Pelvic Exams & Informed Consent

Executive Summary

Pelvic examinations are an important tool in both routine and emergency gynecological medical care. However, instances of these exams being performed without express consent have been reported, particularly in cases where the patient is anesthetized. States and medical facilities have emphasized patient education, autonomy, and informed consent to avoid improper pelvic examinations. However, in teaching hospital settings, absolute rates of unauthorized exams are hard to determine due to potential underreporting. Nineteen states have laws banning unauthorized pelvic exams by medical staff or students. The state of Missouri has similar proposed legislation (HB 1742) seeking to codify these same protections into law.

Highlights

- While the rate of unauthorized exams is unknown, pelvic exams administration has declined from an average of 64.9 to 52.5% of women undergoing the procedure over the last 30 years.
- Standards of legal consent for pelvic examinations vary state-by-state, and are largely addressed by promoting patient education and personal autonomy during informed consent procedures.
- While several states have laws preventing unauthorized pelvic examinations, some of these laws remain vague and may not ensure informed consent was obtained.

Limitations

- Rates of unauthorized procedures at teaching hospitals are hard to determine since many are in low-income urban settings where affordable alternatives may not exist.
- Given that consent standards vary by state, patient perceptions of adequately informed consent may not be entirely addressed with current legislation.

Research Background

Utility of Pelvic Exams

Pelvic exams are often administered either under routine preventive care or in emergency departments when a patient presents with abdominal or vaginal bleeding, pelvic pain, or sexual dysfunction.[1,2] Pelvic exams are also utilized in preventive care for cancer screenings and approving use of oral contraception, but are becoming less common.[3,4]

Virtually no data exists as to how often an anesthetized patient is subjected to an unauthorized pelvic exam.[5] However, nearly 90% of medical students have reported administering a pelvic exam (consent status unknown) on an anesthetized patient.[6] A hospital study also observed that the administration of a pelvic exam changed the medical treatment plan in 6% of patients that

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present with non-specific abdominal or vaginal pain.[1] This may suggest further cost/benefit evaluations and alternatives when deciding to administer in an emergency setting, given the relatively low predictive value for changes to a treatment plan.[1]

Administration of pelvic exams in safe and welcoming settings often determines further seeking of gynecological-related preventive treatment.[7] A case study demonstrated that despite the necessity of preventive screenings, women may avoid scheduling pelvic examinations due to lack of access to a trusted physician, financial concerns, fear of test results, pain, or hesitancy.[8] Efforts have been made to improve the pelvic exam experience, including making tools more anatomically conducive or comfortable and educating physicians on the interpersonal differences of women's anatomy.[8]

Informed Consent and Issues of Malpractice

Many issues regarding the consent of an anesthetized patient during pelvic examinations have been documented, and the drive to address largely by student-physicians.[9] Professional medical societies have endorsed *informed consent* for over a decade when a patient undergoes a pelvic examination, and only when related to another medical procedure.[2] Informed consent is an ethical and legal concept where a health care provider educates a competent patient about the risks, benefits, and alternatives of a given procedure or intervention.[10] With pelvic exams, this includes informing the patient of the process of a pelvic exam, including the use of either gloved fingers or a speculum to access the internal cervix for sample collection and physical inspection.[8] These procedures have potential benefits, such as identifying cervical cancer in sexually active women, as well as risks of the procedure, such as psychological distress, that must be conveyed to a patient.[11]

Sparse U.S. data exists documenting the perception patients have of whether consent was adequately explained and given. This is partially attributable to variable medical education and consent procedures from state-to-state.[12] Claims of *malpractice* (defined as an act by a physician that deviates from accepted norms and causes injury) are handled on a case-by-case basis and judge if a doctor deviated from *standard of care,* often determined by fellow professional testimonial.[12,13] Roughly half of states support a *physician-based* standard of care, whereby a physician is judged by what fellow physicians would have educated the patient on.[12] Alternatively, half of states support a *patient-based* standard, where a physician is responsible for informing the patient of all possible risks a similar patient may face during a medical procedure.[12]

Deferred consent (where consent is unable to be given by the patient or their guardian until the patient is again lucid), is a complicating factor medical staff must navigate in unconscious patients.[14] Growing numbers of U.S. hospitals (roughly 1 in 6) are beginning to circumvent these issues by issuing *bundled consent* forms, whereby hospitals obtain written consent for a predefined set of intensive care unit procedures.[15]

Challenges in Obtaining and Setting a Standard of Consent for Intimate Examinations

A review of explicit consent in intimate examinations found that several difficulties exist in regard to pelvic or anal exams. First, medical-teaching doctors often default to using existing consent forms, since added focus on the intimacy of such exams risks contributing to lower overall doctor visits and poorer health.[16] Second, teaching doctors contend that increased focus on consent may make students focus on doctor-patient dynamics instead of objective physiological practice.[16] Consensus recommendations for improvement have included explicit consent or education of the patient, upgrades to the medical curriculum, and a change in culture in medical teaching that vocalizes student apprehensions in participating in unconsented exams.[16] Further, teaching hospitals are often the only affordable option in urban settings for obtaining care, and may affect perceived consent if other options for care do not exist.[17]

The psychological state of women arriving for routine care is one aspect considered during the administration and consenting of the pelvic exam. One study has noted the use of personalized care techniques: 1) the *educational exam*, where patients are given a mirror or screen and talked through the anatomical process by the doctor, 2) *psychological preparation*, where the patient is informed of the necessity of the exam prior to a surgical procedure, and 3) *personal control*, where doctor and patient are encouraged to vocalize perceived pain, ask for a chaperone, have the ability to stop the procedure, and communicate anxieties and personal coping strategies prior to and during the exam.[18]

Current State-level Legislation

At present, 19 states have explicit rules banning pelvic exams without explicit consent by the patient or their authorized designee (Figure 1).[19] However, several of these laws lack language stating how consent is to be documented and communicated to all medical staff; patients may possibly still perceive that informed consent was not given.[2]

A proposal has been introduced for the upcoming 2022 Missouri legislative session (HB 1742) that bans health care providers or their students from performing any unauthorized pelvic, prostate, or anal examination on an anesthetized patient without explicit written consent from the patient or their guardian. Five other states are also considering similar legislation.

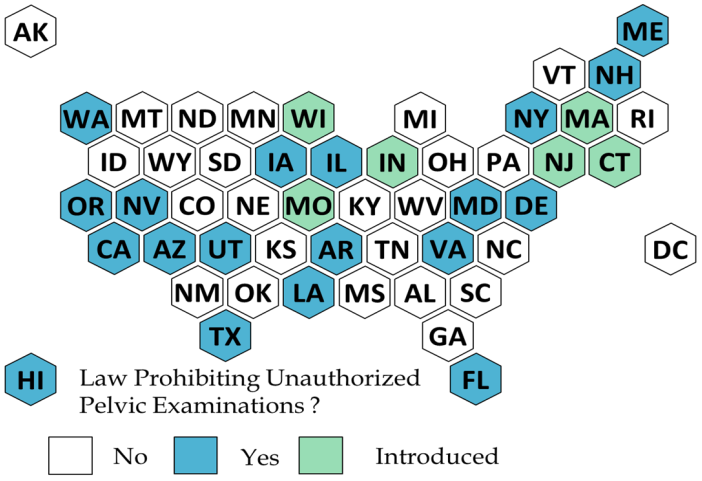

Figure 1: Map of states with documented pelvic exam laws. States with documented laws banning unauthorized pelvic exams shaded in blue. States with laws introduced in the 2021 legislative session shaded in green. Figure adapted from the Epstein Health Law and Policy Program.[19]

References

1. Brown, J., Fleming, R., Aristzabel, J. & Gishta, R. (2011). Does pelvic exam in the emergency department add useful information? West. J. Emerg. Med. 12, 208-212.
2. Hammoud, M. M., Spector-Bagdady, K., O'Reilly, M., Major, C. & Baecher-Lind, L. (2019). Consent for the Pelvic Examination Under Anesthesia by Medical Students: Recommendations by the Association of Professors of Gynecology and Obstetrics. Obstet. Gynecol. 134, 1303-1307, doi:10.1097/aog.0000000000003560.
3. Byron, R. K., Watkins, V. Y., Stiles, A., Trieu, E. & Truong, M. D. (2019). The Utility of Annual Pelvic Exams in Asymptomatic Women [33K]. Obstet. Gynecol. 133.
4. Martinez, G. M., Qin, J., Saraiya, M., and Sawaya, G.F. (2019). Receipt of Pelvic Examinations Among Women Aged 15–44 in the United States, 1988–2017, <https://www.cdc.gov/nchs/products/databriefs/db339.htm>.
5. Friesen, P. (2018). Educational pelvic exams on anesthetized women: Why consent matters. Bioethics 32, 298-307, doi:10.1111/bioe.12441.
6. Ubel, P. A., Jepson, C. & Silver-Isenstadt, A. (2003). Don't ask, don't tell: a change in medical student attitudes after obstetrics/gynecology clerkships toward seeking consent for pelvic examinations on an anesthetized patient. Am. J. Obstet. Gynecol. 188, 575-579, doi:10.1067/mob.2003.85.
7. Wells, G. M. (1977). Reducing the threat of a first pelvic exam. MCN Am. J. Matern. Child Nurs. 2, 304-306, doi:10.1097/00005721-197709000-00010.
8. Taylor, G. A., McDonagh, D. & Hansen, M. J. (2017). Improving the Pelvic Exam Experience: A Human-Centered Design Study. The Design Journal 20, S2348-S2362, doi:10.1080/14606925.2017.1352750.
9. Dwyer, J. & Rothstein, J. (1993). Case Study: One More Pelvic Exam. The Hastings Center Report 23, 27-29, doi:10.2307/3562920.
10. Shah, P., Thornton, I., Turrin, D. & Hipskind, J. E. (2021) StatPearls (StatPearls Publishing Copyright © 2021, StatPearls Publishing LLC).
11. Bloomfield, H. E. et al. (2013). Screening Pelvic Examinations in Asymptomatic Average Risk Adult Women. (Department of Veterans Affairs (US)).
12. Weinmeyer, R. (2014). Lack of standardized informed consent practices and medical malpractice. Virtual Mentor 16, 120-123, doi:10.1001/virtualmentor.2014.16.02.hlaw1-1402.
13. Bal, B. S. (2009)). An introduction to medical malpractice in the United States. Clin Orthop Relat Res 467, 339-347, doi:10.1007/s11999-008-0636-2.
14. van Wijk, R. P. J. et al. (2020). Informed consent procedures in patients with an acute inability to provide informed consent: Policy and practice in the CENTER-TBI study. J. Crit. Care 59, 6-15, doi:https://doi.org/10.1016/j.jcrc.2020.05.004.
15. Espinosa, M. L. et al. (2020). Bundled Consent in US Intensive Care Units. Am. J. Crit. Care 29, e44-e51, doi:10.4037/ajcc2020502.
16. Bruce, L. (2020). A Pot Ignored Boils On: Sustained Calls for Explicit Consent of Intimate Medical Exams. HEC Forum 32, 125-145, doi:10.1007/s10730-020-09399-4.
17. Burgoon, M. L., Miller, P. A., Hoover-Hankerson, B., Strand, N. & Ross, H. (2020). Challenges to Understanding and Compliance Among Surgical Patients in Low-Income Urban Teaching Hospitals. The American Surgeon, 0003134820960078.
18. Domar, A. D. (1986). Psychological Aspects of the Pelvic Exam. Women Health 10, 75-90, doi:10.1300/J013v10n04_07.
19. Legislative Action: States Banning Unauthorized Pelvic Examinations, (2021). <https://www.epsteinprogram.com/states-banning-unauthorized-pelvic-exams>.