WAIT…WHY DID I AGREE TO THAT?
WHY THE PATIENT CENTERED STANDARD UNDER THE DOCTRINE OF INFORMED CONSENT SHOULD BE APPLIED TO PELVIC EXAMS IN ASYMPTOMATIC WOMEN

Lily Burdick*

Abstract: In 2020, Columbia University OBGYN Robert Hadden was arrested for a second time for sexually abusing his patients. By the end of 2020, at least 245 women had accused Hadden of abuse over multiple decades. While most licensed physicians do not sexually abuse patients, the scope of the abuse is difficult to determine. This is because hospitals, clinics, and fellow doctors fail to report misconduct, medical boards handle complaints privately, and most significantly, many patients are misinformed as to when pelvic care is medically beneficial and what to expect during pelvic examinations. As a result, most such abuse is never reported. Moreover, even when pelvic care abuses are reported, patients face insurmountable legal hurdles that often preclude relief in civil suits. This paper argues that the doctrine of informed consent can fundamentally shift the dynamic between patients and doctors in pelvic care, helping to prevent gynecological abuses before they occur. Currently, some jurisdictions apply a "customary professional practice standard" to assess whether a physician has adequately informed a patient about a medical procedure—specifically, pelvic exams—based on prevailing practices among medical professionals. This paper contends that this standard is inadequate for pelvic care. Instead, it advocates for state legislatures and courts to adopt a patient-centered informed consent standard. Such a shift would better inform patients, empower them to make more autonomous decisions about their care, and help to address the power imbalances between patients and physicians that can contribute to physician misconduct.

Keywords: Health; Women; Gender; Pelvic Exams; Healthcare; Informed Consent; Medical Malpractice

* UNC School of Law, US.

Table of Contents

Introduction 3

I. The History of Western Gynecology 7

II. Pelvic Care at Present 11

III. Medical Negligence: Civil Remedies 14

A. Pelvic Care and the Insufficiency of Medical Malpractice Claims 17

1. Negligence or Intentional Torts? Or Both? 17

2. Expert Testimony and Pelvic Exams 19

3. Proving Damages 21

B. The Doctrine of Informed Consent 23

1. The "Customary Professional Practice" Standard 25

2. The "Patient-Centered Standard" 28

Conclusion: The Patient Centered Standard for Pelvic Care 31

INTRODUCTION

In 2012, Evelyn Yang was pregnant and seeking gynecological care.[1] Wanting the best outcome for her baby, she chose well-respected Obstetrician-Gynecologist (OBGYN) Robert Hadden at Columbia University to provide that care.[2] At first, Hadden provided the excellent care Evelyn sought; however, as her pregnancy progressed, her pelvic examinations became longer and more frequent.[3] Yang, in her efforts to ensure a healthy pregnancy for both herself and her baby, decided she "just need[ed] to trust [Hadden]" when he informed her she needed the additional pelvic care.[4] Eventually, Hadden performed a pelvic exam on Yang ungloved.[5] This instance was not the only time Hadden used his position as Yang's gynecologist to perpetrate abuse; looking back, Yang realized she "put up with some inappropriate behavior that [she] didn't know…was straight-up sexual abuse/sexual assault until much later."[6] Yang did not initially report this crime.[7]

That same year, on a Friday in June of 2012, Hadden was arrested for the sexual assault of Laurie Kanyok, who contacted the police after Hadden "orally assault[ed]" her during a routine pelvic exam.[8] By Tuesday of the next week, Hadden was allowed back in the exam room by leadership at Columbia.[9] Despite eight initial allegations of abuse by patients in 2012, Columbia let him practice for an additional five weeks before he was removed from practice, and Hadden managed to settle the 2012 charges without jail time.[10] It was not until Evelyn Yang came forward on CNN with her allegations of abuse in 2020 and Hadden was arrested for a second time that the women Hadden assaulted saw any justice.[11] By the end of his 2020 criminal trial, at least 245 women alleged Hadden had subjected them to unnecessary pelvic exams for his own pleasure, often coercing them to travel to his office (sometimes across state lines) under the guise of providing necessary medical care.[12] Many of these women did not initially report Hadden because, like Evelyn Yang, they did not understand when a pelvic exam was

---

[1] Michael Levenson, *Evelyn Yang, Wife of Andrew Yang, Says She Was Assaulted by Her Gynecologist,* NEW YORK TIMES (Jan. 16, 2020), https://www.nytimes.com/2020/01/16/us/andrew-evelyn-yang-dr-robert-hadden.html.
[2] *Id.*
[3] *Id.*
[4] *Id.*
[5] *Id.*
[6] *Id.*
[7] *Id.*
[8] Chloe Atkins et. al., *'Who's going to believe me?': Survivors of sexual assault by a New York gynecologist talk about the long road to justice,* NBC NEWS (Feb. 17, 2024), https://www.nbcnews.com/news/us-news/survivors-sexual-assault-robert-hadden-interview-rcna138556. *See also* Bianca Fortis & Laura Beil, *How Columbia Ignored Women, Undermined Prosecutors and Protected a Predator for More Than 20 Years,* PRO PUBLICA (Sept. 12, 2023), https://www.propublica.org/article/columbia-obgyn-sexually-assaulted-patients-for-20-years.
[9] Atkins, *supra* note 8.
[10] Fortis, *supra* note 8; Jan Ransom, *Gynecologist Spared Prison in '16 Sex-Crime Plea Faces New Inquiry,* NEW YORK TIMES (Feb. 20, 2012), https://www.nytimes.com/2020/02/20/nyregion/robert-hadden-investigation.html.
[11] Dana Bash, Bridget Nolan, Nelli Black, & Patricia DiCarlo, *Exclusive: Evelyn Yang reveals she was sexually assaulted by her OBGYN while pregnant,* CNN (Jan. 17, 2020), https://www.cnn.com/2020/01/16/politics/evelyn-yang-interview-assault/index.html. At the time, Evelyn Yang's husband, Andrew Yang, was running for president, giving her story an additional spotlight. *Id.*
[12] Fortis *supra* note 8.

necessary or what the standard procedure was, and they did not immediately recognize Hadden's conduct as abusive.[13] Moreover, these patients technically gave Hadden verbal consent to perform pelvic exams under the erroneous assumption that their physician abided by professional standards of care.[14]

The American College of Obstetricians and Gynecologists (ACOG), a "professional membership organization" that represents OBGYNs, medical students, and other health care professionals in the field of gynecology,[15] currently recommends women only receive pelvic exams if they have symptoms,[16] as a part of a pelvic procedure, when a woman is pregnant, or if a woman has a family history of gynecological conditions.[17] Despite this recommendation, in a survey completed for the American Journal of Obstetrics & Gynecology, almost all OBGYNs reported that they would perform a bimanual exam[18] on an asymptomatic patient at a routine visit, even if that woman had a hysterectomy (a surgical procedure which removes the reproductive organs a bimanual pelvic exam is purported to assess),[19] because they believe it is "important for adherence to standard medical practices."[20] Thus, while

---

[13] *Id. See also* Bash, *supra* note 11.

[14] Fortis, *supra* note 8. *See also* Bash, *supra* note 11.

[15] The ACOG represents more than 60,000 ob-gyns, medical students, and other health care professionals. They seek to: maintain the highest standards of clinical practice for women's healthcare; strongly advocate for quality healthcare for women; provide education for its members and the public; and increase awareness of the changing issues facing women's healthcare. *About Us*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, https://www.acog.org/womens-health/about-acog#:~:text=This%20website%20is%20powered%20by,dedicated%20to%20improving%20women's%20health (last visited Nov. 11, 2024).

[16] Symptoms that include abnormal bleeding, abnormal vaginal discharge, pelvic pain, or pain during sex could point to a gynecological problem. A pelvic exam can help your ob-gyn diagnose the issue. *Pelvic Exams,* AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, https://www.acog.org/womens-health/faqs/pelvic-exams#:~:text=The%20American%20College%20of%20Obstetricians,should%20make%20this%20decision%20together (last visited Nov. 11, 2024).

[17] *Id.* Procedures include having an IUD inserted or having an endometrial biopsy. *Id.*

[18] During the bimanual vaginal exam, a physician will insert two lubricated fingers to feel the cervix. Next, the physician will place their other hand on the patient's abdomen palpitate the uterus and, if possible, other reproductive organs such as ovaries (this is not possible in all patients due to factors such as how tense they are and their weight). W. Newton Long, *Pelvic Examination*, in CLINICAL METHODS: THE HISTORY, PHYSICAL, AND LABORATORY EXAMINATIONS, 3D EDITION (HK Walker, WD Hall, JW Hurst, eds., 1990), https://www.ncbi.nlm.nih.gov/books/NBK286/.

[19] *Hysterectomy,* JOHNS HOPKINS MED., https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/hysterectomy.

[20] Laura L. Norell, Miriam Kuppermann, Michelle N. Moghadassi, & George F. Sawaya, *Women's beliefs about the purpose and value of routine pelvic examinations,* 86 AM. J. OBSTETRICS & GYNECOLOGY 1, 3–5 (2017).

abuse is pervasive within the OBGYNpractice,[21] even physicians without abusive intent may perform unnecessary pelvic examinations that cause "fear, anxiety, embarrassment, pain, and discomfort" in patients.[22]

Presently, pelvic care abuses can be handled through the criminal system, the civil system, or through disciplinary action by State Medical Boards.[23] These mechanisms are overwhelmingly reactionary; they require abuse to occur before they offer relief to the patient.[24] Thus, these mechanisms only provide relief to a subset of patient-victims: those who have been abused, recognize that abuse, and report it through the proper legal channels. This ignores the larger population of women who undergo unnecessary and difficult pelvic care without knowing if there is a legitimate purpose behind the procedure in the first place.[25] Moreover, even after abuse occurs, these legal mechanisms are often insufficient to provide relief to patients injured by their physicians.[26]

In addition to further developing relief mechanisms for women injured by their practitioners, states should apply a "patient centered standard" to their informed consent doctrine as applied to pelvic exams, as this would place affirmative burdens on physicians to disclose information their patients' believe is pertinent before performing pelvic examinations, including the reasoning for the pelvic examination; the benefits and harms of the exam; alternative treatment options; and what is standard procedure during the exam. In doing so, the relationship between physicians and patients will shift as physicians relinquish some power in determining medical treatment plans without

---

[21] Hadden is not the first nor the last to abuse his patient. *See, e.g., Ex-NorthShore Gynecologist Fabio Ortega Pleads Guilty To Sexually Abusing Patients,* CBS NEWS (Oct. 20, 2021), https://www.cbsnews.com/chicago/news/ex-northshore-gynecologist-fabio-ortega-pleads-guilty-to-sexually-abusing-patients/; Erin Lowrey, *Louisiana Doctor Arrested, Accused of Sexually Assaulting Patients*, WDSU NEWS (Oct. 30, 2024), https://www.wdsu.com/article/louisiana-st-tammany-doctor-keith-hickey-arrested/62766295; Jessica Schreifels, *Utah OB-GYN David Broadbent Charged with Forcible Sexual Abuse,* PRO PUBLICA (June 29, 2024), https://www.propublica.org/article/utah-ob-gyn-david-broadbent-charged-forcible-sexual-abuse; David Gonzalez, *15 Female Patients Sue Doctor for Alleged Sexual Abuse During Medical Visits at Irvine Office*, ABC EYEWITNESS NEWS (Aug. 30, 2024), https://abc7.com/post/15-female-patients-sue-doctor-alleged-sexual-abuse-during-medical-visits-irvine-office/15244710/; David Nelson, *OB/GYN Doctor Charged with Child Rape for Alleged Assaults Over Multiple Years*, KITSAP SUN (April 17, 2024), https://www.kitsapsun.com/story/news/2024/04/16/obgyn-doctor-charged-with-child-rape-for-alleged-assaults-over-multiple-years/73343984007/. Moreover, a 2009 report that assessed sexual boundary violations by physicians and concluded most self-reported sexual boundary violations were perpetrated by male physicians in the field of family medicine, psychiatry, and obstetrics/gynecology. Randy A. Sansone & Lori A. Sansone, *Crossing the Line: Sexual Boundary Violations by Physicians,* 6 THE INTERFACE: PSYCHIATRY 1, 1 (2009), https://pmc.ncbi.nlm.nih.gov/articles/PMC2720840/pdf/PE_6_06_45.pdf.

[22] Amir Qaseem, Linda L. Humphrey, Russell Harris, Melissa Starkey, & Thomas Denberg, *Screening Pelvic Examination in Adult Women: A Clinical Practice Guideline from the American College of Physicians*, 161 ANN. INTERN. MEDICINE 67, 69 (2014).

[23] *See* Nanci Hamilton, *Stopping Doctor Evil: How to Prevent the Prevalence of Health Care Providers Sexually Abusing Sedated Patients,* 45 HOFSTRA L. REV. 299, 311–17 (2016).

[24] *Id.* Criminal charges can only be brought after an assault has occurred; civil suits often must show damages from a harm that has already occurred; state board investigations require a complaint before an investigation can occur. In other words, there is "nothing in their process that aims to prevent sexual misconduct from occurring" in the first place. *Id.* at 315.

[25] *See* Norell et. al., *supra* note 20, at 3 ("Approximately one-half of the women that we interviewed did not know the purpose of the pelvic examination.").

[26] *See infra* notes 105–09.

much input from their patients and women take that power to make determinations about their own health and care plans. This would reduce the number of, and harms associated with unnecessary pelvic exams.

This paper proceeds in three parts. Part I provides background for the history of women's healthcare, starting with the development of the field of Western gynecology from the 1600s to the 1800s, culminating in the present day. Part II addresses the current pelvic examination recommendations from medical research bodies and addresses the conflict between those recommendations. Part III delves into the civil remedies available to women seeking relief for abusive or faulty pelvic care, starting with addressing the insufficiencies of medical malpractice suits. Part III will then analyze the development of the doctrine of informed consent in the state statutory scheme and the common law, discerning the best way to develop the doctrine of informed consent for pelvic care. Part IV concludes that the doctrine of informed consent has the capacity to offer protection to women seeking pelvic care, and that the "patient centered standard" is best suited to determine whether a physician has met their duty to disclose prior to obtaining the consent of their patient and is thus best suited to protect patients seeking pelvic care.

A. A Note on Language

This paper refers to patients seeking pelvic care as "women." This is because that is the identity of the patients in the case law analyzed in this paper, as well as the patients in the studies this paper contemplates. In addition, this paper briefly delves into the history of gynecological care, which was historically developed to both provide care for women and, perhaps more importantly, to subjugate women at the hands of male medical practitioners as the West solidified the patriarchy through conquest.[27] Because this paper does not address the unique issues queer, gender non-conforming, and transgender patients face while seeking pelvic care, the language used to discuss the experiences of those seeking care is gendered. This is *not* because only women seek pelvic care, and it is certainly not to erase those experiences; they are simply outside the scope of this short paper.[28]

B. The Scope of this Paper

This paper addresses the doctrine of informed consent as it relates to pelvic care for asymptomatic, adult, non-pregnant women.[29] This paper will not address legal

---

[27] *See infra* note 38.

[28] For more on the issues LGBTQ+ individuals face when seeking pelvic care, *see* J. Michelle Schramm, *Seeing our invisible patients: The importance of providing inclusive sexual and reproductive healthcare to LGBTQ populations*, WOMEN'S HEALTHCARE 8 (2016); Maria J. Ruiz et. al., *Sexual and Gender Minority Patients' First Pelvic Examination Experiences: What Clinicians Need to Know*, 37 J. PEDIATRICIAN ADOLESCENT GYNECOLOGY 342 (2024).

[29] This paper includes stories of pregnant women who are injured while seeking pelvic care, such as Evelyn Yang. However, this paper does not address when pelvic exams are necessary and when pelvic exams are unnecessary during pregnant. For the ACOG recommendations for pregnant women, *see infra* note 30, at 1189.

issues of consent pertaining to age;[30] legal issues pertaining to pregnancy and abortion;[31] the specific issues that patients of color face when seeking pelvic care;[32] or the specific issues patients of varying socio-economic statuses face when seeking pelvic care.[33] These issues are important and well worth exploring; however the scope of this paper is both limited and broadened by its focus on the general population of women seeking pelvic care.

I. THE HISTORY OF WESTERN GYNECOLOGY

Current gynecological practices, and the relationship between OBGYNs and their patients, are rooted in a deep history of the displacement and dismissal of women. Before the advent of the Western medicinal field of obstetrics and gynecology, female midwives exclusively officiated births—the earliest written records of midwives are in the Bible and in ancient Greek writings.[34] In the West, female midwives monopolized providing care to pregnant and laboring women throughout the entirety of the Middle Ages.[35] In fact, the earliest record of a man attending a "normal" birth was in 1663.[36] The female model was a collaborative model among women themselves; the male model to come would render the pregnant woman a passive participant in her own labor.[37]

Beginning in the 1600s and 1700s, women were displaced from their roles as midwives and care providers for pregnant women. The 1600s and 1700s marked a period of male colonialism, conquest, and subjugation during which gynecological medical procedures were used to conquer native women.[38] This carried into the 1800s as forced gynecological procedures were used as tools to maintain the colonial structures of slavery, which were dependent on the subjugation of enslaved women and

---

[30] For example, Larry Nassar prolifically abused his minor patients by informing them and their parents that pelvic floor physical therapy was a beneficial treatment for elite gymnasts. *Justice Department Pays $138 Million Over FBI Failures in Larry Nassar Case,* NPR (April 23, 2024), https://www.npr.org/2024/04/23/1246647531/doj-settles-larry-nassar-usa-gymnastics-sexual-assault-victims. This type of abuse is in-line with the type of abuse perpetrated by providers contemplated by this paper, but this specific example presents additional issues of consent and age with regards to pelvic care that are outside the scope of this paper. It is a difficult question to determine what parents should be able to consent to on behalf of their minor children with regard to pelvic care specifically. *See* Kailey Remien & Tanuj Kanchan, *Parental Consent*, in *StatPearls* (StatPearls Publishing 2024) (updated Sept. 18, 2022), available at https://www.ncbi.nlm.nih.gov/books/NBK555889/.

[31] *See, e.g.,* The American College of Obstetricians and Gynecologists, Committee Opinion Number 664, *Refusal of Medically Recommended Treatment During Pregnancy,* 127 OBSTETRICS & GYNECOLOGY 1189 (2016).

[32] *See e.g.,* Jennifer Chyu et. al., *Experiences of Black Women with Pelvic Floor Disorders—–A Qualitative Analysis Study*, UROGYNECOLOGY (June 27, 2024).

[33] *See, e.g.,* Robert E. Bristow et. al., *Disparities in Ovarian Cancer Care Quality and Survival According to Race and Socioeconomic Status,* 105 J NAT'L CANCER INSTITUTE 823 (March 28, 2013).

[34] Judy Barrett Litoff, *An Historical Overview of Midwifery in the United States*, PRE- AND PERI-NATAL PSYCHOLOGY J. 5, 5 (1990).

[35] *Id.*

[36] *Id.* at 6.

[37] *See id.*

[38] Gynecological care and sex have historically been used as a tool of Western colonialism around the world; the language used in this paper describes this history. *See, e.g.,* KAREN VIEIRA POWERS, WOMEN IN THE CRUCIBLE OF CONQUEST: THE GENDERED GENESIS OF SPANISH AMERICAN SOCIETY, 1500-1600 (2005); RICHARD C. TREXLER, SEX AND CONQUEST: GENDERED VIOLENCE, POLITICAL ORDER, AND THE EUROPEAN CONQUEST OF THE AMERICAS (1995).

control over their bodies.[39] Simultaneously, the medicalization of the field of gynecology displaced white women from their roles as midwives—for example, Peter Chamberlin invented obstetrical forceps in the early 1600s, which became popularized throughout the 1700s.[40] The development of scientific theories about pregnancy and childbirth, coupled with the invention of new 'gynecological tools', supplanted the lay midwife with male physicians who underwent specific medical 'training', which pushed women out of the profession as they were denied access to medical school and formal clinical trainings now deemed necessary qualifications for midwives.[41] Those in favor of a move from women as midwives to men in a medical practitioner role at births argued that women were "frail and emotional beings who lacked the intellectual capacity to become competent birth attendants," an attitude that persisted for centuries.[42] By the middle of the 19th century, it looked as though American midwifery would become obsolete as the field of obstetrics became recognized as a "medical specialty" that ought to be performed by a male physician.[43]

The developing field of gynecology thus had its historical origins in assault and nonconsent, performed by men who drove women out of the field completely and, in doing so, advanced a narrative that women lacked the capacity to practice medicine.[44] Forced pelvic examinations and forced gynecological procedures, which were often both unnecessary and harmful, instilled in women that they lacked the knowledge and agency they needed to maintain their own health and status in their societies, as well as control over their own bodies.[45] Furthermore, physician-directed obstetrics did not result in improved health outcomes from pregnant women; in 1917, the federal Children's Bureau reported that "childbirth caused more deaths among women fifteen to forty-four years old than any disease except tuberculosis."[46] Thus, Western gynecology developed in a context of nonconsent and poor health outcomes for the women being "treated."

These deep roots of subjugation, nonconsent, abuse, and poor health outcomes

---

[39] *Id. See also* Danielle McCarthy, *Gendered Anti-Blackness, Maternal Health & Chattel Slavery: OB/GYN Knowledge as a Determinant of Death of Black Women*, 353 SOCIAL SCIENCE AND MEDICINE (2024).

[40] Litoff, *supra* note 34, at 7.

[41] *Id.* at 6–7.

[42] *Id.* at 9.

[43] *Id.* at 9–10.

[44] Stephanie Tillman, *Consent in Pelvic Care,* 65 J. MIDWIFERY & WOMEN'S HEALTH 749, 749 (2020); Jo Anne Morrow, *Women's Health Care and Informed Consent: Who Should Decide What Is Best for Women - Patients or Doctors,* 9 GOLDEN GATE U. L. REV. 553, 556–57 (1978); Litoff, *supra* note 34, at 9.

[45] Tillman, *supra* note 44, at 750. Doctors performed forced internal examinations on people "suspected of venereal infections, sterilizing people of color and people who were poor without their knowledge, unnecessarily requiring pelvic examinations for oral contraceptives, and hymen inspection for virginity testing." *Id.* at 749–50.

[46] Litoff, *supra* note 34, at 10. This is due to many factors. New gynecological tools required additional training and schooling because while forceps, for example, could save lives, if used incorrectly they could cause perineal lacerations to the woman and injuries to the fetus, and while anesthesia could improve comfort for a laboring mother, if administered incorrectly it could result in breathing problems and a prolonged (and thus more dangerous) labor. *Id.* at 11. In addition, "almost any type of intervention by the attending physician brought with it the possibility of harm due to the dangers associated with infection" as physicians themselves also spread diseases among patients. *Id.* Not surprisingly, areas reporting the lowest levels of maternal deaths were also areas with the highest rates of midwife attendants at births. *Id.*

persisted into the 1900s.[47] While physicians might not overtly have used their role as gynecologists as a tool for subjugation, the underlying belief systems regarding how women could participate in their care carried through into the 20th century. In the 1900s, the medical field, including the field of gynecology, was still dominated by white men, solidifying the physician-patient relationship as one rooted in paternalism.[48] Physicians believed "women ha[d] inferior intelligence and an inability to dispassionately evaluate what is 'best' for them."[49] Physicians took on the responsibility of determining what treatment best suited the patient, and the patient "[was] expected to cooperate in her care."[50] In other words, "the patient [was] placed in a submissive role and the doctor exercise[d] authority and control."[51] As male physicians usurped control from their female patients in the physician-patient dynamic, the complaints of female patients were often ignored. Male physicians routinely harmed women by "devaluing their complaints and by subjecting them to unnecessary surgery and to unknown risks of harmful side effects" from widely distributed and under-tested drugs designed specifically for women.[52] Indeed, in the 1930s, the national Committee on the Costs of Medical Care, an organization formed to investigate and research potential economic solutions for the organization of medical care,[53] reported that midwives took better care of patients than did physicians because a midwife "waits patiently and lets nature take its course," while physicians employed "procedures which are calculated to hasten delivery, but which sometimes result harmfully to mother and child."[54] Nevertheless, midwives were blamed for adverse health outcomes in

---

[47] *See, generally* Morrow, *supra* note 44 (an analysis of the historical relationship between physicians and female patients in the early-to-mid-1900s). A 1911 survey determined that "general practitioners lose as many and possibly more women from puerperal infection than do midwives." Litoff, *supra* note 34, at 11.

[48] Klea D. Bertakis, *The Influence of Gender on the Doctor-Patient Interaction,* 76 PATIENT EDUCATION AND COUNSELING 356, 356–57 (2009) ("The percentage of women graduating from medical schools in the United States increased from 5.5% to 49.3% between 1962 and 2008."); *see also* R. Kaba & P. Sooriakumaran, *The Evolution of the Doctor-Patient Relationship*, 5 INT'L J. OF SURGERY 57 (2006); Felicity Goodyear-Smith & Stephen Buetow, *Power Issues in the Doctor-Patient Relationship*, 9 HEALTH CARE ANALYSIS 449, 450 (2001) ("deference to medical authority by patients who were assigned a sick role was necessary for the doctor-patient relationship to function effectively.").

[49] Morrow, *supra* note 44, at 555. The historical trend in Western medicine was to conflate prejudices with medical fact, resulting in a healthcare system that demeaned women and their bodies and assumed women to be incapable of making health decisions for themselves. This, coupled with the historical notion that women are so overtly emotional that they cannot perceive their own symptoms and care with an objective lens resulted in a doctor-patient relationship predicated on the idea that women cannot be trusted as reliable narrators regarding their own health. *Id.* at 559-60. For an overview of how doctors in the 1950s and 1960s determined if women had diagnosable "hysteria," *see* Robert A. Woodruff, *Hysteria: An Evaluation of Objective Diagnostic Criteria by the Study of Women with Chronic Medical Illnesses*, 114 BRIT. J. PSYCHIAT. 1115 (1967).

[50] Morrow, *supra* note 44, at 556.

[51] *Id.*

[52] *Id.* at 554–55. Drugs designed for women include DES, birth control pills, and the Dalkon Shield. *Id.*

[53] Joseph S. Ross, *The Committee on the Costs of Medical Care and the History of Health Insurance in the United States*, 19 EINSTEIN QUART. J. BIOL. MED. 129, 129 (2002). "After 5 years of work, it recommended a system where (1) medical services were provided by physician groups, (2) costs were distributed over persons and time using an insurance program, (3) funds and services dedicated to disease prevention were increased, and (4) community agencies coordinated medical care services." *Id.*

[54] Litoff, *supra* note 34, at 12.

childbirth, reinforcing the importance of obstetric specialists.[55]

As the social, cultural, and political feminist movements worked to shift societal perceptions of women and educational opportunities for women, the physician-patient relationship began to shift as well.[56] Not only have women as patients become more empowered to ask questions and advocate for the medical treatment they want,[57] there are also significantly more female providers in the medical field.[58] Thus, the physician-patient relationship is slowly shifting from a paternalistic one to one that centers the patient.[59] The patient's "story of the illness" is becoming increasingly important in the care plan devised by a physician in conjunction with the patient.[60]

While these shifts are important and beneficial to women's overall health outcomes,[61] "[a] paternalistic approach still dominates."[62] The field of gynecology has thus far been unable to fully shed its origins in nonconsent and the assumption that men better understand the needs of women when it comes to women's pelvic care. This is furthered by the development of the institutionalization of healthcare with modern technologies—for example, the development of laboratory and X-ray tests to aid in diagnosis contributed to a shift of medical care from the home to the hospital—which depersonalizes care between a physician and their patient and creates an arena for abuses at the hands of physicians.[63] To this day, women's reproductive health presents a unique arena in which physicians maintain their power over decision-making because women often do not have an understanding of the benefits, harms, or reasons for pelvic procedures; they agree to said procedures solely at the recommendation of their physician.[64] Indeed, while approximately half of women surveyed by the American Journal of Obstetrics & Gynecology lacked an understanding of the benefits of pelvic examinations, almost all OBGYNs reported that they would perform a bimanual exam on an asymptomatic patient at a routine visit, even if that woman had a hysterectomy, because it is "important for adherence to standard medical practices."[65] Similarly, women continue to have their complaints and pain categorically dismissed as impossible; the physician still knows best.[66]

---

[55] *Id.*
[56] *See* Goodyear-Smith, *supra* note 48, at 450–51.
[57] *See* Alireza Nikbakht Nasrabadi et. al., *Women Empowerment through Health Information Seeking: A Qualitative Study,* 3 INT'L J. COMMUNITY BASED NURSING AND MIDWIFERY 105 (2015).
[58] Bertakis, *supra* note 48, at 357.
[59] *See* Kaba, *supra* note 48, at 61.
[60] *Id.*
[61] *See* Moira A. Stewart, *Effective Physician-Patient Communication and Health Outcomes: A Review*, 152 CAN. MED. ASSOC. 1423 (1995); S. Petrocchi et. al., *Interpersonal Trust in Doctor-Patient Relation: Evidence from Dyadic Analysis and Association with Quality of Dyadic Communication*, 235 SOCIAL SCIENCE AND MEDICINE 1 (2019).
[62] Kaba, *supra* note 48, at 63.
[63] Morrow, *supra* note 44, at 563–64. "The increased technology of modern medicine and the institutionalization of health care have also led to a depersonalization of health care. [This] has the potential for the abuse, in hospitals, of the fundamental rights of patients as individuals." *Id.* For example, "[t]he development of laboratory and X-ray tests to aid in diagnosis and the discovery of new drugs and surgical techniques provided the doctor with a new armamentarium and shifted the bulk of medical care from the home to the hospital." *Id.*
[64] *See* Norell et. al., *supra* note 20, at 3.
[65] *Id.* at 3–5.
[66] *See, e.g.,* Diane E. Hoffman and Anita J. Tarzian, *The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain,* 29 J. LAW MEDICINE AND ETHICS 13 (2021).

II. PELVIC CARE AT PRESENT

The ACOG currently recommends women should receive pelvic examinations only if they have symptoms, as a part of a pelvic procedure, when a woman is pregnant, or if a woman has a family history of gynecological conditions.[67] Standard procedure during a pelvic examination includes a careful inspection of the external genitalia, a speculum and bimanual exam to assess the internal genitalia, and sometimes a Papanicolaou test, also known as a "pap smear," in which a small wand is used to collect cells from the cervix to test for cervical cancer.[68] Pap smears are recommended every 3 years for cancer screening purposes and are not the subject of this paper; pelvic exams can and often are performed without performing a pap smear.[69] Physicians should always wear gloves while performing pelvic examinations, and they should communicate to the patient what they are doing throughout the examination without making inappropriate comments.[70] In addition, patients should be provided with privacy as they change before and after the examination and patients should be provided with coverings if their bodies are exposed.[71] To ensure these standards are met, a chaperone, often a nurse, is typically present.[72] Chaperones for "intimate exams," however, should be "impartial and have no obligation to the doctor"; in a hierarchical structure such as a hospital, a "junior nurse may feel daunted to speak up about the misconduct of a senior doctor."[73] Chaperones are thus not a guarantee of safety for patients.[74] A pelvic examination should take no more than a few minutes.[75] A breach of professional standards could constitute evidence of physician negligence or abuse.

Prior to the current recommendation, ACOG had recommended in 2012 that women aged 21 and over receive annual pelvic exams regardless of their symptoms

---

[67] *Supra* notes 15–18 for more about this recommendation.

[68] *Pelvic Exam,* MAYO CLINIC, https://www.mayoclinic.org/tests-procedures/pelvic-exam/about/pac-20385135 (last visited Nov. 11, 2024); Dr. David Mutch, *Why Annual Pap Smears are History—But Routine Ob-Gyn Visits are Not,* AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, https://www.acog.org/womens-health/experts-and-stories/the-latest/why-annual-pap-smears-are-history-but-routine-ob-gyn-visits-are-not#:~:text=Women%20age%2021%20to%2029,HPV%20test%20every%205%20years (last visited Nov. 11, 2024).

[69] Qaseem et. al., *supra* note 22, at 67.

[70] *See, e.g. What to expect during a routine sensitive exam: frequently asked questions*, UCLA HEALTH, https://www.uclahealth.org/sites/default/files/documents/SensitiveExamBooklet-English.pdf (last visited Nov. 11, 2024).

[71] *Id.*

[72] *See, e.g. Undergoing a Physical Examination: Your Rights*, N. CAROLINA MEDICAL BD., https://www.ncmedboard.org/images/uploads/publications_uploads/NCMB_PhysicalExamBrochure.pdf (last visited Nov. 11, 2024); *The Use of Chaperones During Sensitive Examinations and Procedures*, UNIV. OF MICH. HEALTH, https://www.uofmhealth.org/patient-visitor-guide/patients/use-chaperones-during-sensitive-examinations-and-procedures (last visited Nov. 11, 2024); *Medical Chaperones for Sensitive Examinations, Treatments and Procedures*, YALE HEALTH, https://yalehealth.yale.edu/topic/medical-chaperones-sensitive-examinations-treatments-and-procedures (last visited Nov. 11, 2024).

[73] Paul Marinaccio-Joseph, *Nurses as chaperones: legal obligations and implications,* 115 NURSING TIMES 18, 18 (2019).

[74] *Id.*

[75] MAYO CLINIC, *supra* note 65.

or medical history.[76] The benefit of the annual exam, ACOG opined, was that the "annual visit provides an excellent opportunity to counsel patients about maintaining a healthy lifestyle and minimizing risks."[77] While ACOG stated that "[n]o evidence supports or refutes the annual pelvic examination or speculum and bimanual examination for the asymptomatic, low-risk patient[s]," they also noted, "[a]n annual pelvic examination seems logical."[78] The report concluded that a patient can decide for herself whether she would like to receive a pelvic exam only if "she is asymptomatic and has undergone a total hysterectomy and bilateral salpingo-oophorectomy for benign indications and has no history of vulvar intraepithelial neoplasia, cervical intraepithelial neoplasia 2, cervical intraepithelial neoplasia 3, or cancer; is not infected with HIV; is not immunocompromised; and was not exposed to diethylstilbestrol in utero."[79] Even if all of those conditions applied, ACOG still recommended that "[a]nnual examination of the external genitalia should continue."[80]

In 2014, however, the American College of Physicians (ACP), a community of internal medicine specialists who treat the entire complex system of internal organs in the body—taking a more holistic approach than the OBGYNs in the ACOG[81]—denounced the ACOG's 2012 recommendation, finding that pelvic examinations caused more harm than good.[82] Numerous studies supported the conclusion that bimanual pelvic exams did not actually improve health outcomes for asymptomatic women at all.[83] Indeed, between 2012 and 2018, the time period when ACOG recommended annual pelvic exams, there was no evidence to support the idea that pelvic exams could detect ovarian cancer—in fact, they did nothing to improve health outcomes for those ultimately diagnosed with ovarian cancer because physicians were

---

[76] Gladys M. Martinez et. al., *Receipt of Pelvic Examinations Among Women Aged 15-44 in the United States, 1988-2017,* 339 NCHS DATA BRIEF 1, 1 (2019). Committee Opinion 534 has been removed from the ACOG online archive, but I was able to locate a copy from a saved version of their 2012 website through the "Way Back Machine." The American College of Obstetricians and Gynecologists, Committee Opinion Number 534, *Well-Woman Visit,* OBSTETRICS & GYNECOLOGY (2012) (http://web.archive.org/web/20120815034841/http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Gynecologic_Practice/Well-Woman_Visit).

[77] *Id.*

[78] *Id.*

[79] *Id.* The terms in this recommendation are not defined in this paper because the technicalities are less important than the point that many women, based on this recommendation, would lack sufficient knowledge to be able to decline a pelvic exam.

[80] *Id.*

[81] The American College of Physicians is the largest medical specialty organization in the world. *Who We Are and What We Do*, AM. COLL. PHYSICIANS, https://www.acponline.org/about-acp/who-we-are-what-we-do.

[82] Qaseem, *supra* note 22, at 69–70.

[83] *See, e.g.* U.S. Preventative Services Task Force, *Screening for Gynecologic Conditions with Pelvic Examination: US Preventive Services Task Force Recommendation Statement,* 317 JAMA NETWORK 947, 947 (2017) ("Overall, the USPSTF found inadequate evidence on screening pelvic examinations for the early detection and treatment of a range of gynecologic conditions in asymptomatic, nonpregnant adult women."); Analia R. Stormo, Nikki A. Hawkins, Crystale Purvis Cooper et. al., *The Pelvic Examination as a Screening Tool*, 171 ARCH. INTERN. MEDICINE 2053, 2053 (2011) ("the conditions pelvic examinations hope to detect during these annual visits are unclear, since scientific evidence does not support their use for any specific purpose."); Carol K. Bates, Nina Carroll, & Jennifer Potter, *The Challenging Pelvic Examination*, 26 J. GENERAL INT. MEDICINE 651, 651 (2011) ("While there is a large body of evidence on the effectiveness of Pap smears for cervical cancer screening and on screening for cervical gonorrhea and Chlamydia, there is sparse evidence to support other portions of the pelvic examination and little guidance on examination logistics.").

unable to detect such cancer through the examinations alone.[84] Similarly, no studies suggested that pelvic exams were at all beneficial to the diagnosis or treatment of the other diseases—such as other types of cancer, pelvic inflammatory disease, bacterial vaginosis, and other benign conditions—that pelvic examinations were purported to address in asymptomatic women.[85] And, while there was no evidence to support any benefit of pelvic examinations in asymptomatic women, there was evidence demonstrating harms perpetuated by these unnecessary pelvic exams, including "fear, anxiety, embarrassment, pain, and discomfort."[86] The examinations also led to "false reassurance, over-diagnosis, overtreatment" and unnecessary surgeries.[87] Despite the ACP's findings in 2014, approximately 52 million pelvic exams were performed in the United States in 2015.[88]

It was not until 2018 that ACOG changed course, recommending that pelvic examinations should only be given when "indicated by medical history or symptoms."[89] Despite this shift in policy, OBGYNs often continue to perform pelvic examinations when doing so is not associated with improved health outcomes; i.e. they are unnecessary. [90] This misalignment between the actions of physicians and the effectiveness of pelvic exams as preventative care measures poses particular problems for women who consent to these procedures but do not understand their purpose.[91]

Whether (and how) a patient legally needs to verbally consent to a pelvic examination is determined by the common law created by the state courts, the statutory

---

[84] Qaseem, *supra* note 22, at 68. *See also* The American College of Obstetricians and Gynecologists, Committee Opinion Number 754, *The Utility of and Indications for Routine Pelvic Examination,* 132 OBSTETRICS & GYNECOLOGY 174, 175–76 (2018).
[85] Qaseem, *supra* note 22, at 68–69.
[86] *Id.* at 69.
[87] *Id.* ("pelvic examination led to unnecessary surgery in 1.5% of women screened.").
[88] *National Ambulatory Medical Care Survey: 2015 State and National Summary Tables*, CDC, https://archive.cdc.gov/www_cdc_gov/nchs/data/ahcd/namcs_summary/2015_namcs_web_tables.pdf (last visited Nov. 11, 2024).
[89] The American College of Obstetricians and Gynecologists, Committee Opinion Number 754, *supra* note 84, at 174.
[90] Norell, *supra* note 20, at 3–5.
[91] *See id.* *See also* David M. Studdert, *Geographic Variation in Informed Consent Law: Two Standards for Disclosure of Treatment Risks*, 4 J. EMPIRICAL LEGAL STUDIES 103, 121 (2007) ("[O]ur findings hint at a substantive discrepancy between customary medical practice regarding disclosure of risk . . . and patients' expectations about risk").

scheme of the state[92] and the factual circumstances when a patient presents for care.[93] When a patient is subjected to faulty or unwanted medical procedures, the legal system offers relief through claims for medical negligence in the tort system.[94] Medical malpractice claims, however, only provide relief after an injury has occurred, and often do not provide for adequate relief after said injury.[95] Thus, when Hadden misrepresented the need for a pelvic exam to his patients by advising them that they needed additional pelvic care when they did not, the women were left with little recourse.[96] The doctrine of informed consent can be developed to prevent these occurrences—if the women had known the exams were unnecessary, they might not have continued to consent to them; this disclosure would have been imperative to their decision-making.[97]

III. MEDICAL NEGLIGENCE: CIVIL REMEDIES

Gynecology, specifically pelvic care, is a unique arena in the healthcare system that requires additional and specific legal protections for the women seeking care. Physicians perpetrate abuses across almost all medical fields, but the field of gynecology makes patients particularly vulnerable because they are expected to undress

---

[92] Some states have statutes that generally articulate statutory requirements for informed consent. *See* Lori B. Andrews, *Informed Consent Statutes and the Decision-Making Process*, 5 J. L. MED. 163, 163 (1984). Some states, either in addition to or instead of a more general informed consent statute, have informed consent statutes that apply to particular medical procedures. *See, e.g.,* Ruth Colker, *Uninformed Consent,* 101 B.U. L. REV. 431 (March 2021). Specifically, regarding pelvic care, as of November 2022, twenty states in the U.S. had pelvic examination laws, (Arizona, Arkansas, California, Connecticut, Delaware, Florida, Hawaii, Illinois, Louisiana, Maine, Nevada, New Hampshire, New Jersey, New York, Oregon, Texas, Utah, Virginia, and Washington), though those laws only apply to anesthetized or unconscious patients. Thirteen states have proposed pelvic exam laws (Georgia, Indiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Oklahoma, Pennsylvania, Rhode Island, and Wisconsin), of which eleven only pertain to anesthetized or unconscious patients. Seventeen states have no pelvic exam laws at all (Alabama, Alaska, Colorado, Idaho, Kansas, Kentucky, Mississippi, New Mexico, North Carolina, North Dakota, Ohio, South Carolina, South Dakota, Tennessee, Vermont, West Virginia, Wyoming). Prior to 2021, the Florida statute required a practitioner get informed consent before performing any pelvic examination, even if the patient were conscious. The law was changed in 2021 to only apply to unconscious patients. Mihael Plantak et. al., *Pelvic Exam Laws in the United States: A Systematic Review*, 48 AMERICAN J. OF LAW & MEDICINE 412, 413 (2022).

[93] As noted above, the statutes as they specifically pertain to pelvic exams only apply when a patient is unconscious, thus the factual circumstances are important in determining whether express consent is necessary. *Id.* In addition, in emergency situations in which physicians must act quickly or a patient cannot provide informed consent (for example, they are unconscious) and no surrogate decision-maker is available, physicians need not acquire informed consent before performing a procedure. *See* Max M. Feinstein et. al., *Informed Consent for Invasive Procedures in the Emergency Department,* 39 AMERICAN J. OF EMERGENCY MEDICINE 114, 114 (2020); Laurino v. Bd. of Professional Discipline of Idaho State Bd. of Med., 137 Idaho 596, 606 (2002) (physician appealed professional sanctions after a woman in the emergency room presenting with abnormal pelvic bleeding shortly after giving birth refused a pelvic exam and he did not give one, missing a tear from which she was bleeding out).

[94] Morrow, *supra* note 44, at 555. Medical negligence claims include medical malpractice and informed consent claims. *See* Hamilton, *supra* note 23, at 313–14.

[95] *See* Morrow, *supra* note 44. at 566–67; Stoner v. Bureau of Professional and Occupational Affairs, State Bd. of Med., 10 A.3d 364, 367 (Pa. Cmwlth. 2010).

[96] Fortis, *supra* note 8.

[97] *Id.*

and allow physicians to inspect their pelvis and genitalia.[98] Indeed, an analysis of 100,000 disciplinary documents against physicians from across the country demonstrated how "predatory physicians took advantage of a doctor's special privilege—the daily practice of asking trusting people to disrobe in a private room and permit themselves to be touched."[99] Disrobing and permitting oneself to be touched is typical of the OBGYN practice.[100]

The modern medical system has a history of devaluing the complaints of women, especially when it comes to their experience of pain during reproductive procedures.[101] Moreover, the historical development of the physician-patient relationship in gynecology is one characterized by nonconsent, paternalism, and a lack of agency and intelligence on the part of women patients.[102] Thus, women often do not report abuses by their physicians because they are uncertain an abuse has occurred, or they fear they will not be believed.[103] As a result, physicians are given leeway in this dynamic that allows them to continue their practice, both after sexual misconduct has been conclusively found and while complaints about them are actively investigated.[104]

---

[98] Carrie Teegardin et.al., *License to betray: A broken system forgives sexually abusive doctors in every state, investigation finds,* ATLANTA J. CONSTITUTION, https://doctors.ajc.com/doctors_sex_abuse/?ecmp=doctorssexabuse_microsite_nav (last accessed Nov. 15, 2024). While "there just isn't concrete data," an investigation by the Atlanta Journal-Constitution obtained and analyzed more than 100,000 disciplinary documents from around the country and found that sexual abuse by physicians is pervasive across the entire country. *Id.* "While the vast majority of the nation's 900,000 doctors do not sexually abuse patients, the AJC found the phenomenon is akin to the priest scandal: It doesn't necessarily happen every day, but it happens far more often than anyone has acknowledged." *Id.* OBGYNs also experience great levels of abuse and discrimination in their profession. *See* Margit Endler et. al., *A silent pandemic of violence against providers in obstetrics and gynecology: A mixed-methods study based on a global survey***,** INT. J. GYNECOLOGY & OBSTETRICS 1 (2024) (75.2% of OBGYNs surveyed reported experiencing workplace violence); Ankita Gupta et. al., *Sexual Harassment, Abuse, and Discrimination in Obstetrics and Gynecology: A Systematic Review,* JAMA NETWORK (2024).

[99] Teegardin, *supra* note 98. Offenses ranged from lewd comments during intimate exams to molestation, masturbation by the physician in front of the patient, swapping drugs for sex and even rape. *Id.* As of 2016, the last time CEJA reported statistics on sexual misconduct by healthcare providers was 1991—even then, the report only dealt with physiatrists. *Hamilton, supra* note 23, at 304.

[100] *See supra* notes 15–18; 67–75.

[101] Morrow, *supra* note 44, at 554 ("women should be particularly concerned with the decisions that are made in their behalf, because the health care system has erred seriously in their "behalf' by devaluing their complaints."); Hoffman, *supra* note 66, at 17 (physicians gave women less pain medication than they did men of the same ages for the same procedures). *See also* Sarah Kliff, *Yale Settles with Patients Who Sued Over Painful Egg Retrievals,* NEW YORK TIMES (Sept. 9, 2024) (patients constantly complained of extreme pain during egg retrieval process and were categorically dismissed; turned out a nurse was stealing pain medication and the women received saline solution instead).

[102] *See supra* Part I for a detailed discussion on the paternalistic roots of the physician-patient relationship.

[103] *See* Teegardin, *supra* note 98 ("Some victims say nothing. Intimidated, confused or embarrassed, they fear that no one will take their word over a doctor's. Colleagues and nurses stay silent."); Atkins, *supra* note 8 ("All these things go through your mind. Who do I speak to? How do I get out of here? Who's going to believe me? It's my word against his.").

[104] *See* Teegardin*, supra* note 98 (for example, in Georgia, "two-thirds of the doctors disciplined in the state for sexual misconduct were permitted to practice again."); Fortis, *supra* note 8 (Hadden was permitted back to practice less than a week after sexual abuse allegations were reported to the police and he was arrested).

Once abuse by a gynecologist has been identified, it can be difficult for a patient to obtain relief through legal avenues.[105] Often times, these allegations are handled through criminal proceedings or through disciplinary action with the State Medical Board.[106] In criminal proceedings, a victim can participate in the prosecution of the accused, but the State is considered the 'plaintiff' in the case and is ultimately the decision-maker on if and how to prosecute, and what settlement options are available to the defendant.[107] The State Medical Board is the organization which regulates the practice of medicine, and thus has the ability to suspend or rescind licenses to practice when investigations conclude an abuse has occurred; while victims can make complaints, they ultimately are not decision-makers in how the disciplinary process functions.[108]

While criminal proceedings and State Medical Board disciplinary hearings can punish abusive physicians, these mechanisms do not always provide a path to relief for the injured patient.[109] The civil system, however, can offer relief to patients through various tort legal theories.[110] In the current system, the two main tort theories that could offer relief to injured patients operate under medical negligence theories: medical malpractice and informed consent.[111] Medical malpractice claims, however, are particularly difficult to win in the context of abusive pelvic care, and they only offer relief for patients *after* abuse has occurred.[112] The doctrine of informed consent, however, can proactively protect women by placing an affirmative burden on physicians to disclose all information a woman might want when making decisions about her pelvic health. This is ideal for two reasons: first, it has the capacity to prevent abuses *before* they occur by equipping patients with additional information about the proposed treatment plans, thus protecting women from both abuse and well-intentioned unnecessary pelvic exams; and second, by offering an additional legal mechanism to seek relief if a breach occurs. Given the unique characteristics of pelvic care, a "patient centered standard" should be applied to the doctrine of informed consent specifically

---

[105] Moreover, it is impossible for a patient to seek relief when an abuse has not been found, either for lack of proof or because a patient did not make an allegation in the first place (whether that be because she feared she would not be believed or because she did not recognize an abuse occurred). *See id.*

[106] *See supra* notes 105–12 for a discussion on the types of charges that can be brought and the difficulties for patients using these mechanisms to seek relief. State Medical Board disciplinary action is sometimes hidden as cases are handled secretly—in some cases, medical boards removed "once-public orders from their websites or issue documents that cloak sexual misconduct in vague language." Teegardin, *supra* note 98.

[107] *See id.*

[108] *See id.*

[109] Criminal charges have the potential of punishing an offender, but they do not always offer relief to an injured patient; this is dependent on the laws of the state as some states have statutes that "provid[e] for the compensation of victims of crime for loss of income and unreimbursed medical expenses." Loss of income and unreimbursed medical expenses do not always capture the full picture of injury after a crime has been committed. Herbert S. Denenberg, *Compensation for the Victims of Crime: Justice for the Victim as Well as the Criminal*, 1970 INS. L. J. 628, 628 (November 1970). Civil remedies are the focus of this paper and include various theories of tort law such as the intentional torts of assault and battery and the negligence torts including medical malpractice and negligent hiring. *See* Hamilton, *supra* note 23, at 314. State Medical Boards can investigate claims of misconduct and sanction medical practitioners if the investigation finds evidence of such misconduct. *Id.* at 315. These sanctions can include revoking practitioners' licenses or suspending said licenses, which allows practitioners to continue their medical practice. *Id.* at 316.

[110] Hamilton, *supra* note 23, at 316.

[111] *Id.*

[112] *See id.*

for pelvic care to adequately provide legal protections for women.

A. Pelvic Care and the Insufficiency of Medical Malpractice Claims

When a physician acts negligently and performs care outside the standard applicable to their profession, an injured patient can assert a claim for medical malpractice.[113] Medical malpractice claims are claims for negligence—they allege that a medical professional has negligently provided substandard care to a patient, and as a result, the patient suffered an injury.[114] Generally, to succeed in pursuing a medical malpractice claim, a patient must prove four elements:

> (1) the existence of a legal duty on the part of the doctor to provide care or treatment to the patient; (2) a breach of this duty by a failure of the treating doctor to adhere to the standards of the profession; (3) a causal relationship between such breach of duty and injury to the patient; and (4) the existence of damages that flow from the injury such that the legal system can provide recourse.[115]

Medical malpractice claims present unique barriers to women seeking relief when they are injured by unnecessary pelvic examinations: (a) courts find it difficult to discern if a plaintiff can assert a negligence claim when a physician intentionally abuses them; (b) the conflicting and ever-changing recommendations as to when pelvic exams are necessary makes it difficult for prospective plaintiffs to present the expert testimony required of a malpractice claim; and (c) at times it can be difficult for an injured patient to prove a damage that the legal system can compensate for.

1. Negligence or Intentional Torts? Or Both?

Courts disagree as to whether an unnecessary pelvic exam constitutes malpractice, assault, or both as a matter of law. Where an OBGYN abuses their role as a physician and subjects their patient to unnecessary pelvic exams, courts must decide if the physician's conduct amounts to medical negligence that could be asserted on a medical malpractice theory, or if the conduct has surpassed negligence and instead constitutes intentional battery or assault.[116] If the conduct constitutes battery or assault, a medical malpractice claim cannot be asserted because there is no claim for negligence.

---

[113] Provided they meet the elements thereof. *See* Joseph H. King*, The Common Knowledge Exception to the Expert Testimony Requirements for Establishing the Standard of Care in Medical Malpractice,* 59 ALA. L. REV. 51 (2007).

[114] Sonny Bal, *An Introduction to Medical Malpractice in the United States*, 467 CLINICAL ORTHOPAEDICS AND RELATED RESEARCH 339, 341 (2008).

[115] *Id.* at 342.

[116] Assault is an intentional tort rather than one of negligence, which would preclude the conduct from being asserted in the medical malpractice context. *See* Jerome H. Ehrlich, *Medical Malpractice*, 18 INTRAMURAL L. REV. N.Y.U. 198, 198 (1963) ("Liability of a physician may also result, in the absence of tortious conduct, through a breach of contract or assault and battery, both of which are to be distinguished from malpractice in that the latter is unintentional."); Shirley Qual, *A Survey of Medical Malpractice Tort Reform,* 12 WM. MITCHELL L. REV. 417, 454 (1986) (Congress introduced the "Medical Offer and Recovery Act" in 1984 which precluded "claims for non-economic loss, loss of earning capacity, claims for wrongful death, and injuries intentionally inflicted by health care providers." This Act is not law, but its introduction demonstrates the distinction between intentional and negligence conduct in the malpractice context.).

Courts disagree with each other and within themselves in making this determination, and thus, it is difficult for patients to assert medical malpractice claims that implicate sexual abuse.

The South Dakota Supreme Court articulated their determination in *Martinmaas v. Engelmann.*[117] In *Martinmaas,* the plaintiff asserted claims for both negligence and intentional torts where a physician "used a piece of gauze" to obtain a sample of pelvic discharge, rather than a speculum.[118] Initially, the physician claimed he did so because "he believed the [speculum] was uncomfortable for his patients" and that using gauze would be more comfortable for them; however, he eventually "acknowledged the 'gauze procedure' was one he made up"—he "had never seen anyone perform it, it was not taught in medical school, nor had he ever read about it in any medical literature."[119] At trial, the physician contended that that "the [p]laintiff's evidence, even if believed, showed that he committed intentional acts, not negligence."[120] Thus, the defendant physician argued, his conduct could not constitute medical malpractice because medical malpractice required an act be negligent; intentional torts such as battery and rape could not constitute malpractice.[121]

The Court in *Martinmaas* determined that sexual abuse *can* constitute malpractice. First, they articulated the physician's duty to use due care and skill in their treatment of patients.[122] The Court next concluded that a physician breaches their duty to use due care and skill and thus commits malpractice when they act negligently, meaning they fail "to use 'that care and skill ordinarily exercised under similar circumstances'"[123] Because they concluded malpractice included "any professional misconduct or any unreasonable lack of skill or fidelity in the performance of professional fiduciary duties," and intentional assault demonstrated an unreasonable lack of skill in the performance of professional duties, "for tort liability purposes, sexual misconduct falls within the definition of malpractice."[124]

While the majority in *Martinmaas* concluded that sexual misconduct can constitute negligence and subsequently malpractice, one Justice wrote separately, concurring in the result only.[125] He asked whether "rape and sexual misconduct [can] constitute professional *negligence* if committed by a physician in the course of gynecological exam?"[126] He argued that because "[n]o court has ever held otherwise under these circumstances... [t]he answer is plainly no."[127] When a physician commits an intentional act rather than a negligent one, a claim for malpractice cannot be sustained. Thus, "[r]ape and sexual exploitation in the course of a pelvic exam are intentional acts utterly beyond the concept of failure to use due care and skill."[128]

---

[117] 612 N.W.2d 600 (2000).
[118] *Id.* at 604.
[119] *Id.* at 604–05.
[120] *Id.* at 606.
[121] *Id*.
[122] *Id.* at 607.
[123] *Id.*
[124] *Id.* at 607–08.
[125] 612 N.W.2d 600 (Justice Kokenkamp, concurring in result).
[126] *Id.* at 613 (Kokenkamp concurring in result) (emphasis original).
[127] *Id.*
[128] *Id.* at 614 (Kokenkamp concurring in result).

The New York Supreme Court, Appellate Division also addressed this distinction in *N.X. v. Cabrini Medical Center,*[129] but came to the opposite conclusion. In *Cabrini Medical Center*, the plaintiff woke up from surgery to find a medical practitioner who was not her physician performing a pelvic exam on her without her consent and without the direction of another physician at the hospital.[130] The Court first concluded that there was no question that the physician "committed a sexual assault, not an examination."[131] Thus, the majority concluded "his acts were, as a matter of law, 'wholly personal in nature outside the scope of his employment, and not in furtherance of the defendant hospital's business,' which, of course, is to provide medical treatment."[132] Thus, because the act committed by the physician was an intentional act, the plaintiff did not have a claim against the hospital in which the assault took place.

The dissent in *Cabrini Medical Center* disagreed.[133] One Justice concluded that when a physician performs an "unnecessary pelvic examination" on a patient, that assault is still a medical procedure within the scope of business by the hospital, and thus, the plaintiff ought to have a vicarious liability claim against the hospital for their physician's actions.[134] In other words, "where the examination was conducted for a deviant purpose, an otherwise standard examination may amount to an assault; nevertheless, the deviant mental state of the physician while performing the examination does not remove the task itself from the scope of the physician's employment."[135]

Martinmaas and *Cabrini Medical Center* both articulate the disagreement amongst courts as to whether a plaintiff can assert a claim for medical malpractice when the underlying injurious conduct constitutes sexual abuse. The tension between what conduct constitutes negligence and what conduct constitutes assault or battery makes it difficult for patients injured by unnecessary pelvic exams to assert claims for medical malpractice because whether the claim can be asserted in the first place has to be litigated. This litigation is time consuming, expensive, and often re-traumatizing for the patient—and the end result could be one in which the patients' claim for malpractice is dismissed entirely, as was the case in *Cabrini Medical Center*.[136]

2. Expert Testimony and Pelvic Exams

To assert a claim for medical malpractice, a plaintiff must prove their physician breached their duty of care "by a failure of the treating doctor to adhere to the standards of the profession."[137] Thus, plaintiffs must prove what the "standards of the profession"

---

[129] 280 A.D.2d 34 (2001).
[130] *Id.* at 35–36.
[131] *Id.* at 38.
[132] *Id.*
[133] *Id.* at 49 (Justice Saxe, dissenting).
[134] *Id.* at 55 (Justice Saxe, dissenting).
[135] *Id.*
[136] Victims of sexual abuse who testify in court are often re-traumatized by doing so, especially when reports result in low conviction rates. *See* Michelle Wieberneit et. al., *Silenced Survivors: A Systematic Review of the Barriers to Reporting, Investigating, Prosecuting, and Sentencing of Adult Female Rape and Sexual Assault*, 25 TRAUMA, VIOLENCE & ABUSE 1, 2 (2024) ("If a survivor decides to report the crime and the case moves to trial, the court proceedings can be re-traumatizing for the survivor."). While this study is about criminal investigations of sexual abuse, the principals can be applied to civil trials as well. *See id.*
[137] Bal, *supra* note 114, at 342.

are, and courts require expert testimony to make that determination.[138] This can present difficulties for plaintiffs seeking relief for unnecessary pelvic exams because there has been so much historical (and present) uncertainty as to when a pelvic exam is necessary and thus, there are always practitioners and experts who will testify to that effect.[139] This privileges physicians in medical malpractice claims regarding pelvic care because of the ease with which they can present conflicting expert testimony that their conduct was medically necessary—or at least, medically reasonable.

In *Stoner v. Bureau of Professional and Occupational Affairs*, the defendant physician was accused of sexual misconduct by two patients.[140] The physician in *Stoner* was a specialist in pain management, yet he agreed to see one of the plaintiff-patients for concerns such as eczema.[141] As a part of his intake with this patient, the physician performed a "complete physical examination" on the patient, which included a pelvic exam.[142] When he performed this exam, he did not have a gynecological table, and he did not have a speculum because he did not "routinely perform pelvic examinations."[143] He did the exam by moving her underwear to the side and without a visual inspection due to the lack of speculum, which is not a routine procedure.[144] The other patient accused the physician of performing an unnecessary breast examination, which the physician justified by stating while he did not typically give breast exams, he did so because "she told him she did not know how to do one and was studying nursing."[145]

At trial, to determine if the physician's actions were within the standard course of his practice as a pain management physician, another pain management physician testified that he "does not do breast or pelvic examinations as a part of his regular physical examination unless the patient has a specific complaint."[146] On redirect, however, the physician testified that

> Dr. Stoner was more qualified than he, Dr. Pagan, to perform breast examinations because of his background in breast cancer research. Dr. Pagan also acknowledged that there are certain situations where he would have performed a pelvic examination in the way Dr. Stoner did, i.e., standing at the patient's side, without having the patient's underwear removed and without a visual inspection.[147]

Throughout trial, the defendant physician maintained that the examinations he

---

[138] *See* King*, supra* note 113, at 52.
[139] *See supra* Part II for an in depth discussion of the conflicting recommendations from research bodies regarding pelvic exams.
[140] 10 A.3d 364 (Pa. 2010).
[141] *Id.* at 365–66. In fact, the patient initially made the appointment with Dr. Stoner to sell him a Sam's Club Membership, but during the course of the appointment, asked if he could help her address her eczema concerns. *Id.* at Dr. Stoner conceded these conditions are typically treated by dermatologists, but insisted he could adequately treat the conditions. *Id.*
[142] *Id.* at 366.
[143] *Id.*
[144] *Id.* at 366–67. *See supra* notes 64–69 for a discussion of what is routine procedure during a pelvic exam.
[145] *Id.* at 366.
[146] *Id.* at 368.
[147] *Id.* at 368–69.

performed were medically necessary.[148] Testimony was also presented that the patients "voiced no objection" to the examinations.[149] The plaintiffs did not present any "expert testimony" that the physician's pelvic exams were not medically necessary to contradict the physician's assertion that they were.[150] Thus, the court ultimately concluded, despite all the evidence, that there was "no basis for finding that [his] pelvic examination of [the patient] fell below [the] standard [care]" required of him, and the defendant physician prevailed at trial.[151]

Stoner presents a case in which the plaintiffs did not present expert testimony at all, requiring the court to side with the testimony provided by the defendant physician and his colleagues.[152] However, the number of physicians in *Stoner* who testified that the defendant physician could reasonably perform pelvic examinations without the proper equipment and on patients without the requisite symptoms that would typically prompt a physician to perform a pelvic exam demonstrates the difficulties patients face in litigating expert testimony at trial. First, expert testimony is incredibly expensive.[153] Second, defendant physicians would easily present alternative expert testimony (such as the physicians in *Stoner*) to discount the testimony presented by the plaintiffs, reducing the likelihood that the medical malpractice claim would be successful.[154] While expert testimony presents a difficulty for all medical malpractice cases, this barrier is particularly salient in the pelvic care context because of how easy it is for physicians to obtain expert testimony in their favor due to the ACOG's previous recommendations for annual pelvic exams.[155]

3. Proving Damages

The final element a plaintiff must prove to state a claim for medical malpractice is that they have been damaged by the negligent care provided by their physician.[156] Traditionally, "a medical malpractice plaintiff could not recover damages for emotional distress, no matter how genuine and extreme the psychological harm being suffered, unless there was some physical impact from the defendant's actions on the plaintiff."[157] In other words, there had to be physical damage to the plaintiff, even is said damage

---

[148] *Id.* at 370.
[149] *Id.*
[150] *Id.* at 373.
[151] *Id.* at 374.
[152] *Id.*
[153] Expert Legal Testimony, 97 HARV. L. REV. 797, 809 (1984).
[154] *See* Karen L. Posner et. al., *Variation in Expert Opinion in Medical Malpractice Review,* 85 ANESTHESIOLOGY 1049, 1052 (1996) ("Objectivity has been questioned on the basis of the advocacy relationship that may develop between an attorney and an expert witness.... The results of this study suggest the variability inherent in the implicit judgment process also plays an important role in producing divergent expert opinions."). There are additional problems inherent to the requirement for expert testimony. First, "it is not unheard of for attorneys to attempt to persuade experts to alter the content of their opinions." Steven Lubet, *Expert Testimony,* 17 AM. J. TRIAL ADVOC. 399, 440 (1993). Second, "[u]nder the Federal Rules of Evidence an expert can testify to her opinion with or without explaining the facts or data on which the opinion is based. In theory, then, an expert, once qualified, could simply state her opinion on direct examination, leaving the cross-examiner to search for its basis." *Id.* at 402.
[155] *See supra* Part II for context as to the disagreement amongst medical research bodies regarding pelvic examinations.
[156] *See* Bal, *supra* note 114, at 342.
[157] John L. Ropiequet, *Emotional Distress Claims in Medical Malpractice Cases*, 11 J. LEGAL MED. 59, 59 (1990).

was only slight.[158] This "impact rule" posed problems for patients who experienced an emotional injury at the hands of their physician—for example, if they received an unnecessary pelvic examination that traumatized them without inflicting tangible physical harm.[159]

While not in the context of a pelvic exam, *Brashaw v. Cohen*[160] illustrates this concept. In *Brashaw,* the plaintiffs were the parents of a child who died shortly after birth.[161] The plaintiffs sought damages for the emotional injuries they sustained "as a result of defendants' negligence in providing medical treatment while the mother was pregnant with the decedent."[162] During the course of the pregnancy and the delivery, neither plaintiff (mother nor father) sustained an "independent injury."[163] The New York Supreme Court, Appellate Division concluded that the lower courts properly granted summary judgment to the defendants because the plaintiffs "cannot recover damages for emotional injuries without having sustained an independent injury as a result of the alleged malpractice."[164] Thus, while the deceased infant could assert a claim for damages under a medical malpractice theory, the mother could not.[165]

Some jurisdictions do allow medical malpractices suits that allege exclusively emotional damages.[166] However, these claims often proceed under the theories presented in negligence claims for negligent infliction of emotional distress, which does not clearly apply to the circumstances presented by an unnecessary pelvic exam.[167] The legal theories presented in negligent infliction of emotional distress often provide relief to plaintiffs who witness an atrocity rather than a patient who undergoes negligent medical care and experiences emotional distress and nothing more.[168] In addition, some jurisdictions require a physical manifestation of the emotional distress alleged, reinforcing a requirement that a plaintiff be physically injured.[169] Like the plaintiff in *Brashaw,* it is thus likely that a woman abused while seeking pelvic care would not

---

158 *Id.*
159 *Id.*
160 62 N.Y.S.3d 251 (2017).
161 *Id.* at 251.
162 *Id.* at 252. The court describes the care as follows: "The mother had a history of difficult pregnancies and, after approximately 20 weeks, Cohen diagnosed her as having an incompetent cervix and the mother was admitted to the hospital. Three days later, the mother delivered the decedent. Doctors at the hospital told plaintiffs that the decedent would not survive because his lungs were not fully developed and, indeed, he died only an hour after delivery. During his short life, the decedent had a slow heartbeat, was breathing, and could grab his father's finger, but his skin remained pale blue in color, he did not cry, and he did not move his arms and legs." *Id.*
163 *Id.*
164 *Id.*
165 *Id.* ("Under such circumstances, the infant may commence an action seeking damages for his or her injuries. Absent an independent injury, the mother can recover damages for emotional injuries arising from medical malpractice that causes an in utero injury only if that malpractice results in miscarriage or stillbirth.").
166 *See* Ropiequet, *supra* note 157, at 59 ("Claims for emotional distress are being filed and pursued in many jurisdictions with significant success.").
167 *Id.* at 60, 81.
168 *Id.* at 61. For example, one theory of negligent infliction of emotional distress is the "zone of danger rule." Under the zone of danger rule, a plaintiff can recover for negligent infliction of emotional distress when: "(1) he had a reasonable fear for his own physical safety; (2) he was in such proximity to the accident which physically injured another that there was a high risk of impact on him; and, (3) his emotional distress resulted in physical injury or illness." *Id.*
169 *Id.*

prevail on a medical malpractice theory if she could only prove emotional damage.

B. The Doctrine of Informed Consent

Medical malpractice claims present difficulties for plaintiffs injured while receiving pelvic care. The doctrine of informed consent has the capacity to protect women seeking pelvic care not just by providing a mechanism of relief when a woman undergoes unnecessary pelvic care but by altering the practice around pelvic care. Indeed, if physicians had an affirmative obligation to inform their patients of the information the patient might like to know in advance of treatment, including the reason behind a pelvic exam, the benefits of the pelvic exam (of which there are few in asymptomatic patients), the risks associated with forgoing the pelvic exam, and standard procedure during the exam, there would be both a disincentive to tell patients they need unnecessary care on the part of physicians and women would be better equipped to discern for themselves when a pelvic exam would benefit them. The doctrine of informed consent is thus different from other tort theories that could provide relief to women abused at the hands of their physicians because it could prevent assaults and unnecessary pelvic exams from occurring *before* they happen.[170]

The concept of informed consent for medical procedures is a relatively new one—the doctrine was first introduced in the courts in the twentieth century.[171] The courts played a "leading role" in the development of the doctrine as the forum where its intricacies were litigated and articulated.[172] One of the first cases establishing that a patient "was an active participant in the treatment decision process" took place in 1914.[173] In *Schloendorff v. Society of New York Hospital*,[174] Justice Cardozo explained:

> In the case at hand, the wrong complained of is not merely negligence. It is trespass. Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages.[175]

Thus, when a patient did not consent to a medical treatment, or a physician had obtained consent for one medical treatment and delivered another, the patient had a

---

[170] *See* Hamilton, *supra* note 23, at 314 ("battery, assault, negligent hiring, and intentional infliction of emotional distress...ha[ve] no built-in mechanism to prevent the sexual assault from happening in the first place.").

[171] Peter M. Murray, *The History of Informed Consent*, 10 IOWA ORTHOPEDIC J. 104, 104 (1990) ("For thousands of years physicians felt that deception was an integral part of the practice of medicine."); Anthony Szczygiel, *Beyond Informed Consent,* 21 OHIO N.U. L. REV. 171, 171 (1994); Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L. J. 899, 900 (1994) (the concept of informed consent appeared in a "recognizable, relatively robust form" for the first time in 1957).

[172] Szczygiel, *supra* note 171, at 171.

[173] Murray, *supra* note 171, at 104. *See also* Szczygiel, *supra* note 171, at 183–84. "After 1904, medical consent cases began to appear in state courts, starting slowly and then gradually increasing in number after 1913. The issue in most cases was the extent to which surgeons could exercise their discretion to alter the surgical plan for anesthetized patients. . . Courts declined, however, to trust the surgeons with that decision making power in the absence of a medical emergency." *Id.*

[174] 211 N.Y. 125 (1914).

[175] *Id.* at 129–30.

cause of action for the intentional tort of battery.[176]

As the courts developed the doctrine, however, the cause of action shifted from the intentional tort of battery to one of negligence; courts found, in the absence of consent, that a physician breached "her professionally-defined duty to treat her patient with due care."[177] The duty of a physician to disclose risks associated with a medical procedure was famously articulated in *Salgo v. Leland Stanford Jr. University Board of Trustees*:[178]

> A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. Likewise the physician may not minimize the known dangers of a procedure or operation in order to induce his patient's consent.... The instruction given should be modified to inform the jury that the physician has such discretion consistent, of course, with the full disclosure of facts necessary to an informed consent.[179]

After *Salgo,* courts held physicians liable when their disclosures about invasive procedures "fell below the professional norm and serious harm resulted," though physicians were still allowed considerable discretion in determining what information to disclose.[180]

The doctrine of informed consent thus presents a negligence cause of action resting on the principle that "a patient has a right to receive relevant information from her doctor and a right to decide what treatment should be used."[181] The doctrine has four components: (1) the physician's duty to disclose information relevant to the proposed treatment plan; (2) breach of that duty; (3) causation (i.e., had a reasonable patient known of the undisclosed information, they would not have consented to the

---

[176] Sharon Nan Perley, *From Control over One's Body to Control over One's Body Parts: Extending the Doctrine of Informed Consent*, 67 N.Y.U. L. REV. 335, 339 (1992). The central issue was whether a "touching" had occurred. Szczygiel, *supra* note 165, at 184. For example, in *Fox v. Smith*, the plaintiff asserted a claim for battery where she consented to a laparoscopy and, during the procedure, her physician removed her IUD. 595 So.2d 596, 604 (1992). The Court reversed a directed verdict and remanded the case for trial because there was a factual dispute as to whether the plaintiff had given the physician permission to remove the IUD (or at least implied it). *Id.* at 605. The Court assessed the claim in terms of battery, writing, "The foundation for the consent requirement applicable to medical practitioners is the tort law of assault and battery-the legal doctrine protecting the right of each individual to be touched only when and in the way authorized by that individual." *Id.* at 604.

[177] *Id. See also* Szczygiel, *supra* note 171, at 191 ("The state courts hearing these cases unanimously held that medical professionals had a legally enforceable duty to provide information to the patient on the nature and purpose of the procedure as well as its risks and alternatives.").

[178] 154 Cal.App.2d 560 (1957).

[179] *Id.* at 578.

[180] Szczygiel, *supra* note 171, at 191.

[181] Morrow, *supra* note 44, at 564. *See also* Perley, *supra* note 176, at 340 ("a physician must now disclose 'all information relevant to a meaningful decisional process,' including the nature and purpose of the contemplated procedures, the alternative available procedures, and the anticipated benefits and risks associated with such procedures.").

treatment); and (4) damages as a result the treatment they received.[182] To prevail on a negligence claim under the doctrine of informed consent, patients must prove either: they were injured by a medical procedure which they did not consent to (a clear breach of the physician's duty to disclose); or that their physician breached their duty to inform by not providing sufficient information, and that if a reasonable patient—not the individual plaintiff, but a reasonable patient—had the missing information, they would have opted out of the procedure.[183]

The question then becomes how to determine whether or not a physician had breached their duty to disclose pertinent information about a procedure; in other words, what standard to use to judge whether a physician's disclosures were sufficient.[184] There are two standards that persist in the present day: the "customary professional practice" standard and the "patient centered" standard, and there is roughly an even split amongst U.S. jurisdictions as to which standard applies.[185] Currently, 25 states and the District of Columbia have adopted the patient centered standard, while 23 states have adopted the customary professional practice standard.[186] As discussed below, the patient centered standard should be adopted by all jurisdictions as applied to pelvic care to ensure women are adequately informed of their treatment plans before consenting to pelvic exams.

1. The "Customary Professional Practice" Standard

The "customary professional practice" standard requires a physician to disclose information to a patient that "a reasonable practitioner in the same or similar circumstances would have disclosed."[187] This standard is thus essentially a matter of professional judgment on the part of physicians who compare their conduct to the conduct of other practitioners; in other words, it is the typical malpractice standard.[188]

In states that adopt the customary professional practice standard, plaintiffs are

---

[182] William J. Morton, *The Doctrine of Informed Consent*, 6 MED. & L. 117, 118 (1987). Of course, the patient's ability to consent is dependent on whether the physician has provided sufficient information to the patient so that they may make an informed decision. *See* Perley, *supra* note 176, at 340. By grounding the claim in negligence, courts recognize the duty placed on physicians to disclose information to patients before obtaining consent. *Id.*

[183] Perley, *supra* note 176, at 341.

[184] *Id.* at 340–41 ("The courts are split, however, regarding what constitutes 'sufficient' information."). Some works frame the different standards for the doctrine of informed consent as the majority and minority rules. *See id.* at 340 ("The traditional view, held by a majority of the states..."); Morton, *supra* note 182, at 118 ("This is the prevailing view in the majority of jurisdictions in the United States."). This paper does not adopt this framing, instead viewing the split as between the statutory codification of the doctrine of informed consent and the doctrine at common law.

[185] Morton, *supra* note 182, at 118. *See also* Szczygiel, *supra* note 171, at 190 ("The jurisdictions are almost evenly split between the professionally oriented and the lay standard of disclosure.").

[186] Studdert *supra* note 91, at 105. The laws in the other two states (CO and GA) are not easily classifiable as one or the other. *Id.* These laws exist both in common law and in state statutes depending on the jurisdiction. *Id.*

[187] Morton, supra note 182, at 118. *See also* Schuck, *supra* note 171, at 916.

[188] Morton, supra note 182, at 118.

less likely to succeed in their suits.[189] For example, in *Foard v. Jarman,*[190] the plaintiff patient contacted the defendant physician regarding a surgical operation for her obesity concerns.[191] On her first visit, plaintiff's physician gave her a pamphlet entitled, "What You and Your Family Should Know about Gastric Operations for the Treatment of Obesity."[192] The plaintiff read the pamphlet multiple times, including the section about the risks associated with the procedure.[193] The plaintiff made the decision to proceed with the procedure, despite the stated risks in the pamphlet.[194] Following the surgery, the plaintiff fell extremely ill due to "complications resulting from a perforation in the stomach wall."[195]

In North Carolina, informed consent was codified in the statutory scheme using the customary professional standard; the statute provided that the actions of the health care provider in obtaining consent had to be "in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities" and a "reasonable person" would have an understanding of the procedure or would have undergone such treatment at the advisement of their physician.[196] In other words, the Court stated:

> To meet this statutory standard, the health care provider must provide the patient with sufficient information about the proposed treatment and its attendant risks to conform to the customary practice of members of the same profession with similar training and experience situated in the same or similar communities.[197]

At trial, the defendant physician had another general surgeon testify "it is my opinion that the surgery, care and treatment given the plaintiff by Dr. Jarman was, in every respect, consistent and in accordance with the standard of care."[198] This, in conjunction with the pamphlet the plaintiff read before agreeing to surgery, was sufficient evidence that the physician had met his duty to inform prior to the surgery and thus, the trial court's grant of summary judgment in favor of the defendant was affirmed.[199] As such, because the pamphlet noted the risks associated with surgery, the plaintiff could not be successful on an informed consent claim, even if her physician

---

[189] Studdert, *supra* note 91, at 120 ("Our analysis of informed consent verdicts from 25 states—13 with patient standards in place and 12 with professional standards—found that when the verdicts were grouped according to the two types of jurisdictions, the groups were similar in virtually every respect except the odds of a verdict in the plaintiff's favor, which were more than twice as high in states with patient standards. Overall, plaintiffs' injuries were generally quite serious and payouts were large, averaging more than $1 million per compensated case.").
[190] 326 N.C. 24, 387 S.E.2d 162 (1990).
[191] *Id.* at 25, 387 S.E.2d at 164.
[192] *Id.* at 26, 387 S.E.2d at 164. The pamphlet, as is relevant here, stated that there was a 12% risk of "Wound infection," a 5% risk of "Leaks or perforations causing intestinal infection and the need for reoperation," and a 2% risk of "death." *Id.* at 28, S.E.2d at 165. The pamphlet did not detail what these risks meant. *Id.*
[193] *Id.* at 26, 387 S.E.2d at 164.
[194] *Id.*
[195] *Id.*
[196] *Id.* (citing N.C. Gen. Stat. § 90-21.13(a) (1985)).
[197] *Id.* at 26–27, 387 S.E.2d at 164.
[198] *Id.* at 28, 387 S.E.2d at 165.
[199] *Id.* at 29, 387 S.E.2d at 166.

failed to discuss the risks and benefits of the surgery with her and the concrete implications of those risks on her daily life.

Not all plaintiffs under the customary professional standard fail. In *Ipcock v. Gilmore*,[200] Judith Hill submitted to a laparoscopy for sterilization, an elective surgery that requires a few small incisions in the abdomen.[201] She "signed a written consent form authorizing the defendant, Dr. Samuel J. Gilmore, 'to perform the following operation and/or operations—Laparoscopy with Fulguration of Tubes or Application of Hulka Clips.'" [202] While Hill was under anesthesia, however, her physician determined she had adhesions in her pelvis that prevented the sterilization procedure.[203] Rather than awaken Hill and discuss further treatment options with her, he removed all her reproductive organs, a massive surgical undertaking.[204] After her surgery, Hill was denied pain medication and subsequently suffered brain damage due to loss of oxygen to the brain either during or immediately after surgery.[205]

At trial, Hill's physician argued that her consent form authorized him to perform additional surgical procedures to successfully sterilize her because it authorized him to perform the laparoscopy and any other procedures necessary to "accomplish such purpose."[206] The Court disagreed, determining that purpose was the laparoscopy, *not* sterilization.[207] Because the laparoscopy and the adhesions did not amount to a medical emergency, and the physician had not adequately obtained Hill's consent prior to removing all her reproductive organs, Hill prevailed on an informed consent claim under the customary professional standard.[208]

These two examples are from the same jurisdiction—North Carolina—and thus illustrate what showing is required on the part of a plaintiff to succeed under the customary professional standard. In *Foard*, the plaintiff was unsuccessful because the injury she sustained as a result of her surgery was a standard risk of the surgery that was noted in the pamphlet she read, and thus, her physician abided by the customary professional standard of disclosure even though he did not directly discuss the risks associated with the proposed surgery in person.[209] Conversely, in *Ipcock,* the plaintiff was successful under the customary professional standard, but in her case, the physician completely removed all her reproductive organs because he determined he could not successfully complete an elective sterilization procedure by laparoscopy.[210] There was no medical emergency warranting the removal of these organs without the plaintiff's consent.[211] Arguably, the outcome of Hill's procedure is *not* a standard risk of a laparoscopy—in fact, when the physician realized he could not complete the elective sterilization procedure because of the adhesions in the patient's abdomen, he could have simply ended the surgery and informed the patient when she woke up that he had been

---

200 73 N.C. App. 182, 326 S.E.2d 271 (1985).
201 *Id.* at 183, 287 S.E.2d at 273.
202 *Id.*
203 *Id.*
204 *Id.*
205 *Id.*
206 *Id.*
207 *Id.* at 194–95, 287 S.E.2d at 279–80.
208 *Id.*
209 *Foard*, 326 N.C. at 29, 387 S.E.2d at 166.
210 *Ipcock,* 73 N.C. App. at 183, 287 S.E.2d at 273.
211 *Id.*

unsuccessful.[212]

The customary professional practice standard presents problems for patients seeking pelvic care. The customary professional practice standard does not require physicians to communicate directly the benefits or risks of a procedure to a patient; a generalized pamphlet could suffice. In addition, while the customary professional standard potentially affords severely injured plaintiffs, like Hill, relief when their physicians perform extreme and unwarranted surgeries, the standard does not require physicians to contemplate what a reasonable patient might like to know in advance of the procedure. As a result, because annual pelvic exams without much disclosure are arguably customary professional practice for OBGYNs, this standard does not require practitioners to disclose important information about the exams before obtaining patient consent. If physicians were asked to contemplate this in the arena of pelvic care, abuses and unnecessary surgeries may be avoided.[213]

2. The "Patient-Centered Standard"

The "patient-centered" standard for the doctrine of informed consent centers the needs of a patient.[214] It requires that a physician disclose the risks associated with a proposed treatment plan "that would be material to a reasonable and prudent person in the patient's position."[215] Prior to 1972, "courts adopted the customary professional practice... as the standard of disclosure."[216] In 1972, the courts took a "dramatic turn," instead imposing a patient centered standard.[217] After the courts began imposing the patient centered standard, physician lobbying groups took to the state legislatures, advocating for a statutory customary professional practice standard.[218] At the time, the state legislatures were handling a medical malpractice insurance crisis, and added informed consent to their debates as to what legislation should be adopted to address these matters.[219] Thus, between 1975 and 1977, "almost half the states enacted statutes that made the legal doctrine less threatening to the medical profession" by codifying the doctrine of informed consent using the customary professional practice standard.[220]

---

[212] *Id.* at 195, 287 S.E.2d at 280 (concluding the "total abdominal hysterectomy was unnecessary surgery.").

[213] *See* Studdert, *supra* note 91, at 120, Nina A. Kohn, *Informed Consent in the New Restatement on Medical Malpractice: A Friendly Critique*, 52 SOUTHWESTERN L. REV. 478, 479 (2024).

[214] Morton, *supra* note 182, at 118.

[215] *Id.*

[216] Szczygiel, *supra* note 171, at 191.

[217] Before changing course and imposing the patient-centered standard, the court in *Canterbury v. Spence* noted, "The larger number of courts, as might be expected, have applied tests framed with reference to prevailing fashion within the medical profession. Some have measured the disclosure by "good medical practice," others by what a reasonable practitioner would have bared under the circumstances, and still others by what medical custom in the community would demand. We have explored this rather considerable body of law but are unprepared to follow it." Canterbury v. Spence, 464 F.2d 772, 786 (D.C. Cir. 1972).

[218] Szczygiel, *supra* note 171, at 191.

[219] *Id. See also* Morrow, *supra* note 44, at 571 ("The term, medical malpractice "crisis," is used most commonly to refer to the urgent situation created within the medical profession due to the tremendous rise in the cost of professional liability insurance for physicians and surgeons. The insurance premiums paid by nonsurgical doctors rose 540.8% and those paid by surgeons rose 949.2% between 1960 and 1970."). The medical malpractice insurance crisis drove much legislative tort reform in the 1970s and 1980s. Studdert, *supra* note 85, at 105.

[220] Szczygiel, *supra* note 171, at 192. Georgia was the final state to codify informed consent, passing their legislation in 1988. *Id.*

In states where a common law standard was clearly articulated by the courts, these informed consent statutes "either froze those disclosure standards or replaced non-professional disclosure rules with professional practice standards."[221]

The classic articulation of the patient centered standard in 1972 comes from *Canterbury v. Spence.*[222] In *Canterbury v. Spence,* the plaintiff-patient, who suffered from back pain, "submitted to an operation without being informed of a risk of paralysis incidental thereto."[223] As a result of this procedure, the plaintiff was left paralyzed, and sued for damages arguing that he would not have agreed to the procedure if he had been adequately informed of the risks associated with it.[224] The Court thus had to determine "the scope of the disclosure the physician is legally obliged to make"—or the standard for defining the adequacy of the physician's disclosures.[225] The court opted for a standard that focused on the patient's "right of self-decision"—a right that only be effectively exercised "if the patient possesses enough information to enable an intelligent choice."[226] The Court articulated:

> The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is the information material to the decision. Thus the test for determining whether a particular peril must be divulged is its materiality to the patient's decision: all risks potentially affecting the decision must be unmasked. And to safeguard the patient's interest in achieving his own determination on treatment, the law must itself set the standard for adequate disclosure.[227]

The Court thus remanded the case for a new trial, reversing the previous grant of a directed verdict in favor of the physician and hospital.[228]

The way the Court in *Canterbury* defined the patient centered standard does not protect the individual patient, but rather the "reasonable" patient. A few courts have gone further, creating a patient centered standard that does not ask whether a reasonable patient would consent to a procedure in similar circumstances, but rather whether the individual patient would have consented to a procedure if they had been given additional disclosures.[229] Regardless of whether the courts adopt the reasonable patient

---

221 *Id.*
222 464 F.2d 772 (D.C. Cir. 1972).
223 *Id.* at 776.
224 *Id.*
225 *Id.* at 786.
226 *Id.*
227 *Id.* at 786–87.
228 *Id.* at 796.
229 *See* Scott v. Bradford, 606 P.2d 554 (Ok. 1979). "The Canterbury view certainly severely limits the protection granted an injured patient. To the extent the plaintiff, given an adequate disclosure, would have declined the proposed treatment, and a reasonable person in similar circumstances would have consented, a patient's right of self-determination is Irrevocably lost. This basic right to know and decide is the reason for the full-disclosure rule. Accordingly, we decline to jeopardize this right by the imposition of the "reasonable man" standard. If a plaintiff testifies he would have continued with the proposed treatment had he been adequately informed, the trial is over under either the subjective or objective approach. If he testifies he would not, then the causation problem must be resolved by examining the credibility of plaintiff's testimony. The jury must be instructed that it must find plaintiff would have refused the treatment if he is to prevail." *Id.* at 559.

or the individual patient standard within the patient centered standard, patient autonomy continues "to be the chief value honored by the courts."[230]

The patient centered standard is preferable to the customary professional standard in the realm of pelvic care because of the information that the standard often requires physicians to disclose to their patients. In states that adopt the patient centered standard, plaintiffs are often more successful.[231] For example, in *Hubbard v. Neuman,*[232] the Wisconsin courts sustained the denial of a motion to dismiss where the physicians failed to inform a patient that they would remove her ovaries during a surgical intervention to address concerns related to endometriosis.[233] In doing so, the Court articulated that physicians have a duty to provide "a reasonable disclosure to the patient of the significant risks in view of the gravity of the patient's condition, the probabilities of success, and any alternative treatment or procedures if such are reasonably appropriate," and since the removal of ovaries would be a material risk of the surgery that a reasonable patient would like to know prior to consent, the claim survived a motion to dismiss.[234] Because the patient centered standard requires physicians to at minimum disclose information a reasonable patient would find pertinent to their decision-making in their treatment plans, the patient centered standard is preferred by disability rights activists.[235]

The patient centered standard has a unique capacity to change the way that OBGYNs interact with patients seeking pelvic care. Indeed, while both standards require physicians to disclose pertinent information to patients, the patient centered standard asks what patients think they need to know when determining what specific alternatives, benefits, and risks need to be disclosed, rather than what a physician thinks is important. This is significant because, as explained above, historically, male physicians have dismissed and ignored the concerns of women seeking pelvic care. Requiring physicians to think about what patients might like to know—and perhaps even asking patients what they might like to know—would likely result in information sharing between the physician and the patient that would equip patients with the knowledge they need to make decisions about their pelvic exam before they consent simply because their physician recommended the exam. In addition, it would encourage physicians to further detail what patients can expect during the actual exam, which would help women immediately identify deviations from standard practice; to make those identifications, women must be informed what the standard practice is. While other criminal, civil, and disciplinary mechanisms can potentially offer relief to injured patients, the doctrine of informed consent with a patient-centered standard is the best mechanism for preventing unnecessary and potentially abusive pelvic care *before* it happens in the first place by requiring physicians to confront their standard practices and integrate current scientific recommendations for pelvic exams into their treatment plans with the patient's needs at the forefront.[236]

---

[230] Szczygiel, *supra* note 171, at 193.
[231] Studdert, *supra* note 91, at 114–17.
[232] 411 Wis.2d 586 (2024).
[233] *Id.* at 598.
[234] *Id.*
[235] Studdert, *supra* note 91, at 109.
[236] *See supra* Part II for an in-depth discussion of the scientific research and recommendations around pelvic exams.

CONCLUSION: THE PATIENT CENTERED STANDARD FOR PELVIC CARE

As discussed above, the problems presented by pelvic exams in asymptomatic women without family histories of pelvic conditions are two-fold.[237] First, abusive physicians have extensive leeway to perpetrate their abuse because women often consent to pelvic exams simply because their physicians tell them to.[238] Second, despite changing recommendations from research groups including the ACOG and the ACP, physicians with the best of intentions continue to perform unnecessary pelvic exams on women with no knowledge that said exam is unnecessary.[239] This is problematic because pelvic exams have harms—they cause "fear, anxiety, embarrassment, pain, and discomfort" in patients, and often result in overdiagnosis and unnecessary surgeries due to their inaccuracies in diagnosing pelvic problems in women without symptoms.[240] Given the limitations of criminal charges, state disciplinary board charges, and medical malpractice lawsuits in civil court,[241] the doctrine of informed consent patient centered standard should be applied to pelvic care in customary professional standard jurisdictions.

The doctrine of informed consent is implemented across all fifty states at common law and by statute.[242] Some states have general informed consent statutes, while others have statutes specific to particular medical procedures.[243] For example, many states have implemented statutes to specifically cover pelvic examinations on patients who are under anesthesia.[244] Thus, it would not be abnormal nor unheard of for a state to implement a particular standard under informed consent for pelvic care. The adoption of the patient centered standard will not necessarily provide women with great relief when they undergo abusive or unnecessary pelvic exams; however, the patient centered standard has the capacity to shift the way that physicians interact with their patients, dismantling the historically paternalistic dynamic. Rather than continuing to abide by the idea that the physician knows best,[245] patients would have the information they need to make determinations for themselves regarding when to receive pelvic exams.

---

[237] *See supra* Parts I and II.
[238] *See* Norell, *supra* note 20, at 3–5. *See also supra* note 20 for additional examples of abusive OBGYNs.
[239] *See supra* Part II.
[240] Qaseem, *supra* note 22, at 69.
[241] *See* Hamilton, *supra* note 23, at 311–17. *See also* Part III Section A for an in-depth discussion of the limitations of medical malpractice suits.
[242] Studdert, *supra* note 91, at 105.
[243] *See supra* note 92 for a discussion about informed consent statutes.
[244] *Id.*
[245] *See supra* Part II for a discussion on the paternalistic patient-patient relationship.