"Go Do a Pelvic": A Critical Analysis of Nonconsensual Pelvic Exams

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Abstract

In the United States, a nonconsensual pelvic exam typically occurs when a medical student is brought into an operating room at a teaching hospital to conduct a pelvic exam for training purposes on an unconscious and nonconsenting patient, purely for the student's own educational fulfillment. Regarding this concerning practice, I am particularly interested in how what is commonly viewed as sexual assault and/or rape outside of hospital settings can manifest as standard procedure in obstetrics and gynecology (OBGYN) training spaces. Additionally, I am investigating how nonconsensual pelvic exams represent a historical trend in U.S. science and gynecology to nonconsensually utilize certain gendered, raced, and classed bodies in the name of moving the medical profession forward. I argue that it is because U.S. medical institutions are vested with large amounts of authority and claims to "truth" and knowledge making processes that a practice like nonconsensual pelvic exams on certain bodies can become normalized and part of the fabric of OBGYN training. To gather data for my thesis, I conducted 12 semi-structured interviews with medical students who have recently completed their OBGYN training in U.S. teaching hospitals. I engaged in self-reflective feminist qualitative research throughout these interviews, which meant that what the medical students shared with me often framed my own thoughts and analysis of the data. Through my analysis of the interview data, I revealed a disturbing tendency in OBGYN training to allow for the continued practice of nonconsensual pelvic exams, while at the same time the medical students often assured me their institutions were following best practices in terms of always obtaining informed consent. This contradiction reveals a systematic continuation of nonconsensual pelvic exams, under the guise of U.S. medical institutions respecting patient autonomy and agency. If teaching hospitals in the U.S. really want to end the practice of nonconsensual pelvic exams, a thorough anti-hierarchical restructuring of OBGYN training spaces would be required.

Keywords: Pelvic exams; nonconsensual; OBGYN; medical students; feminist analysis

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Declaration

I hereby declare that this thesis is the result of original research; it contains no material accepted for any other degree in any other institution and no materials previously written and/or published by another person, except where appropriate acknowledgement is made in the form of bibliographical reference.

I further declare that the following word count for this thesis are accurate:

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Signed: Doris Donelan

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Chapter 1: Introduction

In 2022, an article was published detailing that 84% of 305 medical students surveyed from various medical schools in the United States had performed at least one pelvic exam under anaesthesia. From this group, only 42% of students said they observed informed consent procedures most or every time, and within this group, 67% of students reported that they did not witness a specific explanation that medical students may conduct a pelvic exam while the patient was under anesthesia.[1] This article came out *19 years* after an earlier study that detailed that 90% of medical students in the U.S. reported conducting pelvic exams under anaesthesia during their rotation in OBGYN.[2] Both of these articles are detailing the ongoing practice of a phenomenon called nonconsensual pelvic exams.

In the U.S., nonconsensual pelvic exams occur in teaching hospitals[3] when a patient is put under anaesthesia for a gynecological procedure, and a medical student performs a pelvic exam for training purposes on the patient, without the patient's prior knowledge or consent.[4] The patient may have been put under anesthesia for a gynecological procedure unrelated to a pelvic exam, and a medical student is brought in to perform a pelvic exam on the patient for the educational benefit of the student. Within this practice, I am particularly interested in the fact that what is often considered sexual assault outside of medical spaces manifests as standard practice in various U.S. teaching hospitals. My research therefore critically analyzes the practice of nonconsensual pelvic exams by medical students in OBGYN departments at teaching hospitals in the U.S.

[1] Karampreet Kaur et al., "Medical Student Perspectives on the Ethics of Pelvic Exams Under Anesthesia: A Multi-Institutional Study," *Journal of Surgical Education* 79, no. 6 (2022): 1413.
[2] Peter A. Ubel, Christopher Jepson, and Ari Silver-Isenstadt, "Don't Ask, Don't Tell: A Change in Medical Student Attitudes after Obstetrics/Gynecology Clerkships toward Seeking Consent for Pelvic Examinations on an Anesthetized Patient," *American Journal of Obstetrics & Gynecology* 188, no. 2 (2003): 579.
[3] A teaching hospital is a hospital or medical center that provides medical education and hands-on training to medical students and other future medical professionals.
[4] Phoebe Friesen, "Educational pelvic exams on anesthetized women: Why consent matters," *Bioethics* 32, no. 5 (June 2018): 303.

Nonconsensual pelvic exams reflect how certain bodies in medical spaces can become a special site for the production or denial of consent. They also reflect how hegemonic institutions, when vested with large amounts of authority and claims to "truth" and knowledge making processes, can facilitate nonconsensual procedures on certain gendered, raced, and classed bodies. Although my topic is focused on nonconsensual pelvic exams, I view said exams as symptomatic of how medical institutions can use their power to maintain certain practices as standard procedure. Therefore, my main research question is: In which ways do nonconsensual pelvic exams, which can be viewed as sexual assault and/or rape outside of hospital settings, become a normalized practice in medical institutions that allows for the belief that certain bodies need to be nonconsensually examined in the name of moving the medical profession forward? From my research, I expect to gain a better understanding of the overall medical discourse towards nonconsensual pelvic exams for training purposes that medical students witnessed during their clinical rotation in OBGYN, and how these discourses further the idea that some bodies are normalized as more fitting for nonconsensual experimentation and examination than others.

1.1 What Is a Nonconsensual Pelvic Exam?

Changing perceptions of gender and consent in the U.S. have led to a heightened scrutiny towards practices like nonconsensual pelvic exams. The #MeToo movement, which took off in 2017 after revelations of Harvey Weinstein's sexual misconduct, created a heightened sense of awareness.[5] Activists and survivors were openly calling out how men in positions of power often acted violently towards women with no threat of repercussions. Debates surrounding abortion also highlighted criticism towards doctors getting to decide what a birthing person could do with their

[5] Jaclyn Diaz, "Where the #MeToo movement stands, 5 years after Weinstein allegations came to light," *NPR*, October 28, 2022, https://www.npr.org/2022/10/28/1131500833/me-too-harvey-weinstein-anniversary.

body. These debates, which revolved around the idea of consent and bodily autonomy in Hollywood, the workplace, and medical spaces, are closely tied to public perceptions of nonconsensual pelvic exams.

There was also heightened scrutiny towards nonconsensual pelvic exams after several articles exposing the practice were published. As Jennifer Tsai wrote in her article detailing such exams, "The idea of medical students performing nonconsensual pelvic exams on women under anesthesia shocks people outside of medicine."[6] *The New York Times* also published a harrowing article detailing stories from women who realized after the fact that they had been submitted to a nonconsensual pelvic exam under anesthesia.[7] As more of these articles were published, legislation was introduced in multiple states banning the practice. As of May 2022, 21 states have passed legislation explicitly banning nonconsensual pelvic exams.[8] However, as part of my research I am interested in examining if teaching hospitals have in fact changed their approach to pelvic exams as to make them always consensual. For example, in response to the public outcry about nonconsensual pelvic exams, some doctors have argued that such exams are a crucial part of a medical student's education, and that by learning how to conduct these exams, medical students benefit OBGYN patients overall by developing a vital skill that will be used on them in the future.[9] However, studies have shown that patients feel violated and sometimes experience psychological distress when they learn they have been practiced on by a medical student without their informed consent to the procedure.[10]

[6] Jennifer Tsai, "Medical Students Regularly Practice Pelvic Exams on Unconscious Patients. Should They?" *Elle*, June 24, 2019, https://www.elle.com/life-love/a28125604/nonconsensual-pelvic-exams-teaching-hospitals/.
[7] Emma Goldberg, "She Didn't Want a Pelvic Exam. She Received One Anyway," *The New York Times,* February 17, 2020, https://www.nytimes.com/2020/02/17/health/pelvic-medical-exam-unconscious.html.
[8] The Epstein Health Law and Policy Program, "Unauthorized Pelvic Exams: Public Engagement Initiative." Accessed October 31, 2022. https://www.epsteinprogram.com/states-banning-unauthorized-pelvic-exams.
[9] Friesen, "Educational pelvic exams on anesthetized women: Why consent matters," 303.
[10] J. Bibby et al., "Consent for Vaginal Examination by Students on Anaesthetised Patients," *Lancet (London, England)* 2, no. 8620 (November 12, 1988): 1150, https://doi.org/10.1016/s0140-6736(88)90577-6.

In 2011, the American College of Obstetricians and Gynecologists condemned the practice of nonconsensual pelvic exams. They wrote, "Pelvic examinations on an anesthetized woman that offer her no personal benefit and are performed solely for teaching purposes should be performed only with her specific informed consent obtained before her surgery."[11] However, the College does not include a discussion of what this informed consent might look like, and there is also no implication that nonconsensual pelvic exams have resulted from systemic ethical violations in U.S. gynecology. Despite this official condemnation from the College, the interviews I will analyze in my analytical chapters point to the continuing occurrence of nonconsensual pelvic exams.

Nonconsensual vaginal penetration is a distressingly large problem in the U.S. outside of medical spaces,[12] and the fact that nonconsensual pelvic exams are sanctioned in some U.S. hospitals points to a concerning tendency of medical institutions to protect themselves from scrutiny and criticism. By investigating nonconsensual pelvic exams and speaking with medical students for my research, I aim to frame nonconsensual pelvic exams as a very specific manifestation of how hegemonic medical practices, if left unexamined and framed as "standard procedure," result in the bodily exploitation of OBGYN patients. Additionally, my analysis will show how when OBGYN patients are exploited, certain discourses of race, gender, and class are reinforced at those sites where they happen.

1.2 A History of Violence

How I view nonconsensual pelvic exams in my analysis is positioned against a wider backdrop of U.S. medicine that has historically used gendered, raced, and classed bodies for

[11] American College of Obstetricians and Gynecologists: Committee on Ethics, "Committee Opinion No. 500," *Obstetrics and Gynecology* 118, no. 2 (August 2011): 400.
[12] Statistics from RAINN state that 1 out of 6 U.S. women are survivors of attempted or completed rape. https://www.rainn.org/statistics.

experimental purposes. Examples include the Tuskegee Syphilis Study, Marion J. Sims' experiments on enslaved black women, forced sterilization campaigns, eugenic campaigns, and the nonconsensual use of Henrietta Lacks cells for cancer research.[13] Regarding gynecology specifically, the "father" of modern gynecology in the U.S., J. Marion Sims, developed his technique for repairing vesico-vaginal fistulas (VVF) on unanesthetized enslaved black women.[14] As these women were legally not able to give or withdraw consent as enslaved persons,[15] Sim's operations eliminated the possibility to perform consensual gynecological procedures.

Additionally, the case of Sims is not the only piece of U.S. history that has utilized black bodies for the sake of science. The scientists involved in the infamous Tuskegee experiment developed a similar rhetoric when experimenting on poor black men from the south to better understand the disease Syphilis. This study exploited nonconsenting black bodies in the name of scientific discovery and progress. The men in the study could not consent to being experimented upon, because they were never fully informed as to the techniques and aims of the study.[16] In my analysis regarding the relationship between this history and the contemporary practice of nonconsensual pelvic exams, it is because these bodies were and continue to be "othered" in U.S. society that they are considered more fitting for nonconsensual medical procedures. To create medical cultures that don't act violently against gendered, raced, and classed bodies, nonconsensual pelvic exams are something that should be understood against this historical backdrop, and not as a practice that appeared out of nowhere and goes against the values of the medical profession.

[13] See Susan M. Reverby (2009), Terri Kapsalis (1997), Gisela Bock (1983), and Rebekka Skloot (2010).
[14] Terri Kapsalis, "Mastering the Female Pelvis: Race and the Tools of Reproduction," in *Public Privates: Performing Gynecology from Both Ends of the Speculum* (Durham, NC: Duke University Press, 1997), 31-59.
[15] Monica Cronin, "Anarcha, Betsey, Lucy, and the women whose names were not recorded: The legacy of J Marion Sims," *Anaesthesia and Intensive Care* 48, no. 3 (2020): 6-13.
[16] Susan M. Reverby, *Examining Tuskegee: The Infamous Syphilis Study and Its Legacy* (Chapel Hill: University of North Carolina Press, 2009).

1.3 Literature Review

I am grateful to the many scholars and physicians who have written literature on and brought attention to the current practice of nonconsensual pelvic exams. *Feeling Medicine* by Kelly Underman was the work on pelvic exams for training purposes that I found myself constantly referring to in the analysis of my interview data.[17] In this book, Underman is focusing specifically on the use of gynecological teaching associates, or GTAs, as a means to train medical students how to conduct pelvic exams. She writes that her argument in the book

> uses the case of teaching and learning the pelvic exam in contemporary United States medical education to understand the complicated ways in which affect—that is, bodily capacities to sense, relate, and form connections—are appropriated by expert knowledges and practices in the service of maintaining professional dominance and biopolitical control.[18]

Therefore, throughout this book Underman writes about how medical institutions have appropriated feminist knowledges and activism to incorporate technologies of empowerment into training medical students for the pelvic exam, without really examining or restructuring the medical hierarchies at play that have historically made patients feel uncomfortable or violated during pelvic exams. Although Underman does not discuss the phenomenon of nonconsensual pelvic exams in-depth in her book, her writing specifically on the way teaching hospitals have appropriated technologies of patient empowerment, and how in so doing create "model" and "non-model" patients, was extremely useful for me in my analysis.

To turn to the topic of nonconsensual pelvic exams specifically, Shawn Barnes has written a pivotal article on the practice of nonconsensual pelvic exams entitled, "Practicing Pelvic Exams on

[17] Kelly Underman, *Feeling Medicine: How the Pelvic Exam Shapes Medical Training* (New York: New York University Press, 2020).
[18] Ibid., 22.

Women Under Anesthesia: Why Not Ask First?"[19] and his article is often cited in the literature surrounding the practice. In his article, Barnes describes how not asking for explicit consent for a pelvic exam harms OBGYN patients as well as medical students, because they end up caring less about consent. The bulk of Barnes' article mainly refutes common arguments in favor of nonconsensual pelvic exams. These arguments generally claim that nonconsensual pelvic exams are standard practice, that when patients accept care at a teaching hospital they are giving implied consent for a pelvic, that pelvic examinations are no different from other minor activities medical students take part in, that no pelvic exams are only for practice, and that women would not give their consent if asked, thus jeopardizing learning opportunities for the student. Barnes also describes the medical hierarchy that exists during training, and writes, "My medical education experience has reinforced the notion that the medical student should not question the practices of those above him or her."[20]

Helpfully for my own argument, this article is complicating the notion of consent, because, although it mostly describes a violation of patient consent, there is also the complicated position of the medical student, who might be uncomfortable, but feels unable to say so. This complication of consent mapped out by Barnes leads me to consider that nonconsensual pelvic exams are a result of teaching hospitals claiming a certain medical authority, as opposed to the result of a few "bad egg" doctors and medical students. With this point of view, the medical students are robbed of their ability to fully consent as well when it comes to nonconsensual pelvic exams. Other physicians and scholars in response to Barnes have also written on the power dynamics that exists between the medical student and the attending physician.[21]

[19] Shawn S. Barnes, "Practicing Pelvic Examinations by Medical Students on Women Under Anesthesia: Why Not Ask First?" *Obstetrics & Gynecology* 120, no. 4 (2012): 941-943.
[20] Ibid., 941. I will note that, although this article was published in 2012, in the interviews I conducted the interviewees describe a similar hierarchy.
[21] See Carey York-Best and Jeffrey Ecker (2012).

Phoebe Friesen has also written a piece on nonconsensual pelvic exams that was very useful for me in framing in which context these exams have happened and continue to happen.[22] In her article, Friesen outlines how nonconsensual pelvic exams are sometimes defended on the grounds of doing "what needs to be done" for medical students to be properly trained. This argument is crucial for me in thinking about how nonconsensual pelvic exams reflect historical discourses in U.S. medicine that utilized bodies delegated to the margins of U.S. society in the name of scientific "progress." Through critically analyzing the practice of nonconsensual pelvic exams, I can see these historical discourses echoing within contemporary teaching hospitals that have supposedly left such nonconsensual practices in the dustbins of history.

Another article that was formative for my own argument is titled "A Pot Ignored Boils On: Sustained Calls for Explicit Consent of Intimate Medical Exams" by Lori Bruce.[23] Bruce argues for the importance of informed consent in her article, because not getting consent, for her, leads to the moral erosion of students. For Bruce, moral erosion details how the ethical principles of medical students diminish over time as they witness others participating in unethical behaviors, and as they participate in these behaviors themselves.[24] In this article, Bruce describes how historically physicians "viewed patients' bodies as vessels for research and physician education."[25] Although there are now more guidelines for medical ethics, Bruce is still concerned with nonconsensual intimate medical exams being conducted, because such exams showcase to medical students that perhaps consent is not as important as their own educational fulfilment. She also describes how there is a "dichotomy between societal and medical views of the intimate regions of the body."[26] Both Bruce's historical

[22] Friesen, "Educational pelvic exams on anesthetized women: Why consent matters," 298-307.
[23] Lori Bruce, "A Pot Ignored Boils On: Sustained Calls for Explicit Consent of Intimate Medical Exams," *HEC Forum* 32, no. 2 (2020): 125–45.
[24] Ibid., 136.
[25]Ibid.," 126.
[26] Ibid., 127.

argumentation and her description of this dichotomy assist me in framing nonconsensual pelvic exams specifically as a bodily manifestation of the "neutral" medical gaze normalizing such a practice. Though Bruce only specifically discusses the female pelvis once in her article, I am focusing on nonconsensual pelvic exams to argue that they are a specific site for framing some OBGYN patients, but not all, as not in need of consent.

In a similar vein to Bruce's argument, research has been conducted that has shown medical students caring less about obtaining consent specifically after their OBGYN rotation. Whenever I was conducting an interview, I asked the interviewee if they were aware of a study conducted by Peter Ubel, Christopher Jebsen, and Ari Silver-Isenstadt in 2002.[27] This study found that medical students in Philadelphia who had completed their OBGYN clerkship were less likely to view consent as important than those who had not yet started their clerkship. Additionally, this decline in attitude towards the importance of consent was only observed after the OBGYN rotation, and not after any of the other clerkships.

The study also found that 90% of the students surveyed had performed pelvic exams under anesthesia during their OBGYN rotation.[28] This study was formative for me in thinking about the larger kinds of discourses that are reproduced when a practice like nonconsensual pelvic exams are permitted to happen. Not only are patients exploited through these practices, but medical students themselves are taught that perhaps the informed consent of patients ranks lower in importance than their own educational experience. What does this tell us about where and to whom U.S. medical institutions decide to assign value and dignity?

[27] Peter A. Ubel, Christopher Jepson, and Ari Silver-Isenstadt, "Don't Ask, Don't Tell: A Change in Medical Student Attitudes after Obstetrics/Gynecology Clerkships toward Seeking Consent for Pelvic Examinations on an Anesthetized Patient," *American Journal of Obstetrics & Gynecology* 188 no. 2 (2003): 575-579.
[28] Ibid., 578.

Sally Mahood also writes on the phenomenon of moral erosion of medical students with her discussion of the "hidden curriculum" in medical education.[29] Mahood describes how often during medical education, the formal message of the institution's curriculum is undermined by the norms and values that attending physicians and residents transmit to the medical students. I view nonconsensual pelvic exams as deeply related to Mahood's concept of the hidden curriculum, because although medical institutions are formally in favor of obtaining informed consent for every medical procedure, the reality of what happens in the operating room may look very different. Mahood also refers to the concept of "sticky knowledge" to describe how often the informal norms and values that medical students observe outside of the formal curriculum can be more memorable for them.[30] Again, I view the ways in which medical students are implicitly trained to deal with OBGYN patients as potentially more formative than the lectures on informed consent they were required to go to before they entered the operating room.[31]

Other articles have assisted me in thinking about how nonconsensual pelvic exams do not only contribute to the exploitation of patients with a vagina and uterus, but also of patients of color and patients coming from a lower socioeconomic background. One of these articles is "Autonomy Suspended: Using Female Patients to Teach Intimate Exams Without Their Knowledge or Consent" by Robin Fretwell Wilson.[32] This article, like many others, is concerned with nonconsensual pelvic exams, but Wilson describes classed and raced aspects of such exams as well. He writes, "Teaching hospitals have long been the refuge of last resort for poor and uninsured patients."[33] The article details how, for patients who don't have the luxury of choosing which doctor and/or hospital they

[29] Sally Mahood, "Medical education: Beware the hidden curriculum," *Canadian Family Physician* 57 (September 2011): 983-985.
[30] Ibid., 984.
[31] Many of my interviewees described attending lectures on informed consent and other ethical issues before they started their rotations.
[32] Robin Fretwell Wilson, "Autonomy Suspended: Using Female Patients to Teach Intimate Exams without Their Knowledge or Consent," *Journal of Health Care Law & Policy* 8, no. 2 (2005): 240–63.
[33] Ibid., 248.

would like to go to, teaching hospitals are often the only option.[34] Wilson outlines how there is a difference in how physicians treat private patients versus public patients. He sees this as a problem because patients are often left unaware as to what kind of an institution they are being treated in, and as to whether or not medical students are involved in their care.[35]

Therefore, Wilson's article assists me in thinking about the classed and raced dimensions of nonconsensual pelvic exams. If patients on public insurance are often brought to teaching hospitals, the implication is that poorer patients and patients of color are more often on the receiving end of a nonconsensual pelvic exam. Again, I am interested here in how some bodies, but not at all, are brought into spaces where they are more likely to be used in nonconsensual procedures. Here we can see the reverberation of the history of U.S. gynecology acting on certain bodies in the name of progress and the education of future medical professionals.

Nonconsensual pelvic exams have been an area of concern even prior to the #MeToo movement,[36] and, unfortunately, the current literature on the topic, as well as the interviews I conducted, point to their continued existence. They continue despite research on women's attitudes towards nonconsensual pelvic exams showing that women patients are willing to participate in pelvic exams for training purposes, but that they expect to be asked first.[37] These findings refute the idea that asking permission to conduct a pelvic exam on a patient for training purposes would "jeopardize" learning opportunities for the students.

The existence of nonconsensual pelvic exams implies that the historical evolution of informed consent, from paternalistic and exploitative care to respecting the pillars of autonomy and

[34] This is not to imply that teaching hospitals and medical students don't provide quality care, but rather to point out that patients at teaching hospitals are more likely to be treated by medical students, which raises the risk of a nonconsensual pelvic exam.
[35] Being on public health insurance (Medicaid) in the U.S. often indicates that you have a lower socioeconomic status.
[36] See J. Bibby et al. (1988).
[37] See Peter Ubel and Ari Silver Isenstadt (2000) and Sara Wainberg et. al (2010).

informed consent,[38] is not as linear and smooth as we are meant to believe. However, many of the current works on nonconsensual pelvic exams tend to position the practice as existing in a vacuum and only contributing to nonconsensual attitudes among medical students.[39] Therefore, I aim to complicate the conversation by placing nonconsensual pelvic exams within wider relations of medicine and power that willfully have and continue to exploit gendered, raced, and classed bodies, while at the same time crafting such practices as normal and acceptable. In so doing, in my analysis nonconsensual pelvic exams are positioned as a practice that continues to legitimatize the discourse of some bodies as more fitting for nonconsensual procedures than others, and as a practice that keeps the OBGYN machine functioning as it is supposed to, as opposed to framing it as a disturbing practice that appeared one day in teaching hospitals. As Robin Wilson writes, current legislation that increases the sanctions for unauthorized pelvic exams do nothing to "remedy the underlying pressures that have fostered the use of patients as teaching tools without permission."[40]

1.4 Methodology

To gather data for my research, semi-structured interviews were conducted with 12 medical students who were either in rotation at or had recently completed a clerkship in OBGYN departments in the U.S. The medical institutions I interviewed students from were Columbia University in New York, Boston University in Massachusetts, Hofstra University in New York, SUNY Upstate in New York, Dartmouth University in New Hampshire, and the University of Chicago in Illinois. These students were in a 25 to 30 year age group, and, due to their status as future doctors at prestigious medical institutions in the U.S., they are heading towards a middle class

[38] David Lee, "Don't Examine without Me – the Role of the Patient in Learning Pelvic Exams." *Bioethics* 6 (2020).
[39] For examples, see Jennifer Tsai (2019), Kimberly Liu et al. (2010), and Stephanie Schniederjan and Kevin Donovan (2005).
[40] Robin Fretwell Wilson, "Unauthorized Practice: Teaching Pelvic Examination on Women under Anesthesia," *Journal of the American Medical Women's Association (1972)* 58, no. 4 (2003): 219.

earning of high social status.[41] I chose to conduct interviews with medical students, because, as nonconsensual pelvic exams are mainly done for training purposes, medical students are the actors most typically told to conduct said exams.[42] Additionally, due to the nature of nonconsensual pelvic exams, many patients will not know whether such an exam has happened to them. Therefore, finding patients to interview would be difficult and potentially lead to issues around memory and trauma. To find interview participants, I used snowball sampling to reach out to medical students through personal connections of friends and family.[43] I also used a social media post to recruit interview participants. After getting interviewees, the interviews were conducted and recorded over Zoom.

I chose semi-structured interviews due to the sensitive nature of the research topic. This format of interviewing provided me with greater flexibility when it came to each individual interview.[44] During the interviews, I wanted to create an atmosphere that was open for discussion and conversation, as opposed to me sitting across from an interlocutor and asking them a list of questions. Many of my questions were open-ended and open to interpretation, and I often changed my questions depending on how the interviewee was engaging with the questions in general. As a Gender Studies student who has spent the last two years reading feminist theorists and scholars, it was important for me that I ground my interviews in a feminist methodology that rejected the classic hierarchical relationship between interviewer and interviewee.[45] Therefore, how the interlocutors engaged with my questions framed how I myself thought about my research question, and what was useful for me to focus on.

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[41] Nikita Tambe, "What Is the Average Salary of U.S. Doctors In 2023?" *Forbes*, May 2, 2023, https://www.forbes.com/advisor/in/education/doctor-salary-in-us/.
[42] Barnes, "Practicing Pelvic Examinations by Medical Students on Women Under Anesthesia: Why Not Ask First?" 941.
[43] See Ayesha Mallick et al. (2023) and Fabiola Baltar and Ignasi Brunet (2012).
[44] Donald A Ritchie, *Doing Oral History: Practical Advice and Reasonable Explanation for Anyone* (New York: Twayne, 1995), 77.
[45] Jasmine R. Linabary and Stephanie A. Hame, "Feminist Online Interviewing: Engaging Issues of Power, Resistance and Reflexivity in Practice," *The Feminist Review Collective* (2017): 97–113.

All my thesis interviews were conducted over Zoom. Despite potential limitations that come with interview participants online, I believe it also provided, in some cases, more openness and flexibility.[46]After the interviews, the data from the interviews were gathered through transcriptions of the Zoom audio recordings. The transcripts were then analyzed for core themes relating to my main research question. I utilized discourse analysis when coding the interviews, because it is a useful methodology when considering the significance of omissions and assumptions.[47] As Norman Fairclough writes, "Assumed meanings are of particular ideological significance — one can argue that relations of power are best served by meanings which are widely taken as given."[48] In other words, when someone chooses not to say something, or says something in such a way that it wouldn't be questioned, there is as much ideological investment in such statements as when something is clearly stated. As I have said earlier, the interviews were sometimes sensitive and uncomfortable due to the nature of the topic, so omissions and assumptions the participants make throughout the conversation were analyzed for their significance.

Regarding my positionality, I would also like to note that I myself am not from a medical background, and I have limited knowledge on many topics related to the medical profession. Therefore, while conducting and analyzing the interviews, I regarded myself as a "traveler" heading into a discipline about which I have a very specific and limited knowledge, and then for the analysis returning to my own "home base" of Gender Studies and feminist theory.[49] In my analytical chapters, to the best of my ability I portrayed accurately what my interlocutors shared with me, while

[46] Paul Hanna, "Using Internet Technologies (Such as Skype) as a Research Medium: A Research Note," *Qualitative Research* 12, no. 2 (April 1, 2012): 239–42.
[47] See Summerfield (2004) for a case study of the usefulness of analyzing omissions in interviews.
[48] Norman Fairclough, "Intertextuality and assumptions," in *Analysing Discourse: Textual Analysis for Social Research* (Routledge, 2003), 58.
[49] Susan Stanford Friedman, "Academic Feminism and Interdisciplinarity," *Feminist Studies* 27, no. 2 (Summer 2001): 508.

at the same time acknowledging that my own critical and analytical lens of the interview data is felt heavily throughout the chapters.

In the following chapters, I first lay out my theoretical framework that informs how I think about and analyze my interview material. The following three analytical chapters examine the hierarchy at play in OBGYN training spaces, the murky waters my interviewees described when it came to obtaining consent for a pelvic exam, and finally, the intersectional implications of the kinds of patients who are more likely to be subjected to a nonconsensual pelvic exam. In my conclusion, I consider the implications of what I have found, discuss the limitations of my research, and suggest possible places for hope and steps forward in the U.S. medical community.

Chapter 2: Theoretical Framework

In my theoretical framework, I have mapped out three key concepts I will use in the analysis of my thesis topic: Nonconsensual pelvic exams by medical students in U.S. OBGYN training spaces. I have called my three concepts "The Medical Gaze & God Vision," "Exploitation & Power," and "The Coloniality of Knowledge." Although I have separated the concepts, they relate to each other in several ways that I will describe throughout the theoretical framework, as well as in my conclusion. Relating the theoretical concepts to each other allows me to see how nonconsensual pelvic exams reflect *multiple* relations of power that position some bodies as more fitting for nonconsensual examinations than others. These relations of power refer to the ability of hegemonic institutions to position violent and exploitative practices as standardized procedure, as well as bringing certain bodies into those violent and exploitative spaces. Therefore, in my analysis, it is not just random bodies that are nonconsensually examined, but gendered, raced, and classed bodies that have been systematically "othered" in U.S. society.

In "The Medical Gaze & God Vision," I discuss how patients are objectified by the medical gaze, and how this relates to the current phenomenon of nonconsensual pelvic exams. In "Exploitation & Power," I analyze how U.S. medicine exists in a space that historically has and continues to choose certain bodies to experiment on in the name of science and progress. In the "Coloniality of Knowledge" section, I am interested in the relationship between processes of knowledge making and coloniality, and how these concepts relate to the current treatment of certain OBGYN patients. In my conclusion, I write about how the texts I have discussed interact with one another to help me in the final research and analysis of my thesis topic.

2.1 The Medical Gaze & God Vision

The idea of the "medical gaze," and its relationship to pelvic exams specifically, is a core analytical concept I will use in the construction of my argument. The medical gaze is discussed extensively in the book *The Birth of the Clinic* by Michel Foucault. In his book, Foucault analyzes how, in the clinic, patients were "brought into the light" and subjected to the medical gaze.[50] In this sense, the patient was objectified by the roaming eye of the medical professional. Foucault describes how this change came about in 18th century France, through a revolutionary and post-revolutionary quest for "truth" and absolute knowledge in medicine. Where before death and bodies, for example, were something to be feared and kept in the dark, cadavers became a point of knowledge for medical professionals, and they were exposed to the medical gaze to consume.[51]

Crucially, this objectification of the patient by medical professionals had to do with power, as it assigned outmost authority to medicine as a means of knowledge-making, often at the expense of the patient. In life as well as in death, bodies were made to be completely scrutinized and dissected in the name of moving the medical profession forward. For instance, Foucault writes of modern medicine's view of itself as a practical science: "One is not favouring a small handful of individuals, but, through qualified intermediaries, one is helping the people to feel the benefits of truth."[52] The idea of medicine as a profession not benefiting the few, but the masses, is a key concept I will use when discussing the practice of nonconsensual pelvic exams as an educational tool for future doctors. (Often nonconsensual pelvic exams are defended on the grounds of medical students benefiting future OBGYN patients by developing a vital diagnostic skill.)

There are several other reasons why *The Birth of the Clinic* is useful for me in my research. Crucially, when Foucault is referring to the clinic, he is talking about the spaces in which doctors

[50] Michel Foucault, *The Birth of the Clinic* (Routledge, 1973), 39.
[51] Ibid., 143.
[52] Ibid., 70.

were expected to learn and gain mastery through the hands-on experience of honing their craft on the patient's body. As my research is concerned with the practice of pelvic exams in teaching hospitals for educational purposes, the links between Foucault's analysis and my own research are clear. *The Birth of the Clinic* perhaps provides an analysis where I can see clearly the link between the advent of "modern," westernized medicine, and the contemporary practice of nonconsensual pelvic exams. Additionally, Foucault's description of the advent of the teaching hospital in France is useful in that it contextualizes where some of our westernized ideas of modern medicine come from. Although U.S. medicine has the power to position itself as transcending location and subjectivities, *The Birth of the Clinic*, in its specificity of a certain time and place in which these ideas came about, is a powerful reminder that western medicine is culturally and geographically specific.

Foucault numerous times also describes how important it was in the 18th century for future doctors not to learn through listening and reading, but through seeing, touching, and practice.[53] Although Foucault is talking about revolutionary 18th century France in his book, his analysis provides a helpful framework for me in understanding how hegemonic western medical practices became standard practice in many places, including the U.S. By looking at the ways in which teaching hospitals were places in which patients were objectified in the name of gaining knowledge and medical prowess, it becomes easier to place nonconsensual pelvic exams within this context of authority and power. Medical students are encouraged to practice pelvic exams, whether consensually or not, on patients, because it is a hands-on experience that they would not be able to gain from sitting in a classroom lecture. The importance of touch as a means of gaining knowledge is therefore a direct link between *The Birth of the Clinic* and my thesis topic.

In *The Birth of the Clinic,* Foucault is discussing an advent of medicine in France that was later exported to the U.S., but other geographic sites are also useful for me in thinking about how the

[53] Foucault, *The Birth of the Clinic,* 76.

medical gaze situates certain "othered" bodies at sites of contention and power. For example, Ellen Amster, in her book on the colonial encounter in Morocco, describes how traditional birthing practices were violently changed by the French. Whereas traditionally in Morocco birth was a private event and done in an all-female environment, after French colonization the mother was exposed on a hospital table in a French clinic. Amster writes that the mother was made into "a passive, blind object in her birth process; her sex organs are visibly presented to the obstetrical surgeon for his intervention."[54] This quote reminds me strongly of my own research questions, because with nonconsensual pelvic exams I am interested in how the gendered body becomes a site for intervention and experimentation in the operating room.

Amster's argumentation is useful for my framing of nonconsensual pelvic exams as a site for "intervention" as well. There is a dehumanization of the body that happens in this medical process, and Amster's example shows that using the female pelvis as a site for constructing scientific narratives is something that occurs across time and space. Clearly, colonial Morocco and the contemporary U.S. are two very different spaces, but, in both examples it is important to note that the OBGYN body works as a *site* for crafting medical narratives that serve hegemonic forces. Similarly to Foucault's book, Amster is also pinpointing a moment in time where these sorts of discourses were created by colonial powers. By highlighting that the French completely changed the way in which birth was approached in Morocco, Amster showcases that many westernized medical practices we claim as universal today were actually created at a very specific moment, and through the exploitation of and nonconsensual practices on colonized subjects. Power, in Amster's example, operated to disenfranchise traditional birthing practices in the name of hygiene, modernity, and progress.

[54] Ellen Amster, "A Midwife to Modernity: The Biopolitics of Colonial Welfare and Birthing a Scientific Moroccan Nation," in *Science, Islam, and the Colonial Encounter in Morocco, 1877-1956* (Austin, Texas: University of Texas Press, 2013), 192.

Donna Haraway is also formative for me in how I think about nonconsensual pelvic exams and their relation to power in scientific and medical narratives. Haraway's theories assist me in showcasing how the practice of nonconsensual pelvic exams reveals certain subjective narratives in U.S. medicine and gynecology. For example, in her musings on fact and fiction, Haraway writes, "But in all its meanings, fiction is about human action. So, too, are all the narratives of science—fiction and fact—about human action."[55] I can use this quote, where Haraway is talking about fact and fiction, to analyze how U.S. medicine justifies its own practices by drawing a hard line between objective, scientific knowledge, and subjective, situated knowledge.

In the context of my research, medicine is positioned as fact, although it was made by very specific groups of people at a certain historical moment. By juxtaposing "subjective" knowledges with "hard" medicine, medical institutions draw a boundary between themselves and knowledges that are widely perceived as subjective. Medicine thus becomes harder to criticize, because it exists as knowledge that is difficult to dissect without being "anti-science" or "anti-knowledge." Therefore, Haraway is very influential for me in how she views science (which I was taught is neutral and/or objective) as constructing a narrative much in the same way fiction is constructed. This is not to say that medical narratives are unique in emerging from the circumstances of their context in a way reminiscent of fictional narratives. However, the uniqueness arises because U.S. medicine had positioned itself as going beyond the circumstances of its own context.

In the context of my research and analysis, the existence of nonconsensual pelvic exams is indeed worrying on its own, but the practice itself also reveals *how* medical institutions normalize a practice that in different arenas might be viewed, at the very least, as deeply problematic. What is at stake here is not only that the exams exist, but that they exist and are normalized through medical

[55] Donna Haraway, "Introduction: The Persistence of Vision," in *Primate Visions: Gender, Race, and Nature in the World of Modern Science* (London: Routledge, 1989), 4.

narratives. Donna Haraway provides me with a framework for thinking about how certain prevalent discourses are served by positioning themselves as beyond fictional narratives and beyond points of criticism. For example, if nonconsensual pelvic exams are positioned as besmirching the good name of U.S. medicine, the implication is that U.S. medicine has a good name to besmirch. However, what if certain practices in U.S. gynecology have emerged, *because* of the context in which they exist, not despite it? Throughout my analysis, I view nonconsensual pelvic exams as a tool that keeps the gears of the OBGYN machine running, as opposed to something that works against the values of OBGYN training. Again, Haraway's argument allows me to analyze the connection between nonconsensual pelvic exams, and the construction of U.S. medical institutions as spaces transcending the culturally specific.

Additionally, in a separate piece of writing, and similarly to Foucault's discussion of the medical gaze, Haraway describes an all-knowing vision that she calls "the god trick." She writes, "All seems not just mythically about the god trick of seeing everything from nowhere, but to have the myth put into ordinary practice."[56] The all-knowing medical gaze is, in my opinion, an example of how the myth of the gendered OBGYN patient in need of medical intervention becomes standard procedure in the form of nonconsensual pelvic exams. Of course, along with this myth is the additional discourse of a medical intervention that needs to take place for the sake of progress and modernity, because of the nature of medicine positioning itself as a modern and rational response to the world. Therefore, the medical gaze, like the god trick, positions itself in such a way that it cannot be questioned or critiqued. There is less of a need to question certain practices when the people ordering such practices have extremely powerful claims to truth, authority, and knowledge-making processes, and this is especially the case in highly prestigious U.S. medical institutions. Medical

[56] Donna Haraway, "Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective," *Feminist Studies* 14, no. 3 (Autumn 1988): 581.

institutions make claims to practices such as pelvic exams under the discourse of "We know best," but a more accurate claim might read something like, "We have the authority to claim we know best."

Finally, the concepts I have discussed in this section all relate to the idea of "normalization," which is a concept I refer to frequently in the analysis of my data. In my analysis, normalization is crucial because it is one of the key ways in which nonconsensual pelvic exams are allowed to happen, and in so happening further discourses of medical power. For example, in *The Birth of Biopolitics,* Foucault writes, "Disciplinary normalization consists first of all in positing a model . . . and the operation of disciplinary normalization consists in trying to get people, movements, and actions to conform to this model."[57] This quote relates to the topic of nonconsensual pelvic exams, because the idea of disciplinary normalization relates to the idea that "model" patients are expected to do regular pelvic exams and/or OBGYN procedures to take part in preventative healthcare. As Kelly Underman writes, the routine pelvic exam has become a "tool served to expand the reach of biopolitics by coding reproductive bodies as always already at risk and in need of medical surveillance."[58] By positioning nonconsensual pelvic exams as part of this process of biopolitical normalization in medical spaces, I again aim to frame such exams as an integral part of OBGYN training, and not a phenomenon of the past as many physicians would have us believe.

2.2 Exploitation & Power

Foucault, Amster, and Haraway were scholars who were thinking more fundamentally about discourses of power in relation to science and medicine. However, Terri Kapsalis's more specific tale of U.S. gynecology was the original theoretical inspiration for my thesis. Like Foucault, Kapsalis

[57] David Newheiser, "Foucault, Gary Becker and the Critique of Neoliberalism," *Theory, Culture & Society* 33, no. 5 (2016): 7.
[58] Underman, *Feeling Medicine*, 30.

provides a specific historical moment in which we can trace back the thread of contemporary practices, like pelvic exams, in U.S. gynecology. Kapsalis writes about how the father of modern gynecology in the U.S., J. Marion Sims, developed his technique for repairing vesico-vaginal fistulas (VVF) on unanesthetized enslaved black women.[59] As I described in the introduction, these women were legally not able to give or withdraw consent as enslaved persons,[60] and Sim's operations eliminated the possibility to perform consensual gynecological procedures. Sims also wrote in his diaries chronicling his experiments that these enslaved women were "clamorous for him to continue."[61] That Sims writes that these women wanted him to operate on them echoes an argument made about nonconsensual pelvic exams: mainly, that such exams are both necessary for students and done for the overall benefit of future OBGYN patients.

This paternalistic argumentation reflects a historical trend in U.S. science and gynecology to use certain bodies, without consent, for educational purposes in the name of scientific progress. Kapsalis' example of Sims is foundational for me in thinking about how certain bodies in the U.S. were viewed as ripe for intrusion and experimentation. Sims did not experiment on enslaved black women randomly, he operated on them *because* they were black, because they were enslaved, and because they were women. Therefore, Sims' experiments tell me something about how he viewed some bodies as more fitting for experimentation than others, which also relates to what I will discuss in the next section concerning viewing black bodies as closer to nature and thus more "fitting" for experimentation. Therefore, Kapsalis is useful for me in thinking about how nonconsensual pelvic exams act as a bodily manifestation of these exploitative practices. In much the same way that the nonconsensual pelvic exam is a site of medical claims to authority, the fistula, for Kapsalis, is a site

[59] Kapsalis, "Mastering the Female Pelvis: Race and the Tools of Reproduction," 31-59.
[60] Cronin, "Anarcha, Betsey, Lucy, and the women whose names were not recorded: The legacy of J Marion Sims," 6-13.
[61] Ibid., 10.

upon which many of these discourses revolve as well. Although the specific examples differ, the positioning of the medical gaze in both cases tells a similar story.

Now, if we fast forward to today, clearly the circumstances under which nonconsensual pelvic exams are performed are very different. However, the argumentation from Sims' that arises in Kapsalis' piece is eerily similar to the argumentation I have encountered in the investigation of nonconsensual pelvic exams. The argumentation that often arises in regards to pelvic exams is that they are absolutely necessary for a medical student in order to learn. What doesn't seem to be often interrogated here is the emphasis on the medical student learning above all else. As we learned from Foucault, gaining medical knowledge through touching and feeling, is a relatively recent practice in the history of western medicine. So, the fact that it is taken for granted when it comes to medical students learning to conduct pelvic exams is telling in and of itself.

In her historical account, Kapsalis was writing about a very specific moment: the practice of developing gynecological techniques on enslaved black women. However, the story of Sims' experimentation allows me to analyze a process of normalization that happens within medical spaces. The example of the VVF operations are deeply disturbing by themselves, but they also tell me something about knowledge making apparatuses in U.S. gynecology. The operations reveal something about medical authority, claims to truth and necessity, and how a disturbing practice can be normalized in a certain time and space. By viewing this historical backdrop Kapsalis narrates as a key foundational moment for U.S. gynecology, nonconsensual pelvic exams shift to something that is not an outlier in contemporary medical practice, but something that fits neatly into the fabric that holds up the entire system.

Kapsalis' piece also showcases how certain gendered and raced bodies become a special site for the production or denial of consent. In the process of doing research for my thesis topic, I am interested in investigating whether certain bodies are more likely to have pelvic exams done to them

than others. Clearly, pelvic exams have a sexed and gendered aspect to them because of the presence of a pelvis and a uterus, but there are other aspects at play that Kapsalis' writing leads me to investigate. For example, are low-income patients more likely to be the recipient of a nonconsensual pelvic exam. What about patients of color? Patients with disabilities? Patients who don't have English as a first language? These are all questions that Kapsalis writing about the intersectional dynamics of U.S. gynecology push me to consider.

In her chapter, Kapsalis is writing about consent, and how consent is something that was not considered to be necessary for enslaved black women. Obviously, as the phenomenon I am researching in my thesis is nonconsensual pelvic exams, consent is an important part of my analytical framework. However, in my research I am viewing the lack of consent in nonconsensual pelvic exams as a *symptom* of certain norms and narratives of power in U.S. medicine and gynecology. This viewpoint is in contrast to analyzing the lack of consent as a problem that exists in a vacuum, or as merely a violation of the bodily autonomy of the patient. It is in this specific sense that I am making my research paint a picture of nonconsensual pelvic exams that is more deeply grounded in these narratives of power and knowledge production in U.S. medicine.

In my attempt to problematize a more superficial notion of consent, I will investigate the very existence of nonconsensual pelvic exams as pointing to a wider discussion of power in medical institutions that goes beyond the prevalence of bodily autonomy in the discourse. In this I am informed by Alix Masters, who uses feminist theory to describe how focusing on bodily autonomy as the focal point of consent ignores the backdrop of wider relations of power intrinsic to medical institutions.[62] For example, between a doctor and a patient there is an unequal power relation, so what does "informed consent" really look like in such a space? If a doctor asks a patient if a medical

[62] Alix Masters, "Feminist Theory Reveals a Need for Justice over Autonomy in Research Ethics," *Voices in Bioethics* 4 (2018): 1-6.

student can perform a pelvic exam under anesthesia, the patient may certainly say yes. In the eyes of the medical institution (and in much of the literature critiquing nonconsensual pelvic exams) this is sufficient consent and thus cancels the problem of non-consent in that specific instance.

However, this situation does not take into account the power relationships between a patient and a doctor, between a patient and a medical student, and between a student and a doctor/attending/resident. When this frame is taken, the patient's consent to a pelvic exam in that exact moment becomes more complicated. From personal experience, I have not always felt comfortable to tell a doctor completely honestly how I felt about something. Therefore, if the "solve" of nonconsensual pelvic exams is posited merely as a patient saying "yes" in that exact moment, then the relationships of exploitation inherent to these kinds of medical institutions have not really been solved. Masters' piece, therefore, leads me in my research to investigate the relationships between various actors in the operating room. In the analysis of my data, instead of looking at nonconsensual pelvic exams as only a violation of bodily autonomy, I will place them within a wider discourse of medicine that has historically made gendered, raced, and classed bodies a site for crafting technologies of medical knowledge.

As I am thinking about the relation of nonconsensual pelvic exams to the bodies of patients at the cross-sections of various "othered" identities, the theory of intersectionality is also crucial for me as a theoretical and analytical framework. The term "intersectionality" was coined by Kimberlé Crenshaw in 1989, and her writing on the experience of black women in the U.S. legal system specifically influenced the way we examine power and overlapping systems of oppression.[63] She argued that people living at the intersection of multiple subjugated identities will experience discrimination specifically targeted towards the intersection of those identities, while at the same

[63] Kimberlé Crenshaw, "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Policy," *The University of Chicago Legal Forum* (1989): 139–167.

time the law does not account for this specific kind of discrimination. As I examine specifically in Chapter 5, the intersectional implications of which *kinds* of patients are more likely to be subjected to a nonconsensual pelvic exam is extremely telling. Patricia Hill Collins also writes on how using an intersectional framework allows us to see power relations more clearly, which is a crucial part of my analytical argument: mainly, that nonconsensual pelvic exams reflect the power relations at play at the heart of U.S. medical institutions.[64] Kathy Davis also writes about how intersectionality allows us to see "the interaction between gender, race, and other categories of difference in individual lives . . . and the outcomes of those interactions in terms of power."[65] In my analysis, the outcomes of the interactions of power result in some bodies, but not all, being more likely to receive a nonconsensual pelvic exam.

2.3 The Coloniality of Knowledge

The topic of nonconsensual pelvic exams by medical students in U.S. teaching hospitals is very specific. However, I want to relate my research topic to wider discourses of power, as well as to the relationship between modernity and coloniality. Prestigious U.S. medical institutions are widely considered to be some of the best in the world. From a global perspective, they represent a key space of modernity, progress, and aspiration. Therefore, one of the key analytical concepts I will be working with throughout this section is the idea that Euro-American knowledge production is closely tied to narratives of colonialism and domination. Additionally, U.S. medicine historically has and continues to craft specific narratives around what is accepted, standard modern medical practice, and what is not.

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[64] Patricia Hill Collins, "Intersectionality's Definitional Dilemmas," *Annual Review of Sociology* 41 (2014): 1–20.
[65] Kathy Davis, "Intersectionality as Buzzword: A Sociology of Science Perspective on What Makes a Feminist Theory Successful," *Feminist Theory* 9, no. 1 (2008): 68.

However, these narratives are slippery, because they position themselves as a point of view that "represents itself as being without a point of view."[66] This means that even though contemporary medical practice in the U.S. was crafted in a specific moment using non-universal methods, U.S. medical practice positions itself as transcending a politics of location. Therefore, when analyzing the current practice of pelvic exams in U.S. OBGYN training spaces, it can be difficult to criticize the ways in which these exams happen, because they position themselves as modern and universally legitimate.

What is also important to note is that Euro-American knowledge production, although regionally specific, was spread throughout the globe, starting with the colonization of the Americas in the 15th and 16th centuries.[67] That Eurocentric knowledge production became the established "norm" in the Americas meant that specific discourses surrounding medicine and bodies were implemented in the colonies. Therefore, it is impossible to analyze contemporary U.S. medical practices without discussing this European colonial history that is deeply entangled in current U.S. medical epistemology. Analyzing the colonial legacy at play in current U.S. medical practice can help to explain why certain bodies are subjected to experimentation more so than others.

For example, Ramón Grosfoguel describes how, intrinsic to the European colonial project of establishing inferior and superior knowledge, was the designation of inferior and superior people and races.[68] He also describes how modernity as a European project was colonial from its point of departure.[69] As European colonizers worked to "civilize" the indigenous groups they met in the Americas, they also worked to establish their specific ways of knowing, which included valuing

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[66] Ramón Grosfoguel, "Decolonizing Post-Colonial Studies and Paradigms of Political Economy: Transmodernity, Decolonial Thinking, and Global Coloniality," *Journal of Peripheral Cultural Production of the Luso-Hispanic World* (2011).
[67] Aníbal Quijano, "The Coloniality of Power, Eurocentrism and Latin America," *Nepantla: Views from South* 1, no 3 (2000): 549-550.
[68] Grosfoguel, "Decolonizing Post-Colonial Studies and Paradigms of Political Economy: Transmodernity, Decolonial Thinking, and Global Coloniality."
[69] Ibid.

rationality and a mind/body dichotomy over other ways of knowing and being. That the colonizers saw themselves as superior to the other groups they encountered justified their violent treatment of the people in the colonies. In other words, as subjectivity was systematically stripped away from entire groups of people, it becomes easier to justify colonization and, later, experimentation.

Aníbal Quijano also writes how the colonizers worked to suppress colonized forms of knowledge.[70] Not only were alternative forms of knowledge suppressed during colonization, but the racialized justification for the domination of indigenous people came from the idea that their bodies were less rational and closer to nature. Quijano describes how, because the bodies were viewed as closer to nature, they were to be studied and experimented on as non-rational subjects.[71] I bring up all these examples to show that colonial history in the Americas is deeply tied up with establishing Euro-centric forms of knowledge and knowledge-making processes on groups of people deemed inferior. Eurocentric ways of knowing are so dominant in our world today that it becomes difficult to even question where some of our ways of thinking come from. However, the existence of nonconsensual pelvic exams, and the ways in which OBGYN patients are treated in U.S. medical spaces, reveals flashes of this specific colonial legacy predicated on violence. Lastly, Grosfoguel writes it is a "'god-eye view' that always hides its local and particular perspective under an abstract universalism."[72] As I have described in the previous sections, this "god-eye view" is closely tied to the ways in which medical institutions look upon their patients, as described by Foucault and Haraway.

[70] Quijano, "The Coloniality of Power, Eurocentrism and Latin America," 541.
[71] Ibid.," 555.
[72] Grosfoguel, "Decolonizing Post-Colonial Studies and Paradigms of Political Economy: Transmodernity, Decolonial Thinking, and Global Coloniality."

2.4 Conclusion

In my theoretical framework, I have described three key concepts that I am using to analyze my research topic of nonconsensual pelvic exams. Although I have separated my theoretical framework into different sections, they overlap in several different ways. For example, the conversation around the coloniality of knowledge is deeply related to Haraway's discussion of "god vision" and Foucault's discussion of the medical gaze. These scholars, although writing different texts, are disrupting the narrative of a specific, Eurocentric form of knowledge making as universal and transcending location. Additionally, not only is Eurocentric epistemology geographically and culturally specific, but it created its dominant forms of knowledge through the subjugation of people and alternate ways of knowing.

I am also arguing that with the specific example of nonconsensual pelvic exams, we can see these larger discourses of knowledge-making and power at play. The question I am trying to ask is not so much, "Did they give consent or not," but rather, "How are some patients normalized by the medical gaze as not in need of consent?" And, of course, what might the answer to this question tell us about the role of power in hegemonic institutions like prestigious U.S. teaching hospitals, and conversely how U.S. teaching hospitals further discourses of power. Similarly to how Kapsalis used the example of VVF operations to describe larger relations of gendered and raced violence in U.S. gynecology, I will use the example of nonconsensual pelvic exams to explore how contemporary U.S. medicine can "get away" with exploitative practices *through* claiming ultimate authority to knowledge making processes. The following chapter examines how the hierarchy at play within OBGYN training spaces, as described to me by the medical students I spoke with, placed nonconsensual pelvic exams beyond a place where they could be questioned or critiqued.

Chapter 3: The Hierarchies at Play within OBGYN Training

In this chapter, I will analyze a hierarchical and often toxic educational and workplace environment that many of my interviewees described during their OBGYN clerkships. These hierarchies are useful for me in thinking about how nonconsensual pelvic exams reflect wider symptomatic relations of exploitation and power in U.S. medical institutions that position nonconsensual pelvic exams beyond a space where they can be critiqued. In my analysis, these relations of power challenge respecting bodily autonomy as the sole space for intervention when it comes to ending the practice of nonconsensual pelvic exams.

As I discussed in the theoretical framework, post- and decolonial theory from Ramón Grosfoguel and Aníbal Quijano help to showcase how U.S. medicine, in having the power and capital to position itself as transcending knowledge coming from a specific time and place, and serving specific locations and people, can *normalize* a practice like nonconsensual pelvic exams. Similar to Donna Haraway, Grosfoguel describes this as a point of view that represents itself as not having a point of view.[73] In my analysis in relation to pelvic exams, this intentional blurring of a point of view has the political effect of making practices that in other arenas might be perceived as rape and/or sexual assault manifest as standard procedure in prestigious teaching hospitals. This manifestation of standard procedure has the effect of making nonconsensual exams happen, and to happen to certain kinds of people.

In this chapter, I will also use Michel Foucault's description of the "medical gaze," Donna Haraway's idea of "god vision," and Barbara Marshall's explanation of "black-boxing" to showcase how the ultimate authority that is invested in U.S. medical institutions leads to exploitative practices being taken for granted through a process of normalization. In other words, if a practice exists

[73] Grosfoguel, "Decolonizing Post-Colonial Studies and Paradigms of Political Economy: Transmodernity, Decolonial Thinking, and Global Coloniality."

within an institution that is generally considered by the U.S. population to be universally legitimate, then why question it? In my discussion of consent later in this chapter, I will cite Kelly Underman's book *Feeling Medicine* to showcase how certain medical technologies, when vested with large amounts of authority, can frame consent as something that is fulfilled through the ticking of a box on a form. Lastly, I analyze theory from Terri Kapsalis to think about the gendered and intersectional implications of OBGYN being an especially intense and uncomfortable training environment.

Pelvic exams, whether nonconsensual or not, are considered an absolutely vital part of a medical student's educational experience.[74] Even if a medical student is not planning to go into OBGYN, every medical student in the U.S. has to do an OBGYN rotation (also sometimes referred to as a "clerkship") before they graduate. During this clerkship, medical students will learn how to conduct pelvic exams. Pelvic exams are, according to the students I interviewed, crucial to learn because they are needed for diagnostic purposes. Physicians conduct pelvic exams to search for existing abnormalities or signs of cancer. Normally, a Pap test, which screens for cervical cancer, is also conducted during a pelvic exam.

Therefore, when pelvic exams are nonconsensual, they become more difficult to criticize, because they exist in a space that encourages medical students to conduct pelvic exams on patients on the grounds of doing what is necessary for a medical student to learn, and to benefit future patients. In the literature denouncing nonconsensual pelvic exams, such exams are almost always positioned against a universally legitimate, consensual exam that should be a part of every medical student's training.[75] However, throughout this chapter, I also argue that *any* pelvic exam, due to the nature of hierarchies within medical systems, reflects certain relations of power.

[74] Stephanie Schniederjan and G. Kevin Donovan, "Ethics versus Education: Pelvic Exams on Anesthetized Women," *The Journal of the Oklahoma State Medical Association* 98, no. 8 (August 2005): 386.
[75] For an example, see Kimberly E. Liu, Jodi Shapiro Dunn, Deborah Robertson, Susan Chamberlain, and ETHICS COMMITTEE, "Pelvic Examinations by Medical Students," *Journal of Obstetrics and Gynaecology Canada: JOGC = Journal d'obstetrique et Gynecologie Du Canada: JOGC* 32, no. 9 (2010): 872–74.

Therefore, the aim of this chapter is to outline how the practice of nonconsensual pelvic exams is deeply tied up with a narrative of hierarchy in the OBGYN clerkship that made many of the students I interviewed feel like they could not speak if they felt uncomfortable, or wanted to voice a concern. In this chapter, I will highlight three ways in which the interviewees experienced (and at times reproduced) hierarchies at play in OBGYN training. These three sections highlight that nonconsensual pelvic exams are not an anomaly that goes against the values of medical institutions, but rather serve as an example of what kinds of practices are encouraged in an environment where dissent is often not allowed. Additionally, the chapter sections showcase how nonconsensual pelvic exams function to organize different power relations on multiple levels.

In my analysis, the hierarchical relationship in the OBGYN operating room matters, because it highlights nonconsensual pelvic exams as existing in a medical space that systematically discourages voicing concerns and questions. This silencing of dissent functions to reproduce notions of OBGYN patients as passive and mute, while cementing the idea that physicians know best, and that medical students should do as they're told. Therefore, OBGYN patients find themselves in situations where even if a medical student felt uncomfortable conducting a pelvic exam, they might not feel empowered to speak up about it, which normalizes the practice taking place without critique.

3.1 "No Questions Asked."

The link between a more general discussion of power in U.S. medical institutions and nonconsensual pelvic exams came about in my research through hearing how the medical students discussed their unwillingness to tell a higher-ranking physician if they did not want to conduct a pelvic exam. During the OBGYN rotation, medical students are being taught and observed by either

a resident at the teaching hospital, or an attending physician.[76] Medical students, at this time, still have to graduate from their university before they can apply and be accepted to a residency position, and the residents and attendings help to determine where they end up doing their residencies. Therefore, it is under the supervision of either the resident or the attending that the medical student will learn how to conduct a pelvic exam. They will not decide for themselves when they are going to conduct the exam, but will instead be told when to do one by a higher-ranking physician.

To give an example of the OBGYN environment, I will showcase a quote from one of my interviewees named Allison. Allison is a current medical student at the Donald and Barbara Zucker School of Medicine at Hofstra University in New York. Allison said she became interested in medicine through her passion for STEM subjects, as well as through her experiences volunteering and researching. However, some of her experiences during her OBGYN rotation made her feel like she was merely there to follow instructions.

For example, I asked Allison, if she was in a situation where she was not sure if she had obtained consent for a pelvic exam[77], if she would feel comfortable voicing an unwillingness to conduct the exam with the attending physician. She replied right away, "Absolutely not. Not on OB (obstetrics). No way. If the resident said, 'do a pelvic exam,' then you do a pelvic exam. Period. End of story." When I asked her what she thought might happen hypothetically if a medical student voiced a concern, she said, "Um, they probably just would've been like, 'Why, why won't you do that?' Or like, I don't know. They would've failed me. I don't know. It's just not something, it's not an option . . . especially on OB."

[76] Residents are medical school graduates in training with a Doctor of Medicine (MD) degree, and attending physicians are doctors who have completed their residency and now supervise residents and medical students.
[77] Generally, medical students know they have obtained consent for a pelvic exam because they have met the patient beforehand and received verbal consent, or they have been assured by the resident/attending that the patient signed a form consenting to a practice pelvic exam by a medical student.

When I prompted Allison as to why she said, "especially in OB," she described how she was very "scared" of the residents, and that they did not get along well. Allison's description of her hypothetical unwillingness to voice a concern when it came to a potential nonconsensual pelvic exam complicates the narrative of who ultimately is interacting with who in the practice of nonconsensual pelvic exams. Allison admitted to me during the interview that she had certainly conducted pelvic exams on patients under anesthesia without receiving their consent to the procedure. However, when she told me about not voicing her concerns, she was speaking hypothetically, because, as her quote described, it would not have occurred to her to question a resident/attending telling her to do a pelvic exam. Therefore, In Allison's story, it is not merely the medical student and patient who are involved, but the higher-ranking resident who bestows ultimate authority on what happens in the operating room.

This authority was also described by Shawn Barnes in his article, when he described that as a medical student the notion was reinforced to him that he should not question the practices of those above him.[78] He wrote, "Owing to both the culture of medicine and my own lack of courage, I did not immediately speak out against what I was asked to do by residents and attendings."[79] Although Barnes' article was published and made waves on the topic of nonconsensual pelvic exams in 2012, it is telling now to see that, more than ten years later, some of the same hierarchical dynamics are at play in OBGYN training spaces. Although many of the interviewees I spoke with said there was progress being made in terms of consent and patient-student-physician relations, it seems as if, for Allison, progress had not been made for her in this realm.

In the case Allison describes, there are two factors at play. Firstly, on the surface it is clear from her words that she does not feel comfortable to say that she does not want to conduct a pelvic

[78] Barnes, "Practicing Pelvic Examinations by Medical Students on Women Under Anesthesia: Why Not Ask First?" 941.
[79] Ibid.

exam. However, I am also arguing that this moment Allison describes is a moment of normalization that places the nonconsensual pelvic exam beyond a space of being questioned or critiqued. In other words, if the OBGYN operating room is not a place where practices are questioned, then in Allison's specific experience at her institution, why should she question them? Here, the concept of "black-boxing" is useful in my analysis, because, to put it in very basic terms, black-boxing describes a process of delineating: This is the way things are, and of course we already know what it is, so we don't have to question it. The term itself originated in the social construction of technology, where it referred to "the tendency for technologies to become stabilized in such a way that they appear to be naturalized and/or immune to political critique."[80]

The concept of black-boxing also relates to Donna Haraway's writing on fact and fiction, where she describes that "fact," like fiction, is related to human action.[81] Haraway, therefore, is also describing a process of placing narratives of science in a space that is so widely considered to be legitimate that there is no need for its practices and aims to be questioned. In relation to my thesis, certain medical narratives, like the narrative of medical students absolutely needing to learn how to conduct a pelvic exam, leads to the advent of nonconsensual pelvic exams as something that is naturally valid and normal. Barbara Marshall describes how, through black-boxing, "the very assumptions about sexual bodies that made them possible are both consolidated and obscured."[82] In the case of the pelvic exam, the framing of the patient as someone who might be in need of consent is made blurry through the absolute authority of the resident or physician saying that this exam is simply what needs to be done.

[80] Barbara L. Marshall, "'Hard Science': Gendered Constructions of Sexual Dysfunction in the 'Viagra Age,'" *Sexualities* 5, no. 2 (2002): 150.
[81] Haraway, "Introduction: The Persistence of Vision," 4.
[82] Marshall, "'Hard Science': Gendered Constructions of Sexual Dysfunction in the 'Viagra Age,'" 144.

Additionally, black-boxing as an analytical framework indicates that, in the story Allison shares, she is not necessarily describing a moment of being *forced* to do something. Instead, she is confronted with a normalizing moment in which, according to her own testimony, it would not occur to her to question the resident/attending's decision to do a pelvic exam at that moment. Kelly Underman, in her book on teaching pelvic exams, helpfully invokes Foucault to describe this phenomenon. She writes, "Foucault wrote of discipline as a key mechanism of power by which the major institutions in society (such as the prison, *the clinic*,[83] or the school) shape the behavior of its members."[84] In the OBGYN training environment Allison describes, power is operating much in this way Underman maps out. It is not operating to force Allison to do something in an oppressive way, but rather to put her in a position where she would not think to question an OBGYN resident's decision to do a practice pelvic exam.

Therefore, I argue that in this specific moment, under the auspice of the medical gaze, a nonconsensual pelvic exam is not necessarily done against the will of the patient or against the will of the medical student. Instead, the nonconsensual pelvic exams transcends the question of: Is this morally permissible, or is it not? Although it may seem counterintuitive, the question of consent does not necessarily come into play in this circumstance, because the permissibility of the pelvic exam is so assumed that consent does not even need to be considered. Therefore, the problem here does not so much become a question of consent, but a question of what sorts of practices are sanctioned through a process of normalization when physicians are granted ultimate authority in the operating room.

Similarly to Allison, other interviewees also brought up this framing of OBGYN being an especially high intensity clerkship with little to no room for concerns or questions. Tory, a medical

[83] Italics mine
[84] Underman, *Feeling Medicine*, 19-20.

student at The Geisel School of Medicine at Dartmouth College in New Hampshire, described her especially tumultuous relationship with the residents and attendings she worked with during her OBGYN clerkship. She stated, "I think it's a matter of that, like the residents had way too much work and didn't have time to teach or interact with me, and routinely dismissed me, and I eventually kind of came to the point where I was like, okay, speak when spoken to." She went on to describe how, although she felt like if she really had a big concern, she would say something, overall she did not feel comfortable to voice concerns, or even ask questions to the higher-ranking physicians. Eventually, according to her, she just felt uncomfortable after a while "because it was just not a great culture." She also stated that in her experience, her friends at other medical institutions had bad memories associated with their OBGYN clerkship.

Tory, like Allison, is a current medical student in her third year. She described how her own decision to pursue a career in medicine came about from having pelvic surgery when she was 22. This experience showed her how well-executed healthcare can have a significant impact on a person's health and wellbeing, and this was inspiring to her. However, Tory, unlike Allison, had her own theory about why specifically the OBGYN culture was so negative. In her experience, it had to do with the fact that the residents and attendings were overworked, and also that OBGYN is a women-dominated field. Tory suggested that the culture was so toxic because there is a kind of competitive energy that comes across when women specifically are working with one another. According to Tory, her male counterparts had a better experience than her, because they did not have to deal with this women-on-women competition.

Tory's observations were interesting in that they highlighted some negative stereotypes about women in positions of power: namely, that they are cutthroat, competitive, and do not support one another. For Tory, the root issue of a toxic OBGYN training space had to do with the residents and attendings, and didn't have so much to do with the wider structures that the residents and attendings

found themselves in. Although Tory's description of a toxic OBGYN training space does say something important about the specific culture that exists within OBGYN, I disagree with the framework she used to explain this culture.

In my eyes, perhaps the intensity and toxic nature of the rotation is not so much due to the fact that most of the providers are women in OBGYN, but that most of the patients are. For example, Hannah Cundall and her fellow authors describe how historically, what they term "female genitalia" has long been mysticized and stigmatized.[85] For Cundall, this has the effect of spreading misinformation about exams conducted within OBGYN. Terri Kapsalis also argues that it is something about the "female pelvis" *specifically* that makes it, from a medical perspective, a "model" site for nonconsensual experimentation.[86] What might this tell us about the gendered implications of nonconsensual pelvic exams? Several of my interviewees also mentioned to me that doctors in other fields would often refuse to do exams that they felt fell under the purview of OBGYN. Perhaps this had something to do with the "mysticization" of genitalia that Cundall described. Therefore, the fact that the residents and physicians in OBGYN specifically were snappy, overworked, and rushed, tells me something about how specifically OBGYN physicians are left with and trained to deal with their gendered patients.

As I mentioned earlier with the first interviewee example of Allison, she felt like, ultimately, if she expressed concerns or refused to do an exam, this would reflect badly on her final grade and evaluation. As I came to understand from interviewing multiple medical students, a bad evaluation in one of your clerkships can affect your chances at landing a residency, which are already extremely competitive. Allison was not the only interviewee who expressed a concern about her evaluation, and one of the students I interviewed, Ethan, described a case where expressing a concern about a

[85] Hannah Cundall, Sally MacPhedran, and Kavita Shah Arora, "Consent for Pelvic Examinations Under Anesthesia by Medical Students: Historical Arguments and Steps Forward," *Obstetrics Gynecology* 134, no. 6 (December 2019): 4.
[86] Kapsalis, "Mastering the Female Pelvis: Race and the Tools of Reproduction," 47.

pelvic exam did ultimately lead to him receiving a negative evaluation. In Ethan's case, while doing his OBGYN clerkship at Boston University, he was asked to do a pelvic exam on a patient who he had never met before.

Ethan was at the time at an outside hospital affiliated with BU, and was surprised at what he was being asked to do, because at the main BU teaching hospital, Boston Medical Center (BMC), he felt like he had always seen the consent process done relatively well. He described that at BMC, "I don't think I had a single experience there where they didn't ask the patient if it was okay that a medical student specifically be involved in the exam or perform the exam." For Ethan, the consent process was done well when the patient was given the opportunity to provide verbal and written consent before the pelvic exam for training purposes. Additionally, he preferred if he had the opportunity to meet the patient beforehand and introduce himself. He said that he always felt uncomfortable if he was in a situation with a patient where the patient did not know who he was. Therefore, it goes to follow that Ethan would be very uncomfortable if asked to do a pelvic exam on a patient under anesthesia who he had never met before.

Ethan described his response after being asked to do this pelvic exam that was, in his view, nonconsensual: "I remember, so I refused to do it. I was like, I don't feel comfortable doing this exam. And I got in trouble for it. It was on my evaluation that I wasn't, like, I think they interpreted it as like, I wasn't comfortable doing the exams." Ethan also described how, at least at his school, evaluations made up 70% if not more of their final grades, and that residency programs can see "every single comment from every single rotation." Ethan further explained, "So, it does ultimately damage your ability to apply for residency to have a negative evaluation." For Ethan, he felt like this made it difficult in general to stand up to superiors, because it could have a real material effect on job prospects further down the line.

As I described earlier with Allison's case, she felt like the OBGYN clerkship was an especially high intensity rotation for medical students. Tory described how she was "scared" of the residents, and that they did not get along well. In Ethan's case, he felt strongly that going against the wishes of a higher-ranking physician could damage future plans for a residency program. I can thus conclude from these observations that OBGYN appears to be an especially challenging arena in which to raise concerns or feelings of discomfort. On the one hand, there is the problem of addressing concerns with higher-ranking physicians more generally. On the other hand, the OBGYN space, according to Allison and Tory, was an especially intense environment that did not foster feelings of comfort or ease. Therefore, it seems safe to assume that medical students would not always address their concerns if they felt like they were performing a nonconsensual pelvic exam.

As I argued earlier in this chapter, the very establishment of total authority to the attending physician and residents in OBGYN works to preclude any need to express concerns regarding consent and pelvic exams. Instead, the bodies of the OBGYN patients are often viewed as bodies not in need of consent. Again, to reference the concept of black-boxing, the authority that is vested in these medical institutions is so great that it becomes natural to conduct a pelvic exam on a patient who you are not sure has given their consent. Black-boxing is also linked to the idea of normalization, which in my analysis is one of the key ways in which nonconsensual pelvic exams happen, and in happening further discourses about what is standardized, medical practice.

Terri Kapsalis, although writing about the U.S. in the 19th century, described a similar phenomenon when she wrote about Marion J. Sims operating on enslaved black women.[87] Kapsalis describes that it was because these women were black, and because they were enslaved, that Sims did not consider asking the women for their consent. However, when operating on white women, Sims

[87] Kapsalis, "Mastering the Female Pelvis: Race and the Tools of Reproduction," 31-59.

used anesthesia and did not employ the same nonconsensual practices. Therefore, Kapsalis is highlighting the gendered and raced implications of situating the female pelvis "as a model receptacle for medical intervention."[88] Her analysis helps me to consider that the history of gynecology in the U.S. is so deeply entangled with narratives of racism, misogyny, and exploitation, that some practices we see today, like nonconsensual pelvic exams, are, horribly, perhaps not so surprising. Almost two centuries after the events Kapsalis described, I interviewed medical students who described a culture in which it is often not permissible to raise concerns about a potential nonconsensual pelvic exam. This leads me to ask: Which bodies are normalized as bodies not in need of consent?

3.2 "She Should Have Asked Him When I Wasn't in the Room."

These power hierarchies at play regarding the relationship between medical students and attending physicians and/or residents implies, in my opinion, that true consent for a pelvic exam may not be so easily solved through merely ticking a "yes" box on a form. This is because some of my interviewees described their own feelings of discomfort regarding doing a pelvic exam, along with not always being sure if the consent coming from their patients was legitimate. For example, another interviewee, Becket, who went to Boston University as well, described how, in his surgery rotation, he was brought into a room and told to take a patient's nasogastric tube out. Becket described, "We didn't ask him if it was okay. I mean, I guess we asked him if it was okay that I did it, but I was in the room with the resident, so like, she (the resident) should have asked him when I wasn't in the room."

Admittedly, this example is not about the OBGYN clerkship or about a pelvic exam, but it highlights an example in which consent was technically given for Becket's involvement in the eyes of

[88] Kapsalis, "Mastering the Female Pelvis: Race and the Tools of Reproduction," 47.

BU, but nevertheless Becket did not necessarily feel like the consent was valid. The interviewee seemed to imply that his presence in the room might have made the patient feel pressured to say yes at that moment. Another interviewee, Haley, who went to Hofstra, similarly described a few scenarios in which a patient was asked for their consent while Haley was in the operating room with them. Haley said, "If I was looking at a student, and being asked, 'Oh, can she participate in your care?' I'd have a harder time saying no." She also admitted that patients are often anxious before a medical procedure, and that this can influence their decision to consent to a pelvic exam as well. What does a patient saying "yes" to a pelvic exam by a medical student mean, when these complicated factors are put into play?

In a similar vein, Alix Masters describes how, when it comes to nonconsensual pelvic exams, focusing on bodily autonomy as the focal point of consent ignores the backdrop of wider relations of power intrinsic to medical institutions.[89] She argues that, if the aim is to make patients feel comfortable before or during a practice pelvic exam, then focusing only on patient autonomy hides the power dynamics that are systemically at play in medical institutions.[90] In the eyes of the medical institutions my interviewees described, the bodily autonomy of the patient is secured through either the signing of a form, or through a verbal "yes." However, Becket and Haley's stories, as well as Masters' analysis, complicates this idea of consent for a pelvic exam being obtained through the patient saying that it is okay. This "solution" does not factor in how medical hierarchies might contribute to whether a patient decides to say "yes" or "no" at a given moment.

Complementing Masters, Foucault also wrote on the complex and multiple character of power, and how power operates not just as domination, but also works productively to make people into the right kind of subjects, so they are constantly questioning themselves if they are the "right"

[89] Masters, "Feminist Theory Reveals a Need for Justice over Autonomy in Research Ethics," 1-6.
[90] Ibid., 4.

kind of person.[91] Within this understanding of power, physically or verbally forcing someone to conduct or to receive a pelvic exam becomes not the only way in which power is exercised in the U.S. operating room. It also operates in that perhaps patients feel like they should give a certain answer at a specific moment to make the entire process run more smoothly. Helpfully for my analysis, both Becket and Haley provided real-world, concrete examples of why perhaps a "yes" from a patient does not always mean that hierarchical power has been taken out of the equation.

With these examples from the interviewees I am also arguing that a "yes" that consents to a practice pelvic exam by a medical student becomes part of a kind of technology of standardization that is very prevalent in medical spaces. This also ties into my earlier discussion of normalization. For example, Kelly Underman describes how the affective and empathetic relationship intrinsic to a medical student successfully practicing a pelvic exam on a patient cannot be translated into standardized forms. Instead, she writes that from the perspective of the medical institution, "Empathy in the pelvic exam has to become an object that a GTA[92] can mark 'Well Done' or 'Needs Improvement' in a regular fashion across all students."[93] Underman refers to this as one of the technologies of medical institutions. Although, in contrast to Underman's analysis, the interviewees I have cited in this chapter did not mention having GTAs at their institution, I am interested in the ways in which consent and patient autonomy become standardized checkmarks on a form that is filed away. The idea of consent becoming a checkmark on a form does, in my view, relate to the subtle yet effective way in which power operates in medical spaces to maintain the status quo.

In the scenarios I mapped out earlier in this chapter, the medical students were the ones who felt like they would not voice a concern if they had one. In Becket and Haley's case, they described

[91] Michel Foucault, *The History of Sexuality: Vol. I, an Introduction* (New York: Pantheon, 1978), 3-91, 135-159.
[92] A Gynecological Teaching Associate, or GTA, is someone who is trained specifically to teach breast and pelvic examinations to medical students using their own bodies.
[93] Underman, *Feeling Medicine,* 80.

situations in which they were not sure if the consent provided by the patient was legitimate. Clearly, in this case I do not have the perspective of how the patients felt themselves, which makes the testimony from the medical students second-hand. However, the stories shared by the interviewees reveals an environment in which medical students certainly, and patients probably, feel like they cannot share how they really feel about either doing a pelvic exam, or having a pelvic exam done to them.

3.3 "I'm Just Acting as a Very Advanced Robot."

A final example of the hierarchy in OBGYN training spaces I would like to discuss is the idea that consent, according to several of my interviewees, was usually defined by the higher-ranking physician, and not by the patient or the medical student. For example, I spoke with one current fourth-year medical student at Columbia University in New York, Madeline, who noted to me that she specifically wanted to go into OBGYN as a specialty after she finished medical school, because she wanted to be part of creating a positive experience for patients when it came to their medical care. However, during Madeline's OBGYN rotation, she felt like she only discussed consent with the current resident or attending if they wanted to talk about it. She described, "I would say it (consent) would be discussed only if it kind of came from the top down." Additionally, she felt like "the people having the conversation are already the ones who are kind of trying to do the right thing." According to Madeline, whether a resident or attending cared about getting informed consent for a pelvic exam really varied, and there was not a strong systemic push to make sure that patients were really giving consent for training pelvic exams by medical students.

It is important to link Madeline's example with my earlier analysis of bestowing ultimate authority on the higher-ranking physicians in the operating room. Earlier in this chapter, I discussed how physicians have the power to position OBGYN patients as not in need of consent. This is done

by creating an atmosphere in which the permissibility of pelvic exams on patients need not and should not be questioned. When the permissibility of pelvic exams, if they are perhaps nonconsensual, does not come into play, then there is no need to view certain patients as requiring consent. Alternatively, with Madeline's example, she describes how if residents or attendings did care about getting informed consent for a pelvic exam, they were the ones who laid out the parameters of what that consent process should look like. Therefore, the physicians, according to Madeline's testimony, are still the ones ultimately deciding what consent is, what it looks like, and when it should be required.

Another interviewee, Kelsa, is a current medical student at SUNY Upstate in Syracuse, New York. She told me that she has wanted to be a doctor since she was little, so going to medical school was a "self-fulfilling prophecy." Although she described to me that, in her OBGYN rotation, no exams were done without consent, she felt like emphasizing the importance of consent in OBGYN was a relatively recent phenomenon. When I asked her about whether discussing consent in her orientation was a response to criticism, or something that would have happened anyway, she said, "Just certainly a response. I can't imagine they were doing it, like, five years ago."

This was because, according to Kelsa, it was not in the public discourse five years ago to be raising concerns about nonconsensual medical examinations. According to Kelsa's testimony, residents and attendings at her institutions were concerned about consent in *response* to concerns raised regarding pelvic exams. For example, she mentioned a *New York Times* article that came out at the beginning of her third year as a medical student. According to Kelsa, after the article came out, nonconsensual pelvic exams were definitely discussed in her rotations and orientation. Once again, Kelsa is describing a moment where the higher-ranking physicians decide if and when consent will be addressed as an area of importance in OBGYN. The parameters of asking for consent are still under the auspice of the medical gaze, which, as Foucault describes in the *Birth of the Clinic,*

"circulates within an enclosed space in which it is controlled only by itself; in sovereign fashion, it distributes to daily experience the knowledge that it has borrowed from afar and of which it has made itself both the point of concentration and the centre of diffusion."[94] This quote highlights the phenomenon I am discussing in this chapter section: mainly, that power in medical institutions operates to craft the very idea of what "proper" pelvic exams, carried out with informed consent look like.

The last interviewee I will discuss in this chapter is Emily, who, in contrast to the other interviewees I have mentioned, is a current OBGYN resident at the University of Illinois at Chicago. It was clear from our discussion that she took questions of consent in OBGYN very seriously, and that it was a topic she had taken time to consider long before our interview. Emily also did her OBGYN rotation at Boston University, and described how, during any medical clerkship, the medical students are followers and not leaders. She said about her OBGYN rotation specifically, "I'm being supervised the whole time. I'm not making any decisions. I'm just acting as a very advanced robot who is following directions extremely carefully." This quote implies that, again, the higher-ranking physicians are the ones deciding the process during every step of the OBGYN clerkship. I do not believe this is a phenomenon unique to OBGYN training, but because consent and pelvic exams are such a big part of OBGYN, the fact that the defining of the processes of consent is coming from the top down seems deeply problematic. If medical institutions are really trying to adopt a "patient-centered" approach, it would be more fruitful to think about how patients define consent, and what would make them feel the most comfortable.

[94] Foucault, *The Birth of the Clinic,* 31.

3.4 Conclusion

The analysis I have made throughout this chapter maps out the relationship between nonconsensual pelvic exams, OBGYN hierarchies, and absolute medical authority. These relationships are crucial for my analysis, because they showcase specifically how the pelvic exam reveals the ways in which medical authority is utilized in the operating room. It is also important to note that this medical authority is not exercised arbitrarily, but, in the case of pelvic exams, specifically affects OBGYN patients. Although not incorporating a gender analysis specifically, Foucault writes, again in *The Birth of the Clinic*, "In the clinic, it was a question of a much more subtle and complex structure in which the integration of experience occurred in a gaze that was at the same time knowledge, a gaze that exists, that was master of its truth."[95] I have argued throughout this chapter that the interviewees described various scenarios in which the OBGYN operating room acted as the "master of its truth." This has the effect of, even when a patient is being consented to a pelvic exam, investing so much authority within the medical institutions themselves that they have the capital to frame the consent process and pelvic exams as they see fit.

From the testimonies of the interviewees, it does indeed seem that the medical gaze in OBGYN acts as the arbiter of what truth, knowledge, and best practices are. The medical gaze, as described by the interviewees throughout this chapter, worked to position the pelvic exam, whether nonconsensual or not, as a practice beyond doubt, criticism, and questioning. Additionally, when a medical institution did attempt to always obtain informed consent from the patients, the parameters of this consent process were still defined by the top. This brings my analysis back to the problematic nature of culturally and geographically specific knowledge positioning itself as universally permissible, and this appears to be what is happening when practices of obtaining consent in the operating room are defined by a small and elite group of physicians. The contemporary use of

[95] Foucault, *The Birth of the Clinic*, 81.

practice pelvic exams by medical students in the U.S. is largely considered to be permissible. However, the example of nonconsensual pelvic showcases what is lost, and who is exploited, when certain practices are taken for granted and viewed as transcending questions of permissibility or consent.

Chapter 4: Hedging Around Questions of Consent in the OBGYN Rotation

In the previous chapter, I analyzed the hierarchy at play in OBGYN training rotations, to emphasize how the culture of OBGYN can normalize nonconsensual pelvic exams taking place, through placing them in a context in which they cannot be questioned or critiqued. In this chapter, I will further my discussion of normalizing nonconsensual pelvic exams by examining the ways in which my interviewees generally claimed their institutions were not doing any pelvic exams without getting informed consent for the procedure. However, these claims appeared to often clash with what the same students described as actually happening when it came to conducting a pelvic exam for training purposes. Therefore, what I will outline in this chapter is several instances in which there appeared to be a dissonance between what the students' said was their institution's official policy regarding informed consent and pelvic exams, and what actually happened in the operating room.

This chapter fits into my larger argument about how nonconsensual pelvic exams represent the subtle ways in which power operates in medical spaces to frame certain practices as part of normal, standardized procedure. Throughout this chapter, I will discuss the ways in which the medical students often framed their institutions as employing best practices and doing the "right" thing. However, in my analysis, this framing of medical institutions as always ticking the boxes of informed consent when it came to pelvic exams had the effect of sometimes allowing nonconsensual pelvic exams to happen, as opposed to making them less likely to occur. What I will keep drawing my analysis back to is the idea that power operates subtly in U.S. medical institutions to pull pelvic exams into our contemporary and post "Me Too" idea of bodily autonomy, while not really changing, and in fact reinforcing, the structures of power that allow U.S. medical institutions to operate as they currently are.

4.1 "We Weren't Doing Anything Without Consent."

Kelsa is a current medical student at the State University of New York (SUNY) Upstate Medical University. As I mentioned in the previous chapter, she told me that she knew she wanted to be a doctor since she was little. She even described her journey to medical school as a "self-fulfilling prophecy," because she was always interested in involvement in the medical field, and she took a lot of science courses growing up. When Kelsa and I got to talking about nonconsensual pelvic exams, she explained that they did not happen at her institution. For Kelsa, a pelvic exam on a non-consenting patient under anesthesia was a relic from a time long past. (Kelly Underman describes a similar sentiment in her book on teaching the pelvic exam: "In my interviews, medical students, medical faculty, and GTAs all contrasted the contemporary moment of valuing patient empowerment with a historical past that did not."[96]) Kelsa explained that at SUNY Upstate, "We definitely spoke about just, like, it being a thing of the past . . . Obviously, we had to talk to all of our patients before surgery. We had to meet them. We weren't doing anything without consent."

She also told me that she knows for a fact she did not practice any pelvic exams under anesthesia, which, according to current literature on the topic, is generally when a nonconsensual pelvic exam occurs.[97] However, later in the interview Kelsa told me that she sometimes felt like patients were nudged towards allowing her to conduct a pelvic exam for training purposes on them. She described, "I wouldn't say they were *coerced*, but maybe they were, like, a little . . . Definitely nudged toward allowing me to do it." Although Kelsa stated earlier, with certainty, that they were not doing pelvic exams without consent at her institution, here is an example where consent for a pelvic exam, at the very least, becomes a little murkier.

[96] Underman, *Feeling Medicine,* 179.

[97] Wilson, "Autonomy Suspended: Using Female Patients to Teach Intimate Exams Without Their Knowledge or Consent," 240-263.

Another student, Simon, also described how nonconsensual pelvic exams were not something that would happen at his current institution, Dartmouth College in New Hampshire. Like Kelsa, Simon told me that be became interested in a career in medicine from a very young age. He had a younger brother who battled leukemia, and Simon was a respiratory therapist in the United States Army before he went to medical school. Throughout the interview with Simon, it was clear that he was thinking carefully about questions of consent regarding pelvic exams. For him, at Dartmouth they didn't have to constantly discuss the possibility of a pelvic exam happening non-consensually, because it was not going to happen. Simon said, "I think we weren't necessarily specifically educated on the concept of, 'Hey, nonconsensual pelvic exams happen.' I think it was more of the approach of like, 'That's never going to happen, and here's why.'" Like Kelsa, Simon did thought nonconsensual pelvic exams were not happening at his institution, because it was not in the realm of the possibility, with all the formal consent procedures in place. He also described to me that Dartmouth was "unabashedly liberal," which he connected to Dartmouth being adamant about not practicing nonconsensual pelvic exams.

However, towards the end of the interview, it became clear that Simon was thinking about the impossibility of conducting a nonconsensual pelvic exam on a *conscious* patient. I explained to him that nonconsensual pelvic exams generally happen on anesthetized patients, and then he had a very different narrative to share with me. He said,

> I've, I've definitely, you know, experienced things like that. I mean, you know, where I'm performing a pelvic exam on a patient who's under anesthesia, who I've met, I've met the patient beforehand, and, they knew I was gonna be in the room. They signed consent forms. I don't know what was said on that form, and I certainly didn't say to the patient, 'I may perform a pelvic exam on you while you're under anesthesia.'

For Simon, there was a clear difference between conducting a pelvic exam on a patient who is verbally telling you not to, and conducting a pelvic exam on a patient under anesthesia where the state of their consent is unclear. He explained, "I for sure though never said, 'I'm gonna perform a pelvic exam on you,' in the same way I would with a patient who is conscious."

Simon further shared with me that, in his opinion, the general attitude at Dartmouth regarding pelvic exams under anesthesia with unclear proof of consent is that "it's not a big deal." At the very end of the interview he said, "I'll tell you that the current climate is that, you know . . . go do a pelvic." This sentiment seemed to stand in stark contrast to what Simon told me earlier about Dartmouth's policy regarding consent for pelvic exams. In the same interview, Simon told me both that nonconsensual pelvic exams could not happen at his institution, and also that he conducted pelvic exams on patients under anesthesia who may have not been told they would be subjected to a pelvic exam by a medical student for training purposes. How can we reconcile these two extremely very different narratives?

As I stated in the introduction, the answer to this question relates to the subtle ways in which power operates in medical spaces to always position itself as "the right kind of institution doing the right thing." Similarly to how in the first chapter I outlined how nonconsensual pelvic exams occur in spaces where they can often not be questioned, in this chapter they occur because they are happening in spaces where they are, by official doctrine, not going to happen. Kelly Underman describes this phenomenon when she writes, "Medical students are taught one thing in their formal curriculum and another thing by their attendings in the clinic, a space in which medical hierarchies dominate."[98] This quote relates to Simon's experience, in which his description of Dartmouth's official policy on obtaining informed consent contrasted sharply with an operating

[98] Underman, *Feeling Medicine,* 140.

room culture in which the norm is to "you know, go do a pelvic."

Additionally, as I already noted, Simon was someone who appeared to be thinking thoughtfully about the harm that the medical profession can do to patients when consent is not obtained. However, from my perspective it appeared he had not thought about this harm when it came to an anesthetized patient. Simon's experience also relates to the idea of the "hidden curriculum" as described by Sally Mahood, who writes that often what is implicitly taught in the day to day of medical education is more influential for medical students than the explicit teaching they receive prior to their hands-on training.[99] It is also useful to think about how the norms at play in medical spaces delineate what is considered to be possible. Foucault writes on this phenomenon in *The Birth of the Clinic,* when he describes how cadavers, though historically considered taboo and heretical to dissect, became a site for crafting narratives of medical knowledge through dissection and experimentation.[100] With this example we can see how something that is normalized frames the way certain bodies are thought about in medical spaces by students, attendings, and residents.

Another medical student, Kiera, told me a narrative that contrasted with Simon's. Kiera is currently in her final rotation at the University of Chicago in Illinois. She went into the medical profession when she realized, as a doctor, she could affect patient outcomes, as opposed to working in a lab where it can be more difficult to see the results of your labor. Kiera was the first medical student who told me they learned how to conduct a pelvic exam on "patient educators"[101] who volunteered to come in every year to help the students practice. It was only after this training session with volunteers that Kiera was permitted to practice pelvic exams on conscious patients, and then on patients under anesthesia. Kiera told me that if a patient was under anesthesia, the consent form specifically asked the patient if they would allow a medical student to conduct a pelvic exam on

[99] Mahood, "Medical education: Beware the hidden curriculum," 983.
[100] Foucault, *The Birth of the Clinic,* 166.
[101] This can also be referred to as gynecological teaching associate, or GTA.

them while they were asleep.

Kiera appeared to have a very good understanding of what the consent process for pelvic exams looked like at her institution. I got the impression from her that consent for pelvic exams was not merely assumed, but something that was actively encouraged. When I asked her if nonconsensual pelvic exams were discussed at her institution she said, "Yeah, definitely. I feel like it's something I thought about a lot, and it was talked about a lot . . . it was definitely a topic that came up many times." This answer was in contrast to what Kelsa and Simon told me about nonconsensual pelvic exams not necessarily being an active point of concern at their institutions, because they were not happening. However, interestingly, Kiera was one of only two medical students who mentioned using GTAs to me, as well as one of the interviewees who seemed the most sure that pelvic exams specifically under anesthesia by a medical student were explicitly stated in the consent form.

With these three student examples, it appears that the institution that talked the most about nonconsensual pelvic exams as a current point of concern is the institution where consent processes were thought about more critically. At the institutions where nonconsensual pelvic exams were framed as not going to happen, there was perhaps less critical reflection from the medical students on whether or not they happened in reality at the institutions. According to my interlocutors, all three medical schools cared about obtaining informed consent for pelvic exams. However, it seems that where the consent process was the most thorough, nonconsensual pelvic exams were discussed more as something in the realm of possibility.

In relation to my argument regarding how nonconsensual pelvic exams reflect subtle structures of medical power, what I see happening in these narratives is that when nonconsensual pelvic exams are described as something that is simply not going to happen, they work to deny their own existence. In other words, if nonconsensual pelvic exams are not a going to happen at this

institution, then why should physicians worry about them? In this line of thinking I am again influenced by Kelly Underman, who writes specifically on the topic of patient empowerment when it comes to teaching pelvic exams.[102] Much of the discourse on nonconsensual pelvic exams is related to patient autonomy and empowerment,[103] and virtually all my interviewees told me that nonconsensual pelvic exams should not happen because they are a violation of patient autonomy. Therefore, patient empowerment is a crucial narrative that comes up often when critiquing nonconsensual pelvic exams. I would argue that during my interviews it was the most prevailing theoretical framework for why medical institutions denounce nonconsensual pelvic exams as a violation of patient rights.

On patient empowerment, Underman writes, "The prevalence of patient empowerment in medical education should not be taken as evidence that the profession or, indeed, healthcare systems on the whole have reorganized around the patient."[104] For Underman, she understands patient empowerment as a technology deployed by physicians to uphold society's more contemporary ideas of patient autonomy, while still achieving the physician's goal. Underman describes how it is easier to conduct a pelvic exam on a relaxed patient, so it actually works to the physician's benefit to have the patient feeling relaxed, respected, and empowered.[105] A patient put at ease is a more "ideal" patient than one who is tense and uncomfortable. Underman writes, "In this way, the patient empowerment values of connecting with the patient, listening to the patient, and being more empathetic allows physicians greater access to the 'truth' of the disease."[106]

When referencing the "truth" of the disease, Underman also cites Foucault, whose theories

[102] Underman, *Feeling Medicine*, 174.
[103] See Phoebe Friesen (2018) and Kimberly Liu et al. (2010).
[104] Underman, *Feeling Medicine*, 174.
[105] Ibid., 187.
[106] Ibid.

she is clearly influenced by. In *The Birth of the Clinic,* Foucault discusses how the clinic was a place where physicians could deploy the medical gaze to get at the "truth" of disease. This had the political effect of leading to an objectification of the patient, as their body was completely on display, to be surveyed by physicians trying to find the knowledge, or truth, of their affliction.[107] Foucault writes, "The necessity of the truth that communicated itself to the gaze was to define its own institutional and scientific structures." With this quote, Foucault is describing how the "truth" that the clinic was crafting was a reflection of its own gaze upon the ailing patient, as opposed to the gaze witnessing an a priori state of disease that already existed within the patient.

Though writing more than 50 years later, Underman, with her analysis of patient empowerment, is also describing how medical institutions continue to position patients in such a way so they can accomplish their goals as a physician to uncover the "truth" of the disease.[108] Within the historical context Foucault was writing in, there did not exist the tenets of patient autonomy that we often take for granted today. However, Underman describes how, even within medical institutions today that espouse patient empowerment as one of their main tenets, this is perhaps more of an cooptation of feminist ideology than a structural reevaluation of how patients should be treated.[109] For Underman, feminists advocating for more feminist models of care[110] were crucial in making practice pelvic exams more comfortable for patients. However, she also writes how "Feminists were able to bring their political practices into the medical school so long as they followed the rules of the game. When they attempted to challenge basic tenets of medical power, they were unsuccessful."[111] I view something very similar happening right now with pelvic exams,

[107] Foucault, *The Birth of the Clinic*, 69.
[108] Pelvic exams are normally conducted to screen for cervical cancer with a pap smear.
[109] Underman, *Feeling Medicine,* 26.
[110] One example of this is The Women's Community Health Center, which emerged as part of the women's health movement in the 1970s.
[111] Underman, *Feeling Medicine, 36*.

where consent is formally obtained without really examining the hierarchical structures that allow such exams to exist in the first place.

Underman is very useful for me in thinking about how medical narratives in favor of patient empowerment, patient autonomy, and informed consent, not only do not necessarily mean these values are being deployed, but even work to continue "business as usual" in teaching hospitals. From the interview I conducted with Simon especially, it appeared that because he was convinced his institution was employing the correct practices in terms of obtaining informed consent, he did not consider the importance of consent in the same way when it came to a pelvic exam on an anesthetized patient. In this way, the value of respecting patient autonomy worked insidiously to leave some other practices unexamined.

Again, it is important to note that Simon, Kelsa, and Kiera all took these issues very seriously. They all spoke thoughtfully with me about how consent for a pelvic exam was extremely important to make patients feel respected and taken care of. However, it seems to me that the amount of critical reflection from the students shifted depending on the messaging from the medical institution of whether or not a nonconsensual pelvic exam is something that could possibly happen. Much as Underman described patient empowerment as a medical technology used to continue the physician's ultimate goal, I view the narrative of "Oh, this won't happen here" as a technology that could allow patients to be subjected to nonconsensual pelvic exams. On medical technologies, Foucault also writes how they are deeply related with political ideologies that "alter the specific laws governing disease," which harkens back to the idea that medical institutions are deeply ideological spaces masquerading as neutral and supremely modern.[112] Additionally, the idea that medical institutions have moved past conducting nonconsensual pelvic exams is entwined with the argument I made in the previous chapter about standardization and normalization. However, in this chapter

[112] Foucault, *The Birth of the Clinic,* 38.

the standardization worked to position the practice of nonconsensual pelvic exams as beyond the realm of possibility.

4.2 "It Was Built into the Consent Forms of Surgery."

In this section I will further my discussion by analyzing interviewees who told me they were not exactly sure what was stated on their patient's consent forms in OBGYN. Similarly to my first section, these testimonies will highlight how interviewees telling me they always obtained formal consent via paperwork from patients contrasted with not knowing exactly what was stated on the consent forms. Consent forms in this section worked to, again, make it seem as if medical institutions were employing best practices, but at the same time the specific parameters of those forms were left unexamined. In my analysis, the signing of a form, or the ticking of a box, has the effect of making a practice pelvic exam officially consensual, while also denying the existence of potential nonconsensual pelvic exams, because said exams officially don't exist when all the formal consent procedures have been followed.[113]

Allison is a current fourth-year medical student at the Donald and Barbara Zucker School of Medicine at Hofstra in Long Island, New York. Allison did tell me she believes she conducted pelvic exams on patients under anesthesia without their formal consent, and she was unsure what was stated on the patient's consent forms when they were admitted to the hospital. She told me, "I don't know if our . . . consent forms anywhere, say that like, 'Oh, we're a teaching hospital and therefore students will be involved,' or anything like that. Um, yeah, I don't know about that." What was striking to me was the way in which Allison told me that she conducted nonconsensual pelvic exams, and also that consent forms were involved in the process. However, she told me she didn't

[113] With this section, I am also not implying that it is a medical student's responsibility to know exactly what is said on their institution's consent forms. Rather, I view the murkiness of the forms as a medical technology that works to normalize practice pelvic exams when the state of consent is unclear.

know what was on the form, so whether the consent forms mentioned a pelvic exam under anesthesia by a medical student was left unclear.

Another medical student, Elli, told me about her experience with consent forms regarding pelvic exams. Elli is currently a third-year medical student at a school in the Mid-Atlantic region of the U.S.,[114] and she described how her desire to talk with people and patients led her to a career in medicine. She told me she loved helping people, and she always loved science, and medicine was the perfect combination of both these interests. Like Simon, she described to me how her institution positioned consent as something that absolutely must be obtained. She also described how she doesn't think she heard the term nonconsensual pelvic exam specifically at her school, but they did talk about getting consent for pelvic exams. She said, "I wouldn't say that we, we don't really talk about it in the other, like, the other context of like, 'If you don't get consent,' it's kind of like we learn it as, 'You must get consent. There is no alternative.'" She also told me that the process of consenting patients felt deeply ingrained in the system of her medical institution. Finally, she confirmed that, "It would be actually impossible for it (a nonconsensual pelvic exam) to happen today."

Elli also told me that most of the time, she practiced a pelvic exam on conscious patients, but that she sometimes conducted pelvic exams on anesthetized patients. When I asked her about this process, again her answer seemed to shift from what she said earlier about the impossibility of not obtaining consent, but in this case, she discussed the consent forms specifically. I asked her, if a patient was under anesthesia, if there was a consent process prior to the surgery. She replied, "Yeah. It's like on the, on the, um, consent form, which I have not read in its entirety. But my

[114] Elli requested that I not include the name of her institution in my thesis.

understanding is that on the consent form, it, you know, basically states: 'This is a teaching hospital, you'll have medical students, residents . . . who will be part of the surgery and part of your care.'"

I then asked her if she knew whether pelvic exams were specifically included on the consent form, and she replied, "Um, I think it's a general form for all, like, for all surgeries. So, I don't think it says something specifically about . . . Pelvic exams. I'm not a hundred percent sure on that. Um, but it does say like that we, you know, would be sort of involved in any procedures involved in the case." It felt like Elli was not completely sure if patients were made aware that a training pelvic exam by a medical student under anesthesia is something that could happen, because she did not know if it was included on the form. Yet, at the same time, she felt very strongly that her institution was always making sure they obtained informed consent for a pelvic. Perhaps, rather like Simon, the confidence that a nonconsensual pelvic exam would not happen at her institution left the finer nuances of consent regarding pelvic exams to be taken for granted.

I was also struck by Elli describing how the patients were made aware that medical students could be involved in any procedures involved in the case. The claim that consent is obtained through a general form is based off the assumption that patients always know when a pelvic exam is to be expected. However, OBGYN patients are not always necessarily aware that, if they are undergoing surgery, a pelvic exam under anesthesia is a standard part of the operation.[115] From the medical perspective, a pelvic exam is assumed, but that does not mean the patient is assuming it will happen without being explicitly told so.

Another medical student shared with me that he was not sure whether patients knew that a medical student specifically performing a pelvic exam under anesthesia was something in the realm of possibility. Martin was the final student I interviewed, and he is currently studying at a medical

[115] Cundall, MacPhedran, and Arora, "Consent for Pelvic Examinations Under Anesthesia by Medical Students: Historical Arguments and Steps Forward," 1300.

institution in Massachusetts, but wanted the name of his school to remain anonymous. Martin told me he went into medicine because he liked the practical side of medicine much more than studying books. He also volunteered at a hospital emergency room while he was in college, and it was a formative experience for him. When it came to pelvic exams, Martin told me that although the patients were always told they would be given a pelvic exam under anesthesia, he was not sure if it was made clear to them a student could be doing that procedure for training purposes.

When I asked Martin what was on the consent form specifically, he said, "I mean, it's definitely mentioned in terms of, like, the atten[ding] in the surgery, that that (a pelvic exam) will be necessary, but it wasn't mentioned that students might be, or I'm not sure that it was mentioned that students could do it." He also told me in very clear terms towards the end of the interview: "I did perform pelvic exams under anesthesia, like, four times, and every time I introduced myself to the patient, but I would say the words, 'I'm working with Dr. So-and-So, and I'm gonna be observing the procedure.' That was it." He told me he never explicitly mentioned to the patient he would or could be conducting a pelvic exam in these scenarios. However, every patient signed a consent form and went through the process of consent with their physician prior to being put under anesthesia. Here again we can see a discrepancy between official consent procedures from medical institutions, and the "hidden curriculum" of what happens in the operating room.[116]

Research on nonconsensual pelvic exams has highlighted this harmful gap between what the physician assumes is common knowledge, and what the patient expects to happen while undergoing surgery. This is sometimes referred to as the "implied consent" argument in favor of nonconsensual pelvic exams. Hannah Cundall and her fellow authors write, "The majority of patients do not have

[116] I also emailed every interview participant to ask if they had access to the consent forms we discussed in the interview. Only a few responded to me, but those who did said they did not have access to the form.

extensive knowledge of the steps involved in gynecologic surgery."[117] Phoebe Friesen calls a similar concept "the presumed consent objection," [118] and describes how physicians defending nonconsensual pelvic exams often claim that a pelvic exam by a medical student at a teaching hospital while under anesthesia is "pretty much covered in an overall consent form."[119] This "overall consent form" is similar to what Elli described as a general consent form for surgery that patients sign. Once again, we see consent forms operating as a medical technology that ticks off what the medical institution requires for consent, but the critical patient-centered perspective is left unexamined, while at the same time considered fulfilled.

4.3 Conclusion

The idea that patients are always given the opportunity to consent through signing a form or being explicitly asked by the physician is also related to the narratives of patient autonomy and empowerment I described in the previous section. Throughout this chapter I highlighted how the narrative of "This won't happen here," as well as the use of consent forms, worked to position a nonconsensual pelvic exam as beyond the realm of possibility. However, rather than this actually being the case, I felt like the medical students who sometimes seemed the most sure about their institutions consent procedures would later tell me about a situation in which consent for a pelvic exam seemed extremely problematic or, at the very least, undefined. Therefore, the narrative of nonconsensual pelvic exams as not existing when institutions are employing standardized consent procedures often appeared to sometimes have the effect of causing them to exist, and to exist without being questioned.

[117] Cundall, MacPhedran, and Arora, "Consent for Pelvic Examinations Under Anesthesia by Medical Students: Historical Arguments and Steps Forward," 1300.
[118] Friesen, "Educational Pelvic Exams on Anesthetized Women: Why Consent Matters," 305.
[119] This comment was made by the then head of OBGYN clerkships at UCLA in 2003.

Kelly Underman, with her description of the cooptation of feminist empowerment narratives by the medical profession, allows me to consider how "empowerment" narratives in medical spaces work to position hospitals as respecting patient autonomy, while at the same time continuing business as usual. This is an extremely insidious form of power that allows medical institutions to place nonconsensual pelvic exams in a vault of the past, from a paternalistic history long gone. I even noticed that several of my interviewees mentioned nonconsensual pelvic exams as something that happened years ago, but as something that is by no means happening today.

The idea of empowerment and pelvic exams is also closely related to feminist debates around the topic of consent, which clearly is a key component of why nonconsensual pelvic exams are a "hot button" issue in the U.S. today. As I mentioned in my introduction, the "#MeToo" movement was one of the catalysts that brought attention to the continued practice of nonconsensual pelvic exams. However, one of the frameworks I am attempting to complicate in my analysis of nonconsensual pelvic exams is the model of consent in the liberal, individual sense of "I" am making this choice to say no, as if this choice exists free from the ideologies that construct it. I would argue that oftentimes current discussions of consent in the U.S. center around the individual women who feels *empowered* to say no and to make choices in her own best interests. Angela McRobbie gives an example of this kind of women as a "top girl," who can see herself as a privileged subject of social change.[120]

However, I would further argue that the idea of "choice" in and of itself cannot separate itself from structural preconditions that allow some agents to move back and forth between "yes" and "no" more easily than others. In this line of thinking I am influenced by Elspeth Probyn, who writes that the answer of "choice" to the question, "What do women want?" is a "choice freed of

[120] Angela McRobbie, "Top Girls? Young Women and Post-Feminist Symbolic Violence," in *The Aftermath of Feminism,* (Sage, 2009), 54-93.

the necessity of thinking about the political and social ramifications of the act of choosing."[121] In this way, I am positioning a more liberal notion of individualized consent against a more feminist analysis of the power structures that have allowed nonconsensual situations to exist in the first place. It is these complicated and intersectional dynamics of saying "no" when it comes to a practice pelvic exam specifically that I will explore in the next chapter.

[121] Elspeth Probyn, "New Traditionalism and Postfeminism: TV Does the Home," in *Feminist Television Criticism: A Reader,* eds. Charlotte Brunsdon et al. (Clarendon Press, 1997), 156.

Chapter 5: The Intersectional Implications of Nonconsensual Pelvic Exams

This chapter will examine the intersectional implications of the *kinds* of patients who were more likely to be submitted to a nonconsensual pelvic exam, according to my interviewees. This chapter aims to highlight that nonconsensual pelvic exams do not exist in a vacuum, but serve to highlight gendered, classed, and raced discourses about which kinds of bodies are viewed as bodies not in need of consent. Based on what my interviewees shared with me, this chapter will also analyze the implications of teaching hospitals favoring patients who have high health literacy and the knowledge that they can, or in some cases have to, advocate for themselves in medical spaces. As I discussed in my theoretical framework, I view intersectionality here as an analytical tool to highlight how patients living at the cross-sections of various power relations find themselves unfavorable targeted by hegemonic institutions.[122] This chapter therefore aims to highlight the real lived consequences of nonconsensual pelvic exams. As Yvette Taylor writes, using intersectionality theory can describe "a lived experience that can be empirically researched and understood, where lives are more than a descriptive list."[123]

My analysis of what kinds of gendered, raced, and classed hierarchies nonconsensual pelvic exams reproduce is positioned against a wider backdrop of U.S. medicine that has historically used already marginalized bodies for experimental purposes. Examples include the Tuskegee Syphilis Study, Marion J. Sims' experiments on enslaved black women, forced sterilization campaigns, eugenic campaigns, and the nonconsensual use of Henrietta Lacks cells for cancer research.[124] I view nonconsensual pelvic exams as a further example of this kind of unethical experimentation, in so far as nonconsensual pelvic exams are carried out in the name of the future of the medical profession,

[122] See Kimberlé Crenshaw (1989), Patricia Hill Collins (2014), and Kathy Davis (2008).
[123] Yvette Taylor, "Complexities and Complications: Intersections of Class and Sexuality," in *Theorizing Intersectionality and Sexuality*, eds. Yvette Taylor, Sally Hines, and Mark E. Casey (Houndsmills: Palgrave Macmillan, 2011), 52.
[124] See Susan M. Reverby (2009), Terri Kapsalis (1997), Gisela Bock (1983), and Rebekka Skloot (2010).

at the expense of the patients. Therefore, I argue that in 2023 we can see this same historical rhetoric still being carried out: mainly, that some nonconsensual processes on certain bodies are normal and necessary in the name of moving science and the medical profession forward. Examining the ways in which some patients, but not all, are submitted to nonconsensual pelvic exams, allows me to foreground these gendered, raced, and classed discourses.

5.1 "One of the Harder Things to Swallow as a Student."

In the interviews I conducted with medical students, I asked them if they knew whether they were mainly treating private (on private insurance) patients, or public (on Medicare or Medicaid) patients. Although not every interviewee knew specifically whether their patients were public or private, they did generally know the demographics of the patient population they were serving. Emily, who went to medical school at Boston University from 2018 to 2022, went into medicine because she wanted to have the training to take care of the people around her. Regarding the patient population she served at Boston Medical Center,[125] she told me: "Since it's the only safety net hospital[126] in Boston, [it] tends to draw from more, like, lower resource . . . human population. So, a lot of people of color . . . unfortunately, because they're overrepresented in the underprivileged community."

Although Emily was talking more broadly about the patient population she served at BMC, other interviewees had more specific ideas of whether they were mainly encountering public or private patients. Allison, a fourth-year medical student at Hofstra in Long Island, New York, described to me how service patients were the patients who had residents taking care of them, instead of private doctors. She told me, "Those were the patients that they told me that I could go

[125] BMC is the medical center affiliated with BU.

[126] In the U.S., a safety net hospital is a medical center that provides healthcare to patients, regardless of their insurance status or ability to pay.

into and deliver and stuff like that. Because those were the resident patients, or, like, public patients versus patients who were, um, private attending's patients. And those [private patients] tended to be waspier."[127] She also told me that service patients had lower socioeconomic status in general.

Another current medical student at Hofstra, Haley, described to me an uncomfortable awareness that she was mostly treating public patients during her time in medical school. She described to me:

> So, there are some patients who are just private patients and they often refuse medical students. And then there are patients who do not have private doctors and they come to the hospital and they get bombarded with teaching physicians and students, or learning physicians and students. Um, and that kinda sucks because those patients are often patients of color, patients without insurance, patients, like, without established care. Um, patients of lower socioeconomic status. And that's, I mean, that's definitely been one of the harder things to swallow as a student is, how do I rectify this, like, uncomfortable feeling of, I'm doing most of my learning on . . . People who are probably disadvantaged in some way, compared to other patients. Not that that's a hundred percent of the time, but certainly a majority of the time.

Haley vocalized in this quote the disturbing fact that at her institution more vulnerable patients were submitted to medical students for learning purposes. Crucially, medical students conduct nonconsensual pelvic exams on OBGYN patients for learning purposes. Privileged patients who have the ability and structural agency to go to their own private physician may never be subjected to the nonconsensual practice of a medical institution.

[127] WASP is an acronym for White Anglo-Saxon Protestant.

Like Haley, Elli, a third-year medical student, also described working mostly with public patients. She described how her teaching hospital was public and federally funded, which meant that they received many patients on Medicare or Medicaid as well as uninsured or underinsured patients. She told me that this was not just part of OBGYN, but was a practice in every ward of the hospital. Simon, a current third-year medical student at Dartmouth in New Hampshire, said to me, "I think, yeah, I probably did see a higher proportion of public patients than I would have if I was not a medical student." Kelsa, a current student at SUNY Upstate in New York, told me that her institution has certain clinics that are around 95% Medicaid patients. Finally, Kiera, a third-year student at UChicago, described how, due to the university's location in the city, the vast majority of their patients are black, on Medicaid, or Medicare.

All of these examples serve to highlight the intersectional implications of nonconsensual pelvic exams, and how nonconsensual pelvic exams produce and reproduce certain notions about who is granted consent, and who is not. There are scholars who have written about this phenomenon in relation to nonconsensual pelvic exams as well. For example, Robin Fretwell Wilson describes how "Teaching hospitals have long been the refuge of last resort for poor and uninsured patients."[128] For Wilson, this is a problem because disadvantaged populations are being practiced on in ways that will benefit society as a whole. Therefore, the wealthier patients will be able to reap the benefits of medical students leaning to conduct pelvic exams, without having to be part of the experimentation.

Wilson's observation is not necessarily a new concept, as in the *Birth of the Clinic* Foucault also describes the relationship between class status and the clinic. He outlines the post French revolution setting in which a poor patient, seeking assistance at a clinic, would find themselves to be

[128] Wilson, "Autonomy Suspended: Using Female Patients to Teach Intimate Exams Without Their Knowledge or Consent," 248.

the object of the medical gaze, and what was deciphered through them would be contributing to the more advanced knowledge of others.[129] The idea of experimentation on poor patients for the "greater good" of medical knowledge is an argument strikingly similar to arguments made in favor of nonconsensual pelvic exams today.[130] Foucault also highlighted this same conflict when he wrote, "The most important moral problem raised by the idea of the clinic was the following: by what right can one transform into an object of clinical observation a patient whose poverty has compelled him to seek assistance at the hospital?"[131]

Wilson and Foucault both provide examples of poor, uninsured, or underinsured patients being the patients more likely to be submitted to practice examinations by medical students. However, what I am also interested in is analyzing the kinds of discourses that reproduce nonconsensual pelvic exams on disadvantaged patients. In the previous chapters, I discussed how nonconsensual pelvic exams come about through processes of normalization that both make the position of the nonconsensual pelvic exam as beyond the realm of possibility, while allowing it to happen. Here, I am arguing that there is something about the bodies of those patients submitted to nonconsensual pelvic exams that make them more likely to be subjected to said exams, as well as allowing the practice to not be as questioned as it might be if practiced on more privileged bodies.

There are clear gendered implications of nonconsensual pelvic exams, as pelvic exams are generally conducted on patients with a uterus, vagina, and vulva. However, with the added dimension of class that comes into play, there are also racialized dimensions to nonconsensual pelvic exams. The history of OBGYN in the U.S. is connected to extremely disturbing gendered and racialized discourses. As I mentioned in the introduction and theoretical framework, the "father" of

[129] Foucault, *The Birth of the Clinic*, 83.
[130] See Phoebe Friesen (2018) and Shawn Barnes (2012).
[131] Foucault, *The Birth of the Clinic,* 83.

modern gynecology in the U.S., J. Marion Sims, developed many of his gynecological advancements by experimenting on non-consenting, enslaved black women in the 19th century.[132] Terri Kapsalis writes on this history in depth. What is crucial in her argument is the idea that it was *because* these women's bodies were black, poor, and female, that Sims considered them to be fit for his inhumane experimentation. Kapsalis describes how Sims viewed enslaved black women "as inherently more durable than white women."[133] This belief is still, disturbingly, echoed in our world of modern medicine, with studies showing that some physicians and medical students believe black patients to be more impervious to pain than their white counterparts.[134]

The gendered implications of nonconsensual pelvic exams is best captured by Kapsalis' argument, where we can see how "the passive, powerless female pelvis is thus situated as a model receptacle for medical intervention.[135] In her book on the colonial encounter in Morocco, Ellen Amster also describes how French colonialists purposefully utilized the Moroccan and Muslim women's body to further western scientific discourses that justified colonization.[136] They did this by framing traditional Moroccan birthing practices as backwards, irrational, and unhygienic, while positioning the French colonists' idea of giving birth on a hospital table in full view of the physician as the modern, rational, and responsible way to give birth. Amster argues that in this way the Moroccan women's body was unveiled, and her "sex organs are visibly presented to the obstetrical surgeon for his intervention."[137] Amster's narrative is also related to Foucault's argument in the *Birth of the Clinic,* because in his telling the patient was brought into the "light" to be subjected to the

[132] Kapsalis, "Mastering the Female Pelvis: Race and the Tools of Reproduction," 31.
[133] Ibid., 40.
[134] Olga Bougie, Jenna Healey, and Sukhbir S. Singh, "Behind the times: revisiting endometriosis and race," *American Journal of Obstetrics and Gynecology* 35, no. 1 (July 2019): 36.
[135] Kapsalis, "Mastering the Female Pelvis: Race and the Tools of Reproduction," 47.
[136] Amster, "A Midwife to Modernity: The Biopolitics of Colonial Welfare and Birthing a Scientific Moroccan Nation," 186.
[137] Ibid., 192.

medical gaze.[138] Of course, the discussion of the link between coloniality and modernity/rationalism is also entwined with Quijano's argument that modernity was always colonial from its point of departure.[139] Thus, with both Kapsalis' and Amster's historical examples, we can see how the female pelvis has long been utilized to justify exploitative and colonial medical practices, utilized in the name of scientific progress.

In line with Amster's argument, I am also linking my argument to the history of European colonization in the Americas and nonconsensual pelvic exams. In "The Coloniality of Power," Aníbal Quijano describes how, when western Europeans colonized the Americas, they viewed the indigenous and enslaved bodies they encountered there as bodies closer to nature, and thus perfect subjects for experimentation.[140] It was through this racialized discourse of othering that Europeans came to view indigenous and enslaved people as sources of knowledge, and it was the "mission" of the colonizers to extricate that knowledge for their own advancement from those they viewed as inferior to them.

Although contemporary nonconsensual pelvic exams may seem very distant from violent colonial history in the Americas, I view nonconsensual pelvic exams as sites for similar discourses of neocolonization that position certain bodies as more viable for experimentation, or practice examinations, than others. It is through the linking of nonconsensual pelvic exams with a violent and racist history of gynecology and coloniality that we can see what is really at stake when OBGYN patients are viewed as bodies not in need of consent. Additionally, I view nonconsensual pelvic exams as closely tied up with narratives of coloniality when it comes to processes of normalization and standardization. Ramón Grosfoguel describes how, when the Americas were colonized, western

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[138] Foucault, *The Birth of the Clinic,* 195.
[139] Grosfoguel, "Decolonizing Post-Colonial Studies and Paradigms of Political Economy: Transmodernity, Decolonial Thinking, and Global Coloniality."
[140] Quijano, "The Coloniality of Power, Eurocentrism and Latin America," 555.

Europe established their culturally and geographically specific knowledge as universally legitimate and applicable. At the same time, the European colonizers subaltern and indigenous ways of knowing were subjugated.[141]

Grosfoguel's analysis is crucial for my argument, in that nonconsensual pelvic exams are clearly showcasing problematic values and discourses at the heart of U.S. teaching hospitals, while the teaching hospitals at the same time position themselves as the right people doing the right thing. Thus, a very specific agenda emerges at the heart of U.S. medicine as a discourse of universal modernity that other nations, especially in the Global South, should aspire to. As we can see from the quotes I included above from my interviews, the ways in which we are used to nonconsensual experimentation on patients have not really changed, the medical institutions have simply found a way to keep furthering the same discourses of othering while keeping up with the dominant ideas of empowerment and consent.

5.2 "I Had the Privilege to Know I Could Say No."

In this section, I will discuss how teaching hospitals in the U.S. may work in favor of patients who have the agency to advocate for themselves in situations where they feel uncomfortable. In my analysis, and according to the testimonies of the interviewees, these "self-advocating" patients were more likely to be white, upper-middle class, and with a high level of health literacy. Ethan, a current internal medicine resident in Chicago, graduated from Boston University School of Medicine in 2022. In our interview, Ethan shared a powerful personal experience with me during medical school in which he was surprised to learn he was being treated for a medical problem at a teaching hospital. Ethan described that a doctor "barged" in and asked if a medical student

[141] Grosfoguel, "Decolonizing Post-Colonial Studies and Paradigms of Political Economy: Transmodernity, Decolonial Thinking, and Global Coloniality."

could do the exam. Ethan described how he felt in that moment: "I was like, wait a minute, this is a teaching hospital?" He also felt like he was being pressured by the doctor to let a medical student come in, but Ethan insisted he did not want a medical student in the room. Ethan then said, "But I had the, the privilege, or like, the background to know that I could say no to that, and I don't think everybody knows you can say no to that." For Ethan, the fact that he was a student studying medicine at a prestigious school, Boston University, allowed him to know he could refuse a medical student's involvement at that moment. A little earlier in the interview, Ethan also described to me how not all patients have the privilege of knowing they can advocate for themselves or refuse treatment in hospital settings:

> There's definitely a difference between the different types of hospitals and their environments and how much autonomy patients get in each type of hospital. And I think that mostly, um, it relates to privilege and maybe, like . . . privilege and educational background to know that these types of things happen,[142] or to know that you have to kind of advocate for yourself because the system is, is very entrenched.

From both Ethan's personal experience where he knew he could refuse a medical student coming into the room, and from his experience working as a medical student, he knew that patient self-advocacy was a privileged experience, and not something that every patient had access to. Ethan was not the only interviewee to speak on this phenomenon. Kiera, a medical student at the University of Chicago, described to me how sometimes patients would not be admitted if the physicians thought they might not come back for a follow-up appointment. She described these particular patients as "potentially younger, or on Medicaid, or didn't really come in with a support system." She added, "So I think there was a little bit of bias in who we would end up admitting to

[142] He was referring here to a nonconsensual pelvic exam.

monitor, because we didn't trust that they would, you know, come back on their own." From this quote, we can again see an example of teaching hospitals favoring patients who can advocate for themselves, which has class, gender, and race implications regarding the profession's judgment on what kinds of patients would feel comfortable doing so.

Kiera also admitted that the structures of teaching hospitals are rather complex and not something that the average person understands. When I asked her if patients at her hospital were made aware they were at a learning institution, she replied: "I don't know, I feel like most people in general knew, like, this is a teaching hospital, but sometimes I wondered if they knew what the nuances of that meant." Kiera told me that it took her going to medical school to even understand what a resident is, and that, as a patient, you might never see the overseeing doctor. Allison, the fourth-year medical student at Hofstra, also told me that it was made clear to the patients they were at a teaching hospital, but she didn't think the patients necessarily knew what that meant. As I mentioned earlier, Allison told me that at her teaching hospital, residents were working more with service patients, who tended to be, according to Allison, of a "lower socioeconomic status."

Kiera's and Allison's comments complicate the notion that telling a patient they are at a teaching hospital empowers them to understand what exactly that means, and who they will be dealing with. To provide another example, third-year medical student Elli told me that, because they receive many patients with lower socioeconomic background, the patients don't necessarily have the best understanding of the medical world. She described, "We have a lot of lower socioeconomic status patients, who don't have the best literacy and especially health literacy." It additionally appears that the institution did not make up for that lack of knowledge. To me, the lack of informing the patients means that the system would perhaps want to maintain the situation and take advantage of that ignorance.

Another medical student, Martin, who currently studies at an institution in Massachusetts, also felt like sometimes the language physicians used with patients was not exactly accessible. He shared with me, "Especially in prenatal care, and even in GYN stuff, um, I think doctors really assume most of the patients have a higher understanding of medicine than . . . they actually do." Like Kiera, he described how he only knew certain terminology because he was pursuing a career in medicine. He explained, "Some attendings will kind of briefly give a quick rundown[143], and I'm like, if I were an average person not in the medical field, I would understand 0% of that." Tellingly, he also told me, "There's some patients I can tell had very little, very little healthcare literacy, and the attending wouldn't accommodate that to the extent that I would think was appropriate, so."

All of these different comments from the interviewees serve to highlight how the possibility of saying "no" to a pelvic exam by a medical student while under anesthesia has clear dynamics of gender, race, and class relations. Knowing that you can say no often comes with the privilege of having a high level of health literacy, as well as feeling confident in a medical space that has historically mistreated patients of color, female patients, and poor patients. In the previous chapter, I discussed how in some ways patient "empowerment" can be utilized to maintain the status quo. Regarding the topic of my research, this means continuing the practice of nonconsensual pelvic exams at the expense of particular bodies, while maintaining the advantage of others within our more contemporary parameters of "respecting patient autonomy." A nonconsensual pelvic exam is more likely to happen on a patient who perhaps does not fully understand what they are being asked, and that they are permitted to say no.

For example, Kiera shared with me her own experience of patients being asked to sign a consent form at her teaching hospital in Chicago. Although she told me the consent process was

[143] He was referring here to giving a rundown to a patient.

always formally undergone, she felt like sometimes a practice pelvic exam by a medical student was not fully offered as a question. She explained,

> One other thing that I did notice sometimes about the language of our consent forms is the way they were presented. I feel like patients weren't . . . it didn't always sound like a choice, if that makes sense. Um, you know, sometimes it was like, 'Okay, after we go to the operating room and anesthesia puts you to sleep, um, the attending and the resident and the medical student are going to do a pelvic exam. Like, do you have any questions?' Or, I don't know, I guess sometimes they say, 'Oh, is that okay?' Um, I don't know. I feel like sometimes it was presented as like, 'This is what's gonna happen,' versus like, 'Is it okay if we do this?'

In this example, it appears that any patient would have a difficult time saying no, especially patients who might not be informed that they always have the right to refuse.

In *Feeling Medicine,* Kelly Underman discusses how, in the eyes of medical institutions, a "good patient" is someone who can be their own advocate.[144] Underman also draws on a Foucauldian perspective to describe how the burden of biopower has shifted to "individuals' self-surveillance and the private sector."[145] For Underman, who is also drawing on the theorist Nikolas Rose, these news ways of monitoring ourselves does not mean we are more liberated or free, but rather that we are increasingly required to make ourselves into the right kind of subject.[146] From a medical perspective, this means that patients are required to be an expert on their own health, especially when it comes to preventative care and seeking treatment at hospitals, but not when it comes to questioning the pre-prescribed wisdom on "consent."

The patients who are not, in the eyes of teaching hospitals, model patients, might not enjoy

[144] Underman, *Feeling Medicine,* 176.
[145] Ibid.
[146] Ibid.

the right to say no. Underman writes, "Certain patients cannot be brought into the fold—namely, patients who have very good *structural* reasons for distrusting the medical profession."[147] Patients who have systematically been disenfranchised and historically exploited in the U.S. cannot then find themselves to be the kind of patient that teaching hospitals particularly favor. For Underman, she is thinking about how a medical technology like patient empowerment marks some subjects as "ideal," while rendering others "as targets for either exclusion or disciplinary regimes of control."[148]

Regarding my own argument, I view Underman's analysis as useful in thinking about how medical institutions, when it comes to consenting for a pelvic exam, empower a particular kind of white, cis, well-off patient, who can claim that they themselves know the parameters of informed consent, while at the same time producing a less than ideal patient who is failing at monitoring their own health and their own rights in hospital settings. My interviewees quotes showcase that it is much easier for patients who possess medical technologies of empowerment to refuse a pelvic exam by a medical student, whereas the same practice might be much more difficult to refuse for patients who don't possess those technologies. Additionally, if, as a patient, one is expected to be their own advocate, are teaching hospitals really showcasing patient-centered care? The idea of a liberal, autonomous subject who can say "no" to a practice pelvic exam blurs the multiple dynamics of power that are at work in the practices of consent of these medical institutions, as highlighted in my analysis of how some of these more insidious power structures operate.

5.3 Conclusion

In this chapter, I have highlighted two main ways in which nonconsensual pelvic exams operate to reinforce discourses of gendered, raced, and classes bodies. In the first section, I

[147] Underman, *Feeling Medicine,* 194.
[148] Ibid., 195.

highlighted that the interviewees did more of their practicing on low-income patients and patients of color, which reinforces the legacy of using bodies in U.S. medicine that are classified as "other" in the name of medical learning and progress. I used contemporary literature on nonconsensual pelvic exams, as well as Foucault's *The Birth of the Clinic* to showcase how this phenomenon is unfortunately neither new nor progressive.

Additionally, Terri Kapsalis's writing on the history of U.S. gynecology allowed me to place nonconsensual pelvic exams against a historical backdrop that has repeatedly exploited black women of lower income and educational background in the name of scientific progress. I also utilized critiques of colonial practices to showcase how women's bodies, indigenous bodies, and enslaved bodies were violently utilized in the name of scientific progress and knowledge making, to the advantage of the white, middle-class, Christian colonizer. At the same time, postcolonial theory allows me to think about how U.S. teaching institutions come from historical knowledge making practices that positioned "modernity" and "rationality" as a universal way of knowing that, in turn, made itself superior to local and subaltern ways of knowing. By pulling out these threads of U.S. history, coloniality, and knowledge making processes, the link between nonconsensual pelvic exams and violence against gendered, raced, and classed bodies becomes more telling.

In the second section, I discussed how the interviewees presented patient self-advocacy as belonging to more privileged groups in U.S. society. I discussed Underman's discussion of patient advocacy in *Feeling Medicine* to analyze how patient empowerment works as a medical technology, producing the ideal patient who is constantly monitoring themselves and knows about processes of informed consent. At the same time, patients who are not empowered to advocate for themselves in medical spaces becomes non-model patients, legitimizing the abuse of their access to consented procedures. In my other chapters, I have discussed how consent for pelvic exams for training purposes is viewed by medical institutions as complete when the patient says yes to the procedure.

However, with the example of patient advocacy in this chapter, we can see how the consent process becomes more like a superficial routine, resulting in nonconsensual pelvic exams and violence against bodies that are "othered," revealing how these exams, though very specific and local, reflect wider relations of power in U.S. medicine.

Chapter 6: Conclusion

Before I started conducting my thesis interviews with medical students, I did not expect to hear as many disturbing accounts of the culture in OBGYN training spaces regarding pelvic exams as I did. What was especially surprising was the sometimes casual tone that the medical students would use when speaking about practices that I thought sounded deeply problematic. Additionally, I did not speak to a single medical student who did not seem to take pelvic exams and the comfort of patients seriously. Everyone I spoke with had extremely thoughtful information to share with me, along with an acknowledgement that, although the medical profession has made strides in fulfilling patients' rights, there it still work to be done. It was this dissonance between the students' real concerns about consent, and a belief in nonconsensual pelvic exams as a phenomenon of the past, contrasted with the descriptions of the actual practice in the operating room revealing a lack of consent, that I became more and more interested in examining throughout the writing of this thesis.

Time and again throughout my analysis I argued that, according to what I gleaned from the testimonies of the medical students, nonconsensual pelvic exams do not exactly happen against the wishes of the patients, residents, attendings, and medical students who are there in the OR, but happened in a much more insidious manner that reflects the multiple dynamics of power at play in these medical spaces. Although it has, horribly, happened in recent memory,[149] in my view it is not so much the case nowadays that a patient is saying "no" to a practice pelvic exam, and they are forcibly given one anyway, but rather that the multiple dynamics of consent, of pelvic exams, of the inner workings of teaching hospitals, are not necessarily made very clear to the patient, or to the medical student, at every moment. Therefore, perhaps a nonconsensual pelvic exam can happen without anyone really knowing exactly that it has happened. It was also clear to me throughout

[149] Goldberg, "She Didn't Want a Pelvic Exam. She Received One Anyway."

conducting many of the interviews that oftentimes the medical students thought of nonconsensual pelvic exam in this vein of a patient being forced against their will, but maybe didn't consider a pelvic exam nonconsensual if the exact wording of the consent form was a little murky.

My chapter on the hierarchy at play in the OBGYN rotation showed that often medical students were encouraged to normalize an environment in which it was not comfortable to voice a discomfort or an objection in the operating room. In this sense, nonconsensual pelvic exams happened because it was not acceptable to voice an objection to one happening in the pressure-cooker of an environment that is the OBGYN operating room. The second analytical chapter highlighted how medical students, though assured that their institutions were doing all the proper consent procedures, at the same time described moments in which it seemed consent specifically for a pelvic exam by a medical student under anesthesia was not made clear to the patient. The final analytical chapter described how patients on public insurance, patients of low socioeconomic status, and patients of color were often normalized as patients who would be more likely to receive a nonconsensual pelvic exam under anesthesia.

Tying these different analytical chapters together were threads of the violence inherent in dominant knowledge making processes and claims to "truth." These claims to truth were part of the normalizing process of nonconsensual pelvic exams that also normalized conducting such exams on bodies that have been systemically "othered" in U.S. society. Every medical institution the students I interviewed went to were very prestigious institutions existing in a country that often claims it is the "best" and most "modern" country in the world. Additionally, with the exception of one medical student, every interviewee studied in a "blue" state, meaning they studied in states that generally tend to claim to be more "progressive" when it comes to issues such as consent, gender-based violence, and women's autonomy. However, as the testimonies show, deeply problematic cultures of

OBGYN are occurring in these states that are allegedly employing the best practices for their citizens and their patients.

From the transcripts and theories I gathered and read, I also see a very interesting relationship occurring between our contemporary ideas of "consent," and the fact that these nonconsensual pelvic exams continue to happen. What are the implications of the fact that, although we have seemingly made great strides in terms of respecting the autonomy of gendered bodies, these exams are happening as standard procedure across the U.S.? I would argue that there is a link between thinking of consent as an individual choice in the liberal sense of "I" can make my own decisions, and an unwillingness to see, or perhaps an intentional blurring, of the network of power that makes consent such an issue in our world in the first place. One of the medical students, Emily, told me powerfully towards the end of our interview: "I didn't learn what consent was until it was already a problem. I think that's pretty common." In this quote, I see a strong diagnosis of the problem at the heart of these medical institutions, as well as highlighting what is missed when informed consent is viewed as someone being able to choose at one specific moment to say "yes" or "no."

We can see from the data throughout this research that formal consent procedures put in place have not entirely obliterated the practice of nonconsensual pelvic exams. As I argued many times throughout this thesis, these nonconsensual pelvic exams exist as an integral part of OBGYN in the U.S. Pelvic exams are currently absolutely required for medical students to perform, and they need to be quick, standardized, and impersonal in order to keep the gears of the machine running smoothly. Therefore, to really stop the occurrence of nonconsensual pelvic exams, a more critical and structural reorganization of how U.S. medical institutions operate, and a strong reckoning with what the ultimate goals of teaching hospitals are, would be required. What I have attempted to show with my analysis is that the ways in which power operates in medical spaces makes consenting to a

pelvic exam more complicated than simply ticking a box on a form. I have also not offered a solution to the occurrence of nonconsensual pelvic exams in my analysis, but rather attempted to reflect the "gaze" back as it were, to really see what is happening with these exams in medical spaces. Through the conversations I had with various medical students, as well as my own engagement with the literature surrounding this complex topic, I am assured that I am not the only person concerned with these issues and thinking critically about them.

6.1 Limitations

This research was by no means a far-ranging survey of medical students' experience with nonconsensual pelvic exams in U.S. teaching hospitals. The sample was quite limited in size, and my analysis that came out of the interviews should not be taken as generalizable or statistically significant. Also, with the exception of two of my interviews, every interlocutor I spoke with went to medical school in the Northeastern United States. Therefore, this study was not wide-ranging in terms of geographic locations in the U.S. My interviewees were also predominantly white, and more than half of them were women.

I would also like to note that I am aware that pelvic exams are an important part of OBGYN care for patients. With this research, I risk stigmatizing a part of OBGYN care that is essential for reproductive health. I went into this research not meaning to attack physicians who are providing care, but rather to better understand how nonconsensual pelvic exams are manifesting in teaching hospitals today. I also am not implying with this research that pelvic exams are the only area of nonconsensual exams in medical spaces. Further research would be necessary to examine in what other arenas of medicine patients are nonconsensually examined. Additionally, by focusing on training pelvic exams as a site for attention and concern, I do not want to mystify OBGYN bodies at a time when such bodies are widely misunderstood and misinformation is rampant. Instead, I aim to

frame nonconsensual pelvic exams as a bodily manifestation of the kinds of disturbing practices that can develop when hegemonic institutions are vested with large amounts of authority and claims to truth.

6.2 Steps Forward

To conclude, I would like to note that several of my interviewees shared with me that they felt like consent was talked about the most in their OBGYN rotation, compared to their other clerkships. In this section, I would like to include some thoughts my interviewees shared with me that offer some hope and possible steps forward. For example, Emily, one of the medical students at Boston University, told me, "Unlike in surgery, the sensitive nature of these exams and these moments is sort of paid closer attention to. And so, the fact that consent is even talked about, I think is very different from any of the other surgical rotations that I did, and any of the emergency rotations that I did." She told me that the U.S. leaves a lot to be desired in terms of sexual education and learning about bodily autonomy, and she feels like it is strange there are laws banning nonconsensual pelvic exams, when there is no national law to educate people on what a pelvis even is. In this sense, she felt like her OBGYN department did well at paying attention to these sensitive issues in ways that other medical departments did not.

Another interviewee, Kiera, who did her OBGYN rotation at the University of Chicago, told me: "I feel like OBGYN was the rotation that we talked the most about consent." She did not leave her OBGYN rotation feeling like consent was unimportant at all, and was surprised when I told her about the Ubel study in 2002, where medical students left their OBGYN rotation caring less about informed consent. Elli, another current medical student who wanted to keep her institution anonymous, also felt like, if anything, consent was talked about more in her OBGYN rotation than in other rotations. Other interviewees shared this sentiment as well, and the final student I

interviewed told me that his OBGYN department was headed by two women who cared deeply about educating the medical students on OBGYN's racist history.

These examples perhaps showcase that much work still remains to be done, as according to my data and analysis, talking about the importance of consent did not necessarily always translate in the operating room. Additionally, if OBGYN is the department talking the most about consent, again, further research would be needed to examine concerning practices in other medical departments. However, many of my interviewees spoke hopefully about their OBGYN departments as taking seriously the importance of consent, and really respecting the wishes of the patients. There was not a single person I spoke to during my research who acted blasé about the topic at hand, or was not concerned about the implications of nonconsensual pelvic exams.

If I were to continue this research, I would be very interested in speaking with the residents and attending physicians who are overseeing pelvic exams during the OBGYN rotation. Throughout my argument, I have aimed to highlight how medical students themselves are not callously conducting pelvic exams on patients for the fun of it, but find themselves to be caught in a crossroads of power relations that often makes them feel uncomfortable. As one of my interview participants told me: "No one does a pelvic exam for funsies." In my analysis, medical students themselves, as well as the patients, are victim to this system. I believe that higher-ranking physicians are caught in these webs as well, and it would be interesting to hear how they view current consent procedures for pelvic exams. Would they be more or less critical than the medical students who are effectively working under them? An analysis that includes all the actors at play in OBGYN training spaces would surely reveal more clearly the ways in which power operates in the operating room to normalize a pelvic exam without consent.

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Appendix I: Interviewee Overview

Number	Name	Gender	Institution	Location
1	Madeline	Woman	Columbia University Irving Medical Center	New York, New York
2	Emily	Woman	Boston University Medical Campus	Boston, Massachusetts
3	Ethan	Man	Boston University Medical Campus	Boston, Massachusetts
4	Allison	Woman	Donald and Barbara Zucker School of Medicine at Hofstra/Northwell	Hempstead, New York
5	Haley	Woman	Donald and Barbara Zucker School of Medicine at Hofstra/Northwell	Hempstead, New York
6	Kelsa	Woman	SUNY Upstate Medical University	Syracuse, New York
7	Tory	Woman	Geisel School of Medicine at Dartmouth	Hanover, New Hampshire
8	Simon	Man	Geisel School of Medicine at Dartmouth	Hanover, New Hampshire
9	Becket	Man	Boston University Medical Campus	Boston, Massachusetts
10	Elli	Woman	Anonymous	Mid-Atlantic Region of the U.S.
11	Kiera	Woman	The University of Chicago Pritzker School of Medicine	Chicago, Illinois
12	Martin	Man	A medical school in Massachusetts	Massachusetts

Appendix II: Interview Consent Form

Consent Form

My name is Doris, and I am pursuing a Master of Arts in Gender Studies at Central European University. As part of my program, I am writing a thesis on pelvic exams and informed consent in U.S. OBGYN spaces. My thesis aims to comprehend medical students' perception of nonconsensual pelvic exams, and whether they believe these exams are something of the past, or something that continues to this day. I am also interested in the culture towards pelvic exams overall that medical students observed during their OBGYN rotation. The purpose of this interview is for you to share your ideas and opinions regarding the topic of my research. My aim is to explore this topic in its complexity, to better understand how to think about this issue in relation to larger discourses regarding gender.

I want to request your permission for the interview to be audio recorded. This recording will be transcribed and anonymized. Your personal data will remain confidential and will be known only to me. In the publication of my thesis, I will safeguard your privacy, and quotations will appear under a pseudonym.

I also want to remind you that your participation in the interview is voluntary, and that you may terminate your participation and consent at any time. You may also choose not to answer some of my questions. The interview typically lasts for 40 minutes to an hour.

I agree to participate in this interview.

_____

Signature and Date