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## Exposing Sedated Legal Responses to Non-Consensual Pelvic Exams Under Anesthesia

Ashleigh Austel

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# EXPOSING SEDATED LEGAL RESPONSES TO NON-CONSENSUAL PELVIC EXAMS UNDER ANESTHESIA

ASHLEIGH AUSTEL \*

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I. INTRODUCTION

When Ashley Weitz, a woman from Utah, underwent sedation for treatment of vomiting, the last thing she expected was to wake up in the middle of an invasive pelvic exam that she did not consent to.<sup>1</sup> The doctor informed her he was collecting a sample to test for sexually transmitted diseases, but the doctor had previously determined a pelvic exam was unnecessary.<sup>2</sup> Reflecting on the experience, Ashley said, “in any other setting, someone putting their fingers into my vagina without my consent is assault. I did not consent to this exam, and he did it anyway.”<sup>3</sup>

Janine, a woman from Arizona, underwent anesthesia for stomach surgery, during which medical students performed a pelvic exam on her without her

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1. See Misha Valencia, *Hospitals Are Allowing Medical Students to Perform Pelvic Exams on Unconscious Women — Without Their Consent*, HEALTHY WOMEN (Apr. 26, 2021), <https://www.healthywomen.org/your-care/pelvic-exams-unconscious-women> (recounting Weitz’s experience of receiving a nonconsensual pelvic exam while under anesthesia for an unrelated medical condition).

2. See *id.* (concluding that, prior to administering anesthesia, an internal exam was unnecessary based on her medical history).

3. See *id.* (emphasizing the traumatic nature of being the victim of a nonconsensual vaginal exam).

consent.<sup>4</sup> The only reason Janine<sup>5</sup> learned of the non-consensual exam is because a resident informed her after the surgery that while the students were conducting the exam, they saw she had gotten her period.<sup>6</sup> Janine's doctor later informed her that the students performed the non-consensual exam because the surgery team noticed she was due for a Pap smear.<sup>7</sup> The experience brought up past trauma for Janine, who is a survivor of sexual abuse.<sup>8</sup>

While stories like Ashley and Janine's are egregious, they are not uncommon.<sup>9</sup> In a 2019 survey of 101 medical students from seven major American medical schools, 92% reported performing a pelvic exam on an anesthetized patient, and 61% reported performing such an exam without explicit patient consent.<sup>10</sup> While twenty-one states restrict the practice of performing non-consensual pelvic exams on anesthetized patients,<sup>11</sup> it remains legal in the other twenty-nine.<sup>12</sup>

This Comment argues that current approaches for restricting the practice

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4. See Emma Goldberg, *She Didn't Want a Pelvic Exam. She Received One Anyway.*, N.Y. TIMES (Feb. 19, 2020), <https://www.nytimes.com/2020/02/17/health/pelvic-medical-exam-unconscious.html> (explaining that Janine told her doctor before the surgery that she did not want medical students directly involved).

5. For anonymity purposes, Janine's last name was not included in the story reporting her experience. See *id.*

6. See *id.* (stating that the resident initially informed Janine of the pelvic exam by telling her that she was on her period rather than telling her the exam was conducted).

7. See *id.* (explaining why the students conducted the nonconsensual pelvic exam).

8. See *id.* (describing the panic attacks and distress Janine experienced after discovering that she was sexually assaulted in the operating room).

9. See Jennifer Tsai, *Medical Students Regularly Practice Pelvic Exams on Unconscious Patients. Should They?*, ELLE (June 24, 2019), <https://www.elle.com/life-love/a28125604/nonconsensual-pelvic-exams-teaching-hospitals/> (finding a class size of 165 Harvard Medical students performed as many as 825 pelvic exams on anesthetized women annually).

10. See *id.* (demonstrating the frequency that nonconsensual pelvic exams occur in teaching hospitals).

11. This Comment will use the term "patient" to refer to those who are victims of nonconsensual pelvic exams in recognition that not everyone with a vagina is a woman. See Len Meyer, *Why Are Pronouns So Important?*, PLANNED PARENTHOOD (June 30, 2021, 7:44 PM), <https://www.plannedparenthood.org/planned-parenthood-illinois/blog/why-are-pronouns-so-important-2>.

12. See *States Banning Unauthorized Pelvic Exams*, EPSTEIN HEALTH L. & POL'Y PROGRAM, <https://www.epsteinprogram.com/states-banning-unauthorized-pelvic-exams> (last visited Mar. 1, 2023) (states outlawing nonconsensual pelvic exams on anesthetized patients include Ariz., Ark., Cal., Conn., Del., Fla., Haw., Ill., Iowa, La., Md., Me., Nev., N.H., N.J., N.Y., Or., Tex., Utah, Va., and Wash.).

of non-consensual exams are inadequate because they do not properly address the key issue of informed consent. Part II provides background on the use of non-consensual pelvic exams as an educational tool in teaching hospitals.<sup>13</sup> Part II also provides an overview of the criminal and tort aspects of non-consensual pelvic exams, as well as current state laws that restrict the practice.<sup>14</sup> Part III analyzes the criminal and tort aspects of non-consensual pelvic exams and argues that these avenues are insufficient to effectively deter this practice.<sup>15</sup> Part III also analyzes the exceptions within existing state laws and asserts that such exceptions create loopholes that allow the practice to continue.<sup>16</sup> Part IV recommends that states implement laws that specifically require consent for student-conducted pelvic exams on patients under anesthesia.<sup>17</sup> Part V concludes by emphasizing that to end non-consensual pelvic exams, the issue of informed consent must be adequately addressed.<sup>18</sup>

## II. BACKGROUND

### A. *Pelvic Exams on Anesthetized Patients as a Medical Educational Tool*

A pelvic exam is a procedure in which a medical professional checks the vulva, vagina, cervix, ovaries, uterus, rectum, and pelvis for any abnormalities.<sup>19</sup> The exam typically consists of an external visual exam, an internal visual exam using a speculum, a Pap smear to collect a sample of cervical cells, and/or a physical exam.<sup>20</sup> During the internal portion of the

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13. See *infra* Part II (describing the history of pelvic exams on anesthetized patients as a teaching tool and the disregard for informed consent with respect to pelvic exams within the medical education community).

14. See *infra* Part II (comparing the criminal sexual battery statutes of four states, providing the history of medical battery and informed consent in tort law, and comparing state laws restricting nonconsensual pelvic exams).

15. See *infra* Part III (analyzing state laws criminalizing the nonconsensual touching of intimate body parts as sexual battery and analyzing medical battery and informed consent claims in tort law).

16. See *infra* Part III (analyzing exceptions within current state laws restricting nonconsensual pelvic exams).

17. See *infra* Part IV (recommending the Utah statute as a model for other states).

18. See *infra* Part V (concluding that the law must do more to protect bodily autonomy).

19. See *Pelvic Exam*, MAYO CLINIC (July 24, 2021), <https://www.mayoclinic.org/tests-procedures/pelvic-exam/about/pac-20385135> (explaining that pelvic exams often involve multiple parts of the reproductive system and other organs surrounding the reproductive system).

20. See *id.* (describing the process of conducting a pelvic exam).

exam, a provider will insert two fingers into the vagina while using the other hand to press on the lower abdomen to check the size and shape of the uterus and ovaries.<sup>21</sup> Pelvic exams are routinely given as a pre-operation procedure for gynecological surgeries like hysterectomies.<sup>22</sup>

Pelvic exams are often conducted on unconscious patients as part of medical students' educational training.<sup>23</sup> Medical schools and teaching hospitals believe that pelvic exams under anesthesia provide a valuable teaching experience that is not available through the use of pelvic mannequins or paid, standardized<sup>24</sup> patients.<sup>25</sup> When a patient is anesthetized, the abdominal and pelvic muscles are completely relaxed, which allows medical students to feel the uterus and ovaries more readily.<sup>26</sup>

The medical community has a long history of using anesthetized patients to teach pelvic exam procedures.<sup>27</sup> A 1995 survey of 401 students from five Philadelphia-area medical schools found that ninety percent of students performed pelvic exams on unconscious patients as part of their educational training.<sup>28</sup> A 2019 study revealed that not much has changed in the past twenty-five years.<sup>29</sup> Ninety-two percent of students reported performing a

21. See *id.* (describing the invasive nature of the internal portion of a pelvic exam).

22. See *id.* (explaining the purpose of pelvic exams); see also Tsai, *supra* note 9 (explaining that pelvic exams are conducted for preventative care and treatment).

23. See Dean Scheibel, *Appropriating Bodies: Organ(izing) Ideology and Cultural Practice in Medical School*, 24 J. APPLIED CMMC'N. RSCH. 310, 318 (1996) (stating that five or six students will conduct successive pelvic exams on the same anesthetized patient).

24. See About ASPE, ASS'N OF STANDARDIZED PATIENT EDUCATORS, <https://www.aspeducators.org/about-aspe> (A standardized patient is "a person trained to portray a patient in realistic and repeatable ways.").

25. See Jennifer Goedken, *Pelvic Examinations Under Anesthesia: An Important Teaching Tool*, 8 J. HEALTH CARE L. & POL'Y 232, 233-34 (2005) (explaining that pelvic mannequins are expensive and provide only minimal educational benefits and that paying standardized patients is not feasible or practical because of the frequency of practice required).

26. See *id.* at 234 (explaining that many medical students only feel an ovary for the first time after performing a pelvic exam on an anesthetized patient).

27. See Frank G. Lawton et al., *Patient Consent for Gynaecological Examination*, 44 BRIT. J. HOSP. MED. 326, 326 (1990) (detailing the history of conducting pelvic exams on anesthetized patients to teach medical students about the biologically female anatomy).

28. See Peter A. Ubel et al., *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*, 188 AM. J. OBSTETRICS & GYNECOLOGY 575, 577 (2003) (explaining the frequency that pelvic exams on unconscious patients occur).

29. See Tsai, *supra* note 9.

pelvic exam on an anesthetized patient, and sixty-one percent reported performing a pelvic exam without explicit patient consent.<sup>30</sup>

Teaching hospitals commonly use patients for medical training.<sup>31</sup> The patients used for this medical training are disproportionately public patients, who tend to be low-income and minority patients.<sup>32</sup> A 1990 survey revealed that 47.5% of teaching hospitals used publicly insured patients to teach pelvic exams, while 20.3% used privately insured patients for such exams.<sup>33</sup> This reflects a mentality among many medical teaching faculty that using public patients is justified because they receive free or subsidized health care.<sup>34</sup> Patients who are seen in teaching hospitals are often unaware that medical students are providing their treatment.<sup>35</sup> A survey conducted in 2000 revealed that 42% of third-year medical students did not consistently inform conscious patients they were students when conducting pelvic exams.<sup>36</sup>

The issue of patient consent is critical to the history of pelvic exams on anesthetized patients.<sup>37</sup> The 1995 survey of Philadelphia area medical students found that only fifty-one percent of students that completed an obstetrics/gynecology clerkship during their medical training believed consent was important for pelvic examinations on anesthetized patients.<sup>38</sup> Comparatively, seventy percent of students who did not complete such a

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30. *See id.*

31. *See* Robin Fretwell Wilson, *Autonomy Suspended: Using Female Patients to Teach Intimate Exams Without Their Knowledge or Consent*, 8 J. HEALTH CARE L. & POL'Y 240, 246 (2005) (detailing how patients are used to teach medical students).

32. *See id.* at 248 (citing a 2000 study that revealed that 63% of patients who live in areas where the median income is less than \$25,000 are seen in teaching hospitals).

33. *See id.* at 249 (demonstrating that low-income and uninsured patients are more likely to be used for teaching purposes because they are more likely to be seen at teaching hospitals).

34. *See id.* (explaining how teaching faculty justify using public patients to teach medical students how to conduct pelvic exams).

35. *See id.* at 247 (citing a 1992 survey that revealed that every third- and fourth-year medical student at the University of Connecticut School of Medicine had been introduced as a doctor by hospital staff at some point).

36. *See id.* (demonstrating why patients are often unaware of medical students' involvement in procedures at teaching hospitals).

37. *See id.* at 249-56 (explaining that, historically, the medical community disregards explicit consent when performing pelvic exams on unconscious patients).

38. *See* Ubel et al., *supra* note 28, at 577 (emphasizing that the medical community views pelvic examinations on unconscious patients as a mere educational tool and disregards the patient's opinion and the importance of informed consent for such examinations).

clerkship believed consent was important for such pelvic exams.<sup>39</sup> The 2019 survey found that of the medical students surveyed, thirty percent had not read their hospital's consent forms.<sup>40</sup> These results demonstrate a general disregard for informed consent in the context of procedures considered important to medical training purposes.<sup>41</sup>

In 2019, the Connecticut State Legislature attempted to pass a bill restricting the practice of non-consensual pelvic exams on anesthetized patients.<sup>42</sup> Four medical organizations provided public testimony opposing the bill: Yale University School of Medicine, the American Congress of Obstetricians and Gynecologists Connecticut Chapter, the Connecticut State Medical Society, and the Connecticut Hospital Association.<sup>43</sup>

The concerns and basis for the opposition in each of these testimonies was that the legislation would restrict medical professionals' ability to care for patients and prohibit a critical teaching tool in medical training settings.<sup>44</sup> Notably, Yale School of Medicine's statement recommended that the Legislature "rely upon medical societies to establish evidence-based, well-vetted standards for obtaining consent."<sup>45</sup> The opposition to S.B. 16 by leading Connecticut medical organizations emphasizes the problematic attitude of consent with respect to pelvic exams under anesthesia within the medical education community.<sup>46</sup>

39. *See id.* (highlighting the influence that the medical community's view on informed consent has on medical students).

40. *See Tsai, supra* note 9 (emphasizing the disregard for the hospital's informed consent policies).

41. *See Wilson, supra* note 31, at 249-50 (detailing three justifications medical professionals offer for not obtaining consent: (1) patients implicitly consent to medical students caring for them by accepting care at a teaching hospital; (2) patients consent to students caring for them by signing the general consent form during hospital admission; and (3) patients would not consent if asked).

42. *See S.B. 16, 2019 Leg., Jan. Sess. (Conn. 2019)* (prohibiting anyone from performing a pelvic exam on a patient under anesthesia without prior consent).

43. *See An Act Prohibiting an Unauthorized Pelvic Examination on a Female Patient Who is Under Deep Sedation or Anesthesia or Unconscious: Hearing on S.B. 16 Before the Pub. Health Comm., 2019 Leg., Jan. Sess. (Conn. 2019)* (statement by Conn. Hosp. Ass'n) (opposing the legislation on the grounds that it would restrict medical professionals' ability to care for patients).

44. *See id.* (expressing concerns that restricting pelvic exams under anesthesia would inhibit patient care and medical students' education).

45. *See id.* (describing the need for pelvic exams under anesthesia as an educational tool and cautioning against legislating to ensure consent is obtained).

46. *See Ubel et al., supra* note 28 at 577 (explaining that medical students view informed consent for these exams as unnecessary after completing a clerkship where they conducted several pelvic exams on patients under anesthesia).



*B. Criminal Aspects of Non-consensual Pelvic Exams**1. Non-consensual Pelvic Exams Meet the Elements of Certain State Sexual Battery Statutes*

The act of conducting a non-consensual pelvic exam can be characterized as sexual battery. For instance, the Louisiana statute on sexual battery states, in pertinent part, “[s]exual battery is the intentional touching of the . . . genitals of the victim by the offender using any instrumentality or any part of the body of the offender . . . when . . . the offender acts without the consent of the victim.”<sup>47</sup> Sexual battery is a general intent crime in Louisiana.<sup>48</sup> To prove sexual battery, the state does not need to prove that a victim sustained an injury.<sup>49</sup> Intent to arouse or gratify the sexual desire of either the offender or the victim is also not an element of sexual battery in Louisiana.<sup>50</sup>

Defining intimate parts as “the primary genital area,” the Georgia statute states that “[a] person commits the offense of sexual battery when he or she intentionally makes physical contact with the intimate parts of the body of another person without the consent of that person.”<sup>51</sup> Proving sexual battery in Georgia requires that the offender: (1) have physical contact with the victim’s intimate body parts; (2) have intent to make such contact; and (3) does not have consent to make such contact.<sup>52</sup> Similar to the Louisiana statute, the Georgia statute provides that physical contact does not need to be sexual in nature to constitute sexual battery.<sup>53</sup>

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47. LA. STAT. ANN. § 14:43.1 (2022).

48. *See Louisiana v. Stevenson*, 908 So. 2d 48, 52 (La. Ct. App. 2005) (holding that because “intentional” is included in the statute without a qualifying provision, sexual battery only requires general intent).

49. *See Louisiana v. Lefleur*, 350 So. 3d 562, 570 (La. Ct. App. 2022) (holding that injury is not an element of sexual battery because it is not included in the statute).

50. *See Louisiana v. Schenk*, 513 So. 2d 1159, 1164 (La. 1987) (holding that subjective sexual intent is not required to prove sexual battery because it is not included in the statute).

51. GA. CODE ANN. § 16-6-22.1(a)-(b) (West 2022).

52. *See Nembhard v. Georgia*, 859 S.E.2d 118, 121 (Ga. Ct. App. 2021) (holding that the State can prove sexual battery if all three elements are satisfied).

53. *See Watson v. Georgia*, 777 S.E.2d 677, 678 (Ga. 2015) (explaining that the “intent” means intent to make physical contact).

## 2. *Non-consensual Pelvic Exams Also Meet the Elements of State Sexual Battery Statutes Exempting Medical Examinations*

Some states' sexual battery statutes provide an exemption for medical examinations. For instance, the Florida statute defines sexual battery as, "oral, anal, or vaginal penetration by, or union with, the sexual organ of another or the anal or vaginal penetration of another by any other object; however, sexual battery does not include an act done for a bona fide medical purpose."<sup>54</sup> The Florida statute makes sexual battery a general intent crime, and the elements include only: (1) vaginal penetration; (2) with an object.<sup>55</sup> However, unlike the Louisiana and Georgia statutes, the Florida statute includes a provision excepting "bona fide medical purposes."<sup>56</sup>

The South Carolina statute, in pertinent part, defines sexual battery as "any intrusion, however slight, of any part of a person's body or of any object into the genital or anal openings of another person's body."<sup>57</sup> The elements of the crime include only: (1) intrusion; (2) of a body part or object; (3) into the genital openings of another person's body.<sup>58</sup> Similar to the Florida statute, the South Carolina statute provides an exception for "when such intrusion is accomplished for medically recognized treatment or diagnostic purposes."<sup>59</sup>

### C. *Civil Aspects of Non-consensual Pelvic Exams: Medical Battery and the Doctrine of Informed Consent in Tort Law*

#### I. *Medical Battery*

Medical battery is a tort claim that provides a patient with relief if they establish a lack of consent to the procedure performed.<sup>60</sup> The following factors can establish medical battery: (1) total lack of consent to the

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54. FLA. STAT. ANN. § 794.011 (West 2022) (criminalizing the genital penetration of another, subject to medical exceptions).

55. See *Olenchak v. Florida*, 183 So.3d 1227, 1229 (Fla. Dist. Ct. App. 2016) (holding that liability under Florida law does not require a perpetrator to commit sexual battery with specific intent); see also FLA. STAT. ANN. § 794.011 (West 2022) (lacking a requirement for specific intent).

56. See *id.* (exempting medical examinations from the sexual battery definition).

57. S.C. CODE ANN. § 16-3-651 (2022).

58. See *id.* (criminalizing the intrusion into a person's genital openings without requiring sexual gratification of the perpetrator).

59. See *id.* (exempting medical examinations from the sexual battery definition).

60. See 6A C.J.S. *Assault* § 10 (2022) (explaining the elements of medical battery law and under what circumstances a patient can recover); see also *Shuler v. Garrett*, 743 F.3d 170, 172 (6th Cir. 2014) (quoting *Blanchard v. Kellum*, 975 S.W.2d 522, 524 (Tenn. 1998)) (defining medical battery as performing an unauthorized procedure on a patient).

procedure performed; (2) the procedure was performed contrary to the patient's will; or (3) the procedure varied substantially from the procedure consented to.<sup>61</sup> Medical battery is an intentional tort, making intent an essential element of the claim.<sup>62</sup> Medical battery is distinct from, but related to, the doctrine of informed consent.<sup>63</sup> To succeed on a medical battery claim, a patient must prove that the doctor failed to obtain consent before performing a procedure.<sup>64</sup> Alternatively, if a doctor is performing a procedure with express or implied consent, a patient must prove that consent was not fully informed or was withdrawn before the procedure was conducted.<sup>65</sup>

Some courts hold that a doctor commits battery when they perform a procedure on a patient who did not consent to that specific doctor treating them.<sup>66</sup> One court reasoned that, under these circumstances, surgeons that operate without the patient's consent commit medical battery because they "violate the patient's right to control [their] own body."<sup>67</sup> Courts have also found medical battery where doctors conduct a procedure outside the scope of a patient's limited consent,<sup>68</sup> and where doctors conduct a procedure that

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61. *Id.* (listing the ways that lack of patient consent can establish a medical battery claim).

62. *See Vitale v. Henchey*, 24 S.W.3d 651, 657-58 (Ky. 2000) (holding that the "intent" element of medical battery means the intent to make contact, not the intent to cause harm).

63. *See Shuler*, 743 F.3d at 172-73 (differentiating medical battery from informed consent and explaining that the question for medical battery is whether there was any consent at all).

64. *See Andrew v. Bagley*, 203 S.W.3d 165, 172 (Ky. Ct. App. 2006) (holding that to prevail on a medical battery claim, a patient must prove absence of consent).

65. *See Mims v. Boland*, 138 S.E.2d 902, 907 (Ga. Ct. App. 1964) (holding that to prove withdrawal of consent, a patient must show that: (1) the patient clearly communicated to the doctor their withdrawal of consent; and (2) it is medically feasible for the doctor to discontinue treatment without harming the patient's health or life).

66. *See Vitale*, 24 S.W.3d at 659 (holding that the patient's limited consent was violated when the patient did not agree to be touched by the doctor that performed the surgery); *but see Myers v. Epstein*, 282 F. Supp. 151, 154-55 (S.D.N.Y. 2003) (distinguishing lack of consent for a particular doctor to conduct surgery from total lack of consent and holding that there was no medical battery).

67. *See Perna v. Pirozzi*, 457 A.2d 431, 439 (N.J. 1983) (noting that the American College of Surgeons finds it unethical to mislead the patient as to the identity of the operating surgeon).

68. *See Duncan v. Scottsdale Med. Imaging, Ltd.*, 70 P.3d 435, 439-40 (Ariz. 2003) (holding that administering a drug other than the one patient consented to receive was outside the patient's limited consent and therefore constituted medical battery).

is substantially different than the one consented to.<sup>69</sup> While many medical battery cases involve surgical operations, at least one court has held that any unauthorized contact between a doctor and a patient during an examination or surgery can constitute a medical battery.<sup>70</sup>

## 2. *Informed Consent*

Informed consent in tort law allows patients to bring negligence claims for treatment they consented to without key information that would have allowed them to make an informed decision about receiving treatment.<sup>71</sup> Informed consent in medical settings is a fairly recent legal doctrine.<sup>72</sup> Courts developed the doctrine of informed consent on the basis that “physicians have a duty to disclose relevant medical information that would be material to a patient’s decision about whether to proceed with a particular medical treatment.”<sup>73</sup>

Unlike a medical battery case, the question in an informed consent case is not whether there was consent, but whether the doctor provided the necessary information about the medical procedure so the patient could make an informed decision about whether to consent.<sup>74</sup> Many courts have moved away from informed consent as a battery claim and towards a negligence claim.<sup>75</sup> Instead of focusing on physical touching without any consent, informed consent focuses on physical touching without sufficient

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69. See *Cobbs v. Grant*, 502 P.2d 1, 8 (Cal. 1972) (holding that intent to deviate from consent is met when a patient consents to one treatment and the doctor performs another).

70. See *Mims*, 138 S.E.2d at 906 (holding that the “right of inviolability of one’s person” makes any nonconsensual touching a battery).

71. See *id.* at 1089 (discussing the development of the legal doctrine of informed consent as a separate cause of action from medical malpractice claims).

72. See Nadia N. Sawicki, *Ethical Malpractice*, 59 HOUS. L. REV. 1069, 1090-91 (2022) (explaining that prior to the 1950s, doctors were not required to obtain consent to treat patients).

73. *Id.* at 1090 (explaining that informed consent disclosure includes information about the patient’s diagnosis and prognosis, risks and benefits of receiving treatment, and alternatives to treatment, including no treatment).

74. See *Vitale v. Henchey*, 24 S.W.3d 651, 655 (Ky. 2000) (distinguishing a situation where a doctor fails to obtain any consent from a situation where a doctor obtains consent but fails to disclose risks).

75. See, e.g., *Baltzell v. Van Buskirk*, 752 S.W.2d 902, 906 (Mo. Ct. App. 1988) (“[W]here the consent to the treatment was given but with insufficient or incomplete disclosure of risks, the cause of action is in medical malpractice based on negligence of the physician to meet a recognized standard of care”).

information.<sup>76</sup>

Informed consent has five elements: (1) failure to disclose material information; (2) actual harm (3) resulting from risks the patient was not informed of; (4) the patient would not have consented had they been provided that information; and (5) a reasonable, properly informed patient would not have consented to the procedure.<sup>77</sup> The evolution of the informed consent doctrine reflects the legal and societal shift toward respecting human autonomy.<sup>78</sup> In summation, “[t]he doctrine of informed consent is intended to ensure that patients are not just the objects of medical practice but also free and willing participants.”<sup>79</sup>

#### *D. State Legislative Response to Non-consensual Pelvic Exams Under Anesthesia*

Twenty-one states have enacted laws in their civil codes restricting the practice of conducting pelvic exams on anesthetized patients without prior consent.<sup>80</sup> Some statutes, such as those in Utah and Arkansas, contain specific provisions about the level of requisite consent in order for a medical student to conduct a pelvic exam on an anesthetized patient.<sup>81</sup> Utah’s statute provides for specific requirements of the written consent document, including font size, language, and check box options.<sup>82</sup> Arkansas’ statute requires that four conditions be satisfied for a medical student to perform a pelvic exam on an unconscious patient: (1) explicit consent by the patient; (2) relevance of the exam to the planned or performed procedure; (3) performed by a student whose status as a student has been made to known to

76. See Pamela Laufer-Ukeles, *Reproductive Choices and Informed Consent: Fetal Interests, Women’s Identity and Relational Autonomy*, 37 AM. J.L. & MED. 567, 575 (2011) (describing the transition of the tort of informed consent from battery to negligence).

77. Dan B. Dobbs et al., LAW OF TORTS § 308 (2d ed. 2022) (explaining that a doctor is negligent by failing to inform the patient as to the possible risks of the procedure).

78. See Laufer-Ukeles, *supra* note 76, at 576 (describing the doctrine of informed consent as one focusing on bodily autonomy).

79. *Id.* at 577 (highlighting the purpose of informed consent as ensuring that patients have autonomy in their medical care).

80. See EPSTEIN L. & HEALTH POL’Y PROGRAM, *supra* note 12 (finding bans on unauthorized pelvic exams in twenty-one states).

81. See UTAH CODE ANN. § 58-1-509(3) (West 2022) (requiring a separate consent form for a student-conducted pelvic exam); ARK. CODE ANN. § 20-9-606 (West 2022) (requiring written patient consent for student-conducted pelvic exams).

82. See UTAH CODE ANN. § 58-1-509(3) (West 2022) (detailing the technical requirements of consent forms).

the patient; and (4) conducted under the supervision of an educator.<sup>83</sup>

Other statutes, such as those in Maine and Illinois, provide little to no guidance on what level of consent is required or how it should be obtained. Maine’s statute prohibits pelvic exams under anesthesia without “specific, informed consent, orally and in writing.”<sup>84</sup> Illinois’ statute is even vaguer; it only requires that any medical professional performing any physical examination, including a pelvic examination, informs the patient of their profession upon providing the treatment.<sup>85</sup>

While these laws range in specificity as to what degree of consent is required, they all contain exceptions.<sup>86</sup> The most common exceptions include: (1) if the pelvic exam is within the scope of the surgery or procedure to which the patient consented; (2) if the pelvic exam is for diagnostic purposes and/or medically necessary due to an emergency; (3) a court orders the pelvic exam for collection of evidence (e.g., in the case of a sexual assault<sup>87</sup>).<sup>88</sup> Of the statutes that contain exceptions, even those that clearly state how to obtain consent fail to specify who determines when such an exception applies.<sup>89</sup>

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83. See ARK. CODE ANN. § 20-9-606 (West 2022) (listing the specific requirements that must be satisfied before a medical student conducts a pelvic exam on a patient under anesthesia).

84. See ME. REV. STAT. ANN. Tit. 24, § 2905-B (West 2022) (failing to define “specific, informed consent” or when the consent should be obtained).

85. See 410 ILL. COMP. STAT. 50/7 (2022) (requiring only that a medical professional inform the patient of their profession upon providing treatment).

86. See UTAH CODE ANN. § 58-1-509 (West 2022); 5 R.I. GEN. LAWS § 5-37-5.1 (2022); ARK. CODE ANN. § 20-9-606 (West 2022); ME. REV. STAT. ANN. Tit. 24, § 2905-B (West 2022).

87. This exception will not be discussed in detail; however, it is worth noting that it violates the sexual assault survivor further by denying them the opportunity to refuse bodily intrusion.

88. See UTAH CODE ANN. § 58-1-509 (West 2022); 5 R.I. GEN. LAWS § 5-37-5.1 (2022); ARK. CODE ANN. § 20-9-606 (West 2022); ME. REV. STAT. ANN. Tit. 24, § 2905-B (West 2022).

89. See UTAH CODE ANN. § 58-1-509 (West 2022) (providing specific information about how a doctor should obtain consent for a pelvic exam but failing to detail how a doctor should decide if an exception applies); ARK. CODE ANN. § 20-9-606 (West 2022).

## III. ANALYSIS

*A. A Comparison of Sexual Battery Statutes in Several States  
Demonstrate the Criminal Aspect of Non-consensual Pelvic Exams*

The elements of sexual battery in Louisiana are: (1) intentional touching; (2) of the genitals of the victim; (3) using any instrumentality or body part; (4) without the consent of the victim.<sup>90</sup> Applying these elements to non-consensual internal pelvic exams on anesthetized patients is straightforward: medical students intentionally insert their fingers into the vaginas of patients who have not consented to the exam.<sup>91</sup>

Similarly, the elements of the Georgia sexual battery statute are (1) physical contact with the victim's intimate body parts; (2) intent to make such contact; and (3) no consent to make such contact.<sup>92</sup> Again, applying these elements to non-consensual internal pelvic exams on anesthetized patients is straightforward: medical students intentionally insert their fingers into the vaginas of patients who have not consented to the act.<sup>93</sup> Thus, non-consensual pelvic exams performed on anesthetized patients meet the elements of sexual battery in both Louisiana and Georgia.<sup>94</sup>

Florida and South Carolina's statutes are similar to Louisiana and Georgia's statutes because they contain the same basic elements: (1) intrusion into the genital or anal openings of another; (2) with an object or body part by the perpetrator.<sup>95</sup> Unlike Louisiana and Georgia's sexual battery statutes, Florida and South Carolina's statutes include medical exceptions.<sup>96</sup>

The Florida statute exempts an "act done for a bona fide medical

90. LA. STAT. ANN. § 14:43.1 (2022) (indicating that the sexual gratification of the perpetrator is not required to prove sexual battery).

91. See MAYO CLINIC, *supra* note 19 (explaining that for an internal pelvic exam, the doctor inserts two fingers into the vagina to check the uterus and ovaries).

92. GA. CODE ANN. § 16-6-22.1 (West 2022) (indicating that the sexual gratification of the perpetrator is not required to prove sexual battery).

93. See MAYO CLINIC, *supra* note 19 (explaining that for an internal pelvic exam, the doctor inserts two fingers into the vagina to check the uterus and ovaries).

94. Compare LA. STAT. ANN. § 14:43.1, with GA. CODE ANN. § 16-6-22.1.

95. See FLA. STAT. ANN. § 794.011 (West 2022) (criminalizing the genital penetration of another as a general intent crime); S.C. CODE ANN. § 16-3-651 (2022) (criminalizing the intrusion into a person's genital openings without requiring sexual gratification of the perpetrator).

96. See FLA. STAT. ANN. § 794.011 (exempting bona fide medical purposes from sexual battery definition); S.C. CODE ANN. § 16-3-651 (exempting medically necessary acts from the sexual battery definition).

purpose.”<sup>97</sup> As discussed in Part II, the medical community views student-conducted pelvic examinations on anesthetized patients as a “bona fide” procedure because they are critical teaching tools for medical students in training.<sup>98</sup> However, the statute does not provide an exception for a bona fide medical *educational* purpose, but for a bona fide *medical* purpose.<sup>99</sup>

Medical professionals argue that a pelvic exam conducted by a medical student for educational purposes can be for the patient’s benefit, i.e., a genuine medical purpose.<sup>100</sup> However, if a medical student is conducting the pelvic exam in order to learn how to do the procedure, the primary purpose of the exam is not for the patient’s benefit, but for the student’s education.<sup>101</sup> Furthermore, if a medical student is performing the exam as part of a medical lesson, the patient may receive a substandard exam or the supervising physician may have to repeat the exam to ensure the medical student did not miss anything.<sup>102</sup> Because a non-consensual pelvic exam performed primarily for the student’s benefit would not qualify for the “bona fide medical purpose” exception, it meets the elements of sexual battery in Florida.<sup>103</sup>

Similarly, the South Carolina statute for sexual battery provides an exception that the intrusion is permissible “when . . . [it] is accomplished for medically recognized treatment or diagnostic purposes.”<sup>104</sup> When a medical student conducts an internal pelvic exam on an anesthetized patient primarily to learn the procedure or feel for the ovaries, there is neither a treatment nor

97. See FLA. STAT. ANN. § 794.011 (providing an exception within the sexual battery definition).

98. *But see* Wilson, *supra* note 31, at 256-58 (refuting the justifications offered by the medical community and asserting that patients do not impliedly consent to pelvic exams by consenting to surgical operations).

99. See FLA. STAT. ANN. § 794.011 (emphasis added) (providing for an exception that does not specifically include educational purposes).

100. See Wilson, *supra* note 31, at 258 (explaining that teachers justify student-conducted exams as medically beneficial to the patient because they are within the scope of the consented surgery).

101. See *id.* (asserting that for the purposes of consent, a procedure cannot be both beneficial to a medical student for educational purposes *and* medically necessary or beneficial for the patient).

102. See *id.* (emphasizing that a student-conducted pelvic exam under these circumstances is not primarily for the patient’s benefit but for the medical student’s education).

103. See FLA. STAT. ANN. § 794.011 (excepting only genuine medical purposes from the definition of sexual battery).

104. S.C. CODE ANN. § 16-3-651 (2022) (exempting medical examinations from the sexual battery definition).



diagnostic purpose — the purpose is primarily educational.<sup>105</sup> The primarily educational purpose is even more evident if multiple students are conducting pelvic exams on a single patient — the purpose of each successive exam is not to diagnose or treat the patient but to teach the medical students how to conduct the exams.<sup>106</sup> Thus, non-consensual pelvic exams performed under these circumstances would meet the elements of sexual battery in South Carolina because they would not qualify for the “medically recognized treatment or diagnostic purposes” exception.<sup>107</sup>

*B. A Patient May Seek Redress for a Non-consensual Pelvic Exam as a Medical Battery or Informed Consent Violation, Depending on Context*

Non-consensual pelvic exams on patients under anesthesia raise issues of whether there is a lack of informed consent or a total lack of consent to the procedure.<sup>108</sup> If a patient consents to surgery, and a pelvic exam is within the scope of that surgery, did they also consent to a medical student conducting the exam?<sup>109</sup> Determining whether a pelvic exam on an anesthetized patient is conducted entirely without consent or informed consent determines what kind of legal action a patient could bring.<sup>110</sup>

*1. Non-consensual Pelvic Exams as Medical Battery*

Medical battery can be established by proving: (1) a total lack of consent to the procedure performed; (2) the procedure was performed contrary to the patient’s will; or (3) the procedure varied substantially from the procedure consented to.<sup>111</sup> All three ways in which medical battery is established could apply to a non-consensual pelvic exam conducted by a medical student on a

105. See Goedken, *supra* note 25, at 232-35 (describing student-conducted pelvic exams on patients under anesthesia primarily as a teaching tool).

106. See Scheibel, *supra* note 23, at 318 (describing how five or six students will do successive pelvic exams on the same anesthetized patient).

107. S.C. CODE ANN. § 16-3-651 (excepting only medical treatment or diagnosis from the sexual battery definition).

108. See *Shuler v. Garrett*, 743 F.3d 170, 172-73 (6th Cir. 2014) (explaining that medical battery is a question of total lack of consent while informed consent is a question of properly obtaining consent).

109. See *Perna v. Pirozzi*, 457 A.2d 431, 439 (N.J. 1983) (holding that a patient has a right to determine what surgery is performed on them *and* who performs the surgery on them).

110. See C.J.S., *supra* note 60 (explaining that total lack of consent constitutes a medical battery claim, while a lack of informed consent constitutes a negligence claim).

111. *Id.* ((1) a patient may not consent to a pelvic exam at all; (2) a patient may explicitly refuse a pelvic exam; or (3) a pelvic exam may be substantially different from the procedure the patient originally consented to).

patient under anesthesia. For example, in Janine's experience, she did not consent to anyone on her medical team performing a pelvic exam on her.<sup>112</sup> Thus, there was a total lack of consent to the pelvic exam performed on her.<sup>113</sup>

Second, Janine explicitly told the doctor before her surgery that she did not want medical students directly involved in the procedure.<sup>114</sup> Thus a student-conducted pelvic exam was performed contrary to Janine's will.<sup>115</sup> Third, the medical team did not perform the pelvic exam because it was necessary for or related to Janine's surgery, but because they saw an unrelated note in Janine's chart that she was due for a Pap smear.<sup>116</sup> Thus, the pelvic exam performed on Janine substantially varied from the stomach surgery she consented to.<sup>117</sup>

Janine's case would be further bolstered in jurisdictions that have found medical battery where a patient did not consent to a particular doctor conducting the procedure, but where that doctor nonetheless did so.<sup>118</sup> Courts in these jurisdictions have found that in addition to having the right to determine what procedures are performed on them, patients have the right to determine who performs those procedures.<sup>119</sup> Courts have additionally recognized that when unauthorized medical personnel perform procedures on a patient, it violates the patient's right to control their own body.<sup>120</sup> Janine did not consent to the medical students performing a pelvic exam on her; she

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112. See Goldberg, *supra* note 4 (describing Janine's confusion as to why she received a pelvic exam when she only consented to the stomach surgery).

113. See Shuler, 743 F.3d at 173 (holding that there is medical battery if: (1) the patient was unaware the procedure was going to be performed; or (2) the patient did not authorize performance of the procedure).

114. See Goldberg, *supra* note 4 (describing Janine's explicit instructions to her doctor to not allow medical students to be actively involved in her medical care).

115. See Shuler, 743 F.3d at 175 (holding that a prior general grant of consent to a surgery does not trump the subsequent withdrawal of consent).

116. See Goldberg, *supra* note 4 (explaining that the medical team's justification for conducting the exam on Janine was not related to or necessary for the surgery).

117. See *Cobbs v. Grant*, 502 P.2d 1, 8 (Cal. 1972) (holding that a patient's consent to one procedure does not extend to the performance of another, unrelated procedure).

118. See *Vitale v. Henchey*, 24 S.W.3d 651, 659 (Ky. 2000) (holding that when a patient does not consent to be touched by the doctor in question, there is medical battery).

119. See, e.g., *Perna v. Pirozzi*, 457 A.2d 431, 439 (N.J. 1983) (holding that a patient has a right to decide who performs surgery on them).

120. See, e.g., *id.* at 440 ("Where a competent patient consents to surgery by a specific surgeon of his choice, the patient has every right to expect that surgeon, not another, to operate.").

only consented to her surgeon performing the stomach surgery.<sup>121</sup> By performing the pelvic exam, the medical students exceeded the bounds of Janine's limited consent and committed medical battery.<sup>122</sup>

Ashley Weitz's story illustrates a similar case of medical battery.<sup>123</sup> First, Ashley did not consent to the doctor performing a pelvic exam on her; in fact, Ashley and her doctor had agreed before she was sedated that a pelvic exam was unnecessary and thus outside of the scope of her medical care.<sup>124</sup> Therefore, by proceeding with the pelvic exam, the doctor acted without Ashley's consent and contrary to her understanding that a pelvic exam would not be performed.<sup>125</sup>

## 2. *Non-consensual Pelvic Exams as Lack of Informed Consent*

Applying the doctrine of informed consent to non-consensual pelvic exams on anesthetized patients fits less neatly than the tort of medical battery. Informed consent doctrine is traditionally applied to cases where a patient did not receive adequate information about the risks and hazards of the surgery, not where the patient received inadequate information about who was involved in the surgery.<sup>126</sup> However, informed consent still applies to non-consensual pelvic exams because the doctrine was founded on the principle of bodily autonomy.<sup>127</sup>

The doctrine of informed consent was developed based on the idea that patients have the right to bodily autonomy and to decide the kind of medical treatment they receive.<sup>128</sup> Informed consent rests on the principle that doctors have a duty to disclose any information that could impact a patient's

121. See Goldberg, *supra* note 4 (indicating that Janine explicitly stated she did not want to be examined by medical students).

122. See Perna, 457 A.2d at 439 (reasoning that this situation is medical battery because it violates the patient's right to control who touches their body).

123. See Valencia, *supra* note 1 (detailing how Ashley woke up from anesthesia in the middle of the doctor performing the nonconsensual pelvic exam on her).

124. See *id.* (explaining the conversation that Ashley had with her doctor that led to the conclusion that a pelvic exam was outside the scope of necessary care).

125. See Andrew v. Bagley, 203 S.W.3d 165, 172 (Ky. Ct. App. 2006) (holding that the absence of consent establishes medical battery); see also Shuler v. Garrett, 743 F.3d 170, 175 (6th Cir. 2014) (holding that performing a procedure against the patient's express will violates the patient's right to reject medical treatment).

126. See Guebard v. Jabaay, 452 N.E.2d 751, 756 (Ill. App. Ct. 1983) (holding that informed consent did not apply to a claim where a patient gave consent for one doctor to perform surgery, but another doctor performed it).

127. See Natanson v. Kline, 350 P.2d 1093, 1104 (Kan. 1960) (explaining that informed consent is based on the notion of individual self-determination).

128. See *id.* (describing the theory of informed consent).

decision to receive treatment.<sup>129</sup> Thus, informed consent necessarily includes being informed about who is providing the treatment — especially in the context of student-conducted pelvic exams.<sup>130</sup> Janine’s experience illustrates this principle: she did not want medical students involved in her procedure at all.<sup>131</sup> If Janine had been previously informed that medical students would be performing a pelvic exam, she likely would have refused.<sup>132</sup> Even if she would have consented to receiving such an exam, giving her the opportunity to accept or reject the procedure is the purpose of the informed consent doctrine.<sup>133</sup>

Medical students are not licensed doctors. A potential risk to the patient is that the medical student will not properly diagnose any health concerns the pelvic exam is designed to reveal.<sup>134</sup> The informed consent doctrine gives the patient the right to decide if they are willing to accept such a risk.<sup>135</sup> Further, informed consent focuses on the “preferences of particular patients.”<sup>136</sup> As Janine’s experience illustrates, the decision to allow a medical student to conduct a pelvic exam is each individual patient’s preference.<sup>137</sup>

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129. See Sawicki, *supra* note 72, at 1090 (emphasizing that failure to disclose material information to a patient is a breach of a doctor’s duty of care).

130. See, e.g., Perna v. Pirozzi, 457 A.2d 431, 439 (N.J. 1983) (“The failure of a surgeon to perform a medical procedure after soliciting a patient’s consent, like the failure to operate on the appropriate part of a patient’s body, is a deviation from standard medical care. It is malpractice whether the right surgeon operates on the wrong part or the wrong surgeon operates on the right part of the patient.”).

131. See Goldberg, *supra* note 4 (describing how Janine told her doctor prior to surgery that she did not want medical students to be directly involved in her procedure).

132. See *id.* (detailing the distress and panic attacks Janine experienced upon learning medical students had conducted a nonconsensual pelvic exam on her).

133. See Laufer-Ukeles, *supra* note 76, at 577 (describing the purpose of informed consent as ensuring that patients have autonomy in their own medical care and decisions).

134. See Goedken, *supra* note 25, at 234 (explaining that many medical students only feel an ovary for the first time when performing a pelvic exam on an anesthetized patient).

135. See Laufer-Ukeles, *supra* note 76, at 578 (describing the ethical endeavor of informed consent as providing basic medical information before obtaining consent).

136. *Id.* (explaining that informed consent requires doctors to ensure that individual patients have the information they need to make informed decisions about their medical care).

137. See Goldberg, *supra* note 4 (explaining that Janine told her doctor before the surgery that she did not want medical students directly involved in her procedure).

*C. Existing State Laws Restricting Non-consensual Pelvic Exams Create Loopholes that Allow the Practice to Persist.*

Laws restricting non-consensual pelvic exams on anesthetized patients are a step in the right direction because they provide medical teaching professionals with a framework for obtaining proper consent for student-conducted exams.<sup>138</sup> Some state laws provide a more detailed framework for obtaining consent for a pelvic exam conducted on an anesthetized patient.<sup>139</sup> Utah's statute provides specific requirements for the written consent document for pelvic exams conducted on anesthetized patients, including font size, language, and check box options.<sup>140</sup> Similarly, Arkansas' statute requires that four conditions be satisfied for a medical student to perform a pelvic exam on an unconscious patient: (1) explicit written consent by the patient; (2) relevance of the planned exam or procedure to be performed; (3) performed by a student whose status as a student has been made known to the patient; and (4) conducted under the supervision of an educator.<sup>141</sup>

Conversely, exceptions written into many statutes create loopholes that could allow the practice to persist.<sup>142</sup> For example, Illinois' statute is vague: it only requires that the medical professional inform the patient of their profession upon administering treatment, or in the case of an unconscious patient, that the exam was related to their illness or condition.<sup>143</sup> Pelvic exams are within the scope of certain surgeries because they can provide the doctor with diagnostic information.<sup>144</sup> However, the fact that an anesthetized patient needs a pelvic exam should not allow medical students to use the patient to learn how to feel for ovaries without prior informed consent.<sup>145</sup>

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138. See Valencia, *supra* note 1.

139. See, e.g., UTAH CODE ANN. § 58-1-509(3) (West 2022); ARK. CODE ANN. § 20-9-606 (West 2022).

140. See UTAH CODE ANN. § 58-1-509(3) (West 2022) (requiring a separate notice or agreement that contains specific language about consenting to an exam of the pelvic region and student involvement in the exam).

141. ARK. CODE ANN. § 20-9-606 (West 2022) (listing the specific requirements that must be satisfied before a medical student conducts a pelvic exam on a patient under anesthesia).

142. See EPSTEIN HEALTH L. & POL'Y PROGRAM, *supra* note 12 (listing the states that ban unauthorized pelvic exams).

143. See 410 ILL. COMP. STAT. 50/7 (2022) (requiring only that any medical professional performing any physical examination, including a pelvic examination, informs the patient of their profession upon providing the treatment).

144. See MAYO CLINIC, *supra* note 19 (explaining that a doctor will perform a pelvic exam to help diagnose the cause of certain gynecological symptoms).

145. See also Goedken, *supra* note 25, at 234 (detailing how pelvic exams are used to teach medical students how to feel for the size and shape of ovaries and the uterus).

While these laws range in specificity as to what degree of consent is required, they all contain exceptions.<sup>146</sup> The most common exceptions include: (1) if the pelvic exam is within the scope of the surgery or procedure to which the patient consented; (2) if the pelvic exam is for diagnostic purposes and/or medically necessary due to an emergency; (3) a court orders the pelvic exam for collection of evidence (e.g., in the case of a sexual assault<sup>147</sup>).<sup>148</sup> The specificity with which legislation is written and the extent to which exceptions are included may determine how effective these laws are at preventing non-consensual pelvic exams on anesthetized patients.<sup>149</sup>

*1. The Statutory Exceptions for “Prior Consent” Negate Any Requirement for Actual Consent to a Pelvic Exam Under Anesthesia*

While the impetus behind states passing laws restricting non-consensual pelvic exams is consent, the exceptions in many of these laws gut this intention by allowing implicit consent to suffice, if consent is mentioned in the statute at all. For example, the Illinois statute does not include the word consent.<sup>150</sup> As discussed in Part II, the Illinois statute requires only that the medical professional inform the patient of their profession upon performing a procedure.<sup>151</sup> This is impossible when the examination is conducted on a patient already under anesthesia. Because this statute does not require any specific prior consent about whether a medical student can conduct an exam on a patient, it does not provide the patient with the opportunity to refuse a student-conducted exam.<sup>152</sup>

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146. *E.g.*, UTAH CODE ANN. § 58-1-509(3); 5 R.I. GEN. LAWS § 5-37-5.1 (2022); ARK. CODE ANN. § 20-9-606; ME. REV. STAT. ANN. tit. 24, § 2905-B (West 2022).

147. This exception will not be discussed in detail; however, it is worth noting it violates the sexual assault survivor further by denying them the opportunity to refuse bodily intrusion.

148. *E.g.*, UTAH CODE ANN. § 58-1-509 (excepting court orders, exams within the scope of a procedure, and emergencies); 5 R.I. GEN. LAWS § 5-37-5.1 (excepting exams within the scope of procedure and emergencies); ARK. CODE ANN. § 20-9-606 (excepting court orders, exams within the scope of a procedure, and emergencies); ME. REV. STAT. ANN. tit. 24, § 2905-B (excepting court orders and emergencies).

149. *See Valencia, supra* note 1 (explaining that certain exceptions in legislation may still allow nonconsensual pelvic exams to occur).

150. 410 ILL. COMP. STAT. 50/7 (2022) (failing to provide a specific consent requirement and requiring only that the pelvic exam under anesthesia be related to the patient’s health issue).

151. *See id.* (describing when a patient must be informed of a medical professional providing treatment or care).

152. *See id.* (requiring only that the patient be informed of the provider’s medical profession, not that the patient consent to the provider conducting the exam).

Additionally, the vagueness of these provisions makes it unclear when the exceptions apply. For instance, in statutes that contain an exception for an examination that is “within the scope of the procedure consented to” or “related to the patient’s condition,” a medical student could perform a pelvic exam without consent in any gynecological surgery under the guise of a reproductive diagnostic exam.<sup>153</sup>

One justification medical professionals offer for not obtaining explicit consent for unconscious pelvic exams conducted by medical students is that patients implicitly consented to receive treatment from medical students by attending a teaching hospital.<sup>154</sup> Some teaching hospital admission forms state that medical students may be part of a patient’s care team, while others do not. For example, the admission form for George Washington University Hospital states “I understand that my health care team will be made up of hospital personnel . . . to include interns, residents, fellows and medical students.”<sup>155</sup> Conversely, the consent form for Georgetown University Hospital does not include information about medical students, stating only, “I agree that I . . . voluntarily consent to and authorize such care and treatments . . . by employees and authorized agents of Georgetown University Hospital.”<sup>156</sup>

In evaluating whether a patient consents to a medical student performing a pelvic exam, the structure of the admission form and what the patient believes they are consenting to are critical considerations.<sup>157</sup> For instance, information about medical students at the University of Texas Southwestern Medical Center is not in the “Application for Admission and Consent for Treatment” section but instead is in the “Agreements and Understandings” section.<sup>158</sup> The placement of information on medical students in the

153. *E.g.*, UTAH CODE ANN. § 58-1-509; 5 R.I. GEN. LAWS § 5-37-5.1; ARK. CODE ANN. § 20-9-606; ME. REV. STAT. ANN. tit. 24, § 2905-B.

154. *See* Wilson, *supra* note 31, at 243, 256 (explaining that many medical teaching professionals believe that patients clearly authorize exams by medical students by signing teaching hospital admission forms).

155. Geo. Wash. Univ. Hosp., *Preregistration General Admission Form* (Apr. 2015) (on file with author).

156. Georgetown Univ. Hosp., *Consent for Treatment, Releases, Acknowledgements and Financial Agreement Form* (May 2019) (on file with author) (failing to define “authorized agents”).

157. *See* Wilson, *supra* note 31, at 257 (explaining that contract interpretation plays a role in examining how patients understand what they are consenting to).

158. *See* Univ. of Tex. Sw. Med. Ctr., *Consent for Admission/Treatment* (July 2017) (on file with author) (“As a teaching institution, UT Southwestern welcomes medical residents and students in other disciplines, including nursing and University approved observers engaged in an educational purpose.”).

“Agreements” section instead of the “Consent” section could make it likely that patients do not understand they are consenting to a medical student performing a pelvic exam on them.<sup>159</sup> Even including information about medical students, without expressly indicating what procedures they will perform, in the “Consent to Treatment” section does not clearly authorize pelvic exams by medical students.<sup>160</sup>

Pelvic exams performed by medical students on unconscious patients are done for teaching purposes, not for the treatment of the patient.<sup>161</sup> When a patient signs a general admission and consent form, they agree to receive care and treatment for their benefit, not to undergo procedures for the educational benefit of medical students.<sup>162</sup> This is not to say that a pelvic exam that is not explicitly consented to should never be conducted.<sup>163</sup> Depending on the patient’s illness or condition, once the patient is under anesthesia, a surgeon could realize that the health concern is related to the reproductive system and requires a pelvic exam.<sup>164</sup>

Under these circumstances, the consent issue is raised in the context of who the patient agreed could perform the procedure.<sup>165</sup> Unless the patient explicitly agrees that in that situation, a medical student can perform the pelvic exam, the surgeon should conduct the exam. Moreover, if the situation is so imminent that the exam on the anesthetized patient must be conducted immediately, it is likely detrimental to the patient to spend time teaching a medical student how to perform the pelvic exam.<sup>166</sup>

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159. See *id.* (failing to include information about medical students in the “Consent” section).

160. See Geo. Wash. Univ. Hosp., *supra* note 155 (including information about medical students in such a way that patients may not understand they are consenting to medical students conducting procedures on them for purposes unrelated to the patient’s benefit).

161. See Wilson, *supra* note 31, at 258 (explaining that even at a teaching hospital, an admission form authorizes treatment and procedures for the patient’s benefit, not for the educational benefit of medical students).

162. See *id.* at 259 (explaining that implied consent only extends as far as treatment that provides the patient with a direct benefit).

163. See, e.g., UTAH CODE ANN. § 58-1-509 (West 2022) (creating an exception for a medical emergency in which a pelvic exam is required for a diagnostic purpose).

164. See Tsai, *supra* note 9 (explaining that pelvic exams are often used during gynecological surgeries to diagnose health concerns).

165. See *id.* (discussing students’ omission from patients’ consent form).

166. See Wilson, *supra* note 31, at 258 (emphasizing the importance of conducting medical procedures with the patient’s benefit as the primary purpose).



## IV. POLICY RECOMMENDATION

Current state laws restricting pelvic exams under anesthesia are a step in the right direction, but they must go further to effectively stop these exams. Utah and Arkansas provide model statutes for other states.<sup>167</sup> These statutes detail how teaching hospitals can obtain explicit consent for pelvic exams, including under what conditions they can be conducted and who can conduct them.<sup>168</sup> By enacting statutes that clearly describe how hospitals should obtain consent for pelvic exams under anesthesia, states can ensure that patients have a say in who is involved in their medical care.<sup>169</sup>

While tort law has historically been an avenue for patients to bring medical battery and informed consent claims, the tort system is reactionary and arguably too slow to effectively address the issue of non-consensual pelvic exams. First, while a non-consensual pelvic exam is clearly a medical battery, the fact that the patient is under anesthesia when it occurs makes it difficult, if not impossible, for the patient to even know whether they need to bring a claim.<sup>170</sup> Second, the informed consent doctrine needs to undergo a few key changes before it can adequately address non-consensual pelvic exams.<sup>171</sup>

Informed consent has traditionally been applied to cases where the patient consented to a procedure but was unaware of all of the material risks or hazards associated with the procedure.<sup>172</sup> To fit the issue of non-consensual

167. See UTAH CODE ANN. § 58-1-509(3) (requiring a separate notice or agreement that contains specific language about consenting to an exam of the pelvic region and student involvement in the exam); ARK. CODE ANN. § 20-9-606 (West 2022) (listing the specific requirements that must be satisfied before a medical student conducts a pelvic exam on a patient under anesthesia).

168. See UTAH CODE ANN. § 58-1-509(3) (requiring that the consent form state whether a medical student may be conducting a pelvic exam); see also ARK. CODE ANN. § 20-9-606 (requiring that the patient explicitly consent to a student-conducted pelvic exam).

169. See, e.g., *Perna v. Pirozzi*, 457 A.2d 431, 439-40 (N.J. 1983) (holding that a patient has a right to decide who performs surgery on them).

170. See *Shuler v. Garrett*, 743 F.3d 170, 173 (6th Cir. 2014) (holding that there is medical battery if: (1) the patient was unaware the procedure was going to be performed or (2) the patient did not authorize performance of the procedure).

171. See *Guebard v. Jabaay*, 452 N.E.2d 751, 756 (Ill. App. Ct. 1983) (holding that the informed consent doctrine did not apply to a claim where the patient gave consent for one doctor to perform surgery, but another doctor performed the surgery).

172. See *Dobbs*, *supra* note 77 (listing the elements of informed consent as: (1) failure to disclose material information; (2) actual harm (3) resulting from risks the patient was not informed of; (4) the patient would not have consented had they been provided that

pelvic exams more closely, the doctrine of informed consent should be expanded to include information not just about the risks and hazards of the procedure but about the basic logistics of the procedure, including if medical students will be involved in any way. This expansion of the doctrine of informed consent would be in line with the original purpose of the doctrine — to ensure patient autonomy.<sup>173</sup>

Finally, while non-consensual pelvic exams arguably meet the elements of criminal sexual battery in certain states, criminal prosecution is likely an ineffective way to deter the practice.<sup>174</sup> First, the people conducting these exams are young medical students who are acting at the direction of the attending physicians.<sup>175</sup> Introducing criminal liability in this setting presents the complicated issue of who is liable for the action and under what circumstances. Second, because criminalization is such a harsh penalty, it is likely that no one will report the activity except in egregious circumstances, especially considering that the medical community values pelvic exams under anesthesia as a critical teaching tool.<sup>176</sup>

## V. CONCLUSION

The right to bodily autonomy is one that includes the ability to say who touches one's body and under what circumstances.<sup>177</sup> Non-consensual pelvic exams under anesthesia are an affront to this fundamental right, and the law must do more to prevent and deter this practice.

The tort system has doctrines in place that could apply to the issue of non-

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information; and (5) a reasonable, properly informed patient would not have consented to the procedure).

173. See *Natanson v. Kline*, 350 P.2d 1093, 1104 (Kan. 1960) (explaining that informed consent is based on the notion of individual self-determination).

174. See LA. STAT. ANN. § 14:43.1 (2022) (criminalizing the intimate touching of another without consent); see also GA. CODE ANN. § 16-6-22.1 (West 2022) (criminalizing the intimate touching of another without consent); FLA. STAT. ANN. § 794.011 (West 2022) (criminalizing the genital penetration of another, subject to medical exceptions); S.C. CODE ANN. § 16-3-651 (2022) (exempting medical procedures from the definition of sexual battery).

175. See Tsai, *supra* note 9 (recounting stories of medical students who felt pressured into performing pelvic exams on unconscious patients by their attending physicians).

176. See Goedken, *supra* note 25, at 238 (noting that reporting failure to obtain consent would be unlikely if the consequences were so severe).

177. See *Perna v. Pirozzi*, 457 A.2d 431, 439 (N.J. 1983) (holding that a patient has a right to control their own body, and this includes who touches it for medical procedures); see also *Mims v. Boland*, 138 S.E.2d 902, 906 (Ga. Ct. App. 1964) (holding that a patient's absolute right to determine who touches their body makes any nonconsensual touching unlawful).

consensual pelvic exams, but they are not expansive enough.<sup>178</sup> Further, the reactionary quality of tort law makes it ineffective to adequately address the problem. While there is arguably a criminal nature to non-consensual pelvic exams, criminalizing the behavior is unlikely to deter the practice because of the degree of punishment and liability issues.<sup>179</sup>

Enacting legislation that requires a patient undergoing anesthesia to explicitly consent to a student-conducted pelvic exam is the most effective way to swiftly end the practice of non-consensual exams. Some states have already taken the initial step of enacting these laws; however, for the laws to be effective, they must specifically address the issue of patient consent prior to medical student involvement.<sup>180</sup> Ensuring that patients have the right to decide who touches their bodies and under what circumstances is a critical first step.

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178. See generally Sawicki, *supra* note 72 (discussing the gaps in tort law as they relate to medical malpractice and informed consent).

179. See Goedken, *supra* note 25, at 238 (noting that reporting failure to obtain consent would be unlikely if the consequences were so severe).

180. See EPSTEIN HEALTH L. & POL'Y PROGRAM, *supra* note 12 (listing states prohibiting pelvic exams).