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Medical Necessity and Consent for Intimate Procedures

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In their feature article, Marit van der Pijl and colleagues (1) argue it is unethical for healthcare providers to perform unconsented episiotomies on persons in labour. In particular, they suggest that, outside of certain rare emergencies in which, for example, the person giving birth is incapacitated[1] and the procedure cannot be delayed until consent becomes possible without introducing a significant risk of serious harm (call these "medically necessary"[2] procedures), "presumed consent" is the incorrect standard to apply. Instead, they stress that, especially when a proposed intervention involves a person's genital, sexual, or reproductive organs, the need to obtain their explicit consent in advance of proceeding must be honoured.

As the authors note, the broader social significance of our genitalia—widely regarded as 'private' anatomy—is not erased by being in a medical context [see also (9–11)]. Boundaries must still be observed. Ethically, this "leaves a very small margin for error because invasion of these body parts without consent is an, unfortunately, relatively widespread and well-known social phenomenon with a specific degrading, humiliating and dehumanising meaning" (1) (p. 4).

[1] For a critique of binary conceptions of in/capacity, see the commentary by Anna Nelson and Beverley Clough (2). For discussions of how the capacity of persons in labour may be erroneously discounted (e.g., due to epistemic injustice), see commentaries by J. Y. Lee (3) and Kelsey Mumford (4).
[2] For recent discussions of this concept in the bioethics literature, see (5–8).

In the recent literature, not only surgical procedures, but also unconsented acts that involve "merely" touching patients' genitals (or breasts, anus) have come in for heightened scrutiny (12). These include pelvic or prostate exams that are sometimes performed by healthcare providers for teaching purposes on persons who are sedated or under anaesthesia (13–19). In regard to such cases, which rely on the presumption that patients' bodies may be used as teaching tools, several justifications have been offered. These include the perceived low risk of undergoing such an exam, the assumed lack of sexual connotation or intent on the part of the provider, and the intended benefits of the practice (i.e., to medical students learning how to perform such exams correctly, and thus, indirectly, to their future patients) (20).[3] Nevertheless, in response to growing outcry by patients, as well as dissenting providers —including many medical students who were jarred by the expectation that they should perform such exams as a part of their training—more than a dozen U.S. states have formally banned such procedures since 2019 (16).

In a parallel set of developments, the global movement for intersex rights has been gaining steam of late, with multiple countries recently passing or considering legislation to prohibit medically unnecessary genital 'normalisation' surgeries in children with diverse sex characteristics: that is, in persons too young to consent (23–26). This has coincided with increasingly vocal opposition to non-therapeutic infant penile circumcision for similar reasons (27–29), part of a broader, international human rights campaign that advocates for "genital autonomy" for all persons, that is, irrespective of sex characteristics or gender (30).

Meanwhile, a string of high-profile court cases since 2015—spanning England, the United States, and Australia—have been testing the limits Western liberal tolerance (31) for medicalised religious practices involving children's genitalia. Often carried out by healthcare professionals in high-prevalence settings (32), the procedure at the heart of these cases is female genital cutting or circumcision: specifically, the ritual nicking, pricking, or partial removal of the clitoral prepuce/hood or labia (i.e., without modifying the clitoral body or glans) (33–35). This practice, which has been explicitly defined as an illegal instance of 'female genital mutilation' in the United States and Australia (the analogous UK law remains

[3] To estimate the prevalence of such unconsented intimate exams (UIEs), we conducted a nationally representative survey 1,169 U.S. residents (21). When asked if they had, to the best of their knowledge, received a pelvic or prostate exam in a medical setting in the past five years without their explicit prior consent, 1.3 percent of females and 1.4 percent of males answered affirmatively. If extrapolated to the entire U.S. population, this figure suggests that potentially 3.6 million U.S. residents may have received such an exam within the stated timeframe. Disturbingly, although women and men reported similar rates of UIEs, nearly four times as many Black respondents as White respondents answered 'Yes' to the same question (3.6 percent versus 0.9 percent; RR = 3.90, 95 percent CI [1.29, 11.75], z = 2.40, p = 0.016). As Elizabeth Lanphier and Leah Lomotey-Nakon argue in their commentary, such findings stress the need for intersectional analyses in this space (22).

open to interpretation), is customary for girls within a subset of South and Southeast Asian Muslim immigrant communities (36–38).

The 'ritual nick' controversy may be instructive for the present discussion concerning the ethics of episiotomy. Noting that certain female genital rituals are "less extensive" than newborn penile circumcision, a popular birth custom in the United States even outside of religious communities, the American Academy of Pediatrics (AAP) suggested in 2010 that 'ritual nicking' should plausibly also be allowed. Penile circumcision, they reasoned, is routinely carried out by healthcare providers on persons unable to consent despite not being medically necessary. Since their "policy statement on newborn male circumcision expresses respect for parental decision-making and acknowledges the legitimacy of including [nonmedical factors, such as cultural or religious beliefs] when making the choice of whether to surgically alter a male infant's genitals," it might, therefore, be seen as inconsistent or unfair not to offer a comparable procedure for girls, if requested by the parents, provided it is "not physically harmful and is much less extensive than routine newborn male genital cutting" (39) (p. 1092).

But as van der Pijl and colleagues stress through their article on episiotomies, analyses in this vein (which problematically assume the permissibility of proxy decision-making even for non-medically necessary genital interventions) overlook a crucial moral point. As they see it, the ethics of a healthcare provider intervening into a patient's genitalia in the absence of a relevant medical emergency does not primarily turn on third-party judgments of expected levels of physical harm versus benefit, or on related notions such as extensiveness or invasiveness; rather, it turns on the patient's own consent.[4]

As they note, there is "apparent disagreement concerning the invasiveness of an episiotomy; some care providers believe it is not [invasive], and therefore consent can be presumed" (1) (p. 5). But such a conclusion does not follow. First, as with ritual nicking or circumcision, "an episiotomy invades tissue and leaves a wound [and] is therefore invasive." Second, "the sensitive nature" of the involved body parts is such that "even touching requires consent." And finally, "the arbiter of invasiveness for the purposes of consent requirements should surely be the person experiencing the procedure and its consequences; not the person executing it" (*ibid.*).

The "sensitive nature" aspect of this argument requires elucidation. Why should interventions into our genitalia be held to a higher standard when it comes to potentially

[4] For a discussion of how these sorts of arguments might apply to adolescents, especially in light of paediatric surgeon's (lack of) awareness of how and why to obtain 'assent' from minors, see the paper in this issue by Krista Lai and colleagues (40).

bypassing—or presuming—consent than any other intervention into the human body? As Talia Mae Bettcher has recently argued, such notions do require theorisation. Bettcher begins by asking us to consider the moral distinction between non-consensually "grabbing a person's genitals" and non-consensually "grabbing their hand." The former, she suggests, involves a "distinctive violation" that is not involved in the latter (41) (p. 6).

But what is the nature of that distinctive violation?

It has to do with the preconditions for human intimacy. Sensory and discursive exchanges between persons, Bettcher hypothesises, "are governed by normative boundaries constraining informational transmission and sensory access between us." Without such boundaries, "there would merely be unselective, unfettered sensory and informational access to one another." There can be no intimacy without selective exclusion. Thus, our very ability to experience intimacy with others, including sexual intimacy, requires that these selective exclusions—these boundaries—are generally not crossed unless certain background conditions are met. Importantly, outside of certain medical emergencies as described above, where a person's consent really can be presumed,[5] the most important such condition is that this crossing of boundaries—what Bettcher calls 'traversal'—should reflect our "intimate agency." That is, our ability to control, through our conscious will or choice, how close or distant we are, in terms of intimacy, to others.

When a physician gains intimate access to our bodies for medical purposes, Bettcher notes, "the pursuit of intimacy is not the aim" (40) (p. 7). Rather, "health is, and the traversal of sensory boundaries may be *necessary* for medical purposes" (emphasis added). If it is not necessary, however—and we have also not consented—the background conditions for appropriate traversal have not been met. Our boundaries are violated. Which is to say, the very boundaries that make certain forms of intimacy possible in our lives may be degraded by such unconsented traversals.

In recognition of such considerations, it is increasingly proposed [e.g., (42)] that it is categorically unethical for healthcare providers to engage – to any extent – with the genital or sexual anatomy of individuals within their care unless (a) the individual has personally consented to the intervention in question, or (b) the individual is experiencing "a medical emergency that threatens their welfare while they are incapacitated and they are not expected to (re)gain capacity in time to give informed consent" (21) (p 7). Accordingly, it is time for

[5] That is, barring an advance directive or other similar evidence that the person would *not* consent to a given genital operation even if, for instance, it was necessary save their life.

medicine to reorient these decisions back to affected person, starting with reforms to association guidelines, hospital policy, and medical education (43).

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