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Treating Patients in Non-Labor and Delivery OB/GYN Examinations and Procedures

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Abstract

Non-labor and delivery obstetrics and gynecology (OB/GYN) procedures are an important and necessary part of reproductive health care. However, performing a pelvic exam or procedure, which requires entry through the pelvis, is often an uncomfortable, painful, embarrassing, and anxiety-provoking experience. Given the delicate nature of these examinations and procedures, it is imperative that physicians uphold the inherent trust placed in them that derives from the patient-physician relationship. Respecting a patient's privacy—including physical, informational, decisional, and associational privacy—is a prerequisite for ensuring that a fundamental foundation of trust exists between the patient and physician. This essay explores the ethical issues physicians face during clinical practice when performing non-labor and delivery OB/GYN examinations and procedures.

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Ethics in Non-Labor and Delivery Obstetrics and Gynecology Practice

Non-labor and delivery obstetrics and gynecology (OB/GYN) examinations and procedures are an important and necessary part of reproductive health care. However, performing a pelvic exam or procedure, which requires entry through the pelvis, is often an uncomfortable, painful, embarrassing, and anxiety-provoking experience that raises several important ethical questions during clinical practice.[1] Given the delicate nature of these examinations and procedures, it is imperative that physicians uphold the inherent trust placed in them that derives from the physician-patient relationship.[2] Respecting a patient's privacy—including physical, informational, decisional, and associational privacy—is a prerequisite for ensuring that a fundamental foundation of trust exists between the patient and physician.[3]

This essay explores some of the ethical issues addressed in the American Medical Association (AMA) *Code of Medical Ethics* that physicians face during clinical practice when performing non-labor and delivery OB/GYN examinations and procedures. Additionally, this article explores ethical approaches to everyday clinical OB/GYN

practice, including when to have a chaperone present during pelvic and other sensitive examinations and procedures and how to manage patients who are difficult to examine or refuse a necessary pelvic examination, who are suspected of having experienced or of currently experiencing abuse, and who experience functional chronic pelvic pain.

The AMA *Code* and Sensitive Physical Examinations

Performing non-labor and delivery OB/GYN examinations and procedures requires the physician to recognize the sensitive and intimate nature of the patient encounter and to be cognizant that the patient is likely experiencing discomfort, embarrassment, anxiety, and pain. The AMA *Code* recognizes that the "health and well-being of patients depends on a collaborative effort between patient and physician in a mutually respectful alliance."[4] It follows that physicians have an ethical responsibility to protect their patients' dignity, privacy, and confidentiality, all of which build the fundamental foundation of trust inherent in the patient-physician relationship.[2,3,4] Additionally, the AMA *Code* supports open communication during the informed consent process,[5] and ethics literature recommends "explicit consent for intimate exams."[6] Therefore, physicians should foster an environment that encourages patients to be "truthful and forthcoming" and to "cooperate with agreed-on treatment plans."[7]

Managing a patient who is difficult to examine or refuses a necessary pelvic examination or procedure. Performing a pelvic examination for screening purposes to detect pathology or for a procedure, such as inserting an intrauterine device (IUD), is an essential part of reproductive health care. Although Pap smears are associated with reduced morbidity and mortality from cervical cancer,[8] patients might be reluctant to undergo pelvic examinations because of the potential embarrassment, pain, and emotional distress associated with this intrusive procedure.[1,9] Additionally, people with minoritized sexual and gender identities are the most underserved population with respect to gynecological health care and often avoid necessary pelvic examinations due to stigma and discrimination.[1,10] Physicians should be aware of their own inherent biases and their professional obligation to both avoid stereotyping and prevent bias from impacting their medical judgment.[11]

When managing a patient who is difficult to examine or refuses a necessary examination or procedure, empathy, compassion, and open communication are essential. First, it is important to have an open conversation to determine the underlying reason for the patient's discomfort or refusal. For example, try to determine if the patient has experienced abuse or if they are afraid of pain or embarrassment. To the extent possible, provide support to alleviate the patient's concern. Once you have listened to the patient, try to address the patient's concerns and assure them of your ethical obligation to protect their dignity, privacy, and confidentiality. Offer the use of a chaperone, appropriate gowns, private facilities for undressing, and sensitive use of draping, and make it clear that the patient is allowed to pause or end the exam at any time that they feel uncomfortable.[12] Importantly, before beginning the examination or procedure, it is imperative that you establish informed consent.

Managing a patient whom you suspect has experienced or is experiencing abuse. Physicians have an ethical obligation to inquire about physical, sexual, and psychological abuse as a routine part of the patient's medical history.[13] Approximately 1 in 3 women globally and over 50% of transgender people will be or have been subjected to sexual violence; thus, while challenging, this inquiry is essential for providing high-quality care and ensuring that the patient's well-being is protected.[14,15] Empathy and compassion

when making inferences about a patient's physical, sexual, and psychological history are imperative for encouraging the patient to be truthful and forthcoming. If you have any suspicion of abuse, you should be sensitive to the patient's needs and have this conversation in private. Qualitative research has identified 3 facilitators of a patient disclosing domestic violence: trust in the clinician; directly being asked about abuse; and the availability of informational resources, privacy, and—specifically for female patients—the option to see a female clinician.[16] Patients who have been or are currently being subjected to abuse have diverse needs, which requires that physicians focus on building trust and active listening in order to provide the necessary and appropriate care and support for each individual patient throughout their visit.[17]

Following suspicion or disclosure of violence or abuse, you should inform the patient about your obligation to report it and to do so in keeping with applicable requirements.[13] You should also be mindful that reporting incidences of violence or abuse can be a traumatic experience for patients due to the potential for patients' self-blame; meeting with disbelief from friends, family, or authorities; or reliving experiences through questioning or through pelvic examinations.[15,16] Therefore, information sharing and consent during exams and throughout the reporting process must be prioritized to ensure that the patient feels autonomous. In addition to reporting, it is important to provide the patient with information about available community and health resources and, when appropriate, to consult other physicians or health care workers, such as psychologists, psychiatrists, or social workers to provide further support to ensure the patient's welfare.[1]

Managing the inclusion of chaperones during pelvic and other sensitive examinations and procedures. Having a chaperone present during pelvic and other sensitive examinations and procedures ensures that the patient's dignity is respected.[12] It is important to be mindful that racial, cultural, and gender differences between the patient and the physician could result in the patient feeling uncomfortable.[18,19,20] While many patients might not have a preference regarding the presence of a chaperone during a sensitive exam, chaperones could be key to helping a patient with a history of abuse feel safer and are often used to provide comfort to both the patient and the physician when there is a gender difference or the physician is still in training.[21] Chaperones might help alleviate discomfort and misunderstandings between the patient and physician and ensure that the patient feels respected. To uphold the patient-physician relationship, it is important to communicate to patients that they can request a chaperone during sensitive examinations. It is imperative to always honor a patient's request to have a chaperone and to have an authorized member of the health care team serve as a chaperone, even when a trusted companion of the patient is present. While a chaperone is present, be mindful to minimize inquiries and discussions of a sensitive nature.

Managing a patient who is experiencing functional chronic pelvic pain. There remains a lack of scientific research on—and persistence of misconceptions about—both physical and psychological conditions contributing to chronic pelvic pain, which often results in the ongoing mistreatment and dismissal of patients.[22,23] When treating patients with functional chronic pelvic pain, it is essential to establish trust and open communication, which encourages patients to share personal details essential for identifying psychological causes of pain, as there is an association between chronic pelvic pain with no known pathology and abuse or depression.[24,25] While having truthful and open conversations about patients' psychological state can be uncomfortable, "withholding pertinent medical information from patients … creates a conflict between the physician's

obligations to promote patient welfare and to respect patient autonomy."[26] To help promote open conversation, take a holistic approach to identifying causes of chronic pelvic pain by discussing all possible contributing physical and psychological factors. If psychological components are identified, uphold patient trust by having an honest conversation with the patient about taking a psychological approach to treatment and consider involving other disciplines in the patient's care if appropriate, including psychology or psychiatry. However, be mindful that accepting mental health treatment might be difficult for some patients, especially those who have suffered or are suffering abuse.[27]

Importance of Informed Consent

Due to a lack of regulatory laws and agreed-on ethical principles regarding pelvic examinations, these examinations have been performed on anesthetized patients for teaching purposes regardless of whether consent was obtained.[28,29] Many states have enacted laws or proposed bills prohibiting pelvic examinations under anesthesia without consent.[30] However, 17 states lack regulations despite the practice conflicting with the ethical and legal principles of patient autonomy and informed consent.[30] Proponents of performing pelvic exams on anesthetized patients argue that performing such sensitive exams on relaxed, anesthetized patients allows for a better educational experience and that because obtaining consent would decrease these opportunities for students, it is justified to forego this requirement.[31] Harms and benefits of performing routine pelvic exams on nonpregnant adult women are understudied[32]; however, the risk of compromising trust and engendering emotional harm cannot be justified by the known benefits of receiving a pelvic exam. Therefore, in addition to violating patient autonomy and nonmaleficence, performing exams on patients without their consent unquestionably contradicts physicians' "ethical obligation to put the welfare of patients ahead of other considerations."[33]

Conclusion

Performing non-labor and delivery OB/GYN procedures requires physicians to recognize that the patient may experience discomfort, pain, embarrassment, and anxiety during the encounter. As health care cannot be successful without ongoing collaboration between the patient and physician, physicians should communicate with patients openly and honestly and with empathy and compassion while also ensuring that patients' privacy (including physical, informational, decisional, and associational privacy), confidentiality, and dignity are upheld.

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