

AUTONOMY SUSPENDED: USING FEMALE PATIENTS TO TEACH INTIMATE EXAMS WITHOUT THEIR KNOWLEDGE OR CONSENT

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INTRODUCTION

Recent reports of medical students performing pelvic exams for training purposes on anesthetized women without their consent have produced a firestorm of controversy¹ and calls for greater regulation.² Despite periodic efforts to reform the practice,³ such unauthorized practice is neither a recent phenomenon nor unique to the United States.

Two small-scale studies published in 2003 hint at the extent of this unauthorized practice. In February, Peter Ubel and colleagues reported that 90% of medical students at five Philadelphia-area medical schools performed pelvic examinations on anesthetized patients for educational purposes during their obstetrics/gynecology rotation.⁴ Although trumpeted as proof that physicians are

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1. See, e.g., Letter from American Academy of Nurse Practitioners et al., to Jordan J. Cohen, M.D., President, Association of American Medical Colleges (March 25, 2003) (requesting on behalf of fourteen nursing organizations that the AAMC condemn the practice of using patients without consent), www.hospitalconnect.com/aone/docs/aamc.doc (last visited April 11, 2005).

2. Avram Goldstein, *Practice vs. Privacy on Pelvic Exams: Med Students' Training Intrusive and Needs Patient Consent*, *Activists Say*, WASH. POST, May 10, 2003, at A1.

3. See, e.g., AM. MED. ASS'N, ETHICS OPINION E-8.087: MEDICAL STUDENT INVOLVEMENT IN PATIENT CARE 4-9 (December 2000) (suggesting methods to reform practices involving students caring for patients), http://www.ama-assn.org/apps/pf_new/pf_online?f_n=resultLink&doc=policyfiles/HnE/E-8.087.HTM&s_t=medical+student+involvement+in+patient+care&catg=AMA/HnE&catg=AMA/BnGnC&catg=AMA/DIR&&nth=1&&st_p=0&nth=1& (last visited March 16, 2005); ROYAL COLL. OF OBSTETRICIANS AND GYNAECOLOGISTS, GYNAECOLOGICAL EXAMINATIONS: GUIDELINES FOR SPECIALIST PRACTICE (2002) (urging that verbal consent be obtained before all pelvic examinations).

4. Peter A. Ubel et al., *Don't Ask, Don't Tell: A Change in Medical Student Attitudes After Obstetrics/Gynecology Clerkships Toward Seeking Consent for Pelvic Examinations on an Anesthetized Patient*, 188 AM. J. OBSTETRICS & GYNECOLOGY 575, 577 (2003).

lax in securing permission, the study was not clear on the matter of consent.⁵ Coldicott and colleagues reported in January that 53% of students at a single English medical school performed intimate examinations on anesthetized patients.⁶ Together, they performed roughly 700 exams.⁷ Students acted without any written or oral consent in 24% of the exams.⁸

To the consternation of some medical school faculty and students,⁹ these two studies focused a white-hot spotlight last year on this teaching practice. As the controversy unfolded, it appeared initially that real reform might finally result. At least half a dozen medical schools announced that they would voluntarily begin to ask patients for explicit consent when medical students perform intimate exams.¹⁰ One day after the Federal Trade Commission and the Department of Justice heard testimony on this issue,¹¹ the American Association of Medical Colleges (AAMC), which represents 125 accredited U.S. medical schools and over 400 teaching hospitals, issued a brief press release. This “Statement on Patient Rights and

5. *Id.*

6. Yvette Coldicott et al., *The Ethics of Intimate Examinations – Teaching Tomorrow’s Doctors*, 326 BRIT. MED. J. 97, 98 tbl. 2 (2003).

7. *Id.*

8. *Id.* at 98. Written consent was obtained for less than a quarter of the practice exams. *Id.* In 24% of the cases, students conducted exams without any written or oral consent. *Id.* In the remaining cases, students could not say what consent, if any, patients gave to the exam. *Id.*

9. See, e.g., Karen Garloch, *N.C. Schools: Pelvic Exams Not Gratuitous*, CHARLOTTE OBSERVER, Mar. 24, 2003, at 1E (discussing physician reaction to the publicity surrounding the studies), 2003 WL 3048594; Goldstein, *supra* note 2; Liv Osby, *MUSC May Change Pelvic Exam Practice*, GREENVILLE NEWS (S.C.), Mar. 13, 2003 (quoting the OB/GYN clerkship director at the Medical University of South Carolina, who indicated that “no specific permission” is sought for educational pelvic exams and acknowledged, “maybe this is something we need to revisit”), <http://greenvilleonline.com/news/2003/03/12/200303122797.htm> (last visited Mar. 16, 2005); Darin L. Passer, *Medical Students Respect Their Patients*, THE STATE (N.C.), July 19, 2003 (indicating that the author, a third-year medical student, always secures patient permission, and asking critics of student exams to “respect the role of the medical student just as I value each patient”), <http://www.thestate.com/mld/thestate/6338382.htm> (last visited Mar. 16, 2005); Evan P. Schulz, *Not Rape, But Still Not Right: Hospitals Should Get Clearer Consent Before Med Students Probe Anesthetized Women*, LEGAL TIMES, Mar. 17, 2003 (quoting Dr. Anthony Scialli of the Department of Obstetrics and Gynecology at Georgetown University Medical Center, as saying, “Separating the exam from the remainder of the surgery is artificial”); Audrey Warren, *Doctor Training Faces Scrutiny: Allowing Student Exams on the Unconscious Raises Patients-Rights Issues*, WALL ST. J. (EUROPE), Mar. 13, 2003, at Tech. & Health, <http://www.med.umich.edu/pihcd/news/pelvic/wsj031203.htm> (observing that “[a] number of hospitals say their current consent procedures are adequate”).

10. David Caruso, *Pelvic Exams Without Consent, More Med Schools Now Ask Patients*, THE TALLAHASSEE DEMOCRAT, Mar. 12, 2003, at A3, 2003 WL 2902646; Marilyn Marchione, *Medical College of Wisconsin Revises Pelvic Exam Policy*, MILWAUKEE J. SENTINEL, March 13, 2003, <http://www.jsonline.com/Alive/news/mar03/124975.asp> (last visited March 16, 2005).

11. FED. TRADE COMM’N (FTC) & DEP’T OF JUSTICE (DOJ), IMPROVING HEALTH CARE: A DOSE OF COMPETITION app. A (July 2004), http://www.usdoj.gov/atr/public/health_care/204694.htm; FTC, JOINT FTC/DEPARTMENT OF JUSTICE HEARING ON HEALTH CARE AND COMPETITION LAW AND POLICY 8 (June 10, 2003) (testimony of Robin Fretwell Wilson), <http://www.ftc.gov/ogc/healthcarehearings/030610ftctrans.pdf> (last visited Mar. 16, 2005).

Medical Training” labeled the performance of “pelvic examinations on women under anesthesia, without their knowledge and approval . . . unethical and unacceptable.”¹² The American College of Obstetrics and Gynecology (ACOG) – which asserted in 1997 that patients have “an obligation to participate in the teaching process,”¹³ issued a one-paragraph statement affirming the importance of informed consent. If the exam offers a woman “no personal benefit and is performed solely for teaching purposes,” ACOG declared, “it should be performed only with her specific informed consent, obtained when she has full decision-making capacity.”¹⁴ One state, California, has made unauthorized examinations a misdemeanor and grounds for the loss of a physician’s license.¹⁵

These early gains quickly petered out. Many hospitals and medical schools publicly defended the practice. For instance, Dr. William Dignam, UCLA’s OB/GYN Clerkship Director, explains that doctors at UCLA “don’t discuss student participation” with patients because “I’m reasonably certain that patients know medical students will be participating . . . it’s pretty much all covered in the overall consent form.”¹⁶ He is not alone in this view. An OB/GYN professor at the Medical University of South Carolina (“MUSC”), Dr. Steven Swift, acknowledged that MUSC does not secure specific consent for pelvic exams by students “because it has always been considered a part of ordinary medical practice in the specialty . . . no different than holding a retractor or helping with surgical staples.”¹⁷ Claiming to be a policy minimalist, another faculty member, Dr. John Larsen, George Washington University Hospital’s OB/GYN Chairman, told the Washington Post he “has no plan to amend the hospital’s policies.”¹⁸ Dr. Andrea Rapkin, an OB/GYN professor at the UCLA Medical Center, indicated that, “we don’t specify that it is a pelvic exam We have no reason to specifically state that a medical student will [perform the exam] [sic] It’s usually one or two.”¹⁹

12. Press Release, Am. Ass’n of Med. Colls., AAMC Statement on Patient Rights and Medical Training (June 12, 2003), <http://www.aamc.org/newsroom/pressrel/2003/030612.htm> (last visited March 16, 2005).

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

14. Press Release, ACOG, Statement of the ACOG Committee on Ethics Regarding Ethical Implications of Pelvic Examination Training (Apr. 25, 2003), http://www.acog.org/from_home/publications/press_releases/nr04-25-03.cfm (last visited March 16, 2005).

15. CAL. BUS. & PROF. CODE § 2281 (West 2004 & Supp. 2005).

16. Audrey Warren, *Doctor Training Faces Scrutiny: Allowing Student Exams on the Unconscious Raises Patients-Rights Issues*, WALL ST. J. (Europe), March 13, 2003 at Tech. & Health. See also Osby, *supra* note 8 (quoting Dr. Steven Swift, Associate Professor of Benign Gynecology, Medical University of South Carolina, as saying, “Patients understand this is a teaching hospital and that residents and medical students are involved in their care.”).

17. Osby, *supra* note 9.

18. Goldstein, *supra* note 2.

19. Judy Foreman, *Pelvic Exams Performed Without Permission*, BOSTON GLOBE, July 13, 2004, at E1.

A contemporary²⁰ of such long-discarded customs as the forced sterilization of women²¹ and the warehousing of the mentally disabled,²² this turn of the century practice persists—unlike its nineteenth century cousins—precisely because many teaching faculty believe that using patients without explicit permission is justified. Like Drs. Dignam and Swift, many operate under the assumption that patients have actually or impliedly consented to such exams by coming to a teaching hospital. Other teaching faculty fiercely believe that patients will not consent if asked, so asking for permission should not be required as a matter of necessity. Finally, some especially blunt teaching faculty contend that “public” patients owe it to the facility and society to participate since they receive free or subsidized care.²³

This article considers the merits of these defenses and justifications. It briefly examines in Part I the scope and extent to which patients are used as “live cadavers” for training the next generation of healthcare providers. Part II then documents how these practices have a disproportionate impact on the poor and uninsured, despite the fact that the benefits – proficient physicians – are distributed across society. This Part shows that teaching hospitals are adequately compensated for the care of “public” patients, undercutting the notion of a subsidy and therefore of a debt owing. Finally, Part III tests the justifications based on implied consent, actual consent, and necessity for dispensing with the simple step of asking patients for permission before conducting educational exams. Where these justifications rest on factual assumptions, this Part evaluates how well those assumptions stack up with what is known about patient behavior and knowledge.

20. Michael R. Albert, *The Diverse and Controversial Career of Dr. George Henry Rohé (1851-1899)* 10 (Feb. 6, 2003) (unpublished manuscript, on file with the author) (quoting George Henry Rohé, *The Practical Teaching of Obstetrics and Gynecologists for the Year 1890*, TRANSACTIONS OF THE AM. ASS'N OF OBSTETRICIANS & GYNECOLOGISTS FOR THE YEAR 1890 (1891) (indicating that Rohe, the director of the Maryland Maternity Hospital, stated in an address to the American Association of Obstetricians and Gynecologists' annual meeting in 1890 that “a class of ten students is summoned to every case in the Maryland Maternité: by the time each man has examined the patient twice, and the professor has also examined her twice, there are twenty-two examinations . . .”).

21. See Michael G. Silver, Note, *Eugenics and Compulsory Sterilization Laws: Providing Redress for the Victims of a Shameful Era in United States History*, 72 GEO. WASH. L. REV. 862, 862 (2004) (observing that the sterilization of women was prevalent in the early twentieth century).

22. See Timothy S. Hall, *Legal Fictions and Moral Reasoning: Capital Punishment and the Mentally Retarded Defendant after Penry v. Johnson*, 35 AKRON L. REV. 327, 329-30 n.13 (2002) (explaining that the “U.S. Supreme Court has held that states may not ‘warehouse’ the mentally ill solely by reason of their illness . . .”); Ronald L. Wisor, Jr., Note, *Community Care, Competition and Coercion: A Legal Perspective on Privatized Mental Health Care*, 19 AM. J.L. & MED. 145, 148 (1993) (noting that “many institutions remained indefensible warehouses for the mentally ill . . . until the legal reforms of the 1970s”).

23. Jude T. Waterbury, *Refuting Patients' Obligations to Clinical Training: A Critical Analysis of the Arguments for an Obligation of Patients to Participate in the Clinical Education of Medical Students*, 35 MED. EDUC. 286, 287 (2001) (noting that “[a] number of people in the health care field believe that patients are obligated to participate in clinical training . . . [to] compensate[e] for inability to pay for the health care”).

This article ultimately concludes that greater respect for patients in medical teaching is achievable but will result only when teaching faculty acknowledge the weaknesses of justifications routinely offered for using female patients as teaching tools without their knowledge or permission.²⁴

I. THE SCOPE AND EXTENT OF THE USE OF PATIENTS TO TEACH INTIMATE EXAMS

The Ubel and Coldicott studies are not isolated reports of unauthorized pelvic examinations. A number of other studies suggest that many medical schools and teaching hospitals continue to use unauthorized educational pelvic exams to train students. Turner and colleagues reported in 2000 that 94% of Oxford Medical School graduates learned to perform an “intimate exam” on a male or female patient, some of whom were anesthetized.²⁵ The authors “suspect” consent was not obtained.²⁶ Last year, nearly half of Canadian medical students, 47% at the University of Toronto, reported “pressure to act unethically” and named as the leading culprit the collision between medical education and patient care.²⁷ Many were asked to perform pelvic examinations without consent.²⁸ Importantly, anesthetized patients present practice opportunities not only for medical students but other aspiring professionals as well, such as certified nurse anesthetists, paramedics, and others.²⁹

The unauthorized use of women is not a localized phenomenon confined to a handful of errant medical schools. National surveys in Great Britain, Canada, and the United States demonstrate that anesthetized patients are being used to teach second year medical students how to do their first pelvic exam. For example, 46% of British medical students learned to perform pelvic exams using unconscious women awaiting surgery.³⁰ Twenty-three percent of U.S. and Canadian schools

24. For some physicians, a searching investigation into these practices is seen as an affront. A spokesman for Royal College of Obstetrics and Gynecology labeled concerns over the practice as “academic nitpicking” and “snide, sexual innuendo.” Daniel Cohen et al., Letter to the Editor, *Teaching Vaginal Examination*, 2 *The Lancet* 1375 (Dec. 1988).

25. K.J. Turner & S.F. Brewster, *Rectal Examination and Urethral Catheterization by Medical Students and House Officers: Taught but Not Used*, 86 *BJU INT'L* 422, 423 (2000). Anecdotal accounts in the United States also confirm that men are not immune from such indignities. See, e.g., Suz Redfean, *While You Lay Sleeping*, *MEN'S HEALTH*, Aug. 2004, at 146.

26. Turner & Brewster, *supra* note 25, at 425 (noting that the authors “suspect” that consent for the students’ exams was lacking).

27. Lisa K. Hicks et al., *Understanding the Clinical Dilemmas that Shape Medical Students’ Ethical Development: Questionnaire Survey and Focus Group Study*, 322 *BRIT. MED. J.* 709, 709 (2001).

28. *Id.*

29. Kenneth V. Iserson, *Teaching Without Harming the Living: Performing Minimally Invasively Procedures on the Newly Dead*, 8 *J. HEALTH CARE L. & POL’Y* 224 (2005).

30. Cohen et al., *supra* note 24, at 1375 tbl. 1.

surveyed in 1983 reported using anesthetized patients to teach pelvic exams.³¹ This percentage grew to 37.3% by 1990.³² Students at 25% of U.S. medical schools reported using patients to learn gynecological exams.³³ One in ten were anesthetized at the time.³⁴ In these educational exams, students learn not only the mechanics of a pelvic exam but what normal anatomy feels like.³⁵

While these are older studies, we know the practice persists, especially for teaching abnormal anatomy to third- and fourth-year students, because teaching faculty have publicly defended it over the last year. For instance, the director of gynecologic surgery at the University of North Carolina - Chapel Hill, Dr. Wesley Fowler, noted that “students do do pelvic exams under anesthesia because that is their patient, and it is related to that patient’s care.”³⁶ Researchers also tell us that using women to teach abnormal anatomy without their consent has “long been practiced.”³⁷ Stanley Zinberg, Vice President of Practice Activities for ACOG, acknowledged this history of performing exams under anesthesia, although he asserts it is becoming “less common.”³⁸

We also know that the practice persists because students tell us this. For instance, a student in a 1996 narrative published by a Duke University professor described five or six students doing successive pelvic exams on the same woman:

[it was like] all these medical students parading in to each take their turn, y’know, like going to a vending machine, and walking by. Only

31. Charles R.B. Beckmann et al., *Initial Instruction in the Pelvic Examination in the United States and Canada, 1983*, 151 AM. J. OBSTETRICS & GYNECOLOGY 58, 60 (1985).

32. Charles R.B. Beckmann et al., *Gynaecological Teaching Associates in the 1990s*, 26 MED. EDUC. 105, 106, tbl. 1 (1992).

33. Daniel L. Cohen et al., *Pelvic Examinations by Medical Students*, 161 AM. J. OBSTETRICS & GYNECOLOGY 1013, 1014 (1989).

34. *Id.*

35. Jennifer Goedken, *Pelvic Examinations Under Anesthesia: An Important Teaching Tool*, 8 J. HEALTH CARE L. & POL’Y 234 (2005).

36. Garloch, *supra* note 9. Similarly, at Duke University, Dr. Alison Weidner, chief of the division of gynecology, stated that “students perform exams only if they’re part of a patient’s care team.” *Id.* See also Liz Szabo, *Medical Students Check Women Without Approval*, VIRGINIAN-PILOT, Mar. 14, 2003 (noting that at the Washington University School of Medicine, Johns Hopkins University, and the University of Pennsylvania, “patients are told that students will be part of their care team, but aren’t specifically told the treatment could include a pelvic exam for educational purposes”). Ironically, medical students are generally not willing to examine each other for teaching purposes. Emery H. Chang & David V. Power, Abstract, *Are Medical Students Comfortable with Practicing Physical Examinations on Each Other?*, 75 ACADEMIC MED. 384 (2000) (reporting that a majority of students were “opposed to peer breast, genital, and rectal examinations”), <http://www.academicmedicine.org/cgi/content/full/75/4/384> (last visited March 16, 2005).

37. Lawton et al., *Patient Consent for Gynaecological Examination*, 44 BRIT. J. HOSP. MED. 326 (1990).

38. Letter from Dr. Stanley Zinberg, Vice President, Practice Activities, American College of Obstetrics and Gynecology, to Dr. Gere B. Fulton (Jan. 2, 2002) (on file with author).

it's not a vending machine, it's a woman's vagina. And you're each taking your turn, walking by and sticking your hand in.³⁹

While helpful, existing studies of educational pelvic exams do not definitively indicate whether intimate exams for training purposes occur without consent. This is because, with the exception of the Coldicott study, researchers generally do not ask both (a) whether students perform educational exams and (b) what consent, if any, was given for that training exam. Students may not know what consent preceded the exam.⁴⁰ Nonetheless, consent practices for this and other types of medical education leave a lot to be desired.

As Dr. Iserson details in this issue, educational pelvic exams are just one way in which patients are used for medical training. Recently-deceased patients are routinely intubated, have central venous catheters placed in them, and are used to practice a variety of other techniques.⁴¹ This nearly always occurs without the consent of the now-deceased patient or the patient's family.⁴² Likewise, conscious patients are prodded, poked, examined, used to take spinal taps and insert chest tubes, and subjected to other invasive procedures⁴³ – sometimes by students who

39. Dean Scheibel, *Appropriating Bodies: Organ(izing) Ideology and Cultural Practice in Medical School*, 24 J. APPLIED CMTY. RESEARCH 310, 318 (1996).

40. Interview with Tom Mayo, Professor, Southern Methodist University School of Law, in Columbia, S.C. (May 30, 2003) (on file with author).

41. See Iserson, *supra* note 29 at 222; Robert M. McNamara et al., *Requesting Consent for an Invasive Procedure in Newly Deceased Adults*, 273 JAMA 310 (1995) (describing the practice on the recently deceased of techniques like thoracostomy or the “establishment of an opening into the chest cavity,” pericardiocentesis or the passing of a needle into the heart sac to remove fluid; cricothyrotomy, which involves making an incision through the skin and cricothyroid membrane to relieve a respiratory obstruction; liver biopsy; intraosseous needle placement or the placement of a needle in the bone; central line placement; chest tube placement; abdominal paracentesis or passing a needle into the abdomen to remove fluid; the application of cervical traction tongs; and retrograde tracheal intubation, which is used when routine intubation is not successful).

42. Christopher J. M. Denny & Daniel Kollek, *Practicing Procedures on the Recently Dead*, 17 J. EMERGENCY MED. 949, 951 (1999) (discussing the results of a survey of learners and teachers at teaching hospitals in a medium-sized Canadian city and finding that “[n]one of the participants [in the survey] obtained consent before practicing or teaching a procedure on a recently dead patient”); Mark W. Fourre, *The Performance of Procedures on the Recently Deceased*, 9 ACAD. EMERGENCY MED. 595, 596 (2002) (noting the results of a survey of 116 emergency medical programs, in which 76% of the programs using deceased patients for teaching “‘almost never’ obtain[ed] consent from family members”).

43. Numerous anecdotal accounts highlight the impulse by physicians in training to gloss over the risks of doing a procedure for the first time. In his novel, *Complications*, Atul Gawande described his conversation while a resident at Brigham and Women's Hospital in Boston, Massachusetts, with a “fiftyish, stout” male patient about his need for intravenous nutrition, which involves “threading” a “special line” into the patient's chest as he lay flat. He noted:

I did not say that the line was eight inches long and would go into his vena cava, the main blood vessel to his heart. Nor did I say how tricky the procedure would be . . . [and] I said nothing of . . . bad outcomes that could follow [such as] the woman who had died from massive bleeding when a resident lacerated her vena cava; the man who had had to have his chest opened because a resident lost hold

identify themselves as such, but often by “white coats” who are introduced as physicians but who have yet to graduate. In one survey, more than one in three teaching hospitals reported that “as a matter of policy their institutions specifically informed patients at the time of the admission about medical student involvement.”⁴⁴ This knowledge gap is rarely rectified after admission. In the same study, a mere 6.1% of internal medicine departments indicated that they obtained specific consent from the patient for the student to perform a particular procedure, while 73% did not specifically inform patients “that the students would actually perform the procedures.”⁴⁵ Pediatric departments were no more forthcoming.⁴⁶ Less than 5% of the departments surveyed obtained specific consent from the patient for the student to perform the procedure, while 65% kept silent.⁴⁷

Many teaching facilities place the obligation in the students’ hands.⁴⁸ Yet students routinely fail to inform patients about their student status. In another recent survey, 42% of third-year medical students in the United States did not consistently disclose their student status when performing pelvic exams on conscious women.⁴⁹ In an attempt to instill confidence in soon-to-be physicians, department chairs and hospital staff facilitate this deception. In a 1992 survey of third- and fourth-year medical students at the University of Connecticut School of Medicine, every medical student reported having been introduced to a patient as “doctor” by a hospital staff member at some point.⁵⁰ Six out of every ten students never bothered to correct the misrepresentation with the patient.⁵¹ This misrepresentation sometimes begins at the top. One study reported that 5% of

of the wire inside the line which then floated down to the patient’s heart; the man who had had a cardiac arrest when the procedure put him into ventricular fibrillation. [Instead I explained that] [t]here were ‘slight risks’ involved . . . such as bleeding or lung collapse; in experienced hands, problems of this sort occur in fewer than one case in a hundred.

ATUL GAWANDE, *COMPLICATIONS* 11-12 (2002).

44. Daniel L. Cohen et al., *Informed Consent Policies Governing Medical Students’ Interactions with Patients*, 62 J. MED. EDUC. 789, 792 (1987) (reporting that 37.5% of teaching hospitals inform patients upon admission).

45. *Id.* at 794-95.

46. *Id.* at 794.

47. *Id.*

48. See Larry R. Faulkner & Jerry Reves, *Patients’ Rights vs. Medical Training: Med Students in Need of Hands-On Learning Experiences*, GOUPSTATE.COM, Sep. 21, 2003 (on file with the author) (arguing that in addition to providing notice in the admission form, “learners should identify themselves and inform patients of their role in the delivery of care”).

49. Cohen, *supra* note 33, at 1014. See also Peter A. Ubel & Ari Silver-Isenstadt, *Are Patients Willing to Participate in Medical Education?*, 11 J. CLINICAL ETHICS 230, 230 (2000) (speculating that some students “may even deceive patients about their status as medical students”).

50. Mark E. Beatty & Judy Lewis, *When Students Introduce Themselves as Doctors to Patients*, 70 ACAD. MED. 175, 175 (1995).

51. *Id.* (reporting that only 42% corrected the patient’s misimpression).

department chairs in obstetrics and gynecology advise their students to introduce themselves as doctors and just proceed.⁵²

In any event, it is this pattern of deception and less-than-candid disclosure that is giving medical students license to engage in “unauthorized practice.” As the next Part discusses, the widespread practice of using vulnerable and unsuspecting patients for training purposes is particularly alarming because of the higher rate at which poor and uninsured patients, many of whom are minorities, receive care at teaching hospitals and therefore become teaching material.

II. THE TEACHING BURDEN IS DISPROPORTIONATELY BORNE BY THE POOR AND UNINSURED

It is important to note the impact of unauthorized exams on the poor and “public” patients, many of whom are uninsured or minorities.⁵³ To see concretely why the poor bear a larger share of the teaching load, consider data from the Healthcare Cost and Utilization Project published by the Agency for Healthcare Research and Quality.⁵⁴ For instance, for “Other Therapeutic OB Procedures,” poor patients are much more likely to be seen in teaching facilities than non-teaching ones. For patients who live in zip codes where the median income is less than \$25,000, 36% are seen in non-teaching hospitals, while nearly double, 63%, are seen in teaching hospitals. In contrast, patients in wealthier areas in which the median income exceeds \$25,000 have more choices: slightly more than half are seen at non-teaching hospitals.⁵⁵ Wealthier patients may have both teaching hospital and non-teaching hospital options available to them under their insurance.⁵⁶ This should come as no surprise. Teaching hospitals have long been the refuge of last resort for poor and uninsured patients.⁵⁷ Obstetrics and gynecology departments are no exception.

52. Ubel & Silver-Isenstadt, *supra* note 49, at 232 (citing Cohen et al., *supra* note 47).

53. ETHICAL ISSUES, *supra* note 13 at 1-2 (noting that “[w]hile the benefits generally accrue to society at large, the burdens fall primarily on individual patients, especially the economically disadvantaged”).

54. AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, HEALTHCARE COST AND UTILIZATION PROJECT, 2000 NATIONAL STATISTICS (on file with author).

55. *Id.* This asymmetry occurs for other obstetrical procedures as well. For procedure code 119, “Oophorectomy – unilateral and bilateral,” 55% of poor patients were seen in teaching hospitals, whereas only 41% of wealthier patients were seen in teaching hospitals; for procedure code 132, “Other OR Therapeutic Procedures – female organs,” 63% of poor patients were seen in teaching hospitals, whereas only 50% of wealthier patients were seen in teaching hospitals. For procedure code 121, “Ligation of fallopian tubes,” 51% of patients in lower income areas were seen in teaching hospitals compared to 36.5% of patients in wealthier areas. *Id.*

56. *Id.*

57. *Teaching Hospitals – Social Missions at Risk*, AHA TREND WATCH (Am. Hosp. Ass’n & The Lewin Group, Washington, D.C. & Falls Church, V.A.), May 2002, at 2 (comparing uncompensated care as a percentage of total expenses by teaching status and finding that for major teachings hospitals, uncompensated care exceeded 7%, compared to 5% for all hospitals).

There is a second reason to be concerned about a disproportionate impact on the poor and uninsured: teaching institutions are far more willing to use “public” patients than “private” patients for medical education. In a 1990 survey, 47.5% of teaching hospitals reported using public patients to teach pelvic exams, while only 20.3% used private patients.⁵⁸ Thus, the experiences of patients within the same institution vary according to insurance status.⁵⁹ This is intentional. Some physicians believe “public” patients should carry a greater share of the teaching load because they receive free or subsidized care.⁶⁰

In summary, poor and uninsured patients are much more likely to be seen at teaching facilities than wealthier patients, and are therefore more likely to be involved in teaching practices, whether voluntarily or involuntarily. This is problematic because the benefits of such teaching – better and more proficient physicians – flow to everyone in society (or at least those that have access to healthcare).

III. JUSTIFICATIONS OFFERED BY TEACHING FACULTY FOR UNAUTHORIZED PRACTICE

Teaching faculty articulate three primary justifications for dispensing with specific consent for educational pelvic exams. First, many believe that patients who accept care at teaching hospitals know and agree, at least implicitly, to permit students to care for them.⁶¹ Second, some faculty believe that patients consent to the participation of students on their care team when they sign their general consent form at admission.⁶² Third, many believe patients would not consent if

58. Beckmann et al., *supra* note 31, at 106 tbl. 1.

59. This “two tier” system is nothing new. See KENNETH M. LUDMERER, *TIME TO HEAL: AMERICAN MEDICAL EDUCATION FROM THE TURN OF THE CENTURY TO THE ERA OF MANAGED CARE* 228 (1999). Ludmerer notes:

The United States, like most Western nations, had traditionally had a two-class system of health care. Private health care, for those who could pay for it, was patient-oriented, personalized, and based on continuity of the doctor-patient relationship. It offered patients minimal waiting time to see their physicians and convenient, comfortable, personalized service in both ambulatory and hospital settings. In contrast, the “clinic” mode of care, for those who received charity medical services, was depersonalized, somewhat inefficient, and sometimes degrading – even if the same technical quality of care was rendered. Typically this care was provided by interns, residents, and fellows of a teaching hospital under the supervision of a member of the medical faculty, who was not the patient’s personal physician. Continuity of care was often broken by the regular rotation of house staff and faculty.

Id.

60. See *supra* note 21 and accompanying text.

61. See *infra* notes 64-65 and accompanying text.

62. See *infra* notes 97-98 and accompanying text.

asked, making unauthorized training procedures necessary.⁶³ It is crucial to test each of these rationales in order to evaluate the need for regulating or modifying existing practices.

A. Patients Do Not Implicitly Consent to Serve as Practice Subjects

The first justification that teaching faculty cite for not obtaining specific consent for educational pelvic exams is that patients have implicitly consented to educational exams by accepting care at a teaching hospital.⁶⁴ As ACOG noted in 1997, a sentiment persists in medicine that patients “understand from the beginning that they are admitted for teaching purposes.”⁶⁵ Courts, on occasion, have accepted this claim when the hospital asserting it is a well-known academic medical center.⁶⁶ However, the claim that patients know which hospitals are

63. See *infra* note 107.

64. Osby, *supra* note 9.

65. ETHICAL ISSUES, *supra* note 13, at 1 (noting also the prevailing opinion that patients must be “willing to submit to this when pronounced physically fit”). See also Scheibel, *supra* note 39, at 320 (quoting a teaching faculty member as saying “our patients understand that this is a teaching hospital”).

66. See *Bowlin v. Duke Univ.*, 423 S.E.2d 320 (N.C. Ct. App. 1992). In this case, the appellate court upheld the lower court ruling that rejected the plaintiff’s claims of constructive fraud and breach of the duty to provide informed consent. *Id.* at 323. The plaintiff brought the claims against his doctor, his clinic, and Duke University Medical Center for injury to his sciatic nerve that allegedly resulted from a bone marrow harvest performed by a medical student. *Id.* The trial court rejected the informed consent claim on two distinct bases. *Id.* at 323-24. First, the court held that the use of medical students in teaching hospitals is standard practice. *Id.* at 323. In addition, the court concluded that the signed consent form adequately informed the plaintiff that Duke University Medical Center was a teaching hospital. The signed consent form read, in pertinent part, as follows: “TEACHING INSTITUTION, I understand that Duke University Medical Center is a teaching institution, and I agree that students training to be physicians, nurses, [and] allied health personnel may assist in providing my care” *Id.* Agreeing with the lower court, the appellate court noted that there is “no statutory or common law duty for an attending surgeon to inform a patient of the particular qualifications of individuals who will be assisting” *Id.* The court concluded that this combination of circumstances defeated the plaintiff’s lack of informed consent and constructive fraud claims. *Id.* at 324. See also *Henry v. Bronx Lebanon Med. Ctr.*, 385 N.Y.S.2d 772, 775 (N.Y. App. Div. 1976) (denying an action for lack of informed consent because the plaintiff should have been aware that Bronx Lebanon Medical Center was a teaching hospital, in which it was the custom to allow residents to perform complicated deliveries). It is unclear whether implied consent would suffice as a defense, in the absence of explicit notice in the admission form or a well-known custom or practice of the hospital.

Courts have, in fact, rejected implied consent as a defense to the duty to provide informed consent in cases in which the defendant hospital gave no explicit disclosure. For instance, in *Tom v. Lenox Hill Hosp.*, 627 N.Y.S.2d 874, 875 (N.Y. Sup. Ct. 1995), the patient signed a consent form authorizing the first doctor “and whomever he may designate as his associate or assistants’ to provide the surgical services.” *Id.* at 875. The hospital claimed that it was well known that Lenox Hill is a teaching hospital; consequently, the plaintiff, by seeking treatment at Lenox Hill, consented to having residents and fellows assist in his surgery. *Id.* The plaintiff then contended that he would not have undergone the procedure if he knew it was to be a teaching exercise. *Id.* at 876. The court distinguished *Henry*, *supra*, because the defendant, in this case, provided no evidence that it was well-known custom of Lenox Hill to allow residents to assist. *Tom*, 627 N.Y.S.2d at 876. The court

teaching hospitals and consequently have chosen consciously to accept care in a training facility lacks factual support.

King and colleagues surveyed elderly patients in a teaching facility in Great Britain, the Royal Liverpool Hospital.⁶⁷ They found that 60% of the patients had no idea that training was going on at the hospital until they encountered it for the first time.⁶⁸

Not only are patients usually unaware of a hospital's teaching status, but outside a select group of renowned medical centers, there is little reason they should know. Disclosure to the public of the hospital's teaching mission varies wildly from hospital to hospital. Some hospitals indicate their medical school affiliation in their name. Duke University Medical Center⁶⁹ and NewYork-Presbyterian – The University Hospital of Columbia and Cornell⁷⁰ are two examples. However, this is not the norm. Of the 381 members of the Council of Teaching Hospitals and Health Systems, only eighty-seven – slightly more than 20% – contain the word “university” in their name.⁷¹ Consider two prominent examples: Harvard and Brown Universities. Only one of Harvard Medical

concluded that fact issues existed as to whether the plaintiff consented to the procedure performed by a doctor other than the one for whom consent was given. *Id.* at 877.

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

68. *Id.* at 363. This lack of understanding extends to knowledge of *precisely what a “medical student” is*. Nearly a third, 29% of patients, did not realize that medical students train to be doctors. *Id.* at 360. Fourteen percent thought they were either nursing or pharmacy students, and 15% simply could not say. *Id.* at 361.

69. *See, e.g.*, Duke University Medical Center website, at <http://www.mc.duke.edu/index3.htm> (last visited March 24, 2005). *See also* The University Hospital, University of Medicine & Dentistry of New Jersey website, at <http://www.theuniversityhospital.com> (last visited March 24, 2005); Johns Hopkins Hospital & Health System website, at <http://www.hopkinsmedicine.org> (last visited March 24, 2005).

70. NewYork-Presbyterian, The University Hospital of Columbia and Cornell is the primary teaching hospital of Columbia University College of Physicians & Surgeons and the Weill Medical College of Cornell University. *See* NewYork-Presbyterian, The University Hospital of Columbia and Cornell website at <http://www.nyp.org> (last visited March 24, 2005). This full title appears on the exterior building and on all hospital publications. Personal communication with Cathy Thompson, Office of Public Affairs & Media, Columbia-Presbyterian Medical Center. (Oct. 29, 2003) (on file with author).

71. ASS'N. AM. MED. COLLS., MEDICAL SCHOOLS OF THE U.S. AND CANADA – ALPHABETICAL LISTING, <http://www.aamc.org/members/listings/msalphaae.htm> (last visited March 25, 2005). *See also* CONFERENCE OF BOSTON TEACHING HOSPITALS (COBTH) (Jul. 22, 2004) (describing COBTH as a coalition of twelve hospitals in Boston that train Massachusetts' future health professionals. None of these hospitals would readily appear, on the basis of name, to be associated with a medical school: Beth Israel Deaconess Medical Center, Boston Medical, Brigham and Women's Hospital, Cambridge Health Alliance, Caritas Carney Hospital, Children's Hospital Boston, Dana-Farber Cancer Institute, Faulkner Hospital, Lahey Clinic, Massachusetts Eye and Ear Infirmary, Massachusetts General Hospital, and Tufts-New England Medical Center Floating Hospital for Children), at www.bu.edu/cobth/welcome.html (last visited March 25, 2005).

School's eighteen affiliated teaching institutions references Harvard in its name.⁷² Brown University in Rhode Island lacks a university-owned hospital, so it affiliates with seven hospitals in the state to provide clinical education for its medical students.⁷³ The names of those hospitals provide no indication of the affiliation.⁷⁴ Similarly, not a single one of the Veteran's Administration's 161 hospitals affiliated with medical schools includes the word "university" or "college" in its name.⁷⁵

While the majority of teaching hospitals have names that obscure their medical school ties, some disclose the relationship to patients in other ways. Many indicate the strength of the affiliation on their websites. Massachusetts General Hospital, Harvard's principal teaching hospital, indicates this association on the title bar of its homepage.⁷⁶ Other teaching facilities bury the affiliation among the

72. The eighteen Harvard Medical School affiliated hospitals and institutions are: Beth Israel Deaconess Medical Center, Brigham and Women's Hospital, Cambridge Hospital, C.B.R. Institute for Biomedical Research, Children's Hospital Boston, Dana-Farber Cancer Institute, Forsyth Institute, Harvard Pilgrim Health Care, Joslin Diabetes Center, Judge Baker Children's Center, Massachusetts Eye and Ear Infirmary, Massachusetts General Hospital, Massachusetts Mental Health Center, McLean Hospital, Mount Auburn Hospital, Schepens Eye Research Institute, Spaulding Rehabilitation Hospital, and Veterans Affairs Boston Healthcare System. HARVARD MED. SCH., HARVARD MEDICINE, at <http://www.hms.harvard.edu/> (last visited March 25, 2005). Of the eighteen, only Harvard Pilgrim Health Care, a non-profit health plan, contains the word "Harvard." *Id.* See also HARVARD MED. CTR. NETWORK, at <http://www.hmcnet.harvard.edu/txtmap.html> (last visited March 25, 2005).

73. To provide its medical students with clinical experience, Brown University affiliates with seven area hospitals: The Memorial Hospital of Rhode Island, The Miriam Hospital, The Emma Pendleton Bradley Hospital, Butler Hospital, Rhode Island Hospital, The VA Medical Center, and Women and Infants Hospital of Rhode Island. BROWN MED. SCH., AFFILIATED HOSPITALS, at http://bms.brown.edu/academics/clinical_sites.html (last visited March 25, 2005). Brown and Harvard are not unique. For example, The University of Arizona is also affiliated with a number of Phoenix-area institutions. UNIV. OF ARIZONA HEALTH SCIENCES CTR. PHOENIX CAMPUS, TEACHING HOSPITALS (listing nine area institutions with which the university is affiliated: Barrow Neurological Institute, Carl T. Hayden Veteran's Administration Medical Center, Good Samaritan Regional Medical Center, Maricopa Integrated Health System, Mayo Clinic-Scottsdale, Phoenix Baptist Hospital & Health System, Phoenix Children's Hospital, Scottsdale Memorial Healthcare and St. Joseph's Hospital, and Medical Center), at www.ahsc.arizona.edu/phoenix/students/teachhosp.htm (last visited March 25, 2005).

74. See BROWN MED. SCH., *supra* note 73.

75. See DEP'T OF VETERANS AFFAIRS, FACILITIES LOCATOR & DIRECTORY (giving the legal names for each of the affiliated hospitals and showing that only six of the VA's 167 hospitals are not affiliated with a medical school), <http://www.appc1.va.gov/directory/guide/division.asp?divisionId=1> (last visited Feb. 24, 2005).

76. MASS. GEN. HOSP., at <http://www.mgh.harvard.edu> (last visited Mar. 25, 2005). Some hospitals are more forthcoming about their affiliations than others. For example, Long Island Jewish Medical Center's affiliation with Albert Einstein Medical College appears in the first and third paragraphs of its homepage, and Montefiore Medical Center states in the first paragraph on its website that it "has been The University Hospital and Academic Medical Center for the Albert Einstein College of Medicine (AECOM) since 1963." LONG ISLAND JEWISH MED. CTR., at http://www.lij.edu/lij_home_page_ns.html (last visited Mar. 25, 2005); MONTEFIORE MED. CTR., at <http://www.montefiore.org/>

mass of information contained on their websites. Consider an affiliate of the Columbia Medical University College of Physicians & Surgeons, Northern Westchester Hospital. The hospital's affiliation with Columbia appears midway through a list on the "Affiliations/Approvals" page, which is reached by accessing a link on the "About NWHC" page, which, in turn, is accessed through the hospital's homepage.⁷⁷ Of course, for many elderly and poor, notification through the Internet is ineffective because they lack Internet access or are not computer savvy.⁷⁸

While a hospital's name or website may tip off patients to its teaching mission, physical proximity to a medical school would also put patients on notice. Clearly, a patient who walks into New York-Presbyterian, located less than sixty feet from the Columbia Medical University College of Physicians & Surgeons, can reasonably be expected to know the facility is a teaching hospital.⁷⁹ But for those

about/albert/content.html (last visited Mar. 25, 2005); in contrast, the affiliation between Children's Hospital Boston and Harvard Medical School appears in the fourth paragraph of the "About Us" page, which is accessed through the hospital's main page. CHILDREN'S HOSP. BOSTON, at <http://www.childrenshospital.org/about> (last visited Mar. 25, 2005). Some hospitals are schizophrenic in their disclosure of affiliations with multiple medical schools. On Beth Israel Deaconess Medical Center's homepage, "Harvard Medical School Teaching Affiliate" appears next to the hospital's name. However, Beth Israel Deaconess Medical Center's affiliation with Albert Einstein College of Medicine is not easily accessed via the menu on its website; one must search for "Albert Einstein College of Medicine" to find it mentioned. BETH ISRAEL DEACONESS MED. CTR., at <http://www.bidmc.harvard.edu/sites/bidmc/home.asp> (last visited Mar. 25, 2005); CONTINUUM HEALTH PARTNERS, at http://www.wehealny.org/medical_training/albert.html (last visited Apr. 20, 2005).

77. NORTHERN WESTCHESTER HOSP. CTR., at <http://www.nwhc.net/NWH/index.htm> (last visited Mar. 25, 2005). Note, too, the VA Great Lakes Health Care System, which touts as its mission "to serve the health care needs of America's veterans. This is accomplished through . . . Excellence in Education and Research." This mission statement appears on the "Mission and Vision" page, which is accessed via the "About VA Great Lakes" page, linked to the health system's homepage. VA GREAT LAKES HEALTH CARE SYSTEM, MISSION AND VISION, at <http://www.vagreatlakes.org/ABO/mission.asp> (last visited Mar. 25, 2005).

The affiliation of other VA hospitals are more transparent. *See, e.g.*, EDITH NOURSE ROGERS MEM'L VETERANS HOSP. (noting its medical school affiliation on its homepage under "Affiliations"), at <http://www.visn1.med.va.gov/bedford> (last visited Mar. 25, 2005); VA MARYLAND HEALTH CARE SYSTEM, OVERVIEW (noting in the third paragraph of "Overview" page that "[a]s a leader in education, the VA Maryland Health Care System prides itself on [an] active affiliation with the University of Maryland School of Medicine . . ."), at <http://www.vamhcs.med.va.gov/overview.htm> (last visited March 25, 2005).

78. Because only 26% of the elderly regularly access the Internet, a substantial majority of the elderly are unlikely to be aware of a hospital's teaching affiliation through that medium. PEW INTERNET & AMERICAN LIFE PROJECT, DEMOGRAPHICS OF INTERNET USERS (Jan. 2005), at http://www.pewinternet.org/datasets/datasetfiles/Regional_Data_sheets.xls. Like the elderly, the underprivileged have reduced access to the Internet. Less than one-half of Americans with incomes below \$30,000 use the Internet. *Id.* (reporting this figure as 48%).

79. Mapquest gives the distance from Columbia's location at 630 W. 168th Street to New York Presbyterian's location at 622 W. 168th Street as less than 0.01 miles. Mapquest, <http://www.mapquest.com/directions> (last visited Mar. 25, 2005).

teaching hospitals that are removed geographically from their affiliated medical schools, the public is not even put on constructive notice.

Columbia's medical school partners with more than 50 different facilities located throughout New York, New Jersey, and Connecticut.⁸⁰ Although only a stone's throw from New York-Presbyterian, the medical school is over fifteen miles from its affiliate in New Jersey, Valley Hospital, and 73 miles from New Milford Hospital in Connecticut.⁸¹ Columbia's affiliated hospital in Cooperstown, New York, the Mary Imogene Bassett Hospital, is a staggering 217 miles from the medical school—nearly a four hour drive.⁸² Similarly, Harvard Medical School is nearly twenty-five miles from its affiliate, Brockton/West Roxbury VA Medical Center.⁸³

Columbia's and Harvard's far-flung affiliations are typical of the new face of teaching hospitals. Medical schools are creating new relationships that further erode the ability of patients to "know" they have entered a teaching institution. As a result of its joint venture with Columbia/HCA, Tulane University Medical Center affiliated "with seventeen of Louisiana's thirty hospitals to train medical students and residents."⁸⁴ Duke University Medical Center participates in "a joint venture with Sanus Corporation Health Systems, a for-profit subsidiary of the New York Life Insurance Company, to provide managed-care products in North Carolina, South Carolina, and Virginia."⁸⁵

80. NEWYORK-PRESBYTERIAN HEALTHCARE SYS. (noting that "[a]ll [s]ystem members are academic affiliates of two Ivy League medical institutions: Weill Medical College of Cornell University and Columbia University College of Physicians & Surgeons"), at <http://www.nypsystem.org/> (last visited Mar. 25, 2005).

81. COLUMBIA UNIV. MED. CTR., HOSP. AFFILIATIONS (listing affiliated facilities), at http://www.cumc.columbia.edu/health/hw_affiliates.html (last visited Mar. 25, 2005); Mapquest (providing distance from Columbia's location at 630 W. 168th Street, New York, NY, to Valley Hospital, 233 N. Van Dien Avenue, Ridgewood, NJ, as 15.46 miles, with an estimated driving time of 25 minutes; and to New Milford Hospital, 21 Elm Street, New Milford, CT, as 72.67 miles, taking an estimated 1 hour and 28 minutes to travel), at <http://www.mapquest.com/directions> (last visited Mar. 25, 2005).

82. Mapquest (mapping distance from Columbia's location at 630 W. 168th Street, New York, NY, to Mary Imogene Bassett Hospital, One Atwell Road, Cooperstown, NY, as 217 miles, with an estimated driving time of 3 hours and 50 minutes), at <http://www.mapquest.com/directions> (last visited Mar. 25, 2005).

83. HARVARD MED. SCH., HARVARD MED. CTR. NETWORK (listing facilities affiliated with Harvard Medical School), at <http://www.hmcnet.harvard.edu/txtmap.html> (last visited March 25, 2005); Mapquest (giving the distance from Harvard Medical School, 9-25 Shattuck Street, Boston, MA, to 940 Belmont Street, Brockton, MA, as 24.95 miles, with an estimated driving time of 32 minutes), at <http://www.mapquest.com/directions> (last visited Mar. 25, 2005).

84. Jeffrey E. Shuren, *Financing the Nation's Graduate Medical Education: A Hybrid Approach*, 33 VAL. U. L. REV. 181, 188-89 (1998).

85. *Id.* at 189. Washington University Medical Center in St. Louis has aligned with seven hospitals. *Id.*

Compounding the confusion caused by large networks, many medical schools consciously strive to provide learning opportunities in rural communities. One model medical school program creates rural primary care clerkships for students in clinics in “smaller communities.”⁸⁶ Some of these clinics are hundreds of miles away from the teaching hospital with which they affiliate.⁸⁷ The migration of learning opportunities away from large urban teaching hospitals into smaller, more rural contexts further undercuts the notion that patients have impliedly consented to serving as teaching tools.

Aside from the factual problems with implied consent, there are other problems with the idea of imputing to patients an agreement to be practiced upon. First, patients often do not make deliberate choices to be seen in teaching facilities – some simply go to the facility at which their physician has admitting privileges. They may not even know that their doctor holds a medical school faculty appointment. Other patients seek the best reimbursement from the health plan in which the teaching hospital participates as a preferred provider. Some health plans will only reimburse certain services, like organ transplantation, if provided at a designated center of excellence, often an academic medical center.⁸⁸ Patients may also select a facility based on its expertise for a given procedure, like a coronary artery heart bypass, not because of a conscious choice to act as a “practice dummy.”

Notions of implied consent are even more far-fetched for patients seeking emergency care. Often, these patients do not come to the hospital on their own but are brought in by others.⁸⁹ Thus, the emergency room patient who is later admitted as an in-patient may not have deliberately selected the hospital. In short, the idea

86. Faulkner & Reves, *supra* note 48 (describing the Deans' Rural Primary Care Clerkship developed by the Medical University of South Carolina and the University of South Carolina School of Medicine to provide clerkship opportunities in Spartanburg, Anderson, Florence, Greenville, and Greenwood, South Carolina).

87. Mapquest (reporting the distances from the Medical University of South Carolina in Charleston, SC, to Greenwood, Greenville, and Spartanburg as 198.61, 212.68, and 204.69 miles, respectively; and from the University of South Carolina School of Medicine in Columbia, SC, as 90.24, 104.31, and 96.31 miles, respectively), at <http://www.mapquest.com/directions> (last visited Mar. 28, 2005).

88. JOHN C. GOODMAN, NAT'L CTR. FOR POL'Y ANALYSIS (NCPA), TWO CHEERS FOR THE BUSH HEALTH PLAN, BRIEF ANALYSIS NO. 465 (Jan. 30, 2004), <http://www.ncpa.org/pub/ba/ba465/ba465.pdf> (last visited June 6, 2005); NCPA, SOLVING THE MEDICARE CRISIS, <http://www.ncpa.org/ba/ba163.htm> (last visited June 6, 2005). *But see* AM. FED'N OF STATE, COUNTY, AND MUNICIPAL EMPLOYEES (AFSCME), HEALTH FOCUS, TROUBLE AT TEACHING HOSPITALS (Jan. 2000) (reporting that managed care organizations are becoming less-inclined to pay the higher prices charged by academic medical institutions for specialty services such as coronary artery bypass, graft surgery, and neonatal infant care), at http://www.afscme.org/publications/health_focus/focus100.htm (last visited Apr. 20, 2005).

89. *See e.g.*, Michael Ardagh, *May We Practise Endotracheal Intubation on the Newly Dead?*, 23 J. MED. ETHICS 289, 291 (1997) (discussing patients brought by ambulance to the emergency room who die there and are subsequently used for teaching purposes).

that patients know, or even quietly suspect, that they are in a teaching facility is frequently a fiction.

We should be loath to impute consent to patients for a more fundamental reason: patients care deeply about being asked. Two separate studies have found that “all patients” would want to know that vaginal examinations were being done by medical students.⁹⁰ Validating these findings, Ubel and colleagues measured the importance patients placed on being asked.⁹¹ Out of a possible five points, patients gave an importance rating of 4.3 to being asked about a pelvic exam conducted before their surgery.⁹² This question received among the highest importance ratings in the study, suggesting that “patients placed great importance on being asked permission.”⁹³

Finally, guidelines of the Joint Commission on Accreditation of Health Care Organizations state that “[p]articipation by patients in clinical training programs should be voluntary.”⁹⁴ As the Council on Ethical and Judicial Affairs of the American Medical Association concluded, such guidelines “make clear that it is inappropriate to assume that a patient is implicitly willing to participate in the training of medical students or other health professionals merely by being admitted to an academic medical center.”⁹⁵

B. Actual Consent is Missing

Many faculty believe that student participation as members of the care team is clearly authorized by the patient upon admission.⁹⁶ This claim takes two forms. In the stronger form, teaching faculty assert that the student’s pelvic exam is an ordinary component of the surgery to which the patient has consented.⁹⁷ A

90. ROYAL COLL. OF OBSTETRICIANS AND GYNAECOLOGISTS, INTIMATE EXAMINATIONS: REPORT OF A WORKING PARTY (1997); D. Magrane et al., *Student Doctors and Women in Labor: Attitudes and Expectations*, 88 OBSTETRICS & GYNECOLOGY 298 (1996). Likewise, in a study of first-time spinal taps, 80% of patients reported that they would want to know “the experience level of the person doing the spinal tap” Charles Telfer Williams & Norman Fost, *Ethical Considerations Surrounding First Time Procedures: A Study and Analysis of Patient Attitudes Toward Spinal Taps by Students*, 2 KENNEDY INST. OF ETHICS J. 217, 221 (1992).

91. Ubel & Silver-Isenstadt, *supra* note 49, at 234 (citing Ari Silver-Isenstadt & Peter A. Ubel, *Erosion in Medical Students’ Attitudes About Telling Patients They Are Students*, 14 J. GEN. INTERNAL MED. 481 (1999)).

92. Silver-Isenstadt & Ubel, *supra* note 91, at 484.

93. *Id.*

94. The Council on Ethical and Jud. Aff. of the Am. Med. Ass’n, *Medical Students’ Involvement in Patient Care*, 12 J. CLINICAL ETHICS 111, 112 (2001) (quoting the JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS (1985)).

95. *Id.*

96. ETHICAL ISSUES, *supra* note 13, at 1.

97. Osby, *supra* note 9 (explaining that MUSC does not secure specific consent for educational pelvic exams because, as Dr. Steven Swift, an OB/GYN professor at MUSC noted, “it has always been

variant on this claim holds that if consent was obtained for one procedure, it encompasses consent for additional, related procedures.⁹⁸

Unpacking these claims becomes an interesting problem of contract interpretation. In a typical consent form, patients will:

agree and give consent to [teaching hospital], its employees, agents, the treating physician . . . medical residents and Housestaff to diagnose and treat the patient named on this consent to any and all treatment which includes, but might not be limited to . . . examinations and other procedures related to the routine diagnosis and treatment of the patient.⁹⁹

considered a part of ordinary medical practice in the specialty . . . no different than holding a retractor or helping with surgical staples”).

98. Ardagh, *supra* note 89, at 292 (making this observation with respect to practicing resuscitation procedures on the recently deceased); A.D. Goldblatt, *Don't Ask, Don't Tell: Practicing Minimally Invasive Resuscitation Techniques on the Newly Dead*, 25 ANNALS EMERGENCY MED. 86, 87 (1995) (analogizing to “construed consent,” which authorizes related tests or diagnostic procedures).

99. PALMETTO RICHLAND MEMORIAL HOSP., CONSENT FOR MEDICAL TREATMENT.(on file with author). Palmetto Richland Memorial Hospital is a teaching hospital for the Medical University of South Carolina. PALMETTO HEALTH RICHLAND, HOSPITAL QUICK FACTS, <http://www.palmettohealth.org/about/index.html> (last visited Apr. 8, 2005); *see also* MUSC MEDICAL CENTER AMBULATORY CARE, MUSC, CONSENT FOR MEDICAL TREATMENT (2000) (on file with author). This consent form states:

I/we voluntarily consent to medical treatment and diagnostic procedures provided by the Medical University Hospital Authority Medical Center and its associated physicians, clinicians and other personnel. I/we understand that the transfusion of blood or blood components may be a necessary part of my treatment. I/we consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician.

Id. Other consent forms simply acknowledge “the presence of other persons during the surgical procedure, such as medical students, nursing students, other healthcare students or healthcare providers, and/or healthcare company representatives.” VA HOSPITAL, REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES, OPTIONAL FORM 522 (1994), (on file with author). Importantly, this disclosure does not authorize these observers to perform healthcare services or exams on the patient.

Other teaching hospitals disclose students’ role but do not explicitly ask for consent for medical student participation or explain that students may perform services for the student’s educational benefit, rather than the patient’s care. *See, e.g.*, LOYOLA UNIV. HEALTH SYSTEM, LOYOLA UNIV. CHICAGO, INFORMATION GUIDE FOR PATIENTS AND FAMILIES, PATIENT RIGHTS & RESPONSIBILITIES (on file with author) (“Since Loyola University Medical Center is a major teaching institution, students in all phases of health care training may also be attending in your care.”); *see also* GREENVILLE HOSP. SYSTEM, CONSENT FOR TREATMENT (on file with author) (indicating that “GHS is a medical teaching institution; therefore *residents* may be involved in your care under the supervision of an attending physician”). The Greenville consent form says nothing about *students*, a puzzling omission since the hospital system’s Outpatient Authorization notes that services may be provided by “physicians in a residency training program . . . or by medical students under the supervision of Medical Staff members.” GREENVILLE HOSP. SYSTEM, OUTPATIENT AUTHORIZATION (on file with author) (emphasis added); *see also* Szabo, *supra* note 36 (noting that at the Washington University School of Medicine, “patients are told that students will be part of their care team, but aren’t specifically told the treatment

As a threshold matter, it is necessary to determine who the form authorizes to perform services. “Housestaff” is a term of art and means “[p]hysicians and surgeons in specialty training at a hospital who care for the patients under the direction and responsibility of the attending staff.”¹⁰⁰ It does not encompass students. Students arguably are not hospital “agents,” as they are not credentialed by the hospital and have no standing to provide care independently.¹⁰¹

More fundamentally, however, the typical admission form authorizes care for the patient’s benefit, not for educational purposes. As Lawton explains, “A vaginal examination performed by a student in a teaching situation can make no contribution to patient care and implied consent in that case has no meaning.”¹⁰² Teaching faculty nonetheless maintain that the exam is an included component of the surgery and consequently is authorized as necessary care.¹⁰³

Deciding whether something is for the patient’s care or the student’s education is sometimes a vexing question but not impossible. The key question seems to be whether the student’s examination would not have been performed but for the fact that her physician was a member of the teaching faculty. Consider two scenarios. In the first, a woman is admitted for surgery, and the surgeon does a pelvic exam to reconfirm her diagnosis before removing the patient’s ovaries. The student then repeats the pelvic exam for her own training purposes. The second is a duplicate of the first, that would not have been performed but for the surgeon’s status as a medical school member. In the second scenario, the surgeon permits the student to do the pelvic exam in her place. In this instance, a substitution effect occurs in which the patient receives a different and potentially substandard exam that she would not have received but for the fact that the surgeon also teaches. Under either scenario, the student-performed exam would not have occurred as it did and consequently is not necessary for the patient’s care. Because it is not medically necessary, it cannot be authorized by the typical admission form.¹⁰⁴

could include a pelvic exam for educational purposes” and that similar policies are in place at the University of Pennsylvania).

100. STEDMAN’S MEDICAL DICTIONARY FOR THE HEALTH PROFESSIONS AND NURSING 684 (5th ed. 2005).

101. COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS: THE OFFICIAL HANDBOOK, MS 6.2.2 & “Intent of MS.6 Through 6.4” (2000) (on file with author).

102. Lawton et al., *supra* note 37, at 327.

103. See e.g., Osby, *supra* note 9 (quoting Dr. Steven Swift, Associate Professor, Medical University of South Carolina).

104. Arguably, exams performed for educational purposes are not authorized, even under the explicit disclosure and consent discussed in *Bowlin v. Duke Univ.*, 423 S.E.2d 320 (N.C. Ct. App. 1992). The consent form discussed in *Bowlin* read, in pertinent part, as follows: “TEACHING INSTITUTION, I understand that Duke University Medical Center is a teaching institution, and I agree that students training to be physicians, nurses, [and] allied health personnel may assist in providing my care” *Id.* at 323. While the consent form authorizes students to assist in medical procedures, it

The same limiting principle applies to conscious patients. Their “express consent” to an examination cannot be extended to authorize any procedure that a trainee needs to practice that day. As Lawton explains, “The fact that a patient attends for a medical consultation implies that he or she agrees to a medical examination being carried out. This, however, does not imply consent for any procedure more complex or invasive than inspection, palpation or auscultation.”¹⁰⁵

At most then, implied consent encompasses treatment that the patient could reasonably expect to receive when checking into a health care facility, that is, treatment that provides the patient with a direct benefit.¹⁰⁶

C. Exaggerated Fears of Refusal

As a final justification, many faculty argue that performing educational exams without specific consent is necessary. Essentially, these faculty argue that “we can’t ask you, because if we ask you, you won’t consent.” As one researcher reports, “It is traditional to feel that a patient may refuse permission for a vaginal examination because it is uncomfortable, painful or embarrassing and that examination under general anaesthesia will prevent these problems, and therefore formal consent need not be sought.”¹⁰⁷

Few would dispute that “patients are indispensable to the education and training of medical students”¹⁰⁸ or that practice makes perfect. Trainees confirm the pedagogical value of educational pelvic exams. Every trainee who responded in one study found the experience helpful in seeing and palpating the anatomy and increasing the students’ confidence.¹⁰⁹ The question is not whether training procedures should be performed, but whether the patient’s consent should be

limits them to assisting in the patient’s care. One can reasonably read the form as permitting students to actively participate only in care that is medically necessary for the patient.

105. Lawton et al., *supra* note 37, at 326.

106. Ardagh, *supra* note 89, at 291-92 (making this observation with respect to practicing on recently deceased patients).

107. Lawton et al., *supra* note 37, at 326; *see also* Foreman, *supra* note 19 (quoting Dr. Marcia Angell, Senior Lecturer in Social Medicine at Harvard Medical School, who explains that “the reason doctors don’t ask is that women might refuse”). Lawton et al., *supra* note 37, at 326. As Dr. Goedken explained in this issue, this logic – that a duty to ask arises from and reflects the potential for harm and that formal consent is not necessary because an exam under anesthesia cannot cause discomfort, pain, or embarrassment – ignores a patient’s dignitary interest in deciding what happens with, and to, her own body. Goedken, *supra* note 35, at 235-38.

108. G. Wykurz, *Patients in Medical Education: From Passive Participants to Active Partners*, 33 MED. EDUC. 634, 634 (1999).

109. D. Gary Benfield et al., *Teaching Intubation Skills Using Newly Deceased Infants*, 265 JAMA 2360, 2362 (1991) (reporting a 75% response rate for trainee surveys).

required.¹¹⁰ One important element of this analysis is whether a consent requirement will radically reduce or eliminate training opportunities.

The impulse not to obtain consent is driven, in part, by students' concerns about their technical short-comings. Students assume patients share these concerns and as a consequence will likely not agree to the exam, limiting the students' practice opportunities. In one study, researchers asked medical students to rate their technical skills and ability to conduct physical and vaginal exams, and then compared the scores to how patients actually rated them.¹¹¹ While medical students gave themselves low scores, patients viewed them in a much more favorable light,¹¹² suggesting that students dramatically overestimate their perceived incompetence.

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

One study in the United Kingdom found that 46% of women in outpatient care did not object to having students perform pelvic exams on them.¹¹³ The survey asked patients to answer hypothetical questions¹¹⁴ and to give actual consent to actual exams.¹¹⁵ Patients seen in a private physician's office are even more generous with their consent. Lawton asked women who came into his private practice for consent to perform educational pelvic exams. He found that "over an 8-month period, refusal rates have been in the order of 5%."¹¹⁶ In another

110. Goldblatt, *supra* note 98, at 86 (noting with respect to the dead that "using the necessity of maintaining competence in these [medical] techniques as a justification for assuming consent is ethically unacceptable," despite the practical need of medical students to practice procedures on the dead, and arguing that family consent must be obtained).

111. Magrane et al., *supra* note 90.

112. *Id.* For instance, on a scale of 1 to 3, with 1 being the best, patients found students to be considerably more competent than students found themselves, on every measure. Specifically:

	Patients' Rating of Students	Students' Rating of Themselves
Found Answers	1.3	1.4
Bedside Manner	1.6	2.0
Technical Skills	1.8	2.6
Physical Exam	1.6	2.1
Vaginal Exam	1.5	2.0

Id. at 300.

113. J. Bibby et al., *Consent for Vaginal Examination by Students on Anaesthetised Patients*, 2 LANCET 1150, 1150 (1988). Lawton et al., *supra* note 37, at 326 (discussing study by J. Bibby et al).

114. Bibby et al., *supra* note 113.

115. Lawton et al., *supra* note 37, at 329.

116. *Id.*

“hypothetical” study, 61% of outpatients reported that they would definitely allow, probably allow, or were unsure whether they would allow a pelvic examination.¹¹⁷

Even more women consent to examinations before surgery. In one study in the United Kingdom, 85% of patients awaiting surgery consented to educational exams by students while the patient was under anesthesia.¹¹⁸ Again, these were actual patients giving actual consent to real exams by real students. Responding to hypothetical questions, more than half of the patients surveyed in another study (53%) would consent or were unsure if they would consent to pelvic exams, if asked prior to surgery.¹¹⁹

In fact, patients will consent not only to examinations but to riskier procedures by students as well. In a recent study conducted in Australia, 62% of the women surveyed would allow students to participate in their childbirth.¹²⁰ Nine percent of patients in the consenting group would allow medical students to participate in cesarean sections, 25% in normal deliveries, and fully 64% would allow students to participate without putting any limitations on what they do.¹²¹

This willingness to participate in training extends beyond the OB/GYN department. Williams and Fost found that 52% of patients surveyed were willing to have a medical student perform that student’s first spinal tap on them, provided the student was “under close supervision.”¹²² A significant percentage of patients would let medical students make an incision (48%), hold a retractor (82%), suture them up (41%), intubate them (44%), and perform a rectal exam (52%).¹²³

Some patients consent precisely because they see a benefit to themselves. One-third to one-half of patients in each of three studies cite this benefit as a reason for consent,¹²⁴ while two additional studies found a significant percentage of patients (83% and 85%) believe that student participation improves their care.¹²⁵

117. Ubel & Silver-Isenstadt, *supra* note 49, at 232-33.

118. Lawton et al., *supra* note 37, at 329.

119. Ubel & Silver-Isenstadt, *supra* note 49, at 234.

120. Devika Grasby & Julie A. Quinlivan, *Attitudes of Patients Towards the Involvement of Medical Students in their Intrapartum Obstetric Care*, 41 AUSTL. N.Z. J. OBSTETRICS & GYNAECOLOGY 91, 93 (2001).

121. *Id.* at 95.

122. Williams & Fost, *supra* note 90.

123. Ubel & Silver-Isenstadt, *supra* note 49, at 234.

124. David S. Adams et al., *The Effect of Patients’ Race on Their Attitudes Toward Medical Students’ Participation in Ambulatory Care Visits*, 74 ACAD. MED. 1323, 1324 (1999) (discovering that roughly 50% of patients saw student participation as a benefit); J. Bentham et al., *Students Conducting Consultations in General Practice and the Acceptability to Patients*, 33 MED. EDUC. 686, 687 (1999) (reporting that 30% of patients saw student participation as a benefit); Grasby & Quinlivan, *supra* note 120, at 94-95 (finding that 36% of patients saw student participation as a benefit).

125. Diane Magrane, *Obstetric Patients’ Assessment of Medical Students’ Role in Their Care*, 63 J. MED. EDUC. 713, 716 (1988) (finding that of obstetric patients at the Medical Center Hospital of Vermont who received care from medical students, 83% noted that a participating medical student contributed to their care in some concrete way); P. H. Richardson et al., *Patients’ Attitudes to Student*

Patients thought that students would be more willing to track down answers to their questions and to discuss their illness and care.

Beyond this selfish motivation, there is a significant streak of altruism among patients. In a recent survey, the primary reason given by pregnant women who consented to student participation is a wish to benefit medical education – 73% cited this as the driving motivation for them.¹²⁶ Contrast this again with student perceptions. Only 40% of students responding to a 1996 study identified the patient's desire to contribute to medical education as the most important reason for patient consent.¹²⁷ This disconnect leads physicians and students not to seek consent for fear of being denied. In the end this fear is without basis. As Lawton flatly observes, "Consent . . . is rarely withheld."¹²⁸

Thus, asking a woman for oral or written permission is essential, even for exams by students on the care team. This is not to say, however, that securing specific consent will be costless. It will not. For example, asking a patient for permission may make teaching invasive examinations harder than teaching external exams¹²⁹ and may make it harder to provide learning opportunities for students than for residents and interns.¹³⁰ Moreover, it may limit the number of students who can learn from a single patient.¹³¹ These irreducible costs of consent

Doctors, 20 MED. EDUC. 314, 315 (1986) (reporting that 85-87% of patients participating in the study believed "[i]t was helpful being able to talk to the student doctors").

126. Diane Magrane et al., *Obstetric Patients Who Select and Those Who Refuse Medical Students' Participation in Their Care*, 69 ACAD. MED. 1004, 1005 (1994).

127. Magrane et al., *supra* note 90, at 300.

128. Lawton et al., *supra* note 37 at 329 (noting that refusals occurred only five percent of the time over an eight-month period).

It is plausible that consent rates in the U.S. will differ, although there is no reason to believe they will do so. If these rates hold, however, medical students are not likely to be starved of practice opportunities: "The small number of women who would not consent to vaginal examination under anaesthesia by medical students will not reduce our ability to teach gynaecological examination" *Id.*

129. Mark E. Beatty & Judy Lewis, *When Students Introduce Themselves as Doctors to Patients*, 70 ACAD. MED. 175 (Mar. 1995) (reporting that 72% of patients would be upset to find they had been the unsuspecting subject of the novice's first spinal tap); Bibby et al., *supra* note 113 (finding that more women will consent to a medical student performing an external exam or taking patient history than will consent to an internal exam).

130. Williams & Fost, *supra* note 90. Williams and Fost discovered evidence of a "gray hair phenomenon," in which the willingness of patients to allow doctors to perform a first-time spinal tap on them increases with the experience of the doctor. Sixty-six percent of patients would allow a supervised resident (a licensed doctor with several years of training) to perform a first-time spinal tap on them, but only 62% of patients would allow an intern (a first-year doctor) to perform the procedure. *Id.* Further, only 52% would allow a medical student to perform the procedure. *Id.*

131. ROYAL COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, *supra* note 3. Numbers matter a great deal to women. Bibby and colleagues asked women about the number of medical students who should be present during gynecological consultations and examinations. Bibby et al., *supra* note 113. If a gynecological consultation was to be performed, 84% of respondents felt that no more than two medical students should be present. *Id.* If a vaginal examination was to be performed, 100% of respondents felt that only one medical student should be present. *Id.*

may help to explain why unauthorized practice persists, even after the promulgation of laws and guidelines requiring the patient's express consent.¹³²

CONCLUSION

At bottom, the propriety of using patients with or without consent to teach essential medical skills is a question of practicality for many teaching faculty and administrators. As Dr. Jennifer Goedken candidly acknowledges in her contribution to this issue, cost matters.¹³³ The frequency of learning opportunities that can be provided matters.¹³⁴ This is so because knowing how to do a pelvic examination is an essential skill not only for OB/GYNs but for primary care and other physicians.¹³⁵ It is equally essential to teach resuscitation techniques to emergency medical personnel and others.¹³⁶ Neither use of patients for teaching leaves them physically harmed or worse off.¹³⁷ Patients – both anesthetized and deceased – provide the best opportunity to impart these critical skills.

This unyielding reality has short-circuited the ethical sensitivity of many medical educators, who clutch to a variety of rationales for dispensing with the simple step of disclosing forthrightly the educational nature of practice procedures and asking permission. This refusal to enlist patients as “respected partners”¹³⁸ stems from misinformation about patient awareness of a hospital's teaching mission, over-reliance on less-than-candid paper consent, and simple distrust of patients, who – if allowed – will make this gift on all our behalves.

132. See generally CAL. BUS. & PROF. CODE § 2281 (West 2003 & Supp. 2005) (“A physician and surgeon or a student undertaking a course of professional instruction or a clinical training program, may not perform a pelvic examination on an anesthetized or unconscious female patient unless the patient gave informed consent to the pelvic examination . . .”); ETHICAL ISSUES, *supra* note 13 (“If a pelvic examination(s) that is planned for an anesthetized woman undergoing surgery offers her no personal benefit and is performed solely for teaching purposes, it should be performed only with her specific informed consent . . .”); AAMC, *supra* note 12 (“Recent reports have suggested that medical students are performing pelvic examinations on women under anesthesia, without their knowledge and approval. AAMC believes that such practice is unethical and unacceptable.”). *Id.*

133. Goedken, *supra* note 35, at 233 (arguing that “at a cost of fifty dollars or more per patient per hour, the ability to use [standardized patients] with frequency is very limited”).

134. *Id.*

135. *Id.* at 234.

136. Iserson, *supra* note 29, at 218.

137. Goedken, *supra* note 35, at 235 (observing that pelvic exams under anesthesia are “probably one of the safest procedures that can be performed on a patient”); Iserson, *supra* note 29 (discussing minimally invasive resuscitation techniques that leave no readily apparent marks on the deceased).

138. Goedken, *supra* note 35, at 235.