

Not Just “Bodies with Vaginas”: A Kantian Defense of Pelvic Exam Consent Laws

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Abstract:

Medical students commonly learn how to administer pelvic exams by practicing on unconscious patients, often without first obtaining explicit consent from patients to do so. While twenty-one states currently have laws that require teaching hospitals to obtain consent from patients to participate in this educational experience, opposition from the medical community has stymied legislative progress. In this paper, I respond to the two most common reasons offered to oppose legislation, which appeal to (1) the educational benefits of these exams, or (2) protecting institutional autonomy. Kantian ideas about autonomy help to illuminate the problematic ways in which these arguments supplant the importance of women’s choices over how their bodies are used while seeking medical treatment. Ultimately, neither argument offers sufficient reason to oppose laws that require explicit consent before administering training pelvic exams.

Key Words: autonomy, pelvic exams, informed consent, women’s health, Kantian ethics.

I. Introduction

There is still no consensus in the U.S. about whether performing unauthorized pelvic exams (UPEs) on unconscious female patients violates informed consent, and the practice remains legal in twenty-nine states. While the medical community has shown increasing support for legislative requirements for consent in recent years, a significant number of doctors and hospitals across the country still oppose these measures, arguing that the practice is essential to student education and institutional autonomy. In this article, I argue that both of these justifications fail when we employ a Kantian conception of human dignity to guide the ethical treatment of patients. Because giving an unauthorized exam circumvents a patient's capacity for self-determination in the name of secondary ends, these arguments against legislation reduce her body to a site for experiential education and therefore do not conclusively justify opposing consent legislation.

II. Unauthorized Pelvic Exams: Defining the Issue

During a pelvic exam, the physician examines the uterus and ovaries by inserting two gloved fingers into the patient's vagina. While pelvic exams are an important diagnostic tool, the procedure can elicit feelings of distress and/or physical discomfort because it is inherently invasive. It can be particularly difficult for patients with a history of sexual abuse.¹ In the U.S., biomedical ethical standards require protecting the patient's autonomy by obtaining her or his informed consent prior to treatment. However, standard procedure does not require a woman's explicit consent prior to this exam. Janine and Sarah's stories

¹ Taylor, G. A., McDonagh, D., & Hansen, M. J. (2017). Improving the pelvic exam experience: a human-centered design study. *The Design Journal*. 20(1), S2348-S2362.

demonstrate the disorienting and even traumatic impact that this discovery can have on patients.

Janine, a nurse in Arizona, checked into the hospital for stomach surgery in 2017. Before the procedure, she told her physician that she did not want medical students to be directly involved. But after the operation, Janine said, as the anesthesia wore off, a resident came by to inform her that she had gotten her period; the resident had noticed while conducting a pelvic exam ... Distressed, she tried to piece together what had happened while she was unconscious. Why had her sexual organs been inspected during an abdominal operation, by someone other than her surgeon? ... “I have a history of sexual abuse, and it brought up bad memories ... Patients put such trust in the medical profession, especially on sensitive topics such as going under anesthesia.”²

Sarah Wright, a science teacher in Madison, Wis., said she was given a diagnosis of extreme vulvar sensitivity after a surgery in 2009. She wondered how an operation performed through incisions in her abdomen could have affected her sexual organs ... So when scheduling another operation with University of Wisconsin School of Medicine and Public Health’s hospital system in 2018, she asked to draft her own consent contract ... She said department administrators rebuffed her request. “They told me: ‘Is this a deal breaker for you? Because if so, you should have your surgery somewhere else.’”³

Research studies, medical professionals, and patient testimonies have revealed that the practice of administering pelvic exams to nonconsenting, anesthetized patients is common.⁴ Because the exam takes experience to learn, instructors direct students to practice on women who are under anesthesia for surgical procedures, many times without

² Goldberg, E. (2020). *She didn't want a pelvic exam. She received one anyway.* The New York Times. Retrieved from <https://www.nytimes.com/2020/02/17/health/pelvic-medical-exam-unconscious.html>

³ Ibid.

⁴ McDermott, J. & Johnson, C. K. (2019). *States seek explicit patient consent for pelvic exams.* AP News. Retrieved from <https://apnews.com/article/north-america-ut-state-wire-bills-wa-state-wire-ct-state-wire-c309d388b10b4fe582753e3b1f768f94>; Barnes, S. S. (2012). Practicing pelvic examinations by medical students on women under anesthesia: why not ask first? *Obstetrics and Gynecology.* 120(4), 941-943; Schniederjan, S., & Donovan, G. K. (2005). Ethics versus education: Pelvic exams on anesthetized women. *The Journal of the Oklahoma State Medical Association.* 98(8), 386–388; Ubel, P. A., Jepson, C., & Silver-Isenstadt, A. (2003). Don't ask, don't tell: A change in medical student attitudes after obstetrics/gynecology clerkships toward seeking consent for pelvic examinations on an anesthetized patient. *American Journal of Obstetrics and Gynecology.* 188(2), 575-579.

first ensuring that those women explicitly consent to the exams.⁵ Students typically practice these exams during gynecological surgeries. However, as in Janine's case, a patient may undergo these exams even in cases where her surgery is non-gynecological.⁶ The patient may experience multiple consecutive pelvic exams while she is unconscious, depending on how many students need to practice.⁷ These exams are thus performed solely for the educational benefit of the student(s).⁸

Because these exams are not disclosed to patients, it is unclear how many women have unknowingly been subjected to the procedure. Sarah's story highlights the challenges that this can present when a patient experiences seemingly unrelated complications following a procedure and is left to piece together what may have happened in the operating room. However, the exams are commonplace. A 2003 study found that of 401 Pennsylvania medical students interviewed, ninety percent had practiced pelvic exams on unconscious patients as part of their training.⁹ Disturbingly, many of those students saw informed consent as less important after doing so.¹⁰ Bioethicist Phoebe Friesen's 2018 article, which recently catalyzed public awareness of the issue, drew on accounts from

⁵ Wahlberg, D. (2020). *Bill seeks informed consent for pelvic exams under anesthesia by medical students*. Wisconsin State Journal. Retrieved from https://madison.com/wsj/news/local/health-med-fit/bill-seeks-informed-consent-for-pelvic-exams-under-anesthesia-by/article_ab30b282-0507-5c0f-93c5-83143f74ae86.html; Friesen, P. (2018a). Educational pelvic exams on anesthetized women: Why consent matters. *Bioethics*. 32(5), 298-307; Phoebe Friesen, P. (2018b). *Why are pelvic exams on unconscious, unconsenting women part of training?* Slate. Retrieved from <https://slate.com/technology/2018/10/pelvic-exams-unconscious-women-medical-training-consent.html>.

⁶ Fretwell Wilson, R. & Kreis, A. M. (2018). *#JustAsk: Stop treating unconscious female patients like cadavers*. Chicago Tribune. Retrieved from https://www.chicagotribune.com/opinion/commentary/ct-perspec-pelvic-nonconsensual-exam-medical-students-vagina-medical-1203-story.html?int=lat_digitaladshouse_bx-modal_acquisition-subscriber_ngux_display-ad-interstitial_bx-bonus-story; Wahlberg, *op. cit.* note 5.

⁷ Friesen, *op. cit.* note 5 (2018b); Fretwell Wilson, R., Cakan, A., Chong, A., Hubaishy, J., Monzel, A., & Noon, M. J. (2022). *Unauthorized pelvic exams: Public engagement initiative*. The Epstein Health, Law, and Policy Program. Retrieved from <https://www.epsteinprogram.com/pelvic-exams>.

⁸ Friesen (2018b), *op. cit.* note 5; Fretwell Wilson, R., et al., *op. cit.* note 7.

⁹ Ubel, P. A., et al., *op. cit.* note 4.

¹⁰ *Ibid.*

many of her New York medical students who described their personal discomfort when instructed to perform UPEs.¹¹ Yet this indeterminacy can detrimentally affect the patient's health. She is unresponsive during the procedure, so she cannot report uncomfortable and potentially damaging missteps as they occur. Should these pelvic exams lead to complications, the patient has no recourse because she does not know about the exams and there is no record that they've occurred.

Both women's stories highlight their painful discovery of being unable to control whether they are subjected to this invasive teaching procedure, which in turn precipitated a loss of trust in their physicians. This trust is essential to every successful, professional patient-physician relationship because without it, a patient may feel treated as a less-than-autonomous individual and question whether her doctors are truly committed to her well-being. In such a situation, the patient-physician relationship begins to erode. Janine's case demonstrates how this practice might unearth past trauma, prompting a host of negative emotions that compound the already stressful experience of having surgery. Sarah's case demonstrates how powerless a patient may feel when her reasonable exercise of control over her own body is restricted. Sarah will never know whether she was given a pelvic exam during her operation. Yet her efforts to assert her autonomy over what would happen to her in the operating room during her second surgery was denied. In both women's cases, their physicians violated the principle of informed consent which grounds the trust between patient and physician.

This practice is troubling for many morally significant reasons. It sanctions digital penetration without consent, which in other, non-medical contexts is considered rape. It

¹¹ Friesen, *op. cit.* note 5 (2018a).

precipitates the loss of trust in physician beneficence. Unlike other procedures performed by medical students, these training pelvic exams serve a purely educational purpose.¹² Further, because this practice is performed specifically on unconscious patients, women cannot control whether their bodies are enlisted in this purely educational exercise. Every woman should be able to refuse having her sexual organs appropriated as teaching tools during surgery.

The longstanding acceptance of this ethically fraught practice has catalyzed patients, bioethicists, and legislatures, as well as a number of physicians and medical students, to advocate for laws requiring that explicit patient consent be obtained prior to these exams. To date, twenty-one states have passed such laws.¹³ Given the extensive abuse perpetrated by this practice, ensuring that women have the legal right to opt out of educational pelvic exams is an important measure to safeguard women's autonomy and privacy in the operating room.

III. Objections to Legally Requiring Consent

While UPEs are officially condemned as “unethical and unacceptable” by both the American College of Obstetricians and Gynecologists and the Association of American Medical Colleges, medical institutions across the country have lobbied to prevent laws that require consent.¹⁴ Generally, one of two arguments are offered against legislative measures:

¹² Friesen (2018a), *op. cit.* note 5. A medical student may discover a potential problem while practicing the exam, and this could conceivably be beneficial. However, this doesn't justify not seeking the patient's consent to complete such an exam.

¹³ Fretwell Wilson, R., Cakan, A., Chong, A., Hubaishy, J., Monzel, A., & Noon, M. J. (2022). *Legislative action*. The Epstein Health, Law, and Policy Program. Retrieved from <https://www.epsteinprogram.com/states-banning-unauthorized-pelvic-exams>.

¹⁴ American College of Obstetricians and Gynecologists. (2011). Professional responsibilities in obstetric-gynecologic medical education and training. Committee opinion no. 500. *Obstetric Gynecology*. 118, 400–404; Association of American Medical Colleges. (2003). *AAMC Statement on Patient Rights and Medical Training*. Retrieved from <https://www.aamc.org/newsroom/pressrel/2003/030612.htm>; Wahlberg, *op. cit.* note 5.

1. *The Educational Benefit Justifies Absence of Consent*

Proponents of this view say that UPEs are not truly ethically reprehensible because they provide an irreplaceable learning experience. Consequently, if patients could decline to participate in such exams, valuable learning opportunities would be forfeited, and this would hurt both future physicians and future patients.¹⁵

Proponents often support this line of reasoning by arguing that practicing pelvic exams on unconscious patients gives students the best understanding of female anatomy. University of Wisconsin's Health Spokesman Tom Russell defended UPEs by noting that "patients under anesthesia are relaxed, affording students the opportunity to examine and understand anatomy in ways not possible in non-relaxed, awake patients."¹⁶ Both the chancellor and medical school dean of the University of Hawai'i at Manoa echoed this sympathy in a joint legal statement from 2012, noting that "[p]erforming a pelvic exam while a patient is anesthetized is a superb learning experience, as the patient is fully relaxed and the intra-abdominal organs are easier to palpate."¹⁷ The worry is that a legal requirement to tell women about the practice explicitly and give them the option to decline will significantly decrease the number of these so-called "superb" learning opportunities.

2. *Resisting Legislative Encroachment on Institutions*

The other typical justification does not outright defend the practice of UPEs. Proponents of this second view acknowledge that this longstanding practice can be morally and

¹⁵ Friesen (2018a), *op. cit.* note 5.

¹⁶ Wahlberg, *op. cit.* note 5.

¹⁷ Moser, E. (2019). *As other states require consent for pelvic exams, Connecticut bill stalls*. The Day. Retrieved from <https://www.theday.com/article/20190723/NWS01/190729803>; Hawaii State Commission on the Status of Women. (2012). *Testimony in support of HB 2232, HD 1, relating to health*. Retrieved from https://www.capitol.hawaii.gov/session2012/Testimony/HB2232_HD1_TESTIMONY_JUD_02-16-12_2_.PDF, p. 3.

professionally problematic in certain cases. However, they express concern that legislative action will detrimentally impact the regulative autonomy of medical organizations and hospitals. This objection posits that any legal action could set a troubling precedent for political intervention in decisions that are best made by medical professionals. Further, many hospitals have already chosen to adopt institutional guidelines that require obtaining consent for these procedures, making legal action unnecessary.¹⁸ Some claim that the practice is already nonexistent, rendering such legislation “redundant” and unnecessarily alarming to patients.¹⁹

For example, Yale Medical School convinced Connecticut lawmakers to table a legal requirement for informed consent for UPEs, arguing that such a law would take away control from healthcare providers and place it in the hands of less knowledgeable politicians.²⁰ In an official statement, the School “recommended that [Connecticut’s Public Health] committee rely upon medical societies to set standards rather than enacting legislation.”²¹ The Wisconsin Hospital Association gave similar reasons for opposing

¹⁸ Moser, *op. cit.* note 17.

¹⁹ Ibid. A separate though related objection claims that legislation could “stigmatize” women’s health care because it would introduce different standards for obtaining consent for pelvic exams versus other medical procedures (Connecticut State Medical Society. (2019). *Testimony in opposition to Senate Bill 16 an act prohibiting an unauthorized pelvic exam on a woman who is under deep sedation or anesthesia*. Retrieved from <https://csms.org/media/uploads/sb-16-pelvic-exams-final-020419.pdf>). In response, I would suggest that the medical community’s lack of transparency regarding UPEs has led to greater stigmatization of the procedure and has harmed women’s health care more than any legal efforts to remedy this. Further, there is evidence that many women consider pelvic exams to be a special kind of procedure that deserves extra care and transparency when it is being administered. Cf: Wainberg, S., Wrigley, H., Fair, J., & Ross, S. (2010). Teaching pelvic examinations under anaesthesia: What do women think? *Journal of Obstetrics and Gynaecology Canada*. 32(1), 49-53; Bruce, L. (2020). A pot ignored boils on: Sustained calls for explicit consent of intimate medical exams. *HEC Forum*. 32(2), 125-145. Thanks to an anonymous reviewer for bringing this objection to my attention.

²⁰ McDermott & Johnson, *op. cit.* note 4.

²¹ Connecticut General Assembly. (2019). *Statement of Yale University School of Medicine concerning SB 16, an act prohibiting an unauthorized pelvic exam on a woman who is under deep sedation or anesthesia*. Retrieved from <https://www.cga.ct.gov/2019/phdata/tmy/2019SB-00016-R000204Yale%20University%20School%20of%20Medicine-TMY.PDF>, p. 2.

bipartisan moves to introduce a state bill that would require explicit consent for pelvic exams.²²

Together, these objections form the basis for resistance to a legal ban on UPEs. In what follows, I will argue that both fail to provide compelling reasons to abandon legislation governing pelvic exams. The testimonies of Janice, Sarah, and others demonstrate the incredibly harmful and dehumanizing effects this practice can have on female patients. It also troubles medical students and desensitizes them to the importance of consent, because the medical community aspires to one thing while modeling another. Ultimately the reasons given to stymie legislative action rely on a misguided calculus which prioritizes educational opportunities and institutional self-governance over patient autonomy, security, and self-determination.

IV. The Limiting Condition of Humanity: A Kantian Response to the Debate

Both objections claim that, in some cases, a patient's autonomy over the use of her body for medical training is secondary to other worthwhile ends. Legal prohibitions of UPEs would protect her self-determination in these cases. She would have a guaranteed right to refuse such a procedure and could pursue legal recourse if her decision is not respected. However, opponents of legislation argue that this would have detrimental results for medical students' training and for institutional autonomy.

Consequently, each argument holds that a formal protection of women's autonomy will interfere with a different, possible good which ought to receive priority. In this respect both arguments reflect the more pervasive issue of dehumanization and mechanization within the American medical field, where the focus has increasingly shifted to outcome

²² Wahlberg, *op. cit.* note 5.

maximization at the expense of sustaining interpersonal patient-physician relationships and protecting autonomy.²³ In defending the claim that a formal consent requirement is needed, I propose that drawing from Kant's account of humanity is instructive. Within Kantian ethics, the duty human beings have to promote and protect humanity, which is his term for rational self-determination, is paramount.²⁴ By infusing Kant's ideas about the absolute value of individual rational choice into the standard bioethical rhetoric of informed consent, we can construct a compelling response to such objections that succeeds in recentering the building of trust between patients and their physicians, not minimizing procedural inconveniences or maximizing educational experiences at the patient's expense.

My reasons for including Kant in this debate are twofold. First, the medical community in the US more specifically (and the West, more generally) has come to define itself and its conduct in terms of respect for patient autonomy. As Donaldson argues, this – along with the rapid and rampant privatization of health care in the US – has generated a “checklist” code of ethics characterized by adherence to certain principles (autonomy being one of them) that often conflict in practice.²⁵ Kant developed a sophisticated account that translates well into modern discussions about patient autonomy, in particular by providing morally compelling reasons for not subverting an individual's control over herself. Kant's understanding of autonomy has important differences from the modern understanding; however, as we shall see the nuances in Kant's account make it a useful complement to the modern account.²⁶ Consequently, his ethical theory seems well-suited in this situation to

²³ Donaldson, C. M. (2017). Using Kantian ethics in medical ethics education. *Medical Science Educator*. 27, 841-845, p. 841.

²⁴ Korsgaard, C. M. (1996). Kant's Formula of Humanity. *Kant-Studien*. 77(2), 183-202, p. 187, 198.

²⁵ Donaldson, *op. cit.* note 23, p. 842.

²⁶ *Ibid.*

serve as one possible guide for navigating how to weigh considerations of patient autonomy and dignity against other, competing ends.

Second, Kant's prioritization of rational self-determination as *the* utmost end, never as a means to other ends, seems to cohere well with women's personal experiences with UPEs. As we saw in Section II, many of them describe this violation in terms of harm. Though the concept of harm is a philosophically rich and varied term, a simple definition will suffice for our purposes: an action harms an individual when it leaves them worse off than they previously were or "were entitled to be."²⁷ Violating a patient's autonomy is thus harmful in itself since it leaves her worse off than she is entitled to be by the principle of informed consent. As Janine and Sarah's stories demonstrated, patients who are subjected to UPEs may also experience emotional and/or physical harm, depending on their personal circumstances (including whether they ever discover that they were given one or more UPEs during their procedure). If the medical profession's overarching dictum remains a commitment to do no harm, it must be sensitive to and take serious steps to address those patients who have experienced harm under prevailing standards of practice. These women have expressed that the core issue is a loss of autonomy. What this means is that efforts to correct the harm caused by this practice must involve a renewed commitment to protecting that autonomy. Kant's account provides helpful context for the intrinsic value of personal autonomy, as well as theoretical resources for pushing back on such instances of encroachment when medical practice fails to live up to its own aspirations (as it is

²⁷ Zwolinski, M. & Wertheimer, A. (2017). *Exploitation*. The Stanford Encyclopedia of Philosophy. Retrieved from <https://plato.stanford.edu/entries/exploitation/>.

particularly prone to do when it comes to respecting the autonomy of individuals who are not white, male, native, able-bodied, economically well-off, and so on).

I want to emphasize that my argument is not that training competent medical personnel or preserving the autonomous decision-making of medical organizations are unimportant. On the contrary, these are both significant and deserving of protection in their own right. I will show that ultimately neither consideration significantly conflicts with the goal of anti-UPE legislation. For this reason, it is misguided to oppose laws that protect female patients' autonomy when this opposition is done in the name of furthering ends which are actually compatible with this legislation.

Within Kant's moral framework, every action contains an end or is done with "some end in view."²⁸ Since the penultimate moral law, the categorical imperative (known in its formal iteration as the Formula of Universal Law), commands action in conformity to one's moral duty, it similarly must have some "absolute" end to which all moral actions strive toward, and, as expressed in the Formula of Humanity, that end is humanity.²⁹ According to the Formula of Humanity, one must always "act so that you treat humanity, whether in your own person or in that of another, always as an end and *never as a means only*" (emphasis added).³⁰ Unlike animals or inanimate objects, each of us as rational beings possesses humanity, which is the capacity to determine what we do through reason.³¹ Consequently, every person's existence is itself an end because the worth of their existence is not defined in any way by its worth to others, but rather by their capacity for moral action through

²⁸ Korsgaard, *op. cit.* note 24, p. 184.

²⁹ Ibid: 187; Kant, I. (1996). *Groundwork of the Metaphysics of Morals*. In M. J. Gregor, *Practical Philosophy* (pp. 37-108). Cambridge, UK: Cambridge University Press, 4:428.

³⁰ Kant, *op. cit.* note 29, 4:428.

³¹ Ibid: 4:429; Korsgaard, *op. cit.* note 24, p. 187.

rational self-determination.³² The ability to set our own ends is unique (because only rational beings possess it) and important (because it makes morally significant action possible). Both of these qualities confer value upon humanity as an end in itself, and that value is not contingent on any value we might ascribe to it.

Because it is the only end in itself, humanity is the one rightful restriction on human beings' actions. Kant says that rational beings are the "limiting condition of all other merely relative and arbitrary ends," which means that all other ends besides promoting rational free choice are arbitrary and thus secondary in value.³³ Already we can see that the objections offered by opponents of consent legislation fall short when approached from this Kantian standpoint. Any justification claiming that we achieve some other "relative," lesser end at the expense of patients' humanity is simply impermissible.

According to Kantian moral theory, these objections have the true order of things reversed. Janice's, Sarah's, or any other patient's ability to say no to having educational pelvic exams must restrict the pursuit of other, lesser ends such as educational experience or institutional autonomy. Both of these are lesser ends because they are ends that we imbue with value based on what we want – highly competent OB/GYNs, for example, or policies developed by medical professionals rather than politicians. But a patient's choice over her body and how it is used is an end that is valuable in itself because she is a rational, self-determining being with her own ends. As such, the morally required course of action is to ask for her consent before subjecting her to a pelvic exam. To not do so is to treat her as a merely a means to an end rather than an autonomous agent with her own ends.

³² Kant, *op. cit.* note 29, 4:429; Korsgaard, *op. cit.* note 24, p. 184.

³³ Kant, *op. cit.* note 29, 4:436.

Notably, the Kantian view as I've presented it does not go so far as to endorse legislation that makes consent for pelvic exams mandatory. Yet this is not necessary to advance my position. Instead, the Kantian view on the importance of humanity gives us good reason to not endorse two of the most prominent arguments against legal regulations, since both rely on a one-sided calculus which elevates the avoidance of procedural inconveniences above patients' autonomy.

This is not to say that considerations of education or institutional autonomy are completely without value. Rather, I argue that neither of them provides sufficient justification for opposing legislative action. This is because both arguments elevate educational and institutional opportunities above a woman's right to self-determination as a patient, her physical safety, and any sense of violation she may experience in the aftermath.

This argument is also not intended to justify the protection of individual free choice at all cost. To conclude this would be to seriously mischaracterize Kant's Formula of Humanity. When Kant describes humanity as the one limiting condition on action, this also entails that my exercise of my personal choice must not infringe on the personal choice of my neighbor. There are cases in the medical field where an individual's free choice can be overridden, and ethically so, if their free choice impinges on the autonomy and/or well-being of others. Imagine a case where a physician feels strongly that physician-assisted suicide is a violation of the physician's duties to their patient. If that physician has a patient who wants his help in ending her life, we could not use this Kantian argument to require that physician to assist his patient.³⁴ The patient must respect that her physician is an

³⁴ For simplicity, assume that physician-assisted suicide is legal in the patient's resident state.

autonomous moral agent with his own ends; requiring him to assist her would be to disregard his ends and treat him merely as a means to her ends. In the case of legislating UPEs, on the other hand, requiring patient consent before conducting practice pelvic exams does not involve treating others as mere means. On the contrary, it is the practice of conducting UPEs that reduces female patients to mere means.

In reality, neither reason given to oppose legislation is actually incompatible with a legal requirement for consent. Both ends of education and institutional autonomy can still be achieved under pelvic exam consent laws. Medical students currently practice pelvic exams on conscious, consenting patients as well as trained educators who instruct students while undergoing these exams themselves.³⁵ Contrary to what opponents claim, medical students would also still have many opportunities to practice pelvic exams on unconscious women if they were asked for permission beforehand. One study found that sixty-two percent of women were willing to let students to practice on them while unconscious *if* they knew that their consent was required and respected.³⁶ This is highly significant in light of current legislative efforts. In the same way, it is unclear how consent legislation about pelvic exams specifically would hamper the autonomy of hospitals and medical organizations significantly more than existing general consent legislation already does. Emergency exams are almost universally exempted from existing pelvic exam laws.³⁷ We as a society – patients and physicians alike – accept and support legal restrictions on conduct in healthcare settings because of the value we place on patient rights. It’s not obvious that pelvic exams on unconscious female patients falls into a different category or constitutes an

³⁵ Friesen (2018b), *op. cit.* note 5.

³⁶ Wainberg, S., et al., *op. cit.* note 19.

³⁷ Fretwell Wilson, R., et al., *op. cit.* note 8.

undue burden on hospitals. As such, I argue that both goals raised in the objections can still be met under consent legislation.

My argument also does not imply that every single action taken by a doctor or a medical student must first be consented to; this would be impossible, and in cases of emergency it would be life-threatening. We can justify this restriction within the Kantian framework by referring back to the Formula of Humanity. To disrespect a person's humanity is to treat them as a "means only" – to ignore or violate the ends that they themselves have set for themselves. This means that on a Kantian account there are cases where medical care can be administered without prior consent, so long as the patient is not being treated as a mere means. For example, we might imagine a case where a patient is in critical condition and needs an emergency pelvic exam but cannot consent to it (perhaps she is unconscious). In such a situation, administering a pelvic exam to the patient would be permissible because it is necessary to preserve the very condition of the patient's autonomy: her life. The patient is not being treated as a mere means to an end. Rather, her value as an end in itself is being affirmed, since she cannot make free choices at all if she dies due to lack of care. We can see this exception reflected in existing legislation which distinguishes between "educational" pelvic exams, which serve no purpose in the patient's care, and pelvic exams that contribute to the patient's health.³⁸ But, as we saw in Section II, this is not the case for purely education UPEs. Unlike most other procedures performed by medical students in training, UPEs only benefit the students practicing them and serve no purpose for the woman undergoing them.³⁹ This important difference thus explains why

³⁸ Fretwell Wilson, R., et al., *op. cit.* note 13.

³⁹ *Ibid.*

Kant's argument can be used to justify legislation banning UPEs without encompassing all types of medical care. My argument contends that objections to legal restrictions around the particular practice of subjecting unconscious women to pelvic exam practice without first asking for permission, and not medical student involvement or medical care generally, conflict with upholding patient autonomy.

Lastly, I want to address what this account means for non-rational patients.⁴⁰ If respect for a patient's autonomy is grounded in their capacity for rational self-determination, as Kant suggests, then this argument appears to exclude patients who lack this capacity, including patients who are unconscious or have a severe cognitive impairment. This would be a serious problem for my account for two reasons. First, my account would fail to protect those individuals who are most vulnerable and thus most in need of care and respect. Second, my account would fail to accomplish what it claims, since UPEs are almost universally performed while the patient is anesthetized and would thus be exempt from Kant's argument. Fortunately, though Kant himself does not address the case of non-rational persons in detail, there are standard interpretations of his definition of humanity that include them. A person's rational nature is what gives her moral worth, and this status "does not come in degrees."⁴¹ Rather, since this status is grounded in the individual capacity for rational choice, it is conferred on all individuals regardless of the extent to which this capacity has been "developed, realized, or exercised."⁴² This means that the moral status of an unconscious patient, or a patient with a cognitive impairment,

⁴⁰ Thanks to an anonymous reviewer for noting this in their comments.

⁴¹ Johnson, R. & Cureton, A. (2022). *Kant's moral philosophy*. The Stanford Encyclopedia of Philosophy. Retrieved from <https://plato.stanford.edu/entries/kant-moral/#Aut>.

⁴² Ibid.

cannot be suspended simply because they cannot actively exercise this capacity. Kant does seem to suggest that those with “the most severe cognitive disabilities lack dignity and are not ends in themselves,” and this is a point of concern.⁴³ However, we have the resources to counter this with Kant’s own words, as he asserts in the Groundwork that “all human beings ... are ends in themselves.”⁴⁴ Consequently, my argument encompasses all patients regardless of their immediate capacity to exercise rational self-direction.

V. The Gravity of Omission

Suppose the opponent of consent legislation responds to this reasoning by denying that nonconsensual pelvic exams violate patients’ humanity. This argument alleges that pelvic exams given to unconscious female patients are ethically permissible because they are not truly unauthorized.

For instance, whenever a patient is admitted to a teaching hospital for treatment, she must sign a general form consenting to treatment. UW Health’s Tom Russell put it this way: “patients were not routinely asked to provide specific consent for pelvic exams while under anesthesia ... [but] were, however, asked to provide consent generally, which included the involvement of medical student learners.”⁴⁵ Presumably, if the patient knowingly consents to medical students’ involvement in her treatment, then she implicitly consents to undergoing practice pelvic exams during surgery. On this line of reasoning, to call such pelvic exams nonconsensual or unauthorized is incorrect and misleading. Doctors and medical students still uphold patients’ autonomy through general consent forms.

⁴³ Johnson & Cureton, *op. cit.* note 41.

⁴⁴ Kant, *op. cit.* note 29, 4:428-429, referenced in Johnson & Cureton, *op. cit.* note 41.

⁴⁵ Wahlberg, *op. cit.* note 5.

One obvious problem with this argument is that UPEs are by nature training procedures and not part of the woman's treatment, so she has not truly consented to them. But we can undermine this objection even further by turning once again to the Kantian notion of humanity and arguing that the woman's humanity is not truly being upheld or protected in such cases. This is because, by intentionally withholding pertinent information about the patient's treatment that she would reasonably like to know, the physician reduces the autonomous individual to a means to an end. This is why Kant claimed that lying is always wrong: it violates the end-in-itself which is humanity. In this case, the female patient does not know the true nature of medical students' involvement in her treatment because of actions taken by the hospital and her physician, so she cannot truly consent to these exams.

Kant condemned all forms of lying because he argued that the practice transforms a person into a means to the liar's end. To illustrate, he gives a case where one person falsely promises something to another.⁴⁶ This is a morally impermissible action because the promise-maker has made "use of another human being *merely as a means*, without the other at the same time containing in himself the end."⁴⁷ The lying person, by virtue of being deceptive, acts in such a way that the other person can never agree to how s/he is being treated.⁴⁸ This reduces the other person to a means to the liar's end because it restricts that other person's ability to self-determine for the liar's benefit. The liar acts immorally by

⁴⁶ Kant, *op. cit.* note 29, 4:429.

⁴⁷ *Ibid.*

⁴⁸ *Ibid.*: 4:430; Korsgaard, C. M. (1986). The right to lie: Kant on dealing with evil. *Philosophy and Public Affairs*. 15(4), 325-349, p. 332.

elevating her or his contingently valuable desires, whatever they may be, over the other person's absolutely valuable humanity.

A separate paper could consider whether patients who sign general consent forms are being actively deceived by hospital personnel, as this is beyond the scope of my argument. Rather, I suggest that the objection raised here also fails to sufficiently undermine consent legislation because it claims to uphold patient autonomy when it cannot. The medical community has long been aware that consent for pelvic exams matters to women.⁴⁹ In light of this, medical practitioners should make information about pelvic exams explicit out of consideration for their patients. For this reason the general consent form objection fails, regardless of intentionality, because by presenting ambiguous treatment information to patients, they cannot truly choose to participate in these pelvic exams. To continue claiming that women consent to pelvic exams when consenting to treatment is to misrepresent the very conditions for consent.

The problem with lying gives us a better understanding of the problem with consent forms, as these forms omit information which is reasonably important to the patient. Kant's example demonstrates that the problem with lying is that people "cannot *assent* to a way of acting when they are given no chance to do so."⁵⁰ If a woman scheduled for surgery does not know that medical students at the teaching hospital commonly practice pelvic exams on unconscious patients, she cannot decline being used for these pelvic exams and is deprived of the ability to determine what happens to her body. In this case, she lacks both

⁴⁹ Bibby, J., Boyd, N., Redman, C. Redman, & Luesley, D. (1988). Consent for vaginal examination by students on anaesthetized patients. *The Lancet*. 332(8620), 1150; Fretwell Wilson, R. (2005). Autonomy suspended: Using female patients to teach intimate exams without their knowledge or consent. *Journal of Health Care, Law, and Policy*. 8(2), 240-263; Wainberg, S., et al., *op. cit.* note 19.

⁵⁰ Korsgaard, *op. cit.* note 48, p. 332.

“knowledge of what is going on” in the operating room and “power over the proceedings,” and so has not consented to the exams.⁵¹ She is never given a chance to decline.

The hospital and/or her physicians know about the practice and can divulge it to her but do not. As a result, they benefit because this practice maximizes the number of learning opportunities for students training at the hospital, but this is done at the expense of her humanity. In this case, as in the other two objections, a secondary end is elevated above patients’ self-determination. These considerations upend the claim that general consent forms ensure patient autonomy over pelvic exams.

VI. Conclusion

In conclusion, the practice of giving nonconsensual pelvic exams to unconscious female patients is unethical when understood in the context of Kant’s special regard for the human ability to choose. This paper examined two of the most common arguments against requiring explicit consent for pelvic exams, and showed that each argument fails because it places limits on a female patient’s capacity for self-determination in the name of some other good. The inherent value of humans’ rational capacity to choose is the one legitimate limit on all other contingent ends. Neither argument succeeds because both invert this order.

When we consider the importance of patient autonomy and consent, as informed by Kantian principles, we can conclude that ethical behavior on the part of doctors must prioritize their patients’ unique capacity for self-determination. Humanity must not be sacrificed in the name of convenience, education, medical advancement, or even to preserve the autonomous functioning of medical institutions. Unauthorized pelvic exams

⁵¹ Korsgaard, *op. cit.* note 48, p. 332.

involve a selective violation of patients' humanity and so cannot be adequately justified by the attainment of other, lesser ends. If the medical community is truly committed to protecting patient autonomy and consent, then it cannot subsume either underneath these goals because to do is to be inconsistent. Given the continued deception involved in the practice of UPEs, as well as its longstanding acceptance among medical professionals, legally banning nonconsensual pelvic exams could go a long way toward rebuilding trust and reestablishing women's autonomy in the operating room.⁵²

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