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Using Tort Law to Secure Patient Dignity

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Using tort law to secure patient dignity

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Often used as teaching tools for medical students, unauthorized pelvic exams erode patient rights. Litigation can reinstate them.

To the surprise of many people and the consternation of some medical school faculty and students, a media firestorm erupted last year over teaching hospitals’ practice of allowing medical students to perform pelvic exams on anesthetized patients without their express consent.¹

This practice, common since the late 1800s,² was largely unchallenged until a 2003 study reported that 90 percent of medical students who completed obstetrics and gynecology (ob-gyn) rotations at four Philadelphia-area medical schools performed pelvic exams on anesthetized women for educational purposes.³

Although medical students performing educational exams on anesthetized women do not receive feedback and thus cannot hone critical communication skills, teaching faculty argue that being unconscious relaxes the patient’s muscles, making it easier to palpate anatomy, and spares the patient the humiliation of being examined multiple times while conscious.⁴

As the controversy unfolded, it appeared initially that informed consent policies might change for the better. The American College of Obstetricians and Gynecologists (ACOG)—which tepidly defended the practice in 1997, asserting that patients have “an obligation to participate in the teaching process”⁵—issued a one-paragraph statement two months after the 2003 study was published, affirming the relevance of informed consent.

If the pelvic exam, ACOG declared, offers a woman “no personal benefit and is performed solely for teaching purposes, it should be performed only with her specific informed consent, obtained when she has full decision-making capacity.”⁶

The day after the Federal Trade Commission and the Department of Justice heard testimony on the topic, the Association of American Medical Colleges (AAMC), which represents 125 accredited U.S. medical schools and over 400 teaching hospitals, issued a three-paragraph news release that called the use of women under anesthesia without their knowledge and approval “unethical and unacceptable.”⁷

California enacted new legislation making unauthorized examinations a misdemeanor and grounds for revoking a physician’s license.⁸ Finally, a half-dozen medical schools

announced that they had voluntarily begun, or would begin, to ask patients for explicit consent before medical students perform pelvic exams.⁹

Unfortunately, these early victories quickly stalled. At the same time a handful of schools revamped their policies, an equal number of hospitals and medical schools publicly dug in, defending the practice:

- Andrea Rapkin, a professor of obstetrics and gynecology at the University of California at Los Angeles (UCLA) Medical Center, noted that while UCLA doctors inform patients that they will be examined under anesthesia, they “don’t specify that it is a pelvic exam.” She explained that “we have no reason to specifically state that a medical student will [perform the exam]. It’s not the whole team of medical students—it’s usually one or two.”¹⁰

Last year, William Dignam, UCLA professor emeritus and former ob-gyn clerkship director, elucidated why an explicit discussion with patients of student participation is unnecessary: “I’m reasonably certain that patients know medical students will be participating,” adding, “it’s pretty much covered in an overall consent form.”¹¹

- An ob-gyn professor at the Medical University of South Carolina (MUSC), Steven Swift, acknowledged that medical students who are directly involved in a patient’s care perform pelvic exams after the patient is anesthetized for gynecological surgery. They do not secure specific consent for the exam, he noted, as it is considered regular medical practice in the field, like helping with surgical staples. Furthermore, he said, “patients understand this is a teaching hospital and that residents and medical students are involved in their care.”¹²
- John Larsen, George Washington University Hospital’s ob-gyn chairman, noted that he had “no plan to amend the hospital’s policies. ‘I’m a policy minimalist,’ he said.”¹³

Clearly, relying on media exposure or government regulation will be slow going. When the media loses interest, what incentive is there for teaching faculty or hospitals to voluntarily change? Teaching hospitals take patients who are in the worst position to know what’s occurring—they are unconscious—and use them in ways that leave no physical signs and are often undocumented in the patients’ medical records.

Given the inherent secrecy of pelvic exams on anesthetized patients, hospitals and faculty have yet to defend their conduct in courtrooms. This secrecy, and the resulting lack of legal oversight and accountability, have reinforced the sense that doctors and hospitals don’t really need to obtain consent when patients are most vulnerable.

Although patients have been unable thus far to enforce their own interests, the tort system may yet succeed in securing the right of patients to decide who touches their bodies and under what circumstances.

The practice of using anesthetized patients to teach pelvic exams has been well documented for years. A 1992 study showed that 37 percent of U.S. and Canadian medical schools allowed students to use anesthetized women without their consent to learn how to perform pelvic exams.¹⁴

In 1989, students at 25 percent of U.S. medical schools reported using female patients to learn how to do gynecological exams.¹⁵ One in 10 was anesthetized at the time, and it is unclear what, if any, consent was given.

In 2002, Stanley Zinberg, vice president of practice activities for ACOG, acknowledged the long history of this practice, asserting that it was becoming “less common.”¹⁶ Anecdotal accounts show that even men are not immune from the indignity of unauthorized, invasive exams while anesthetized.¹⁷

Disputed numbers

The number of students who perform pelvic exams on a single anesthetized patient is a significant element in making them actionable. Perhaps this is why teaching faculty vehemently dispute the number. When asked last year by a regional newspaper, ob-gyn residency directors in North Carolina invariably said that only those students on a patient’s “care team” participate in pelvic exams.¹⁸

Yet in 1997, a Duke University professor published narratives of medical student training experiences that described as many as five or six students performing pelvic exams in succession on a single anesthetized patient. As one student said, “[It was like] all these medical students parading in to each take their turn, y’know, like going to a vending machine, and walking by. Only it’s not a vending machine, it’s a woman’s vagina. And you’re each taking your turn, walking by and sticking your hand in.”¹⁹

Although it is unclear how prevalent this “vending machine” approach is, it is likely to cause grave concern, particularly among women. One study of patient-consent practices found that while women willingly consent to pelvic exams for training purposes, the number of students involved matters a great deal.

Nearly all the women in this study, 84 percent, wanted to limit participation to no more than two students.²⁰ And in two different studies, all the women who consented to student exams wanted to be asked for permission, regardless of the number of students involved.²¹

Despite consistently strong reactions, apparently some faculty have not questioned the practice. As Jessica Bienstock, director of resident and medical student education at the Johns Hopkins School of Medicine and residency program director for the school’s ob-gyn department, noted, “I don’t think any of us even think about it. It’s just so standard as to how you train medical students.”²²

Some faculty justify unauthorized exams by medical students as a vital and irreplaceable part of physician education, to which patients would not consent if given the opportunity.²³ But research and experience have shown that patients are quite willing to help with medical student training. A study in the United Kingdom found that 85 percent of women who were asked consented to pelvic exams by medical students.²⁴ In the United States, only 39 percent of patients surveyed said that they would definitely or probably object to a pelvic exam by a student while being cared for as an outpatient.²⁵ In fact, patients will consent to not only examinations, but also riskier procedures by students: One study found that 52 percent of participants were willing to allow a medical student to perform his or her first spinal tap on them.²⁶

Researchers who have studied consent practices flatly reject the notion that medical students will be starved of practice opportunities when patients are allowed to give consent: “The small number of women who would not consent to vaginal examination under anesthesia by medical students will not reduce our ability to teach gynecological examination to undergraduates.”²⁷

When teaching normal anatomy, medical schools and teaching hospitals can always use paid volunteers, called gynecological teaching associates; when teaching abnormal anatomy, they could compensate patients. More fundamentally, as one researcher noted about the common use of deceased patients for medical teaching purposes without the family’s consent, “the likelihood of refusal is hardly a justification for deciding a consent is unnecessary.”²⁸

Theories of recovery

Performing a pelvic exam on an anesthetized patient as a training exercise for medical students is not inherently tortious as long as the patient knows about it and consents. But some teaching hospitals do not candidly inform patients about nontherapeutic and purely educational exams that will be performed. Most hospitals make only general disclosures like the following, taken from George Washington University Hospital’s 2002 admission form:

I have come to [this hospital] for medical treatment. I ask the health care professionals at the hospital to provide care and treatment for me that they feel is necessary . . . I understand that my health care team is made up of hospital personnel . . . under the direction of my attending physician and his/her assistants and designees (to include interns, residents, fellows, and medical students).²⁹

Many physicians believe that nothing more needs to be said, arguing that patients “understand from the beginning that they are admitted for teaching purposes.”³⁰ But the refusal to allow women to make informed choices about educational pelvic exams implicates several possible causes of action.

For instance, claims for medical battery and malpractice, failure to obtain informed consent, and breach of fiduciary duty could lead to recovery of actual and punitive

damages. Where the teaching hospital is state- or federally owned, a civil rights cause of action may arise under 42 U.S.C. §1983. Courts may also be persuaded to issue injunctions or make declaratory judgments that prohibit unauthorized pelvic exams on anesthetized women.

Women who suspect that unauthorized pelvic exams have been performed will face an uphill battle proving such exams took place and, consequently, changing the behavior of large teaching hospitals. But the task is not impossible.

Medical battery and malpractice. As intentional, unwanted, and offensive touching, unauthorized pelvic exams fall into the category of the most basic of torts: battery. Actual damages are generally presumed in battery cases, and punitive damages are available because battery requires intent by the wrongdoer. However, intent, whether specific or general, is hard to prove, particularly where the wrongdoer is hiding evidence of wrongdoing from the victim. In addition, many insurance policies exclude coverage for intentional touching.

To overcome these problems, plaintiff lawyers could instead base an action on negligence or medical malpractice. In that case, the patient will not have to show intent—only that the wrongdoer created an unreasonable risk of bodily harm.³¹ Medical malpractice depends on deviation from accepted standards. Some states set standards in their statutes and regulations; others require expert testimony. Failure to obtain informed consent can be considered a type of medical malpractice.

But how does a patient prove that an unauthorized exam occurred? Some prominent teaching hospitals—including those at George Washington University, the University of North Carolina at Chapel Hill, UCLA, and MUSC—have admitted to and defended the practice. To survive summary judgment in a medical battery or malpractice case, a patient need only establish through medical records that she was a patient under anesthesia in an ob-gyn ward during the period in which the hospital admits it allowed the practice.

This should suffice to let the plaintiff conduct discovery of hospital records to find lists of students on the ob-gyn rotation—and other patients seen by them. Certainly, courts will struggle with balancing the interests of public disclosure of personal medical information, but the Health Insurance Portability and Accountability Act of 1996 provides a mechanism to maintain confidentiality in judicial proceedings: qualified protective orders.³²

Even if students performed unauthorized exams and can be questioned, they may not admit having done so on any given patient. Likewise, faculty members may not admit that they directed students to do so. In addition, medical records for ob-gyn patients may not show evidence of any teaching exam.

This failure to document educational exams—particularly when the exams are unrelated to the reason for surgery—may be spoliation of evidence. Without recourse, the evidence

will depend on eyewitnesses and nonpatient records like operating room logs, video surveillance of the operating room and approaching hallways, and rotation assignments from medical schools.

Hospitals and physicians who participate in Medicare or Medicaid are required to maintain a record of all medical procedures performed on a patient, which becomes the patient's chart.³³ Similarly, state regulations or hospital policies may require thorough record-keeping, which could also create an enforceable right for patients or a risk of discipline for noncomplying doctors or hospitals. If a claim of spoliation is made, the burden could be shifted to the hospital and physicians to prove that an unauthorized exam did *not* occur. A finding that the defendant concealed its activity may be sufficient to prove actual malice and support a punitive damages award.³⁴

Failure to obtain informed consent. In most jurisdictions, failure to obtain informed consent is considered professional negligence. To prevail, the plaintiff must establish the standards for disclosure and consent in the defendant's branch of medicine, any breach of the standards, and damages proximately caused by the breach.

Establishing the duty to inform the patient of a student performing a pelvic exam on her may seem a low hurdle. Yet, teaching hospitals are full of well-qualified, experienced, and respected doctors who will state that no express consent is necessary for educational pelvic exams because patients already consented to the procedures that required anesthesia and so have impliedly consented to these exams as well.

A successful plaintiff will have to show that she would not have consented even if the hospital or doctor had provided the missing information and that she suffered some damage as a result. To properly frame this claim, the plaintiff must demonstrate that the hospital and supervising physician had a duty to inform her expressly about the student exams.

Here, the standard for disclosure varies by state. Most jurisdictions follow the "professional" standard imposed by common law or state statutes, while a growing minority ascribe to the "material risk" standard.³⁵

Under the professional standard, physicians must disclose to patients what a reasonably prudent physician would disclose in similar circumstances.³⁶ The near-uniform failure of hospitals and faculty to candidly disclose practice exams would seem to make it easy for defendants to meet this standard; however, premier institutions like Harvard now require specific patient consent for pelvic exams under anesthesia.³⁷ Ethics guidance from the American Medical Association also calls for specific consent,³⁸ as do guidelines from the AAMC and ACOG.³⁹

Some states incorporate this ethical guidance into their medical practices act, which governs physician conduct and makes the guidance authoritative in these jurisdictions.⁴⁰ Recent reviews of ethics have also resoundingly called for specific consent.⁴¹ Thus, even in professional-standard jurisdictions where most physicians do not disclose unauthorized

pelvic exams, plaintiffs can present evidence that a reasonably prudent physician would do so.

In jurisdictions that follow the material risk standard for informed consent, doctors must disclose the risks to which a person in the patient's position would "be likely to attach significance . . . in deciding whether or not to forgo the proposed therapy."⁴² The successful plaintiff will need to show that the failure to inform her of the exam violated her right to autonomy in matters of her own body.

Because pelvic exams performed on an anesthetized patient present some risk—usually resulting from keeping the patient anesthetized longer than she would be otherwise and the distress of discovering that one's body was used in this way—and because the patient receives no medical advantage from it, the risk necessarily outweighs the benefit to the patient. Moreover, being unwittingly subjected to this risk constitutes damage itself, as does a patient's loss of trust in her physician for not informing her of the exam beforehand.⁴³

One hurdle in informed-consent claims is satisfying "but for" causation. The same studies that the plaintiff may use to help establish that unauthorized pelvic exams occur also demonstrate that many women consent to such exams if asked before surgery. It would seem that the successful plaintiff needs to establish that she and other reasonable patients would have refused the exam if candidly informed.

One solution to this dilemma would be to show that the plaintiff—and other reasonable patients—would have selected a nonteaching hospital had they been told that students would practice performing pelvic exams on them. This may be problematic, however, because not all women have a nonteaching hospital option nearby, especially if they are poor or without insurance. Not coincidentally, a disproportionate share of unauthorized pelvic exams are performed on such disenfranchised patients who cannot readily complain.⁴⁴

Breach of fiduciary duty. Few fiduciaries enjoy more respect or receive more trust than doctors with their patients. Failure to obtain informed consent for a medical procedure while the patient is under anesthesia cannot satisfy the doctor's fiduciary duty to the patient.⁴⁵ Some doctors and hospitals even mislead patients about the need for educational exams, with some admission forms authorizing only medical treatment that is "necessary."⁴⁶

Fiduciary duty cases require a duty not to injure the plaintiff, a failure to observe the duty, and an injury proximately resulting. The plaintiff must also show the wrongful conduct was within the scope of the fiduciary relationship.⁴⁷ Health care providers who misrepresent a treatment's risks have been found liable for fraud and misrepresentation.⁴⁸ Fraud requires the plaintiff to prove intent and reliance, but the fiduciary relationship between doctor and patient eliminates these requirements in a claim for breach of fiduciary duty.

Further, where the supervising physician knows he or she will allow multiple medical students to perform pelvic exams on the patient after she is anesthetized, the physician might not inform the patient for fear that she will withhold consent. As a result, the doctor tacitly represents his or her disclosure to be complete, while the patient justifiably relies on the inadequate disclosure and signs the consent form agreeing to have the surgery.

This misrepresentation violates the patient's right to rely without reservation on the belief that her doctor will act only to protect her body and not expose her to unnecessary risks. Breach of the special doctor-patient relationship in favor of other interests leads to a loss of trust in medical professionals and can cause distress and humiliation. The patient suffering a breach of fiduciary duty would be a strong candidate to recover both actual and punitive damages.

Defenses

In defending this practice, hospitals and teaching faculty insist that patients have consented, expressly or impliedly. Presumably, they would make the same argument in litigation.

Express consent. Obviously, express consent is valid only when there is a complete disclosure. Consider again George Washington University Hospital's admission form: Nowhere does it mention the possibility of educational exams unrelated to the patient's treatment.

In such forms, a single principle applies to consent for all care being disclosed: The care provided constitutes "medical treatment" necessary for the patient's well-being. Whatever benefit society may gain from training physicians, this admission form and others do not inform the patient of or authorize exams that are for solely educational purposes unrelated to the surgery.

When a student repeats an exam he or she just watched the attending physician perform, the student's exam offers no medical benefit to the anesthetized patient and cannot be said to be necessary. As a matter of contract law, these forms provide consideration only for the initial, medically necessary exam, not for additional exams done for students' benefit.

Although some consent or admission forms notify patients that students will be part of their "care team," a person of ordinary sensibilities would understand "care" to be synonymous with "treatment." Repeated exams performed solely to train students, which offer no benefit to the patient and are not medically necessary, cannot be considered treatment or care under any analysis. Consequently, the patient's consent on an admission form without specific disclosures cannot be stretched to cover nontherapeutic pelvic exams that confer no benefit to her and may even increase her risk.

Implied consent. The claim that patients give implied consent for training exams when they accept care also fails under scrutiny.

Patients often select a particular hospital because they think they will receive good care or because that is where their health plan offers the best reimbursement for treatment. Some patients simply show up at the facility designated by their physician and may not even know that it is a teaching facility or that their doctor also teaches. One study reports that most elderly patients are unaware of a facility's teaching status.⁴⁹ Some patients are simply taken to a hospital in an emergency and may even be unconscious at the time.

In fact, there is little reason that patients should know. Disclosure to the public of a hospital's teaching mission varies widely. A small fraction indicate their affiliation with a university in their name, but this is far from the norm. Of the 353 members of the Council of Teaching Hospitals and Health Systems, only 75—or roughly 1 in 5—contain the word “university” in their name. Only one of Harvard Medical School's 18 affiliated hospitals and institutions references Harvard in its name.⁵⁰

The solution

A patient's right to control what happens to her body when she is most vulnerable is protected by tort law. Doctors and hospitals refusing to affirm this right should be exposed to significant liability.

In a trial, many female jurors may quietly wonder whether they too were subjected, without consent, to pelvic exams during surgery, and most men on the jury may be able to imagine it happening to their wives and daughters. It is likely that no one on the jury will ever have had a conversation with a physician about students performing such intimate exams on them.

Failing to ask patients for permission smacks of paternalism. It also reveals a deep distrust of the generosity and goodwill of patients and their commitment to training the next generation of physicians.

The solution is simple: Just ask. But recent experience has shown that meaningful and complete hospital-by-hospital change is unlikely to come until a hospital or physician pays a substantial award for this error in ethical judgment. We believe that day is coming soon.

Notes

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2. Michael R. Albert, *The Diverse and Controversial Career of Dr. George Henry Rohé (1851-1899)* 1-28 (Feb. 6, 2003) (unpublished manuscript, on file with authors).

3. Peter Ubel et al., *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*, 188 AM. J. OBSTETRICS & GYNECOLOGY 575 (2003).
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6. Press Release, American College of Obstetricians and Gynecologists, Statement of the ACOG Committee on Ethics Regarding Ethical Implications of Pelvic Examination Training (Apr. 25, 2003), available at www.acog.org/from_home/publications/press_releases/nr04-25-03.cfm (last visited Sept. 7, 2004).
7. Press Release, Association of American Medical Colleges, AAMC Statement on Patient Rights and Medical Training (June 12, 2003), available at www.aamc.org/newsroom/pressrel/2003/030612.htm (last visited Sept. 7, 2004).
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11. Audrey Warren, *Doctor Training Faces Scrutiny: Allowing Student Exams on the Unconscious Raises Patients-Rights Issues*, WALL ST. J. (Europe), Mar. 13, 2003, at A7.
12. Liv Osby, *MUSC May Change Pelvic Exam Practice*, GREENVILLE NEWS, Mar. 13, 2003, at B1.
13. Goldstein, *supra* note 1.
14. C. Beckmann et al., *Gynaecological Teaching Associates in the 1990s*, 26 MED. EDUC. 105 (1992).
15. Daniel L. Cohen et al., *Pelvic Examinations by Medical Students*, 161 AM. J. OBSTETRICS & GYNECOLOGY 1013 (1989).
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18. Karen Garloch, *N.C. Schools: Pelvic Exams Not Gratuitous*, CHARLOTTE OBSERVER, Mar. 24, 2004, at 1E.
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23. Redfearn, *supra* note 17; Lawton et al., *supra* note 20.
24. Lawton et al., *supra* note 20.
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29. Patient Authorization Form, The George Washington University Hospital, Form 80-010 (Mar. 2002) (on file with authors).
30. Statement of the ACOG Committee on Ethics, *supra* note 6.
31. *See* RESTATEMENT (SECOND) OF TORTS §18 (1965).
32. 45 C.F.R. §164.512(e) (2003).
33. 42 C.F.R. §482.24 (2003).
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40. *See, e.g., S.C. State Bd. of Med. Examiners v. Hedgepath*, 480 S.E.2d 724 (S.C. 1997).
41. L. Lewis Wall & Douglas Brown, *Ethical Issues Arising from the Performance of Pelvic Examinations by Medical Students on Anesthetized Patients*, 190 AM. J. OBSTETRICS & GYNECOLOGY 319 (2004).
42. *Canterbury v. Spence*, 464 F.2d 772, 787 (D.C. Cir. 1972).
43. *See Lugenbuhl v. Dowling*, 701 So. 2d 447, 455 (La. 1997).
44. Beckmann et al., *supra*, note 14, at 107.
45. *See Moore v. Regents of the Univ. of California*, 793 P.2d 479, 485 (Cal. 1990).
46. Patient Authorization Form, The George Washington University Hospital, *supra* note 29.
47. *See Korper v. Weinstein*, 783 N.E.2d 877, 881 (Mass. App. Ct. 2003).
48. John P. Ludington, Annotation, *Medical Malpractice Liability Based on Misrepresentation of the Nature and Hazards of Treatment*, 42 A.L.R. 4th 543 (1985).
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