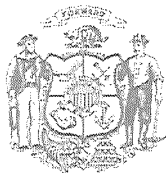

ANDRÉ JACQUE

STATE SENATOR • 1ST SENATE DISTRICT

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State Capitol - P.O. Box 7882
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Testimony before the Senate Committee on Government Operations, Technology and Consumer Protection
Senator André Jacque
January 29, 2020

Chairman Stroebel and Committee Members,

Thank you for holding this hearing on Senate Bill 635, the Patient Privacy Protection Act, relating to requiring hospitals to have a policy requiring written and verbal informed consent before a medical student may perform a pelvic exam on a patient who is under general anesthesia or otherwise unconscious.

Historically, one practice of teaching medical students how to perform pelvic exams has been on unconscious, sedated patients undergoing gynecological medical procedures. This practice, however, for the sole educational benefit of a medical student, often failed to obtain the specific, informed consent of the sedated patient.

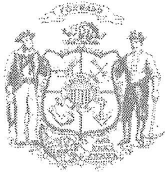
Unfortunately and unbelievingly, this practice continues at some hospitals, as detailed in a 2018 article in Bioethics and anecdotal reports right here in Wisconsin. At certain hospitals, gynecological surgery patients under anesthesia continue to be used as practice tools for medical students, often without the patient's specific consent that they will be undergoing a pelvic exam by a medical student for solely educational purposes. This is a violation of a patient's rights and trust between patient and doctor, and directly ignores a patient's right to bodily autonomy.

A 2005 study conducted at the University of Oklahoma found that a large majority of medical students had participated in performing pelvic exams on unconscious patients for solely educational purposes. In nearly three quarters of these cases, the researchers found there was no specific consent given by the patient.

Informed verbal and written consent in these instances should be required. Like any medical procedure, there should be an explicit explanation of what will happen while the patient is under anesthesia, including the presence and practice of pelvic exams by medical students for solely educational purposes.

In recent years, many women have felt empowered for the first time to discuss experiences of sexual assault and harassment. The practice of trauma informed care has emerged as an essential treatment tool in clinical settings to address the experience of trauma patients. This bill helps ensure compassionate practice and that the experiences and voice of the patient is respected.

Wisconsin's two medical schools either have a policy or are in the process of adopting a policy to require specific written consent before a pelvic exam may be performed by a medical student. This bill makes certain that all hospitals training and teaching medical students also abide by obtaining specific patient consent in these instances.



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Under the Patient Privacy Protection Act, hospitals must obtain a patient's written and verbal consent before allowing a medical student to perform a pelvic exam on a sedated patient. Senate Bill 635 closely tracks a proposed UW Hospital policy.

Wisconsin should join the growing list of states, including Hawaii, California, Oregon, Iowa, Illinois, and Virginia that already have legislation prohibiting this practice of teaching. Female patients deserve to have their bodily integrity respected when they are unconscious and vulnerable during a medical procedure.

Thank you for your consideration of Senate Bill 635.

JANEL BRANDTJEN

STATE REPRESENTATIVE • 22ND ASSEMBLY DISTRICT

Testimony on SB 635

Dear Senator Stroebel and the Senate Committee on Government Operations, Technology and Consumer Protection,

The practice of teaching medical students how to perform pelvic exams on unconscious, sedated patients undergoing gynecological medical procedures is solely for the educational benefit of a medical student. As of today, there is no requirement that these patients give their consent to these examinations. Imagine going into a medical procedure and later finding out that medical students used you as a human laboratory test animal.

Here in Wisconsin, gynecological surgery patients under anesthesia continue to be used as practice tools for medical students, often without the patient's specific consent. Informed verbal and written consent in these instances should be required. Like any medical procedure, there should be an explicit explanation of what will happen while the patient is under anesthesia, including the presence and practice of pelvic exams by medical students for solely educational purposes.

Wisconsin's two medical schools either have a policy or are in the process of adopting a policy to require specific written consent before a pelvic exam may be performed by a medical student. This bill makes certain that all hospitals training and teaching medical students also abide by obtaining specific patient consent in these instances.

With SB 635, hospitals must obtain a patient's written and verbal consent before allowing a medical student to perform a pelvic exam on a sedated patient. This bill closely tracks a proposed UW Hospital policy.

Wisconsin should join the growing list of states, including Hawaii, California, Oregon, Iowa, Illinois, and Virginia that already have legislation prohibiting this practice of teaching. Female patients deserve to have their bodily integrity respected when they are unconscious and vulnerable during a medical procedure.

Thank you,

State Representative Janel Brandtjen

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A Personal Perspective on Senate Bill 635/Assembly Bill 694
Testimony by Sarah Wright

My name is Sarah Wright. I am a resident of Madison and a constituent of Rep. Chris Taylor and Sen. Risser. I want to thank Sen. Stroebel and members of the committee for scheduling this hearing today. I'm here to speak in support of SB 635.

Picture this: A woman lies unconscious on a table. She has placed her trust in a surgeon to help her—perhaps to remove a tumor from an ovary or assess a problem with fertility. She is at her most vulnerable, sedated and unclothed except for a hospital gown; she has signed a form to document that she is entrusting the surgical team to respect her bodily autonomy when she is unable to speak for herself. Should she have done so? The answer is, it depends. How do I know? Because I have been this woman, twice, and had two radically different experiences.

After she is under anesthesia and her muscles are relaxed, she will be subjected to pelvic exams. A pelvic exam requires penetration of the vagina with a gloved hand in order to palpate organs and feel for positioning and possible abnormalities. Does the woman know that the surgeon needs to do this exam to prepare for surgery? Perhaps, and perhaps not; it depends on whether the surgeon remembers or thinks it is important to inform her. What she almost certainly would not know, if she is at a teaching hospital, is that in addition to the attending surgeon, a resident and a medical student will perform the exam as well. The attending and the resident need to do the exam in order to perform the surgery. As for the medical student? Performing the pelvic exam is done solely for his or her own education, to get practice in how exactly to insert their fingers through the vagina, and what to feel for and observe. How does this affect the woman under anesthesia? Perhaps she will never know. As she recovers from surgery, perhaps she will have some unsettling feeling that something is wrong, but not know why. If she is truly unfortunate, she may awake in the middle of the exam, utterly confused about what is happening. If she is like me, she may try to get answers about what happened to her while she was under anesthesia, and never get them. If she is like me, not getting any clear answers is as traumatic as the physical pain she experiences.

You may be wondering, what about that form that she signed? Didn't the form specify how medical students would be involved? The answer is no. The consent form I was required to sign simply states that (and I quote): "medical student(s) or other assistant(s) present during my procedure will be able to, while under the supervision of my primary physician(s)/surgeon(s), perform and assist with important parts of the procedure(s)." (unquote) As written, it is the prerogative of the individual surgeon whether to inform patients about which "important parts of the procedure" may be performed by students. Adding a line to such forms to require explicit, specific written consent for educational pelvic exams may seem like a small matter. But I am here to tell you how this one act can avert suffering like what I have experienced, and why it is imperative to support this bill.

The recovery from my surgery in 2009 was difficult in many ways, but the most troubling and lasting effect was an extreme sensitivity of the vulva, the folds of skin that make up the entrance to the vagina. I was dumbfounded: the surgeon had accessed my ovaries through my abdomen, not through the vagina. So what could explain the obvious trauma to my sexual organs? The attending surgeon I had in 2009 did not inform me that HE would do a pelvic exam, much less that a resident and medical student would as well. Neither a pelvic exam nor any instruments used to penetrate the vagina were documented in the sparse, 2-page record of my 2009 surgery; it simply states that (quote) "the vagina was prepped properly." Because I happen to have a sister who has worked in ORs for two decades and because of my second surgery, I know that in addition to several pelvic exams being performed, an instrument called a uterine manipulator was very likely to have been used in my 2009 surgery. This tool penetrates the vagina and is left in place for the duration of the surgery, so it is most likely responsible for the enduring pain I experienced.

Someday, I would love to see the expectations for informed consent apply to uterine manipulators and to pelvic exams performed by all practitioners. But it is especially urgent that we require explicit written consent for pelvic exams done by medical students for two reasons: 1) the exam done by a medical student is of no benefit to the patient at all, so failing to inform her of it is an especially egregious violation; in essence, she is being used as a test subject. 2) I have spoken with physicians young and old who agree that having consistent expectations for informed consent will protect not only patients, but also medical students who feel uncomfortable doing pelvic exams without clear consent. In any case, this bill would raise awareness so that more patients will at least have a better idea what questions to ask.

Prior to my surgery in 2018, I was determined to be fully informed, and to help protect the rights of all women undergoing pelvic surgery. I even drafted my own "informed consent contract" that I intended to use with my surgeon and shared it with hospital officials in the hope that it could be useful to others. However, I was told that if having the opportunity to withhold consent for an educational pelvic exam was "a dealbreaker," I should have my surgery elsewhere. I went through with the surgery as scheduled anyhow. Fortunately, my surgeon was receptive to my concerns and held herself to the highest ethical standards. Her 12-page record of my surgery carefully documented the pelvic exam she performed, as well as every part of the procedure and every instrument used. She personally informed me that while she attempted surgery without a uterine manipulator, she needed to use the tool. My recovery was much faster and I experienced none of the vaginal pain that I had in 2009. I believe that being fully informed resulted in a completely different experience, even in the same hospital and undergoing a similar procedure as I did in 2009. For me, this compassionate surgeon made all the difference.

But patients' bodily autonomy must be respected, no matter who performs their surgery or where it takes place. Standardizing the expectation for informed consent prior to a pelvic exam on an unconscious patient and requiring written documentation will ensure that every woman's rights are respected.

Perhaps what upsets me most is how the notion of informed consent has devolved in recent years. The origin of informed consent is simple: its intent was to protect the autonomy of patients, especially when they are at their most vulnerable. Today, the "consent forms" that patients must sign are there primarily to protect the legal and financial interests of hospitals. We need to get back to the true meaning of informed consent: First do no harm. Ask for permission. Treat the unconscious patient as though they can see what you are doing. Document actions taken and instruments used in the medical record. These are simple steps that should be required and not left up to individual interpretation.

I hope I have convinced you that the need for this legislation is clear. We must all treat informed consent as if it is of the utmost importance, because it is. I am forever grateful to my Representative, Chris Taylor, for listening to me, taking this issue seriously, and bringing this bill into existence. I am grateful to Rep. Brandtjen and Sens. Jacques and Lena Taylor for co-sponsoring this bill, and to the many legislators from throughout Wisconsin who have signed on. You help to restore my faith that most of us want to do what's right. Please do not leave women's consent up to chance. I urge you to support scheduling a vote on this important bill, and to vote YES on Senate Bill 635.

A Personal Perspective on Senate Bill 635/Assembly Bill 694
Testimony by Sarah Wright

Picture this: A woman lies unconscious on a table. She has placed her trust in a surgeon to help her—perhaps to remove a tumor from an ovary or assess a problem with fertility. She is at her most vulnerable, sedated and unclothed save for a hospital gown; she has signed a form to document that she is entrusting the surgical team to respect her bodily autonomy when she is unable to speak for herself. Should she have done so? The answer is, it depends. How do I know? Because I have been this woman, twice, and had two radically different experiences.

After she is under anesthesia and her muscles are relaxed, she will be subjected to pelvic exams. A pelvic exam requires penetration of the vagina with a gloved hand in order to palpate organs and feel for positioning and possible abnormalities. Does the woman know that the surgeon needs to do this exam to prepare for surgery? Perhaps, and perhaps not; it depends on whether the surgeon remembers or thinks it is important to inform her. What she almost certainly would not know, if she is at a teaching hospital, is that in addition to the attending surgeon, a resident and a medical student will perform the exam as well. The attending and the resident need to do the exam in order to perform the surgery. As for the medical student? Performing the pelvic exam is done solely for his or her own education, to get practice in how exactly to insert their fingers through the vagina, and what to feel for and observe. How does this affect the woman under anesthesia? Perhaps she will never know. As she recovers from surgery, perhaps she will have some unsettling feeling that something is wrong, but not know why. If she is truly unfortunate, she may awake in the midst of the exam (yes, this has happened), utterly confused about what is happening. If she is like me, she may try to get answers about what happened to her while she was under anesthesia, and never get them. If she is like me, not getting any clear answers is as traumatic as the physical pain she experiences.

You may be wondering, what about that form that she signed? Didn't the form specify how medical students would be involved? The answer is no. The consent form I was required to sign simply states that "medical student(s) or other assistant(s) present during my procedure will be able to, while under the supervision of my primary physician(s)/surgeon(s), perform and assist with important parts of the procedure(s)." As written, it is the prerogative of the individual surgeon whether to inform patients about which "important parts of the procedure" may be performed by students. While adding a line to such forms to require explicit, specific written consent for educational pelvic exams may seem like a small matter, I am here to tell you how this one act can avert suffering like what I have experienced, and why it is imperative to support this bill.

The recovery from my surgery in 2009 was difficult in many ways, but the most troubling and lasting effect was an extreme sensitivity of the vulva, the folds of skin that make up the entrance to the vagina. I was dumbfounded: the surgeon had accessed my ovaries through my abdomen, not through the vagina. So what could explain the obvious trauma to my sexual organs? The attending surgeon I had in 2009 did not inform me that HE would do a pelvic exam, much less that a resident and medical student would as well. Neither a pelvic exam nor any instruments used to penetrate the vagina were documented in the sparse, 2-page record of my 2009 surgery; it simply states that "the patient was prepped in the usual way." Because I happen to have a sister who has worked in ORs for two decades and because of my second surgery, I know that in addition to several pelvic exams being performed, an instrument called a uterine manipulator was very likely to have been used in my 2009 surgery. This tool penetrates the vagina and is left in place for the duration of the surgery, so it is most likely responsible for the enduring pain I experienced. Someday, I would love to see the expectations for informed consent apply to uterine manipulators and to pelvic exams performed by all practitioners. But I believe that this bill, and requiring explicit written consent for pelvic exams done solely for educational purposes is an especially urgent need, both to protect patients and medical students. Having consistent expectations for informed consent will protect everyone involved, and raise awareness so that more patients will at least have a better idea what questions to ask.

Prior to my surgery in 2018, I was determined to be fully informed, and to help protect the rights of all women undergoing pelvic surgery. I even drafted my own "informed consent contract" that I intended to use with my

surgeon and shared it with hospital officials in the hope that it could be useful to others. However, I was told that if having the opportunity to withhold consent for an educational pelvic exam was "a dealbreaker," I should have my surgery elsewhere. I went through with the surgery with my previously scheduled surgeon, who was receptive to my concerns and held herself to the highest ethical standards. Her 12-page record of my surgery carefully documented the pelvic exam she performed, as well as every part of the procedure and every instrument used, and she personally informed me that while she attempted surgery without a uterine manipulator, she needed to use the tool. My recovery was much faster and I experienced none of the vaginal pain that I had in 2009. I believe that being fully informed resulted in a completely different experience, even in the same hospital and undergoing a similar procedure. For me, this compassionate surgeon made all the difference.

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Perhaps what upsets me most is how the notion of informed consent has devolved in recent years. The origin of informed consent is simple: its intent was to protect the autonomy of patients, especially when they are at their most vulnerable. Today, the "consent forms" that patients must sign are there primarily to protect the legal and financial interests of hospitals. We need to get back to the true meaning of informed consent: First do no harm. Ask for permission. Treat the unconscious patient as though they can see what you are doing. Document actions taken and instruments used in the medical record. These are simple steps that should be required and not left up to individual interpretation.

I hope I have convinced you that the need for this legislation is clear. We must all treat informed consent as if it is of the utmost importance, because it is. I am forever grateful to my Representative, Chris Taylor, for listening to me, taking this issue seriously, and bringing this bill into existence. I am grateful to Rep. Brandtjen and Sens. Jacques and Lena Taylor for co-sponsoring this bill, and to the many legislators from throughout Wisconsin who have signed on. You help to restore my faith that most of us want to do what's right. Please do not leave women's consent up to chance. I urge you to support scheduling a vote on this important bill, and to vote YES on Senate Bill 635.

Support for 2019 Assembly Bill 694/Senate Bill 635
January 29, 2020
Sarah Katherine Lazarus

Members of the Committee:

My name is Sarah Lazarus, and I am a first year medical student. Thank you so much for letting me speak with you today.

Most of my classmates sign up for medical school because we want to help people. We spent years building our application to prove that point to admissions committees. Once we are finally given that golden ticket to start medical school, things quickly take a turn towards an endless list of what we need to do to perform well on tests, get a high class-rank, and ultimately place into a residency of choice. I realize that in clinical rotations, there will be things that make me uncomfortable: attending physicians who might make a crude comment, or pay more attention to the patients they like. And I realize that I will often have to decide whether to say something or keep quiet for the sake of my grade and my career opportunities.

Performing a pelvic exam on an unconscious, non-consenting woman does not need to be one of those tough decisions. I would never do an exam on an awake woman without her permission. To skip asking, and waiting until she is unconscious, is a clear loophole. It is vulnerable to be sick. It is scary to put trust in a healthcare system that you can only hope will help and respect you. With an exam as intimate as a pelvic exam, we must be more careful than we usually are—not less—to obtain consent.

Of course, it is important for students to learn. Luckily, a U.S. poll saw that the majority of women would consent to a pelvic exam by a medical student while anesthetized. This does not surprise me. In my clinical experience thus far, I introduce myself to patients, explain my role, and ask if it is okay for me to participate in their visit. Everyone who I have worked with so far has been happy to have me. They have asked me questions about what it is like to be a medical student, and I have gotten to ask them more about their lives. This process has helped me learn how to build genuine, honest relationships with patients.

The MD curriculum consistently emphasizes trust in the doctor-patient relationship. Trust is critical if we expect people to show up to the clinic, be forthcoming, and comply with treatments. Practicing a pelvic exam for my education and without consent is a violation of that woman's bodily autonomy. It is an antiquated practice that would make me feel uncomfortable as a patient. And if this is the style that we are learning as medical students, it is not surprising that the doctor-patient relationship is often strained with suspicion and skewed power-dynamics.

I decided to go into medicine because I deeply care that people feel healthy and in control of themselves. I do not want to be asked to invade someone's body while they are unconscious. It erodes the values that urged me to become a doctor. It is not a tradition I want to be a part of passing on.

Thank you.

Support for 2019 Assembly Bill 694
Relating to Pelvic Exams Under Anesthesia performed by Medical Students
January 29, 2020

Members of the Committee:

Hello. My name is Taryn McGinn Valley, and I'm an MD/PhD candidate in Medical Anthropology in the state of Wisconsin. I have finished my third year of medical school, which means that I have had the honor to work in a training role with physicians and patients across disciplines and across our state. My testimony today will cover three main points, and then I'd be happy to take any questions.

1. As a woman and a sexual assault survivor, I know pelvic exams under anesthesia that occur without explicit consent are themselves assault.
2. As a medical student, I want to know that my patients are completely aware of what's going to happen on a day they may already be understandably apprehensive. My learning to perform pelvic exams does not have to be, and should not be, at the expense of patient autonomy.
3. As a future doctor in Wisconsin, I know that having this bill on the books will make me feel more secure in my conversations with and treatment of patients.

I'm going to quickly review some of the context of this conversation, and I apologize if this is repetition for anyone. Some of this language will be explicit in the effort to be clear. People have gynecological surgery for a number of reasons—one common reason is a hysterectomy, or removal of the uterus, but there are also more rare indications, like cancer or growths. In the majority of gynecological surgeries there is a pelvic exam that's performed at the beginning of the surgery. This occurs after anesthesia is administered, so after the patient is already asleep. The exam is performed with one gloved hand, and the physician inserts their hand into the patient's vagina to assess the location of pelvic organs and develop a plan for the surgery to proceed. In the vast majority of teaching hospitals, this exam is also performed by the medical student or students who are working on the case. Now, this medical student is not an integral part of the team deciding how the surgery proceeds (unlike the resident physician). The medical student, like me, performs this exam simply to learn more about anatomy, understand the surgical plan, and develop better technique for the future.

In many states including Wisconsin, medical students have stepped up[1] to say that they have been asked to perform this exam without the patient having consented, particularly to the role of the medical student. They say that patients receive this extra invasive and not medically

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[1] Friesen P. Why Are Pelvic Exams on Unconscious, Unconsenting Women Still Part of Medical Training? Slate Magazine. https://slate.com/technology/2018/10/pelvic-exams-unconscious-women-medical-training-consent.html. Published October 30, 2018. Accessed January 29, 2020.

necessary exam from a medical student without any forewarning, and then, under anesthesia, the patients are neither aware of the exam nor able to refuse it.

My story is somewhat different. While I certainly have performed dozens of pelvic exams on patients under anesthesia, I understood all of these patients to have been explicitly consented to that procedure, and my participation in it, beforehand. In fact, that is in practice what this bill proposes: that hospitals require patients to explicitly consent before a medical student like me performs a very intimate and invasive exam while the patient is under anesthesia.

This is a commonsense bill allowing medical students to learn to be doctors keeping in mind what has been called the fundamental moral code of medicine: "to seek trust and be deserving of it."[2] I have received and performed dozens of pelvic exams. It is an honor as a student to be given permission to perform this invasive and personal exam. In my experience as a patient, when the provider takes a moment to acknowledge my autonomy, she's seeking and deserving of my trust. I hope to be able to carry forward that example for all of the patients I hope to serve as a physician. This bill will make that path clearer, for me and for my future patients.

Thank you for your time. I am happy to take any questions.

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[2] Friesen P. Educational pelvic exams on anesthetized women: Why consent matters. *Bioethics*. 2018;32(5):298-307.

School of Medicine and Public Health
UNIVERSITY OF WISCONSIN–MADISON

To: Members of the Senate Committee on Government Operations, Technology and Consumer Protection

From: American College of Obstetricians and Gynecologists – Wisconsin Section
Medical College of Wisconsin
University of Wisconsin School of Medicine and Public Health
Wisconsin Hospital Association

Date: January 29, 2020

RE: Wisconsin Hospital, Physician and Medical School Coalition's Opposition to Senate Bill 635

The above referenced coalition representing Wisconsin hospitals, medical schools and obstetricians and gynecologists oppose Senate Bill 635. If enacted, this legislation would result in the legislature creating a new type of unnecessary regulatory burden. Multiple safeguards are already in place to inform, provide choice, and ultimately protect patients. These safeguards include consent procedures already in place with providers and hospitals, as well as formal complaint and investigation processes through the Department of Health Services and the Department of Safety and Professional Services.

Wisconsin's hospitals, medical school faculty and physicians all greatly value the physician-patient relationship and take their respective informed consent obligations very seriously. Physician faculty are trained to show medical students appropriate informed consent practices and provide students with clinical training opportunities that are relevant to the patient's condition. Further, through the existing informed consent process, a patient will have a choice to have student learners involved in their care. If the patient chooses not to involve students, that is the patient's choice and it is respected by their provider.

Any patient who believes that their wishes have not been respected by a provider practicing within a hospital should report a complaint to the Department of Health Services' Division of Quality Assurance (DQA) for review. DQA is the state's entity for regulating hospitals and DQA surveyors have authority to interview providers, hospital staff and even investigate a patient's medical record when a complaint has been filed. No other state official, including elected officials, are ever able to see a complete picture of the patient's care because of patient confidentiality laws.

In addition to DQA's regulatory enforcement authority over hospitals, physicians and other health care providers are regulated by their respective examining boards through the Department of Safety and Professional Services. Any complaints regarding unprofessional conduct by a health care provider should be submitted to DSPS.

The health care coalition above believes Senate Bill 635 takes decisions regarding patient care out of the hands of health care providers and their patients, inappropriately inserting state government in the physician-patient relationship. In addition, the coalition remains concerned about the impact this legislation will have on the number of hospitals willing to provide medical students with training experiences and the precedent this legislation sets for creating new procedure-specific consent requirements in state statute.

We ask Committee members to oppose Senate Bill 635.

Testimony

To:	Members of the State Senate Committee on Government Operations, Technology and Consumer Protection
From:	Wisconsin Coalition Against Sexual Assault (WCASA)
Date:	January 29, 2020
Re:	Senate Bill 635
Position:	Support

The Wisconsin Coalition Against Sexual Assault (WCASA) appreciates the opportunity to offer this written testimony for your consideration. WCASA is a statewide membership agency comprised of organizations and individuals working to end sexual violence in Wisconsin. Among these are the sexual assault service provider agencies located throughout the state that offer support, advocacy and information to survivors of sexual assault and their families.

WCASA thanks Committee Chair Stroebel for bringing this important piece of legislation forward for a hearing today. We also thank the leading sponsors of the bill, Senators Jacque and Taylor and Representatives Brandtjen and Taylor for their leadership on this legislation in both houses. Additionally, WCASA appreciates the bipartisan list of over 20 other cosponsors of Senate Bill 635/Assembly Bill 694.

SB 635 requires hospitals to have and enforce a policy requiring written and verbal informed consent before medical student may perform a pelvic examination upon a patient who is under general anesthesia or otherwise unconscious. WCASA appreciates the emphasis on consent in this legislation, particularly because consent represents a concrete example of what it takes to end sexual violence. This bill not only reflects the values of the anti-sexual violence movement, it also is extremely important for survivors who are seeking health care. By ensuring that a survivor's boundaries are respected during medical procedures, this legislation can prevent re-traumatization by ensuring no pelvic examination is performed without their written and verbal permission.

This legislation also reflects the values of patient-centered health care, which is defined as care that "is respectful of and responsive to individual patients' preferences, needs and values, and ensures the patients' values guide all clinical designs."[1] Given the invasive nature of a pelvic exam, it only makes sense that a patient's consent is obtained before a medical student performs such an exam upon a patient who is not able to provide informed consent. Patient-centered health care represents a cultural shift in our health care system, and this legislation honors that shift by focusing on the patient's preferences and shared decision making with their health care provider.

We thank you for your attention to this matter and for your continued efforts to health care responses for sexual assault survivors. If you have any questions, you can reach me at ianh@wcasa.org.

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[1] "What are Important for Patient Centered Care?" Journal of Caring Sciences. Published November 2013.

2801 West Beltline Highway Ste 202 · Madison, WI 53713 · P: (608) 257-1516 · F: (608) 257-2150 · www.wcasa.org

Wisconsin Alliance for
Women's Health
www.supportwomenshealth.org

TO: Senate Committee on Government Operations, Technology and Consumer Protection
FROM: Sara Finger, Executive Director, Wisconsin Alliance for Women's Health (WAWH)
RE: Testimony in Support of SB 635
DATE: January 29, 2020

Chairman Stroebel and members of the Senate Committee on Government Operations, Technology and Consumer Protection, thank you for the opportunity to provide testimony in support of the Patient Privacy Protection Act.

Our vision is that every Wisconsin woman - at every age and every stage of life - is able to reach her optimal health, safety and economic security. In the spirit of our vision, we support legislation that will have a positive impact on women's health and wellbeing in Wisconsin.

It seems obvious that if a woman is in a hospital and unconscious, then she should not have to worry about having a pelvic exam performed on her body that she did not explicitly consent to. However, the disturbing reality of what is occurring to patients in hospitals and clinics, especially teaching facilities, has brought this issue to the public's attention.

While a medical student at the University of Hawaii in 2012, Dr. Shawn Barnes wrote about the shame he felt after being instructed to practice pelvic exams on anesthetized women[i]. His article and activism brought this issue to light and helped to pass legislation that ban unauthorized pelvic exams in the state of Hawaii. In 2019, ELLE magazine conducted a survey of 101 medical students from seven medical schools and found that 92% percent reported performing a pelvic exam on an unconscious patient[ii]. 61% percent reported performing this procedure without explicit patient consent[iii]

A 2005 survey conducted at the University of Oklahoma found that a majority of medical students had performed pelvic exams to gynecologic surgery patients under anesthesia, and that in nearly three quarters of these cases the women had not consented to the exam[iv]. These survey results are incredibly alarming and indicate that it is necessary to clarify consent requirements to provide certainty for patients.

At the national level, the American Congress of Obstetricians and Gynecologists (ACOG) position is that "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"[v]. The Patient Privacy Protection Act aligns with ACOG's position to ensure that unconscious patients are not used as teaching tool without their knowledge and explicit consent. SB 635 simply requires hospitals and clinics in Wisconsin to have consent policy in place for pelvic exams on a patient who is under general anesthesia or otherwise unconscious.

Nine states currently have laws that ban non-consensual pelvic exams. Wisconsin needs to join Utah, Maryland, New York, California, Illinois, Virginia, Oregon, Hawaii and Iowa to ensure our patients are protected.

Thank you State Representatives Taylor and Brandtjen and State Senators Taylor and Jacque for introducing the Patient Privacy Protection Act. We and ask this committee to support this bipartisan legislation and move SB 635 forward to ensure that Wisconsin's consent requirements are crystal clear.

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[i] https://journals.lww.com/greenjournal/Citation/2012/10000/Practicing_Pelvic_Examinations_by_Medical_Students.28.aspx
[ii] https://www.elle.com/life-love/a28125604/nonconsensual-pelvic-exams-teaching-hospitals
[iii] Id.
[iv] https://www.ncbi.nlm.nih.gov/pubmed/16206868
[v] https://bit.ly/2O6kwPr

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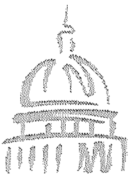

CHRIS TAYLOR
STATE REPRESENTATIVE ◈ 76th ASSEMBLY DISTRICT

TESTIMONY OF REP. CHRIS TAYLOR IN SUPPORT OF SB 635

1/29/20

Dear Chairman Stroebel and Committee Members,

Thank you so much to Chair Stroebel and the other members of this committee for hearing testimony on this important, bipartisan bill, SB 635. It has been a real pleasure to work on this bill with Senator Jacque, Senator Taylor and Representative Brandtjen. This is a bill we should all be able to agree on.

When I first became aware of the practice of teaching medical students to perform pelvic exams on sedated women who do not provide specific, informed consent I was in disbelief. How could this be in the 21st century? Yet, as I researched this issue and had many conversations with medical professionals, I learned this practice has been occurring for decades. It is time for this practice to end.

A 2005 study conducted at the University of Oklahoma found that a large majority of medical students had participated in performing pelvic exams on unconscious patients for solely educational purposes. In nearly three quarters of these cases, the researchers found there was no specific consent given by the patient.

This practice is not ethical. The AMA Council on Ethical and Judicial Affairs, The Association of American Medical Colleges, and The Committee on Ethics of the American College of Obstetricians and Gynecologists (ACOG) have all taken the position that consent should be granted before medical students perform pelvic exams on an unconscious patient.

SB 635 ends this practice, and requires which I think we all thought was required—women must be informed about this practice and give explicit consent to it.

Our two medical schools have adopted policies that require patients to give consent before allowing medical students to practice on sedated patients. One policy, adopted by University of Wisconsin, extends this consent to all sensitive exams, stating: "Health Professions Students will be informed by the relevant course instructor that they may not perform an educational Sensitive Exam on a patient under anesthesia unless it has been confirmed in the patient's medical record that consent to the Educational Sensitive Exam was obtained". Medical College Wisconsin, has a policy that requires patients to give consent prior to a medical student practicing a pelvic exam while they are sedated.

Yet these policies do not always follow the student into their clinical experience. That is why it is important for every hospital to have a policy requiring specific consent.

This bill makes certain that all hospitals require that medical students performing pelvic exams on unconscious or sedated women have the explicit consent of the patient.

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We would not be the first state to specifically ban this practice. Currently, there are ten states that have enacted similar policies, including: California, Hawaii, Illinois, Iowa, Oregon, Virginia, New York, Maryland, Delaware, and Utah.

Further, requiring specific consent is consistent with the current emphasis on trauma-informed care. Health care professionals are not always aware of what patients have experienced in their lives before a medical encounter. But current best practices emphasize that compassion, safety, trustworthiness, and transparency are among the most important things when working with patients where trauma may not necessarily be known to a medical professional. SB635 echoes those tenants.

I would urge you all to support this bill.

Thank you for your consideration of this important issue.

Representative Chris Taylor
76th Assembly District

A Personal Perspective on Senate Bill 635/Assembly Bill 694
Testimony by Sarah Wright

My name is Sarah Wright. I want to thank Sen. Stroebel and members of the committee for scheduling this hearing today. I'm here to speak in support of SB 635.

Picture this: A woman lies unconscious on a table. She has placed her trust in a surgeon to help her—perhaps to remove a tumor from an ovary or assess a problem with fertility. She is at her most vulnerable, sedated and unclothed except for a hospital gown; she has signed a form to document that she is entrusting the surgical team to respect her bodily autonomy when she is unable to speak for herself. Should she have done so? The answer is, it depends. How do I know? Because I have been this woman, twice, and had two radically different experiences.

After she is under anesthesia and her muscles are relaxed, she will be subjected to pelvic exams. A pelvic exam requires penetration of the vagina with a gloved hand in order to palpate organs and feel for positioning and possible abnormalities. Does the woman know that the surgeon needs to do this exam to prepare for surgery? Perhaps, and perhaps not; it depends on whether the surgeon remembers or thinks it is important to inform her. What she almost certainly would not know, if she is at a teaching hospital, is that in addition to the attending surgeon, a resident and a medical student will perform the exam as well. The attending and the resident need to do the exam in order to perform the surgery. As for the medical student? Performing the pelvic exam is done solely for his or her own education, to get practice in how exactly to insert their fingers through the vagina, and what to feel for and observe. How does this affect the woman under anesthesia? Perhaps she will never know. As she recovers from surgery, perhaps she will have some unsettling feeling that something is wrong, but not know why. If she is like me, she may try to get answers about what happened to her while she was under anesthesia, and never get them. Which is as traumatic as the physical pain she experiences.

Didn't the form she signed specify how medical students would be involved? The answer is no. The consent form I was required to sign simply states that (and I quote): "medical student(s) or other assistant(s) present during my procedure will be able to, while under the supervision of my primary physician(s)/surgeon(s), perform and assist with important parts of the procedure(s)." (unquote) As written, it is the prerogative of the individual surgeon whether to inform patients about which "important parts of the procedure" may be performed by students. Adding a line to such forms to require explicit, specific written consent for educational pelvic exams may seem like a small matter. But I am here to tell you how this one act can avert suffering like what I have experienced, and why it is imperative to support this bill.

The recovery from my surgery in 2009 was difficult in many ways, but the most troubling and lasting effect was an extreme sensitivity of the vulva, the folds of skin that make up the entrance to the vagina. I was dumbfounded: the surgeon had accessed my ovaries through my abdomen, not through the vagina. So what could explain the obvious trauma to my sexual organs? The attending surgeon I had in 2009 did not inform me that HE would do a pelvic exam, much less that a resident and medical student would as well. Neither a pelvic exam nor any instruments used to penetrate the vagina were documented in the sparse, 2-page record of my 2009 surgery; it simply states that (quote) "the vagina was prepped properly." Because I happen to have a sister who is a surgical nurse in the OR for the last two decades and because of my second surgery, I know that in addition to several pelvic exams being performed, an instrument called a uterine manipulator was very likely to have been used in my 2009 surgery. This tool penetrates the vagina and is left in place for the duration of the surgery, so it is most likely responsible for the enduring pain I experienced.

Someday, I would love to see the expectations for informed consent apply to uterine manipulators and to pelvic exams performed by all practitioners. But it is especially urgent that we require explicit written consent for pelvic exams done by medical students for two reasons: 1) the exam done by a medical student is of no benefit to the patient at all, so failing to inform her of it is an especially egregious violation; in essence, she is being used as a test subject. 2) I have spoken with physicians young and old who agree that having consistent

expectations for informed consent will protect not only patients, but also medical students who feel uncomfortable doing pelvic exams without clear consent. In any case, this bill would raise awareness so that more patients will at least have a better idea what questions to ask.

I used to think of medical students as complicit in causing harm to patients who are subjected to pelvic exams without their consent. But as I talk to more medical professionals and read more studies, it is clear to me that medical students are often victims as well. The current system of medical training is intensely hierarchical; a student who objects to the instructions of a superior risks their future career. While a medical student at the University of Hawaii, Dr. Shawn Barnes wrote an opinion article in the medical journal *Obstetrics and Gynecology* in 2012 in which he described the shame he felt after being instructed to practice pelvic exams on anesthetized women. His article and activism helped to pass legislation to ban unauthorized pelvic exams in the state of Hawaii; the consequence was that Barnes was unable to obtain a medical license there

Back in 2003, the "whistle was blown," so to speak, about pelvic exams being performed on unconsenting women, by Dr. Ari Silver-Isenstadt. As a medical student, Silver-Isenstadt took the courageous—and lonely—position of refusing to conduct any procedure on a patient without explicit informed consent. He ended up taking a leave of absence from medical school for a year to study medical ethics and published his work several years later in the *American Journal of Obstetrics and Gynecology*. His study, entitled, "Don't Ask, Don't Tell," found the troubling result that "students who had completed an obstetrics/gynecology clerkship thought that consent was significantly less important than did those students who had not completed a clerkship." In other words, as medical trainees are repeatedly exposed to cavalier attitudes toward patient autonomy, they are less able to see unethical practices for what they are. I believe that this system of training, in which students are coerced into doing things they find questionable and lose their own ethical bearings as a result, is profoundly sad for both patients and budding doctors. We must do better by everyone involved. Moreover, this ethical erosion is completely avoidable without compromising training opportunities. Phoebe Friesen's 2018 article in the journal *Bioethics* states, "studies show that as many as 62% of women would consent to an exam for educational purposes if they were asked for permission. To do such exams without explicit consent, figuring that the patient will never know, is beyond reprehensible, and not even necessary."

There is clear evidence documenting that this problem persists, and that performing pelvic exams without consent is damaging to women and medical students alike. So what is the way forward? Can we rely upon medical schools and hospitals to revise their policies and self-regulate? I argue that we cannot. The Medical College of Wisconsin updated their policy on educational pelvic exams back in 2003, partly in response to news coverage of the study by Ari Silver-Isenstadt and his colleagues. But it is unclear whether updating a policy results in a change in practice, and I am skeptical that it has. Currently, much is left up to individual discretion of the surgeon, and it is clear that institutional inertia has stood in the way of meaningful change.

Prior to my surgery in 2018, I was determined to be fully informed, and to help protect the rights of all women undergoing pelvic surgery. I even drafted my own "informed consent contract" that I intended to use with my surgeon and shared it with hospital officials in the hope that it could be useful to others. However, I was told that if having the opportunity to withhold consent for an educational pelvic exam was "a dealbreaker," I should have my surgery elsewhere. I went through with the surgery as scheduled anyhow. Fortunately, my surgeon was receptive to my concerns and held herself to the highest ethical standards. Her 12-page record of my surgery carefully documented the pelvic exam she performed, as well as every part of the procedure and every instrument used. She personally informed me that while she attempted surgery without a uterine manipulator, she needed to use the tool. My recovery was much faster and I experienced none of the vaginal pain that I had in 2009. I believe that being fully informed resulted in a completely different experience, even in the same hospital and undergoing a similar procedure as I did in 2009. For me, this compassionate surgeon made all the difference.

But patients' bodily autonomy must be respected, no matter who performs their surgery or where it takes place. Standardizing the expectation for informed consent prior to a pelvic exam on an unconscious patient and requiring written documentation will ensure that every woman's rights are respected.

Perhaps what upsets me most is how the notion of informed consent has devolved in recent years. The origin of informed consent is simple: its intent was to protect the autonomy of patients, especially when they are at their most vulnerable. Today, the "consent forms" that patients must sign are there primarily to protect the legal and financial interests of hospitals. We need to get back to the true meaning of informed consent: First do no harm. Ask for permission. Treat the unconscious patient as though they can see what you are doing. Document actions taken and instruments used in the medical record. These are simple steps that should be required and not left up to individual interpretation.

I hope I have convinced you that the need for this legislation is clear. We must all treat informed consent as if it is of the utmost importance, because it is. I am forever grateful to my Representative, Chris Taylor, for listening to me, taking this issue seriously, and bringing this bill into existence. I am grateful to Rep. Brandtjen and Sens. Jacques and Lena Taylor for co-sponsoring this bill, and to the many legislators from throughout Wisconsin who have signed on. You help to restore my faith that most of us want to do what's right. Please do not leave women's consent up to chance. I urge you to support scheduling a vote on this important bill, and to vote YES on Senate Bill 635.

Jan 28, 2020

Representative Chris Taylor
Room 306 West
State Capitol
PO Box 8953
Madison, WI 53708
Rep.Taylor@legis.wisconsin.gov

Re: Senate Bill 635 Consent for pelvic examination on an anesthetized or unconscious patients

Dear Representative Taylor:

I am writing in support of Bill 365, which requires hospitals in Wisconsin to have a policy requiring written and verbal informed consent before a medical student can perform a pelvic examination on a patient who is under general anesthesia or otherwise unconscious. While these examinations are an important teaching tool, performing them without the consent of patients is a violation of patient rights and is a remnant of medicine's paternalistic past. It is time to follow the rest of the world and the country in requiring consent before pelvic examinations are performed on anesthetized patients.

Below, I speak to three topics that I have considered within my research in medical ethics: I. Medical Student Experiences and Moral Distress, II. Non-consensual Exams as Violations of Autonomy, Bodily Rights, and Trust, III. Objections to a Legal Consent Requirement.

I. Medical Student Experiences and Moral Distress

I first learned of this practice while teaching ethics to medical students in New York. The students were asked to write summaries of ethical dilemmas they had encountered in their training so that I could help them engage in ethical analyses of these cases. Countless students wrote about their experiences of performing pelvic examinations on anesthetized patients who had not consented to the examination. Many of these students reported considerable moral distress accompanying the experience, reporting that it felt wrong and inappropriate, and that they wouldn't want the same to be done to them. Importantly, because the teaching faculty that were asking them to perform the examinations were also the ones that were evaluating them within medical school, and often writing their reference letters for residency, very few students felt comfortable raising their concerns with their instructors. Beyond the discomfort of medical students, engaging in this practice without consent teaches a problematic lesson to our future doctors: using an unconscious woman's body as a teaching tool, without her consent, is permissible. Today's students are aware that medicine has moved beyond the paternalism that has characterized its past and that practices like this need to be made into history [1].

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[1] Barnes, S. S. (2012). Practicing pelvic examinations by medical students on women under anesthesia: why not ask first? *Obstet Gynecol, 120*(4), 941-943. Tsai, J., June 24, 2019). Medical Students Regularly Practice Pelvic

In the years since I learned of this practice, I have spoken to medical students across the country and have heard the same concerns expressed from coast to coast. The evidence is limited, but the data that does exist suggests that the practice is widespread. Last year in 2019, ELLE magazine polled students from across the United States and found that 61% of students had performed a pelvic examination on a female patient under anesthetic without her explicit consent. Of these students, 49% had never met the patient and 47% of these students felt uncomfortable with how their schools had handled these exams [2]. In 2005, a survey of medical students at the University of Oklahoma found that a large majority of the sample had given pelvic examinations to patients under anesthesia, and that consent had not been obtained in nearly three quarters of the cases [3]. Similarly, a survey from 2003 reported that the majority of medical students at five medical schools in Philadelphia has performed pelvic examinations on patients who were anesthetized before a gynecological surgery and it was unclear how many of them had consented [4]. Research has also shown that educational pelvic examinations under anesthesia have been common in the United Kingdom, Canada, and New Zealand, each of which is taking, or has already taken, measures to ensure that specific consent for these examinations is always obtained [5]. Within the United States, consent has become a legal requirement for educational pelvic examinations in California, Hawaii, Illinois, Oregon, Virginia, Utah, Maryland, and New York. At least 13 more states have bills under consideration [6]. It is time that Wisconsin joins them in putting patient rights first.

II. Non-consensual Exams as Violations of Autonomy, Bodily Rights, and Trust

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Exams On Unconscious Patients. Should They? *ELLE*. Retrieved from https://www.elle.com/life-love/a28125604/nonconsensual-pelvic-exams-teaching-hospitals/

[2] Tsai, J. (2019, June 24, 2019). Medical Students Regularly Practice Pelvic Exams On Unconscious Patients. Should They? *ELLE*. Retrieved from https://www.elle.com/life-love/a28125604/nonconsensual-pelvic-exams-teaching-hospitals/

[3] Schniederjan, S., & Donovan, G. K. (2005). Ethics versus education: pelvic exams on anesthetized women. *J Okla State Med Assoc, 98*(8), 386-388.

[4] Ubel, P. A., Jepson, C., & Silver-Isenstadt, A. (2003). 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, 188*(2), 575.

[5] Coldicott, Y., Pope, C., & Roberts, C. (2003). The ethics of intimate examinations--teaching tomorrow's doctors. (Education and debate). *British Medical Journal, 326*(7380), 97. Gibson, E., & Downie, J. (2012). Consent requirements for pelvic examinations performed for training purposes. *CMAJ : Canadian Medical Association Journal, 184*(10), 1159-1161. Malpas, P. J., Bagg, W., Yielder, J., & Merry, A. F. (2018). Medical students, sensitive examinations and patient consent: a qualitative review. *The New Zealand Medical Journal (Online), 131*(1482), 29-37. General Medical Council. *Intimate examinations and chaperones.* Retrieved from https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/intimate-examinations-and-chaperones/intimate-examinations-and-chaperones Liu, K. E., Dunn, J. S., Robertson, D., Chamberlain, S., Shapiro, J., Akhtar, S. S., . . . Simmonds, A. H. (2010). Pelvic Examinations by Medical Students. *Journal of Obstetrics and Gynaecology Canada, 32*(9), 872-874. Bagg, W., Adams, J., Anderson, L., Malpas, P., Pidgeon, G., Thorn, M., . . . Merry, A. F. (2015). Medical Students and informed consent: A consensus statement prepared by the Faculties of Medical and Health Science of the Universities of Auckland and Otago, Chief Medical Officers of District Health Boards, New Zealand Medical Students' Association and the Medical Council of New Zealand. *N Z Med J, 128*(1414), 27-35.

[6] Wilson, R. F. (2019). Bioethics & Health Law. Retrieved from https://robinfretwellwilson.com/legal-bioethics-health-law

Teaching medical students to perform pelvic examinations on unconscious patients who have not consented constitutes a significant violation of the autonomy, the bodily rights, and the trust of those who are subjected to these examinations [7]. Autonomy refers to one's ability to self-govern, to act in accord with one's values, goals, and desires [8]. This ability is not afforded to those on whom pelvic examinations are performed while they are anesthetized and who have not been given an opportunity to consent. Consent allows patients to exercise their autonomy, to choose what is aligned with their goals and values within their medical care. Crucially, the vast majority of patients do consent to medical students performing pelvic examinations on them when asked [9]. However, 100% wish to be specifically consented for such examinations beforehand [10]. This shows how consent is not merely an instrumental act of gaining permission, but is an intrinsically valuable one, which respects the rationality and values of those being asked [11].

Within medicine, consent also operates as a waiver of one's bodily rights; such waivers displace the usual boundaries around one's body, temporarily and in a limited way. The waiver that is given in a consent form before a surgery permits the surgical team to perform several acts on a body in order to promote the patient's wellbeing, some of which may be unanticipated and risky. In a teaching hospital, the surgical team may include the medical students, although this is not often understood by patients [12]. In the case of pelvic examinations performed at the start of a gynecological surgery, however, medical students are not contributing to the care of the patient, but are merely using her body as an educational tool. This constitutes a clear violation of her bodily rights, rights that are not waived within the consent form.

Finally, this practice violates trust, the foundation of medicine. When seeking care, patients are required to make themselves extremely vulnerable in order to access treatment; they admit to engaging in unhealthy or stigmatized behaviors, remove their clothing, and allow themselves to be poked and prodded, often with little understanding of why [13]. It only physicians who have been given the power and privilege to treat patients who are vulnerable in this way. Such power and privilege combined with such vulnerability creates a strong obligation for doctors to seek trust and be deserving of it [14]. Performing pelvic examinations on unconscious patients without their consent significantly jeopardizes this foundation of trust, as can be demonstrated by the

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[7] Friesen, P. (2018). Educational pelvic exams on anesthetized women: Why consent matters. *Bioethics, 32*(5), 298-307.

[8] Dworkin, G. (1988). *The Theory and Practice of Autonomy* (Vol. 102): Cambridge University Press.

[9] Wainberg, S., Wrigley, H., Fair, J., & Ross, S. (2010). Teaching pelvic examinations under anaesthesia: what do women think? *J Obstet Gynaecol Can, 32*(1), 49-53. Martyn, F., & O'Connor, R. (2009). Written consent for intimate examinations undertaken by medical students in the operating theatre--time for national guidelines? *Irish medical journal, 102*(10), 336-337.

[10] Bibby, J., Boyd, N., Redman, C., & Luesley, D. (1988). Consent for vaginal examination by students on anaesthetized patients. *Lancet, 2*, 115

[11] Dworkin, G. (1988). *The Theory and Practice of Autonomy* (Vol. 102): Cambridge University Press.

[12] Goedken, J. (2005). Pelvic Examinations Under Anesthesia: An Important Teaching Tool. *Journal of Health Care Law and Policy, 8*(2), 232-239.

[13] Rhodes, R. (2001). Understanding the Trusted Doctor and Constructing a Theory of Bioethics. *Theoretical Medicine and Bioethics, 22*(6), 493-504.

[14] Ibid.

shock and outrage of many who have learned about this practice [15]. I have received countless emails and messages from women who are horrified that this is still occurring within medical schools. It is important to consider these responses in light of the prevalence of sexual assault. One in three women in the United States have experienced sexual violence, but this jumps to nearly one in two for American Indian / Alaska Native women or women who are multiracial. One in five women have been raped [16]. Pelvic examinations can be very distressing to those with a history of sexual trauma, even when performed while patients are conscious and have consented [17]. To learn that a sensitive examination has occurred, or may have occurred, while one was unconscious and without consent, can amplify this trauma, leading to significant harm and disengagement from clinical care.

III. Objections to a Legal Consent Requirement

Some argue that a legal requirement for specific consent for educational pelvic examinations under anesthesia will stand in the way of medical education and prevent future clinicians from learning the skills they need. Because the majority of women consent to these examinations when asked, this is very unlikely to be the case. There are also no reports of issues related to student training in those states, and other countries, where consent is legally required.

Others insist that consent to pelvic examinations by medical students is already implied when a patient signs a consent form before a surgery [18]. As has been argued, this is only the case for aspects of the surgery that are part of the clinical care and contribute to the wellbeing of the patient. As these examinations are purely educational, they serve to benefit the medical trainees and not the patient [19]. Furthermore, the consent that is obtained before surgery is a legal one, but often not an informed one [20].

Others argue that the law is not the appropriate tool for changing this practice and that medical professionals should be responsible [21]. However, a long history of medical professionals speaking out about this practice has led to little traction in terms of changing practice. An opinion published in 2001 by the American Medical Association's Council on Ethical and

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[15] See the comments section of: Friesen, P. (2018, October 30, 2018). Why Are Pelvic Exams on Unconscious, Unconsenting Women Still Part of Medical Training? *Slate*. Retrieved from https://slate.com/technology/2018/10/pelvic-exams-unconscious-women-medical-training-consent.html

[16] National Sexual Violence Resource Center. (2020). Statistics. Accessed Jan 28, 2020. Retrieved from https://www.nsvrc.org/node/4737

[17] Larsen, M., Oldeide, C. C., & Malterud, K. (1997). Not so bad after all..., Women's experiences of pelvic examinations. *Family Practice, 14*(2), 148-152.

[18] See interview with William Dignam, head of OB-GYN clerkships at UCLA in: Warren, A. (2003). Using the Unconscious to Train Medical Students Faces Scrutiny. *The Wall Street Journal,* (March 12). Retrieved from http://www.wsj.com/articles/SB104743137253942000

[19] Barnes, S. S. (2012). Practicing pelvic examinations by medical students on women under anesthesia: why not ask first? *Obstet Gynecol, 120*(4), 941-943.

[20] Wilson, R. F. (2005). Autonomy suspended: using female patients to teach intimate exams without their knowledge or consent. *J. Health Care L. & Pol'y, 8*, 240.

[21] Yale University School of Medicine. (2019). *Statement of Yale University School of Medicine Concerning SB 16, An Act Prohibiting an Unauthorized Pelvic Exam on a Woman Who is Under Deep Sedation or Anesthesia.* Retrieved from https://www.cga.ct.gov/2019/PHdata/Tmy/2019SB-00016-R000204-Yale%20University%20School%20of%20Medicine-TMY.PDF

Judicial Affairs, a press release by the Association of American Medical Colleges in 2003, as well as an opinion from the American College of Obstetricians and Gynecologists in 2011, all asserted that explicit consent ought to be obtained for educational pelvic examinations on patients who are anesthetized [22]. Given that the practice is still common, we can conclude that recommendations from professional bodies are not sufficient, and a more effective tool, such as a legal one, is needed.

Others have suggested that the practice itself is trivial and that patients do not need to be consented because, in the eyes of medical professionals, these examinations are not sensitive or sexual at all; they involve parts of the body that are just like any other [23]. This objection is a paternalistic one that has no place in medicine today. It is not the perspective of the clinician that matters, but that of patients, who have the right to decide what they deem sensitive and what happens to their bodies while they are unconscious.

IV. Closing

It is overwhelmingly clear that foregoing consent before educational pelvic examinations leads to moral distress in medical students, violates the autonomy and bodily rights of women, and jeopardizes the foundation of trust on which the health care system rests. Embedding explicit consent requirements into law will not threaten educational goals, as the majority of women will consent to these examinations, and will improve the system of medical education, as students will leave their training with more respect for patient's bodies and knowledge of the importance of informed consent.

Respectfully yours,

Phoebe Friesen
Assistant Professor
Biomedical Ethics Unit
McGill University[24]

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[22] American Medical Association, *Medical Student Involvement in Patient Care: Report of the Council on Ethical and Judicial Affairs.* Virtual Mentor, 2001. **3**(3). Association of American Medical Colleges. (2003). Statement on Patient Rights and Medical Training. *Committee opinion no. 500: Professional responsibilities in obstetric-gynecologic medical education and training.* Obstet Gynecol, 2011. **118**(2 Pt 1): p. 400-4.

[23] Carugno, J. A. (2012). Practicing pelvic examinations by medical students on women under anesthesia: why not ask first? *Obstet Gynecol, 120*(6), 1479-1480.

[24] Academic affiliation is for identification purposes only. I write in my individual capacity and my university takes no position on this or any other bill.

January 28, 2020

BY EMAIL

Senate Committee on Government Operations, Technology, and Consumer Protection

Re: Senate Bill 635 Consent for pelvic examinations by medical students on an anesthetized or unconscious patients

Dear Senators:

I am a physician in Baltimore, Maryland, and co-author of one of the last large-scale studies of consent practices for educational pelvic exams in the United States. In this study, my co-authors and I found that 90% of medical students at five medical schools in the Philadelphia area reported performing pelvic examinations on anesthetized patients for educational purposes during their obstetrics/gynecology rotation.[1] It was unclear whether consent was obtained.

After that work, I went into private practice as a pediatrician. I continue to follow with great interest the work of lawmakers to end the practice of using women for medical teaching without having specifically asked for their permission.

I write today to give some perspective on why you as lawmakers should finally lay to rest that antiquated practice.

1. **All Healthcare Procedures Require Consent.**

Every state requires not just consent, but *informed* consent before any procedure can be done on a patient. We learn in medical school that absent this consent, we can be liable to patients for battery.

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Ubel P, Jepson C, Silver-Isenstadt A. 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. *Am J Obstet Gynecol.* 2003;188:575-579.

We take this obligation seriously as medical professionals because our oath to patients requires that we do no harm. Moreover, we are taught that the right to give consent is based in respect for persons' agency. As Justice Cardozo famously observed in 1914, "[e]very human being of adult years and sound mind has a right to determine what shall be done with his body."

Senate Bill 365 would extend that promise of autonomy and respect to intimate teaching exams with women.

2. **Asking Takes Approximately One Minute.**

I know first-hand how busy physicians are and how many patients we see every day. That fact alone might lead you to want to avoid burdening physicians further. I have had countless conversations wih patients, explaining that we would like to have medical learners involved in their care precisely so we can educate the next generation of providers. I explain that participation in medical education is voluntary, that the students are supervised, and that educating medical students is a powerful service to the next generation of physicians and their patients. This candid disclosure and request for permission takes less than a minute. It empowers the patient and preserves autonomy. It also empowers the student, who now knows that the patient has consented. The student does not feel pressure to ofuscate the true nature of the interaction—the student's own education.

3. **Patients Will Consent, But They Want to be Asked.**

In earlier work I did with Professor Peter Ubel,[2] we showed that patients are altruistic—they want to assist with medical education but prize being asked. We worried that some students "may even deceive patients about their status as medical students" because they have not learned first-hand, from asking permission and receiving it, that patients will in fact consent.

4. **When Attending Physicians Dispense With Asking, We Teach New Physicians That Consent Does Not Matter.**

A significant literature shows that the ethical judgments of aspiring doctors get worse as they progress through their medical education. That is, first and second

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2 See Peter A. Ubel & Ari Silver-Isenstadt, Are Patients Willing to Participate in Medical Education?, 11 J. CLINICAL ETHICS 230, 230 (2000).

year students identify more ethical concerns than in later years of their education. This suggests that their sensibilities harden, likely because the attending physicians are not treating patients with the respect they deserve. Role models matter.

5. **Honesty in Practice Is Essential to Maintaining Trust as a Profession.**

The trust patients place in physicians is sacrosanct. It matters to good outcomes. As patients, we are at our most vulnerable. Ethics and law teaches us that as physicians we have fiduciary duties to patients, precisely because we have a knowledge and experience advantage that most patients lack. The whole system is imbued with duties to respect patients because their trust is so central to the healthcare system working. Without trust, patients will delay treatment.

If we continue to treat a category of patients—anesthetized women—as not deserving of our respect, or if we exempt a category of care as not requiring consent because, after all, no one will know, that trust will collapse on itself like a house of cards.

I know you must weigh many things when deciding to regulate a field. I hope that my perspective as a physician can assist you to see that ensuring that women's autonomy is respected will not tax our profession. Quite the contrary, it will allow us to safeguard the wellbeing of all our patients and the integrety of our profession.

I write in my individual capacity.

Very Truly Yours,[3]

Ari Silver-Isenstadt, MD

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Academic affiliation is for identification purposes only. I write in my individual capacity and my university takes no position on this or any other bill.

UNIVERSITY OF ILLINOIS
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Robin Fretwell Wilson

Associate Dean for Public Engagement
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January 23, 2020

BY EMAIL

Senate Committee on Government Operations, Technology, and Consumer Protection

and

Wisconsin Representative Chris Taylor
Room 306 West
State Capitol
PO Box 8953
Madison, WI 53708
Rep.Taylor@legis.wisconsin.gov

Re: Senate Bill 635 Consent for pelvic examinations by medical students on an anesthetized or unconscious patients

Dear Senators and Representative Taylor:

I write to urge the members of Senate Committee on Government Operations, Technology, and Consumer Protection to support Senate Bill 635, which prohibits intimate pelvic examinations[1] on female patients for medical teaching purposes, *without the patient's consent.* The passage of Senate Bill 635 will ensure that norms of autonomy and respect for all persons are honored and that no one is treated as a means to an end. As I explain below, requiring explicit consent for intimate exams guarantees the dignity and respect that female patients deserve *without* jeopardizing the quality of medical education in Wisconsin.

Part A of this letter applauds this important legislation, the passage of which would place Wisconsin squarely within the growing number of states giving patients the right to decide whether medical students will perform intimate exams on them for the students' learning. Part B addresses the claim that lawmakers should *not* act because unconsented exams simply do *not* occur. If unconsented exams do occur, asking for specific consent gives women the dignity and autonomy all patients deserve—and if teaching exams never occur without consent, Senate Bill 635 still

[1] *See generally* Mayo Clinic, Pelvic Exam, https://www.mayoclinic.org/tests-procedures/pelvic-exam/about/pac-20385135.

reinforces the norm that all patients should be respected in deciding what happens with their bodies.

Part C details the extent of intimate examinations for medical training without the patient's consent. Part D describes legislation in ten states that proscribes unauthorized educational pelvic examinations. The consensus of medical ethics groups is that such intimate exams should not occur without consent. Parts E, F, and G refute common justifications for performing such intimate exams without permission. Specifically, Parts E and F rebut the unfounded justification that women have impliedly or expressly consented upon admission to the hospital. Part G shows empirically, that when asked patients consent to practice exams in overwhelming numbers and consequently, should be enlisted as "respected partners"[2] in medical teaching.

A. Senate Bill 635 Would Provide Crucial Protections

Passage of Senate Bill 635 would place Wisconsin squarely within an emerging legislative trend among states to require healthcare providers to ask permission before using women as tools for teach intimate exams. Virginia, California, Delaware, Hawaii, Illinois, Iowa, Maryland, Oregon, Utah, and most recently New York all require explicit consent for pelvic examinations performed on unconscious patients for teaching purposes.[3]

Like the laws of those states, Senate Bill 635 would require every hospital to "have and enforce a policy that requires written and verbal informed consent to be obtained before a medical student may perform a pelvic examination on a patient who is under general anesthesia or otherwise unconscious" In addition, it would require every hospital to "inform medical students and the physicians supervising" them of the policy and to "take appropriate action to discipline any individual who violates the policy or instructs a medical student to conduct an examination in violation of the policy."[4]

Charging hospitals with oversight in wise: hospitals agree with medical schools to serve as teaching venues and hospitals frequently facilitate the duty by physicians to obtain informed consent to medical procedures.[5] Thus, hospitals can fulfill this role easy with no added cost.

In the AMERICAN BAR ASSOCIATION JOURNAL, the former director of the Center for Bioethics and Medical Humanities at the Medical College of Wisconsin, Robyn Shapiro, said:

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[2] Jennifer Goedken, *Pelvic Examinations Under Anesthesia: An Important Teaching Tool*, 8 J. HEALTH CARE L.& POL'Y 234, 235 (2005).

[3] See *infra* Part C.

[4] Senate Bill 635. *Compare* Cal. Bus. & Prof. Code § 2281 (2010) ("A physician and surgeon or a student undertaking a course of professional instruction or a clinical training program, may not perform a pelvic examination on an anesthetized or unconscious female patient unless the patient gave informed consent to the pelvic examination, or the performance of a pelvic examination is within the scope of care for the surgical procedure or diagnostic examination to be performed on the patient or, in the case of an unconscious patient, the pelvic examination is required for diagnostic purposes").

[5] Alan Meisel, *Canterbury v. Spence: The Inadvertent Landmark Case*, HEALTH LAW AND BIOETHICS: CASES IN CONTEXT (Sandra H. Johnson, Joan H. Krause, Richard S. Saver, & Robin Fretwell Wilson, eds., Aspen Publishers, 2009).

"I would be very surprised to run across a state that didn't have that sort of a law."[6] Wisconsin does not, and, as Representative Taylor has said, "that just needs to end."

B. Answering The "It Does Not Happen Here" Claim

Some medical educators and hospital administrators reflexively assume that unconsented to exams never occur. Later parts of this testimony show that intimate teaching exams without consent have persisted for the two decades I have worked on this question. As Magill University Bioethics Professor Phoebe Friesen explains in companion testimony, medical students widely report being asked to do such exams without the specific consent of the patients.

Against this evidence, some medical educators contend that laws are unnecessary because unconsented exams *never* occur.

Now, it is difficult to prove that unconsented exams occur. Only in the last year have patients come forward after discovering that they have been used for medical teaching without permission, as I show below. That should surprise no one, however. By its very nature, teaching intimate exams while the patient is under anesthesia or unconscious takes patients who are in the worst possible position to know—they are asleep—and asks them to police what is happening to them while being cared for. Patently, asking medical students to act as whistleblowers to end this practice is unrealistic and unfair—teaching faculty have considerable control over students' futures.

Given the fast pace of medical education and teaching on the wards, hospital administrators may simply be unaware if teaching faculty forget to ask for specific permission, whether advertently or not. Further, given the rise of community teaching hospitals, it is difficult for medical schools and their principal teaching hospitals to know whether their rigorous consent practices are adhered to at smaller, far-flung hospitals where medical teaching occurs.[7] Hence the need for strong policies and norms that Senate Bill 635 would instill.

Indeed, Senate Bill 635 builds on the leadership already shown by the University of Wisconsin School of Medicine and Public Health, which adopted a policy in 2019 governing "educational sensitive exams," including breast, pelvic, urogenital, prostate and rectal exams on patients under anesthesia or otherwise sedated.[8]

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[6] Lorelei Laird, *Pelvic exams performed without patients' permission spur new legislation,* AMER. BAR. ASSN. J. (Sept. 1, 2019), http://www.abajournal.com/magazine/article/examined-while-unconscious.

[7] 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 (2005).

[8] David Wahlberg, *Bill seeks informed consent for pelvic exams under anesthesia by medical students*, WISCONSIN STATE JOURNAL (Jan 7, 2020).

More fundamentally, Senate Bill 635 is valuable and should be enacted, *whether or not* strong evidence shows that unconsented exams are occurring. If unconsented exams do occur, asking for specific consent gives women the dignity and autonomy all patients deserve. And if such exams never occur without consent, Senate Bill 635 will serve to reinforce the norm that all patients should be respected in deciding what happens with their bodies.

Senate Bill 635 is a no-harm-no-foul proposition, even as to facilities that have already instituted policies that respect patient autonomy.

C. The Extent of the Practice

Despite widespread ethical condemnation recognizing that "the practice of performing pelvic examinations on women under anesthesia, without their knowledge and approval [is] unethical and unacceptable,"[9] experience shows that unauthorized exams continue across the U.S. I wrote recently about a woman in Arizona who discovered she was subjected to an unauthorized pelvic exam after *stomach*, not gynecological surgery.[10] In testimony to the Utah Senate Health and Human Services Committee, another patient, Ms. Ashley Weitz, testified that she had been subjected to an unauthorized pelvic exam while sedated in the emergency room.[11] Medical students from Duke and other institutions say that they have been asked to do exams without consent.[12]

Empirical studies document the persistent nature of unauthorized pelvic examinations. A 2005 survey of medical students at the University of Oklahoma found that a large majority had performed educational pelvic examinations on patients under anesthesia—in nearly three of four instances, consent was not obtained.[13] In 2003, Peter Ubel and Ari Silver-Isenstadt reported that 90% of medical students at five Philadelphia-area medical schools performed pelvic examinations on anesthetized patients for educational purposes during their obstetrics/gynecology rotation.[14] In 1992, Charles Beckmann reported that 37.3% of United States and Canadian medical schools

[9] Am. Ass'n of Med. Colls., AAMC Statement on Patient Rights and Medical Training (June 12, 2003).

[10] Robin Fretwell Wilson & Anthony Michael Kreis, *#JustAsk: Stop Treating Unconscious Female Patients Like Cadavers*, CHI. TRIB. (Nov. 30, 2018), https://www.chicagotribune.com/news/opinion/commentary/ct-perspec-pelvic-nonconsensual-exam-medical-students-vagina-medical-1203-story.html.

[11] Lorelei Laird, *Pelvic exams performed without patients' permission spur new legislation*, AMER. BAR. ASSN. J. (Sept. 1, 2019), http://www.abajournal.com/magazine/article/examined-while-unconscious.

[12] Associated Press, Bills seek special consent for pelvic exams under anesthesia (May 12, 2019), https://www.savannahnow.com/zz/news/20190512/bills-seek-special-consent-for-pelvic-exams-under-anesthesia/1.

[13] S. Schniederjan G.K. Donovan, *Ethics versus education: pelvic exams on anesthetized women*, 98(8) *J Okla State Med Assoc* 386 (2005).

[14] 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*, 635635 AM. J. OBSTETRICS & GYNECOLOGY 575, 579 (2003).

reported using anesthetized patients to teach pelvic exams.[15] A study from the United Kingdom found that 53% of students at a single English medical school performed approximately 700 intimate examinations on anesthetized patients.[16] Students acted without any written or oral consent in 24% of the exams.[17]

D. The Legislative and Professional Response

In response to this widespread use of patients, ten U.S. states by legislation now require explicit consent for pelvic examinations on unconscious patients for medical teaching purposes.[18]

This legislation reflects the consensus of American professional medical organizations that healthcare providers should obtain explicit for intimate teaching exams.[19] In the "Statement on

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[15] Charles R. B. Beckmann et al., *Gynaecological Teaching Associates in the 1990s*, 26 MED. EDUC. 105, 106 (1992).

[16] Yvette Coldicott et al., *The Ethics of Intimate Examinations -- Teaching Tomorrow's Doctors*, 326 BRIT. MED. J. 97, 98 tbl. 2 (2003).n

[17] *Id.* at 98.

[18] *See* Va. Code Ann. § 54.1-2959 (2010) ("Students participating in a course of professional instruction or clinical training program shall not perform a pelvic examination on an anesthetized or unconscious female patient unless the patient or her authorized agent gives informed consent to such examination, the performance of such examination is within the scope of care ordered for the patient, or in the case of a patient incapable of giving informed consent, the examination is necessary for diagnosis or treatment of such patient"); 410 ILCS 50/7 (2010) ("Any physician, medical student, resident, advanced practice nurse, registered nurse, or physician assistant who provides treatment or care to a patient shall inform the patient of his or her profession upon providing the treatment or care, which includes but is not limited to any physical examination, such as a pelvic examination. In the case of an unconscious patient, any care or treatment must be related to the patient's illness, condition, or disease"); Cal Bus & Prof Code § 2281 (2010) ("A physician and surgeon or a student undertaking a course of professional instruction or a clinical training program, may not perform a pelvic examination on an anesthetized or unconscious female patient unless the patient gave informed consent to the pelvic examination, or the performance of a pelvic examination is within the scope of care for the surgical procedure or diagnostic examination to be performed on the patient or, in the case of an unconscious patient, the pelvic examination is required for diagnostic purposes"); Oregon Rev. Stat. § 676.360 ("(1) A person may not knowingly perform a pelvic examination on a woman who is anesthetized or unconscious in a hospital or medical clinic unless: (a) The woman or a person authorized to make health care decisions for the woman has given specific informed consent to the examination; (b) The examination is necessary for diagnostic or treatment purposes; or (c) A court orders the performance of the examination for the collection of evidence (2) A person who violates subsection (1) of this section is subject to discipline by any licensing board that licenses the person"); Haw. Rev. Stat. § 453-18 ("A physician, osteopathic physician, surgeon, or student participating in a course of instruction, residency program, or clinical training program shall not perform a pelvic examination on an anesthetized or unconscious female patient unless: (1) The patient gives prior verbal or written informed consent to the pelvic examination; (2) The performance of a pelvic examination is within the scope of care for the surgical procedure or diagnostic examination scheduled to be performed on the patient; or (3) The patient is unconscious and the pelvic examination is required for diagnostic purposes.").

More recently, in 2019, Utah, Maryland, Delaware and New York have enacted laws requiring specific consent. *See* NY CLS Pub Health § 230-a; 2019 Utah S.B. 188; 2019 Maryland H.B. 364; Delaware H.B. 239.

[19] *See, e.g.*, Am. Ass'n of Med. Colls., AAMC Statement on Patient Rights and Medical Training (June 12, 2003); American College of Obstetricians and Gynecologists Committee on Ethics, Professional Responsibilities in Obstetric-Gynecologic Medical Education and Training, Ruling No. 500 (August 2011), http://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Ethics/co500.ashx?dmc=1&ts=20120

Patient Rights and Medical Training" in 2003, the American Association of Medical Colleges, which represents 125 accredited U.S. medical schools and over 400 teaching hospitals, described "pelvic examinations on women under anesthesia, without their knowledge and approval ... [as] unethical and unacceptable."[20]

In an August 2011 Committee on Ethics ruling, the American College of Obstetricians and Gynecologists affirmed that "[r]espect for patient autonomy requires patients be allowed to choose to not be cared for or treated by [medical student] learners when this is feasible."[21] The Ethics Committee ruling applied this ethical tenant to pelvic examinations specifically: "Pelvic examinations on an anesthetized woman that offer her no personal benefit and should be performed only with her specific informed consent before surgery."[22] In the January 2019 AMA Forum, Professor of Medical Science Eli Y. Adashi at Brown University's Warren Alpert Medical School called unconsented exams "a lingering stain on the history of medical education," and concluded:

> 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.[23]

As the next Parts of this letter demonstrate, however, some teaching faculty offer a number of justifications for dispensing with the simple step of asking for permission[24] — justifications that simply do not withstand scrutiny.

D. Patients Have Not Implicitly Consented to Intimate Educational Exams.

The first justification that teaching faculty advance for not obtaining specific consent for educational pelvic exams is that patients have implicitly consented by accepting care at a teaching

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112T1021153539; Joint Statement of The Association of Academic Professionals in Obstetrics and Gynaecology of Canada and Society of Obstetricians and Gynaecologists of Canada, No. 246 (Sept. 2010) ("[P]atient autonomy should be respected in all clinical and educational interactions. When a medical student is involved in patient care, patients should be told what the student's roles will be, and patients must provide consent. Patient participation in any aspect of medical education should be voluntary and non-discriminatory").

[20] Am. Ass'n of Med. Colls., AAMC Statement on Patient Rights and Medical Training (June 12, 2003).

[21] American College of Obstetricians and Gynecologists Committee on Ethics, Professional Responsibilities in Obstetric-Gynecologic Medical Education and Training, Ruling No. 500 (August 2011), http://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Ethics/co500.ashx?dmc=1&ts=20120112T1021153539.

[22] *Id.*

[23] Eli Y. Adashi, *Teaching Pelvic Examination Under Anesthesia Without Patient Consent*, JAMA FORUM (Jan. 16, 2019), https://newsatjama.jama.com/2019/01/16/jama-forum-teaching-pelvic-examination-under-anesthesia-without-patient-consent/.

[24] Robin Fretwell Wilson, *Unauthorized Practice: Regulating the Use of Anesthetized Recently Deceased, and Conscious Patients in Medical Training*, 44 IDAHO L.REV. 423, 427 (2008) (presenting comments by faculty at George Washington University Hospital, UCLA Medical Center, and the Medical University of South Carolina).

hospital. Empirical evidence suggests that many patients do not consciously chose teaching facilities or even know they are in one.

One study, for example, found that 60% of patients at a teaching hospital in Great Britain were unaware that they were at a teaching hospital until they encountered students for the first time.[25] Indeed in the U.S., an overwhelming number of facilities in the United States give little indication to prospective patients of the hospital's teaching status.[26] Public disclosure of hospitals' teaching status varies drastically. Some hospitals, like Duke University Medical Center[27] and New York-Presbyterian —The University Hospital of Columbia and Cornell,[28] indicate their medical school affiliation in their name. These two examples are exceptions to the rule, however. Of the approximately 400 members of the Council of Teaching Hospitals and Health Systems, only 94 —less than 25%—contain the word "college" or "university" in their name.[29]

The University of Wisconsin School of Medicine and Public Health partners with multiple healthcare facilities, including Marshfield Medical Center in Marshfield, Aurora BayCare Medical Center in Green Bay, Meriter Hospital and St. Mary's Hospital in Madison, and Milwaukee Academic Campus of Aurora Healthcare in Milwaukee.[30] Many of these institutions' names do not suggest any affiliation with the UW School of Medicine and Public Health or otherwise tip patients off to their status as a teaching hospital.

While a hospital's name or website may not relay its teaching mission to patients, physical proximity to a medical school can, arguably, give patients constructive notice of a hospital's teaching status. It is reasonable to assume that a patient at New York-Presbyterian, located less than sixty feet from the Columbia Medical University College of Physicians & Surgeons, knows the facility is a teaching hospital.[31] But, patients at the 50 different facilities associated with

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[25] D. King et al., *Attitudes of Elderly Patients to Medical Students*, 26 MED. EDUC. 360 (1992) (reporting on results of survey, prior to discharge, of patients whose average age was 80 years old).

[26] Wilson, *supra* n. 17, at 432.

[27] *See, e.g.,* Duke University Medical Center website, at http://www.dukehealth.org. See also The University Hospital, University of Medicine & Dentistry of New Jersey website, at http://www.uhnj.org/; Johns Hopkins Hospital & Health System website, at http://www.hopkinsmedicine.org.

[28] New York-Presbyterian, The University Hospital of Columbia and Cornell is the primary teaching hospital of Columbia University College of Physicians & Surgeons and the Weill Medical College of Cornell University. See NewYork-Presbyterian, The University Hospital of Columbia and Cornell website at http://www.nyp.org https://members.aamc.org/eweb/DynamicPage.aspx?site=AAMC&webcode=AAMCOrgSearchResult&orgtype=Hospital/Health%20System. This full title appears on the exterior building and on all hospital publications. Personal communication with Cathy Thompson, Office of Public Affairs & Media, Columbia-Presbyterian Medical Center. (Oct. 29, 2003) (on file with Robin Fretwell Wilson).

[29] AAMC Hospital/Health System Members, Council of Teaching Hospitals and Health Systems, https://members.aamc.org/eweb/DynamicPage.aspx?site=AAMC&webcode=AAMCOrgSearchResult&orgtype=Hospital/Health%20System.

[30] https://www.med.wisc.edu/.

[31] Google Maps gives the distance from Columbia's location at 630 W. 168th Street to New York Presbyterian's location at 622 W. 168th Street as less than 0.01 miles, maps.google.com.

Columbia's medical school located throughout New York, New Jersey, and Connecticut,[32] cannot possibly be on constructive notice.

The same is true in Wisconsin. Consider the Wisconsin Academy of Rural Medicine (WARM) program, a far-flung network of rural facilities that act as a "clinical campus for the University of Wisconsin School of Medicine and Public Health, providing third and fourth-year UW-Madison medical students in clerkship rotations in Eau Claire, Marshfield, Minocqua, Rice Lake, and Wausau."[33]

E. Patients Have Not Expressly Consented to Intimate Educational Exams

Many teaching faculty assert that the patient has consented upon admission to a teaching facility.[34] This claim takes two forms: In the stronger form, teaching faculty assert that the student's pelvic exam is an ordinary component of the surgery to which the patient has consented.[35] A variant on this claim holds that if consent was obtained for one procedure, it encompasses consent for additional, related procedures.[36]

This is just not so as a matter of contract interpretation. In a typical consent form, patients will:

> [A]gree and give consent to [teaching hospital], its employees, agents, the treating physician ... medical residents and Housestaff to diagnose and treat the patient named on this consent to any and all treatment which includes, but might not be limited to ... examinations and other procedures related to the routine diagnosis and treatment of the patient.[37]

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[32] NEW YORK PRESBYTERIAN HEALTH SYS. (noting that "In collaboration with two renowned medical schools, Weill Cornell Medicine and Columbia University College of Physicians and Surgeons, NewYork-Presbyterian is consistently recognized as a leader in medical education, groundbreaking research, and innovative, patient-centered clinical care."), at https://www.nyp.org/about-us.

[33] UW, MARSHFIELD CLINIC HEALTH SYSTEM RECOGNIZE EDUCATION PARTNERSHIP WITH NAME CHANGE, https://www.marshfieldclinic.org/news/news-articles/uw-name-change.

[34] AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS (ACOG), COMM. OPINION 181: ETHICAL ISSUES IN OBSTETRIC-GYNECOLOGICAL EDUCATION 2 (1997).

[35] Liv Osby, *MUSC May Change Pelvic Exam Practice*, GREENVILLE NEWS (S.C.), Mar. 13, 2003 (quoting the OB/GYN clerkship director at the Medical University of South Carolina, who indicated that "no specific permission" is sought for educational pelvic exams and acknowledged, "maybe this is something we need to revisit").

[36] *See e.g.*, Michael Ardagh, *May We Practise Endotracheal Intubation on the Newly Dead?*, 23 J. MED. ETHICS 289, 292 (1997) (making this observation with respect to practicing resuscitation procedures on the recently deceased); A.D. Goldblatt, *Don't Ask, Don't Tell: Practicing Minimally Invasive Resuscitation Techniques on the Newly Dead*, 25 ANNALS EMERGENCY MED. 86, 87 (1995) (analogizing to "construed consent," which authorizes related tests or diagnostic procedures).

[37] Palmetto Health Richland, *About Prisma Health*, https://www.palmettohealth.org/patients-guests/about-prisma-health.

The typical admission form authorizes care for the patient's benefit, not for student educational purposes.

This authorization should encompass only the treatment that a patient would reasonably expect to receive when checking into a health care facility— treatment that provides the patient with a direct benefit to herself.

F. Exaggerated Fears of Widespread Refusal

Some members of the medical education community argue that performing educational exams without specific consent is necessary. Their argument is essentially that "we can't ask you, because if we ask you, you won't consent."

These fears are wholly misplaced. Study after study has shown that women will consent to pelvic examinations for educational purposes. These include not only "hypothetical" studies—studies asking patients how they would respond if asked to do a variety of things—but also studies of actual women giving actual consent to real exams.

A 2010 Canadian study found that 62% of women surveyed said they would consent to medical students doing pelvic examinations, 5% would consent for female students only, and only 14% would refuse.[38] A study in the United Kingdom found that 46% of women in outpatient care did not object to having students perform pelvic exams on them.[39] In a private practice setting, another study found refusal rates of approximately 5% to perform educational pelvic exams.[40] In yet another study, 61% of outpatients reported that they would definitely allow, probably allow, or were unsure whether they would allow a pelvic examination.[41]

Even more women consent to examinations before surgery. In one study in the United Kingdom, 85% of patients awaiting surgery consented to educational exams by students while the patient was under anesthesia.[42] These studies involved *actual patients* giving *actual consent* to *real exams* by *real students*. Responding to hypothetical questions, more than half of the patients surveyed in another study (53%) would consent or were unsure if they would consent to pelvic exams, if asked prior to surgery.[43]

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[38] S. Wainberg et al., *Teaching pelvic examinations under anaesthesia: what do women think?*, 32 J OBSTET. GYNAECOL CAN 49 (2010).

[39] J. Bibby et al., *Consent for Vaginal Examination by Students on Anaesthetised Patients*, 2 LANCET 1150, 1150 (1988). Lawton et al., *Patient Consent for Gynaecological Examination*, 44 BRIT. J. HOSP. MED. 326, 326 (1990) (discussing study by J. Bibby et al).

[40] Lawton, *supra* n. 38, at 329.

[41] Peter A. Ubel & Ari Silver-Isenstadt, Are Patients Willing to Participate in Medical Education?, 11 J. CLINICAL ETHICS 230, 232-33 (2000)

[42] Lawton, *supra* n. 38, at 329.

[43] Ubel & Silver-Isenstadt, *supra* note 40, at 234.

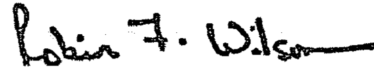
G. Conclusion

Without adequate safeguards to protect the autonomy of women to consent to medical teaching, many will be reduced into acting as "medical practice dummies" without their permission. You should simply not allow such disrespectful treatment of patients who would gladly consent if only asked.

Representative Taylor is right that not asking for permission to perform intimate teaching exams on women is a vestige of the past. Senate Bill 635 would bring Wisconsin into line with other states that give women the autonomy to decide to participate in medical teaching; it would build on the University of Wisconsin School of Medicine and Public Health's sensible example and leadership; and it would affirm the dignity of persons at a time of great vulnerability, building trust in the healthcare system.

I welcome any opportunity to provide further information, analysis, or testimony to the Wisconsin State Legislature.

Respectfully Yours,[44]



Robin Fretwell Wilson
Associate Dean for Public Engagement
and Roger and Stephany Joslin Professor of Law
Director, Epstein Health Law and Policy Program

[44] Academic affiliation is for identification purposes only. I write in my individual capacity and my university takes no position on this or any other bill.

Schmidt, Melissa

From:	Collins, Megan <MCollins@publichealthmdc.com>
Sent:	Wednesday, January 29, 2020 1:42 PM
To:	Sen.Stroebel; Sen.Kapenga; Sen.Craig; Sen.Wirch; Sen.Smith; Rep.Taylor; 'Sen.Schactner@legis.wisconsin.gov'; Schmidt, Melissa; 'Sen.Jacques@legis.wisconsin.gov'; Sen.Taylor
Subject:	Please vote YES on Senate Bill 635

To the Senate Committee on Government Operations, Technology, and Consumer Protection:

I urge you to vote YES on SB 635, the bill that would require explicit, written consent in order for a medical student to perform a pelvic exam on an anesthetized woman in Wisconsin.

My name is Meg Collins. I am a public health nurse, and I am a TA who teaches the GYN exam to medical students at the University of Wisconsin Madison.

I need you to vote YES on Senate Bill 635.

I take great pride in teaching future NP, PA and MD students at our great institution. My job is to teach the exam so that it is safe, professional, and trauma-informed for clinician and patient alike. I cannot and I will not in good faith, continue to teach future medical professionals who will be coerced into performing unethical pelvic exams on non-consenting patients. I need your YES vote today so that I can continue teaching what is known to be the 'gold standard' of learning the pelvic exam in medicine – with a professional teacher/pelvic model like myself.

I am also a clinician. I do no harm. I practice at the top of my scope of practice with plenty of ethical review and peer review. I take pride in enacting robust informed consent with decisional patients prior to each and every interview/procedure. I believe in my medical colleagues, I believe they want to do the same. Do not denature the Hippocratic Oath by undermining it when you allow the equivalent of medical sexual assault. Do not lay my medical colleagues open to the harm that authority can do when it requires a vulnerable, learning professional to perform what is clearly unethical.

Vote yes on SB 635 today and support good health care practice. It is not difficult to obtain medical consent prior to surgical procedure in the pre-op phase, and all of us working in health and medicine know that.

Vote yes on SB 635 and protect consumers and professionals alike.

Thank you,

Meg Collins