# JOY GOEBEN

STATE REPRESENTATIVE • 5th ASSEMBLY DISTRICT




These statistics demonstrate a clear gap in patient protection. While many hospitals and medical schools have implemented consent policies, this legislation ensures consistency and accountability statewide.

Some have raised concerns about whether requiring explicit consent might hinder medical training. However, research shows that most patients agree to participate in educational pelvic exams when asked directly. Rather than hindering education, this bill reinforces ethical training standards that will benefit future physicians.

Additionally, clear consent policies protect medical students by ensuring they are never put in a position where they are expected to perform an exam without patient knowledge. No student should face the moral dilemma of whether consent was obtained.

The purpose of AB 11 is simple: no patient should be subjected to an intimate medical exam without their informed, written consent. This bill aligns Wisconsin with national best practices, reinforces ethical medical education, and strengthens patient rights in a way that benefits everyone—patients, medical providers, and students alike.

I urge the Committee to support and advance this bill to ensure every Wisconsin patient is treated with the respect, dignity, and autonomy they deserve.

Thank you for your consideration of Assembly Bill 11.


Post Office Box 8952 • Madison, WI 53708-8952 • +1 (608) 237-9105
Rep.Goeben@legis.wisconsin.gov

# JOY GOEBEN

STATE REPRESENTATIVE • 5th ASSEMBLY DISTRICT


**Testimony before the Assembly Committee on Health, Aging and Long-Term Care**

Representative Goeben
February 12th, 2025

Thank you for the opportunity to testify on Assembly Bill 11, the Patient Privacy Protection Act. This bill ensures that patients maintain control over their bodies by requiring written informed consent before a pelvic exam is conducted for educational purposes while they are under anesthesia or unconscious.

The doctor-patient professional relationship is built on trust, which begins with consent. When patients undergo a medical procedure, they should have complete knowledge and control over what happens to them. However, there have been longstanding concerns that some educational pelvic exams are performed on anesthetized patients without their explicit consent.

This bill is about respect, dignity, and ethical medical practice. It does not prohibit educational training—instead, it ensures that patients are informed and choose whether to participate in such training. Wisconsin would join at least 20 other states in implementing similar protections.

AB 11 builds upon AB 125 from the previous legislative session, refining its approach based on stakeholder input and best practices. The main differences include:

1. Written Consent Requirement Only—AB 125 initially required verbal and written consent, but Assembly Substitute Amendment 1 adjusted this to written consent only for clarity and enforceability. AB 11 carries this forward to maintain a transparent, documented process.
2. Focus on Hospital Policies—AB 125 included broad language about enforcement and education for hospital staff. AB 11 streamlines this by requiring clear policies that mandate consent before an educational pelvic exam. AB 11 has a new technical amendment, and the Legislative Counsel can provide any further explanations.

Studies and personal testimonies have highlighted the ongoing concerns with pelvic exams performed without patient knowledge or consent. In one national study:

- Over 80% of medical students at major training hospitals reported performing pelvic exams on anesthetized patients.
- Only 17% said patients were always informed, while nearly half reported that patients were rarely or never explicitly told.


Post Office Box 8952 • Madison, WI 53708-8952 • +1 (608) 237-9105
Rep.Goeben@legis.wisconsin.gov

ANDRÉ JACQUE
STATE SENATOR • 1ST SENATE DISTRICT

Phone: (608) 266-3512
Fax: (608) 282-3541
Sen.Jacque@legis.wi.gov

State Capitol · P.O. Box 7882
Madison, WI 53707-7882

# *Testimony before the Assembly Committee on Health, Aging and Long-Term Care*

*Senator André Jacque*

*February 12, 2025*

Mr. Chairman and Members, thank you for the opportunity to testify as the author of Assembly Bill 11, the *Patient Privacy Protection Act*, which would require informed consent before performing a pelvic exam on a patient who is under general anesthesia or 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, has often failed to obtain the specific, informed consent of the sedated patient.

Unfortunately and shockingly, this practice continues at some hospitals, as detailed in scholarly articles, professional surveys and lived experiences 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.

Studies document the persistent nature of unauthorized pelvic examinations. A 2020 survey accepted to the 2021 Council on Resident Education in Obstetrics and Gynecology & The American College of Obstetricians and Gynecologists Annual Meeting reported that 83.6% of the medical students surveyed across five medical schools attached to large academic medical centers performed a pelvic exam on a patient under anesthesia. When asked how often patients were explicitly told that an educational pelvic examination would take place under anesthesia, only 17% of surveyed students replied "every time." Notably, 22.3% replied "rarely" and 20.3% replied "never."

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.

Under Assembly Bill 11, hospitals must ensure written informed consent is obtained from a patient before a pelvic exam is performed on the patient solely for educational purposes while

the patient is under general anesthesia or otherwise unconscious. The legislation also requires that a hospital must maintain written policies and procedures requiring written informed consent to be obtained from a patient before a pelvic exam is performed on the patient solely for educational purposes while the patient is under general anesthesia or otherwise unconscious.

This legislation passed the State Senate on a voice vote and passed the Senate and Assembly Health committees unanimously last session as 2023 SB 127/AB 125, when it had strong bi-partisan co-sponsorship by more than 30 legislators and the formal support of the Wisconsin Coalition Against Sexual Assault, Wisconsin Family Action, End Domestic Abuse Wisconsin among others, with no known opposition.

Wisconsin should join the list of 28 states that already require explicit consent for pelvic examinations on unconscious patients for medical teaching purposes. Female patients deserve to have their bodily integrity respected when they are unconscious and vulnerable during a medical procedure. Foregoing consent before educational intimate examinations leads to moral distress in medical students, and embedding explicit consent requirements into law will not threaten educational goals, as the majority of patients 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.

Thank you for your consideration of Assembly Bill 11. I'd be happy to answer any questions.

**Testimony in support of Assembly Bill 11**
**Sarah Wright**
**2.12.25**

Dear Rep. Moses and Members of the Committee on Health, Aging, and Long-Term Care:

I intend to deliver oral remarks at the hearing. Two of my previous *four* testimonies follow. I am not going anywhere until we get this across the finish line.

My first trauma was when people I entrusted with my care penetrated my vagina without my knowledge or permission.

My second trauma was that when I approached people in positions of power in our medical system, hoping to prevent this from happening to others, they treated me as an enemy. I approached legislators when no one else would listen, which was the origin of this bill.

I know that many of you are supporters of this bill, and it is my hope that all of you will become so. This is about basic human dignity and decency, and the power of legislators to make a difference in people's lives.

Thank you to Sen. Andre Jacque for keeping this bill alive since it was first written by my former Rep., Chris Taylor. Thank you to the many co-authors and co-sponsors who have supported this pivotal legislation. I urge you to pass this bill without delay.

Sincerely,

Sarah Wright
(resident of Fitchburg, Dane County)
sdwright79@gmail.com
608.509.5936

Testimony in support of Assembly Bill 128
Sarah Wright
7.29.21

Chairman Sanfelippo and Members of the Health Committee:

My name is Sarah Wright, and I am proud to say that it is partly because of me that this bill exists and we are here today. I am here because my bodily autonomy was violated during surgery, and I am determined to prevent others from suffering as I have. I am thankful to my former Representative, Chris Taylor, for listening to me and taking action when I told her my story. She helped to craft the original version of the pelvic exam bill. I am grateful to Representative Janel Brandtjen and Senator Andre Jacque, who sat next to me as I testified for the first time in 2020 and struggled to get through my story, and to Rep. Rachael Cabral-Guevara for joining them to revive this bill. And I thank Rep. Sanfelippo and the members of the Committee on Health for hosting this hearing.

**This testimony could be extremely short. It could go something like this:**
*People put their fingers in the vaginas of unconscious women without their knowledge or permission. This happens in hospital operating rooms. We do not know how often this happens. The consent forms that patients are required to sign are written to be intentionally vague and cover a broad range of procedures.*

**I predict that people hearing this would be thinking two things:**
1. If that truly does happen, that is reprehensible and should be stopped immediately. It only takes common sense and basic human decency to understand that penetrating the vagina of an unconscious woman without her consent is wrong.
2. This sounds so outrageous that this can't *really* happen, right? And you might need to hear more evidence. And that is why we are here, except that I wish we could just stop at point #1.

When I was here in 2020 to testify, I felt a need to summarize all the research and previous efforts to stop this practice, as though my testimony might be the only one. Today, I prefer to spend the rest of my time giving you a more personal perspective on the importance of this bill. I will also offer counterarguments to what you will hear from opponents of this bill. But I urge you to read the testimony submitted by the legal

scholar, Robin Fretwell Wilson, who has worked on this issue for decades; bioethicist, Dr. Phoebe Friesen, who has extensively documented the occurrence of educational pelvic exams without clear consent; and Dr. Ari Silver-Isenstadt, who took a leave from medical school to study bioethics after refusing to conduct pelvic exams on anesthetized women. Dr. Silver-Isenstadt is a huge inspiration. I repeat: he actually left medical school rather than be coerced into learning how to perform a pelvic exam without clear consent. This was a lonely and courageous position, and shows that this is an issue that affects and must be solved by both men and women.

In late 2018, I was preparing myself to undergo surgery to remove a potentially cancerous ovary. It was stressful, to say the least, to face the possibility of a serious illness while attending to my everyday life as a teacher and a mom. But what made the situation even worse was that I had had a traumatic experience with a similar surgery in 2009.

Certainly, it is hard to prove definitively what happened to me; after all, I was unconscious! But I entered that operating room as a healthy woman whose medical history included nothing more exciting than a wisdom tooth removal. When I emerged, I was nauseous for days, had trouble urinating, and was covered with purple bruises along my left torso from my ribcage to my hips. The worst of the injuries also took the longest to heal: an extreme sensitivity of the vulva, the tissue surrounding the entrance to the vagina. I was dumbfounded. **The surgeon had accessed my ovaries through incisions in my abdomen. *No one had given me any indication prior to the surgery that my vagina would be involved in any way.* What on earth had happened to me when I was on that operating table?**

My post-op appointment yielded no answers; the surgeon seemed to take it as a personal affront that I had a difficult recovery in any way. I obtained my medical records, but the sparse, 2-page document didn't provide any useful information either. They simply stated, "the vagina was prepped properly." Nothing in the pink pamphlet I was given about pelvic surgery stated anything about the vagina at all. Reading WebMD and MayoClinic.org did not specify anything either. The only way I had any idea what may have happened to me to result in the vulvar pain was that I am lucky to have a close relative who has worked in operating rooms for decades at multiple hospitals, often assisting during pelvic surgeries. She told me that an instrument called a uterine manipulator, which penetrates the vagina, is commonly used in order to position the uterus and hold it in place during surgery. She inferred that this device may have caused my vulvar pain, since it remains in place throughout surgery, although I most likely was subjected to pelvic exams for educational purposes as well.

By the way… 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.

When I needed surgery again in 2018, I was determined to be fully informed. Surely, I thought, things have changed since 2009. I approached hospital and medical school officials to inquire about their policies regarding informed consent for pelvic exams under anesthesia, as well as uterine manipulators. I even drew up my own "informed consent contract" that I intended to share with my surgeon, and sent it to hospital officials with the suggestion that something like it could be used for all pelvic surgeries. That afternoon, I had a voicemail from the Patient Relations office asking me to call about my document.

At least I had drawn enough attention to get a call from the *head* of Patient Relations! In the course of our conversation, that Patient Relations head made many of the same arguments that are laid out in the joint statement from the medical lobbyists that was submitted against the bill in 2020 (although the lobbyists were notably absent from the hearing). She told me that if having the opportunity to withhold consent for an educational pelvic exam was "a dealbreaker," I should have my surgery at a private, all-female clinic (as if only women are capable of performing surgeries ethically). Here are arguments she and the lobbyists made against strengthening informed consent, and my counterarguments:

Opponents' argument #1. ***Not everyone wants to know what exactly will happen to them when they undergo a procedure.***
To this I say, it is the responsibility of the medical system to ensure that complete information is provided to all patients. Then, it is the choice of the patient what to do with that information. But attempting to hide behind the supposed squeamishness of some fraction of hypothetical patients is a poor excuse for failing to obtain fully informed consent. Moreover, as I said to the PR person, we are not talking about someone's cornea or hand or liver; we are talking about sexual organs. Touching them without first informing the patient is an especially heinous violation. When I pressed her, "can you

imagine anyone NOT wanting to know that their vagina is going to be penetrated?", she conceded, "well, as a woman, I would want to know."

(By the way, this is not simply a "woman's issue." The same problem applies to rectal exams performed on unconscious patients undergoing colonoscopies, for example, as reflected in medical schools' updated policies on sensitive exams.)

Opponents' argument #2. ***We cannot possibly have a separate informed consent document for every procedure.*** 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 to fail to do so leaves open the possibility that women's bodies could be violated like I was. And as Dr. Silver-Isenstadt points out, it is NOT difficult or time-consuming to obtain true consent, if one really values it.

Opponents' argument #3. ***If a patient feels that their rights were violated or their informed consent was not obtained, they have recourse through the Department of Justice.***
First of all, patients are often unaware that this option exists. I did not learn of it until years after my surgery, when it was far too late for me to submit a complaint. Furthermore, in the aftermath of a traumatic incident, it is understandable for someone to simply want to try to forget about it and move on, or feel too emotionally fragile to pursue a complaint. The way that I was treated by the surgeon who failed me, who was only defensive and dismissive, definitely discouraged me from pursuing any recourse.

Opponents' argument #4. ***It is not the place of the legislative system to interfere in the patient-provider relationship.***
First of all, it IS the place of the legislative system to intervene when private or public entities fail to do their job, or cause harm to others. Ideally, hospitals would successfully regulate themselves. But this is not the case. Frankly, we may not be here if the officials I contacted had treated me as a patient in need of care, rather than an enemy to be avoided and discredited. If they had answered my questions about their informed consent policies, if they had conducted an investigation of my surgery like they promised, if they had truly listened to me and given an answer other than "have your surgery somewhere else," I would not have felt the need to approach my legislator in

the first place. The medical school I contacted only updated their sensitive exams policy after Chris Taylor applied pressure on them to do so.

I can only speak to my own experience in having two surgeries, but in both instances, I was simply assigned the first available surgeon at a clinic covered by my insurance. It's not as if there was some personal connection from which to build a foundation of trust. All I had to go on was the general assumption that someone working in medicine is motivated to help others. Beyond that, currently, **the burden of information-seeking is placed too heavily on the patient. A first-time patient does not know enough to even understand what questions to ask.** It is mainly because I had learned the hard way what to expect that I knew what to ask of my second surgeon. It would have been so simple for the surgeon in 2009 to just tell me that he needed to perform a pelvic exam, as well as his resident, and ask if it was okay for trainees to do so as well in order to learn proper technique. I likely would have said yes—after all, I am a teacher! But having been deceived and ill-informed has left me guarded and less likely to offer my consent in the future.

There are questions that haunt me. Who were the doctors-to-be who put their hands inside my unconscious body? Did they realize that no one had explicitly asked for my permission, that I had no idea any pelvic exam would occur? Did they think they had the right to use my body as a test subject, simply because I was there? Or did they believe the surgeon had informed me, and later realized with shame what had really happened? Did they even know my name? I will never know theirs. I do not even know who to ask to get these answers. I have spent years trying to reconcile myself with the knowledge that I never will get answers.

I know I will never receive anything close to an apology, and I am learning to be okay with that. What is NOT okay, and what keeps me fighting, is that what happened to me can still happen to other women. I will live with what happened to me for the rest of my life. It has changed me. I underwent physical therapy to address the tangible pain of that traumatic surgery. But my body was violated, and my sense of safety punctured in that operating room on August 31, 2009. So my body has forced me to pay attention. In situations that chip away at my sense of control, my body tingles with panic. Getting my teeth cleaned triggers unwarranted alarm. Unexpected touch makes me jump. I have exited crowded buses to escape the jostle of fellow passengers, my heart pounding and my vision blurring. I have delayed medical screenings and treatments because of the anxiety they induce. **For me, the damage is done. But this should not keep happening to others. You have the power to ensure that it does not.**

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 grateful to the bipartisan coalition of 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 Assembly Bill 128.

**References**

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

Ubel, PA, C Jepson & A Silver-Isenstadt (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 & Gynecology* 188(2): 575-9.

A Personal Perspective on Senate Bill 635/Assembly Bill 694
Testimony by Sarah Wright
1/30/2020

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 vagina 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 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.

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 officials at UW 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 at a private clinic.

I went through with the surgery as scheduled with a UW 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.

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, and that there are more Ari Silver-Isenstadts out there than we think. 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.

February 12, 2025

Assembly Committee on Health, Aging and Long-Term Care

Re: Assembly Bill 11: An Act to create 50.373 of the statutes relating to: pelvic exams on unconscious patients and creating an administrative rule related to hospital requirements for pelvic exams on unconscious patients

Dear Chair Moses and members of the Assembly Committee on Health, Aging and Long-Term Care:

My name is Ari Silver-Isenstadt and I support Assembly Bill 11. I am a pediatrician based in Baltimore, Maryland, and I co-authored one of the significant studies about consent practices for educational pelvic exams in the United States. This research has been highlighted in At Your Cervix, a new award-winning documentary.

I am asking for your help—for my patients, my students, and my profession.

30 years ago—when I was in medical school during my gynecology rotation, I was expected to hone my pelvic exam skills on already anesthetized women. It was clear to me that these women did not know that I was there for my own educational needs and that my teachers expected me to use the patients' intimate parts as my classroom without their knowledge or permission. I was not expected to provide useful information for the care of the patient based on the pelvic exam I performed. Shortly after this experience, I published a study that showed that 90% of the surveyed medical students in Philadelphia had practiced pelvic examinations on anesthetized patients for educational purposes.

Often, doctors and hospitals provide the following excuse for not obtaining explicit consent for the educational intimate (pelvic and rectal) exam; they say that students are part of the healthcare team. This is very misleading. While students may help support the healthcare team, they are paying for the opportunity to learn, to have access to people receiving medical care so that, as students, they may learn. Students pay for access to patients' bodies. Patients have the right to provide their explicit consent to participate in the student's education.

This practice of using patients without their explicit consent for educational examinations hurts medical students. I published another study that demonstrated that the importance medical students place on informed consent erodes as they progress through their education. I found this with many of my own classmates.

For the last 20 years, I have taught medical students. Students have cried in my office, worried about how a patient would feel if they found out that the student used the patient's body for their own education without having given explicit consent.

People outside of medicine see this problem more clearly. It seems obvious that people be able to explicitly authorize how their bodies are going to be used and by whom. Medical professionals and hospitals defend this outdated practice. They use arguments similar to those used in the past defending the lack of required consent for participation in medical research.

We need you, as legislators, to help put an end to this offensive and embarrassing training practice. As a medical profession, we have been unable to do this ourselves.

Arguments against getting explicit informed consent fall flat under scrutiny. And research shows that patients are willing to provide consent to these examinations, but they want to be asked.

Patients' trust in physicians is crucial for successful health outcomes. Without it, patients may delay seeking care or avoid it completely.

Don't we want our physicians to value truth-telling and to respect our bodily autonomy? Why do we accept a training model that indoctrinates the opposite? I want my profession to stop training practices that hurt both patients and students. I hope you will help ALL of us and vote favorably on this bill.

I believe this bill will be even stronger with the addition of the following protections:

- Broaden the bill to include all pelvic and rectal exams. Once under anesthesia, everyone is vulnerable to non-consensual educational examinations.
- Clarify the role of the medical student by requiring explicit consent for student educational pelvic and rectal examinations. Medically necessary examinations done by the surgeons and student educational examinations may happen during the same surgery. Students do not do these pelvic and rectal examinations as part of the healthcare team; they do them to learn. And they pay tuition for that access.
- Require patients to explicitly provide consent to student pelvic and rectal examinations.
- Require that patients who do not give consent are able to receive care without consequences.
- Provide medical students specific whistleblower protections. Students are not employees, nor are they licensed. They are in a vulnerable position and need protection from consequences if they witness, report, or refuse to participate in non-consensual exams.

Thank you for your consideration and time.

I write in my individual capacity.

Very Truly Yours,

Ari Silver-Isenstadt, MD

**At Your Cervix Testimony**
**Committee on Health**
**Assembly Bill 11**

February 11, 2025

Dear Chair Moses and Members of the Committee:

My name is A'magine Goddard. I am the director and producer of ***At Your Cervix,*** an award-winning documentary film and the only film about the issue of non-consensual intimate examinations on patients under anesthesia. Please accept my testimony in support of Assembly Bill 11, with some suggestions that will strengthen the protections it can provide to all of Wisconsin's residents. The suggested amendments are based upon my two decades of experience researching this issue, working closely with medical students, physicians, and patients who have been impacted by non-consensual intimate exams, and my experience as a Gynecological Teaching Associate.

I taught medical students for 10 years, and I have researched this issue for the past two decades. During that time, I have interviewed hundreds of people, including medical students, patients, doctors, midwives, lawyers and legislators. I have learned a great deal about the kinds of situations in which non-consensual intimate exams happen,the reasons why, their impact on the students and patients involved, and - most importantly - how to prevent them.

**RESEARCH**

It was reported in a 2019 survey conducted by Dr. Jennifer Tsai, MD, a Yale physician, that a disturbing 92% of students had done exams on anesthetized patients, and 61% without consent.

In 2022, The Journal of Surgical Education published new data showing that 84% of students surveyed at six institutions in five different states had done at least one intimate exam on an anesthetized patient, and that 67% of the time those exams were conducted without the knowledge or consent of the patient.

What does this data, taken from across many states, tell us? It tells us this is a systemic issue – this is "the way this is done." Moreover, a 2021 Hastings Report revealed that Black patients are four times more likely to experience non-consensual exams under all circumstances - one of the many racial disparities we see in healthcare provision today.

**PROFESSIONAL STANDARDS**

The practice of non-consensual intimate examinations has been condemned by leading professional organizations, including the American College of Obstetricians and Gynecologists, the American Medical Association, and the American Association of Medical Colleges.

**For reference, you can find those statements linked below:**
American College of Obstetricians and Gynecologists
American Medical Association
American Association of Medical Colleges

**In ACOG's position statement, they are clear that these exams should only be done with *specific* informed consent, and only in situations (typically surgeries) that relate to the sexual/reproductive organs - two important things to include in any law about this issue.**

Despite condemnation of the practice by leading professional organizations, the practice of non-consensual intimate exams persists at the institutional level. This demonstrates that, regrettably, healthcare institutions and medical schools cannot be trusted to hold themselves accountable - or even to hold themselves to the standards set by their own profession's leaders. The public needs - and deserves - their elected legislators to step in and provide the protections that healthcare institutions have not. They are relying on you to pass a strong law so that they can access needed healthcare without fear that they will be violated while unable to speak for themselves.

**VULNERABILITY OF PATIENTS DURING "INTIMATE EXAMS"**
To entrust your life to a doctor while you are under anesthesia is the biggest trust you can put in someone. **No one should be afraid of being assaulted when they have entrusted their surgeon to care for them.** People who wake up from anesthesia, or a coma, to find they have been assaulted may experience PTSD and/or tremendous emotional and psychological pain. Every patient I have interviewed who has experienced one of these non-consensual exams has experienced PTSD and has had their life disrupted by this experience. This is not acceptable. I hope you will agree with me that we cannot afford to entertain the possibility that people will be harmed, even assaulted, as part of their medical care.

This practice has now been named "medical sexual assault" in the academic literature. This is due to the fact that in any other circumstance when a person was under the influence of a drug and their body was penetrated by implements or hands and they had not consented, it would be defined as "sexual assault" or "rape."

Indeed, many of the patients I have interviewed who have experienced this have the same PTSD symptoms as someone who has been sexually assaulted. Moreover, they learn not to trust their medical providers and sometimes avoid accessing needed care because of their fears.

**PATIENT STORY:**

One such patient is Janine. Janine was a nurse who found out she had been given medically unnecessary pelvic exams while she was under anesthesia for a non-gynecological surgery in the very facility where she worked. A resident had performed a pelvic examination for the purpose of practicing - there was no benefit to Janine whatsoever. Both the resident who performed the educational exam without her consent and her surgeon freely admitted to it. Yet, when she went to speak to three different attorneys, she was told all three times that she had no legal case because there was not a law in her home state of Arizona at the time specifically banning the practice. Therefore, nothing was done that was illegal and she had no recourse for the harm that had been done to her. Most people are shocked to find out they have no recourse for such a clear violation if they live in a state without a law specifically banning non-consensual intimate exams.

**HARM TO STUDENTS & THE HIDDEN CURRICULUM**

Not only are patients being harmed by this practice - students are too. Students are told – and expected – to perform non-consensual exams on anesthetized patients and can face retribution if they question it or say "no."

This is what is known as the "hidden curriculum" in medicine (which we discuss in <u>At Your Cervix</u>). Medical schools are teaching students that not only is consent not important, but that they can "do to patients whatever they can get away with" as Elizabeth Lorde-Rollins, MD - an OBGYN states. This leaves them unable to properly relate to or care for future patients.

Students are also traumatized by this practice. I have spoken with many who report gaslighting, bullying, and tangible threats of failing grades or denial of a residency placement if they refuse to perform examinations without first obtaining the patient's consent. Those who are pressured into performing non-consensual exams report extreme guilt and moral injury as they are forced to reckon with the fact that they succumbed to pressure and intimidation from authority figures and ultimately engaged in actions that harmed patients - the very people they entered medical school to help. The toll this is taking is invisible, yet widespread.

Furthermore, students are denied a real educational opportunity when they are barred from taking part in a robust consent process with patients. As future physicians, they will one day be responsible for obtaining patient consent to examinations and surgeries, but they are not being permitted to learn how to do so during their clinical rotations. This will hinder their ability to care for their patients effectively when they do become physicians and does them a real disservice as learners.

**STATE-BY-STATE**

Thus far, 25 states have passed laws banning non-consensual intimate exams. **To pass this law in Wisconsin would bring medical practices and policies into line with what the general public overwhelmingly already expects from healthcare providers, and make Wisconsin a leader in passing a new wave of laws that cover all intimate exams - not just pelvic exams - and include robust protections for students as well as patients as well as real accountability mechanisms for those who violate the law.**

We know that Wisconsin residents are at risk without robust policies and laws banning these harmful exams. Medical providers and educators need to be held to the same high standard of consent that we expect in any other situation. It is an egregious violation of patient trust and a misuse of medical authority to perform intimate exams on patients in this manner.

In *At Your Cervix,* we calculate the numbers of patients and students affected with the example of one former student who did approximately 144 of these nonconsensual exams during his 3-4 week OB/GYN rotation. Even one per student is too many, but we know that this is often a repeated act, and for some, it is multiple-times-a-day during their OB/GYN surgical rotations. This means that literally thousands of these exams happen every year in communities where these antiquated exams are still a regular part of medical education.

## Amendments the At Your Cervix team and I hope you will consider:

Based upon my extensive experience educating medical students and interviewing hundreds of patients, students, and physicians, the following are my suggestions for amendments to this bill that would strengthen its protections for patients and implement protections for medical students, ensuring they are not penalized for refusing to perform and/or reporting non-consensual intimate exams.

When I spoke at the American Medical Student Association National Conference, I spoke to many students who had been told to perform non-consensual intimate exams on patients under anesthesia in states that DO have laws on the books. Disturbed by

this revelation, my team and I did a deep dive into how that could be possible. What we found is that **without specific whistleblower protections for students and support staff, anybody who could possibly report these exams does not do so out of fear of retribution**. And **without specific enforcement mechanisms, the laws themselves are not enough of a deterrent to prevent non-consensual intimate exams**. Wisconsin has the opportunity now to avoid these issues going forward by making some important changes to this bill now.

**1. Who does the bill apply to?** Non-consensual exams happen to everyone. That is why we are asking you to broaden the bill to include rectal and prostate exams in addition to pelvic exams for all people, regardless of gender. Many states have used the language "intimate exams" and defined that as "pelvic, prostate and rectal exams." Some also include breast exams.

**2. Include an explicit description of the consent process**. This process needs to be separate and discrete (as stated by ACOG and AMA), making it clear who is doing the exams and why. It should include both its own consent form, and a verbal discussion with the surgeon and should not be done under duress, i.e. right before a patient's surgery. We see you have stated it should be in writing. Here are a few more details that should be included in order to make this a robust and clear consent process:

- → Include on the form a question about **how many exams the patient is willing to undergo.** The patient should be able to say how many people/exams they consent to
- → **Patients should have the opportunity to meet students/trainees before undergoing educational exams** (just as patients have the opportunity to meet their surgeon prior to an operation), and the student names should be added to the consent form to ensure the patient is only being examined by the specific people they have consented to (just as patients consent to being operated on by a specific surgeon, and an alternate physician cannot be swapped in or included without the patient's knowledge and permission).
- → We also recommend there be a **limit to how many exams any patient is asked to submit to** so as not to overburden any one altruistic patient and put them at more risk of harm, which can happen. We suggest you limit this to 3 exams maximum for any one patient, as more than three is too much for any patient's body. The risk of coercion could place a greater burden on one person's body if there are no parameters.
- → **No one should be able to opt someone else in or consent for them to be the recipient of these exams.** We know from research that plenty of patients will say "yes" when asked properly. Minors and people with physical or

developmental disabilities should be excluded from educational exams if they cannot willingly consent themselves.

**3. Related procedures.** Intimate examinations for educational purposes should be limited to surgeries related to such exams (i.e. gynecological surgeries for pelvic exams and colorectal surgeries for prostate and rectal exams). The American College of Obstetricians and Gynecologists takes this position regarding pelvic examinations, and as a researcher and educator, I strongly agree. Allowing these exams in the context of unrelated surgeries (i.e. knee surgeries, stomach surgeries, etc.) which has often happened, places patients at increased risk of coercion and fosters an environment in which non-consensual examinations are more likely to occur.

**4. Liability/accountability/oversight.** Who is liable? To whom? If the enforceability is strictly internal within the hospital or institution, this issue will not change, as we have seen in other states with weaker laws. **Providers and institutions need to be accountable to an external body, such as the Department of Public Health.** There must be clear liability for the institution and doctors/preceptors who engage in non-consensual exams or there is unfortunately, no incentive for providers to follow the law.

**5. Whistleblower protections.** We need to protect students/residents/nurses/etc who speak out when they witness or are instructed to do non-consensual intimate exams. Because of their low status within medicine, students, in particular, face significant retribution if they choose to speak up when instructed to perform non-consensual exams. This can range from a failing grade to the inability to secure a residency and other consequences that pose a significant threat to their education and future career. I have personally heard many such stories. Existing whistleblower laws do not protect students. They only apply to licensed providers or employees. Since students are not licensed nor are they employees, it is critical that this is included in this bill, otherwise they remain completely vulnerable and unprotected.

**6. Exceptions.** I suggest including a line specifying that informed consent is not required for intimate examinations (pelvic, prostate, and rectal) **ONLY** in the event that such examinations are necessary to the provision of emergency care, the patient is incapacitated, **AND** the exam is only being performed by a licensed physician or other healthcare provider qualified to perform the exam and make a diagnosis and *not* for educational or training purposes. Such a provision will preserve access to needed emergency care while protecting patients in such situations from being used for teaching purposes/undergoing extra medically unnecessary exams without their consent. Additionally, consent should be obtained whether the patient is awake or

asleep, and this bill only applies to an unconscious patient. This bill should apply under all circumstances as stated here.

**CLOSING**

These improvements will make this a strong model law that will protect both patients and students in Wisconsin. Wisconsin has the opportunity to pass one of the strongest laws in the country with these changes.

I will include some helpful resources below including a **10-minute legislative cut of our film**. If you wish to see the whole film, we are happy to provide a private screener to you. If there is anything else you may need, please do ask and we will be happy to get it to you if we can.

You can reach me directly at the number and email below.

Respectfully,
A'magine Goddard
Director/Producer/Researcher, *At Your Cervix*
718.974.6554
aj@atyourcervixmovie.com

**Additional Resources:**

**Non-consensual Intimate Exams Fact Sheet**

**AYC Map of states and standing**

**10-minute Video**

We have made a 10 minute legislative cut of our film for you that we hope will be informative and supportive for this process. Feel free to watch and share with whomever you wish to share it with. It will help you get some of the key aspects of the issue and hear from some patients. This can be shared freely with other legislators/committee members.

UNIVERSITY OF ILLINOIS
AT URBANA-CHAMPAIGN

**College of Law**

231 Law Building
504 East Pennsylvania Avenue
Champaign, IL 61820-6996

**Robin Fretwell Wilson**

*Mildred Van Voorhis Jones Chair in Law*
University of Illinois College of Law

February 11, 2025

**BY Email**

Chair Clint Moses
2 E Main Street
Madison, WI 53703

**Re: Assembly Bill 11**

Dear Chair Moses:

We write to support Assembly Bill 11 which would require that "written informed consent is obtained from a patient before a pelvic exam is performed solely for educational purposes on the patient while the patient is under general anesthesia or otherwise unconscious."[1]

The passage of Assembly Bill 11 will ensure that norms of autonomy for patients are honored and that patients are not treated as a means to an end. As we explain below, requiring written informed consent for pelvic exams done for teaching purposes guarantees the dignity and respect that patients deserve *without* jeopardizing the quality of patient care or medical education in Wisconsin.

Part A of this letter applauds this important bill, which if signed into law, would make Wisconsin the 29th state in the nation to give patients the right to decide whether medical trainees will perform pelvic exams on them for the students' learning. Part B addresses the claim that intimate exams solely for educational purposes simply *no longer* occur in Wisconsin.[2] Asking for specific consent to perform an intimate exam for a student's training gives patients the dignity and autonomy all patients deserve—and it reinforces the norm for medical professionals that all patients should be respected in deciding what happens with their bodies. Part C details the extent of pelvic examinations for medical training without the patient's consent. Part D documents the strong consensus of medical ethics groups is that such pelvic exams should not occur without explicit consent. Parts E, F, and G refute common justifications for performing such pelvic exams without permission. Specifically, Parts E and F rebut the unfounded justification that patients have impliedly or expressly consented to this upon admission to the hospital. Part G shows empirically, that when asked, patients consent to teaching exams in overwhelming numbers and, consequently, should be enlisted as "respected partners"[3] in medical teaching. Part H remarks on the thoughtful construction of the bill's text.

---

[1] A.B. 11.
[2] Emma Goldberg, *She Didn't Want a Pelvic Exam. She Received One Anyway*, N.Y. TIMES (Feb. 17, 2020), https://www.nytimes.com/2020/02/17/health/pelvic-medical-exam-unconscious.html. Cleveland Clinic statement.
[3] Jennifer Goedken, *Pelvic Examinations Under Anesthesia: An Important Teaching Tool*, 8 J. HEALTH CARE L.& POL'Y 234, 235 (2005).

## A. Assembly Bill 11 Would Provide Crucial Protections

To be clear, "the pelvic examination is a critical tool to aid in the diagnosis of women's health conditions and remains an important skill necessary for students to master before becoming physicians."[4] The only question is: Should patients have the ability to consent to such critical medical teaching?

Passage of Assembly Bill 11 would place Wisconsin within an emerging legislative trend to require healthcare providers to ask permission before using patients as tools for teaching pelvic exams. Arizona, Arkansas, California, Connecticut, Colorado, Delaware, Florida, Hawaii, Idaho, Illinois, Iowa, Louisiana, Maine, Maryland, Missouri, Montana, Nevada, New Hampshire, New Jersey, New York, Ohio, Oregon, Pennsylvania Rhode Island, Texas, Utah, Virginia, and Washington all require explicit consent for pelvic examinations performed on unconscious patients for teaching purposes.[5] Twenty-two of these states enacted laws in the last sixty months. **With the passage of Assembly Bill 11, Wisconsin would become the 29h state to require informed consent to educational pelvic exams, as Table 1 shows.**

**Table 1**
**Features of Enacted Pelvic Exam Legislation**

*Table 1. Features of Proposed and Enacted Intimate Exam Legislation*

| | Gender Neutral Language | Types of Exams Covered | | Patients Protected | | Regulates Educational Exams | | | Actors Regulated | | | Regulated Actions | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Enacted Laws | | Pelvic Exams Only | Pelvic Exams and Others | Anesthetized or Unconscious | Conscious | Educational Only | Educational and Others | Other Exams Only | Trainees | Healthcare Professionals | Healthcare Systems* | Perform | Supervise** | Observe |
| MT HB 417 (2023) | ✓ | | ✓ | ✓ | | | ✓ | | ✓ | ✓ | | ✓ | ✓ | |
| CO HB 1077 (2023) | ✓ | | ✓ | ✓ | | | ✓ | | ✓ | ✓ | | ✓ | | |
| MO SB 106 (2023) | ✓ | | ✓ | ✓ | | | ✓ | | ✓ | ✓ | | ✓ | ✓ | |
| CT HB 5278 (2022) | ✓ | | ✓ | ✓ | | | ✓ | | ✓ | ✓ | | ✓ | | |
| NJ S1771 (2022) | ✓ | | ✓ | ✓ | | | ✓ | | | ✓ | ✓ | ✓ | | |
| RI HB5644 (2021) | | ✓ | | ✓ | | | ✓ | | | ✓ | | ✓ | ✓ | |
| NV SB 196 (2021) | ✓ | ✓ | | ✓ | | | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | |
| TX HB 1434 (2021) | ✓ | | ✓ | ✓ | | | ✓ | | ✓ | ✓ | | ✓ | | ✓ |
| AZ SB 1017 (2021) | ✓ | ✓ | | ✓ | | | ✓ | | | ✓ | | ✓ | ✓ | |
| AR HB 1137 (2021) | ✓ | ✓ | | ✓ | | | ✓ | | ✓ | ✓ | | ✓ | | |
| NH HB 1639 (2020) | ✓ | | ✓ | ✓ | | | ✓ | | ✓ | ✓ | | ✓ | | |
| WA SB 5282 (2020) | ✓ | ✓ | | ✓ | | | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | |
| ME LD 1946 (2020) | ✓ | | ✓ | ✓ | | | ✓ | | | ✓ | | ✓ | ✓ | |
| LA HB 435 (2020) | ✓ | | ✓ | ✓ | | | ✓ | | | ✓ | ✓ | ✓ | | |
| FL SB 698 (2020) | ✓ | ✓ | | | ✓ | | ✓ | | ✓ | ✓ | | ✓ | | |
| NY SB 1092 (2019) | ✓ | ✓ | | ✓ | | | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | |
| DE HB 239 (2019) | ✓ | | ✓ | ✓ | | | ✓ | | | ✓ | | ✓ | ✓ | |
| MD SB 909 (2019) | ✓ | | ✓ | ✓ | | | ✓ | | ✓ | ✓ | | ✓ | | |
| UT SB 188 (2019) | ✓ | | ✓ | ✓ | | | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ |
| IL HB 313 (2017) | ✓ | | ✓ | ✓ | | | ✓ | | ✓ | ✓ | | ✓ | | |
| IA HF 653 (2017) | ✓ | ✓ | | ✓ | | | ✓ | | ✓ | ✓ | ✓ | ✓ | | |
| HI HB 2232 (2012) | | ✓ | | ✓ | | | ✓ | | ✓ | ✓ | | ✓ | | |
| OR HB 2908 (2011) | | ✓ | | ✓ | | | ✓ | | ✓ | ✓ | ✓ | ✓ | | |
| VA HB 2989 (2008) | | ✓ | | ✓ | | ✓ | | | ✓ | | | ✓ | | |
| CA AB 663 (2003) | | ✓ | | ✓ | | | ✓ | | ✓ | ✓ | | ✓ | | |

* "Healthcare System" refers to hospitals and institutions.

** Even if trainees are not explicitly mentioned in the language of the bill, the bill applies to them if there is mention of a health care professional "supervising" an exam.

[4] Maya M. Hammoud et al., *Consent for the Pelvic Examination Under Anesthesia by Medical Students*, 134 Obstetrics & Gynecology 1303 (2019).
[5] *See* Table 1.

Like the laws of those 28 states, Assembly Bill 11 would ensure that every hospital will have a policy requiring written consent of the patient before a trainee performs a pelvic examination on the unconscious or anesthetized patient for the student's benefit.

This duty can be fulfilled with no added cost. Hospitals already facilitate the duty by physicians to obtain informed consent to medical procedures.[6] Thus, hospitals can facilitate informed consent to medical teaching.

Bioethicists see this as a given. The former director of the Center for Bioethics and Medical Humanities at the Medical College of Wisconsin, Robyn Shapiro, said: "I would be very surprised to run across a state that didn't have that sort of a law."[7]

### B. Answering the Claim that it "Does Not Happen Here" and "If It Does, We Transparently Ask"

Some medical educators and hospital administrators reflexively assume that medical teaching exams without explicit consent never occur. As we show below, pelvic teaching exams without consent have persisted for more than the two decades that one of us has worked on this question.

As McGill University Bioethics Professor Phoebe Friesen states, medical students widely report being asked to do such exams without the specific consent of the patients.[8]

A 2022 survey of 1,169 people within the United States drawn from a nationally representative sample found that "1.4 percent of respondents reported having received a pelvic or prostate exam within the past five years without their explicit prior consent."[9] The authors extrapolated from that figure to estimate that "potentially 3.6 million U.S. residents may have received an unconsented rectal, prostate or pelvic exam."

Against this evidence, some medical educators contend that laws are unnecessary because the communication about the educational nature of the exam is already transparent.[10]

In recent years, patients have come forward after discovering that they have been used for medical teaching without permission, as we show below. The patients say they were never asked. Without disclosure, how would they have ever known? By their very nature, pelvic exams for the purpose of teaching abnormal anatomy occur while the patient is under anesthesia or unconscious. Asking patients to police what is happening to them while they are asleep is asking them to do the impossible. And asking medical students to act as whistleblowers to end this practice is unrealistic and unfair.

Given the fast pace of medical education and teaching on the wards, teaching faculty may simply be unaware when a student or faculty member forgets to ask for specific permission, whether advertent or inadvertent. Further, given the rise of community teaching hospitals, it is difficult for medical schools and

---

[6] Alan Meisel, *Canterbury v. Spence: The Inadvertent Landmark Case*, in HEALTH LAW AND BIOETHICS: CASES IN CONTEXT (Sandra H. Johnson, Joan H. Krause, Richard S. Saver, & Robin Fretwell Wilson, eds., Aspen Publishers, 2009).
[7] Lorelei Laird, *Pelvic exams performed without patients' permission spur new legislation,* 105 ABA J. 20 (Sept. 1, 2019), https://www.abajournal.com/magazine/article/examined-while-unconscious.
[8] Phoebe Friesen, *Why Are Pelvic Exams on Unconscious, Unconsenting Women Still Part of Medical Training?*, SLATE (Oct. 30, 2018), https://slate.com/technology/2018/10/pelvic-exams-unconscious-women-medical-training-consent.html.
[9] Lori Bruce, Ivar Hannikainen, & Brian Earp, *New Findings on Unconsented Intimate Exams Suggest Racial Bias and Gender Parity*, 52 HASTINGS CENTER REP'T 7 (2022).
[10] Julia Cron & Shefaly Pathy, *2 Ob-Gyns, on Pelvic Exams and Patients' Consent*, N.Y. TIMES, Feb. 24, 2020, https://www.nytimes.com/2020/02/24/opinion/letters/pelvic-exams-consent.html.

their principal teaching hospitals to know whether their rigorous consent practices are adhered to at smaller, far-flung hospitals where medical teaching occurs.[11] Hence the need for this bill.

It is important to unpack exactly what counts as a training exam. In the typical case, an intimate exam may be performed by the attending physician or a resident to reconfirm a diagnosis before surgery, followed by a second or third exam done for the benefit of students who are present.[12] A fourth-year medical student at Ohio University, Alexandra Fountaine, explained last year:

> "This is very common practice," she said. "It happens a lot, unfortunately."
> On her first day of rotations as a third-year medical student, when Fountaine was in the operating room of a Columbus hospital, "the senior resident looked at me and said, 'Hey, now's a good time to practice your pelvic exam,'" she said.
> "I thought, 'Oh my gosh. Is this happening'?" she said. "I knew it was wrong. I almost panicked."
> When asked if the patient required a pelvic exam, Fountaine said, "Not to my knowledge. She did not."[13]

Alexandra said she did not know whether the patient had given consent for the exam, with the doctor assuring her that performing a pelvic exam was fine and "for her education."[14]

Now consider what teaching hospitals and surgical consent forms tell patients about these training exams. A typical consent form reads:

> We require that all providers obtain prior consent from patients before any intimate (genital, rectal or pelvic) examination is performed under anesthesia. ... In addition, these examinations are only performed when medically necessary, as part of the surgery or for surgical planning purposes.[15]

But notice what the first this statement does **not** explain: some exams are duplicates done for the students' training, just as Ms. Fountaine described.

Saying exams are performed only when medically necessary, as part of the surgery, is not enough to secure explicit consent to the training nature of some intimate exams.

Helping care for the patient and training students by using the patient are two different things. Paragraph 9 of OSU's Consent Form does not alert the patient that a pelvic, prostate or rectal examination may be performed for somebody else's educational benefit. Assembly Bill 11 simply requires what medical ethicists agree must be done: explicitly secure the consent of patients to the training of the next generation of medical professionals.[16]

---

[11] 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) [hereinafter Autonomy Suspended].

[12] *See, e.g.*, Autonomy Suspended (documenting this practice and showing that duplicate exams cannot, by definition, be justified as being necessary for the patient's care).

[13] NBC5Cleveland.

[14] AP NEWS [FULL CITATION?]

[15] NBC5Cleveland.

[16] Marti Leitch, Director, Media Relations, Wexner Medical Center, described the duty of explicit consent this way:

> Procedures under anesthesia, such as pelvic, rectal, breast and other examinations for teaching purposes, require specific consent and medical students should not perform such an examination unless that consent has been obtained. Such examinations should be related to the planned procedure, performed by a student who is recognized by the patient as part of their care team and should be done under direct supervision by the educator.

Other states have explained the need for these laws as responding to concerns by medical students that they may be asked to act unethically, by not candidly and forthrightly securing informed consent to their training. Maryland recognized that while the state's teaching hospitals have informed consent policies, an explicit state law would not only protect patients but assure students that they would not be asked to do something unethical.[17] Maine lawmakers enacted a specific consent law precisely so that "medical students asked to perform the procedure know they are acting ethically."[18] The sponsor of New York's law, Senator Jessica Ramos, put it this way: "The importance of instilling the value of informed consent on medical students cannot be underestimated."[19]

In her interview on Wisconsin Public Radio on April 25, 2023, Chief Executive Officer of the Wisconsin Nurses Association Gina Dennik-Champion succinctly captured how consent and voluntary participation forms the essence of medical ethical principles:

> [W]e have our code, and no one should be coerced into number one, performing an exam where they're not comfortable. Secondly, not having the permission of that individual. It smacks us right into our code of ethics....[20]

Trust in the health care system and professions is vital as it affects patient satisfaction, willingness to seek care, and treatment compliance.[21] Moreover, trust is essential to the physician-patient relationship because of the inherent risk and uncertainty of medical care.[22] In 2018, only 34% of Americans reported a positive view of the healthcare industry.[23] This is a staggering decrease from 1975, when 80% reported a positive view.

More fundamentally, Assembly Bill 11 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 patients the dignity and autonomy all patients deserve. And if such exams never occur without consent, Assembly Bill 11 will reinforce the norm that all patients should be respected in deciding what happens with their bodies. And it will teach students that consent is non-negotiable.

Assembly Bill 11 is a no-harm-no-foul proposition, even as to facilities that have already instituted policies that respect patient autonomy. It will ensure that specific consent is afforded to patients.

### C. The Extent of the Practice

Despite widespread ethical condemnation that "the practice of performing pelvic examinations on women

---

NBC5Cleveland.

[17] Jennifer McDermott & Carla K. Johnson, *States Seek Explicit Patient Consent for Pelvic Exams*, NBC CONN. (May 12, 2019, 1:48PM), https://www.nbcconnecticut.com/news/local/bills-seek-special-consent-for-pelvic-exams-under-anesthesia/153538/.

[18] Associated Press, *States seek explicit patient consent for pelvic exams*, NEWS CTR. ME. (May 12, 2019), https://www.newscentermaine.com/article/news/nation-world/states-seek-explicit-patient-consent-for-pelvic-exams/417-03352df8-4979-4152-8b58-26e7b7e205a4.

[19] 2019 New York S. 3353.

[20] Trevor Hook, *Renewed bipartisan legislation pushes for consent for pelvic exams on unconscious patients*, WISCONSIN PUBLIC RADIO (April 25, 2023), https://www.wpr.org/renewed-bipartisan-legislation-pushes-consent-pelvic-exams-unconscious-patients.

[21] *See generally* Oswald A.J. Mascarenhas et al., *Hypothesized Predictors of Patient-Physician Trust and Distrust in the Elderly: Implications for Health and Disease Management*, 1 CLIN. INTERVENTIONS AGING 175 (2006).

[22] Katrina Armstrong et al., *Racial/Ethnic Differences in Physician Distrust in the United States*, 97 AM. J. PUB. HEALTH 1283, 1283 (2007).

[23] Daniel Wolfson, *Commentary: Erosion of trust threatens essential element of practicing medicine*, MOD. HEALTHCARE (Mar. 9, 2019), https://www.modernhealthcare.com/opinion-editorial/commentary-erosion-trust-threatens-essential-element-practicing-medicine.

under anesthesia, without their knowledge and approval, [is] unethical and unacceptable,"[24] experience shows that unauthorized exams continue across the U.S. One of us wrote about a woman in Arizona who discovered she received an unauthorized pelvic exam after ***stomach***, not gynecological surgery.[25] In testimony to the Utah Senate Health and Human Services Committee, Ms. Ashley Weitz testified that she had an unauthorized pelvic exam while sedated in the emergency room.[26] Medical students spanning the country from North Carolina to Ohio to Texas report that they have been asked to do exams without consent.[27]

Empirical studies document the persistent nature of unauthorized pelvic examinations. A 2020 survey accepted by the 2021 Council on Resident Education in Obstetrics and Gynecology & The American College of Obstetricians and Gynecologists Annual Meeting reported that 83.6% of the medical students surveyed across five medical schools attached to large academic medical centers performed a pelvic exam on a patient under anesthesia.[28] When asked how often patients were explicitly told that an educational pelvic examination would take place under anesthesia, only 17% of surveyed students replied "every time." Notably, 22.3% replied "rarely" and 20.3% replied "never." Clearly, ethics pronouncements and media attention alone have not sufficed to ensure that patients are asked to be used for teaching purposes.

Historic studies show the same pattern. 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.[29] 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.[30] In 1992, Charles Beckmann reported that 37.3% of United States and Canadian medical schools reported using anesthetized patients to teach pelvic exams.[31]

As Table 1 above shows, the latest iteration of laws across the country also extends protection to men, for rectal and prostate exams. Yet the overwhelming evidence is that the widespread practice of teaching intimate exams without consent is a practice of using women to teach pelvic exams.[32]

### D. The Legislative and Professional Response

---

[24] AMERICAN ASSOCIATION OF MEDICAL COLLEGES, AAMC Statement on Patient Rights and Medical Training (June 12, 2003).
[25] Robin Fretwell Wilson & Anthony Michael Kreis, *#JustAsk: Stop Treating Unconscious Female Patients Like Cadavers*, CHICAGO TRIBUNE (Nov. 30, 2018), https://www.chicagotribune.com/news/opinion/commentary/ct-perspec-pelvic-nonconsensual-exam- medical- students-vagina-medical-1203-story.html.
[26] Laird, *supra* note 7.
[27] ASSOCIATED PRESS, *Bills seek special consent for pelvic exams under anesthesia*, SAVANNAH MORNING NEWS, May 12, 2019, https://www.savannahnow.com/zz/news/20190512/bills-seek-special-consent-for-pelvic-exams-under-anesthesia/1; Interview with Krithika Shamanna Symone on MSNBC, https://drive.google.com/file/d/14bwqysIJUVzlVtoxQnI1MFIcKpuz9Gpl/view; Lisa Desjardins, *Why more states are requiring consent for pelvic exams on unconscious patients*, PBS NEWSHOUR, Feb. 11, 2023, https://www.pbs.org/newshour/show/why-more-states-are-requiring-consent-for-pelvic-exams-on-unconscious-patients (quoting medical student Alexandra Fontaine).
[28] Hannah Millimet et al., *Medical Student Perspective on Pelvic Exams Under Anesthesia: A multi-Institutional Study* (2020) (unpublished manuscript) (on file with author).
[29] S. Schniederjan & G.K. Donovan, *Ethics versus education: pelvic exams on anesthetized women*, 98 J. OKLA. ST. MED. ASS'N 386 (2005).
[30] Peter A. Ubel, Christopher Jepson, & Ari Silver-Isenstadt, *Don't Ask, Don't Tell: A Change in Medical Student Attitudes After Obstetrics/Gynecology Clerkships Toward Seeking Consent for Pelvic Examinations on an Anesthetized Patient*, 635 AM. J. OBSTETRICS & GYN. 575, 579 (2003).
[31] Charles R. B. Beckmann et al., *Gynaecological Teaching Associates in the 1990s*, 26 MED. EDUC. 105, 106 (1992).
[32] *But see* Bruce et al, *supra* note 11 (reporting that "1.4 percent of male and 1.3 percent of female respondents answer[ed] "yes" to having received a [unconsented intimate teaching exam] within the past five years").

In response to the unauthorized use of patients, twenty-eight states across the U.S. by legislation now require explicit consent for pelvic examinations on unconscious patients for medical teaching purposes.[33] This legislation reflects the consensus of professional medical organizations that healthcare providers should obtain explicit for pelvic teaching exams.[34] In the "Statement on Patient Rights and Medical Training" in 2003, the American Association of Medical Colleges, which—represents 144 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and 90 academic and scientific societies—described "pelvic examinations on women under anesthesia, without their knowledge and approval ... [as] unethical and unacceptable."[35]

In an August 2011 Committee on Ethics ruling reaffirmed in 2020, the American College of Obstetricians and Gynecologists provided 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."[36] 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 are performed solely for teaching purposes should be performed only with her specific informed consent before her surgery."[37] An American Medical Association Forum in January 2019, authored by 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."[38]

A growing chorus of bioethicists challenge the need for unconsented exams. Pelvic examinations have a "different moral significance than suturing a wound."[39] Even when pelvic examinations are done with a woman's knowledge, women are "frequently nervous before [the procedure], reporting feeling vulnerable, embarrassed, and subordinate." Significantly, the feelings of distress are heightened for victims of sexual assault.[40] Pelvic examinations are especially sensitive experiences.

As the next Parts of this letter demonstrate, however, some teaching faculty offer a number of falsifiable justifications for dispensing with the simple step of asking for permission.[41]

### E. Patients Have Not Implicitly Consented to Pelvic Educational Exams

---

[33] *See* https://robinfretwellwilson.com/human-rights-for-all.

[34] *See, e.g.*, AMERICAN ASSOCIATION OF MEDICAL COLLEGES., 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) (hereinafter ACOG Ruling No. 500), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2011/08/professional-responsibilities-in-obstetric-gynecologic-medical-education-and-training; 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").

[35] AMERICAN ASSOCIATION OF MEDICAL COLLEGES, *supra* n. 40.

[36] ACOG Ruling No. 500, *supra* n. 40.

[37] *Id.*

[38] Eli Y. Adashi, *Teaching Pelvic Examination Under Anesthesia Without Patient Consent*, 321(8) JAMA 732 (Feb. 26, 2019), https://pubmed.ncbi.nlm.nih.gov/30806680/.

[39] Phoebe Friesen, *Why Are Pelvic Exams on Unconscious, Unconsenting Women Still Part of Medical Training?*, SLATE (Oct. 30, 2018), https://slate.com/technology/2018/10/pelvic-exams-unconscious-women-medical-training-consent.html.

[40] *Id.*; Robin Fretwell Wilson et al., *supra* note 39.

[41] 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).

The first justification that teaching faculty advance is that patients have implicitly consented by accepting care at a teaching hospital. Empirical evidence suggests that many patients do not consciously choose teaching facilities or even know they are in one.[42]

Indeed, in the U.S., a large number of facilities give little indication to prospective patients of the hospital's teaching status. Public disclosure of hospitals' teaching status varies drastically. Some hospitals, like Duke University Medical Center and The Johns Hopkins Hospital, indicate their medical school affiliation in their name.

Of the approximately 400 members of the Association of American Medical Colleges Hospital/Health System Members, only 94—less than 25%—contain the word "college" or "university" in their name.[43]

To make this concrete, consider the web of relationships in a single teaching hospital, the University of Pennsylvania Hospital. Its webpage notes that the Penn Medicine has "several hospitals and hundreds of outpatient centers throughout the region."[44] While some of them are clearly identified as part of the University of Pennsylvania, other names do not suggest an affiliation with the University of Pennsylvania or otherwise tip patients off to their statuses as teaching facilities. This example is used only to make the point that patients are unaware of the educational nature of many patient encounters.

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. Reasonably, a patient may know that New York-Presbyterian Hospital, located less than sixty feet from the Columbia Medical University College of Physicians & Surgeons, is a teaching hospital.[45] However, patients at the 11 facilities associated with Columbia's medical school throughout New York, Connecticut, and New Jersey cannot possibly know on constructive notice without doing their own research online.[46]

### F. Patients Have Not Expressly Consented to Pelvic Educational Exams

Many teaching faculty assert that the patient has consented to educational exams upon admission.[47] 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.[48] A variant on this claim holds that if consent was obtained for one procedure, it encompasses consent for additional, educational procedures.[49]

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

---

[42] 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).
[43] PENN MEDICINE, https://www.pennmedicine.org/practices.
[44] *Id.*
[45] 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, https://www.google.com/maps.
[46] *Affiliated Hospitals and Institutions*, COLUMBIA VAGELOS COLLEGE OF PHYSICIANS AND SURGEONS, https://www.ps.columbia.edu/about-us/explore-vp-s/affiliated-hospitals-and-institutions.
[47] AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS (ACOG), COMM. OPINION 181: ETHICAL ISSUES IN OBSTETRIC-GYNECOLOGICAL EDUCATION 2 (1997).
[48] 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.").
[49] *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).

> [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.[50]

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

Some teaching faculty and residents believe that additional exams by students are, in fact, for the patient's benefit because the student might detect something missed by others. Yet, a patient would not receive multiple exams in a non-teaching facility context. The better practice would be to ask for permission for all exams—both those needed to reconfirm a diagnosis before surgery and any additional educational exam.

### G. 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 won't consent."

However, studies have shown that women will consent to pelvic examinations for educational purposes. These include not only "hypothetical" studies—asking patients how they would respond if asked to do a variety of things—but also studies of actual women giving consent to real exams.

For example, in 2021 Julie Chor found that after asking for explicit consent in a family planning clinic, 89.6 percent of surgical patients agreed an additional exam for the medical training of the next generation of providers.[51]

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.[52] In a private practice setting, another study found refusal rates of approximately 5% to perform educational pelvic exams.[53] 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.[54]

Even more women consent to examinations before surgery. In one study in the U.K., 85% of patients awaiting surgery consented to educational exams by students while the patient was under anesthesia.[55] 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.[56]

Operationalizing consent so that it is not a barrier to teaching requires nothing more than planning and common-sense devices. Maya and colleagues suggest, as one example, "[s]tickers on the main consent

---

[50] *About Prisma Health*, PALMETTO HEALTH RICHLAND, https://www.palmettohealth.org/patients-guests/about-prisma-health.
[51] J. Chor, "Consenting for Pelvic Exams under Anesthesia with Learners," paper presented at the 33rd Annual MacLean Center Conference, Chicago, IL, November 13, 2021, https://www.youtube.com/ watch?v=wbFWn0K1lVI.
[52] S. Wainberg et al., *Teaching pelvic examinations under anaesthesia: what do women think?*, 32 J. OBSTET. GYNAECOL CAN 49 (2010), https://pubmed.ncbi.nlm.nih.gov/20370981/.
[53] Lawton et al., *Patient Consent for Gynaecological Examination*, 44 BRIT. J. HOSP. MED. 326, 329 (1990).
[54] Peter A. Ubel & Ari Silver-Isenstadt, *Are Patients Willing to Participate in Medical Education?*, 11 J. CLINICAL ETHICS 230, 232-33 (2000).
[55] Lawton, *supra* note 61, at 329.
[56] Ubel & Silver-Isenstadt, *supra* note 62, at 234.

form attesting that discussion of examination under anesthesia was done and consent obtained (similar to "time out" documentation stickers)." [57]

### H. Thoughtful Construction of Assembly Bill 11 and the Need for Regulation

Self-regulation in the medical field is prized.[58] But states, in fact, regulate healthcare and transparency in particular when important societal values are at stake. Consider medical records. Federal Law regulates and protects medical records, as one example.[59]

The sponsors of this bill have put much thought into constructing the language of Assembly Bill 11 so that its implementation does not become a burden. Assembly Bill 11 uses a straight-forward test for when a patient's written consent is not needed: namely when the exam is "performed solely for educational purposes on the patient while the patient is under general anesthesia or otherwise unconscious."[60]

Some have rightly raised concerns that, if badly constructed, an explicit consent statute might inadvertently impede the care of patients who have experienced a sexual assault or who need emergency care.[61] Note that the test in the Assembly Bill 11 does ***not impede care*** for patients who present in an emergency or who present unconscious but may have experienced a sexual assault. Assembly Bill 11 is tailored so it would be feasible in practice and not hinder these vital medical processes.

Importantly, Assembly Bill 11 promotes accountability by establishing a rule that requires hospitals to "maintain written policies and procedures requiring written informed consent to be obtained from a patient before a pelvic examination is performed solely for educational purposes on the patient while the patient is under general anesthesia or otherwise unconscious."[62]

### I. Conclusion

Without adequate safeguards to protect the autonomy of women and men to consent to medical teaching, many will be reduced to acting as "medical practice dummies" without their knowledge or permission. Many patients would gladly consent if only asked.

Assembly Bill 11 would bring Wisconsin into line with other states that give patients the autonomy to decide to participate in medical teaching. It would affirm the dignity of persons at a time of great vulnerability, building trust and accountability in the healthcare system.

We welcome any opportunity to provide further information or analysis or testimony to the State of Wisconsin Legislature.

---

[57] Maya M. Hammoud et al., *Consent for the Pelvic Examination Under Anesthesia by Medical Students*, 134 OBSTETRICS & GYN. 1303 (2019).
[58] Roger Collier, *Professionalism: The Privilege and Burden of Self-regulation*, 184 CAN. MED. ASS'N J. 1559(2012).
[59] 45 C.F.R. § 164.508, Uses and disclosures for which an authorization is required.
[60] A.B. 11.
[61] Trevor Hook, *Renewed bipartisan legislation pushes for consent for pelvic exams on unconscious patients*, WISCONSIN PUBLIC RADIO (April 25, 2023), https://www.wpr.org/renewed-bipartisan-legislation-pushes-consent-pelvic-exams-unconscious-patients (quoting Gina Dennik-Champion, Chief Executive Officer, Wisconsin Nurses Association).
[62] A.B. 11.

Respectfully Yours,[63]

**Robin Fretwell Wilson**
*Mildred Van Voorhis Jones Chair in Law*
University of Illinois College of Law
*Fulbright Scholar in Law and Sustainability*
NOVA School of Law, Portugal

**Katja Brutus**
M.D. Candidate, Class of 2027
University of Florida College of Medicine

**Kimball Yeates**
Bachelor of Liberal Arts Candidate, Class of 2024
Brigham Young University

**Sophia Andrade**
Bachelor of Liberal Arts Candidate, Class of 2025
University of Illinois Urbana-Champaign

[63] Academic affiliation is for identification purposes only. We write in our individual capacities and our universities take no position on this or any other bill.

***Testimony in Support of Assembly Bill 11: An Act to create 50.373 of the statutes; Relating to: pelvic exams on unconscious patients and creating an administrative rule related to hospital requirements for pelvic exams on unconscious patients.***

**February 12, 2025**

**Submitted by Livia Fry**

Dear Chair Moses and Members of the Committee,

Please accept this testimony in support of **An Act to create 50.373 of the statutes; Relating to: pelvic exams on unconscious patients and creating an administrative rule related to hospital requirements for pelvic exams on unconscious patients** and proposed amendments that will close loopholes that have made enforcing existing legislation in other states difficult and afford protections to the medical students who also suffer as a result of non-consensual intimate exams.

I give this testimony as a survivor of non-consensual medical educational practices in a teaching hospital. It began when I was about nine years old, and lasted several years until I was thirteen or fourteen. It happened at the hands of an attending physician, in the name of educating the next generation of doctors. It was justified, much the same way unauthorized pelvic, prostate, and rectal examinations are, as a necessary component of medical education and an "invaluable" experience for the physicians-in-training who participated in it. It was allowed because there were no laws in place to protect me. And it has left me with PTSD and a lifetime of pain. I hope that by sharing my story, I can convince you of the need for this legislation and the amendments I am requesting that you consider adopting before voting for its passage. A robust informed consent law will protect Wisconsin residents from the humiliation and degradation of having one's body reduced to a teaching tool without their explicit and informed consent, and from the short and long-term trauma and distress that accompanies such an experience.

When I was a young child, my family was referred to a physician who practiced out of a teaching hospital to get me treatment for a skin condition called vitiligo. We were given the impression that because of my age, we needed someone who specialized in treating the condition in children. We were told this teaching hospital was the only option - whether we wanted a teaching institution or not, this was where we had to go. And when students entered with the attending physician, my family was under the impression we had to let them stay. Nobody asked her if their presence made us uncomfortable - certainly nobody asked me. The language allowing them to be there was vague and buried in the middle of consent forms - much the same way language allowing intimate exams under anesthesia or sedation or while unconscious often is currently. We didn't understand what we were signing up for - much the same way many of today's victims of unconscious intimate examinations do not. That was the first time I was forced to show my naked body to strangers for the purpose of furthering their education. The first time I was reduced from a human being to a teaching tool - an object, or an exhibition. The first time I learned what it felt like to be violated.

A typical appointment went like this: after being taken back to an exam room, I was told to remove all of my clothes, except for my underwear, and put on a paper gown. Then, the doctor would walk in with whatever doctors-in-training would be viewing my naked, prepubescent body that day. They were oftentimes men - whether someone of the opposite sex staring at the naked body of a little girl was humiliating or scary for me was never considered. At each examination, the doctor looked at my full body, to see if any new patches of skin showed signs of having lost their pigment, which is how my condition manifests. By itself, an examination is innocuous - a necessary part of providing healthcare. But during these examinations he put my full, naked body on display for his students - like an exhibit or a sideshow. And when I say my full body, I mean exactly that. I was forced to lie on a table while he pulled back the flimsy paper gown I was wearing to expose my chest, my back, my belly - and everything else one typically does not show publicly. The part I hated most was when he would pull down my underwear. To this day I feel his hands on me, pulling down the thin piece of cloth that protected me from the strange eyes standing behind him, staring at my most private areas. I was so acutely aware of those eyes - gaping at me like someone usually gawks at an animal in a zoo - that I could physically feel them on my skin. They had no regard for my dignity, my privacy, or my feelings. They only cared about how they could use me - how the use of my body was furthering their education. On one or two occasions, they photographed me. To this day, I live with the fact that naked photos of my body have been viewed by who knows how many students, interns, and residents. I was made to feel lower than an animal every time I stepped into that institution's exam rooms, and I have been left with a lifetime of pain and anxiety - and even Post Traumatic Stress Disorder - because of what was done to me.

Because of what happened - because I learned at such a young age how it feels to have one's bodily autonomy taken away and one's body used for the benefit of others - I am terrified of healthcare settings and healthcare professionals. I have flashbacks, nightmares, and panic attacks. I have struggled with physical intimacy since becoming an adult, as I cannot stand the feeling of eyes or hands on my exposed body. And do you remember the story I told earlier, about my least favorite part of examinations being when the doctor would pull down my underwear and allow his students to view my buttocks and genitalia? Because of that, I can't allow anyone to touch my belly - it is excruciating to me, under any circumstances. His hands would always graze my lower belly when he would move to pull my underwear down - and I still feel them there. The mere sensation of fingertips on the skin triggers a flashback and causes me to involuntarily recoil - at times even to scream involuntarily.

If that is the impact that photographs and examinations that were not physically invasive can have, imagine the suffering someone subjected to an unauthorized pelvic, prostate, or rectal examination for the purpose of student or trainee practice must endure. Even if someone is unconscious, the body remembers. And - horrifyingly enough - some people wake up during these exams, or learn about them later from providers who let the information slip in the course of follow up conversations. What must it feel like to enter a hospital for, let's say, a stomach surgery, only to wake up and learn that you were digitally penetrated without your consent - without knowing that this was even a possibility - so that a student (or even multiple students, several in a row) could tick a box on the list of their required clinical experiences. What must it

feel like to learn, after this sickening revelation, that because there is no legislation in place to protect you, a loophole and overly broad and vague language in one of the many consent forms you had to sign in order to access critical treatment means that you have no legal recourse? Worse yet - you have no way to ensure it won't happen again.

Some medical practitioners and healthcare institutions have tried to argue that by seeking treatment at a teaching hospital, patients are giving "implied consent." The fact is, that argument does not hold up, even under the most superficial scrutiny. Patients often do not have a choice regarding the hospital they are brought to for care. In emergency situations when patients are unconscious or otherwise cannot speak for themselves they cannot choose where they are brought. In such situations consent to lifesaving treatment is implied - but consent to the use of their bodies for practice by medical students or trainees is not. Neither, for that matter, is consent implied for any intimate examination that is not urgently necessary to preserve the patient's life or immediate health. And then there are the cases like mine. The cases in which patients or caregivers are told a particular specialist is the only one that can help them or their loved ones, and that specialist happens to practice exclusively out of a teaching institution. Should we be denied the opportunity to receive care just because we do not want our bodies used as specimens or teaching tools? Medical care exists to serve the needs of patients - not students, not trainees, and not the licensed professionals providing treatment. We should not be required to pay for the services we need with our bodies.

Until the legislature adopts a robust informed consent law, every Wisconsin resident runs the risk of undergoing a forced pelvic, prostate, or rectal examination. And these non-consensual exams do happen in Wisconsin - recent peer-reviewed research suggests that they happen in every state without an informed consent law, and disturbingly enough, in some states with laws that lack enforcement mechanisms or a thorough template of what an informed consent process must look like.

Current laws and policies dealing with consent to intimate examinations are not sufficient. Wisconsin residents need their elected legislators to step in - to adopt amendments to strengthen this bill, pass this legislation, and provide them with certainty that they can safely seek medical care without fear or risk of being violated.

## PROPOSED AMENDMENTS

**1. Who does the bill apply to?** Non-consensual exams happen to everyone. That is why we are asking you to broaden the bill to include rectal and prostate exams in addition to pelvic exams.

We also ask that you make a distinction between examinations performed as a part of a patient's care - in other words, those that are medically necessary and benefit the patient - and those that are done specifically for educational purposes and benefit only

students or trainees. Exams conducted solely for educational or training purposes should be voluntary and transparent.

**2. Explicit description of the consent process**, which needs to be separate and discrete (as stated by ACOG and AMA), making it clear who is doing the exams and why. It should include both its own consent form, and a verbal discussion with the surgeon. Any consent form should include on the form a question about how many exams the patient is willing to undergo. The patient should be able to say how many people/exams they consent to, they should have the opportunity to meet students/trainees before undergoing educational exams (just as patients have the opportunity to meet their surgeon prior to an operation), and the student names should be added to the consent form to ensure the patient is only being examined by the specific people they have consented to (just as patients consent to being operated on by a specific surgeon, and an alternate physician cannot be swapped in or included without the patient's knowledge and permission). We also recommend there be a limit to how many educational exams any patient is asked to submit to so as not to overburden any one altruistic patient and put them at more risk of harm, which can happen. We suggest you limit this to 3 exams maximum for any one patient. The risk of coercion could place a greater burden on one person's body if there are no parameters.

**3. When?** Intimate examinations for educational purposes should be limited to surgeries related to such exams (i.e. gynecological surgeries for pelvic exams and colorectal surgeries for prostate and rectal exams). Allowing them in the context of unrelated surgeries (i.e. knee surgeries, stomach surgeries, etc.) places patients at increased risk of coercion and fosters an environment in which non-consensual examinations are more likely to occur.

**4. Liability/accountability/oversight.** Who is liable? To whom? If the enforceability is strictly internal within the hospital or institution, this issue will not change, as we have seen in other states with weaker laws. **Providers and institutions need to be accountable to an external body, such as the state's Department of Public Health.** There must be clear liability for the institution and doctors/preceptors who engage in non-consensual exams.

**5. Whistleblower protections.** We need to protect students/residents/nurses/etc who speak out when they witness or are asked to do non-consensual intimate exams. Students particularly face significant retribution if they choose to speak up when instructed to perform non-consensual exams, ranging from a failing grade to the inability to secure a residency and other consequences that pose a significant threat to their education and future career. Existing whistleblower laws do not protect students. They

only apply to licensed providers or employees. Since students are not licensed nor are they employees, it is critical that this is included in this bill. Both individual medical students and the American Medical Student Association are staunch advocates for these whistleblower protections.

**6. Exceptions.** I suggest including a line specifying that informed consent is not required for intimate examinations (pelvic, prostate, and rectal) **ONLY** in the event that such examinations are necessary to the provision of emergency care, the patient is incapacitated, **AND** the exam is only being performed by a licensed physician or other healthcare provider qualified to perform the exam and make a diagnosis and not for educational or training purposes. Such a provision will preserve access to needed emergency care while protecting patients in such situations from being used for teaching purposes/undergoing extra medically unnecessary exams without their consent.

WISCONSIN COALITION AGAINST SEXUAL ASSAULT

# Testimony

| | |
|---|---|
| To: | Members of the Assembly Committee on Health, Aging and Long-Term Care |
| From: | Wisconsin Coalition Against Sexual Assault (WCASA) |
| Date: | February 12, 2025 |
| Re: | Assembly Bill 11 |
| Position: | Support |

The Wisconsin Coalition Against Sexual Assault (WCASA) appreciates the opportunity to submit this testimony for your consideration. WCASA is a is a hybrid organization that both supports member Sexual Assault Service Providers (SASPs) and advances the anti-sexual assault movement at the state and national levels.

We extend our gratitude to Committee Chair Moses for bringing this critical piece of legislation forward for a hearing today. We also thank bill's lead sponsors, Representatives Goeben and Subeck and Senators Jacque and Carpenter for their leadership in championing this legislation in both chambers.

A survey of 101 medical students from seven medical schools found that 92% percent reported performing a pelvic exam on an unconscious patient[1], with 61% stating they had done so without explicit patient consent.[2] Additionally, a 2005 survey at the University of Oklahoma revealed that a majority of medical students had performed pelvic exams on gynecologic surgery patients under anesthesia, and nearly 75% of these patients had not consented to the exam[3]. WCASA strongly supports AB 11 as it requires hospitals to ensure written informed consent is obtained from a patient before a pelvic exam is performed solely for educational purposes while a patient is under general anesthesia or otherwise unconscious.

Consent and bodily autonomy are fundamental principles in sexual violence prevention. This legislation aligns with the values of the anti-sexual violence movement and is especially important for survivors seeking healthcare. Survivors of sexual violence have already experienced a profound violation of their bodily autonomy. Subjecting them to a pelvic examination without their informed consent represents another violation – this time within the very setting where they seek critical healthcare services. By ensuring that medical providers obtain written informed consent, AB 11 prevents re-traumatization and upholds survivors' rights to make informed decisions about their bodies.

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."[4] Given the deeply invasive nature of a pelvic exam, obtaining written informed consent before performing such a procedure on an unconscious patient is not only ethical but necessary. AB 11 reflects the broader cultural shift toward patient-centered health care by emphasizing shared decision-making and respecting patient autonomy.

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

[1] https://www.elle.com/life-love/a28125604/nonconsensual-pelvic-exams-teaching-hospitals/
[2] Ibid.
[3] https://www.ncbi.nlm.nih.gov/pubmed/16206868
[4] "What are Important for Patient Centered Care?" Journal of Caring Sciences. Published November 2013.

**Testimony in support of Assembly Bill 11**
**Sarah Wright**
**2.12.25**

Dear Rep. Moses and Members of the Committee on Health, Aging, and Long-Term Care:

I intend to deliver oral remarks at the hearing. Two of my previous *four* testimonies follow. I am not going anywhere until we get this across the finish line.

My first trauma was when people I entrusted with my care penetrated my vagina without my knowledge or permission.

My second trauma was that when I approached people in positions of power in our medical system, hoping to prevent this from happening to others, they treated me as an enemy. I approached legislators when no one else would listen, which was the origin of this bill.

I know that many of you are supporters of this bill, and it is my hope that all of you will become so. This is about basic human dignity and decency, and the power of legislators to make a difference in people's lives.

Thank you to Sen. Andre Jacque for keeping this bill alive since it was first written by my former Rep., Chris Taylor. Thank you to the many co-authors and co-sponsors who have supported this pivotal legislation. I urge you to pass this bill without delay.

Sincerely,

Sarah Wright
(resident of Fitchburg, Dane County)
sdwright79@gmail.com
608.509.5936

Testimony in support of Assembly Bill 128
Sarah Wright
7.29.21

Chairman Sanfelippo and Members of the Health Committee:

My name is Sarah Wright, and I am proud to say that it is partly because of me that this bill exists and we are here today. I am here because my bodily autonomy was violated during surgery, and I am determined to prevent others from suffering as I have. I am thankful to my former Representative, Chris Taylor, for listening to me and taking action when I told her my story. She helped to craft the original version of the pelvic exam bill. I am grateful to Representative Janel Brandtjen and Senator Andre Jacque, who sat next to me as I testified for the first time in 2020 and struggled to get through my story, and to Rep. Rachael Cabral-Guevara for joining them to revive this bill. And I thank Rep. Sanfelippo and the members of the Committee on Health for hosting this hearing.

**This testimony could be extremely short. It could go something like this:**
*People put their fingers in the vaginas of unconscious women without their knowledge or permission. This happens in hospital operating rooms. We do not know how often this happens. The consent forms that patients are required to sign are written to be intentionally vague and cover a broad range of procedures.*

**I predict that people hearing this would be thinking two things:**
1. If that truly does happen, that is reprehensible and should be stopped immediately. It only takes common sense and basic human decency to understand that penetrating the vagina of an unconscious woman without her consent is wrong.
2. This sounds so outrageous that this can't *really* happen, right? And you might need to hear more evidence. And that is why we are here, except that I wish we could just stop at point #1.

When I was here in 2020 to testify, I felt a need to summarize all the research and previous efforts to stop this practice, as though my testimony might be the only one. Today, I prefer to spend the rest of my time giving you a more personal perspective on the importance of this bill. I will also offer counterarguments to what you will hear from opponents of this bill. But I urge you to read the testimony submitted by the legal

scholar, Robin Fretwell Wilson, who has worked on this issue for decades; bioethicist, Dr. Phoebe Friesen, who has extensively documented the occurrence of educational pelvic exams without clear consent; and Dr. Ari Silver-Isenstadt, who took a leave from medical school to study bioethics after refusing to conduct pelvic exams on anesthetized women. Dr. Silver-Isenstadt is a huge inspiration. I repeat: he actually left medical school rather than be coerced into learning how to perform a pelvic exam without clear consent. This was a lonely and courageous position, and shows that this is an issue that affects and must be solved by both men and women.

In late 2018, I was preparing myself to undergo surgery to remove a potentially cancerous ovary. It was stressful, to say the least, to face the possibility of a serious illness while attending to my everyday life as a teacher and a mom. But what made the situation even worse was that I had had a traumatic experience with a similar surgery in 2009.

Certainly, it is hard to prove definitively what happened to me; after all, I was unconscious! But I entered that operating room as a healthy woman whose medical history included nothing more exciting than a wisdom tooth removal. When I emerged, I was nauseous for days, had trouble urinating, and was covered with purple bruises along my left torso from my ribcage to my hips. The worst of the injuries also took the longest to heal: an extreme sensitivity of the vulva, the tissue surrounding the entrance to the vagina. I was dumbfounded. **The surgeon had accessed my ovaries through incisions in my abdomen. *No one had given me any indication prior to the surgery that my vagina would be involved in any way.* What on earth had happened to me when I was on that operating table?**

My post-op appointment yielded no answers; the surgeon seemed to take it as a personal affront that I had a difficult recovery in any way. I obtained my medical records, but the sparse, 2-page document didn't provide any useful information either. They simply stated, "the vagina was prepped properly." Nothing in the pink pamphlet I was given about pelvic surgery stated anything about the vagina at all. Reading WebMD and MayoClinic.org did not specify anything either. The only way I had any idea what may have happened to me to result in the vulvar pain was that I am lucky to have a close relative who has worked in operating rooms for decades at multiple hospitals, often assisting during pelvic surgeries. She told me that an instrument called a uterine manipulator, which penetrates the vagina, is commonly used in order to position the uterus and hold it in place during surgery. She inferred that this device may have caused my vulvar pain, since it remains in place throughout surgery, although I most likely was subjected to pelvic exams for educational purposes as well.

By the way… 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.

When I needed surgery again in 2018, I was determined to be fully informed. Surely, I thought, things have changed since 2009. I approached hospital and medical school officials to inquire about their policies regarding informed consent for pelvic exams under anesthesia, as well as uterine manipulators. I even drew up my own "informed consent contract" that I intended to share with my surgeon, and sent it to hospital officials with the suggestion that something like it could be used for all pelvic surgeries. That afternoon, I had a voicemail from the Patient Relations office asking me to call about my document.

At least I had drawn enough attention to get a call from the *head* of Patient Relations! In the course of our conversation, that Patient Relations head made many of the same arguments that are laid out in the joint statement from the medical lobbyists that was submitted against the bill in 2020 (although the lobbyists were notably absent from the hearing). She told me that if having the opportunity to withhold consent for an educational pelvic exam was "a dealbreaker," I should have my surgery at a private, all-female clinic (as if only women are capable of performing surgeries ethically). Here are arguments she and the lobbyists made against strengthening informed consent, and my counterarguments:

Opponents' argument #1. ***Not everyone wants to know what exactly will happen to them when they undergo a procedure.***
To this I say, it is the responsibility of the medical system to ensure that complete information is provided to all patients. Then, it is the choice of the patient what to do with that information. But attempting to hide behind the supposed squeamishness of some fraction of hypothetical patients is a poor excuse for failing to obtain fully informed consent. Moreover, as I said to the PR person, we are not talking about someone's cornea or hand or liver; we are talking about sexual organs. Touching them without first informing the patient is an especially heinous violation. When I pressed her, "can you

imagine anyone NOT wanting to know that their vagina is going to be penetrated?", she conceded, "well, as a woman, I would want to know."

(By the way, this is not simply a "woman's issue." The same problem applies to rectal exams performed on unconscious patients undergoing colonoscopies, for example, as reflected in medical schools' updated policies on sensitive exams.)

Opponents' argument #2. ***We cannot possibly have a separate informed consent document for every procedure***. 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 to fail to do so leaves open the possibility that women's bodies could be violated like I was. And as Dr. Silver-Isenstadt points out, it is NOT difficult or time-consuming to obtain true consent, if one really values it.

Opponents' argument #3. ***If a patient feels that their rights were violated or their informed consent was not obtained, they have recourse through the Department of Justice.***
First of all, patients are often unaware that this option exists. I did not learn of it until years after my surgery, when it was far too late for me to submit a complaint. Furthermore, in the aftermath of a traumatic incident, it is understandable for someone to simply want to try to forget about it and move on, or feel too emotionally fragile to pursue a complaint. The way that I was treated by the surgeon who failed me, who was only defensive and dismissive, definitely discouraged me from pursuing any recourse.

Opponents' argument #4. ***It is not the place of the legislative system to interfere in the patient-provider relationship.***
First of all, it IS the place of the legislative system to intervene when private or public entities fail to do their job, or cause harm to others. Ideally, hospitals would successfully regulate themselves. But this is not the case. Frankly, we may not be here if the officials I contacted had treated me as a patient in need of care, rather than an enemy to be avoided and discredited. If they had answered my questions about their informed consent policies, if they had conducted an investigation of my surgery like they promised, if they had truly listened to me and given an answer other than "have your surgery somewhere else," I would not have felt the need to approach my legislator in

the first place. The medical school I contacted only updated their sensitive exams policy after Chris Taylor applied pressure on them to do so.

I can only speak to my own experience in having two surgeries, but in both instances, I was simply assigned the first available surgeon at a clinic covered by my insurance. It's not as if there was some personal connection from which to build a foundation of trust. All I had to go on was the general assumption that someone working in medicine is motivated to help others. Beyond that, currently, **the burden of information-seeking is placed too heavily on the patient. A first-time patient does not know enough to even understand what questions to ask.** It is mainly because I had learned the hard way what to expect that I knew what to ask of my second surgeon. It would have been so simple for the surgeon in 2009 to just tell me that he needed to perform a pelvic exam, as well as his resident, and ask if it was okay for trainees to do so as well in order to learn proper technique. I likely would have said yes—after all, I am a teacher! But having been deceived and ill-informed has left me guarded and less likely to offer my consent in the future.

There are questions that haunt me. Who were the doctors-to-be who put their hands inside my unconscious body? Did they realize that no one had explicitly asked for my permission, that I had no idea any pelvic exam would occur? Did they think they had the right to use my body as a test subject, simply because I was there? Or did they believe the surgeon had informed me, and later realized with shame what had really happened? Did they even know my name? I will never know theirs. I do not even know who to ask to get these answers. I have spent years trying to reconcile myself with the knowledge that I never will get answers.

I know I will never receive anything close to an apology, and I am learning to be okay with that. What is NOT okay, and what keeps me fighting, is that what happened to me can still happen to other women. I will live with what happened to me for the rest of my life. It has changed me. I underwent physical therapy to address the tangible pain of that traumatic surgery. But my body was violated, and my sense of safety punctured in that operating room on August 31, 2009. So my body has forced me to pay attention. In situations that chip away at my sense of control, my body tingles with panic. Getting my teeth cleaned triggers unwarranted alarm. Unexpected touch makes me jump. I have exited crowded buses to escape the jostle of fellow passengers, my heart pounding and my vision blurring. I have delayed medical screenings and treatments because of the anxiety they induce. **For me, the damage is done. But this should not keep happening to others. You have the power to ensure that it does not.**

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 grateful to the bipartisan coalition of 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 Assembly Bill 128.

**References**

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

Ubel, PA, C Jepson & A Silver-Isenstadt (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 & Gynecology* 188(2): 575-9.

A Personal Perspective on Senate Bill 635/Assembly Bill 694
Testimony by Sarah Wright
1/30/2020

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 vagina 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 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.

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 officials at UW 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 at a private clinic.

I went through with the surgery as scheduled with a UW 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.

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, and that there are more Ari Silver-Isenstadts out there than we think. 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.

**At Your Cervix Testimony**
**Committee on Health**
**Assembly Bill 11**

February 11, 2025

Dear Chair Moses and Members of the Committee:

My name is A'magine Goddard. I am the director and producer of ***At Your Cervix,*** an award-winning documentary film and the only film about the issue of non-consensual intimate examinations on patients under anesthesia. Please accept my testimony in support of Assembly Bill 11, with some suggestions that will strengthen the protections it can provide to all of Wisconsin's residents. The suggested amendments are based upon my two decades of experience researching this issue, working closely with medical students, physicians, and patients who have been impacted by non-consensual intimate exams, and my experience as a Gynecological Teaching Associate.

I taught medical students for 10 years, and I have researched this issue for the past two decades. During that time, I have interviewed hundreds of people, including medical students, patients, doctors, midwives, lawyers and legislators. I have learned a great deal about the kinds of situations in which non-consensual intimate exams happen,the reasons why, their impact on the students and patients involved, and - most importantly - how to prevent them.

**RESEARCH**
It was reported in a 2019 survey conducted by Dr. Jennifer Tsai, MD, a Yale physician, that a disturbing 92% of students had done exams on anesthetized patients, and 61% without consent.

In 2022, The Journal of Surgical Education published new data showing that 84% of students surveyed at six institutions in five different states had done at least one intimate exam on an anesthetized patient, and that 67% of the time those exams were conducted without the knowledge or consent of the patient.

What does this data, taken from across many states, tell us? It tells us this is a systemic issue – this is "the way this is done." Moreover, a 2021 Hastings Report revealed that Black patients are four times more likely to experience non-consensual exams under all circumstances - one of the many racial disparities we see in healthcare provision today.

**PROFESSIONAL STANDARDS**

The practice of non-consensual intimate examinations has been condemned by leading professional organizations, including the American College of Obstetricians and Gynecologists, the American Medical Association, and the American Association of Medical Colleges.

**For reference, you can find those statements linked below:**
American College of Obstetricians and Gynecologists
American Medical Association
American Association of Medical Colleges

**In ACOG's position statement, they are clear that these exams should only be done with *specific* informed consent, and only in situations (typically surgeries) that relate to the sexual/reproductive organs - two important things to include in any law about this issue.**

Despite condemnation of the practice by leading professional organizations, the practice of non-consensual intimate exams persists at the institutional level. This demonstrates that, regrettably, healthcare institutions and medical schools cannot be trusted to hold themselves accountable - or even to hold themselves to the standards set by their own profession's leaders. The public needs - and deserves - their elected legislators to step in and provide the protections that healthcare institutions have not. They are relying on you to pass a strong law so that they can access needed healthcare without fear that they will be violated while unable to speak for themselves.

**VULNERABILITY OF PATIENTS DURING "INTIMATE EXAMS"**
To entrust your life to a doctor while you are under anesthesia is the biggest trust you can put in someone. **No one should be afraid of being assaulted when they have entrusted their surgeon to care for them.** People who wake up from anesthesia, or a coma, to find they have been assaulted may experience PTSD and/or tremendous emotional and psychological pain. Every patient I have interviewed who has experienced one of these non-consensual exams has experienced PTSD and has had their life disrupted by this experience. This is not acceptable. I hope you will agree with me that we cannot afford to entertain the possibility that people will be harmed, even assaulted, as part of their medical care.

This practice has now been named "medical sexual assault" in the academic literature. This is due to the fact that in any other circumstance when a person was under the influence of a drug and their body was penetrated by implements or hands and they had not consented, it would be defined as "sexual assault" or "rape."

Indeed, many of the patients I have interviewed who have experienced this have the same PTSD symptoms as someone who has been sexually assaulted. Moreover, they learn not to trust their medical providers and sometimes avoid accessing needed care because of their fears.

**PATIENT STORY:**
One such patient is Janine. Janine was a nurse who found out she had been given medically unnecessary pelvic exams while she was under anesthesia for a non-gynecological surgery in the very facility where she worked. A resident had performed a pelvic examination for the purpose of practicing - there was no benefit to Janine whatsoever. Both the resident who performed the educational exam without her consent and her surgeon freely admitted to it. Yet, when she went to speak to three different attorneys, she was told all three times that she had no legal case because there was not a law in her home state of Arizona at the time specifically banning the practice. Therefore, nothing was done that was illegal and she had no recourse for the harm that had been done to her. Most people are shocked to find out they have no recourse for such a clear violation if they live in a state without a law specifically banning non-consensual intimate exams.

**HARM TO STUDENTS & THE HIDDEN CURRICULUM**
Not only are patients being harmed by this practice - students are too. Students are told – and expected – to perform non-consensual exams on anesthetized patients and can face retribution if they question it or say “no.”

This is what is known as the “hidden curriculum” in medicine (which we discuss in At Your Cervix). Medical schools are teaching students that not only is consent not important, but that they can “do to patients whatever they can get away with” as Elizabeth Lorde-Rollins, MD - an OBGYN states. This leaves them unable to properly relate to or care for future patients.

Students are also traumatized by this practice. I have spoken with many who report gaslighting, bullying, and tangible threats of failing grades or denial of a residency placement if they refuse to perform examinations without first obtaining the patient’s consent. Those who are pressured into performing non-consensual exams report extreme guilt and moral injury as they are forced to reckon with the fact that they succumbed to pressure and intimidation from authority figures and ultimately engaged in actions that harmed patients - the very people they entered medical school to help. The toll this is taking is invisible, yet widespread.

Furthermore, students are denied a real educational opportunity when they are barred from taking part in a robust consent process with patients. As future physicians, they will one day be responsible for obtaining patient consent to examinations and surgeries, but they are not being permitted to learn how to do so during their clinical rotations. This will hinder their ability to care for their patients effectively when they do become physicians and does them a real disservice as learners.

**STATE-BY-STATE**

Thus far, 25 states have passed laws banning non-consensual intimate exams. **To pass this law in Wisconsin would bring medical practices and policies into line with what the general public overwhelmingly already expects from healthcare providers, and make Wisconsin a leader in passing a new wave of laws that cover all intimate exams - not just pelvic exams - and include robust protections for students as well as patients as well as real accountability mechanisms for those who violate the law.**

We know that Wisconsin residents are at risk without robust policies and laws banning these harmful exams. Medical providers and educators need to be held to the same high standard of consent that we expect in any other situation. It is an egregious violation of patient trust and a misuse of medical authority to perform intimate exams on patients in this manner.

In *At Your Cervix,* we calculate the numbers of patients and students affected with the example of one former student who did approximately 144 of these nonconsensual exams during his 3-4 week OB/GYN rotation. Even one per student is too many, but we know that this is often a repeated act, and for some, it is multiple-times-a-day during their OB/GYN surgical rotations. This means that literally thousands of these exams happen every year in communities where these antiquated exams are still a regular part of medical education.

## Amendments the At Your Cervix team and I hope you will consider:

Based upon my extensive experience educating medical students and interviewing hundreds of patients, students, and physicians, the following are my suggestions for amendments to this bill that would strengthen its protections for patients and implement protections for medical students, ensuring they are not penalized for refusing to perform and/or reporting non-consensual intimate exams.

When I spoke at the American Medical Student Association National Conference, I spoke to many students who had been told to perform non-consensual intimate exams on patients under anesthesia in states that DO have laws on the books. Disturbed by

this revelation, my team and I did a deep dive into how that could be possible. What we found is that **without specific whistleblower protections for students and support staff, anybody who could possibly report these exams does not do so out of fear of retribution**. And **without specific enforcement mechanisms, the laws themselves are not enough of a deterrent to prevent non-consensual intimate exams**. Wisconsin has the opportunity now to avoid these issues going forward by making some important changes to this bill now.

**1. Who does the bill apply to?** Non-consensual exams happen to everyone. That is why we are asking you to broaden the bill to include rectal and prostate exams in addition to pelvic exams for all people, regardless of gender. Many states have used the language “intimate exams” and defined that as “pelvic, prostate and rectal exams.” Some also include breast exams.

**2. Include an explicit description of the consent process**. This process needs to be separate and discrete (as stated by ACOG and AMA), making it clear who is doing the exams and why. It should include both its own consent form, and a verbal discussion with the surgeon and should not be done under duress, i.e. right before a patient’s surgery. We see you have stated it should be in writing. Here are a few more details that should be included in order to make this a robust and clear consent process:

- ➔ Include on the form a question about **how many exams the patient is willing to undergo.** The patient should be able to say how many people/exams they consent to
- ➔ **Patients should have the opportunity to meet students/trainees before undergoing educational exams** (just as patients have the opportunity to meet their surgeon prior to an operation), and the student names should be added to the consent form to ensure the patient is only being examined by the specific people they have consented to (just as patients consent to being operated on by a specific surgeon, and an alternate physician cannot be swapped in or included without the patient’s knowledge and permission).
- ➔ We also recommend there be a **limit to how many exams any patient is asked to submit to** so as not to overburden any one altruistic patient and put them at more risk of harm, which can happen. We suggest you limit this to 3 exams maximum for any one patient, as more than three is too much for any patient’s body. The risk of coercion could place a greater burden on one person’s body if there are no parameters.
- ➔ **No one should be able to opt someone else in or consent for them to be the recipient of these exams.** We know from research that plenty of patients will say “yes” when asked properly. Minors and people with physical or

developmental disabilities should be excluded from educational exams if they cannot willingly consent themselves.

**3. Related procedures.** Intimate examinations for educational purposes should be limited to surgeries related to such exams (i.e. gynecological surgeries for pelvic exams and colorectal surgeries for prostate and rectal exams). The American College of Obstetricians and Gynecologists takes this position regarding pelvic examinations, and as a researcher and educator, I strongly agree. Allowing these exams in the context of unrelated surgeries (i.e. knee surgeries, stomach surgeries, etc.) which has often happened, places patients at increased risk of coercion and fosters an environment in which non-consensual examinations are more likely to occur.

**4. Liability/accountability/oversight**. Who is liable? To whom? If the enforceability is strictly internal within the hospital or institution, this issue will not change, as we have seen in other states with weaker laws. **Providers and institutions need to be accountable to an external body, such as the Department of Public Health**. There must be clear liability for the institution and doctors/preceptors who engage in non-consensual exams or there is unfortunately, no incentive for providers to follow the law.

**5. Whistleblower protections.** We need to protect students/residents/nurses/etc who speak out when they witness or are instructed to do non-consensual intimate exams. Because of their low status within medicine, students, in particular, face significant retribution if they choose to speak up when instructed to perform non-consensual exams. This can range from a failing grade to the inability to secure a residency and other consequences that pose a significant threat to their education and future career. I have personally heard many such stories. Existing whistleblower laws do not protect students. They only apply to licensed providers or employees. Since students are not licensed nor are they employees, it is critical that this is included in this bill, otherwise they remain completely vulnerable and unprotected.

**6. Exceptions.** I suggest including a line specifying that informed consent is not required for intimate examinations (pelvic, prostate, and rectal) **ONLY** in the event that such examinations are necessary to the provision of emergency care, the patient is incapacitated, **AND** the exam is only being performed by a licensed physician or other healthcare provider qualified to perform the exam and make a diagnosis and *not* for educational or training purposes. Such a provision will preserve access to needed emergency care while protecting patients in such situations from being used for teaching purposes/undergoing extra medically unnecessary exams without their consent. Additionally, consent should be obtained whether the patient is awake or

asleep, and this bill only applies to an unconscious patient. This bill should apply under all circumstances as stated here.

**CLOSING**
These improvements will make this a strong model law that will protect both patients and students in Wisconsin. Wisconsin has the opportunity to pass one of the strongest laws in the country with these changes.

I will include some helpful resources below including a **10-minute legislative cut of our film**. If you wish to see the whole film, we are happy to provide a private screener to you. If there is anything else you may need, please do ask and we will be happy to get it to you if we can.

You can reach me directly at the number and email below.

Respectfully,
A'magine Goddard
Director/Producer/Researcher, *At Your Cervix*
718.974.6554
aj@atyourcervixmovie.com

**Additional Resources:**
**Non-consensual Intimate Exams Fact Sheet**

**AYC Map of states and standing**

**10-minute Video**
We have made a 10 minute legislative cut of our film for you that we hope will be informative and supportive for this process. Feel free to watch and share with whomever you wish to share it with. It will help you get some of the key aspects of the issue and hear from some patients. This can be shared freely with other legislators/committee members.

**Testimony in Support of Assembly Bill 11: An Act to create 50.373 of the statutes; Relating to: pelvic exams on unconscious patients and creating an administrative rule related to hospital requirements for pelvic exams on unconscious patients.**
**February 12, 2025**
**Submitted by Livia Fry**

Dear Chair Moses and Members of the Committee,

Please accept this testimony in support of **An Act to create 50.373 of the statutes; Relating to: pelvic exams on unconscious patients and creating an administrative rule related to hospital requirements for pelvic exams on unconscious patients** and proposed amendments that will close loopholes that have made enforcing existing legislation in other states difficult and afford protections to the medical students who also suffer as a result of non-consensual intimate exams.

I give this testimony as a survivor of non-consensual medical educational practices in a teaching hospital. It began when I was about nine years old, and lasted several years until I was thirteen or fourteen. It happened at the hands of an attending physician, in the name of educating the next generation of doctors. It was justified, much the same way unauthorized pelvic, prostate, and rectal examinations are, as a necessary component of medical education and an "invaluable" experience for the physicians-in-training who participated in it. It was allowed because there were no laws in place to protect me. And it has left me with PTSD and a lifetime of pain. I hope that by sharing my story, I can convince you of the need for this legislation and the amendments I am requesting that you consider adopting before voting for its passage. A robust informed consent law will protect Wisconsin residents from the humiliation and degradation of having one's body reduced to a teaching tool without their explicit and informed consent, and from the short and long-term trauma and distress that accompanies such an experience.

When I was a young child, my family was referred to a physician who practiced out of a teaching hospital to get me treatment for a skin condition called vitiligo. We were given the impression that because of my age, we needed someone who specialized in treating the condition in children. We were told this teaching hospital was the only option - whether we wanted a teaching institution or not, this was where we had to go. And when students entered with the attending physician, my family was under the impression we had to let them stay. Nobody asked her if their presence made us uncomfortable - certainly nobody asked me. The language allowing them to be there was vague and buried in the middle of consent forms - much the same way language allowing intimate exams under anesthesia or sedation or while unconscious often is currently. We didn't understand what we were signing up for - much the same way many of today's victims of unconscious intimate examinations do not. That was the first time I was forced to show my naked body to strangers for the purpose of furthering their education. The first time I was reduced from a human being to a teaching tool - an object, or an exhibition. The first time I learned what it felt like to be violated.

A typical appointment went like this: after being taken back to an exam room, I was told to remove all of my clothes, except for my underwear, and put on a paper gown. Then, the doctor would walk in with whatever doctors-in-training would be viewing my naked, prepubescent body that day. They were oftentimes men - whether someone of the opposite sex staring at the naked body of a little girl was humiliating or scary for me was never considered. At each examination, the doctor looked at my full body, to see if any new patches of skin showed signs of having lost their pigment, which is how my condition manifests. By itself, an examination is innocuous - a necessary part of providing healthcare. But during these examinations he put my full, naked body on display for his students - like an exhibit or a sideshow. And when I say my full body, I mean exactly that. I was forced to lie on a table while he pulled back the flimsy paper gown I was wearing to expose my chest, my back, my belly - and everything else one typically does not show publicly. The part I hated most was when he would pull down my underwear. To this day I feel his hands on me, pulling down the thin piece of cloth that protected me from the strange eyes standing behind him, staring at my most private areas. I was so acutely aware of those eyes - gaping at me like someone usually gawks at an animal in a zoo - that I could physically feel them on my skin. They had no regard for my dignity, my privacy, or my feelings. They only cared about how they could use me - how the use of my body was furthering their education. On one or two occasions, they photographed me. To this day, I live with the fact that naked photos of my body have been viewed by who knows how many students, interns, and residents. I was made to feel lower than an animal every time I stepped into that institution's exam rooms, and I have been left with a lifetime of pain and anxiety - and even Post Traumatic Stress Disorder - because of what was done to me.

Because of what happened - because I learned at such a young age how it feels to have one's bodily autonomy taken away and one's body used for the benefit of others - I am terrified of healthcare settings and healthcare professionals. I have flashbacks, nightmares, and panic attacks. I have struggled with physical intimacy since becoming an adult, as I cannot stand the feeling of eyes or hands on my exposed body. And do you remember the story I told earlier, about my least favorite part of examinations being when the doctor would pull down my underwear and allow his students to view my buttocks and genitalia? Because of that, I can't allow anyone to touch my belly - it is excruciating to me, under any circumstances. His hands would always graze my lower belly when he would move to pull my underwear down - and I still feel them there. The mere sensation of fingertips on the skin triggers a flashback and causes me to involuntarily recoil - at times even to scream involuntarily.

If that is the impact that photographs and examinations that were not physically invasive can have, imagine the suffering someone subjected to an unauthorized pelvic, prostate, or rectal examination for the purpose of student or trainee practice must endure. Even if someone is unconscious, the body remembers. And - horrifyingly enough - some people wake up during these exams, or learn about them later from providers who let the information slip in the course of follow up conversations. What must it feel like to enter a hospital for, let's say, a stomach surgery, only to wake up and learn that you were digitally penetrated without your consent - without knowing that this was even a possibility - so that a student (or even multiple students, several in a row) could tick a box on the list of their required clinical experiences. What must it

feel like to learn, after this sickening revelation, that because there is no legislation in place to protect you, a loophole and overly broad and vague language in one of the many consent forms you had to sign in order to access critical treatment means that you have no legal recourse? Worse yet - you have no way to ensure it won't happen again.

Some medical practitioners and healthcare institutions have tried to argue that by seeking treatment at a teaching hospital, patients are giving "implied consent." The fact is, that argument does not hold up, even under the most superficial scrutiny. Patients often do not have a choice regarding the hospital they are brought to for care. In emergency situations when patients are unconscious or otherwise cannot speak for themselves they cannot choose where they are brought. In such situations consent to lifesaving treatment is implied - but consent to the use of their bodies for practice by medical students or trainees is not. Neither, for that matter, is consent implied for any intimate examination that is not urgently necessary to preserve the patient's life or immediate health. And then there are the cases like mine. The cases in which patients or caregivers are told a particular specialist is the only one that can help them or their loved ones, and that specialist happens to practice exclusively out of a teaching institution. Should we be denied the opportunity to receive care just because we do not want our bodies used as specimens or teaching tools? Medical care exists to serve the needs of patients - not students, not trainees, and not the licensed professionals providing treatment. We should not be required to pay for the services we need with our bodies.

Until the legislature adopts a robust informed consent law, every Wisconsin resident runs the risk of undergoing a forced pelvic, prostate, or rectal examination. And these non-consensual exams do happen in Wisconsin - recent peer-reviewed research suggests that they happen in every state without an informed consent law, and disturbingly enough, in some states with laws that lack enforcement mechanisms or a thorough template of what an informed consent process must look like.

Current laws and policies dealing with consent to intimate examinations are not sufficient. Wisconsin residents need their elected legislators to step in - to adopt amendments to strengthen this bill, pass this legislation, and provide them with certainty that they can safely seek medical care without fear or risk of being violated.

## PROPOSED AMENDMENTS

**1. Who does the bill apply to?** Non-consensual exams happen to everyone. That is why we are asking you to broaden the bill to include rectal and prostate exams in addition to pelvic exams.

We also ask that you make a distinction between examinations performed as a part of a patient's care - in other words, those that are medically necessary and benefit the patient - and those that are done specifically for educational purposes and benefit only

students or trainees. Exams conducted solely for educational or training purposes should be voluntary and transparent.

**2. Explicit description of the consent process**, which needs to be separate and discrete (as stated by ACOG and AMA), making it clear who is doing the exams and why. It should include both its own consent form, and a verbal discussion with the surgeon. Any consent form should include on the form a question about how many exams the patient is willing to undergo. The patient should be able to say how many people/exams they consent to, they should have the opportunity to meet students/trainees before undergoing educational exams (just as patients have the opportunity to meet their surgeon prior to an operation), and the student names should be added to the consent form to ensure the patient is only being examined by the specific people they have consented to (just as patients consent to being operated on by a specific surgeon, and an alternate physician cannot be swapped in or included without the patient's knowledge and permission). We also recommend there be a limit to how many educational exams any patient is asked to submit to so as not to overburden any one altruistic patient and put them at more risk of harm, which can happen. We suggest you limit this to 3 exams maximum for any one patient. The risk of coercion could place a greater burden on one person's body if there are no parameters.

**3. When?** Intimate examinations for educational purposes should be limited to surgeries related to such exams (i.e. gynecological surgeries for pelvic exams and colorectal surgeries for prostate and rectal exams). Allowing them in the context of unrelated surgeries (i.e. knee surgeries, stomach surgeries, etc.) places patients at increased risk of coercion and fosters an environment in which non-consensual examinations are more likely to occur.

**4. Liability/accountability/oversight**. Who is liable? To whom? If the enforceability is strictly internal within the hospital or institution, this issue will not change, as we have seen in other states with weaker laws. **Providers and institutions need to be accountable to an external body, such as the state's Department of Public Health**. There must be clear liability for the institution and doctors/preceptors who engage in non-consensual exams.

**5. Whistleblower protections.** We need to protect students/residents/nurses/etc who speak out when they witness or are asked to do non-consensual intimate exams. Students particularly face significant retribution if they choose to speak up when instructed to perform non-consensual exams, ranging from a failing grade to the inability to secure a residency and other consequences that pose a significant threat to their education and future career. Existing whistleblower laws do not protect students. They

only apply to licensed providers or employees. Since students are not licensed nor are they employees, it is critical that this is included in this bill. Both individual medical students and the American Medical Student Association are staunch advocates for these whistleblower protections.

**6. Exceptions.** I suggest including a line specifying that informed consent is not required for intimate examinations (pelvic, prostate, and rectal) **ONLY** in the event that such examinations are necessary to the provision of emergency care, the patient is incapacitated, **AND** the exam is only being performed by a licensed physician or other healthcare provider qualified to perform the exam and make a diagnosis and not for educational or training purposes. Such a provision will preserve access to needed emergency care while protecting patients in such situations from being used for teaching purposes/undergoing extra medically unnecessary exams without their consent.

RAINN

February 10, 2025

The Honorable Representative Clint Moses and members of the committee, I write to offer our support for AB 11 (Representative Goeben), which would ensure patients in Wisconsin do not wake from anesthesia to find they were subject to an invasive pelvic exam without their knowledge. Requiring informed consent protects physicians, students, and parents and supports best practices. We urge the committee to move AB 11 forward.

RAINN is the nation's largest anti-sexual assault organization. Founded in 1994, RAINN created and operates the National Sexual Assault Hotline (800.656.HOPE and hotline.rainn.org). RAINN also carries out programs to support victims, educate the public, and improve public policy.[1]

Intimate examinations, which include pelvic, prostate, and rectal examinations, are medically necessary routines that healthcare professionals conduct to assess the health of internal organs. Many medical students perform practice examinations on patients, who are under anesthesia for other procedures and have not provided explicit, informed consent for the pelvic exam.

A study of medical students from U.S. medical schools showed 61% of respondents who had performed a pelvic exam on an anesthetized patient reported doing so without the patient's explicit consent. A study at the University of Oklahoma found that nearly 75% of these women had not consented to the medical student's exam. Furthermore, 72% of women expect to be asked for permission before an exam under anesthesia (EUA), and 62% say they would consent if they were asked. This is uncomfortable and possibly retraumatizing for patients, and also places medical students in difficult situations. As they navigate the power dynamics involved in their education, students should be supported in practicing asking for informed consent rather than feeling such actions may compromise their learning.

[1] To learn more about this issue or ask us questions, please contact RAINN's Director of State Legislative Affairs, Mollie Montague through policy@rainn.org

RAINN

RAINN has heard from survivors regarding unauthorized pelvic exams on patients, despite many medical institutions publicly stating they do not allow the practice. We know that some of these survivors avoid needed medical care out of fear that an undisclosed exam will be practiced on them while they are unconscious.

Ohio, Florida, Virginia, Texas, Arkansas and more than 20 other states require informed consent for these exams. American College of Obstetricians and Gynecologists (ACOG) and the American Medical Association (AMA) Code of Medical Ethics support informed consent practices for unconscious educational exams. Additionally, The U.S. Department of Health and Human Services (HHS) issued a memorandum 2024 addressing involuntary pelvic exams and supporting state's requirements of explicit informed consent. We encourage Wisconsin to join the growing number of states ensuring transparency and trust in medical environments.

AB 11 would require written informed consent before any possible practice pelvic examination. Requiring informed consent for invasive pelvic exams will improve the quality of every patient's experience with the medical field and maintain a person's agency over their body during medical interactions. Especially for survivors of sexual assault, ensuring that medical interactions are transparent and safe protects against retraumatization and avoidance of needed healthcare from fear. Transparency cannot occur without both the comfort and consent of patients and medical professionals.

We urge you to move this bill forward and stand with survivors of sexual violence in Wisconsin. Thank you for your consideration and continued leadership.

UNIVERSITY OF ILLINOIS
AT URBANA-CHAMPAIGN

**College of Law**

231 Law Building
504 East Pennsylvania Avenue
Champaign, IL 61820-6996

**Robin Fretwell Wilson**

*Mildred Van Voorhis Jones Chair in Law*
University of Illinois College of Law

February 11, 2025

**BY Email**

Chair Clint Moses
2 E Main Street
Madison, WI 53703

**Re: Assembly Bill 11**

Dear Chair Moses:

We write to support Assembly Bill 11 which would require that "written informed consent is obtained from a patient before a pelvic exam is performed solely for educational purposes on the patient while the patient is under general anesthesia or otherwise unconscious."[1]

The passage of Assembly Bill 11 will ensure that norms of autonomy for patients are honored and that patients are not treated as a means to an end. As we explain below, requiring written informed consent for pelvic exams done for teaching purposes guarantees the dignity and respect that patients deserve *without* jeopardizing the quality of patient care or medical education in Wisconsin.

Part A of this letter applauds this important bill, which if signed into law, would make Wisconsin the 29th state in the nation to give patients the right to decide whether medical trainees will perform pelvic exams on them for the students' learning. Part B addresses the claim that intimate exams solely for educational purposes simply *no longer* occur in Wisconsin.[2] Asking for specific consent to perform an intimate exam for a student's training gives patients the dignity and autonomy all patients deserve—and it reinforces the norm for medical professionals that all patients should be respected in deciding what happens with their bodies. Part C details the extent of pelvic examinations for medical training without the patient's consent. Part D documents the strong consensus of medical ethics groups is that such pelvic exams should not occur without explicit consent. Parts E, F, and G refute common justifications for performing such pelvic exams without permission. Specifically, Parts E and F rebut the unfounded justification that patients have impliedly or expressly consented to this upon admission to the hospital. Part G shows empirically, that when asked, patients consent to teaching exams in overwhelming numbers and, consequently, should be enlisted as "respected partners"[3] in medical teaching. Part H remarks on the thoughtful construction of the bill's text.

[1] A.B. 11.
[2] Emma Goldberg, *She Didn't Want a Pelvic Exam. She Received One Anyway*, N.Y. TIMES (Feb. 17, 2020), https://www.nytimes.com/2020/02/17/health/pelvic-medical-exam-unconscious.html. Cleveland Clinic statement.
[3] Jennifer Goedken, *Pelvic Examinations Under Anesthesia: An Important Teaching Tool*, 8 J. HEALTH CARE L.& POL'Y 234, 235 (2005).

## A. Assembly Bill 11 Would Provide Crucial Protections

To be clear, "the pelvic examination is a critical tool to aid in the diagnosis of women's health conditions and remains an important skill necessary for students to master before becoming physicians."[4] The only question is: Should patients have the ability to consent to such critical medical teaching?

Passage of Assembly Bill 11 would place Wisconsin within an emerging legislative trend to require healthcare providers to ask permission before using patients as tools for teaching pelvic exams. Arizona, Arkansas, California, Connecticut, Colorado, Delaware, Florida, Hawaii, Idaho, Illinois, Iowa, Louisiana, Maine, Maryland, Missouri, Montana, Nevada, New Hampshire, New Jersey, New York, Ohio, Oregon, Pennsylvania Rhode Island, Texas, Utah, Virginia, and Washington all require explicit consent for pelvic examinations performed on unconscious patients for teaching purposes.[5] Twenty-two of these states enacted laws in the last sixty months. **With the passage of Assembly Bill 11, Wisconsin would become the 29h state to require informed consent to educational pelvic exams, as Table 1 shows**.

**Table 1**
**Features of Enacted Pelvic Exam Legislation**

Table 1. Features of Proposed and Enacted Intimate Exam Legislation

| | Gender Neutral Language | Types of Exams Covered | | Patients Protected | | Regulates Educational Exams | | | Actors Regulated | | | Regulated Actions | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Enacted Laws | | Pelvic Exams Only | Pelvic Exams and Others | Anesthetized or Unconscious | Conscious | Educational Only | Educational and Others | Other Exams Only | Trainees | Healthcare Professionals | Healthcare Systems* | Perform | Supervise** | Observe |
| MT HB 417 (2023) | ✓ | | ✓ | ✓ | | | ✓ | | ✓ | ✓ | | ✓ | ✓ | |
| CO HB 1077 (2023) | ✓ | | ✓ | ✓ | | | ✓ | | ✓ | ✓ | | ✓ | | |
| MO SB 106 (2023) | ✓ | | ✓ | ✓ | | | ✓ | | ✓ | ✓ | | ✓ | ✓ | |
| CT HB 5278 (2022) | ✓ | | ✓ | ✓ | | | ✓ | | ✓ | ✓ | | ✓ | | |
| NJ S1771 (2022) | ✓ | | ✓ | ✓ | | | ✓ | | | ✓ | ✓ | ✓ | | |
| RI HB5544 (2021) | | ✓ | | ✓ | | | ✓ | | | ✓ | | ✓ | ✓ | |
| NV SB 196 (2021) | ✓ | ✓ | | ✓ | | | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | |
| TX HB 1434 (2021) | ✓ | | ✓ | ✓ | | | ✓ | | ✓ | ✓ | | ✓ | | ✓ |
| AZ SB 1017 (2021) | ✓ | ✓ | | ✓ | | | ✓ | | | ✓ | | ✓ | ✓ | |
| AR HB 1137 (2021) | ✓ | ✓ | | ✓ | | | ✓ | | ✓ | ✓ | | ✓ | | |
| NH HB 1639 (2020) | ✓ | | ✓ | ✓ | | | ✓ | | ✓ | ✓ | | ✓ | | |
| WA SB 5282 (2020) | ✓ | ✓ | | ✓ | | | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | |
| ME LD 1948 (2020) | ✓ | | ✓ | ✓ | | | ✓ | | | ✓ | | ✓ | ✓ | |
| LA HB 435 (2020) | ✓ | | ✓ | ✓ | | | ✓ | | | ✓ | ✓ | ✓ | | |
| FL SB 698 (2020) | ✓ | ✓ | | | ✓ | | ✓ | | ✓ | ✓ | | ✓ | | |
| NY SB 1092 (2019) | ✓ | ✓ | | ✓ | | | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | |
| DE HB 239 (2019) | ✓ | | ✓ | ✓ | | | ✓ | | | ✓ | | ✓ | ✓ | |
| MD SB 909 (2019) | ✓ | | ✓ | ✓ | | | ✓ | | ✓ | ✓ | | ✓ | | |
| UT SB 188 (2019) | ✓ | | ✓ | ✓ | | | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ |
| IL HB 313 (2017) | ✓ | | ✓ | ✓ | | | ✓ | | ✓ | ✓ | | ✓ | | |
| IA HF 653 (2017) | ✓ | ✓ | | ✓ | | | ✓ | | ✓ | ✓ | ✓ | ✓ | | |
| HI HB 2232 (2012) | | ✓ | | ✓ | | | ✓ | | ✓ | ✓ | | ✓ | | |
| OR HB 2908 (2011) | | ✓ | | ✓ | | | ✓ | | ✓ | ✓ | ✓ | ✓ | | |
| VA HB 2969 (2006) | | ✓ | | ✓ | | ✓ | | | ✓ | | | ✓ | | |
| CA AB 663 (2003) | | ✓ | | ✓ | | | ✓ | | ✓ | ✓ | | ✓ | | |

* "Healthcare System" refers to hospitals and institutions.

** Even if trainees are not explicitly mentioned in the language of the bill, the bill applies to them if there is mention of a health care professional "supervising" an exam.

[4] Maya M. Hammoud et al., *Consent for the Pelvic Examination Under Anesthesia by Medical Students*, 134 Obstetrics & Gynecology 1303 (2019).
[5] *See* Table 1.

Like the laws of those 28 states, Assembly Bill 11 would ensure that every hospital will have a policy requiring written consent of the patient before a trainee performs a pelvic examination on the unconscious or anesthetized patient for the student's benefit.

This duty can be fulfilled with no added cost. Hospitals already facilitate the duty by physicians to obtain informed consent to medical procedures.[6] Thus, hospitals can facilitate informed consent to medical teaching.

Bioethicists see this as a given. The former director of the Center for Bioethics and Medical Humanities at the Medical College of Wisconsin, Robyn Shapiro, said: "I would be very surprised to run across a state that didn't have that sort of a law."[7]

### B. Answering the Claim that it "Does Not Happen Here" and "If It Does, We Transparently Ask"

Some medical educators and hospital administrators reflexively assume that medical teaching exams without explicit consent never occur. As we show below, pelvic teaching exams without consent have persisted for more than the two decades that one of us has worked on this question.

As McGill University Bioethics Professor Phoebe Friesen states, medical students widely report being asked to do such exams without the specific consent of the patients.[8]

A 2022 survey of 1,169 people within the United States drawn from a nationally representative sample found that "1.4 percent of respondents reported having received a pelvic or prostate exam within the past five years without their explicit prior consent."[9] The authors extrapolated from that figure to estimate that "potentially 3.6 million U.S. residents may have received an unconsented rectal, prostate or pelvic exam."

Against this evidence, some medical educators contend that laws are unnecessary because the communication about the educational nature of the exam is already transparent.[10]

In recent years, patients have come forward after discovering that they have been used for medical teaching without permission, as we show below. The patients say they were never asked. Without disclosure, how would they have ever known? By their very nature, pelvic exams for the purpose of teaching abnormal anatomy occur while the patient is under anesthesia or unconscious. Asking patients to police what is happening to them while they are asleep is asking them to do the impossible. And asking medical students to act as whistleblowers to end this practice is unrealistic and unfair.

Given the fast pace of medical education and teaching on the wards, teaching faculty may simply be unaware when a student or faculty member forgets to ask for specific permission, whether advertent or inadvertent. Further, given the rise of community teaching hospitals, it is difficult for medical schools and

---

[6] Alan Meisel, *Canterbury v. Spence: The Inadvertent Landmark Case*, in HEALTH LAW AND BIOETHICS: CASES IN CONTEXT (Sandra H. Johnson, Joan H. Krause, Richard S. Saver, & Robin Fretwell Wilson, eds., Aspen Publishers, 2009).
[7] Lorelei Laird, *Pelvic exams performed without patients' permission spur new legislation,* 105 ABA J. 20 (Sept. 1, 2019), https://www.abajournal.com/magazine/article/examined-while-unconscious.
[8] Phoebe Friesen, *Why Are Pelvic Exams on Unconscious, Unconsenting Women Still Part of Medical Training?*, SLATE (Oct. 30, 2018), https://slate.com/technology/2018/10/pelvic-exams-unconscious-women-medical-training-consent.html.
[9] Lori Bruce, Ivar Hannikainen, & Brian Earp, *New Findings on Unconsented Intimate Exams Suggest Racial Bias and Gender Parity*, 52 HASTINGS CENTER REP'T 7 (2022).
[10] Julia Cron & Shefaly Pathy, *2 Ob-Gyns, on Pelvic Exams and Patients' Consent*, N.Y. TIMES, Feb. 24, 2020, https://www.nytimes.com/2020/02/24/opinion/letters/pelvic-exams-consent.html.

their principal teaching hospitals to know whether their rigorous consent practices are adhered to at smaller, far-flung hospitals where medical teaching occurs.[11] Hence the need for this bill.

It is important to unpack exactly what counts as a training exam. In the typical case, an intimate exam may be performed by the attending physician or a resident to reconfirm a diagnosis before surgery, followed by a second or third exam done for the benefit of students who are present.[12] A fourth-year medical student at Ohio University, Alexandra Fountaine, explained last year:

> "This is very common practice," she said. "It happens a lot, unfortunately."
> On her first day of rotations as a third-year medical student, when Fountaine was in the operating room of a Columbus hospital, "the senior resident looked at me and said, 'Hey, now's a good time to practice your pelvic exam,'" she said.
> "I thought, 'Oh my gosh. Is this happening'?" she said. "I knew it was wrong. I almost panicked."
> When asked if the patient required a pelvic exam, Fountaine said, "Not to my knowledge. She did not."[13]

Alexandra said she did not know whether the patient had given consent for the exam, with the doctor assuring her that performing a pelvic exam was fine and "for her education."[14]

Now consider what teaching hospitals and surgical consent forms tell patients about these training exams. A typical consent form reads:

> We require that all providers obtain prior consent from patients before any intimate (genital, rectal or pelvic) examination is performed under anesthesia. … In addition, these examinations are only performed when medically necessary, as part of the surgery or for surgical planning purposes.[15]

But notice what the first this statement does **not** explain: some exams are duplicates done for the students' training, just as Ms. Fountaine described.

Saying exams are performed only when medically necessary, as part of the surgery, is not enough to secure explicit consent to the training nature of some intimate exams.

Helping care for the patient and training students by using the patient are two different things. Paragraph 9 of OSU's Consent Form does not alert the patient that a pelvic, prostate or rectal examination may be performed for somebody else's educational benefit. Assembly Bill 11 simply requires what medical ethicists agree must be done: explicitly secure the consent of patients to the training of the next generation of medical professionals.[16]

---

[11] 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) [hereinafter Autonomy Suspended].
[12] *See, e.g.*, Autonomy Suspended (documenting this practice and showing that duplicate exams cannot, by definition, be justified as being necessary for the patient's care).
[13] NBC5Cleveland.
[14] AP NEWS [FULL CITATION?]
[15] NBC5Cleveland.
[16] Marti Leitch, Director, Media Relations, Wexner Medical Center, described the duty of explicit consent this way:

> Procedures under anesthesia, such as pelvic, rectal, breast and other examinations for teaching purposes, require specific consent and medical students should not perform such an examination unless that consent has been obtained. Such examinations should be related to the planned procedure, performed by a student who is recognized by the patient as part of their care team and should be done under direct supervision by the educator.

Other states have explained the need for these laws as responding to concerns by medical students that they may be asked to act unethically, by not candidly and forthrightly securing informed consent to their training. Maryland recognized that while the state's teaching hospitals have informed consent policies, an explicit state law would not only protect patients but assure students that they would not be asked to do something unethical.[17] Maine lawmakers enacted a specific consent law precisely so that "medical students asked to perform the procedure know they are acting ethically."[18] The sponsor of New York's law, Senator Jessica Ramos, put it this way: "The importance of instilling the value of informed consent on medical students cannot be underestimated."[19]

In her interview on Wisconsin Public Radio on April 25, 2023, Chief Executive Officer of the Wisconsin Nurses Association Gina Dennik-Champion succinctly captured how consent and voluntary participation forms the essence of medical ethical principles:

> [W]e have our code, and no one should be coerced into number one, performing an exam where they're not comfortable. Secondly, not having the permission of that individual. It smacks us right into our code of ethics….[20]

Trust in the health care system and professions is vital as it affects patient satisfaction, willingness to seek care, and treatment compliance.[21] Moreover, trust is essential to the physician-patient relationship because of the inherent risk and uncertainty of medical care.[22] In 2018, only 34% of Americans reported a positive view of the healthcare industry.[23] This is a staggering decrease from 1975, when 80% reported a positive view.

More fundamentally, Assembly Bill 11 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 patients the dignity and autonomy all patients deserve. And if such exams never occur without consent, Assembly Bill 11 will reinforce the norm that all patients should be respected in deciding what happens with their bodies. And it will teach students that consent is non-negotiable.

Assembly Bill 11 is a no-harm-no-foul proposition, even as to facilities that have already instituted policies that respect patient autonomy. It will ensure that specific consent is afforded to patients.

### C. The Extent of the Practice

Despite widespread ethical condemnation that "the practice of performing pelvic examinations on women

---

NBC5Cleveland.

[17] Jennifer McDermott & Carla K. Johnson, *States Seek Explicit Patient Consent for Pelvic Exams*, NBC CONN. (May 12, 2019, 1:48PM), https://www.nbcconnecticut.com/news/local/bills-seek-special-consent-for-pelvic-exams-under-anesthesia/153538/.

[18] Associated Press, *States seek explicit patient consent for pelvic exams*, NEWS CTR. ME. (May 12, 2019), https://www.newscentermaine.com/article/news/nation-world/states-seek-explicit-patient-consent-for-pelvic-exams/417-03352df8-4979-4152-8b58-26e7b7e205a4.

[19] 2019 New York S. 3353.

[20] Trevor Hook, *Renewed bipartisan legislation pushes for consent for pelvic exams on unconscious patients*, WISCONSIN PUBLIC RADIO (April 25, 2023), https://www.wpr.org/renewed-bipartisan-legislation-pushes-consent-pelvic-exams-unconscious-patients.

[21] *See generally* Oswald A.J. Mascarenhas et al., *Hypothesized Predictors of Patient-Physician Trust and Distrust in the Elderly: Implications for Health and Disease Management*, 1 CLIN. INTERVENTIONS AGING 175 (2006).

[22] Katrina Armstrong et al., *Racial/Ethnic Differences in Physician Distrust in the United States*, 97 AM. J. PUB. HEALTH 1283, 1283 (2007).

[23] Daniel Wolfson, *Commentary: Erosion of trust threatens essential element of practicing medicine*, MOD. HEALTHCARE (Mar. 9, 2019), https://www.modernhealthcare.com/opinion-editorial/commentary-erosion-trust-threatens-essential-element-practicing-medicine.

under anesthesia, without their knowledge and approval, [is] unethical and unacceptable,"[24] experience shows that unauthorized exams continue across the U.S. One of us wrote about a woman in Arizona who discovered she received an unauthorized pelvic exam after ***stomach***, not gynecological surgery.[25] In testimony to the Utah Senate Health and Human Services Committee, Ms. Ashley Weitz testified that she had an unauthorized pelvic exam while sedated in the emergency room.[26] Medical students spanning the country from North Carolina to Ohio to Texas report that they have been asked to do exams without consent.[27]

Empirical studies document the persistent nature of unauthorized pelvic examinations. A 2020 survey accepted by the 2021 Council on Resident Education in Obstetrics and Gynecology & The American College of Obstetricians and Gynecologists Annual Meeting reported that 83.6% of the medical students surveyed across five medical schools attached to large academic medical centers performed a pelvic exam on a patient under anesthesia.[28] When asked how often patients were explicitly told that an educational pelvic examination would take place under anesthesia, only 17% of surveyed students replied "every time." Notably, 22.3% replied "rarely" and 20.3% replied "never." Clearly, ethics pronouncements and media attention alone have not sufficed to ensure that patients are asked to be used for teaching purposes.

Historic studies show the same pattern. 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.[29] 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.[30] In 1992, Charles Beckmann reported that 37.3% of United States and Canadian medical schools reported using anesthetized patients to teach pelvic exams.[31]

As Table 1 above shows, the latest iteration of laws across the country also extends protection to men, for rectal and prostate exams. Yet the overwhelming evidence is that the widespread practice of teaching intimate exams without consent is a practice of using women to teach pelvic exams.[32]

### D. The Legislative and Professional Response

[24] AMERICAN ASSOCIATION OF MEDICAL COLLEGES, AAMC Statement on Patient Rights and Medical Training (June 12, 2003).
[25] Robin Fretwell Wilson & Anthony Michael Kreis, *#JustAsk: Stop Treating Unconscious Female Patients Like Cadavers*, CHICAGO TRIBUNE (Nov. 30, 2018), https://www.chicagotribune.com/news/opinion/commentary/ct-perspec-pelvic-nonconsensual-exam- medical- students-vagina-medical-1203-story.html.
[26] Laird, *supra* note 7.
[27] ASSOCIATED PRESS, *Bills seek special consent for pelvic exams under anesthesia,* SAVANNAH MORNING NEWS, May 12, 2019, https://www.savannahnow.com/zz/news/20190512/bills-seek-special-consent-for-pelvic-exams-under-anesthesia/1; Interview with Krithika Shamanna Symone on MSNBC, https://drive.google.com/file/d/14bwqysIJUVzlVtoxQnI1MFIcKpuz9Gpl/view; Lisa Desjardins, *Why more states are requiring consent for pelvic exams on unconscious patients*, PBS NEWSHOUR, Feb. 11, 2023, https://www.pbs.org/newshour/show/why-more-states-are-requiring-consent-for-pelvic-exams-on-unconscious-patients (quoting medical student Alexandra Fontaine).
[28] Hannah Millimet et al., *Medical Student Perspective on Pelvic Exams Under Anesthesia: A multi-Institutional Study* (2020) (unpublished manuscript) (on file with author).
[29] S. Schniederjan & G.K. Donovan, *Ethics versus education: pelvic exams on anesthetized women*, 98 J. OKLA. ST. MED. ASS'N 386 (2005).
[30] Peter A. Ubel, Christopher Jepson, & Ari Silver-Isenstadt, *Don't Ask, Don't Tell: A Change in Medical Student Attitudes After Obstetrics/Gynecology Clerkships Toward Seeking Consent for Pelvic Examinations on an Anesthetized Patient*, 635 AM. J. OBSTETRICS & GYN. 575, 579 (2003).
[31] Charles R. B. Beckmann et al., *Gynaecological Teaching Associates in the 1990s*, 26 MED. EDUC. 105, 106 (1992).
[32] *But see* Bruce et al, *supra* note 11 (reporting that "1.4 percent of male and 1.3 percent of female respondents answer[ed] "yes" to having received a [unconsented intimate teaching exam] within the past five years").

In response to the unauthorized use of patients, twenty-eight states across the U.S. by legislation now require explicit consent for pelvic examinations on unconscious patients for medical teaching purposes.[33] This legislation reflects the consensus of professional medical organizations that healthcare providers should obtain explicit for pelvic teaching exams.[34] In the "Statement on Patient Rights and Medical Training" in 2003, the American Association of Medical Colleges, which—represents 144 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and 90 academic and scientific societies—described "pelvic examinations on women under anesthesia, without their knowledge and approval ... [as] unethical and unacceptable."[35]

In an August 2011 Committee on Ethics ruling reaffirmed in 2020, the American College of Obstetricians and Gynecologists provided 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."[36] 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 are performed solely for teaching purposes should be performed only with her specific informed consent before her surgery."[37] An American Medical Association Forum in January 2019, authored by 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."[38]

A growing chorus of bioethicists challenge the need for unconsented exams. Pelvic examinations have a "different moral significance than suturing a wound."[39] Even when pelvic examinations are done with a woman's knowledge, women are "frequently nervous before [the procedure], reporting feeling vulnerable, embarrassed, and subordinate." Significantly, the feelings of distress are heightened for victims of sexual assault.[40] Pelvic examinations are especially sensitive experiences.

As the next Parts of this letter demonstrate, however, some teaching faculty offer a number of falsifiable justifications for dispensing with the simple step of asking for permission.[41]

### E. Patients Have Not Implicitly Consented to Pelvic Educational Exams

[33] *See* https://robinfretwellwilson.com/human-rights-for-all.
[34] *See, e.g.*, AMERICAN ASSOCIATION OF MEDICAL COLLEGES., 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) (hereinafter ACOG Ruling No. 500), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2011/08/professional-responsibilities-in-obstetric-gynecologic-medical-education-and-training; 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").
[35] AMERICAN ASSOCIATION OF MEDICAL COLLEGES, *supra* n. 40.
[36] ACOG Ruling No. 500, *supra* n. 40.
[37] *Id*.
[38] Eli Y. Adashi, *Teaching Pelvic Examination Under Anesthesia Without Patient Consent*, 321(8) JAMA 732 (Feb. 26, 2019), https://pubmed.ncbi.nlm.nih.gov/30806680/.
[39] Phoebe Friesen, *Why Are Pelvic Exams on Unconscious, Unconsenting Women Still Part of Medical Training?*, SLATE (Oct. 30, 2018), https://slate.com/technology/2018/10/pelvic-exams-unconscious-women-medical-training-consent.html.
[40] *Id*.; Robin Fretwell Wilson et al., *supra* note 39.
[41] 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).

The first justification that teaching faculty advance is that patients have implicitly consented by accepting care at a teaching hospital. Empirical evidence suggests that many patients do not consciously choose teaching facilities or even know they are in one.[42]

Indeed, in the U.S., a large number of facilities give little indication to prospective patients of the hospital's teaching status. Public disclosure of hospitals' teaching status varies drastically. Some hospitals, like Duke University Medical Center and The Johns Hopkins Hospital, indicate their medical school affiliation in their name.

Of the approximately 400 members of the Association of American Medical Colleges Hospital/Health System Members, only 94—less than 25%—contain the word "college" or "university" in their name.[43]

To make this concrete, consider the web of relationships in a single teaching hospital, the University of Pennsylvania Hospital. Its webpage notes that the Penn Medicine has "several hospitals and hundreds of outpatient centers throughout the region."[44] While some of them are clearly identified as part of the University of Pennsylvania, other names do not suggest an affiliation with the University of Pennsylvania or otherwise tip patients off to their statuses as teaching facilities. This example is used only to make the point that patients are unaware of the educational nature of many patient encounters.

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. Reasonably, a patient may know that New York-Presbyterian Hospital, located less than sixty feet from the Columbia Medical University College of Physicians & Surgeons, is a teaching hospital.[45] However, patients at the 11 facilities associated with Columbia's medical school throughout New York, Connecticut, and New Jersey cannot possibly know on constructive notice without doing their own research online.[46]

### F. Patients Have Not Expressly Consented to Pelvic Educational Exams

Many teaching faculty assert that the patient has consented to educational exams upon admission.[47] 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.[48] A variant on this claim holds that if consent was obtained for one procedure, it encompasses consent for additional, educational procedures.[49]

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

---

[42] 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).
[43] PENN MEDICINE, https://www.pennmedicine.org/practices.
[44] *Id.*
[45] 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, https://www.google.com/maps.
[46] *Affiliated Hospitals and Institutions*, COLUMBIA VAGELOS COLLEGE OF PHYSICIANS AND SURGEONS, https://www.ps.columbia.edu/about-us/explore-vp-s/affiliated-hospitals-and-institutions.
[47] AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS (ACOG), COMM. OPINION 181: ETHICAL ISSUES IN OBSTETRIC-GYNECOLOGICAL EDUCATION 2 (1997).
[48] 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.").
[49] *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).

> [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.[50]

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

Some teaching faculty and residents believe that additional exams by students are, in fact, for the patient's benefit because the student might detect something missed by others. Yet, a patient would not receive multiple exams in a non-teaching facility context. The better practice would be to ask for permission for all exams—both those needed to reconfirm a diagnosis before surgery and any additional educational exam.

### G. 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 won't consent."

However, studies have shown that women will consent to pelvic examinations for educational purposes. These include not only "hypothetical" studies—asking patients how they would respond if asked to do a variety of things—but also studies of actual women giving consent to real exams.

For example, in 2021 Julie Chor found that after asking for explicit consent in a family planning clinic, 89.6 percent of surgical patients agreed an additional exam for the medical training of the next generation of providers.[51]

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.[52] In a private practice setting, another study found refusal rates of approximately 5% to perform educational pelvic exams.[53] 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.[54]

Even more women consent to examinations before surgery. In one study in the U.K., 85% of patients awaiting surgery consented to educational exams by students while the patient was under anesthesia.[55] 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.[56]

Operationalizing consent so that it is not a barrier to teaching requires nothing more than planning and common-sense devices. Maya and colleagues suggest, as one example, "[s]tickers on the main consent

---

[50] *About Prisma Health*, PALMETTO HEALTH RICHLAND, https://www.palmettohealth.org/patients-guests/about-prisma-health.
[51] J. Chor, "Consenting for Pelvic Exams under Anesthesia with Learners," paper presented at the 33rd Annual MacLean Center Conference, Chicago, IL, November 13, 2021, https://www.youtube.com/ watch?v=wbFWn0K1lVI.
[52] S. Wainberg et al., *Teaching pelvic examinations under anaesthesia: what do women think?*, 32 J. OBSTET. GYNAECOL CAN 49 (2010), https://pubmed.ncbi.nlm.nih.gov/20370981/.
[53] Lawton et al., *Patient Consent for Gynaecological Examination*, 44 BRIT. J. HOSP. MED. 326, 329 (1990).
[54] Peter A. Ubel & Ari Silver-Isenstadt, *Are Patients Willing to Participate in Medical Education?*, 11 J. CLINICAL ETHICS 230, 232-33 (2000).
[55] Lawton, *supra* note 61, at 329.
[56] Ubel & Silver-Isenstadt, *supra* note 62, at 234.

form attesting that discussion of examination under anesthesia was done and consent obtained (similar to "time out" documentation stickers)." [57]

### H. Thoughtful Construction of Assembly Bill 11 and the Need for Regulation

Self-regulation in the medical field is prized.[58] But states, in fact, regulate healthcare and transparency in particular when important societal values are at stake. Consider medical records. Federal Law regulates and protects medical records, as one example.[59]

The sponsors of this bill have put much thought into constructing the language of Assembly Bill 11 so that its implementation does not become a burden. Assembly Bill 11 uses a straight-forward test for when a patient's written consent is not needed: namely when the exam is "performed solely for educational purposes on the patient while the patient is under general anesthesia or otherwise unconscious."[60]

Some have rightly raised concerns that, if badly constructed, an explicit consent statute might inadvertently impede the care of patients who have experienced a sexual assault or who need emergency care.[61] Note that the test in the Assembly Bill 11 does ***not impede care*** for patients who present in an emergency or who present unconscious but may have experienced a sexual assault. Assembly Bill 11 is tailored so it would be feasible in practice and not hinder these vital medical processes.

Importantly, Assembly Bill 11 promotes accountability by establishing a rule that requires hospitals to "maintain written policies and procedures requiring written informed consent to be obtained from a patient before a pelvic examination is performed solely for educational purposes on the patient while the patient is under general anesthesia or otherwise unconscious."[62]

### I. Conclusion

Without adequate safeguards to protect the autonomy of women and men to consent to medical teaching, many will be reduced to acting as "medical practice dummies" without their knowledge or permission. Many patients would gladly consent if only asked.

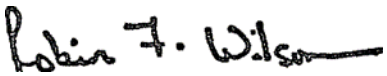
Assembly Bill 11 would bring Wisconsin into line with other states that give patients the autonomy to decide to participate in medical teaching. It would affirm the dignity of persons at a time of great vulnerability, building trust and accountability in the healthcare system.

We welcome any opportunity to provide further information or analysis or testimony to the State of Wisconsin Legislature.

---

[57] Maya M. Hammoud et al., *Consent for the Pelvic Examination Under Anesthesia by Medical Students*, 134 OBSTETRICS & GYN. 1303 (2019).
[58] Roger Collier, *Professionalism: The Privilege and Burden of Self-regulation*, 184 CAN. MED. ASS'N J. 1559(2012).
[59] 45 C.F.R. § 164.508, Uses and disclosures for which an authorization is required.
[60] A.B. 11.
[61] Trevor Hook, *Renewed bipartisan legislation pushes for consent for pelvic exams on unconscious patients*, WISCONSIN PUBLIC RADIO (April 25, 2023), https://www.wpr.org/renewed-bipartisan-legislation-pushes-consent-pelvic-exams-unconscious-patients (quoting Gina Dennik-Champion, Chief Executive Officer, Wisconsin Nurses Association).
[62] A.B. 11.

Respectfully Yours,[63]



**Robin Fretwell Wilson**
*Mildred Van Voorhis Jones Chair in Law*
University of Illinois College of Law
*Fulbright Scholar in Law and Sustainability*
NOVA School of Law, Portugal

**Katja Brutus**
M.D. Candidate, Class of 2027
University of Florida College of Medicine

**Kimball Yeates**
Bachelor of Liberal Arts Candidate, Class of 2024
Brigham Young University

**Sophia Andrade**
Bachelor of Liberal Arts Candidate, Class of 2025
University of Illinois Urbana-Champaign

[63] Academic affiliation is for identification purposes only. We write in our individual capacities and our universities take no position on this or any other bill.

February 12, 2025

Assembly Committee on Health, Aging and Long-Term Care

Re: Assembly Bill 11: An Act to create 50.373 of the statutes relating to: pelvic exams on unconscious patients and creating an administrative rule related to hospital requirements for pelvic exams on unconscious patients

Dear Chair Moses and members of the Assembly Committee on Health, Aging and Long-Term Care:

My name is Ari Silver-Isenstadt and I support Assembly Bill 11. I am a pediatrician based in Baltimore, Maryland, and I co-authored one of the significant studies about consent practices for educational pelvic exams in the United States. This research has been highlighted in At Your Cervix, a new award-winning documentary.

I am asking for your help—for my patients, my students, and my profession.

30 years ago—when I was in medical school during my gynecology rotation, I was expected to hone my pelvic exam skills on already anesthetized women. It was clear to me that these women did not know that I was there for my own educational needs and that my teachers expected me to use the patients' intimate parts as my classroom without their knowledge or permission. I was not expected to provide useful information for the care of the patient based on the pelvic exam I performed. Shortly after this experience, I published a study that showed that 90% of the surveyed medical students in Philadelphia had practiced pelvic examinations on anesthetized patients for educational purposes.

Often, doctors and hospitals provide the following excuse for not obtaining explicit consent for the educational intimate (pelvic and rectal) exam; they say that students are part of the healthcare team. This is very misleading. While students may help support the healthcare team, they are paying for the opportunity to learn, to have access to people receiving medical care so that, as students, they may learn. Students pay for access to patients' bodies. Patients have the right to provide their explicit consent to participate in the student's education.

This practice of using patients without their explicit consent for educational examinations hurts medical students. I published another study that demonstrated that the importance medical students place on informed consent erodes as they progress through their education. I found this with many of my own classmates.

For the last 20 years, I have taught medical students. Students have cried in my office, worried about how a patient would feel if they found out that the student used the patient's body for their own education without having given explicit consent.

People outside of medicine see this problem more clearly. It seems obvious that people be able to explicitly authorize how their bodies are going to be used and by whom. Medical professionals and hospitals defend this outdated practice. They use arguments similar to those used in the past defending the lack of required consent for participation in medical research.

We need you, as legislators, to help put an end to this offensive and embarrassing training practice. As a medical profession, we have been unable to do this ourselves.

Arguments against getting explicit informed consent fall flat under scrutiny. And research shows that patients are willing to provide consent to these examinations, but they want to be asked.

Patients' trust in physicians is crucial for successful health outcomes. Without it, patients may delay seeking care or avoid it completely.

Don't we want our physicians to value truth-telling and to respect our bodily autonomy? Why do we accept a training model that indoctrinates the opposite? I want my profession to stop training practices that hurt both patients and students. I hope you will help ALL of us and vote favorably on this bill.

I believe this bill will be even stronger with the addition of the following protections:

- Broaden the bill to include all pelvic and rectal exams. Once under anesthesia, everyone is vulnerable to non-consensual educational examinations.
- Clarify the role of the medical student by requiring explicit consent for student educational pelvic and rectal examinations. Medically necessary examinations done by the surgeons and student educational examinations may happen during the same surgery. Students do not do these pelvic and rectal examinations as part of the healthcare team; they do them to learn. And they pay tuition for that access.
- Require patients to explicitly provide consent to <u>student</u> pelvic and rectal examinations.
- Require that patients who do not give consent are able to receive care without consequences.
- Provide medical students specific whistleblower protections. Students are not employees, nor are they licensed. They are in a vulnerable position and need protection from consequences if they witness, report, or refuse to participate in non-consensual exams.

Thank you for your consideration and time.

I write in my individual capacity.

Very Truly Yours,

Ari Silver-Isenstadt, MD