FISCAL IMPACT REPORT

SPONSOR Moores/Sedillo Lopez **LAST UPDATED ORIGINAL DATE** 02/05/2024

SHORT TITLE Intimate Exams of Certain Patients **BILL NUMBER** Senate Bill 257

ANALYST Chilton

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT*
(dollars in thousands)

Agency/Program	FY24	FY25	FY26	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
	Indeterminate but minimal	Indeterminate but minimal	Indeterminate but minimal	Indeterminate but minimal	Recurring	General Fund

Parentheses ( ) indicate expenditure decreases.
*Amounts reflect most recent analysis of this legislation.

Sources of Information

LFC Files

Agency Analysis Received From
University of New Mexico (UNM)

Agency Analysis was Solicited but Not Received From
Department of Health (DOH)

SUMMARY

Synopsis of Senate Bill 257

Senate Bill 257 would require that each hospital implement a policy that would prohibit health care providers and health care students from performing intimate examinations (defined in the bill as breast, pelvic, prostate, or rectal exams) on unconscious or anesthetized patients without the written informed consent of the patient or the patient's authorized representative.

This bill does not contain an effective date and, as a result, would go into effect 90 days after the Legislature adjourns, or May 15, 2024, if enacted.

FISCAL IMPLICATIONS

There is no appropriation in Senate Bill 257. If enforcement of the consent requirements of SB257 were left to hospitals, there would be little cost to DOH to ascertain that such policies were in place. If DOH were given authority to police compliance with these policies, a larger cost would be incurred.

SIGNIFICANT ISSUES

In a 2020 New England Journal of Medicine article, *Examining Examinations Conducted under Anesthesia*, Dr. Michael Greene (Massachusetts General Hospital obstetrician-gynecologist) discusses the tension between a patient's bodily autonomy and their desire to have experienced medical personnel giving care. If a trainee does not have experience performing parts of the physical examination, including the intimate parts, how do they develop the experience to perform those exams safely and effectively? The opinion article is attached, an excerpt from which follows:

> The informed-consent process should include an honest conversation between the clinician and the patient during which the clinician does her or his best to level the playing field, minimize any potential for subtle coercion, and make it clear that the patient always has the right to decline examinations by trainees that are conducted for teaching purposes. Clinicians should help patients recognize their shared interest in training future providers and reassure patients that any participation of a trainee in their care will be respectful and supervised appropriately. Ultimately, patients' preferences should be documented and honored under all but the most urgent or unexpected circumstances.

Responding to reports in print and online media on non-consensual intimate exams and legislative efforts to require consent prior to anesthesia for intimate exams to be done during anesthesia and specifically referring to a law proposed in Connecticut, Purdue PhD candidate Samantha Seybold made the following points in an opinion piece in *Bioethics*:

> Research studies, medical professionals, and patient testimonies have revealed that the practice of administering pelvic exams to nonconsenting, anesthetized patients is common.[4] Because the exam takes experience to learn, instructors direct students to practice on women who are under anesthesia for surgical procedures, many times without first ensuring that those women explicitly consent to the exams.[5] Students typically practice these exams during gynecological surgeries. However, as in Janine's case, a patient may undergo these exams even in cases where her surgery is non-gynecological.[6] The patient may experience multiple consecutive pelvic exams while she is unconscious, depending on how many students need to practice.[7] These exams are thus performed solely for the educational benefit of the student(s)…Because these exams are not disclosed to patients, it is unclear how many women have unknowingly been subjected to the procedure...
>
> UPEs [unauthorized pelvic exams] involve a selective violation of patients' humanity and so cannot be adequately justified by the attainment of other, lesser ends. If the medical community is truly committed to protecting patient autonomy and consent, then it cannot subsume either underneath these goals because to do is to be inconsistent. Given the continued deception involved in the practice of UPEs, as well as its longstanding acceptance among medical professionals, legally banning nonconsensual pelvic exams could go a long way toward rebuilding trust and reestablishing women's autonomy in the operating room.

UNM comments that intimate exams such as those that would be subject to SB257 on anesthetized or unconscious patients may be carried out for one of two reasons: for educational purposes and as part of the necessary and standard procedures of care. UNM points out, for

example, that an injured and unconscious patient may need a rectal exam to determine if bleeding internally is occurring. UNM states that patients on whom an educational intimate exam is to be done during anesthesia are, in that institution, asked for consent before anesthesia and exam. Further, UNM states that "It is common for sedated patients in the ICU to require urinary catheter placement, replacement, removal, genital exam/rectal exam for bleeding, and cleaning of genital region and these are considered routine care. Waiting for informed consent would delay care and adversely affect patients."

TECHNICAL ISSUES

In the definition of "intimate examinations," penile and testicular exams are not mentioned.

No enforcement mechanism is suggested; it appears as if hospitals would be required to enforce the policies that had been written.

There is no mention of sedation; at what point is a sedated patient considered to be "unconscious" for application of this rule.

ALTERNATIVES

UNM Hospital states that it "disagrees with legislating the patient/physician relationship as it may cause unintended barriers and inequities in care. Alternatives would include:

- Permitting a pelvic exam without specific consent where the exam is within the scope of care for the patient or required for diagnostic purposes.
- Permitting an exam if the patient is unconscious and incapable of providing consent if the pelvic exam is necessary for diagnostic or treatment purposes."

Attachment

1. *Examining Examinations Conducted under Anesthesia*

LAC/al/ne

the centrality of the pediatric patient. Children should be asked for their assent because their bodies are the site of learning.

Although it's not always reasonable to seek my daughter's assent to medical care, I can identify no barriers to routinely obtaining her assent to trainee involvement. The parallel between training and pediatric research is informative. In pediatric research — unlike in care — there is a clear mandate to obtain the child's assent if the child is capable of making a decision about whether to participate. The same mandate should apply to training. For my young daughter, seeking assent might be as simple as the attending saying: "This is Beth. She goes to school just like you do; at her school, she's learning to be a doctor. Is it okay if she takes a look, too?" My daughter deserves a chance to say "no," particularly when training activities offer no direct benefit to her. There will probably be times when my daughter says "no" when I would have said "yes." Her dissent should be respected.

Finally, it's not just clinical skills that are taught at the bedside. Communication and professionalism are taught there as well. When a trainee is involved in my daughter's care without my explicit permission and her assent, both the trainee and my daughter learn ethically troubling lessons. The trainee's sense of the importance of consent erodes.[4] And my daughter takes harmful cues about her lack of autonomy from what is said and unsaid.[5] By contrast, asking for my permission and her assent demonstrates respect for my daughter as a person, rather than treating her as a convenient teaching tool.

When teaching medical students, I emphasize that ethical reflection can show us areas where we have room to improve. One of these areas is consent for trainee involvement in the care of children — children like my daughter. Further work is needed to develop clear policies and to understand their potential effects on pediatric patients and trainees alike.

Disclosure forms provided by the author are available at NEJM.org.

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Examining Examinations Conducted under Anesthesia

Michael F. Greene, M.D.

The common practice of allowing medical trainees to perform "intimate," intrusive examinations, such as of the vagina or rectum, on patients under general anesthesia in the operating room (OR) immediately before a surgical procedure has received deserved attention and criticism in both the medical and lay press.[1,2] Much of the concern has been focused on issues regarding the frequent lack of informed consent for such examinations, and perhaps more problematic, the common perception among clinicians that failing to obtain consent is an acceptable and routine practice.[3] These concerns have resulted in legislation in several states requiring clinicians to obtain informed, written consent before trainees can conduct examinations when a patient will be under anesthesia.[4] There can be no legitimate objection to respecting patients' rights to privacy and bodily autonomy.

The central dilemma here, which requires acknowledgment, is that all patients want and expect their clinicians to be skilled and experienced before caring for them. Yet people frequently have difficulty reconciling that desire with the notion that, at some point, every competent clinician was an unskilled trainee who needed to learn those skills on real, living human beings with rights to privacy and bodily autonomy. Recoiling at the idea that a less-than-perfectly-skilled trainee could examine you, draw your blood, participate in your surgi-

cal procedure, or perform some other accepted health care function under appropriate supervision is analogous to expecting someone to be an excellent swimmer without ever having been in the water. Ultimately, there is no combination of books, lectures, videos, simulators, and virtual-reality experiences that will ever be adequate to create sensitive, humane, skillful, and truly proficient practitioners.

Considerations regarding consent to examinations conducted by trainees should take into account the intrusiveness of the procedure and the trainee's level of experience. What specific kind of consent from the patient and what degree of direct supervision by a fully trained health care professional are required for each combination of degree of intrusiveness and level of trainee experience? This question is one that most patients, and many practitioners, have never considered in detail, and it would probably engender considerable disagreement. Should an attending physician be required to obtain formal, written, informed consent from a patient and provide continuous supervision in order for a trainee to be present in the OR because of the intrusion into the patient's privacy that will result from being unclothed on the operating table? Is a specific informed-consent process needed for a fourth-year resident to start a peripheral intravenous line, and does that resident need to be supervised by an attending physician for this invasive procedure to be performed safely? Most clinicians would consider these examples *reductio ad absurdum* with regard to the obligation to obtain informed consent for routine care.

There are meaningful differences between "intrusive" examinations of natural body orifices that may be physically and psychologically uncomfortable but are essentially physically harmless and "invasive" procedures involving closed body cavities that are inevitably associated with some risk of physical injury. These differences translate into different requirements for the informed-consent process, as do differences in the patient's state of consciousness during the procedure. The process of obtaining a medical history can include entirely appropriate yet nonetheless intrusive lines of questioning of the patient. Responding truthfully implies consent, but the patient is always free to decline to respond to either a trainee or a licensed provider. An awake, competent adult's verbal assent and ongoing cooperation with an intrusive physical examination of the rectum or vagina implies consent, and few clinicians would think such an examination demands a lengthy, formally documented, informed-consent process. This practice never applies, however, to a patient under general anesthesia or one undergoing an invasive surgical procedure.

The tenor of our times requires that we acknowledge the shameful revelations that have come out of the #MeToo movement, including reports of sexual abuse in health care that has been able to occur in part because of the imbalance of power in the relationship between doctors and patients. The important differences between those abuses and issues related to trainee involvement in examinations are that coerced acquiescence in the setting of an asymmetric power relationship is not freely given consent and that none of those abuses occurred in the context of legitimate medical care that had any potential to benefit the health of the victims. It is also important to recognize that historically, the imbalance of power between doctors and patients has been magnified for publicly insured patients and people of color, who have most likely been subjected to a disproportionate share of unconsented examinations while under anesthesia.

Some critics have called into question the practical value of physical examinations, given the availability of various types of high-definition imaging and citing the fact that both the U.S. Preventive Services Task Force and the American College of Obstetricians and Gynecologists have questioned the utility of routine pelvic examinations in asymptomatic women. Recognizing the low probability that a routine examination in an asymptomatic patient will provide important clinical information does not obviate the importance of trainees learning physical-examination skills, which are an important element of the initial evaluation of a symptomatic patient. Patients who are in the OR for pelvic surgery presumably have documented pathology, and conducting a physical exam in some of these cases may provide trainees with an important educational experience without causing physical harm or discomfort to the patient under general anesthesia.

The reality of modern medical practice in major academic medical centers rarely resembles the idealized version frequently portrayed in the lay media and popular culture. Most commonly,

when a patient is scheduled for a surgical procedure in the OR, the attending surgeon does not know whether trainees will be around to witness or participate in the procedure. Surgeons frequently schedule procedures that they know and must acknowledge to the patient that they may not be able to perform themselves because of medical necessity dictated by the patient's changing condition or scheduling complexities in modern group practices. Physicians and other professionals at academic medical centers must recognize the realities of their dual obligation to provide a cadre of well-trained health care professionals in perpetuity and to respect patients' rights to privacy and bodily autonomy. Although the intimate nature of vaginal and rectal examinations makes them of more than "slight interest to patients," once patients' concerns are fully and frankly addressed, these examinations can be seen as conforming to the other criteria for learning activities proposed by Grady that "add little or no risk for patients already receiving care" and "have overall goals that patients support."[5]

An audio interview with Dr. Greene is available at NEJM.org

The informed-consent process should include an honest conversation between the clinician and the patient during which the clinician does her or his best to level the playing field, minimize any potential for subtle coercion, and make it clear that the patient always has the right to decline examinations by trainees that are conducted for teaching purposes. Clinicians should help patients recognize their shared interest in training future providers and reassure patients that any participation of a trainee in their care will be respectful and supervised appropriately. Ultimately, patients' preferences should be documented and honored under all but the most urgent or unexpected circumstances.

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June Medical Services v. Russo — A Threat to Physicians' Standing to Challenge Abortion Regulations

Joanne D. Rosen, J.D.

In *June Medical Services v. Russo*,[1] the U.S. Supreme Court considered two issues of substantial importance to people seeking abortions and the physicians who provide them: the constitutional validity of Act 620, Louisiana's admitting-privileges requirement for abortion providers, and the legal entitlement, or "standing," of physicians to bring suit to challenge abortion regulations. The Court's decision, issued on June 29, 2020, to invalidate the admitting-privileges requirement — which was "nearly identical" to a Texas law invalidated by the Court in *Whole Woman's Health v. Hellerstedt* in 2016[2] — has deservedly been the focus of most of the attention the case has received. In addition, the Court rejected Louisiana's request to revisit long-established precedent and deny standing to the physicians who challenged the requirement. The dissenting justices' vigorous discussion of physicians' entitlement to challenge abortion regulations signals that the battle over standing is far from over, however. Questions about standing may be a new strategic front in abortion litigation; today's dissenting arguments may, over time — and especially with changes in the composition of the Court — gain greater support and become tomorrow's precedents. Though a seemingly technical legal issue, physicians' standing to sue has serious implications for access to abortion and for the accurate characterization of the relationship between physicians and patients.

Physicians have a storied history of challenging laws that un-