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MEDICAL EDUCATION: PEER-REVIEWED ARTICLE

Learning to Communicate With Patients About Potentially Painful Gynecologic Procedures

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Abstract

Doing painful procedures is a part of obstetrics and gynecology practice. Patients' pain experiences are subjective, diverse, and based on life experiences that can include trauma, adverse childhood events, and previous labor. Learners should have opportunities to gain knowledge about pain and the informed consent process during preclinical medical education, to observe and practice informed consent exchanges that include a discussion of pain and pain management with standardized and real patients during different stages of their training, to receive timely feedback from seasoned clinicians who understand that shared decision-making is an essential component of an informed consent discussion, and to learn from every patient encounter in order to inform the next one (reflective practice).

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Contextualizing Pain

Patients may describe gynecologic office procedures as uncomfortable at best or as more or less painful, depending on many factors, including their age and stage of life or development, life experiences (including trauma and adverse childhood experiences), and past experiences of pain such as dysmenorrhea, endometriosis, or labor.[1,2,3] The experience of pain is also affected by anxiety, depression, and anticipation of pain.[4] A strong case has been made for the universal application of consistent trauma-informed reproductive health care, given the high prevalence of childhood sexual abuse and sexual assault among adults, as well as the fact that many individuals do not disclose their trauma histories.[5,6] Recognizing biopsychosocial aspects of pain is critical for learners prior to their encountering potentially painful procedures that are a part of obstetrics and gynecology (OB/GYN) clinical practice. There have been calls for new curricula in pain and pain management for medical students—in part to address substance use disorder, chronic pain, and the opioid crisis—and these curricula would provide a basis for understanding core concepts of pain pathophysiology and management.[7] Such a curricular thread, in which pain management is framed within the principles of shared decision-making, would ideally begin with didactic and simulation

sessions during preclinical classes and subsequently move to observed clinical interactions and structured debriefing of those interactions during rotations.

Informed Consent

Potentially painful gynecologic procedures include the pelvic exam itself, intrauterine device (IUD) insertion, endometrial biopsy, colposcopy and cervical biopsies (including loop electrical excision procedures), hysteroscopy, and induced abortion. For these office procedures, as for other surgical procedures, it is essential that the patient be appropriately informed not only of why the procedure is recommended for a given condition or diagnosis, the alternatives for management, and the risks and benefits of the procedure, but also of the risks of associated pain.[8] Approaches to the process that has been termed *informed consent* have evolved from paternalism, in which physicians assumed that they knew what was best for patients, to a model of shared decision-making, which has been characterized as "no decision about me without me,"[9] based on the principle of respect for patients' autonomy.[10,11,12] The American College of Obstetricians and Gynecologists' Committee Opinion on informed consent and shared decision-making describes shared decision-making as patient-centered and individualized and delineates the essential elements of the informed consent process based on the American Medical Association's *Code of Medical Ethics*.[13] The informed consent discussion with a patient prior to a planned surgical procedure ideally provides anticipatory guidance about the expectation of pain and options for pain relief, as well as addresses the patient's experience of gynecologic pain, given that expectations of pain influence the subjective experience of pain.[14]

Learning About Informed Consent

The Association of American Medical Colleges considers the process of obtaining informed consent for tests or procedures to be an entrustable professional activity for entering residency, and thus it is a skill that trainees are entrusted to perform unsupervised.[15] While vignettes and standardized scenarios have been developed to facilitate learners' practice of the communication and other skills required for this task, studies suggest that many learners do not feel competent or confident in their ability to engage in an appropriate informed consent discussion.[16,17,18] Thus our current practices of medical education for informed consent, which have consisted mostly of peer observations, should be reassessed. Anandaiah and Rock, in suggesting tips for teaching the informed consent conversation, note that "formal training, observation, and feedback in informed consent represent an unmet educational need."[19] A stepwise learning process with different teaching and learning goals throughout professional medical education should be considered.

Preclinical. During preclinical courses, the duty of informed consent for procedures should be explicitly addressed. Many medical schools include simulated patient encounters on various topics, and a simulated exercise involving informed consent as part of a bioethics class has been described.[20] These and other educational methodologies are likely being used in varying preclinical curricula to address this core principle of biomedical ethics, but their prevalence is unclear.

Clinical rotations. During clinical rotations, all medical students observe potentially painful office procedures, as well as observe experienced clinicians' interactions with patients in obtaining informed consent for those procedures. Simulation activities for informed consent discussions have been described for learners on a surgery rotation, although the authors note that simulations were necessitated by the COVID-19

pandemic limiting students' interactions with patients.[21] Ideally, students on clinical rotations would have the opportunity to practice discussing a painful procedure with a patient while being observed by a senior clinician who can provide direct and immediate feedback and who understands and practices shared decision-making. On the OB/GYN clinical clerkship, students can and should be actively encouraged to thoughtfully approach each informed consent conversation and potentially be primed specifically to attend to discussion of options for pain relief and then to debrief with a resident or faculty member of the clinical team on their observations about both the consent process and the procedure itself. Another approach, in which learners are asked to keep a reflective journal of their clinical experiences and observations,[22] can be used as a starting point for a discussion of learners' concerns about pain and also to inform faculty about learners' educational needs.

Ideally, learners will observe that to facilitate the desired therapeutic alliance, the clinician needs to demonstrate knowledge of the procedure and of pain relief options. One of the challenges for early learners is that they might not yet have acquired the skills to behave confidently, which requires experience—with procedures, modeling the importance of the informed consent process, reinforcing the importance of the patient-clinician relationship, and facilitating shared decision-making. Once advanced learners have had the opportunity to practice such conversations and to receive and reflect on feedback from an experienced clinician, they are better able to have a bidirectional conversation with a patient that avoids medical jargon and that accurately conveys the key elements of informed consent, including information about pain and pain relief.[15] This learning process would suggest that such communication skills should be specifically taught and evaluated in a stepwise manner. However, learning about informed consent for potentially painful procedures in general, or for OB/GYN office procedures in particular, does not always occur in this stepwise fashion. A focus on this topic, along with the awareness that shared decision-making is a major component of the informed-consent conversation, will help us to achieve a therapeutic alliance with our patients, which is one of our goals as healers.

Learning Pelvic Examination Skills

One of the most basic physical examinations in obstetrics and gynecology is the pelvic examination. How this skill set has been taught has changed radically over the last 45 years. Traditionally, students were exposed to the pelvic exam through lectures and the use of plastic models and subsequently expected to perform the exam in the clinic on real patients. The theory was very much "see one, do one, teach one."[23] At many schools—as late as the early 2000s—students were taught the basic maneuvers by performing the exam on anesthetized patients without their consent,[23,24] a practice that today has been denounced as immoral and indefensible.[24] The Association of Professors of Gynecology and Obstetrics' statement on this topic supports the importance of appropriate teaching of pelvic exam skills, noting that for an anesthetized patient, a pelvic exam should be explicitly consented to, related to the planned procedure, performed by a learner as a member of the care team, and directly supervised by the clinical educator.[25] When a learner performs a pelvic examination in an outpatient setting with an awake patient, the patient has the opportunity to agree or to decline, although the supervising clinician has the responsibility to obtain the patient's consent to have a student participate in the exam and to control the learning environment so that the patient can feel empowered to either accept or decline or to pause or stop the procedure rather than feeling pressured to continue.

For students, the skill of performing a pelvic examination is particularly fraught with anxiety. In the 1960s, the concept of "professional patients"—individuals who were trained to simulate an illness or medical condition—evolved into that of gynecologic teaching associates (GTAs)—women who teach students to perform a pelvic examination by serving as both the instructor and the patient. GTAs teach interpersonal communication skills and provide immediate and direct feedback as students perform the pelvic examination on their bodies.[23,26,27] Studies have shown that learners who had been taught by GTAs had better interpersonal skills and higher confidence levels in performing the pelvic examination than those who had been taught in a traditional manner using plastic pelvic models,[28,29] and other studies have shown the examination skills of GTA-taught students to be comparable to those of students taught by faculty members.[30] The GTA model of pelvic examination instruction remains an important one in medical schools today; a 2016 survey of pelvic examination skills curricula in US medical schools reported that GTAs taught pelvic examinations at 72% of responding schools.[31] Hybrid models of teaching that utilize real persons to address communication skills and plastic pelvic models for the exam itself have been described in settings where the GTA model is less acceptable—for example, in an adolescent population.[32] Online videos demonstrating the performance of a pelvic examination can be an adjunct to GTA instruction.[33] Ideally, students will learn to perform a pelvic exam proficiently, quickly, and utilizing techniques that minimize the patient's experience of discomfort or pain.

Pelvic examinations are the most frequently performed procedures in an OB/GYN office but can be particularly difficult, painful, or triggering for some women—a fact that must be acknowledged by clinicians and learners. For individuals who have experienced sexual violence, the exam can trigger flashbacks and increased anxiety, but because not all patients are able to acknowledge their trauma history, a trauma-informed examination should be the norm for all individuals.[5,34] A trauma-informed pelvic examination has been described as being performed "with" the patient, enabling them to have choices about the exam, empowering them to feel safe and in control, and facilitating shared decision-making regarding this procedure.[34]

Communication and Informed Consent Conversations

The following principles, based on tenets of shared decision-making, are communicated as lessons for learners performing gynecologic procedures other than pelvic exams. Prior to a procedure, the patient should be asked what they know or have heard about the procedure; information about the indications, benefits, risks, and alternatives should be provided; and any misinformation or misunderstandings should be corrected.[12] Patients can be asked what they might be worried about with regard to the procedure and how much information they want to receive, as preferences for details vary. It may be helpful to let patients know how most people respond to a given procedure, while acknowledging that individual responses differ. The patient should be told what can be done to alleviate pain, including oral pain medications or anxiolytics, having a dedicated emotional support person present for the procedure, using visual or auditory distraction such as virtual reality during the procedure, or using specific analgesic techniques, such as a paracervical nerve block prior to an IUD insertion, similar to what a dentist would do for a filling.[35,36,37,38] The US Centers for Disease Control and Prevention has recently updated the Selected Practice Recommendations for Contraceptive Use to include the recommendation that lidocaine administered as a paracervical block or topically "might be useful" for reducing the pain of IUD insertion.[36] This recommendation has received

widespread mainstream media attention, presumably as a response to social media posts, some describing the pain of this procedure as "agonizing."[39]

For outpatient procedures, patients should be informed that they can refuse having the procedure performed in the office and given the option of sedation or anesthesia or that they can ask that the procedure be paused or stopped while it is ongoing (within some constraints). And, finally, a presumption of all clinical interactions is that clinicians will let the patient know by their words, demeanor, and actions that they care and that there is a partnership between the patient and them.

Summary

Every patient encounter provides an opportunity to listen to and learn about an individual in ways that will benefit their future care and the care of others. If we are honest about potentially painful gynecologic procedures, we take a step toward earning the patient's trust, facilitating the therapeutic alliance, and setting the stage for a future partnership for better health. We all need to be willing to acknowledge, address, and minimize pain from gynecologic office procedures whenever possible.

A stepwise medical education regarding the topics of pain and informed consent remains a largely unmet educational need. Future innovative educational approaches to these topics should explicitly provide not only information but also interactive experiences. Such interactive experiences could occur initially with simulated patients but should subsequently progress to real-life experiences in which the learner is observed and given appropriate feedback. Finally, reflective medical practice, learned as trainees and carried forward throughout our careers as clinicians, helps us to learn from every clinical encounter and to form more helpful therapeutic alliances with our patients.

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