials within their field. While these institutional guidelines are useful for establishing expectations, they are inadequate to serve as ethical justification for why the practice is wrong.

Others cited our current political moment as reason to re-think this practice, with one doctor pointing to the MeToo movement, implying that because of MeToo and the current historical moment, it is time to re-evaluate how once thought-of “standard” practice might be harmful and in need of change.⁷¹ By gesturing to this social movement, the doctor breaks the barrier of medicine and science being separate from social dynamics and biases. However, this gesture to the mainstream MeToo movement, and not any others, also reflects a lack of attention to decades of prior work, largely driven by Black feminists, advocating against medical violence and nonconsensual procedures.

⁷⁰ Robin Fretwell Wilson, “Autonomy Suspended: Using Female Patients to Teach Intimate Exams Without Their Knowledge Or Consent,” *Journal of Health Care Law and Policy*, (2005), 242.

⁷¹ Michael Green, “Examining Examinations,” *The New England Journal of Medicine*, (2020), 1100.

Many critics of the practice simply cited the fact that most patients, when asked about if consent for this practice mattered to them, responded that it did.”⁷² By using patient preferences as a rebuttal to the argument of nonconsensual exams being routine, and therefore acceptable, these doctors are advocating for more patient-centered care. Centering patient preferences in this discussion undermines the dominant medical paradigm of doctors’ authority over patients. Rather than treating this issue as minor, critics tended to describe the potential harm stemming from nonconsensual EUAs in a more serious manner, citing dignitary harm, emotional damage, and feelings of guilt, shame, and anxiety for medical students who do not want to violate another person.⁷³ Citing these emotional repercussions as evidence for why the practice should not be considered is subversive to the power structures supporting this practice by placing importance emotional safety and valuing the input of medical students over the preferences of doctors.

The Context of the Teaching Hospital & Implicit vs. Explicit Consent

Another prominent point of debate is whether or not consent is implied in the fact that patients choose to accept care at a teaching hospital. Some argue that because patients attend a teaching hospital, they must already be aware and okay with the fact that medical students will be practicing on them, and therefore do not need to be asked for consent prior

⁷² Sanjana Salwi, Alexandra Erath, Pious Patel, Karampreet Kaur, and Margaret Mitchell, “Aligning Patient and Physician Views on Educational Pelvic Examinations Under Anaesthesia: The Medical Student Perspective,” *British Medical Journal*, (2020), 431.; J. Bibby, N. Boyd, C. W. E. Redman, D. M. Luesley, “Vaginal Examination.”; Shawn Barnes, “Pelvic Examinations,” (941).

⁷³ Maya Hammoud, Kayte Spector-Bagdady, Meg O’Reilly, Carol Major, Laura Baecher-Lind, “Consent for the Pelvic Examination Under Anesthesia by Medical Students,” *Obstetrics and Gynecology*, (2019), 1305.; Jennifer Hall, “Examinations and Assault: What is Going On?” *The Practising Midwife*, (2003), 4.; Shawn Barnes, “Pelvic Examinations.”

to an EUA. In this section, I demonstrate how this argument not only fails to take into account issues of access and privilege, but also removes ethical responsibilities from doctors. I highlight how the points made in dispute of this position effectively undermining the assumptions behind it.

One registered nurse reflects, “There was no question of consent for these women. It was a teaching hospital and it was expected that the patients would accept students learning on them.”⁷⁴ This assumption relies on an assumption of implied consent for a very intimate exam, assuming that because the patient sought care at a teaching hospital, they must be okay with students practicing skills using their bodies. By focusing on the patient’s choice to visit a teaching hospital, the discussion about doctors’ ethical obligations is re-focused on individual patient responsibility on where they choose to receive care. This reduced the impetus on medical professionals to reconsider how their norms or assumptions might be causing harm to patients, and encourages them to think that they have the right to use patients’ bodies at teaching hospitals as they see fit.

Furthermore, this justification unapologetically leads to disproportionate violence against marginalized people. Medical student Shawn Barnes responds to the teaching hospital argument by encouraging his superiors to remember that patients may choose teaching hospitals due to location, cost, insurance, and other factors that do not relate to consent to have their bodies used for teaching.”⁷⁵ Teaching hospitals tend to serve individuals from low-income backgrounds and often service a disproportionate number of

⁷⁴ Jennifer Hall, “Examinations and Assault.”

⁷⁵ Shawn Barnes, “Pelvic Examinations,” (942).

patients who are people of color.⁷⁶ By bringing up these factors, Barnes problematizes the other doctors' uses of the liberal notion of choice and sheds light on how the "choice" to go to a teaching hospital might not be made amongst multiple accessible options. Michael F. Green was the only doctor to explicitly recognize the history of doctor-patient power imbalances as having been magnified for patients using public insurance and for patients who are people of color, meaning that they will experience a disproportionate number of these exams.⁷⁷ This history is crucial to understanding the causes of this issue, and this acknowledgement, while limited, is an essential first step to subverting the unequal power dynamics. Both Barnes and Green's discussion provides information that explains how pelvic exam violence is more likely to impact multiply marginalized people.

Furthermore, Barnes, and others, also bring up the fact that both doctors and consent forms at teaching hospitals tend to use vague language like "the medical student will be assisting" or contain a "blanket clause"⁷⁸ such as, " medical students and residents may be involved,"⁷⁹ and do not specify how medical students will be involved during their care and whether any of their actions will solely be conducted for teaching purposes."⁸⁰ This point emphasizes the importance of clear and informed consent rather than relying on an implication or assumption, which has much more risk of potential bodily violations. Green states, "The informed-consent process should include an honest conversation between the

⁷⁶ Tara Murtha, "We Must Ban Nonconsensual Pelvic Exams on Patients Under Anesthesia," *Women's Law Project*, January 15th, 2020.

⁷⁷ Michael Green, "Examining Examinations," 1100.

⁷⁸ Stephanie Schniederjan, "Ethics Versus Education: Pelvic Exams on Anesthetized Women," *Oklahoma State Medical Association*, (2005), 387.

⁷⁹ Shawn Barnes, "Pelvic Examinations," (942).

⁸⁰ Ibid.; Lori Bruce, "A Pot Ignored Boils On: Sustained Calls for Explicit Consent of Intimate Medical Exams," *Springer*, (2020), 127.

clinician and the patient during which the clinician does her or his best to level the playing field, minimize any potential for subtle coercion, and make it clear that the patient always has the right to decline examinations by trainees that are conducted for teaching purposes.”⁸¹This suggestion resists traditional doctor-patient power dynamics by encouraging more open communication and respect for the patient’s experience and boundaries.

Necessity Vs Teaching Opportunity—Does this problem actually exist?

One crucial point of contention was whether or not these exams were only performed for teaching purposes. Some doctors claimed that EUAs conducted by medical students are a legitimate and integral part of patient care and are not performed exclusively for learning. I deconstruct this argument using both anecdotal evidence and counter opinions by other doctors that prove otherwise. I argue that this reflects a commitment to ignorance, in the name of convenience, laden in the argument that nonconsensual EUAs for teaching purposes do not occur. Furthermore, I identify the dismissal of anecdotal evidence from medical students by doctors as more evidence of the construction of doctors as omniscient and unquestionable authorities.

In response to Ubel’s, Jepsen’s, and Silver-Isenstadt’s, study, “Don’t Ask, Don’t Tell: A Change in Medical Student Attitudes After Obstetric/Gynecology Clerkships Toward Seeking Consent for Pelvic Examinations on an Anesthetized Patient”, Doctor Lewis Wall and medical ethics educator Douglas Brown published an article titled, “Ethical issues arising from the performance of pelvic examinations by medical students on anesthetized

⁸¹ Michael Green, “Examining Examination,” (1101).

patients,” about how the issue of EUAs for teaching purposes is largely nonexistent.⁸² Wall and Brown criticize the study’s conclusion as “erroneous” and “flawed”, explaining that they do not believe it is true that EUAs are typically being performed solely for educational purposes in cases of gynecological surgery where medical students will be directly assisting, arguing that it is necessary for all team members to have an understanding of the patient’s anatomy and acquire “knowledge of the patient’s condition that is directly related to the safe achievement of the therapeutic goals of the operation.”⁸³ It can be reasonably presumed that most people would agree that if a pelvic exam was necessary for successful care of the patient, then the exam would not be a violation of patient autonomy.

However, this contradicts the experiences of many medical students who have come forward to share their stories of performing EUAs for the purposes of learning and practice, not for the care of the patient. One of the authors of the study, Doctor Ari Silver-Isenstadt, was himself asked to perform one of these examinations while in medical school. When he asked the surgeon if the patient had consented to a medical student conducting an exam, the surgeon simply responded by saying that the woman knew she was in a teaching hospital, implying that her consent should be implicit.⁸⁴ The surgeon did *not* respond by saying that it was critical for her care that Silver-Isenstadt perform the exam. Another medical student describes her experience with other students conducting EUAs on a single anesthetized patient at Brown University’s Warren Alpert Medical School, recounting, “Everyone’s gloves were handed out, then lubrication was put on those gloves in succession...In the

⁸² Lewis Wall and Douglass Brown, “Ethical issues arising from the performance of pelvic examinations by medical students on anesthetized patients,” *American Journal of Obstetrics and Gynecology*, 2004.

⁸³ Lewis Wall and Douglass Brown, “Ethical issues,” (321).

⁸⁴ David Pesci, “Uproar Over Act of Conscience,” *Wesleyan*, January 20th, 2004.

moment, I felt like I was being accepted into the ob-gyn culture.”⁸⁵ Through his personal experiences, Barnes identifies the belief that EUAs performed under anesthesia are never solely for teaching purposes, and are actually crucial in the care or treatment of the patient, as one common argument provided in favor of continuing this practice and to dismiss the potential harm it can cause. Barnes counters, “Whereas the attending and resident use the pelvic examination for purposes of diagnosis, trocar placement, anatomical layout, or surgical procedure, the medical student is not in the OR to diagnose, plan care, or decide on treatment...He or she is inherently there to learn.”⁸⁶

In response to anecdotes like these, Wall and Brown argue that students who object to this practice out of the belief that their potential implementation of EUAs would solely be for their educational benefit have “a poor understanding of the need for a physician in training to learn the fundamentals of gynecologic surgery and pelvic anatomy.”⁸⁷ By attributing these objections to a lack of knowledge, Wall and Brown fail to adequately address stories that clearly contradict the notion that EUAs are typically performed out of necessity and they reinforce the dominant paradigm of doctor’s as all-knowing arbiters of respectful patient care. Their blatant dismissal of these students suggests an unwillingness to take anecdotal objections with the appropriate level of concern. By insisting that the issue is with students’ intellect, Wall and Brown signify their refusal to adequately value experiences or knowledge that contradicts theirs as doctors. Even students, who figuratively have one foot in the medical system and one foot out, are not considered “expert” enough

⁸⁵ Jennifer Tsai, “Medical Students Regularly Practice Pelvic Exams On Unconscious Patients. Should They?” *Elle*, June 24th, 2019.

⁸⁶ Shawn Barnes, “Pelvic Examinations,” 942.

⁸⁷ Lewis Wall and Douglass Brown, “Ethical issues,” 322.

to be listened to, if contradicting the belief of a doctor. Furthermore, while Wall and Brown attribute medical students' hesitancy to having poor understandings and they critique the authors of "Don't Ask Don't Tell..." as being misguided due to the fact that the none of them were gynecologists or surgeons, this reasoning is easily refuted when taking into account the fact that other gynecologists and obstetricians have written articles with similar positions, critiquing the practice of EUAs as exploiting patients for teaching opportunities.⁸⁸

Although Wall and Brown state that the most important aspect of this issue is whether or not the patient benefits, they place significant importance on pelvic exam competency for medical students, urging,

The trend toward placing inappropriate and unnecessary barriers in the way of medical students who need to learn fundamental medical skills should be resisted... Teaching medical students the fundamentals of surgery requires that they examine patients and learn to function as surgical assistants. We believe that the failure to teach them these fundamentals will be detrimental to every patient with whose care they are charged in later life.⁸⁹

Interestingly, this ending note does not suggest benefit to the patient, but instead is a call for convenient practice opportunities to prepare medical students. Wall and Brown make a call to the Utilitarian principle of benefitting the greater good in the future, prioritizing expertise and knowledge over the recognition of the violence of nonconsensual EUAs.

⁸⁸ Norma O'Flynn and Janice Rymer, "Consent for Teaching: the Experience of Women Attending a Gynaecology Clinic," *Medical Education*, (2003).; Adam J. Wolfberg, "The Patient as Ally—Learning the Pelvic Examination," *New England Journal of Medicine*, (2007).; Carey York-Best and Jeffrey Ecker, "Pelvic Exams Under Anesthesia: A Teachable Moment," *Obstetrics and Gynecology*, (2012).; Eli Adashi, "Teaching Pelvic."

⁸⁹ Lewis Wall and Douglass Brown, "Ethical issues," 322.

The Benefits of EUAs & A Fear of Transparency

Throughout the literature, it is clear that one of the most major points of resistance to consent is the argument that EUAs is that it introduces a risk that medical students may not be able to practice EUAs as frequently as they do now. Many consider EUAs to be very beneficial learning opportunities and fear that if patients are asked for consent for medical students to practice pelvic exams on them, the patients will say no and the number of opportunities for students to practice these exams will be greatly reduced.⁹⁰ In this section, I first evaluate the merit of the cited benefits of this practice, identifying how the supposed “benefits” do not take into account the harm of teaching medical students to devalue consent. Then, I describe how this argument entirely undermines the concept of consent by making the process conditional on whether the patient will say yes. I also critique some of the pushback to this argument as continuing to center teaching opportunities and convenience over the non-negotiable need to respect patients’ liberty to make decisions about the use of their own bodies.

Proponents of this practice brought up what they argue are unique benefits to EUAs.⁹¹ Some physicians cited the particularly relaxed musculature of the pelvis under anesthesia as helpful for students to more easily become acquainted with the anatomy.⁹² Others brought up the lack of communication during the exam as one of its positive attributes. For example, one article brought up the preference for anesthetized exams as being related to the student’s ability to make a mistake without feeling embarrassed by the

⁹⁰ Adam J. Wolfberg, “The Patient as Ally,” 889.; Lori Bruce, “A Pot Ignored,” 131.; Shawn Barnes, “Pelvic Examinations,” 943.; Stephanie Schniederjan, “Ethics Versus Education,” 386-387.

⁹¹ Adam J. Wolfberg, “The Patient as Ally,” 889.

⁹² Jennifer Goedken, “Pelvic Examinations,” 234.; Avram Goldstein, “Practice vs. Privacy on Pelvic Exams,” *Washington Post*, May 10th. 2003.

patient's reaction as if they were conscious.⁹³ Some also assigned anxiety prevention benefits to patients, believing that asking for consent for an EUA would add an unnecessary stressor to a patient.⁹⁴ This argument relies on the belief that if patients don't know they were non-consensually examined, then there is no harm caused. This perpetuates putting all the decision-making in the hands of the doctor. Rather than ruminating on how thoughtful and mindful communication might ease anxiety for the patient, this argument supporting taking away this opportunity, assuming that doctors know what is best for the patient and that the patient would not benefit from being able to choose what happens to their bodies.

Counterproductively, nonconsensual EUAs can cause anxiety for both the students and patients involved. Many medical students report feeling shame, distress, and guilt over the fact that they performed these exams.⁹⁵ It is important to note that medical students are often driving the pushback to these exams, as it implies that individuals who have not been within the medical community for very long might have a greater connection to ethical values and preferences held by the average patient.

There is also great danger in teaching medical students that it is sometimes okay to violate the autonomy of their patients, that it is up to them to decide what constitutes harm, and that they can decide when it is permissible to cause harm. In fact, one study found that medical students rated the process of obtaining consent as less important *after* completing an

⁹³ Lori Bruce, "A Pot Ignored," 130.

⁹⁴ Peter Ubel, Christopher Jepsen, and Ari Silver-Isenstadt, "Don't Ask, Don't Tell," 578.; Adam J. Wolfberg, "The Patient as Ally," 889.

⁹⁵ Shawn Barnes, "Pelvic Examinations," 941.; Maya Hammoud, Kayte Spector-Bagdady, Meg O'Reilly, Carol Major, Laura Baecher-Lind, "Consent for the Pelvic Examination," 1306.; David Alfandre, Cynthia Geppert, Jennifer Goedken, and Toby Schonfeld, "A Step in the Wrong Direction: Florida Lawmakers' Interference with Informed Consent for Pelvic Examinations," *Women's Health Issues*, (2021), 315.; Sanjana Salwi, Alexandra Erath, Pious Patel, Karampreet Kaur, and Margaret Mitchell, "Aligning Patient and Physician Views," 432.; Lori Bruce, "A Pot Ignored," 136.

obstetrics and gynecology clerkship, suggesting that something happens during the clerkship that teaches students that consent is not essential.⁹⁶ Bioethicist Lori Bruce terms this issue of the decline in medical students' respect for consent as "ethical erosion, which may be prevented if students had to ensure consent had been obtained before conducting an examination."⁹⁷ This ethical erosion must be taken into account when measuring the level of benefits that this practice can bring. The damage of teaching students to devalue consent is long-term, widespread, and will affect an unthinkable number of patients.

The most significant point of resistance to explicit consent practices among instructors is the fear that asking patients for consent for medical students to perform EUAs may result in a significantly decreased number of learning opportunities, leading to students being less prepared in their careers.⁹⁸ One survey found, "it was said that research could not be effectively carried out if subjects had to consent and that patients could understand neither the aims nor the importance of research, nor could they adequately assess its risks and benefits."⁹⁹ This argument centers the convenience of student teaching practices and dismisses patients' safety, while also expressing a lack of respect for patients' intellects by dismissing their ability to make thoughtful and well-reasoned decisions about participating in the education process. To confidently defend not asking for consent for fear of not being able to attain it reflects a striking lack of respect for bodily autonomy and a sense of entitlement toward patients' bodies. This debases the entire premise of consent, signaling

⁹⁶ Peter Ubel, Christopher Jepsen, and Ari Silver-Isenstadt, "Don't Ask, Don't Tell," 579.

⁹⁷ Lori Bruce, "A Pot Ignored," 135.

⁹⁸ Adam J. Wolfberg, "The Patient as Ally," 889.; Lori Bruce, "A Pot Ignored," 131.; Shawn Barnes, "Pelvic Examinations," 943.; Stephanie Schniederjan, "Ethics Versus Education," 386-387.

⁹⁹ Daniel Cohen, Rosslyn Kessel, Laurence McCullough, Aristide Apostolides, Kelly Heiderich, Errol Alden, "Pelvic Examinations by Medical Students," *American Journal of Obstetrics and Gynecology*, (1989), 1014.

that physicians only need to ask for consent if they believe they will get it. By revealing an understanding that there may be individuals who are not okay with medical students practicing on them, this argument acts as an admission. Interestingly, this argument appears to invalidate prior points made in defense of nonconsensual EUAs. While those relying on the notion of “implied consent” and “routine procedure” as arguments for why the nonconsensual exam is not a problem, there is a simultaneous fear expressed that if they asked for explicit consent they would not receive, which implies that many instructors know that what they are doing is not consensual, refuting the idea that patients consent to intimate involvement by medical students by the sheer fact of attending a teaching hospital. It also implies that many physicians understand that this practice is not “minor”, as many patients may feel strongly enough against it as to refuse.

Most advocates against the practice responded to this concern by citing various studies that have found the majority of women would consent to undergoing a practice exam if asked beforehand, refuting the idea that these types of opportunities would be entirely eliminated.”¹⁰⁰ While this strategy could effectively calm the fear of a lack of teaching opportunities for students, it does not address the power dynamics upheld within this line of thinking. Rather than deconstructing the idea that potential convenience of teaching opportunities matters more than patient autonomy, this rebuttal simply squelches the fear by assuring that it is unlikely to happen. Suggesting that consent should be mandatory because physicians are likely to receive it continues to make asking for consent

¹⁰⁰ Peter Ubel, Christopher Jepsen, and Ari Silver-Isenstadt, “Don’t Ask, Don’t Tell,” 578.; Shawn Barnes, “Pelvic Examinations,” 943.; Norma O’Flynn and Janice Rymer, “Consent for Teaching,” 1113.; Lori Bruce, “A Pot Ignored,” 131.; Sanjana Salwi, Alexandra Erath, Pious Patel, Karampreet Kaur, and Margaret Mitchell, “Aligning Patient and Physician Views,” 432.; Adam J. Wolfberg, “The Patient as Ally,” 889.

conditional on the predicted outcome, rather than emphasizing its necessity out of respect for bodily sovereignty. Only two physicians asserted that patient autonomy must matter more than the opportunity to practice pelvic exams, writing “even if the more stringent consent procedures did reduce the numbers of patients involved in teaching, the onus remains on educators to ensure that consent procedures comply with the values intended in the formal curriculum.”¹⁰¹ This assertion more effectively addresses the misogynistic entitlement present in the idea of asking for consent not being worth the risk of students losing potential exam opportunities. Rather than arguing within this patriarchal concept, O’Flynn and Rymer shift the conversation to being about the need to prioritize doctors’ ethical responsibilities and teach students ethically-sound values. Unlike prior points that placed the responsibility on patients, these doctors allocate the responsibility of patient respect and safe care to doctors educating their students, which re-frames the power of doctors from power over patients to influence students into behaving appropriately and considerately.

The Culture of Medicine

The issue of the culture of medicine came up repeatedly throughout the literature as part of the reason why nonconsensual EUAs take place, often without resistance from the medical students performing them. Here I examine the two main aspects of the culture of medicine that repeatedly arose: the hierarchal nature of medical school and diverging doctor and patient perspectives on harm. Many suggest the need to change the hierarchal nature of medical school, which I support, but also critique as an ineffective solution to addressing the

¹⁰¹ Norma O’Flynn and Janice Rymer, “Consent for Teaching,” 1114.

harms caused by doctors and instructors and a method of preventing accountability for them as well. I also address the deeply gendered, raced, classed nature of the assumptions and rights over others' bodies that influence doctor perspectives on what qualifies as harmful.

The strong sense of authority that instructing doctors held over medical students is one dominant medical paradigm that made some medical students uncomfortable and is part of the reason that the practice often goes uncriticized. Medical student Shawn Barnes writes about the shame he feels for not speaking up when he was instructed to perform a nonconsensual EUA, but cites his awareness of “the hierarchy that exists during training” as part of the reason as to why he felt he was unable.¹⁰² These feelings of powerlessness or general inability to speak out were also reported by other students, which Nurse Jane Reid conceptualizes as an important aspect of this issue.¹⁰³ The discussion of this issue challenges the absolute authority of doctors by suggesting that medical students may have valuable insights and arguments as to why a common practice should be changed. Others praised both Barnes and Yvette Coldicott, another medical student who published an article about this practice, for publishing pieces about this controversial topic,¹⁰⁴ reflecting a common understanding of the challenges involved with speaking out against this issue.

Because of this, some professionals emphasize the need to alter the strict hierarchy that comprises medical schools. Doctors David Alfandre, Cynthia Geppert, and Jennifer Goedken write, “a health care environment where everyone is empowered to speak up without recrimination is central to maintaining a robust ethical culture that strengthens

¹⁰² Shawn Barnes, “Pelvic Examinations,” 941.

¹⁰³ Jane Reid, “Learning Intimate Examinations,” 71.

¹⁰⁴ Peter Singer, “Intimate Examinations and Other Ethical Challenges in Medical Education,” *British Medical Journal*, (2003), 63.; Carey York-Best and Jeffrey Ecker, “A Teachable Moment,” 742.

medicine's social contract with society."¹⁰⁵ Although changing this hierarchy is important, as the ethical perspectives of medical students should be valued and allowed to be expressed freely, this position continues to shift the responsibility of not perpetuating harm off of physicians and on to other actors in the situation. This neglects the gravity of how and why instructors may violate the consent of their patients and prevents accountability for instructors who are teaching and promoting violence.

Barnes continues in his piece to suggest a striking dichotomy between the culture of medicine that didn't perceive nonconsensual EUAs to be problematic as compared with the general public who tend to feel strongly against the practice.¹⁰⁶ Similarly, other medical students suggest these diverging beliefs about the harm of nonconsensual EUAs prevent explicit consent from being obtained and that it is important for the medical community to shift their understanding of harm to align with those of patients'.¹⁰⁷ Suggesting that physicians change their beliefs about what constitutes harm to align with their patients' perspectives fundamentally challenges patriarchal paradigms of medicine that allow doctors to use patients' bodies as they see fit. Goedken also highlights these diverging perspectives, ultimately arguing that in the perspective of the physician, "the failure to inform patients of the practice of EUA would seem no more offensive than, for instance, failure to alert patients that a student may perform a lung exam using a stethoscope on them while they are unconscious... Unlike the implications of many articles...this practice does not lack respect

¹⁰⁵ David Alfandre, Cynthia Geppert, Jennifer Goedken, and Toby Schonfeld, "Florida Lawmakers' Interference," 315.

¹⁰⁶ Shawn Barnes, "Pelvic Examinations," 941.

¹⁰⁷ Sanjana Salwi, Alexandra Erath, Pious Patel, Karampreet Kaur, and Margaret Mitchell, "Aligning Patient and Physician Views," 431.

for the patient.”¹⁰⁸ Although Goedken ultimately suggests that the practice must end because of the harm that patients report experiencing, her analysis of the issue implies that the intention of the physician defines whether a practice is respectful, rather than whether or not the action violates principles of consent or bodily autonomy. Goedken does not treat the physician perspective as a flaw, but rather a value-neutral difference that must be changed to accommodate the needs of the patient. This ignores how systemic oppression and bias shapes how bodies are understood to be usable. While all people can experience nonconsensual exams, as mentioned previously, these exams disproportionately affect people facing multiple types of oppression. Further, additional anecdotal evidence suggests that students are encouraged to gain more hands-on experience when treating individuals from multiply marginalized backgrounds.¹⁰⁹ These conditions are not coincidental, but underscore the long-standing entitlement toward bodies assigned female at birth, especially bodies of color and those from low-income backgrounds. Goeken’s rhetoric leaves the commodification of AFAB bodies unquestioned, allowing the view of AFAB bodies as usable parts to propagate. Although it is likely that many physicians who engage in this practice are not necessarily bad-intentioned, that does not mean that their actions are not disrespectful—and to suggest otherwise entirely dismisses the deeply rooted attitudes that lead to this practice and other violations of consent.

Gap in the Discourse

¹⁰⁸ Jennifer Goedken, “Pelvic Examinations,” 237.

¹⁰⁹ Emma Goldberg, “She Didn’t Want a Pelvic Exam,” February 17th, 2020.

Through an intersectional feminist lens, it becomes clear that the discourse surrounding nonconsensual EUAs does not fully address the causes of this problem. In this section, I propose that the main gap in the discourse is a lack of discussion about the relevance of the history of gynecology to this issue. I argue that this gap severely limits the ability of the medical actors writing about this to truly challenge the systems of power that harm patients.

Concerningly, none of the articles referenced or implied any awareness of this history of gynecology and its relevance to this issue of nonconsensual EUAs. Some wrote about the need to qualitatively research why instructors are teaching students to breach the patient consent, but no causes were mentioned or eluded.¹¹⁰ Another doctor writes, "A lingering stain on the history of medical education, the age-old practice of unsanctioned pelvic examinations was hardly without consequences. Viewed in hindsight, it is difficult to see how the conduct of unapproved pelvic examinations by medical students could have been rationalized, let alone condoned."¹¹¹ Similarly, nurse Jane Reid writes, "We can only speculate on the reasons. An absence of planning before a training episode, failure to recognise learners' needs, poor communication between trainers and trainees, and lack of guidelines (particularly for rectal examination) may all play a part."¹¹² This inability to understand how this normalization and acceptability of this practice suggests a lack of awareness about the historical development of the pelvic exam. This practice is a natural and direct step in the evolution of gynecology, when the field's origins are taken into

¹¹⁰ Charlotte Rees and Lynn Monrouxe, "Medical Students Learning Intimate Examinations Without Valid Consent: A Multicentre Study," *Medical Education*, (2003), 270.

¹¹¹ Eli Adashi, "Teaching Pelvic," 733.

¹¹² Jane MacDougall, "Commentary: Teaching Pelvic Examination—Putting the Patient First," *British Medical Journal*, (2003), 100.

account. Many advocates against this practice suggests that changes in ethical attitudes towards nonconsensual EUAs are likely due to changes in social norms and ethical principles.¹¹³ This framing of the issue, as a need to keep up with modernity, inadequately considers the full implications of the societal moment during which these norms were constructed on how the field of gynecology functions today. The crux of the issue does not solely lay in practice, but in attitude. While framing this issue as a difference in perception of body parts, benefits, harm, consent, or respect between medical professionals and the public might be appealing and less sinister than fully recognizing the violence behind this issue, it offers a superficial analysis of the potential causes of this issue and does not create an opportunity for medical professionals to take accountability for the violence of their institutions. Two articles mentioned the need to avoid placing blame for this type of violence and instead focus on creating solutions.¹¹⁴ Although attributing blame will likely not be useful to preventing this issue from continuing to happen, the casual suggestion that blame should not be sought stands to question whether medical actors understand this practice to be a type of violence. Even some medical students advocating against the practice conceded that other articles written about it included “sensationalized wording”¹¹⁵ in reference to labeling the practice as assault. The recognition of a nonconsensual EUA as assault is requisite to begin a process of accountability. Accountability for a systemic type of violence does entail ensuring that the violence not continue, but it also requires the

¹¹³ Eli Adashi, “Teaching Pelvic,” 733.; Yvette Coldicott, Catherine Pope, and Clive Roberts, “The Ethics of Intimate Examinations,” 97.

¹¹⁴ Peter Singer, “Intimate Examinations,” 63.; Jane Reid, “Learning Intimate Examinations,” 73.

¹¹⁵ Sanjana Salwi, Alexandra Erath, Pious Patel, Karampreet Kaur, and Margaret Mitchell, “Aligning Patient and Physician Views,” 433.

perpetrators of that violence to reflect on what led that to inflict harm upon others and if there are ways for them to repair some of that harm.

Goedken advocates for a change in culture in both of her articles, but neither address how deeply entrenched racist, patriarchal, and misogynistic attitudes are in the field of gynecology and how it is these forces that create an environment where physicians do not conceptualize instructing medical students to insert their fingers into unconscious patients and feel their reproductive organs without permission as assault, or at least as disrespectful. This influences her understanding of the issue. While she boils down the major contributing factor to be the physician's perspective that this practice is not disrespectful, she attributes this attitude to the professionalism of a physician and desensitization to their respective bodily area of expertise. This perspective lacks the deeper analysis of gynecology's history of medically acceptable breaches of consent in the name of knowledge-building. Goedken continues in the article to write, "Just as the doctor-patient relationship has changed dramatically over the past two decades, from one that was historically paternalistic to more of a partnership between a patient and her physician, so too medical education has evolved and continues to evolve with more emphasis on the patient and her participation in the education process."¹¹⁶ Although she acknowledges the historical paternalism in doctor-patient relationships, she doesn't address the source of the dominant paradigms. It is worth noting that Goedken and others also emphasized the need to obtain explicit consent in order to "maintain" or "safeguard" patient trust in doctors and/or the larger medical community.¹¹⁷ This wording reflects a belief that patients currently trust their providers,

¹¹⁶ Jennifer Goedken, "Pelvic Examinations," 239.

¹¹⁷ Ibid.; Jane Reid, "Learning Intimate Examinations," 73.

however, multiple studies have found a relatively high distrust of doctors and the medical system among Black patients. This either reflects a tendency to conceptualize the default patient as white or a discrepancy in their awareness of the attitudes of Black patients, or both. When reflecting on the legacy of Marion Sims, Harriet A. Washington writes, “Was Sims a savior or a sadist? It depends, I suppose, on the color of the women you ask. Marion Sims epitomizes the two faces—one benign, one malevolent—of American medical research.”¹¹⁸ Different demographics can have drastically different relationships to doctors and medical institutions. For marginalized people, this relationship is *often* complicated, carries historical baggage, and is laced with mistrust. This common ignorance to the racialized history of the medical system and the ongoing discrimination and general mistreatment that Black patients face is aligned with the absence of addressing the historical roots of physicians’ sense of ownership to patients’ bodies in gynecology and medical education.

As further detailed by Washington, Marion J. Sims studied gynecology by examining, experimenting on, and harming enslaved Black women who “did not have to be recruited, persuaded, and cajoled to endure pain and indignity,” as they had no choice but complacency.¹¹⁹ Sims and other physicians would take turns examining the women, gaining knowledge about vulvar and vaginal anatomy for the first time.¹²⁰ It is clear from where the dominant paradigms at play in the nonconsensual EUA issue originate. Physicians do not coincidentally, or happen to, have a disparate notion of harm compared to the average

¹¹⁸ Harriet A Washington, *Medical Apartheid*, 12.

¹¹⁹ Harriet A Washington, *Medical Apartheid*, 142.

¹²⁰ Harriet A Washington, *Medical Apartheid*, 116.

person. The common disregard for a patient's right to privacy and agency, even and especially when in a compromised state, such as when anesthetized, is entrenched in the field of gynecology's history of abuse of women in the pursuit of knowledge, expertise, and authority.

The discourse on this issue will remain fundamentally incomplete as long as it is missing the awareness and analysis of the violent and abusive origins of the pelvic exam and does not explicitly recognize the need to incorporate human rights, which functions to construct a narrative about the culture of medicine contributing to this issue as if it is fortuitous, rather than an inborn consequence of the field's genesis. Although many articles suggest a necessary change in culture, in order for the discourse to be truly and effectively subversive, it must reckon with the dark history of gynecological violence on enslaved women used to develop the science. Some important suggestions were made, including teaching students about ethics and the social factors that will influence behavior, such as the pressure to conform and obey authority figures,¹²¹ and any substantial change to the culture of medicine will entail investigating how its history has influenced the structural elements of gynecology and gynecological education, in addition to how it continues to impact attitudes and practices towards individuals assigned female at birth.

Legal Responses to Nonconsensual EUAs

In response to increased scrutiny of nonconsensual EUAs, twenty states have banned the practice. In this section, I examine the legal advocacy surrounding this issue by analyzing articles written by legal scholars and ethicists. Ultimately, I argue that while legal

¹²¹ Yvette Coldicott, Catherine Pope, and Clive Roberts, "The Ethics of Intimate Examinations," 99.; Charlotte Rees and Lynn Monrouxe, "A Multicentre Study," 270.

reforms pertinent to this issue are necessary and important, they are limited in their ability to prevent this practice, nor do they effectively address the dominant paradigms of power behind this issue.

Although the past several years have brought legislative progress, there is still significant hesitation in many states to address nonconsensual EUAs. As previously mentioned, Ashley Weitz's compelling testimony in front of the Utah legislature led to a state-wide ban of the practice in 2019. Notably, in 2020, legislation to ban EUAs without consent was introduced in Pennsylvania, the site of Ubel's, Jepsen's, and Silver-Isenstadt's popular and controversial study. The bill was sponsored by two new Democratic representatives, Representative Elizabeth Fiedler and Representative Elizabeth Hanbidge, who write, "We believe this common practice is a violation of our bodies and our rights, one that disproportionately, though not exclusively, impacts women...Our legislation will help protect patient's rights and increase the trust that Pennsylvanians have in their medical care."¹²² Unfortunately, this bill was not enacted into legislation.

Robin Fretwell Wilson is a legal scholar, law professor, and long-time legal advocate against nonconsensual pelvic exams. Wilson has dedicated decades of effort to banning nonconsensual EUAs. She first learned of the practice in 2002 from a friend attending medical school and begun to research the issue, discovering it was a disturbing worldwide and longtime educational practice.¹²³ In 2003, she presented her research to the Federal Trade Commission and launched a campaign seeking legislation banning the practice.¹²⁴

¹²² Elizabeth Fiedler and Liz Hanbidge, "It's Time to end PA's Outrageous Practice of Non-consensual, Unnecessary Pelvic Exam," *Pennsylvania Capital-Star*, January 14th, 2020.

¹²³ Lauren Markoe, "'Nonconsensual' Pelvic-Exams Under Scrutiny," *The Chicago Tribune*, June 25th. 2003.

¹²⁴ *Ibid.*

Wilson’s and others’ advocacy helped pass some of the state-wide bans, but as Wilson notes in 2018, the practice persists because “the controversy it periodically sparks dies out eventually. And, like clockwork, attending physicians and medical educators resume using women like test dummies — stripping them of the right to decide who touches their bodies.”¹²⁵ Wilson’s advocacy has spanned two major influxes of attention to the issue, and yet, the practice remains legal in more than half of the country, reflecting strong institutional resistance to progressive change.

Moreover, there are also conflicting beliefs about what legislation banning this practice should include. Wilson recently partnered with Friesen, Goedken, and ethicist Soyoon Kim in an article evaluating various aspects of existing legislation and recommending certain considerations for future legislation.¹²⁶ This article and its legal recommendations reflect how legal responses are limited in their ability to deal with the complexity of the issue. The article begins with a mention of the wave of attention to this issue in 2018, which they attribute to the MeToo movement. They also note the surge of legislation surrounding the issue in 2019. This increase in bills is also largely due to Ashley Weitz’s testimony, after she was examined for an STI by her doctor while anesthetized, even though she had declined while conscious. The article suggests that lawmakers limit their consent regulations to educational exams, arguing that “there is an important moral difference between a pelvic examination performed by a licensed physician as part of the provision of appropriate patient care and an examination performed by a trainee or two for

¹²⁵ Robin Fretwell Wilson, “#JustAsk: Stop Treating Unconscious Female Patients Like Cadavers,” *The Chicago Tribune*, November 29th, 2018.

¹²⁶ Phoebe Friesen, Robin Fretwell Wilson, Soyoon Kim, and Jennifer Goedken, “Consent for Intimate Exams on Unconscious Patients: Sharpening Legislative Efforts,” *Hastings Center Report*, (2022).

the sake of their education.”¹²⁷ This approach effectively ignoring the case that started it all, Weitz’s story. It is true that this type of violence most often occurs in teaching hospitals, but the recommendation to only focus on education exams does not prevent individuals from nonconsensual examinations that they may wish to refuse, but their doctor may deem appropriate. Patients deserve to have their autonomy respected regardless of who is performing their exam, and legislation that does not address this, such as Virginia’s law surrounding this issue, allows cases like Weitz’s to happen again.

The limitations of this approach are becoming increasingly clear as more research about nonconsensual exams emerges. A recent national survey on nonconsensual EUAs found that this practice may be much broader than initially anticipated. With over 1,000 respondents, the survey found that nonconsensual intimate exams—both conscious and unconscious—were experienced by patients at a rate of 1.4%, which, if extrapolated to the entire U.S. population, implied millions of nonconsensual exams.¹²⁸ It is important to remember that many EUAs occur without the patient ever knowing, so this figure may be a conservative estimate. Notably, nonconsensual exams were reported at similar rates between men and women, but Black individuals were almost four times more likely than white individuals to report having experienced one.¹²⁹ The researchers, three ethicists, use these findings to suggest the need for more research about the contexts and causes for these

¹²⁷ Phoebe Friesen, Robin Fretwell Wilson, Soyeon Kim, and Jennifer Goedken, “Sharpening Legislative Efforts,” 30.

¹²⁸ Lori Bruce, Ivar Hannikainen, and Brian Earp, “New Findings on Unconsented Intimate Exams Suggest Racial Bias and Gender Parity,” *Hastings Center Report*, (April 2022), 8.

¹²⁹ Lori Bruce, Ivar Hannikainen, and Brian Earp, “New Findings,” *Hastings Center Report*, (April 2022), 8.

exams, highlighting that much of existing legislation is limited in scope due to a focus on pelvic exams on anesthetized patients in gynecologic and obstetric settings.¹³⁰

Similar to the articles written from medical professionals, articles written by legal scholars and activists also cited the need for cultural change without referencing the violent history of gynecology and how they must be challenged in order to prevent further violations of autonomy and respect. Wilson, Friesen, Goedken, and Kim challenge some hegemonic dynamics by writing about the importance of bills containing gender-neutral language and the need to regulate systems, versus instituting penalties for individual doctors, because

failure to obtain adequate consent for educational pelvic exams is not because of a few bad apples; it's because the system is not in tune with current patient expectations. The change that is needed is a cultural one, so regulatory mechanisms should focus on structures, not individuals. However, processes of oversight need to be in place to ensure that protocols instituted at the health care system- or network level are followed, especially since patients are largely unaware that these exams take place and so are unable to advocate on their own behalf.¹³¹

These authors are correct in that nonconsensual EUAs are a cultural issue, and suggesting processes of oversight is a crucial addition to a simple ban on nonconsensual EUAs in order to help ensure that the practice does not continue even if illegal, as it is likely hard to enforce when patients may not know this happened to them and the only other witnesses may be implicated. However, because legislation cannot necessitate changes to

¹³⁰ Ibid.

¹³¹ Phoebe Friesen, Robin Fretwell Wilson, Soyoon Kim, and Jennifer Goedken, "Sharpening Legislative Efforts," 31.

medical education or active confrontation and repair of the harmful origins of nonconsensual pelvic exams, it is inherently inadequate to address the fundamental underpinnings of the culture of medicine.

Other legal scholars more actively recognize this limitation and connect it to dominant power structures affecting medical institutions. The American Association of Law Schools curated a symposium, including a collection of articles, on the issue of using patients for educational purposes without consent. They conclude,

The use of patients as “teaching material”...disproportionately affects poor people, people of color and, given the specific protocols common to training physicians to perform pelvic examinations, women. The “consent” solution merely enlists the relatively disenfranchised as volunteers in the service of the greater good of training new doctors. As such, this symposium demonstrates...that consent must be obtained, even as they push us to think carefully about the precise scope of that right. Moreover, they teach us about the inherent inability of “consent” to redress harms that grow out of the deeply-entrenched problems of inequality and subordination.¹³²

The symposium introduces the paramount concept of equity to the discussion of obtaining consent for educational exams. Although the law may be able to prevent some explicit violations of consent, it does not fundamentally challenge how certain groups of people’s bodies are more likely to be used for teaching opportunities and how this may both reflect and perpetuate attitudes of obligation among patients who receive reduced-cost care at teaching hospitals. As Dean Spade notes, “racism, transphobia, sexism, ableism, and

¹³² Michelle Oberman, “American Association of Law Schools Panel: Panel on the Use of Patients For Teaching Purposes Without Their Knowledge or Consent,” *Journal of Health Care Law and Policy*, (2005), 215.

homophobia operate through norms that produce ideas about types of people and proper ways to be. These norms are enforced through internal and external policing and discipline.”¹³³ Not only do educational exams typically occur at hospitals that serve marginalized populations, but medical students have also anecdotally noted being encouraged to gain more hands-on practice at publicly insured hospitals compared to private ones.¹³⁴ It has been normalized within medical institutions to use marginalized bodies as teaching tools, and while mandatory consent laws can help provide patients with more power to say no, they do not change which patients are asked or how they are viewed under the gaze of medical institutions.

Furthermore, even if legislation is able to prevent or reduce this practice, it is important to ask, are medical professions only asking for consent for legality purposes? Is it sufficient for doctors to honor patient autonomy simply because they have to? Whose bodies are being used for knowledge production, and who benefits? While legislation requiring consent for intimate exams is crucial and can provide victims of violence with a path to recourse, it does not have the power to change attitudes, underlying beliefs, or the systemic inequities that impact this issue.

Conclusion

Nonconsensual pelvic exams are an insidious form of violence. There have been various waves of attention toward the issue, with the most recent occurring in 2019. These increases in media and academic attention have brought increases in legislation regulating

¹³³ Dean Spade, “Transphobia,” 104.

¹³⁴ Emma Goldberg, “She Didn’t Want a Pelvic Exam,” February 17th, 2020.

consent practices for pelvic examinations, with most focusing on unconscious exams, whether they are performed for educational or other purposes.¹³⁵ Legislation necessitating explicit consent for unconscious intimate exams is essential and may help prevent nonconsensual intimate exams while the patient is under anesthesia. However, legal action is not enough to safely eliminate this practice, due to difficulties regarding enforcement and its lack of ability to address the deeply held attitudes of entitlement and a lack of respect for patient autonomy that fostered the environment where this egregious practice was normalized and largely unquestioned.

In this paper, I utilize a critical discourse analysis to examine attitudes about and barriers to eliminating this practice, including the fact that many doctors do not believe it to be ethically unacceptable, a lack of legislation requiring consent in most of the country, and existing legislation's limited ability to challenge the historical and cultural roots of the issue. Medical discourse reveals that proponents of nonconsensual EUAs support perpetuating harm under the notions of "standard procedure", implied consent at teaching hospitals, denying the practice exists for educational benefit, a fear of losing teaching opportunities, supporting a Utilitarian ethical framework, and a distaste toward alternative options. Further, I find that there is a severe lack of explicit awareness about this practice's ties to the violent history of gynecology, and due to this lack, the dominant and hegemonic paradigms resulting from these origins are present in both the arguments of proponents and opponents of this practice. I also discover that while legislation is important, it is not enough. Legislation may discourage this practice and provide a path of

¹³⁵ Phoebe Friesen, Robin Fretwell Wilson, Soyoon Kim, and Jennifer Goedken, "Sharpening Legislative Efforts," 29.

recourse for victims, but it does not challenge the root causes of this issue, nor does it impact how multiply marginalized bodies are most affected by this issue and tend to be viewed as useable by medical institutions.

Despite the resistance from medical communities, the practice of nonconsensual pelvic exams must change. It is crucial that medical institutions and actors stop violating the autonomy of their patients and begin to recognize their full humanity by respecting the need for consent. A feminist approach to pelvic exams centers a reproductive justice framework, prioritizing values of agency, information, choice, and freedom from reproductive violence throughout the entire process of patient care and assistance in medical education. This framework goes beyond rights, considering issues of access to safe exams, considerate and ethical delivery, and support before, during, and after intimate exams. Such an approach would change the conditions and norms that create an environment where nonconsensual and/or coercive exams are permissible, necessitating consent on the basis of respect for bodily sovereignty and reducing this form of violence and other harms that stem from the same causes.

Although this issue is multifaceted and deeply entrenched in the history and culture of medicine, I offer some tangible steps that may contribute to more comprehensively addressing the issue. One change would be for medical schools to transform their curriculums to directly address its history of violence and exploitation and institutional protections for medical students who raise ethical objections during their education. This would shift the culture that assumes its own objectivity and neutrality, instead recognizing how history and social forces shape doctors' and instructors' attitudes and behavior toward patients and cause harm. Overall, physicians and educators must learn to shift

their perspectives on harm to support the psychological and physical health of their patients and protect them from medical violence and trauma. The approaches of patient-centered care and narrative medicine are sites of opportunity for medical care providers to align their interests with those of patients, relegating the convenience of nonconsensual pelvic exams and their own attitudes toward the practice, in the name of patient safety, health, and well-being. These approaches also align with reproductive justice, upholding the values of equity and attention to individual needs and experiences.

Transformational change of the medical system is inextricably linked with economic, racial, gender-based, and disability liberation, and this must be recognized through theorizing about what equity in medical education and training should look like. The attitudes of doctors are not formed in a vacuum; rather, the dominant and oppressive attitudes found within medical institutions are reflective of overarching societal power dynamics. Therefore, especially when taking into account how pelvic exam violence disproportionately affects multiply marginalized peoples, combatting the causes of pelvic exam violence includes working toward naming, challenging, and dismantling societal systems of interlocking oppressions and privileges.

When considering strategies for patients to limit their engagement with the current medical system, some may look toward the women's health movements of the 1960's and '70's, which encouraged women to take greater control of care for their bodies, as potential sites of resistance.¹³⁶ Some other strategies include turning to midwifery clinics, which may exhibit more sensitivity and patient-centered care,¹³⁷ or finding individual

¹³⁶ Francine H Nichols, "History of the Women's Health Movement in the 20th Century," *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, (1999), 56.

¹³⁷ Anaiz Zamora and Greta Rico, "I Felt Raped."

healthcare providers whose attitudes appear to be more respectful, though these are not accessible options for many. While these strategies are important to have as available options for individuals, they are not the solution to stopping preventing pelvic exam violence. Individuals should be able to receive medical care in doctors' offices without fear of assault. We must urge our providers and institutions to stop abusing their patients.

It is my hope that the most recent influx attention to this issue does not die out in the same way it has in the past. Reproductive justice is an ongoing movement and bodily autonomy continues to be at stake. Regardless of whether or not this attention quickly results in more legislation, let us use this recent influx to inspire deeper conversations about the construction of our medical systems and organize. Let us not accept the violence perpetuated against our bodies, but instead continue to fight and demand change from our medical providers and institutions to create healthcare systems that prioritize patient determination, agency, and fundamental human rights.

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