Episode: *Ethics Talk: How Stigma and Shame Obscure Clinical Purpose*

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[mellow theme music]

[00:00:03] HOFF: Welcome to *Ethics Talk*, the *American Medical Association Journal of Ethics* podcast on ethics in health and health care. I'm your host, Tim Hoff. Feelings of vulnerability are common in clinical settings. Patients are often asked to disrobe to allow clinicians to examine and touch them, and to divulge potentially embarrassing details about their bodies and their habits. But even in sensitive and awkward interactions, clinical professionalism and patient-clinician trust mean that appropriate and inappropriate actions are clearly distinguishable, right?

In 2018, former team physician for the US women's national gymnastics team Larry Nassar was sentenced to 175 years in prison after being found guilty of sexually assaulting his patients for years. In these cases, boundaries between clinically appropriate touching and interacting and assault were tested and violated by a physician who abused his power, creating traumatic confusion among his patients. Jordan Schweickart, a world-class athlete and former member of the US gymnastics team, describes how Nassar used such confusion to perpetuate his crimes. "I had always thought of sexual assault as something more violent, like a rapist holding you down, not something your doctor would do while pretending to help you."

Today on the podcast, medical historian Dr Wendy Kline, the Dema G. Seelye Chair in the History of Medicine at Purdue University, will help trace a history of pelvic examinations of women's bodies, as she does in her new book, *Exposed: The Hidden History of the Pelvic Exam*. She illuminates how stigma and shame can obscure ethical conduct and clinical purposes of many women's reproductive health interventions. Dr Kline, thank you so much for being here.

DR WENDY KLINE: Thank you so much for having me, Tim. I'm delighted to be here.
[music fades]

[00:02:04] HOFF: One point of your new book is that clinical procedures are never just clinical procedures. They're instead deeply embedded in social, cultural, and historical patterns of moral perception and habits of mind. Which procedures are done on whom, and relevant to this particular discussion, how any painful iatrogenic effects are addressed, can provide insight into the ways that social dynamics around gender and race are expressed in clinical practice. So with all that in mind, what do the ways that pelvic examinations have historically and contemporarily been administered suggest to us that we should heed today?

KLINE: That is such a great question and so important. As a medical historian, I like to remind people that something that we think of as simple as a medical procedure does, in fact, have a history. And what's interesting about the case of the pelvic exam is that the actual procedure and the tools used during the procedure, such as the speculum, have changed very little over the past nearly 200 years, but the context obviously has, as well as the alleged purpose of the exam at different periods.

So, really, I see as four major points here in which we really need to understand the historical aspect of this. And one is really of central concern to us today, and that's consent. Historically, consent was not seen as necessary, and in fact, that was embedded in the whole origins of the procedure. So, understanding that, I think, is really important to some of the issues going on today. Secondly, it's important to understand that the first patients receiving pelvic exams were also really the first medical subjects, in a sense, research guinea pigs. Thirdly, the procedure is developed at a time when women, and especially Black women, had very limited rights, were seen as inferior. And this would include things like their concept of pain and tolerance for pain would be very different. And then finally, concerns at the time it's developed. So we're talking 1830s, 1840s is a time of great concern over the whole concept that a woman's body, particularly a white, middle-class woman's body, should be touched by any kind of doctor because of concerns about Victorian morality.

[00:04:39] KLINE: So, the obvious, the person that we all point to as sort of the father of American gynecology, James Marion Sims—who of late has been exposed for a lot of the controversial natures of his procedures, namely that his first patients were enslaved patients in the American South, and many of whom were operated upon multiple times without anesthesia, in part because anesthesia was quite controversial at the time—but regardless, even Sims himself was aware of the kind of, the potential for controversy around looking into a woman's vagina. And he says something in his memoir, which I think is quite telling. He says, "If there was anything I hated, it was investigating the organs of the pelvis." And one would think, why would a gynecologist say something like that, right? Why would he essentially allude to sort of a disgust for this? And I think that really speaks to the time period in which it would've been quite controversial. And he was doing everything he could to appear as the Southern gentleman who only had the best interests in mind of his patients by suggesting that he really wasn't interested in doing it. He just knew it was good for the cause, for the origins of gynecology.

So, I mean, all of these things together remind us that despite the fact that we continue to have pelvic exams in 2024, they are loaded with the culture and the context which brought us to this time period. And we still grapple with a lot of these issues about sexuality, about consent in particular, that potentially color the experience for patients today.

[00:06:32] HOFF: Mm, mmhmm. Also, social and political stigma about women's bodies is still very common. As we're having this interview, debates about women's bodily autonomy are a focal point for the election, as they have been for every election as long as I can remember. But despite this routinization of clinical and political surveillance of women's bodies, abuse is still very frequent, and taboo, fear, and shame are still

rampant, as you note, even in clinical settings, which, ironically, can obscure key purposes and processes of so-called routine gynecological care. So, what should our audiences know about these tensions that are still so commonplace in women's sexual and reproductive health?

KLINE: So, I feel very strongly, based on the research that I've done, that one of the most problematic aspects of how we approach and talk about the pelvic exam today is directly linked to stigma, and particularly stigma about the female body. And we're all familiar with the various ways in which that's true. But let me say a few things about some studies that have been done that suggest a direct link between stigma around the female body and reproductive organs and problems with getting people to go to the gynecologist and the experience that they have.

[00:07:53] So here's one example. A study that was done recently in the UK showed that a majority of UK women between the ages of 16 to 25, in this survey, have a problem using the term "vagina" or "vulva." And why does this matter? Well, in addition to having a problem saying it, there's a link between that and then a basic lack of anatomical knowledge. In other words, by being uncomfortable saying it, it also can potentially lead to a lack of understanding about one's own body parts. So, in that same survey, only half of women aged 25 to 36 in this UK study could accurately identify parts of the vagina on a simple diagram. So they're not even understanding their own body parts or being able to name them. And then nearly one third of this younger women group, 16 to 25, admitted they avoided going to the gynecologist altogether due to shame or embarrassment. So that's really powerful. That is, by our lack of our willingness, our lack of willingness to discuss or talk about or use the terminology of female reproductive health, we are, in fact leading to a larger public health problem by the fact that many women therefore feel reluctant to go.

KLINE: Another example about stigma surrounding female body parts doesn't even have to do with a gynecological exam per se, but it suggests the power that politics plays in this. So, in 2012, Michigan State Representative Lisa Brown was banned from speaking in the House for using the term "vagina" in a debate over an anti-abortion bill. Her Republican colleague found the term offensive, and therefore she was censored. What does she do in response? She ends up with her female colleagues saying the word "vagina" hundreds of times on the Capitol steps by reading *The Vagina Monologues* as sort of a response to that. This idea, you know, what term are we supposed to use if "vagina" is offensive? So these kinds of aspects of stigma really suggest how it leads potentially young women to neglect or feel safe or comfortable talking about this. And I think that is definitely leading to larger problems in terms of getting into the gynecologist's office in the first place.

[00:10:31] A study that was conducted in the United States in 2017 showed that one half of patients surveyed couldn't answer the simple question, "Do you know why this examination is performed" directly after having the pelvic exam. So there's even confusion when you get into the gynecologist office. Why is this procedure done? Why is it required? And interestingly, that is a current debate between various medical organizations. But the fact that there is some confusion about whether it should be

done, how often, particularly when it comes to the pap smear, just simply muddies the water and makes it even more confusing for women to understand how should they best advocate for themselves when it comes to reproductive health.

[00:11:22] HOFF: Hmm. And this confusion about whether and when and even how to advocate for yourself and what the purpose of this kind of care even is, is potentially harmful, especially as most pelvic examinations have unquestionable health benefits. Pap smears, for example, have vastly reduced cervical cancer rates. Yet, as this conversation tries to make clear, pelvic examinations draw in very specific ways on clinicians' power and on patients' vulnerabilities. This notion of chaperoning has been devised as one that potentially protects patients, and when the word "chaperone" is used, it's not always clear that it's the patient who needs protection from the clinician. The protector chaperone is for the patient, but they're still on the clinicians' turf, on their home field, so to speak. Does the notion of chaperoning help us much clinically and ethically, in your view?

KLINE: I think, in essence, the concept of a chaperone is a good thing because it reminds both patient and provider and medical students and everybody else involved in this whole scenario that it is a touchy subject, that it does have the potential to cause damage. And so, by offering the presence of another person in the room, you're making a statement that you understand and respect that potential and want to do everything in your power to avoid any problems taking place.

That said, I know that some people I've talked to don't feel comfortable with the idea of an outsider, an additional person kind of peering in or being part of that scenario. So I think like with many, many issues around reproductive health, choice should be part of that conversation. So, if a patient does not feel comfortable, then talk about alternatives. And one I've talked to is interested in the possibility of the alternative being a chaperone standing right outside the door, so that if at any point that patient feels uncomfortable, they know that there is a person on the other side of the door that can be involved in it.

[00:13:30] KLINE: And the other thing I wanted to say is, I think I sort of already said it, but it's an indicator that this exam may be routine, but its history and reputation mandates that we don't treat it as such. It may be routine, particularly for the provider, but much less so for the patient who is the one in the vulnerable position. So, having a conversation around that and making sure that at the end of the day, it's really the patient's best interests and approach that is important.

On the other hand, I also want to stress that that's not the only thing that should be done. We know that some of this abuse has taken place while there has been another person in the room. Larry Nassar was known to abuse his patients, while oftentimes the patient's mother was standing in the room. If somebody wants to get away with it, they'll figure out a way to get away with it. And so, I don't think anybody should assume that as long as a chaperone is in the room, no abuse can take place.

[00:14:36] HOFF: Mm, mmhmm. Yeah, that's an important caveat. Thank you for drawing that line. In fact, in the introduction to this particular episode, we recounted a

quote from one of Larry Nassar's victims, Jordan Schweickart, who said something to the effect of, I didn't even recognize at first what was happening to me as sexual assault, because I thought it was just part of this routine care I was receiving. So, if both the patient and their chaperone are unclear about the purposes and processes of the examination, that potential for abuse is still there.

[00:15:05] But to wrap up, what should health professions students and trainees specifically at the beginnings of their careers draw from your work and apply to their own educations and practices?

KLINE: This is such a wonderful question because I am not a medical practitioner, nor do I plan to be one or play one on TV or anything. But having done all this research, the idea that it could implement some sort of conversation and ultimately some change is incredibly uplifting to me because I do think it's a problem. So, among the things in terms of looking at the history and the patients who have been part of this conversation historically, who have demanded change, you know, women's health activists in the 1970s were some of the first to say, "Warm the speculum before you insert it into the vagina. Look the person in her eyes when you're talking to her. Perhaps meet this patient before they're naked or draped under a paper sheet. Do things to empower the patient as part of it." All of those things are important, and they have changed, to a certain extent, the dynamic, the patient-doctor or clinician relationship in this way.

But I guess what I want to say to medical students, who may or may not have an appreciation or an opportunity to understand the history, is that it may feel routine or mundane for the provider, but that is often not true for the patient. So, don't lose awareness that it can feel anything but routine to those with their legs in the stirrups. And that's not just about physical pain, which is often the case, that it is uncomfortable and can be very painful for some people, but also fear, anxiety, distrust, vulnerability. It could trigger past abuse. There are so many things that could take place in this kind of scenario that it's really important for the provider to be sensitive to that.

[00:17:11] At one point I was giving a presentation on the history of the pelvic exam to some medical students. And luckily for me, they had the opportunity to evaluate me, to write down the reactions to my lecture, and then those reactions were given to me. And I was really struck by one student at Northwestern University who remarked that they had initially been terrified at doing a physical exam and the power it wielded. But that after six months of desensitization, in their words, through rounds of practice and clinical sessions, the fear and mystique had worn off. But then, after hearing me talk about the history of the pelvic, the student realized how tenuous the physical exam is as a contract between the patient and the physician. And the student now realized that they should be wary of what each action means to the patient, and that their understanding of each action may be different from how the patient understands it, either from history or personal experience. So, those kinds of things. I know that time is limited. The interaction has to take place in a fairly quick period of time but make use of that time to make sure you indicate to the patient your respect and empathy for what that experience might feel like for them. [mellow music returns]

[00:18:27] HOFF: Dr Kline, thank you so much for your time on the podcast today. I really appreciate you sharing your expertise.

KLINE: Thank you so much for having me, Tim.

HOFF: That's all for this month's episode of *Ethics Talk*. Thanks to Dr Kline for joining us. Music was by the Blue Dot Sessions. To read our full issue on Pain Management in Non-Labor and Delivery OB/GYN Procedures, visit our site, visit our site, journalofethics.org. Follow us on X @journalofethics for all of our news and updates. And we'll be back next month with an episode on Regret in the Moral Psychology of Surgical Professionalism. Talk to you then.