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Review

Continuing Education

Consent in Pelvic Care

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Consent is a clear dialogue between individuals to engage in a specific activity. Expectations for consent to intimate examinations in health care should be equal to, if not exceed, expectations for intimate interactions in society. In reality, current definitions of consent in health care vary. These blurry definitions lead to individualized interpretation, incomplete fulfillment, and opportunities for misunderstanding by both patient and health care provider. If a patient does not believe they have consented to an examination or procedure, they are likely to rightfully identify with one of consent's antonyms, assault. Within the field of gynecology, a history of misogyny, racism, and classism illuminates abhorrent contexts of assault disguised as care. Similar practices persist in the modern application of pelvic care, ranging from overt sexual assault to coercion disguised as guidance. Health care providers and students who seek to improve consent practices can look to evidence-based frameworks such as trauma-informed care and shared decision making, both of which are embraced widely by professional organizations. These approaches often take precedence during the first pelvic examination; care for people who are lesbian, bisexual, queer, transgender, or nonbinary; and care for anyone with a known history of sexual assault; they can be easily extrapolated to all intimate examinations. Beyond obtaining consent for the examination itself, health care providers must also intentionally obtain consent to include students in care and openly discuss new universal recommendations for chaperone presence. Scripting for common procedures, such as bimanual examinations for pelvic care or cervical examinations in labor, allows health care providers to practice trauma-informed language, include evidence-based guidance, and avoid unintentional bias. Contemporary providers of intimate pelvic care must work to understand and strengthen the definition of consent and ensure its realization in practice.
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"The pelvic offers a fascinating window into the dynamics of the relationship between doctors and patients, as well as the blurred boundaries between sexuality and medicine. Though the procedure itself is routinely performed on healthy women in a supposedly sterile environment divorced from outside context, it is in reality loaded with context and meaning."
Wendy Kline, Bodies of Knowledge: Sexuality, Reproduction, and Women's Health in the Second Wave[1]

INTRODUCTION

Definitions of consent in health care vary across sources and organizations, and subsequently implementation depends on the health care provider. This individualized application creates opportunities for unintentional misunderstandings between provider and patient, space for coercion disguised as consent, and experiences of assault within the health care setting. Nuances and assurance of consent are especially important in pelvic care and care of sexual and reproductive anatomy. Consent is a concept mirrored across intimate personal lives and intimate examinations, and the same language in both spaces stresses its analogous importance in both experiences for patients: in both circumstances, consent implies an intention to do no harm. Expectations for consent in health care settings should be parallel to, if not exceed those of, expectations in society, where the hierarchical knowledge and power of health care providers over patients must be addressed for consent to be informed and freely given. This higher burden is especially applicable for patients who are not cisgender men: namely, cisgender and transgender women, transgender men, and gender nonbinary people, given similarly experienced intersections of power and bodily autonomy across other social institutions. (This review uses the gender-inclusive terms *person* and *patient*, given that people of all bodies and identities access pelvic care. Quoted resources maintain language of the original version).

In health care settings, actions that would be considered coercion or assault in social settings are often erroneously labeled as clinically or medico-legally rational. The actions are, however, equivalent from the standpoint of a definition of consent: if someone does not consent to something, the actions against them constitute assault. Because health care providers and institutions apply ambiguous definitions of consent in health care, it is ethically challenging to ensure that complete and informed consent is obtained consistently in practice. Vague terminology can lead to inconsistent implementation and risk for assault, or the experience of assault, within the health care setting. Ultimately the onus of ethical informed consent rests on the health care provider, as the more powerful entity in the interaction, and the person seeking consent. For the well-being of patients entrusting providers with pelvic care needs, consent must be held to the highest standard.

HISTORICAL AND CONTEMPORARY CONTEXT

In order to holistically consider current experiences of gynecologic health care consumers, health care providers must acknowledge the profession's historical origins. The field of gynecology built its foundation on assault and nonconsent, beginning with forced examinations and nonanesthetized surgical experiments on enslaved people wholly unable to decline.[2] This occurred as white men, in designing modern medicine,

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Quick Points

- Consent is a process that equalizes the ability to respond either *yes* or *no*.
- The reasonable patient standard, shared decision making, and trauma-informed frameworks are emerging as standards of care for informed consent.
- Pelvic health care mirrors people's consensual and forced sexual experiences: when providing clinical care, health care providers must intentionally choose language and approach during consent processes and examinations to decrease iatrogenic trauma and lessen the risk of triggering past trauma.
- If someone declines recommended care, further attempts by the health care provider to obtain acquiescence are coercion unless a new consent process is initiated because of change in clinical circumstances.
- Chaperones are recommended in all health care settings for all intimate examinations regardless of the health care provider's sex or gender identity.

destabilized historical knowledge held by Indigenous and Black healers.[3] The context of forced and nonconsensual pelvic care continued into the 20th century with practices of quarantining and forcing internal examinations on people suspected of venereal infections,[4] sterilizing people of color and people who were poor without their knowledge,[5] unnecessarily requiring pelvic examinations for oral contraceptives,[6] and hymen inspection for virginity testing.[7] Examples persist in current practice, including medical students performing covert pelvic examinations on patients under anesthesia without their explicit consent,[8] decades of abuse by Larry Nassar,[9] and fear of retribution when declining care recommendations.[10]

People's current lived experiences also affect their interactions in health care spaces. Outside of health care, issues of consent and safety are nonexistent or not able to be assumed for all people across similar social institutions. Examples include inadequate investigation into sexual assaults on college campuses[11] or within religious communities;[12] lack of political and legal support for queer, transgender, and nonbinary people in their struggle to find restrooms;[13] limited or no accountability for politicians who admit to sexual assault, including of minors;[14] and documented rape of migrant people seeking refuge or asylum.[15] One out of every 6 American women reports an attempted or completed rape in their lifetime,[16] with many more attacks going unreported to authorities or dismissed by the survivor as not meeting criteria for assault because of rape culture myths.[17]

Thus, people's own expectations of safety in health care cannot be assumed, as safety has not been the historical context in gynecology, is not currently the societal context in similar social institutions, and is not, even now, guaranteed within health care. This is all despite, in spite of, and beyond the reach of the health care provider's best intentions to create safe spaces. Given the implications of people's lived experiences of consent and safety prior to engaging in health care, especially in intimate circumstances, the process for ensuring informed and active consent in pelvic care must be transparent.

CONSENT IN HEALTH CARE

*Consent*is defined as a "process of communication between a clinician and a patient that results in the patient's authorization or agreement to undergo a specific medical intervention."[18] The simplicity of this definition carries significant weight in health care settings, where situational power, unequal knowledge, and a patient's own potentially traumatic experiences as a health care consumer elevate the importance of the process. Informed consent in health care is both a legal and ethical framework through which patients receive information and ask questions to lead to a decision about their care.[19] The above broad definition reflects the 4 common pillars of medical ethics: *autonomy*, or freedom of choice and bodily integrity; *justice*, or equal application across all people; *beneficence*, or acting in the person's best interests; and *nonmaleficence*, or doing no harm.[20]

Professional Standards

This definition and the 4 ethical pillars are reflected in contemporary documents developed to guide pelvic care providers. The Joint Commission highlights that informed consent is an ongoing process, not merely a signature on a form.[18] The American College of Nurse-Midwives' (ACNM) Hallmarks of Midwifery Practice highlights "advocacy for informed choice, shared decision making, and the right to self determination."[21] Within the midwifery Code of Ethics, key concepts for informed consent are (1) disclosure of information, including risks, benefits, and care options; (2) clarification that the patient understands that information; and (3) assurance of the voluntary nature of the consent. The midwifery Code of Ethics also details various individual circumstances that might affect the voluntary component of the consent process, such as health insurance status, income, privacy, limited access to other health care providers, and relationship safety.[22] The American College of Obstetricians and Gynecologists' (ACOG) Code of Ethics also reflects the above, as well as the importance of presenting medical facts and recommendations "in reasonably understandable terms and include alternative modes of treatment and the objectives, risks, benefits, possible complications, and anticipated results of such treatment."[23]

ACNM and ACOG both use the term *shared decision making* interchangeably with *informed consent*. The ACNM Position Statement "Shared Decision Making in Midwifery

Table 1. The Consent Process

Disclose the information that a reasonable provider would share and/or a reasonable patient would want to know in a similar situation,[29] including the following:
diagnosis or condition prompting the recommendation or treatment
benefits, and probability that the treatment will succeed
risks and complications
available alternatives, and their risks and benefits
possible consequences of forgoing treatment[26]
Tailor information to the patient's literacy and numeracy levels[31]
Speak in the patient's preferred language, with a certified medical interpreter unless it is a shared native language with the health care provider[32]
Share information through the patient's preferred delivery system: verbal communication, decision aids, surveys, checklists, or interactive online models[24,30]
Ensure the decision can be made free from bias or coercion by the health care provider or the patient's family[24,33]
Document all processes of consent, including information shared and the patient's questions and answers, in the clinical record[34,35]

Care" emphasizes patients as authoritative decision makers, uplifts the importance of effective communication between patients and health care providers, and "maintains right to informed refusal."[24] The ACOG Committee Opinion "Informed Consent" similarly reflects on the "moral right to bodily integrity, to self-determination… and freedom to make decisions within caring relationships."[25] A separate ACOG resource details that shared decision making occurs when "decisions about interventions should incorporate the woman's personal values and preferences and should be made only after she has enough information to make an informed choice."[26] Both organizations highlight the importance of consumers' active involvement in their health care decision making and are similar in themes and approaches.

Health care provider practice is guided by the concept of *standard of care*, or what a reasonable provider would do in a similar circumstance. This concept aligns with the traditional informed consent model of a *reasonable provider standard*, or what a reasonable provider would share as part of the consent process in the same situation. In shifting power to shared decision making, the model also shifts toward a *reasonable patient standard*, or what a reasonable patient would need to know to make an informed decision.[27,28] The reasonable patient standard is emerging as standard of care and in many ways overlaps with the more broadly known shared decision-making model.[29] Because the patient themselves would define their own parameters of a reasonable patient, this transition to a reasonable patient standard highlights the responsibility of health care providers to individualize the consent process and consider the patient holistically within cultural contexts and contemporary identities. For pelvic care, this specifically applies to sex and gender identities and requires all health care providers in practice to understand how a unique person's identities and experiences broaden expectations of what should be disclosed, how to disclose it, how to ensure comprehension, and how explicit the consent should be.[30]

Consensus across organizational and ethical resources is that a complete process of consent requires disclosing the information that a reasonable provider would share and/or a reasonable patient would want to know,[29] and that the information be tailored to the patient's literacy and numeracy levels,[31] in the patient's preferred language,[32] and through the patient's preferred delivery system, whether verbal or through decisional aids or interactive models.[24,30] The process should be free from coercion by the health care provider or the patient's family[24,33] and documented completely in the health record.[34,35] (Table 1).

Power Dynamics

The sensitive nature of intimate pelvic examinations calls for an understanding of not only recommendations for informed consent but also the power imbalances between patients and health care providers, which often mimic power imbalances in assault outside of health care. Health care providers, who hold power and knowledge, are tasked with obtaining consent; patients, who by nature of power dynamics in health care are disempowered in both knowledge and role, are tasked with consenting. Overlapping patient-provider discordances of race, sex or gender identity and expression, language, educational status, disability, and class further highlight the imbalance. Although trust in health care providers or deference to authority may guide decision making when patients are otherwise neutral or unsure,[30,36] 2 validated indicators of respectful care are a patient's comfort in declining care and lack of coercion in decision making.[37] If a patient requests the health care provider's recommendation and the counsel given supports ongoing consent processes and continues shared decision making, free from coercion or provider bias, then such guidance still aligns with consent.

Critically important to the process of obtaining consent is equalizing the patient's ability to say *yes* or to say *no*. If a health care provider simply expects a patient's acquiescence

Table 2. Definitions of Consent in Health Care	
Term	**Definition**
Consent	Discussion between patient and health care provider that results in the patient authorizing or declining an intervention[18]
Shared decision making	Patient and health care provider share information and values to make the best decisions regarding a plan of care[24]
Nudging, directed counseling	Health care provider guiding patient toward a decision[40]
Coercion	Health care provider using forceful language or threats to mitigate a decision[38]
Force, assault	Health care provider doing an examination without explicit consent[41]

to the recommended plan, true informed consent does not happen. Patients must be explicitly informed of their right to refusal.[24,29] Informed refusal is in fact a corollary of informed consent, and health care providers must anticipate and respect both outcomes.[38] Documenting that someone *declines* or *decides against*, rather than *refuses*, care may be a word choice more indicative of respect for the patient's decisional authority and may be better perceived by patients when accessing their own health records. Nonetheless, patients who wish to decline a recommendation may be acutely aware of the provider's negative feelings or concerned it will change the therapeutic relationship. Health care providers must thus consider their tone and language when a patient declines a recommendation in order to maintain shared power in the therapeutic relationship.[10] Providers should embrace the consent process as an opportunity for patients to take control of their own care and be empowered within the patient-provider relationship.[39]

Directed Counseling, Coercion, and Force

Consent by any other name is not consent. Any attempt by health care providers to indicate a preferred approach or desired outcome, defined interchangeably across resources as nudging, directed counseling, pressure persuasion, or forced compliance, cannot by definition be consent, as the sway of the provider cannot supersede a patient's decisional authority. If a health care provider weaves their own preferences into recommendations in an effort to guide patients toward a decision that the provider determines best for their welfare, that is not consent. Such tactics are not free from bias and may be ethically congruent with coercion.[38,40,41] Although *coercion* is often defined as involving threat or force, a fine line exists between consent and coercion that can be crossed in practical implementation, especially in emergency circumstances when decisions need to be made quickly (Table 2). Importantly, ACOG asserts that "pregnancy is not an exception to the principle that a decisionally capable patient has the right to refuse treatment, even treatment needed to maintain life."[38] The legal or liability implications of a patient's right to decline recommended care, even when there are emergent risks to the well-being of themselves or their fetus, conflicts with standard medical obligations, or affronts to the health care provider's personal values, are outside of the scope of this article and are covered elsewhere.[38]

INTIMACY OF PELVIC CARE

Clinicians maintain a clinical environment in pelvic care by modifying language and palpation to avoid any parallels with sexual intimacy. This acknowledges the lived proximity of a pelvic examination to the patient's experience of physical intimacy and sexuality. Health care providers must recognize that some patients view pelvic examinations as an experience they would define as intimate. Negative experiences during pelvic examinations may lead patients to delay or avoid future care, which ultimately eliminates any health benefits of gynecologic care.[42] Thus, "engaging patients in the decision-making process can improve patients' comfort with intimate touch."[43]

The Trauma-Informed Framework

Trauma-informed care, the standard of care for all sexual assault survivors, is now considered the standard for all health care and especially for intimate examinations, given that patients may not disclose an assault history or identify previous health care examinations as traumatic.[44–46] This evidence-based framework assumes that all people have experienced trauma, may be currently experiencing it, or will experience it in the future. It embraces the range of effects that trauma may have on one's physical and mental health and guides tone, approach, response, and process at both individual and organizational levels.[47] Health care providers may already consider trauma-informed care consent processes as uniquely relevant in scenarios like the first pelvic examination, care for sexual assault survivors, and care for patients of diverse sexual orientation and gender identities. The Engage, Motivate, Protect, Organize, Self-Worth, Educate, Respect (EMPOWER) Clinic for survivors of sex trafficking and sexual violence in New York details a thorough approach to trauma-informed health care, which can be easily extrapolated to empower and engage all patients regardless of disclosed history.[48]

First Pelvic Examination

Acceptance of pelvic care as central to sexual and reproductive health care may lead to assumptions about what is normal or expected; this was seen in the assaults by Larry Nassar.[9] The first pelvic examination establishes long-term understanding of what the examination entails and imprints experiences on gynecologic health care going forward.[49] Health care providers must take careful steps to obtain consent for the first pelvic examination, including clear discussion about each step, how to notify the provider of discomfort or how to

rescind consent, and explanation that the examination is not mandatory.[50] Providers should be attuned to power transfer throughout, reminding the patient that the examination can stop at any point and ensuring that the patient is in control.[51] The first pelvic examination also serves as a learning opportunity to discuss when different examination components may be appropriate or recommended, including the purposes of external visual examination, internal speculum visualization, and bimanual palpation: differentiation of each step allows informed consent, and informed refusal, as necessary.

History of Sexual Assault

A known history of sexual trauma, regardless of the type of assault, compels health care providers to modify the approach to pelvic care. The experience of the assault itself and subsequent pelvic examinations can intertwine in the survivor's memories.[52] Avoiding common verbiage that mimics sexual innuendo or common assault language, such as "spread your legs wide" or "just relax," decreases possible misinterpretation of the pelvic care provider as partner or assailant and maintains a supportive clinical environment. Individualized accommodations, such as deferring portions of an examination,[53] giving anticipatory guidance on possible sensations like pressure or temperature, and stepwise consent processes, are also sensitive components of care for survivors.[52] Health care providers staying attentive to and supportive of effective coping mechanisms, such as distraction with music or social media and deep breathing techniques, can facilitate patient resilience during difficult examinations.

Lesbian, Gay, Bisexual, Queer, Transgender, and Nonbinary Communities

Any recommendation for pelvic care that includes insertion of a speculum or test swabs or evaluation by bimanual examination must take into consideration the patient's intimate lived experience. Lesbian, gay, bisexual, transgender, and nonbinary people are more likely than their cisgender or cisgender heterosexual counterparts to never have, or vary engagement in, penetrative intercourse. Pelvic health care may be the only time someone experiences something inserted into their vagina or rectum, thus exponentially increasing the sensitivity and physical intimacy, or trauma, of the examination for that individual.[49] In addition, it is important to recognize that a history of sexual assault is higher in queer communities, compounding the need for deliberate trauma-informed care. Finally, transgender and nonbinary individuals may have language for their bodies that differs from medically gendered language. Health care providers should inquire about the individual's anatomical language and use this in consent processes as well as during the examination itself.

Consenting Beyond the Examination Itself: Chaperones and Students

Chaperones

Even with all guidelines for informed consent and shared decision making in place, patients may misinterpret or experience appropriate health care through traumatic lenses.[52] ACOG now recommends the presence of chaperones for all breast or chest, genital, and rectal examinations; this is irrespective of the sex or gender of the person performing the examination and includes all examinations performed in outpatient and inpatient settings, including labor and birth units, as well as during diagnostic studies such as transvaginal ultrasonography.[45] These recommendations occur in the context of significant publicity surrounding Larry Nassar's sexual assault of patients, as well as with increased reporting and disclosure of misconduct among nurses and physicians.[54,55] Chaperones are medical staff trained in clinical best practices and patient privacy, are able to identify misconduct, and have an immediate uncensored pathway to report concerns.[45] Because of these criteria, friends and family of the patient, trainees, and students cannot serve as chaperones, although at the patient's discretion they can be present as advocates or support people. Patients should receive anticipatory guidance regarding the new standard for the presence of chaperones to ensure consensual and appropriate pelvic care; however, they can decline chaperone presence as part of their consent process, and health care providers can then document this decision in the chart.

Students

Clinical education programs must provide structured content around ethics and consent in the context of gynecologic care.[56,57] Two recently published textbooks offer specific guidance about consent and trauma-informed gynecologic care and are relevant for all learners who will provide pelvic care.[58,59] Standard curricula around bioethics and medical ethics can be designed to evolve based on student-identified concerns; this allows opportunities for incoming generations of health care providers to affect the contemporary ethics discourse.[57] Patients must give consent for student involvement as well as receive anticipatory guidance regarding what the student's role will entail: what type of student will be involved in the care, how many students will be present, their capabilities, how many examinations will be performed if the student is involved, and whether the preceptor or attending health care provider will be present at the same time.[8,60] On that theme, patients should be fully permitted to decline student involvement even in educational institutions: presence within a teaching facility is not explicit consent for student involvement, as even in this case the assumption of consent in any capacity does not meet the definition of consent as a standalone concept. Furthermore, not all patients may understand that they are seeking care in a teaching facility, so transparency as to student involvement must be the standard. Preceptors and attending physicians must prioritize patient consent and care over student learning. This models respect for patient autonomy and decision making by specifically seeking informed consent for the care process as well as the student's involvement.[61] Unfortunately, failure to appreciate this is reflected in the continuation of unconsented pelvic examinations on patients under anesthesia. Every few years a medical student publishes a report of being pressured by attending or resident physicians to perform covert bimanual examinations on patients under anesthesia, without the

patient's explicit consent, for the student's learning benefit.[60] These reports fail to detail if patients are notified of the examinations when awakened from surgery, if they ever question the presence of medical gel intravaginally, or if they express a sense of penetration. These reports substantiate patient's own accounts of the same.[62] Such violations parallel drugged rape experiences and rightfully compromise trust of gynecologic care providers. ACOG specifically mandates consent for these examinations.[56]

CLINICAL CONTEXT

Informed consent and shared decision making not only seek to equalize the patient as an active participant in their health care experience but also aim to eliminate experiences of misunderstanding, mistreatment, assault, and abuse. Health care providers must take the time to reconcile aspects of their practice that diverge from what was and continues to be the informed consent process in order to eliminate a patient's experience of abuse within health care settings. Examining common clinical intimate examinations such as the annual pelvic examination or routine cervical examinations in labor provides an opportunity for providers to reflect on their typical consent process. Both scenarios cut across the nexus of patient experience, provider preference, institutional norms, and evidence-based practice as part of consent processes. Every health care provider has their own opinion about whether an annual pelvic examination is needed or how often cervical examinations should be done during labor. Common language used in each scenario can illuminate areas for improvement in these cases and across all health care consent processes (Table 3).

Evidence recommending against the screening pelvic examination in asymptomatic patients is still very new for patients and health care providers.[42,63,64] Both patients accustomed to an annual external or internal examination and health care providers who may continue their preferred practice despite the evidence may struggle or disagree with possible changes to practice. Shared decision making is the posited standard of care, especially in such a circumstance when perhaps no perfect answer exists and when the decision regarding a plan of care is thus best made through sharing information and values.[24,64]

Routine cervical examinations in labor, whether based on clinical circumstances such as labor induction or rupture of membranes, patient request, or hourly recording guidelines mandating scheduled documentation, should be examined for their bias toward health care provider preference and away from patient preference or evidence. Lack of informed consent, including lack of consent prior to vaginal examinations in labor, is now detailed extensively throughout the World Health Organization typology of mistreatment in childbirth as failure to meet professional standards of care. The same classifications were also used for patients' own reports of mistreatment in care in the Giving Voice to Mothers Study.[37,41,65] This lack of consent includes when patients perceive health care providers as merely going through the motions of the consent process.[65]

Example Scripting: Consent in Outpatient Pelvic Care

Complete informed consent for a pelvic examination, whether for an annual visit or during labor, includes the reason for the examination, benefits, risks, alternatives, and time for questions. Gynecologic pelvic care, particularly in outpatient settings, is rarely emergent; thus it affords plentiful opportunities to individualize care. As consent is an ongoing process, pelvic care providers should continue to modify language throughout an examination to continue to transfer power and afford opportunities to consent or decline during the examination itself. Communicating flexibility and alternatives can be done efficiently in language crafted beforehand and chosen by each health care provider for their comfort as well as for that of the patient.

Scripting for common examinations allows students and health care providers to practice language around power transfer, eliciting a patient's concerns as well as prior lived experiences, and anticipating a supportive response if the examination needs to stop unexpectedly for any reason. The following are possible scripts for informed consent for a pelvic examination with a trauma-informed care framework (ellipses indicate pauses when the health care provider waits for the patient to respond before continuing; xxx indicates patient-specific information).

For Someone Who Is Asymptomatic

"Based on your history and current lack of symptoms like pelvic pain, pain with sex, irregular bleeding, or significant pain with your periods, a pelvic exam is not indicated today. Research shows that performing an exam for someone without any symptoms could actually find something that is normal but requires further evaluation that could be unnecessary or harmful. Testing for infections could be completed by urine or self-collected sample, and your Pap test will next be due xxx. I can talk you through how to collect your own samples if you'd prefer. I want you to feel comfortable with your care, and if you believe an exam would be best or if you'd prefer that I collect the swabs, please let me know…"

For Someone Who Is Symptomatic or Someone Who Is Asymptomatic But Requests an Examination After the Above Script

"How have your pelvic examinations been in the past?… Is there anything I can do to make today's exam more comfortable?… When you experienced pain in the past, was it on the outside or the inside?… How would you feel about inserting the speculum yourself?… It is important that you know we can stop at any time for any reason. I may ask you throughout the exam to let me know when you are ready, so that I never start something without your knowing. Language that works for many of my patients is 'pause,' which will cause me to stop moving until you tell me you are ready for me to continue, or 'out,' which if I hear that I will take away my hands or swabs or the speculum immediately. Will those words work for you?… Or would something nonverbal, like raising your hand work better?… Today's exam includes an external exam where I examine the vulva including the labia and clitoris to ensure the skin and structures are normal. Please let me know of any pain

Table 3. Improving Language of Consent for Common Pelvic Examinations: The Annual Pelvic Examination and Cervical Examinations in Labor

Term	Clinical Scenario	Incorrect Language	Revision Toward Consent and Shared Decision Making
Consent and the annual pelvic examination			
Nudging, directed counseling	Health care provider preference for routine annual pelvic examination in asymptomatic people	"I would prefer to do the exam because in my clinical experience…" "What I would want my daughter, mother, spouse, or friend to choose…"	"Given the evidence, having a pelvic exam is your decision. We can defer the exam until the point in time when you might notice a symptom, or can start with an external exam or a speculum exam, and depending on what is visualized we can discuss whether an internal exam is needed."
Coercion	After completing counseling and informed consent, if the patient says "No," the health care provider continues to ask for consent with no change in clinical circumstance	"I hear you saying no, but want I want to emphasize is…" "Okay but that means I cannot provide contraception, referrals, or testing today."	Complete consent with all risks and benefits the first time. Discuss during this first consent process that if clinical circumstances change, you will be revisiting the conversation as risks and benefits change. Do not bring up risks for the first time, or emphasize them repeatedly, after a "no" as part of working toward obtaining a "yes."
Force, assault	Patient consents to one part of the examination, like an external or speculum examination, and health care provider proceeds with internal bimanual examination or rectal examination	"I know you said no before but now what I'm seeing leads me to continue the next step as your provider so I am going to start that now." "It is my job to make decisions in your best interest so I am going to proceed with the next step in the exam."	Only proceed with portions of examination that patient has explicitly consented to, while all other parts of consent process are being met. If clinical scenario changes and health care provider finds need for further examination, restart the consent process before moving forward.
Consent and cervical examinations in labor			
Nudging, directed counseling	Patient questions the need for an examination	"This is what we do for everyone." "How else will we know if labor is progressing?"	"Often we check the cervix every few hours in labor, just to see how labor is progressing…" Then start the consent process outlined above.

(*Continued*)

Table 3. Improving Language of Consent for Common Pelvic Examinations: The Annual Pelvic Examination and Cervical Examinations in Labor

Term	Clinical Scenario	Incorrect Language	Revision Toward Consent and Shared Decision Making
Coercion	Cervical examination is needed, health care provider completes consent process, and patient declines	"So I hear you declining, but what I want to emphasize is…" "I have to do this, or your baby will die." "Trust me, I know what's best."	Ensure all risks and benefits were included in the first consent process, not added on at the end. Then ask when it is okay to revisit the conversation.
Force, assault	Patient asks for cervical examination to stop, and health care provider is almost done Starting a cervical examination without explicitly obtaining consent	"You're doing great." "Just another second." "Almost finished." "I am doing this for you." "You will thank me later." "I just need to check."	Stop the examination immediately. The patient rescinded consent. Never start any examination without the patient's consent.

or discomfort so I can change what I am doing or be alert to a concerning area. Next I will place gel on the speculum, which looks like this and might feel cold, and insert to the end of your vagina. This commonly feels like pressure. If you feel any pulling, pinching, or pain, please let me know at any point so that I can change what I am doing during the exam, or can be alert to the symptoms you are concerned about. When I open the speculum it can sound like clicking, which is normal. The swabs look like this, and when I collect the sample from inside of your cervix it might feel dry or like scratching. When I take the speculum out it might feel like lower pelvic cramp. After I take out the speculum, then I will change my glove and put on gel to do the internal exam. I will then insert 2 fingers to the end of your vagina and put my other hand on your pelvis. By pressing my 2 hands toward each other, first on the center of your abdomen, and then on each side, I can check the size, movement, and normalcy of your uterus and ovaries. Then I take my hand out and the exam is done. I will check in with you to debrief how everything went. At any point in the process we can stop or wait to do a part of the exam until the next visit. If you decide you want to decline this entire exam we can talk about other ways to get the information needed today. A trained medical chaperone will be in the room for your and my safety. Do you have any questions about anything?… Is there anything you'd like more information about before we continue?…"

This script includes reasonable accommodations for accessible and trauma-informed care to offer anyone during their pelvic care, including describing parts of the examination before and during, reviewing a patient's prior experiences and modifying practice appropriately, offering self-swab or self-speculum insertion, stopping or delaying any portion of an examination for any reason, and debriefing afterward[44,49,51] A stepwise process for a trauma-informed pelvic examination after this initial consent process can be found in the textbook *Gynecologic Health Care*.[44]

CONCLUSION

In contemporary society, people who seek gynecologic care unfortunately face several realities. Certain genders and identities may be considered legally and socially second class to others. There are marked power imbalances between patients and health care providers. Patients of color are subjected to racist infrastructures. Some health care providers may assume consent de facto by presentation to care, whereas patients who anticipate informed consent do not follow the same assumptive framework. The intimate nature of people's bodies in health care overlaps with social and legal sexual assault parameters. The real-life implementation of consent often does not match its theoretical intentions. Consent in health care scenarios remains fraught with misinterpretation and open to individualized implementation. The implications for clinicians who do not seek and obtain adequate consent in pelvic care may be minimal, perhaps no more than a regret in hindsight and apologetic debrief with the patient about how to improve communication going forward. However, the implication for a patient who is not appropriately or fully consented, who then experiences forced, coercive, or rough gynecologic and pelvic care, is an experience of assault within health care, by no means minimal or fleeting. Such a discrepancy in experience demands improvement in the process.

Although there are explicit and essential differences between a health care provider knowingly assaulting a patient and a health care provider believing to have adequately consented someone who disagrees with that conclusion, providers must strive toward zero similarity between consent and assault in the context of care provision. A holistic review of consent in pelvic care challenges health care providers to take a personal account of their practice, eliminate language that nudges or coerces patients into a decision, and immediately stop any practice that could be interpreted as, or is, assault. When possible, pelvic care providers should standardize a consent process for common examinations, to ensure consistent application and manage expectations for patients.

It is worth the time, for the bodily autonomy and safety of patients in health care, to build ethical processes and to practice intentional language around trauma-informed frameworks for consent and shared decision making in pelvic health care.

CONFLICT OF INTEREST

The author has no conflicts of interest to disclose.

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