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Pain Management in Non-Labor and Delivery OBGYN Procedures

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FROM THE EDITOR

How We Lie About Pain

Amy Lorber, MD and Andrew Lynch, MD, MSE

The phrase, “This might sting,” is perhaps the phrase that best captures the inspiration behind this issue of the *AMA Journal of Ethics.* Throughout our training, we have both learned and struggled with hearing this phrase. Across clinical settings and patient populations, we have witnessed pain managed well, pain that persists despite our best efforts, and, most hauntingly, pain ignored. While pain is a frequent topic in ethical inquiry in health care, we believe the overwhelming focus in pain ethics remains chronic pain management. Lack of attention to acute pain management, particularly in subpopulations whose needs are under- or unmet, has left us reliant on a vocabulary of vague phrasing: “sting,” “cramp,” or “a sense of pressure,” to name a few. We counsel patients to consent to important procedures that come with iatrogenic pain but find ourselves encouraged to minimize descriptions of pain during consent conversations.

This theme issue originated in the authors sharing stories from clinical rotations and identifying a lack of clear guidance about how to manage pain in obstetrics and gynecology procedures occurring outside of labor and delivery settings. In 2021, for example, intrauterine device (IUD) procedural pain rose in public attention via social media narratives.[1,2] Clinical recommendations regarding pain control during IUD insertion and removal, however, remain sparse.[3] Even non-labor and delivery obstetrics and gynecology (non-L&D OB/GYN) procedures arguably require patients’ bodies to be positioned in one of the most vulnerable possible ways. Patients are physically, epistemically, and emotionally at the mercy of their clinicians, so clinicians’ characters and pain management strategies during such procedures could not be more worthy of ethical investigation.

Given the limited guidance, communication and analgesia approaches are clinician dependent. They are thus heavily reliant upon clinicians’ capacities to discern patients’ needs and to charitably—and as accurately as possible—interpret patients’ behavior, which has been described as a “social transaction.”[4] Furthermore, racial disparities in pain management and inadequate pain treatment are well documented.[5] In the setting of acute pain specifically, quick decision-making may accentuate bias.[6] Finally, expressions of gender identity, racial, ethnic, and age biases in OB/GYN settings have a treacherous, violent history with long legacies and persistent influence on many patients’ experiences. This theme issue considers these and other nuances of acute non-L&D OB/GYN pain.

We have collected manuscripts from authors across fields and institutions that consider this topic. Example cases address the current landscape of reproductive health, such as IUD insertion and abortion. Historical and policy questions address the deep roots of today's clinical practices and highlight a potential road forward that better emphasizes patients' experiences. Other articles publicly wrestle with pain vocabulary for clinicians, rethinking how to ensure that informed consent is truly informed. We hope this issue starts a conversation among clinicians to self-evaluate how they manage and discuss pain, lowers their tolerance of poor pain management practices, and inspires research that may, one day, lessen the pain felt by patients, especially for office-based procedures in gynecology.

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should IUD Placement Pain Be Described and Managed?

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Abstract

This commentary on a case considers recent publicity about pain with intrauterine device insertion and clinically and ethically relevant factors that influence pain and pain management strategies for this effective contraceptive method.

Case

JJ, an 18-year-old nulliparous patient, presents to discuss contraceptive options. JJ is interested in an intrauterine device (IUD) but has seen videos on social media of teenagers talking about their painful experiences with IUD insertion.[1] Dr W is an obstetrician-gynecologist who usually deftly inserts an IUD in about 5 minutes and is aware of conflicting evidence about risks, benefits, and effectiveness of analgesia for the procedure.[2,3,4] Dr W has reviewed both the 2009 Cochrane Review[5] and its 2015 update,[3] which call for improved availability of analgesia interventions but leave uncertainty about effective options that could constitute an analgesia "standard of care."

Dr W has observed mentors and colleagues describe IUD placement to patients as causing some "pressure or cramping, but not sharp pain." But Dr W has observed patients with moderate to severe pain during IUD placement and knows from the literature that discussing pain in advance may increase patients' pain and anxiety.[6] Dr W feels that withholding such information, even if it could increase procedural pain and anxiety, is unethical. Dr W considers how to communicate with JJ about IUD insertion and whether to administer analgesia prior to the procedure.

Commentary

IUDs have both contraceptive and noncontraceptive benefits. IUDs are 99% effective in pregnancy prevention at 1 year[7] and require only a single act of motivation and insertion for many years of use.[8] Copper IUDs provide highly effective contraception for up to 12 years; the most common hormonal IUD provides 3 to 6 years of similarly effective contraception.[7] For postcoital pregnancy prevention, insertion of a copper IUD no more than 5 days after unprotected sex is more effective than emergency contraception pills. Hormonal IUDs can also be effective for emergency contraception: a single trial showed noninferiority of the levonorgestrel IUD to the copper IUD for postcoital contraception.[9] Additionally, hormonal IUDs are approved by the US Food and Drug Administration to

treat heavy menstrual bleeding in women who use them for contraception, and they are frequently recommended for off-label use for reducing bleeding problems and dysmenorrhea in women who do not need contraception.[10]

IUD use has increased dramatically over the last 15 years for all women and especially younger women. In 2015-2017, 14% of women between the ages of 15 and 44 who were using contraception utilized an IUD.[7] Women aged 25 to 34 years had the highest IUD usage (16%). Clinicians have also become more receptive to facilitating IUD use in younger nulliparous patients. In 2013, only 63% of obstetricians and gynecologists (OB/GYNs) thought IUDs were appropriate for nulliparous women and 43% for adolescents.[7] In contrast, a 2017 survey showed that 92% of OB/GYNs offered IUDs to patients under 21 years of age.[7]

While the expansion of eligible candidates for safe, effective, long-acting contraception has improved access, that expansion has had unanticipated consequences. Although higher risk of insertion pain is not a contraindication to IUD use, pain with IUD placement is common in nulliparous patients.[4] As more young, nulliparous women choose an IUD, social media stories of patients' personal, negative, and painful experiences with IUD insertions abound,[1] resulting in heightened professional awareness of the need to address the issue. The purpose of this paper is to discuss current evidence of the effectiveness of pain mitigation with IUD insertion and, given the lack of robust evidence, to encourage patient-centered conversations to help guide contraception and pain management decision-making.

IUD Insertion Pain Management

In IUD insertion, pain occurs with placement of a tenaculum (an instrument to steady the cervix), in passing a uterine sound (an instrument to measure the depth of the uterus), and in inserting the IUD through the internal cervical os.

There is currently no standard of care for pain management with IUD placement in nulliparous adult women, as effective, evidence-based interventions for pain relief are lacking. Evidence suggests lack of effectiveness of misoprostol for routine use in reducing pain in passage of instruments and the IUD through the internal os and in reducing pain associated with IUD insertion.[2,3] While nonsteroidal anti-inflammatory drugs, such as oral naproxen sodium and ketorolac, do not reduce pain during IUD insertion, they do reduce pain after insertion.[2,3,4] Oral tramadol (an opioid) has been shown to result in a clinically significant difference in pain immediately after insertion compared with a placebo.[2] Some lidocaine formulations may lessen pain during or shortly after IUD insertion in specific groups, although the evidence is based on single studies.[3] Given that systematic reviews of topical lidocaine (gel, cream) and injected lidocaine in the form of a paracervical block show mild effectiveness in reducing pain with both tenaculum and IUD placement,[3] the combination of a topical anesthetic and an injected block may also be helpful in reducing pain throughout the procedure. Overall, the evidence is scanty and inconclusive; further studies should be undertaken.[2,3,4] Indeed, the American College of Obstetricians and Gynecologists states that more research is needed to define truly effective interventions.[11]

Evidence is also lacking on the effectiveness of nonpharmacological interventions to manage anxiety and pain during IUD insertion. A systematic review showed no pain reduction among nonpharmacological interventions, but the studies were considered to be of poor quality.[2] Nevertheless, there is some evidence of effectiveness of

nonpharmacological interventions. Informational preparation may lower patients' perception of pain, and "verbicaine," such as reassurance and distraction during the insertion procedure, may reduce anxiety.[12] Inhaled lavender was shown to lower anxiety during IUD insertion in a randomized controlled trial but did not decrease pain after IUD insertion.[2] Overall, the conclusions of several systematic reviews are inconclusive and demonstrate the need for further research on effective pain management strategies for IUD insertion.

Recommendations

A recent update to the Centers for Disease Control and Prevention US Selected Practice Recommendations significantly changed the guidance on pain management for IUD insertion.[13] While acknowledging that paracervical block and topical local anesthetics "might" reduce pain with IUD insertion, the major change in the recommendations is the strong focus on clinicians individualizing the informed consent conversation with each patient by eliciting patients' concerns and prior experiences and exploring their expectations and options, recognizing that "the experience of pain is individualized and might be influenced by previous experiences including trauma and mental health conditions, such as depression or anxiety."[13]

When approaching a nulliparous patient presenting for IUD insertion, it is important to perform the following steps to provide patient-centered care.

Incorporate prior experiences in the patient history. Collect a history focused on prior experiences that may have an impact on IUD insertion pain, such as history of pain with pelvic exams or other gynecologic experiences, intimate partner or sexual violence, anxiety and depression, and high level of anticipated pain.

Incorporate pain in informed consent. Clinicians should alert patients to the discomfort of IUD insertion and, depending on the patient's wishes, discuss the range of pain relief options—from no intervention to topical analgesia with or without paracervical block and advanced sedation options, including oral sedation, moderate intravenous (IV) sedation, and general anesthesia. Some evidence shows that interventions that enhance empathy may reduce patient pain.[14] When discussing pain control options, clinicians should engage patients in a shared decision-making conversation about the range of pain management options, expectations of pain, and expectations of the procedure (eg, length of time, greatest pain experienced) and elicit their values and preferences.

As part of shared decision-making, clinicians should proactively address patients' concerns about pain control and individualize interventions. With patients who are anxious but do not voice a high level of concern, communication interventions may have a small but significant effect on acute pain.[14] Clinicians may also offer such patients topical anesthetic, paracervical block, or oral sedation, although these options are associated with only small reductions in pain. In a study of mostly nulliparous patients who received some form of local anesthetic prior to IUD insertion, 42% experienced "minimal discomfort/nothing" and 41% were "uncomfortable." The pain was acceptable to most survey respondents.[15]

Some patients require advanced sedation options. Patients who may need these advanced options include those with previous trauma with gynecological procedures, a history of sexual assault, adverse childhood experiences, or developmental delay. Conversations about prior experiences with pelvic exams and gynecological procedures

may help determine patients' comfort and readiness for IUD insertion. More intensive pain control options include IV sedation if that level of sedation is available in the clinic or if clinicians can refer patients to centers that provide outpatient IV sedation. Similarly, some procedures may be performed in an operating room under deep sedation. However, IV sedation has not been extensively studied[16] as it is resource intensive, given the regulatory burden of stocking opioids, the need for a ride home, and the need for additional nursing staff resources. Since IV sedation is not commonly offered, clinicians should consider identifying referral centers for the subset of patients who need that care. Regardless of the patient's choice, clinicians should create a supportive environment and ensure that the patient knows they have control over the procedure and can request that it be paused or abandoned at any time.[14]

Avoid a "one- size-fits-all" approach to pain management. Some patients may not want any pain control modalities. Others—those who have difficulty with speculum exams, are anxious, have a history of trauma, have chronic pelvic pain or sexual pain, or are postpartum—experience more pain with IUD insertion and may not experience adequate control with analgesia alone.[4] Prior cesarean delivery, dysmenorrhea, a high degree of expected pain, anxiety, and larger size of the insertion tube may play a role in perceived pain from IUD insertion.[4] While the merits of erring on the side of administering analgesia prior to IUD placement are unknown, the drawbacks are clear: clinically, analgesia may not be desired by the patient and may not be effective; therefore, ethically, the clinician should leave the decision for analgesia or lack of it to the patient. It is ethically reasonable for a patient to receive counseling on pain management options and to choose none of those options.

IUD Access

The effectiveness and safety of the IUD convinced many clinicians that it is the best form of contraception, leading to patients' perceptions of directive and coercive counseling and pressure to adopt the method.[17] This phenomenon of implicit pressure has been documented in a qualitative study of contraceptive decision-making[18] and highlights the importance of nonjudgmental, nondirective counseling in shared decision-making. On the flip side, women with low income seeking contraception from community health centers continue to experience barriers in attempting to access IUDs.[7]

Moreover, there are inequities in pain management in IUD insertion. Research demonstrates racial bias and inequity in pain management in the United States,[19] a phenomenon that must be acknowledged and addressed with an equity lens. Future studies examining pain management with IUD insertion should include diverse participants with a focus on equitable outcomes. Expectations also play a role in the degree of pain patients consider acceptable and suggest the importance of understanding patients' past experiences in shared decision-making processes. Another factor contributing to inequity in pain management is cost. Many patients access care at Title X-funded clinics that provide contraception for women with low income. Pain management in IUD insertion, particularly with opioids, may incur additional expense for clinics, given the regulatory burden. The requirement to offer expensive and currently nonevidence-based pain management options could create yet another barrier to IUD access in already resource-poor settings. Additional barriers that limit IUD access include the lack of knowledge, training, and confidence among health care professionals regarding IUD insertion.[20] Given that there are few contraindications to IUD placement, further efforts should be made to educate health care professionals on the risks and benefits of IUDs.

Conclusion

Clinicians should respect patient autonomy and focus on patient-centered counseling and shared decision-making when discussing and implementing pain management strategies for IUD insertion, thereby promoting patients' satisfaction with the procedure and with their interactions with the health care system.

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The case to which this commentary is a response was developed by the editorial staff.

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The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should Physicians Manage Abortion Pain Experienced by Remote Telehealth Patients?

Eloise Smellie, MBChB and John J. Reynolds-Wright, MBChB, PhD, MFSRH

Abstract

Pain is a recognized adverse effect of medication abortion, but its management has been understudied. This commentary on a case draws on principles of nonmaleficence, beneficence, and autonomy to consider equity in remote and in-person medication abortion pain management.

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Case

JN is a 24-year-old cis woman who has been pregnant twice and given birth vaginally both times. JN lives in a rural area, 75 miles from the nearest pharmacy or clinic. JN's last menstrual period was 7 weeks ago. She had a positive home pregnancy test, and an intrauterine pregnancy was confirmed at an out-of-town urgent care clinic. She wants to terminate the pregnancy and met virtually with Dr OBGYN, who prescribed mifepristone and misoprostol. JN took mifepristone 2 days ago and misoprostol yesterday. JN is experiencing severe cramping pain, despite taking over-the-counter analgesic medication. She messages Dr OBGYN to ask for a prescription medication to help manage her pain. Dr OBGYN considers how to respond.

Commentary

Use of telemedicine for abortion has steadily increased over the last decade and was dramatically accelerated by the COVID-19 pandemic.[1] Remote consultations are safe, effective ways to provide medication abortion, which can particularly benefit patients in remote, rural locations.[2,3,4] Although telemedicine abortion safety has been questioned because physicians at a distance are generally unable to attend as quickly as those in in-person settings to bleeding, ectopic pregnancy, and other urgent complications, adverse events of medication abortion are rare.[3,5,6] In the interests of nonmaleficence, it is important for abortion providers to consider the relative personal, legal, and financial risks to patients of attending telemedicine vs in-person appointments.

Following the US Supreme Court's decision in *Dobbs v Jackson Women's Health Organization* in 2022, abortion facilities across several states have been forced to close, resulting in dramatic increases in the distance some people must travel to their nearest service.[7] Consequently, telemedicine might become increasingly important for the delivery of medication abortion and the management of its adverse effects. However, it is important to highlight the ethical tension between acting within the medico-legal restrictions of each state and providing safe and compassionate abortion care to ensure patient access and to sustain the abortion provider workforce.

Pain is a known adverse effect of medication abortion, but effective interventions for pain management are not well defined. Only a small number of studies have investigated an optimal analgesic regimen, and these provide a low level of certainty due to small sample sizes, high risk of bias, and high levels of between-study heterogeneity.[8] The best available evidence supports the use of ibuprofen, a widely used analgesic that can safely be self-administered without the need for an in-person assessment for medication abortion-related pain relief.[8] Nevertheless, it is important to highlight that pain is a single dimension of an abortion care experience, and considerations such as privacy and disclosure, relationships, clinical or institutional settings, and interventions preferences all factor into acceptability of abortion care. Given limited available evidence of how to manage pain, we review some ethical considerations of telemedicine abortion care and strategies clinicians can draw upon to promote pain management equity for remote and in-person consultations.

Equity of Remote and In-Person Pain Management

Assessment of pain. Pain experience is subjective, and its management is guided primarily by patients' self-report about its nature and severity. Pain can be assessed remotely or in-person and clinicians might, in the best interest of the patient, require a patient to be assessed in-person. In the case, JN had an ultrasound-confirmed intrauterine pregnancy, so it is unlikely to be a pathological pregnancy, and medium-term complications of medication abortion, such as infection or retained products of conception, would typically present after a longer time frame. Dr OBGYN has grounds for confidence that the pain is isolated with no associated features (eg, hemorrhage or vasovagal symptoms).

Traveling to a clinic for an in-person assessment could exacerbate JN's pain and would make it more difficult for her to use nonpharmacological pain management techniques, such as heat or mindfulness. Therefore, remote assessment and analgesia without delay is likely in JN's best interest. If patients are required to make potentially symptom-exacerbating journeys with additional financial and time burdens, it must be recognized that discomfort and risk of travel might outweigh in-person assessment benefits.

Management of pain. Clinicians rely on evidence to act in the best interest of their patients. Because there is limited evidence on the management of pain during medication abortion, there is uncertainty as to what treatment option is the most beneficent and therefore the most ethical.[8] In the absence of specific recommendations for pain management, clinicians routinely apply the World Health Organization's analgesic pain ladder, which advises escalation to weak opioids with or without adjuvants or other nonopioid analgesics for moderate pain.[9] Although there are limitations to applying this model, it can be helpful in the absence of suitable alternatives.[9] Suitability and safety of opioid medication can be assessed equitably using a remote or in-person consultation.

When developing pain management strategies for abortion, it is important to consider how pain is managed during other types of early pregnancy care. There are physiological similarities between an (induced) medication abortion and a miscarriage (spontaneous abortion), resulting in a comparable risk profile. Patients who proceed with expectant or medication management of a first trimester miscarriage are routinely able to do so at home; with adequate counseling, pain relief, and safety advice, it is accepted that the home environment is usually an appropriate location for this care.[10] If we consider at-home pain management to be an acceptable balance of risk and benefit in miscarriage, then it would be reasonable to apply the same approach in medication abortion, and, if we don't, then we need to question whether a different approach is rooted in stigma. Recommendations for pain management during medication abortion advise that opioids only be prescribed when requested and with strict limitations on dose and quantity.[11] These recommendations differ from those for miscarriage, which advise that clinicians provide patients with prescription analgesia.[10] These subtle differences in guidance for 2 physiologically similar processes imply that it is acceptable to trial potent pain relief in miscarriage, but not necessarily in abortion.

Pain is multifactorial in origin, and many psychosocial factors, including stigma, can impact individual pain experiences. The stigma of induced abortion is well documented.[12,13,14] Providing abortion-related care at home increases privacy, which can reduce potential stigmatization by health care professionals and other patients, as well as a patient's need to explain an absence to family or community members. Remote abortion-related care could particularly benefit members of Indigenous communities, who face disproportionate discrimination and can benefit from the cultural safety of remaining within their home environment to receive health care.[15] Managing medication abortion at home is also preferable to many patients due to increased flexibility, convenience, and access to home comforts.[16,17] For some patients, creating an optimal therapeutic environment and reducing the influence of stigmatization could directly reduce their perception of pain. For other patients, these factors might not directly contribute to pain levels but could improve the overall experience of abortion and thereby counteract adverse effects of medication abortion such as pain.

Adapting Pain Management Approaches

Preparing for pain. Informed consent is integral to ethical clinical practice and requires patients to understand the benefits and risks of the proposed treatment and alternative options before proceeding with a medical intervention. Pain is an important adverse effect of medication abortion, so it is essential for clinicians to counsel patients about pain expectations to ensure that valid consent is obtained. A spectrum of pain severity is associated with medication abortion, and though some patients report low-to-moderate levels of pain, we recognize that, for some patients, the pain is severe. As abortion care providers, we have an ethical obligation to ensure that patients considering medication abortion understand the spectrum of pain experiences—including the potential for severe pain—so that they can make an informed choice and to explain alternative options, including inpatient medication abortion and surgical abortion.

Decisions about telemedicine abortion occur at the intersection of nonmaleficence and respect for autonomy. Although we have an obligation to do no harm, many interventions do cause adverse effects, and, in practice, we will often accept an adverse effect if it is outweighed by the overall benefit.[18] As the evidence overwhelmingly supports the safety of telemedicine abortion, determining the balance of burden and

benefit should lie with the patient. If the patient makes the informed decision to proceed with a telemedicine abortion, then we should respect their autonomy.

As clinicians, we act to benefit our patients, and, in this scenario, we can do so by ensuring their mental and physical preparedness for pain. Pain that is worse than expected can result in anger, fear, and overall dissatisfaction with the abortion method.[11,19,20] Although not studied, fear could be even greater for patients living in remote locations who are reliant on telemedicine for support due to the lack of proximity to emergency services. Adequate pain counseling is therefore of particular importance when delivering telemedicine abortion. For patients using telemedicine, physical preparations should be advised, such as ensuring an adequate supply of menstrual pads, pain relief, and any nonpharmacological products they wish to use. It could be recommended that they have a friend, partner, or family member nearby who can support them with pain management and arrange urgent help if required. Patients with caregiving responsibilities should be advised when possible to arrange alternative provision, which might require additional planning if they live long distances from friends or relatives. These preparations help to promote patient welfare and ensure ethical delivery of care.

Responding to pain. Even with good preparation, pain is a common reason for patients to contact health care services during and after an abortion. Importantly, given growing recognition of gender bias in pain estimation,[21] JN's experience of severe cramping pain needs to be acknowledged and appropriately acted upon. Dr OBGYN should ensure that JN, who has specifically asked for further medication to manage her pain, has utilized the maximum safe doses of over-the-counter pain relief, which has the strongest evidence base, and discuss the role of nonpharmacological techniques (eg, a heat pad, hot water bottle, and relaxation techniques) as adjuvants to pain medication. As mentioned, the evidence base for pain relief escalation is limited, but in the absence of specific recommendations, we would advise providing weak opioid medication, which was not provided at JN's initial assessment. Dr OBGYN could consider prescribing a higher dose or quantity of weak opioids than would be prescribed for patients living in urban areas, as it is likely to be more difficult for JN to travel to and from the pharmacy. For patients like JN who travel long distances to access care, it could be in their best interest to provide a small supply of opioids at the initial assessment. This decision—as well as the formulation, dose, and quantity provided—should be made using clinical judgment that takes into account the patient's distance from health care services and the potentially addictive qualities of the drug. For patients using telemedicine, close communication is important to ensure that they are supported. Dr OBGYN could offer a telephone follow-up in a few hours to review JN's pain and arrange an in-person assessment if her symptoms have not improved by this time. Depending on local service provision, this follow-up may require Dr OBGYN to work with other health care professionals or create a network of health care professionals.

Conclusion

Ethical clinical practice is rooted in evidence-based medicine. Pain management during abortion is understudied, demonstrating an ethical need for high-quality research on this topic. Based on available evidence, we believe that standards of pain management equivalent to in-person consultations can be achieved using telemedicine with additional safety considerations. It is important not to exceptionalize abortion and to aim for a standard of pain management that is in line with other areas of early pregnancy care, as structural barriers to pain management can increase stigmatization. Conversely,

mandating that medication abortion only be provided in settings with specific pain resources would limit access to care. Importantly, given the evidence supporting the safety of telemedicine abortion, we must give patients the autonomy to decide if pain—and self-management of pain—is an acceptable level of burden when balanced with the benefits of receiving treatment at home. The growth of telemedicine demonstrates how abortion services can respond to patient needs. Medication abortion pain management is a need that continues to be inadequately met for many, so, as telemedicine abortion expands, we encourage health care services to review their approach to pain management to ensure that patients utilizing telemedicine can access the pain relief that they require and are not disadvantaged in their care. We also encourage further research in this area.

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should a Physician Respond to a Patient's Unexpected Pain During a Pelvic Examination When There Is Clinical Indication of Infection?

Kelsy Schultz, MD and Charita L. Roque, MD, MPH

Abstract

This commentary on a case considers how to navigate a pelvic exam in the context of a patient's personal experience and suggests the clinical and ethical importance of thoughtful, intentional action and consistent, clear communication in these clinical encounters.

Case

Dr B sees CC, who is 16 years old and presents with persistent, foul-smelling vaginal discharge despite finishing antibiotics prescribed by another clinician for a presumed sexually transmitted infection (STI). Dr B explains, "I need to perform a pelvic examination and get a swab sample for the lab to test. Do you understand what that means?" CC responds, "Yes," and nods agreement. Dr B returns with a chaperone. Upon inserting and opening a lubricated speculum in CC's vaginal canal, CC screams, "This hurts too much!" Dr B slowly withdraws the speculum and does not complete the examination.

Given CC's recent health history, Dr B needs an accurate diagnosis to inform appropriate treatment. "Maybe I should have just quickly inserted the swab to get a sample," Dr B wonders.

Commentary

Pelvic exam is used as an umbrella term for one or more potential evaluations: cervical cancer screen, STI screen, speculum exam, bimanual exam, visual inspection, and more.[1] However, patients—especially patients of color—might associate a pelvic exam with anxiety, fear, discomfort, and pain.[1,2,3] Throughout history, people of color and vulnerable populations have been used gynecologically to advance the goals of others: from Dr J. Marion Sims, lauded as the "father of modern gynaecology," who performed pelvic surgeries on slaves without analgesia despite its availability,[4] to physicians threatening to withhold medical care unless people were sterilized and legislative proposals that financially incentivize women of low income to choose contraceptive implants.[5,6] Patients bring experiences of not only systemic racism but personal trauma to the exam room.[7] In surveys of predominantly White and of diverse adult respondents, 64% and 83%, respectively, reported having experienced at least one category of adverse childhood experiences, including sexual abuse.[7] Examinations can trigger

emotions associated with these experiences and retraumatize patients.[7,8] Clinicians thus must actively seek to provide trauma-informed care, especially given the historical context of reproductive injustice.

While many areas of medicine leave an individual vulnerable, seeking help, and placing trust in their clinician, a pelvic exam by nature asks even more of patients by putting them in an even more vulnerable position. Preparing for and conducting pelvic exams are not skills gleaned from a textbook or during clinical skills sessions in medical school. Such sensitive patient care harkens back to the general principles of medical ethics (nonmaleficence and beneficence) and relies heavily on a trusting patient-physician relationship. Knowing when to perform an exam, preparing for an exam, and navigating patient-specific challenges that might arise, such as unexpected pain, are vital to centering a patient's experience and gaining both the most information and a patient's trust. Let's break down our case line by line.

Assessing Pelvic Exam Utility

In the first line, we discover that CC is a 16-year-old who has persistent foul-smelling vaginal discharge after finishing antibiotics for a presumed STI. Pausing here, the first question is whether a pelvic exam is necessary within this context. Pelvic exams are performed to evaluate symptoms such as pain, vaginal bleeding, or discharge and used as a screening tool for cervical cancer and STIs.[8] CC is reporting a concerning symptom for which it would be reasonable to proceed with a pelvic exam for evaluation, with patient consent. However, for an asymptomatic person, the utility of the routine pelvic exam has been called into question when weighing the potential risks we now more openly acknowledge that the exam can carry.[9] According to the American College of Obstetricians and Gynecologists, the screening pelvic exam leads to harms "such as fear, anxiety, embarrassment (reports ranged from 10% to 80% of women) or pain and discomfort (from 11% to 60%)."[3] These concerns about potential harms[3,8,10] are also relevant for symptomatic patients, who might experience more pain and, as such, should be appropriately informed of expected pain. Although an exam might be deemed worthwhile by the clinician, the patient might not share that opinion. After adequate counseling, the patient is in the best position to weigh the personal risks and benefits of the exam and to come to a conclusion, for whatever reason, for themselves.[3,11]

Dr B decides that a pelvic exam is warranted, then tells CC they need to perform the exam to get a swab sample for a test. Framing this as a decision already made instead of a point for shared decision-making can perpetuate negative associations and a lack of control surrounding the exam for the patient.[11] Dr B does ask if CC understands what a pelvic exam means, but phrasing the question as a yes/no question is less likely to elicit what concerns and preferences CC brings to the experience.[11] For example, CC is only 16—is this their first pelvic exam? Which components of a pelvic exam would be acceptable to CC? What is Dr B planning to perform? There are ways to explain what exactly the exam entails, taking into account the age and health literacy of the patient, and to assess true understanding when obtaining consent through means like the teach-back method, all of which help maintain the patient's sense of safety and build trust.[12] Another key element of consent is the right to refuse treatment as long as the patient is aware of the potential risks.[13] Telling patients before starting a pelvic exam that they have the right to discontinue the exam at any point for any reason, pain related or not, can restore patients' agency and sense of security.[13] Acknowledging that the exam is sensitive and can be painful, as well as asking about prior exam experiences, might open the door to communication that better prepares the patient for—and

individually tailors—the exam while building rapport.[1] Although a formal signed consent is not required for a pelvic exam, good practice requires tailored counseling prior to performing such an exam.

Managing Pain

In the next paragraph, Dr B returns with a chaperone, which is a point to applaud in the case. Patients are encouraged to bring support persons, and a chaperone can provide both the support and reassurance a patient needs during an exam.[1] Dr B then places a lubricated speculum—at which CC screams, "This hurts!"—and Dr B ends the exam by removing the speculum. Dr B deserves credit for using a lubricated speculum, which has been shown to decrease discomfort and does not affect results of infection tests.[8] But speculum size, voiding prior to procedure, and patient positioning can also make a difference in ensuring that a patient is comfortable prior to and during the exam, and it is unsaid in the scenario whether these factors were addressed.[8] Regardless, once the speculum is in place, CC reports pain. Instead of immediately removing the speculum, Dr B could have asked CC what hurts or where it hurts, which might reveal that resolving the pain is as simple as releasing an area of pinched skin or repositioning the table and footrests. In the same vein, asking CC if they want to continue the exam centers CC and shows that they are still in control rather than assuming that CC wants to discontinue the exam and deciding for them. Some individuals might react initially or experience pain but still deem the answers from the exam worthwhile and prefer to continue, whereas others might not. However, that determination is up to the patient, not the clinician. This case illustrates why adequate counseling, obtaining patient consent, and reviewing potential challenges and solutions beforehand are helpful to prevent further harm, optimize the chances of a successful exam, and ensure a positive patient experience.

Alternatives to a Pelvic Examination

CC's exam was not satisfactory for obtaining an adequate sample for STI testing, which is important in providing adequate care, given CC's presentation. Fortunately, there are less invasive, yet still effective, means to obtain samples through vaginal self-swabs or even testing from a urine sample. Data have shown that vaginal self-swabs for STIs are just as accurate as those performed by a clinician and that urine samples, while slightly less accurate, are still recommended over no sample.[3,14,15] Either alternative could be an option for those unable to complete a pelvic exam and gives patients control. Additionally, offering a digital exam with one finger might be better tolerated and still adequately assess cervical motion tenderness. These alternatives further emphasize the importance of determining the extent and utility of a pelvic exam for each patient. A downside in a setting of high concern for infection is the inability to assess other potentially important components of the exam (eg, discharge, cervical or vaginal lesions). However, if the patient is aware of these downsides and their impact, deferring the exam and evaluating possible infection by other means in order to tailor treatment is a viable option.

Managing Pain With Communication

The final sentence gets at the heart of the issue throughout CC's entire visit: lack of adequate, open communication. Dr B might wonder what went well or wrong and what could have been done differently, but Dr B's best resource for figuring out that answer is the patient. Dr B could have obtained additional history to assess for risk factors and counseled CC on the exam beforehand, but, even after the exam, Dr B had the opportunity to ask CC how they could have made the exam more comfortable.[10,12]

Medicine and pain unfortunately often coincide. Although we try to standardize it, pain is a personal experience unique to each individual. If pain is personal, the medical care to understand and combat it should also be made personal. Just as we are now learning more about Anarcha, Betsey, and Lucy—the women upon whom Dr Sims experimented without consent—and recognizing their contributions to the field of medicine, so, too, should we respect and support our patients in seeking the care and experience that best suits their needs. Truthfully conveying the details of the exam and placing the patient as the one in control are essential to changing the narrative of the pelvic exam. Including the patient in the decision-making process reinforces autonomy and affirms the pelvic exam not as "a threshold experience for women" but as a judiciously used tool to advance health and reproductive justice.[9]

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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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IN THE LITERATURE: PEER-REVIEWED ARTICLE

How Should Intensity and Duration of Pain Inform Standard of Care for Pain Management in Non-Labor and Delivery OB/GYN Procedures?

Lisa Bayer, MD, MPH and Evelyn Ainsley McWilliams, MD

Abstract

Pain experienced during gynecologic exams and procedures is dismissed, not recognized, and undertreated by some clinicians. This article considers how duration and intensity of pain experienced can be used to direct care. This article also discusses possible consequences of undertreating pain and suggests pain management standards that can be used by clinicians to provide individualized, trauma-informed care and promote shared decision-making.

Historical Roots of Poor Pain Management

Normalization of pain and tolerance of poor pain management in obstetrics and gynecology is pervasive. From labor pain during childbirth to menstrual pain, the belief that pain should be accepted as part of women's health, health care, and life experiences is widespread, including in clinical examination rooms.[1,2,3] In addition to sex-based inequity in pain assessment, racial biases also exist, placing many patients, particularly Black patients, at increased risk for their pain being undertreated.[4] Dismissal of pain in obstetrics and gynecology is not a modern phenomenon and is deeply rooted in the specialty's origins. The field of gynecology was built through the assault on and exploitation of enslaved people, who underwent forced examinations and repetitive surgical experimentation without anesthesia.[5,6]

Despite more recent efforts to eliminate health inequity and increase awareness of implicit and explicit bias, the subjective nature of pain assessment leaves patients vulnerable to clinician bias. Patients' pain during gynecologic procedures continues to be unidentified or undertreated by clinicians.[7,8,9] In this brief review, we first describe how intensity and duration of pain can influence patients' overall experiences and the implications of unrecognized or undertreated pain. We then discuss standards of care for pain management during gynecologic procedures that should guide informed consent and shared decision-making, express clinicians' respect for patients' autonomy, and avoid harm by focusing on trauma-informed, patient-centered care.

Intensity and Duration of Pain

Pelvic examinations and procedures are commonly performed in ambulatory gynecology. These can last a few minutes, like collecting a Pap smear, to upwards of 30 minutes for

an operative hysteroscopy. Many procedures are performed under conditions of increased patient stress or worry, such as obtaining a biopsy to rule out cancer or completing a uterine aspiration procedure for an early pregnancy loss, which can lead to higher pain perception.[10,11] Using intrauterine device (IUD) placement as an example, a recent study showed that nearly half (49.7%) of 1000 patients described pain with placement as intense (7-10 on a 10-point visual analog scale).[12,13] However, even when clinicians recognize pain expressions, some clinicians underestimate the intensity and duration of pain patients experience during this procedure, putting patients at risk of having their pain poorly managed.[7,8] For example, in a recent survey of patients after IUD placement, most reported they were not offered pain control options and 41.6% reported unacceptable pain experiences.[14]

In addition to underestimating pain experienced during gynecologic procedures, clinicians may focus on the relatively short duration of these procedures during the consent process, minimizing and normalizing moderate to severe pain as part of the procedure. By focusing on the short duration of the procedure, clinicians can easily ignore the importance of peak pain intensity. This phenomenon is known as the "peak and end rule," which describes how our recall of emotional episodes focuses on the peak moments and the end of the experience rather than the overall duration.[15] A related phenomenon, known as "duration neglect," holds that the duration of an experience has minimal impact on the recollection of the experience.[15] In effect, when we apply these ideas to clinic-based pain experiences, even when a procedure is short in duration, the intensity of peak pain and how peak pain ended will be the most important parts of an experience a patient recalls. By prioritizing duration over peak intensity, clinicians might harm patients by undertreating their pain. Clinicians should not withhold pain relief options based on a procedure's anticipated short duration alone.

Implications

Failure to recognize and adequately address pain during gynecologic exams and procedures results in unnecessary physical and psychological harm to patients; engenders patients' distrust of the medical community, directly compromising their autonomy; and can lead to patients' avoidance of crucial medical care. False assurances of minimal pain to be expected with the procedure can not only lead to patients' feelings of deception but compromise their autonomy and violate informed consent requirements. A recent study done by Wu et al explored the top 100 videos tagged "#IUD" on TikTok, which collectively had 471 million views and over 1 million shares.[16] The authors found that 97% of the #IUD videos on patient experiences highlighted pain and 28% of videos mentioned distrust of clinicians. Many of the videos portray personal stories of negative experiences related to pain and informed consent. These negative experiences contribute to the growing mistrust of the medical community.[17] Furthermore, negative experiences with previous exams or procedures can act as a barrier to care in the future, leading to delay or avoidance of important medical care.[18] Clinicians' underestimation and undertreatment of pain is in conflict with their obligation to do no harm, respect patient autonomy, and obtain full consent. Clinicians must strive to break down barriers to quality care rather than contribute to barriers their patients face.

Setting Standards

Trauma-informed approach. Individual experiences of gynecologic exams and procedures will vary from person to person, ranging from little or no pain to severe pain. While younger age, history of sexual abuse, and mental health disorders are all

associated with discomfort during pelvic exams, one of the strongest associations is a negative emotional contact between the patient and examiner.[19] The importance of creating trust and rapport prior to sensitive exams or procedures cannot be overstated. A trauma-informed approach provides the foundation for this care. This approach does not assume universal trauma, but instead provides a framework for clinicians and health care organizations to develop a safe space for all patients. The key principles of trauma-informed care are described by the "4 *R*'s": (1) realize "the widespread impact of trauma" and seek to understand "paths for recovery"; (2) recognize "the signs and symptoms of trauma"; (3) respond by "integrating knowledge about trauma into policies, procedures, and practices"; and (4) seek to prevent retraumatization.[20]

Cultivation of trust involves listening to patients and seeking to understand their current or prior traumatic experiences that affect how pain is experienced during gynecologic exams and procedures. Before gynecologic exams or procedures, clinicians should ask patients about current or prior trauma, in line with the American College of Obstetricians and Gynecologists' recommendation for universal screening for trauma.[21] Although we know trauma is extremely common, not all patients will disclose their history. Through building rapport and using open and supportive communication, clinicians can create a safe physical and emotional environment for everyone.

Trauma-informed care focuses on patient-centered communication, which allows patients to regain control, reduce their anxiety, and ultimately build or rebuild their trust in clinicians. Trauma-informed care upholds the ethical principles of nonmaleficence and beneficence: to do no harm and also to promote the patient's welfare. Because of the innate vulnerability associated with sensitive exams and procedures, clinicians must actively work to transfer power back to the patient. This transfer of power involves ensuring that the patient controls when the exam or procedure is to occur, obtaining permission to start the procedure, and reassuring the patient that the exam or procedure can stop at any time. These steps empower the patient to be actively involved in their care. In addition, clinicians and staff can work to create a safe environment in the exam room to avoid retraumatization. Actions as simple as knocking before entering the exam room, speaking to the patient first while they are fully clothed, having a chaperone and support person in the room, and avoiding triggering words can all help create a safe environment.

Person-centered care. Using a person-centered care model also supports patient autonomy and represents a shift from an antiquated medical paternalism approach. By focusing on the patient's individual needs, preferences, and values, the clinician can embrace the diversity of care delivery and move away from a one size-fit-all approach. Clinicians should be careful not to express intentional or unintentional bias or to inject directed counseling into patient conversations, as they conflict with informed decision-making. Just as there are a wide range of patient experiences during gynecologic exams and procedures, so there are an equally wide range of approaches to alleviate pain. Patients should be offered all analgesia options. Through shared decision-making, the clinician and patient will come together to develop the pain management strategy using a holistic, individualized approach. The pain relief approach should be determined after a comprehensive informed consent, based on an honest discussion about the exam or procedure, anticipated pain, options to relieve pain, and available resources.

Clinicians should follow evidence-based practices for pain relief during gynecologic exams and procedures. While national guidelines do not exist in the United States,

evidence supports the use of oral analgesics as well as topical or local anesthetics as part of a multimodal approach for many ambulatory gynecologic procedures.[22,23,24] Clinicians should be familiar with these different strategies and stay current with and open to new approaches to decrease pain. Although clinical context, such as low resource settings, may limit the ability to offer these resources, patients should not be denied pain management when necessary. Due to the complex innervation of the pelvic organs and structures, optimal pain relief for gynecologic procedures in the ambulatory setting is challenging. As pain experienced is dependent on multiple variables, including psychosocial and neurobiological factors, a multimodal approach is often most helpful. Taking into account patients' prior experiences and current psychological state is especially important in determining the pain relief approach. While not every patient will need moderate or deep sedation, certain populations, particularly patients with prior trauma, will benefit from higher levels of analgesia. When necessary and available, patients should be referred to an appropriate care team for the gynecologic exam or procedure to obtain the desired pain management that aligns with their values and preferences.

Conclusion

Pain during gynecologic exams continues to go unrecognized or to be poorly managed and undertreated. Standards of practice for pain management in gynecologic exams and procedures should prioritize patient comfort and well-being and be grounded in trauma-informed care. Despite the short nature of these procedures, we must stop normalizing inadequate pain control, which can lead to patient mistrust and retraumatization. Guiding standards for patient care during these sensitive exams and procedures are outlined in this review. By following these standards, we can build trust, provide patient-centered care, and create an environment that promotes a sense of safety. The field of gynecology must strive to evolve from its historical roots of exploitation to a patient-centered field guided by shared decision-making and trauma-informed care.

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HEALTH LAW: PEER-REVIEWED ARTICLE

Using Policy and Law to Help Reduce Endometriosis Diagnostic Delay

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Abstract

Despite high incidence of endometriosis internationally and domestically, many patients wait a decade after symptom onset for an accurate diagnosis. This article suggests why diagnostic criteria should be clarified and why endometriosis screening should be incentivized among members of the public, clinicians, and health care organizations.

The American Medical Association designates this journal-based CME activity for a maximum of 1 AMA PRA Category 1 Credit™ *available through the* AMA Ed Hub™. *Physicians should claim only the credit commensurate with the extent of their participation in the activity.*

Background

Up to 10% of American women aged 15 to 44 and roughly 176 million women worldwide suffer from endometriosis—a painful condition in which tissue, similar to that which lines the uterus, grows outside the uterine wall—making it one of the most common gynecological diseases.[1,2,3] Despite its high incidence, individuals on average wait 7 years after the initial onset of symptoms to receive an accurate endometriosis diagnosis, usually when they undergo surgery.[4,5] Many factors (eg, disease complexity, compromised access to health care, and insufficient research) likely fuel diagnostic delay and are exacerbated by lack of awareness among the public and clinicians.[4,6,7]

In individuals with the condition, endometrial lesions and scar tissue typically form in the pelvic area, affecting the pelvic peritoneum, ovaries, fallopian tubes, recto-vaginal septum, bladder, intestines, and surrounding organs.[8,9] When a person menstruates, misplaced endometrial tissue sheds, leaving blood trapped in the abdomen, and this build-up leads to inflammation, scarring, and adhesions that worsen over time.[10] Symptoms are sometimes serious and may include severe pain during menstruation and intercourse; chronic abdominal, pelvic, and lower back pain; excessive bleeding; gastrointestinal issues; and infertility.[3,6,9] Endometriosis symptoms are often debilitating, preventing women from attending school and work, damaging relationships, and leading to anxiety and depression.[4] Physicians do not know—and therefore cannot treat—the cause of endometriosis, although treating its symptoms can alleviate suffering.[10] Given that the cause cannot be treated, it is even more imperative that early diagnosis be successful and more widespread so that symptoms of endometriosis can be treated earlier.

Diagnostic Delay

Several factors—financial, clinical, and social—contribute to diagnostic delay.

Financial factors. Endometriosis research is significantly underfunded in the United States. Although funding for endometriosis research in the United States has increased over the last few years, rising from $13 million in 2019 to $16 million by the National Institutes of Health in 2022,[6,7] this increase represents a rise from roughly $1 to $2 per diagnosed patient.[6,7] By comparison, Crohn's disease—which afflicts both men and women and affects only 0.21% of the US population—received $90 million in funding in 2022, which amounts to $130.07 per diagnosed patient in the United States—65 times more per patient than endometriosis received.[6] This disparity is consistent with findings that US research on diseases that primarily affect women is significantly underfunded compared to research on diseases that primarily affect men or that affect both men and women,[11] although there are some notable examples to the contrary, such as breast cancer.

While endometriosis' high incidence, severity, and diagnostic delays should alone inspire increased funding and public attention, there are also significant financial incentives to reduce diagnostic delays and improve treatment options for endometriosis. For example, those suffering from endometriosis typically have significantly higher health care utilization, with the annual economic burden of endometriosis in the United States being estimated to be between $78 billion and $119 billion.[6] During the lag time between symptom onset and accurate diagnosis, people with endometriosis might experience multiple emergency visits and hospitalizations, as well as undergo tests and treatments for conditions that they do not have. In addition, one study found that 75% to 84% of the annual endometriosis costs in Australia are due to productivity loss, as symptoms cause women to take sick days, quit, or be fired from their jobs at staggering rates.[6] Productivity costs are likely similar in the United States and other peer countries. All evidence suggests that the short-term costs of investing in endometriosis research would be greatly outweighed by the long-term benefits of reducing health care utilization and productivity losses.

Clinical factors. While additional research funding would help close the endometriosis information gap, underfunding alone cannot account for the current significant diagnostic delays patients experience. Symptom variation can mean that endometriosis is hard to diagnose; there are a long list of gynecologic, gastrointestinal, and other conditions that present similarly to endometriosis.[9] Hence, no 2 patients with endometriosis are the same, and symptoms and pain levels vary widely. Identifying Patient A and Patient B as suffering from the same condition is often not intuitive, especially when one presents with acute pelvic pain during urination and another presents with mild, chronic lower back pain, for example. Lengthy diagnostic delay might also occur because physicians may be inclined to rule out a long list of other conditions before they consider endometriosis, especially as diagnosing the condition requires surgery,[5] usually a laparoscopic procedure in which "the surgeon can look inside the pelvic cavity."[12] For these reasons, no policy change can ensure that endometriosis patients will be diagnosed during their first hospital or obstetricians and gynecologist (OB/GYN) visit. However, it is likely that these medical realities—that endometriosis symptoms are easy to mistake for other conditions and that securing a diagnosis requires laparoscopic surgery—do not fully account for diagnostic delays.

Social factors. Social factors also contribute to the staggering diagnostic delays. First,

gender bias renders women more likely than men to have their pain and symptoms dismissed as psychological by their clinicians,[13,14,15,16,17] and Black people face this sort of implicit bias at higher rates than White people.[18] If not dismissed as psychological, severe pelvic pain is often written off as a "normal" effect of menstruation.[19]

Another social factor that contributes to diagnostic delays is lack of awareness about endometriosis among health care professionals in training. While medical students and OB/GYN residents learn about endometriosis in their education, greater emphasis on this topic might be needed to improve diagnosis and treatment.[20,21]As mentioned above, mistaking symptoms of endometriosis for those of another condition is reasonable, given their similarity, but failing to consider endometriosis at all in the diagnostic process when relevant symptoms arise is not. Ensuring that all health care professionals—not only specialists—actively consider the possibility of endometriosis when patients present with relevant symptoms would likely drastically reduce diagnostic wait times.

A final social factor is cost, as the cost of accessing specialized care for diagnosis and treatment is disproportionately prohibitive for those belonging to marginalized groups who have lower access to health care.[22] More research is needed, however, to determine how socioeconomic factors impact treatment disparities.[23]

Policy Improvement

We propose incentivizing hospitals and other health care facilities to ask all female patients routine screening questions related to endometriosis during intake. Patients whose answers indicate symptoms associated with endometriosis should have a note in their file flagging the possible diagnosis. Although screening questions will not be able to confirm or deny the presence of endometriosis, employing them will ensure that health care practitioners consider endometriosis among other possible diagnoses. Such a screening tool would be ideal for a wide range of clinicians to use as a basis for referral to specialists like OB/GYNs or radiologists who could then make more timely diagnoses. Indeed, recent clinical research has validated a questionnaire devised to identify patients at high risk of endometriosis.[24] Such tools, when clinically validated, should be incentivized for broader use, with accumulated data being used to further refine the screening tools.

Once an endometriosis screening tool has been clinically validated and medically accepted, one way to ensure that it is broadly implemented in health care facilities is to mandate its use by law. However, a direct legal mandate forcing physicians to use a particular screening tool is problematic, in that it would promote government intervention directly in the practice of medicine when malpractice law and state medical boards already serve to enforce standard of care.

Instead of mandating endometriosis screening, incentivizing it with a financial reward may be more successful in encouraging clinicians to implement such screening quickly. A reward for participating could come directly from the government or from insurance companies. While it is in insurance companies' best interest to shorten the endometriosis diagnostic wait time and reduce health care utilization costs, the federal government can also require insurance companies to provide this reward to participating health care providers.

Conclusion

Ensuring that every health care practitioner—not just OB/GYNs—properly considers endometriosis as a potential cause of relevant symptoms can play a role in decreasing the average diagnostic wait time for patients. Promising screening tools have been developed, and we call for continued research to further refine the tools and for government or insurance provider incentivization of their use. The use of validated screening tools could potentially alleviate pain and improve the lives of millions of women, as well as reduce health care utilization costs and productivity losses. Furthermore, raising awareness about endometriosis among nonspecialist health care professionals and the general public by implementing routine screening could promote greater interest in research and subsequently more funding for it. Given the high incidence, severity, and costs of endometriosis, improving the standard of care for endometriosis diagnosis is well past due.

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AMA CODE SAYS: PEER-REVIEWED ARTICLE

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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POLICY FORUM: PEER-REVIEWED ARTICLE

Key Roles of Epistemic Humility in OB/GYN Care of Patients in Acute Non-Labor and Delivery Pain Care

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Abstract

This article considers ethical, epistemic, and clinical harms of normalizing, discounting, or dismissing patients' experiences of acute pain in non-labor and delivery obstetrics and gynecology (OB/GYN) settings. Discrediting patients' accounts undermines the therapeutic capacity of patient-clinician relationships, causes unjustified suffering, and may even contribute to life-threatening delays in recognizing and treating complications. This article urges OB/GYN practitioners to consider the ways in which structural and individual factors predispose them to discredit patients' testimonies and thereby contribute to epistemic and other harms. OB/GYN practitioners are encouraged to cultivate the virtue of epistemic humility and consider the role of patient satisfaction scores in evaluating care.

Inequitable Pain Treatment

Many clinicians continue to inappropriately respond to their patients' pain by making incorrect assumptions about patients in pain,[1] discounting patients' reports of pain,[2] or ignoring patients' pain altogether.[3] These problems are more pronounced for minoritized patients, who suffer widely documented health inequity in pain assessment, treatment, and care.[4,5,6]

Non-labor and delivery obstetrics and gynecology (non-L&D OB/GYN) settings are no exception. Non-L&D OB/GYN acute pain remains inadequately treated across settings. One example is postoperative care, wherein a high percentage of patients experience moderate-to-severe pain (over 65% in one study),[7] especially younger patients and those with preexisting chronic pain.[8,9] Both inside and outside the hospital setting, there is evidence that patients' reports of pain are minimized and that patients are judged as less than credible. Examples of such evidence include racial and ethnic inequities in postpartum pain care,[10] disparate post-laparoscopic pain prescribing by race and socioeconomic status,[11] racial disparities in the frequency of pain assessments in hospitalized gynecology patients,[12] and significant discounting of Black maternal near-miss survivors' reported pain levels (especially by experienced and male physicians).[13] In fact, many patients who survive a deadly pregnancy complication describe practitioners as discounting or ignoring their repeated reports of pain.[14,15] Normalized, discounted,

and ignored OB/GYN pain contributes to patients' moral, psychological, and physical injuries, ranging from needless suffering to risk of premature death from missed underlying pathologies. As Hossain observed: in medicine, "[w]omen, especially women of color, are dismissed, sometimes to death."[16] While the harms that flow from discrediting patients are completely preventable, correcting for the myriad forces that conspire to undermine ethical decision-making in acute pain care requires understanding and intention.

Decisions about pain are both routine and medically, socially, and culturally complex. Structural, institutional, and individual forces play important roles in these decisions, which are especially prone to bias,[4,5] and can conspire to compromise mutual trust, clinician trustworthiness, and, ultimately, clinical decision-making. It is from this understanding that this article approaches the question of how practitioners and institutions should consider patients' experiences of acute pain in non-L&D OB/GYN care, as reflected in patient satisfaction scores that account for the subjective nature of pain. The short answer is they should consider patients' experiences of pain as fully accurate data points—that is, they should respect patients as knowledge experts about their own bodily sensations. The long answer is more complicated. For clinicians, lingering under the surface of this question are assumptions about patients' lack of credibility, even about their own bodies, experiences, and sensations (whether it's pain or satisfaction with care), as well as fears about legal risk. Fears of institutional and legal scrutiny for prescribing pain relief and for OB/GYN care decisions are particularly salient now. Nonetheless, practitioners still hold disproportionate power in the clinical space and rightly shoulder the burden of recognizing and ameliorating the harms of discrediting patients' reports of acute pain. As Lalumera writes: "Failing to recognize trustworthiness when the conditions exist or rendering a person [patient] incapable of being trustworthy in a certain scenario, are epistemic injustices with ethical impact."[17]

Epistemic Injustice

Decisions about pain are of an ethical nature because they are within the practitioner's control and will show or fail to show respect for the patient.[18] They also hold the promise of benefit and risk of harm. The justice implications are less often addressed but are also profound. Treating patients with acute non-L&D OB/GYN pain implicates both health justice—which requires what Wiley et al describe as "a probing and critical eye to root out the influence of classism, racism, and other forms of social and cultural bias"[19]—and epistemic justice, which requires treating others as trustworthy and credible sources of knowledge, especially about their own bodies and experiences.[20,21]

Epistemic injustice takes 2 forms. Testimonial injustice—being wronged as a "giver of knowledge"[20]—occurs when patients' first-person reports are discounted, discredited, or ignored because of practitioner bias based on the patient's lack of technical knowledge or the patient's membership in a stigmatized group.[22] Practitioners may judge patient reports as "full of irrelevant information," confused, irrational, emotionally laden, and "time consuming"[21] and thus justify discrediting them or ignoring them altogether (epistemic exclusion). The clinical space may, as Medina writes, "erode the epistemic respect that individuals … deserve, and … deprive these individuals of environments in which they can make sense of their experiences."[23] When discrediting is repeated and reinforced, it contributes to a second form of epistemic injustice—hermeneutical injustice, or being "wronged as a subject of social understanding."[20] The lack of collective knowledge and appreciation of marginalized groups' experiences is dehumanizing and leaves group members further discredited and with limited ways to

adequately identify, process, and communicate their experiences. As problems are normalized and even erased, individual and structural harms are worsened and reinforced. Testimonial and hermeneutical injustices are fundamentally ethical problems that work together to inflict harm from without and within.

Epistemic Injustice in Clinical Encounters

Outside the hospital setting, 2 well-publicized situations of acute pain treatment illustrate epistemic injustice in non-L&D OB/GYN acute pain treatment.[24] The first concerns scores of patients who were discredited while reporting excruciating pain during egg retrieval procedures in some clinics; a subsequent investigation revealed that fentanyl had been replaced with normal saline over at least 5 months.[25,26,27] It is unclear why practitioners failed to act for months on myriad, repeated patients' (sometimes screaming) testimonies of procedural pain.[28,29] One patient described a postdiscovery "acknowledgement" by her doctor, who said, "What's the big deal? I mean, you ended up pregnant,"[29] at once discrediting the patient's own testimony and reinforcing the ideas that survived pain and trauma inflict no lasting harms, at least not for women who should be quiet and grateful in the clinical space—even in the space of practitioners who demonstrate untrustworthy behavior.

A second example is clinicians' persistent underestimating and discounting of pain during intrauterine device (IUD) insertion[30,31]—by an average of nearly 50% compared with patients' self-rated pain.[30] IUD placement is a painful and traumatizing experience for too many patients, especially when practitioners don't prepare patients for possible pain.[31,32] Some practitioners actually offer no analgesia,[31,32] especially cisgender men and more experienced practitioners.[33] Individualized care is lacking, even though reported pain levels are higher for patients who are younger, nulliparous, or with a history of anxiety or trauma.[32,34] The disconnect between practitioners' and patients' perceptions was explained by 2 medical students this way: "[d]uring our time on OB/GYN rotations, we regularly observed patients crying in pain after being told they would feel 'just a little pinch.' We found this inconsistency troubling, especially given the historical trivialization of women's pain in medicine."[35]

Recently, people have taken to social media to draw attention to this problem,[36,37] including patients who posted their real-time experiences of IUD insertion on TikTok—nearly 97% of whom communicated the painful nature of the experience, along with side effects.[37,38] Viral social media posts are not intended as, nor do they constitute, "objective" evidence (the type of knowledge privileged in medicine), although "objective" evidence of pain during IUD insertion has existed and been ignored for decades.[39] In fact, the American College of Obstetricians and Gynecologists website still recommends ibuprofen for the "temporary discomfort" that "placement of the IUD may cause,"[7,40] despite no evidence of its effectiveness.[39,41] In contrast, the social media posts showed people seeking to make sense of and communicate collective experiences that differed from the dominant practitioner narratives. The public outcry was an important step in remedying hermeneutical injustice and a powerful force in changing practices. Just this year, Planned Parenthood of St Louis Region and Southwest Missouri announced a sedation option for its patients.[42] In August 2024, the Centers for Disease Control and Prevention published new treatment guidelines acknowledging the pain associated with IUD placement and urging practitioners to offer pain management options.[43]

Exacerbating Epistemic Harm

Institutions and practitioners remain ethically and professionally obligated to minimize the harms of inadequately addressed acute pain. Institutions should interrogate policies, practices, cultures, and processes to identify and correct those that facilitate epistemic injustice.[21] Practitioners should also cultivate their own epistemic humility by, as Buchman et al write, "recogniz[ing] patient testimony and illness interpretations as epistemically privileged in determining the best clinical management," with the understanding that "medical decisions are almost always accompanied by uncertainty and that the testimonies of pain sufferers can help complete the clinical scenario."[22] Epistemic humility requires intentionality and metacognitive strategies to acknowledge and correct for assumptions, cognitive errors, and biases that create credibility deficits.

Furthering health justice requires not only epistemic humility but an understanding of the biases that increase the risk of epistemic harms, which are heightened in OB/GYN care wherein, Donnelly argues, "bodies are seen as fundamentally linked to reproduction and thus deemed fragile, hysterical, and in need of control."[44] Every OB/GYN patient (women, transmasculine, or gender diverse)[45] has faced some level of social subordination and gender-based health inequity,[46,47,48] including in the treatment of acute pain.[49] Those who are members of multiple racialized or minoritized groups (eg, Black transmasculine persons with a disability) experience intersectional harms from the compounding effects of group stigma, bias, discrimination, and oppression.[50] This compounding contributes to further discrediting, which may be exacerbated by the historical and cultural context of OB/GYN care.

The OB/GYN specialty developed in the context of racism and misogyny, and, historically, some OB/GYN practitioners (including nurses)[51] participated in unethical and dehumanizing practices, such as involuntary and unnecessary surgeries,[52] forced sterilizations,[53] and attributing greater fertility and lesser pain sensitivity to Black women.[54] Even today, they sometimes medicalize, pathologize, and racialize female reproduction and pain. As Norman explains in writing about pain, "[i]f women have become synonymous with hysteria, malingering, and hypochondria in the clinical setting, then it has far less to do with the natural inclinations of women and behavior than it does with the history of medicine."[55] And, even recently, some OB/GYN practitioners have participated in systems of oppression[56] by surveilling pregnant patients for law enforcement purposes,[57,58] engaging in unconsented pelvic exams without clinical justification,[59] and performing forced and coerced procedures.[60,61]

In this context, patient skepticism of practitioner trustworthiness and fidelity is understandable, especially in a post-*Dobbs* world, where, as Thompson et al write, "a person's womb [is] a public space, accountable to neighbors and authorities, and regulated by the courts and the medical profession."[62] For practitioners, too, post-*Dobbs* social and legal forces create barriers to therapeutic clinical encounters. OB/GYN care is increasingly overregulated and even criminalized,[63] which, superimposed on ever-escalating surveillance of opioid prescribing,[64] incentivizes practitioner skepticism of patients and worsens practitioner moral distress and clinical uncertainty.[63] Bias and cognitive errors thrive in these environments,[65,66] increasing the risk of clinical errors and patient harms that may extend beyond frustration, humiliation, and moral injury to physical suffering, injury, and even death from ignored symptoms.

Erasing Pain-Related Patient Satisfaction?

Patient satisfaction ratings in modern health care also have implications for the ethical treatment of OB/GYN patients in pain. Relationships between patients' numeric pain ratings and satisfaction are complex. For example, among patients with poor pain relief, satisfaction is positively associated with confidence in their clinicians' knowledge.[67] Attention to factors that improve satisfaction, which track epistemically humble practices, thus may improve care.

These findings are an important counterfactual to the reactionary narratives that tied patient satisfaction questions to excessive opioid prescribing in the last decade. Patient satisfaction scores were never associated with opioid prescribing,[68] despite the mythology surrounding them. Blame was assigned to patient satisfaction tracking through Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys[69] and to the hospital CAHPS (HCAHPS) particularly,[70] the results of which play a very small role in hospital reimbursement.[71] Nonevidence-based regulatory action soon followed. The original HCAHPS pain management dimension (dating from 2006) was targeted because its 3 questions asked if patients needed medication for pain during hospitalization, how well the pain was controlled, and how often the staff "did everything they could" to help with pain.[71] Without evidence but under pressure, the Centers for Medicare and Medicaid Services detached the pain dimension from reimbursement and replaced it with questions about communication effectiveness in 2018.[71] The revised questions—which only asked about the presence of pain, the frequency of assessment, and communication about treatment—would have provided good data, in part because effective communication and feeling trusted do increase satisfaction. Nonetheless, they were similarly doomed and removed in 2019.[72]

While subsequent studies have further established that neither opioid prescribing rates nor receiving opioids drive patient satisfaction,[73,74,75,76] the word *pain* remains absent from the HCAHPS. A handful of other specialized CAHPS surveys include limited pain questions—for example, the surgical care CAHPS asks about the quality of a surgeon's pain care,[77] and the outpatient and ambulatory service centers CAHPS survey includes 2 yes/no questions about the existence of and information provided about postprocedure pain.[78]

Nonetheless, the erasure of the HCAHPS pain dimension structurally reinforces the idea that patients' pain testimonies are nonexistent or insignificant. It also deprives practitioners and institutions of useful data, which makes dismissed pain easier to ignore. Erasure of the pain question serves epistemic injustice by communicating that inquiring about pain care is not necessary—either because pain neglect isn't really a problem or because the resulting harms are inconsequential.

Subjectivity as Unreliability

Why do some patients continue to suffer the epistemic injustice of having their testimony about pain discredited? One pervasive justification for discrediting patients' reports of pain is that pain is subjective—a word that is a euphemism for unreliable in the context of pain and used to rationalize discrediting patients.[22,71,79,80,81] This justification is puzzling because practitioners rely on subjective experiences all the time—their patients' experiences of insomnia, tinnitus, nausea, dizziness, and so on and their own experiences of auscultation of lungs, bowel sounds, and heart sounds, for example. Subjective knowledge as unreliable and untrustworthy is thus reserved for pain assessments in which it is subordinated to practitioners' objective assessments, which

leaves patients rightly feeling betrayed.[22,79,80] Moreover, focusing on the subjectivity of pain centers the problem on (unreliable) patients instead of on the limits of objective knowledge and the delegitimizing actions of practitioners, institutions, and systems. It also reveals the way in which knowledge is privileged depending upon its source. Undermining the legitimacy of patients' accounts is an old problem for patients in pain looking for help in an American culture of entrenched moralism about pain and suffering that rewards stoicism and quiet tolerance as virtuous and regards testimony about pain as weakness. Especially for OB/GYN patients, this moralism is exacerbated by clinician bias (implicit and explicit) toward some patients and entangled with clinicians' fears of overprescribing and stigma around opioids and addiction. These forces conspire with institutional policies and laws (or beliefs about the law) to reinforce the view that patients are unreliable witnesses of their own bodies, experiences, and sensations, which reifies epistemic injustice in pain care.

Epistemic Humility and Respect

Practitioners can work to decrease epistemic injustice, decrease patient harm, and improve patient satisfaction in pain care by treating patients as trustworthy. Doing so requires trustworthy practitioner behavior and the cultivation of certain behaviors and virtues, such as respectful communication, epistemic and clinical humility,[82] and active listening.[83] Established tools for shared decision-making in acute pain care may also be helpful.[84]

Practitioners should presume patients' authority as experts on their own bodies, and when doubt creeps in, they should double-check their own assumptions before questioning a patient's veracity. Epistemic humility requires what Buchman et al describe as "critical reflection about the assumptions made about the trustworthiness of pain sufferers,"[22] including biases that lead to injustice and harmful clinical decisions.[85] Cultivating mindfulness and engaging in metacognition in interpreting clinical interactions can decrease bias and may improve clinical decision-making[86] and moral reasoning.[87]

Patients often tell us something is wrong before the objective signs catch up—acting on those reports can prevent delay and disaster, reduce suffering, and convey trustworthiness. The risks of discounting and discrediting are too great, including missing serious underlying problems. Practitioner hubris in the face of patients' and family members' concerns and reports is an enduring narrative in medical errors and close calls,[88] as well as in medical malpractice and licensure cases. On the other hand, the risks of accepting such reports as credible information justify a few moments of reassessment and discussion, and these efforts show respect, enhance the practitioner's credibility, improve patient satisfaction, and reduce the risks of epistemic and physical harms.

An epistemically humble posture of patients as expert of their own bodies is a clinical stance and virtue worth cultivating. As Saulnier explains: "being allowed to tell one's story and having that story heard and believed are goods unto themselves."[89] Institutions should consider whether the policies, environment, and culture encourage epistemic humility. If practitioners and institutions want to track their progress, they might consider asking themselves if they are taking patients at their word and asking patients whether they were treated as authorities on their own experiences, especially about pain. They could do so by adding voluntary questions to patient satisfaction surveys. As Bello et al explains: "especially in the stressful setting of acute pain relief ...

decisions based on a patient's pain experience, values and expectations should represent the standard of care."[84] The only way to know patients' experiences, values, and expectations is to ask them, take them at their word, and act accordingly.

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MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

How Should Gynecologists Respond in the Moment to Physiological, Historical, and Psychosocial Features of Patients' Pain?

Emma Lantos, MD, Marit Pearlman Shapiro, MD, MPH, and Brian T. Nguyen, MD, MSCP

Abstract

Patients should receive appropriate pain relief when undergoing procedures. This article canvases historical and sociological underpinnings of how clinicians have responded and should respond in the moment to patients' pain during elective gynecologic procedures, such as intrauterine device placement and first-trimester abortion. This article then considers evidence-based techniques for responding to patients' pain expressions and experiences during such procedures. Finally, this article addresses the nature and scope of clinicians' obligations to respond in the moment to patients' needs when complete pain relief might not be possible.

An Introduction to Gynecologic Pain

Physicians have the tools and training to improve patients' experiences by mitigating pain during elective clinical procedures. We believe fully and wholeheartedly that patients should not have to tolerate pain during elective procedures, yet our experiences as gynecologists and family planning specialists repeatedly reveal our and our colleagues' hypocrisy. Gynecologists commonly perform procedures, such as intrauterine device (IUD) insertion and uterine evacuation for pregnancy loss and termination, which patients find painful or even excruciating. In other areas of medicine, potentially painful procedures are not performed without analgesia. With screening colonoscopies, for example, patients undergo invasive procedures and routinely receive moderate or deep sedation.[1] Stark inequity between gynecology and other specialties forces us to reckon with why, for gynecologic procedures, we have been socialized to expect that our patients will tolerate pain. Patients are becoming increasingly and appropriately empowered to expect better pain control from their gynecologists, many of whom have yet to recognize their own inadequate management of expectations of gynecologic pain and often undertreat it. Here, we offer perspectives on how to respond with care to both anticipated and unanticipated pain in office gynecology. We then outline strategies for reducing pain during conscious gynecologic procedures, while acknowledging historical, sociological, and political factors that make eliminating all pain a persistent challenge.

A Physiologic Explanation of Gynecologic Pain

To understand gynecologic pain management, one must understand the differential, rather than the singular, origins of pelvic and gynecological organs' innervation. The upper uterus is innervated by sympathetic nerve fibers deriving from vertebrae T10-L3, while the lower uterus and cervix are innervated by paravertebral ganglia, principally L2-L4. Parasympathetic innervation of the uterine body and fundus derives primarily from S2-S4.[2,3] This complex neurologic anatomy makes a complete nerve block—like one might receive at the dentist or for certain orthopedic procedures—nearly impossible.

Despite having conducted countless research studies aimed at understanding how to prevent procedural pain with local or oral sedation, gynecologists find themselves only able to reduce pain at best. A paracervical block with lidocaine is one of the most successful techniques for reducing pain.[4,5,6] Unfortunately, paracervical blocks involve an injection given at up to 4 sites adjacent to the cervix. To avoid injection site pain, vaginal lidocaine gel administered by the patient has also been studied for first-trimester surgical abortion-related pain and was found to be noninferior to a paracervical block in reducing pain in a randomized trial.[7] Nevertheless, because IUD insertions and uterine evacuation procedures can stimulate the uterine fundus or cause uterine contractions, patients often still experience pain from nerve groups outside the physiologic boundaries of the paracervical block. Unfortunately, most nonsteroidal anti-inflammatory drugs and narcotics, as well as prophylactic misoprostol, have not been shown to effectively alleviate pain during IUD insertions.[8,9,10] Only naproxen and tramadol given prior to IUD insertions have been shown to reduce pain during insertion but, again, do not relieve all pain.[11] Similarly, intrauterine lidocaine infusion was found to be ineffective at reducing pain during first-trimester surgical abortions.[12]

Gynecologic Pain in Historical and Social Context

Some gynecologists attempt to normalize or trivialize the pain endured by patients during procedures. While there are many possible explanations for this practice, one explanation lies in the historical denial of women and pregnancy-capable peoples' pain and in social expectations that women and pregnancy-capable people will endure pain.

We must acknowledge that the origins of modern gynecology are rooted in procedures conducted on enslaved Black women without anesthesia and without consent. Based on racialized and gendered notions of biological difference, physicians ignored subjects' lived experiences, touting themselves as professional experts with a more accurate understanding of the pain sensitivity of female reproductive tissues. For example, Lucy, Betsey, and Anarcha were three of the enslaved women documented to have undergone experimental vesicovaginal fistula surgeries by Dr Marion Simms in the 1840s without anesthesia.[13] Trivialization of these women's pain by once-reputable physicians, together with the long-standing rationalization of pain during childbirth as normal or natural, cemented sociocultural expectations for women and pregnancy-capable people to simply endure pain. Even as pain control for other procedures became available, physiologic challenges of gynecologic pain control and limitations of gynecologic equipment to prevent pain may have tacitly justified even severe pain's inevitability. Consequently, female-bodied patients in all medical fields, particularly patients of color, remain undertreated and misdiagnosed when it comes to pain.[14,15,16]

In order to dismantle these erroneous notions about women's and pregnancy-capable people's pain, it is important for us as gynecologists to name these false beliefs out loud. We must acknowledge our previous failures at managing pain, including their

racist and misogynist origins. We must elucidate and acknowledge patients' concerns about pain and discuss with them which options can be deployed for pain relief prior to the start of any procedure, as well as how pain relief might be adapted during a procedure when needed. Without taking these steps, we have not obtained adequate informed consent.

As abortion clinicians, we, the authors, also commonly care for many patient groups for whom gynecologic procedures can trigger anxiety or trauma. We care for adolescents who may never have had a pelvic exam before. Additionally, we care for patients who are survivors of intimate partner violence or sexual assault. In the United States, 54.3% of women and pregnancy-capable people report some sort of contact sexual violence in their lifetime, and approximately 1 in 4 report a history of rape or attempted rape.[17] Women of reproductive age particularly are at high risk of intimate partner violence.[18] The experience of anxiety and retraumatization leading up to procedures can profoundly exacerbate perceived pain.[19] The social contexts faced by female-bodied patients thus can make gynecologic pain intolerable in ways that a paracervical block could never treat.

To address these cases, gynecologists can use trauma-informed care techniques in addition to pain and anxiety relief modalities to support and empower patients during these procedures. These techniques include, but are not limited to, allowing patients to have a support person with them, discussing patients' concerns and anxiety about pain and pain relief prior to an exam or procedure, anxiolytic medications as needed, asking permission before starting any exam, allowing patients to place the speculum themselves, asking patients to part their knees instead of physically guiding them, warning patients prior to painful aspects of the procedure, and stopping the procedure if and when asked.[20,21] All of these techniques are aimed at restoring patients' sense of control and reducing both physical and psychological pain, although even these techniques may be insufficient.

Complete Gynecologic Pain Relief?

When pain cannot be managed adequately during a conscious procedure, one option is moderate or deep sedation via administration of midazolam and fentanyl or of propofol under the care of a specifically trained clinician.[22,23] While sedation is optimal for pain relief, it remains a limited resource in outpatient settings due to insufficient staffing, training, space, and time. In a recent study of clinics that provide first-trimester aspiration abortion, only 38% of clinicians reported routinely providing moderate sedation.[24] Additionally, only some clinical spaces are equipped and licensed to offer moderate sedation. Lastly, providing moderate sedation safely takes longer, so fewer appointments are available per day. As a result, moderate sedation is not an available option in many outpatient clinics, and, when it is, it often results in delayed care. To receive moderate or deep sedation, patients frequently must be referred to an outpatient surgery center or an operating room.

At the level of individual patients, moderate sedation presents additional barriers. It requires additional screening, as medical conditions such as obesity, active substance use, asthma, and uncontrolled chronic medical conditions are often considered contraindications to moderate sedation in the outpatient setting due to patient safety concerns.[25] Additionally, moderate sedation can add to patients' costs, and someone generally needs to accompany a patient home after moderate sedation. For patients undergoing stigmatized procedures such as abortions, emotional distress caused by

disclosing their health care to another person, finding childcare, paying for additional services, taking additional days off work, or delays in care may dispose them to endure more physical pain and forego moderate sedation. Thus, while a technological option for more complete pain control exists, institutional- and individual-level barriers currently prevent its more widespread adoption.

Clinician Adaptability

Being able to predict what is to come is a particularly valuable skill in medicine. However, like so many things, pain often cannot be predicted. Thus, it can be hard for a gynecologist to decide whether to cause a small amount of physical pain, such as by administering a paracervical block, or logistic pain, such as by requiring the patient to arrange a ride in order to receive moderate sedation, in order to relieve potentially greater physical pain. This risk-benefit analysis should be part of a shared decision-making conversation during the informed consent process with the patient.

Prior to performing a gynecologic procedure, it is important to counsel patients honestly and with transparency on what pain they can expect by using accurate descriptions of pain instead of, for example, "a small prick" or the catchall term "crampy." While clinicians may try to counsel patients by making comparisons to prior experiences, such as menstrual cramps or labor pains, these analogies are frequently insufficient to capture the personal experience of uterine instrumentation. Unfortunately, many patients have no frame of reference for what they will experience. Additionally, many people have lost trust in the patient-physician relationship due to historical trauma.[26]

It is also important to counsel patients on what pain and anxiety relief options are available, including the options mentioned above. After this discussion, patients should be allowed the autonomy to decide the level of pain they can tolerate. Even when painful, gynecologic procedures may be tolerable and acceptable to some patients, depending on their preparedness or their prior experiences with pain.

Yet when patients undergo their procedure, they receive a new set of experiential information that may alter their decision about pain relief and even their consent for the procedure itself. Consequently, clinicians must be able and ready to adapt to these changing patient needs when necessary. A written informed consent should not be seen as binding or protective for clinicians; true informed consent may exist on a continuum based upon the continuously changing context of the patient's experience while a procedure is occurring. If a patient decides at any point that they would no longer like to continue, it is imperative that the clinician stop the procedure at that point. From there, a discussion can be had as to whether to resume the procedure or not, with or without additional pain medication, but the initial request to stop the procedure must be honored.

Preventing Gynecologic Pain Is Political

The medical support system needed to provide all patients undergoing gynecologic procedures with complete and timely pain relief does not currently exist. However, returning to our colonoscopy analogy, the infrastructural and personnel needs for gastroenterologists to offer routine sedation are well established. This inequity in pain control could at least in part be due to a social and systemic undervaluing of women and pregnancy-capable people's pain and health. As discussed above, female-bodied patients, particularly people of color, are frequently undertreated for pain in medical settings.[14,15,16] Recent studies have also shown that procedures performed on female

bodies are reimbursed at lower rates than similar procedures performed on males.[27,28] Lastly, after the Supreme Court's reversal of federal protections on abortion, many outpatient clinics offering family planning services, including pregnancy termination, pregnancy loss management, and intrauterine contraception, have been forced to close nationwide.[29,30] These facts make it harder for gynecologists to see patients and get procedure space and operating room time, thus impeding patients' access to safe and timely care, if they are able to access care at all.

Gynecologists have drawn significant media attention for their perpetration of painful gynecologic procedures, particularly IUD insertions.[31,32] These examples serve as an important reminder for gynecologists to maintain humility in their relationships with patients and openly acknowledge their limitations. Nevertheless, even when applying evidence-based techniques to alleviate pain and providing patient-centered, trauma-informed care, gynecologists may fail to succeed in preventing all pain. This outcome highlights that pain is not solely under the gynecologist's control; it may have deeper roots in historical, social, and political disparities that warrant further attention. Patients deserve to know that their gynecologists have acknowledged these disparities and will work with them to find solutions and treatments that are tolerable to them and, in so doing, contribute to addressing and dismantling pain care inequity.

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MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

What Does Our Tolerance of Poor Management of Patients' Pain Have to Do With Reimbursement Inequity for Office-Based Gynecologic Procedures?

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Abstract

Office-based gynecologic procedures (OBGPs) are reimbursed at lower rates than similar office urology and dermatology procedures. But there is a broader "hidden curriculum" in health professions training that perpetuates clinicians' and organizations' acceptance of these patterns of poor reimbursement, disincentivizes research on improving OBGP pain management, and exacerbates tolerance of poor control of patients' OBGP pain. This article suggests strategies for equitable reimbursement that would also likely motivate better, more equitable OBGP pain control.

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Office-Based Gynecologic Procedures

Office-based procedures confer many advantages over those requiring an operating room (OR), including lower costs, easier scheduling, decreased administrative barriers, and lower potential risks.[1,2] However, several studies have shown that office-based gynecologic procedures (OBGPs) cause significant poorly controlled pain for some patients. For example, in a study of the top 100 TikToks related to intrauterine devices (IUDs) as of April 2022, Wu et al found that 96.8% of 31 videos on patient experiences of IUD insertion or removal highlighted pain and side effects.[3] Importantly, patients might be less likely to make TikToks about positive IUD experiences, and positive experiences likely would receive fewer views. Although positive experiences were less likely to have been captured in this study of the top 100 TikToks related to IUDs, it highlights a public perception of pain during OBGPs, which is important for clinicians to address and is supported by other clinical studies. Specifically, patient testimonials have revealed a disconnect between the significant pain experienced during procedures (typically IUD insertion or loop electrosurgical excision procedures) and the minimization of pain during prior counseling.[4,5] Reports have highlighted that though some clinicians perceive hysteroscopy as a low-pain procedure, patients frequently report severe pain.[6]

The American College of Obstetricians and Gynecologists Committee Opinion Number 672 acknowledges the difficulty of adequate pain control for IUD insertion in the office.[7] The opinion does not mention moderate sedation in the office or anesthesia in the OR as an option.[7] Clinicians providing OBGPs typically have limited or no access to surgical block time,[8] making OR scheduling difficult. Few practices have capacity for in-office moderate sedation, which requires a mid-level practitioner, additional space, and the ability to recover patients from moderate sedation, and is not accounted for by Current Procedural Terminology or Relative Value Unit (RVU) codes. For procedures routinely performed in the office, costs of in-office moderate sedation or scheduling them as OR procedures are not covered by many insurers.

This article canvasses factors contributing to poor pain control for OBGPs. We highlight the importance of reimbursement and compare office-based procedure (OBP) reimbursement rates for similar procedures in gynecology, urology, and dermatology; explore social expectations and stereotypes that contribute to acceptance of pain experienced by gynecologic patients; and consider how these practices are modeled by teachers and internalized by learners during hidden curriculum training, likely engendering trainees' moral distress and burnout and eroding their empathy. Together, these factors contribute to unethical reinforcement and acceptance of poor pain management for gynecologic patients.

Comparing OBP Reimbursements

Like gynecology practices, dermatology and urology practices perform many OBPs and serve as insightful comparators.[9] Urology pain management for OBPs includes local anesthetics as first-line pain control, oral sedation (eg, benzodiazepines) for persisting pain or anxiety, nitrous oxide,[10] and, finally, general anesthesia if the patient declines an office procedure.[11,12,13,14,15,16,17,18] For dermatology, common pain management approaches include local anesthesia—commonly field block, nerve block, wing block, and direct infiltration.[19,20,21,22,23,24] As in urology, in dermatology if local anesthesia is insufficient, procedural sedation remains an option to ensure a relatively painless dermatologic procedure.[24] Mohs microsurgery, a surgical procedure to remove visible lesions on the skin, is performed by dermatology subspecialists in their office. If the lesions are large, local anesthesia might be insufficient pain control; these cases are then referred to specialized surgical oncologists to perform complete removal of the lesion in the operating room.[23] In both urology and dermatology, procedural pain control and adequately responsive anesthesia are deemed important during OBPs. Direct comparison of pain levels experienced by patients undergoing gynecologic, dermatologic, and urologic procedures has not been done and would be difficult to achieve, given the subjective nature of pain perception and differences between visceral and cutaneous pain. Nevertheless, the lack of pain control options afforded gynecologic patients starkly contrasts with the myriad and tailored options afforded urologic and dermatologic patients.

A comparison of reimbursement rates across the 3 specialties highlights that gynecology is systematically underfunded relative to urology and dermatology. RVUs set by the Centers for Medicare and Medicaid Services (CMS) determine reimbursement rates for various medical encounters and interventions in terms of the value of a service or procedure relative to all services and procedures. RVUs are calculated by a committee within the American Medical Association and then reviewed and typically accepted by CMS. They reflect the physician's work (both time and intensity), the practice's expenses, and liability protection. RVUs for procedures for women tend to be lower than

RVUs for similar procedures for men and for dermatologic procedures.[25,26,27] This inequity likely suggests a variety of factors at play, including misogyny as it relates to both the persons treated and clinicians, as most obstetrician- gynecologists (OB/GYNs) are women. In short, we suggest that reimbursement inequity expresses devaluation of "women's work."[28]

We believe correcting billing inequity would empower clinicians and others to create methods for better pain control in office settings. As proof of concept, we explore changes in reimbursement, research, and practice related to office hysteroscopy. In 2017, the CMS RVU for office hysteroscopy increased by 237% to incentivize moving this procedure from OR to office.[29,30] Prior to 2017, studies showed that the most common reason for office hysteroscopy procedural failure was pain.[31,32,33]1/29/2025 9:58:00 AM Following this reimbursement change, a number of studies investigating pain management interventions for office hysteroscopy were published,[34,35,36,37,38,39,40] and several subsequent studies have evidenced improvement in pain control for these procedures.[37,38,39,41,42,43] In-office performance of hysteroscopy and other procedures like endometrial ablation has likely increased since 2017, given better pain control and development of new, less painful modalities for these procedures.[6,30,44] Thus, changes in reimbursement for in-office hysteroscopy have prompted changes in practice and innovative technology that have resulted in better and appropriate pain control for patients.

This case in point supports our hypothesis that appropriate and equitable reimbursement for OBGPs can translate into better pain control through novel technology. While raising reimbursement rates for OBGPs is only one factor in improving pain control, it is ethically justified and perhaps required. However, cultural and professional changes are still necessary to ensure that pain complaints by gynecologic patients are not dismissed or minimized in our capitalistic health care system.

Income-Based, Gendered, and Racialized Pain Norms

Persistence of OBGP pain partly reflects discrimination, as revealed by comparing patient populations in gynecology, urology, and dermatology. Gynecologists care for people with uteri (as well as many women and gender/sexual minorities without uteri) of diverse socioeconomic status (SES).[45] In contrast, several dermatology studies have found that outpatient dermatology care is less accessible for those with Medicaid than those with private insurance.[46,47] Indeed, high cost of care was found to be the top barrier to dermatologic care.[48] One study found that every $10 000 increase in median household income was associated with a 2.3 day reduction in wait times at dermatology clinics, suggesting greater systemic efficiency for patients of higher SES.[49] Another study found that dermatology practices are more likely to be located in wealthier zip codes.[50] Finally, income, insurance status, and education—measures of SES—were all found to contribute to disparities in melanoma survival.[51] Together, these studies suggest that dermatology disproportionately cares for patients of higher SES.[47,48,51] And a prevailing belief is that people of low SES feel less pain than people of high SES.[52]

Sexual discrimination might also help explain the persistence of OBGP pain. The urology patient population is generally assumed to be majority male—with female patients facing concerning disparities.[53,54,55] While urology patient demographics in terms of gender are difficult to come by, one study investigating the gender distribution of patients in surgical case logs by gender of urologist found that, among 558 female urologists, 54.5% of their patients were female, while among 6 058 male urologists, only 32.5% of

their patients were female.[53] And women's pain is routinely underestimated compared to men's. Studies show that people expect men to be less likely to report pain and more likely to withstand greater pain than women.[56,57] Consistent with this view, studies have shown that observers are more likely to rate males' pain as greater than that of females, raising concern for dismissal of female pain due to gendered stereotypes,[58,59] particularly of women as hysterical or emotional and as more likely to present with psychogenic pain, which many clinicians are biased against.[60,61] However, studies of sexual differences in physical perception of pain are controversial and have mixed results.[62,63] Despite being more likely to have their pain dismissed, women have a higher burden of medical conditions associated with pain.[62,63] Gendered and income-based stereotypes likely contribute to the paucity of offers made and research done to control the pain of gynecologic patients.

Lack of adequate pain control and the failure to believe a patient's expression of their own pain are exacerbated for persons of color. A 2016 study showed that approximately 50% of White medical trainees believed Black people felt less pain than White people.[64,65] Furthermore, a 2019 study found that Black and Latinx patients experienced more severe pain than White and Asian patients, yet patients from all 3 minoritized groups were prescribed less pain medication after cesarean delivery than White patients.[66] These inequitable practices have been attributed to racist ideology, including "obstetrical hardiness"—the troubling but still-prominent idea that Black women are relatively unaffected by expected pains of labor and childbirth—and the false beliefs in Black hyperfertility, the Black "primitive pelvis," the absence of endometriosis in Black patients, and lessened sensitivity of Black women's vaginal tissues.[67,68]

Lack of adequate pain control for OBGPs thus highlights intersectional systems of oppression, including classism, sexism, and racism, which contribute to poor reimbursement for OBGPs and a medical culture that perpetuates and normalizes pain in gynecologic patients.[69,70] Options to address inequitable reimbursement for OBGPs include a broader transformation of the US health care system—a consideration worthy of more robust analysis—and creating equitable reimbursement rates for OBGPs, which would enable and encourage clinicians to utilize a broader range of pain management options and tools to ensure comfort for their patients.

Finally, patients with histories of sexual trauma and interpersonal violence ought to be met with greater sensitivity, including with adequate pain management. In a 2016-2017 survey, 19.6% of US women reported sexual violence by an intimate partner, while 7.6% of men reported the same.[71] However, pain persists to a greater degree in the gynecologic setting than in the urologic setting despite a higher prevalence of sexual trauma in predominantly female gynecologic patients. Although it is important to care appropriately for all individuals with sexual trauma, the greater prevalence of sexual violence in women than men highlights the relatively greater need for trauma-informed care in gynecologic settings, which necessitates equitable reimbursement to support appropriate and adequate pain control.[72]

Hidden Curriculum in Training

The structural inequity trends described above contribute to norms for OBGPs that are taught to trainees. Education involving "lessons learned that are embedded in culture and are not explicitly intended"[73] is called the hidden curriculum.[73,74,75] Studies have shown that gender and racial bias can be prominent in health professions' so-called hidden curricula.[67,76,77,78,79] Oral "traditions" that pass along ethically troubling

stereotypes perpetuate bias that influences patients' care.[67,79] Hidden curricula not only affect patients but contribute to distress, burnout, and decreased empathy in medical trainees.[73,80,81,82] More generally, clinician burnout and moral distress have been associated with decreased empathy,[73,80,83,84,85,86,87] and compromised empathy can muddle clinicians' perceptions of what patients deserve from them, which can compromise pain management quality.

Specifically, in OB/GYN, the hidden curriculum has been identified as contributing to mistreatment of trainees. Studies have shown that medical students report rates of mistreatment in OB/GYN clerkships as high as 25%,[88] which have been attributed to stressful settings, high acuity situations common in labor and delivery, and communication breakdown.[89] Following the Association of Professors of Gynecology and Obstetrics' efforts to emphasize the hidden curriculum's positive consequences and minimize its negative ones,[90] the culture of OB/GYN training will change. One study of a workshop for OB/GYN faculty to address negative elements of the hidden curriculum, such as mistreatment and neglect, found that most faculty were more aware of negative elements and committed to changing their interactions with trainees after the workshop.[91] However, the hidden curriculum's influence on pain control during OBGPs should be further studied. Establishment of equitable reimbursement for OBGPs would afford attending physicians and trainees alike the option of centering patient comfort during procedures and thus encourage a culture that refuses to accept routine, poorly controlled pain.

Moral distress, which occurs in situations in which clinicians are prevented from taking action to do good or prevent harm due to institutional constraints, has yet to be studied in trainees performing OBGPs.[92,93] Medical trainees are particularly vulnerable to moral distress,[94] which has been observed in residents executing end-of-life care decisions with which they disagree.[85] As of 2017, the rate of burnout among OB/GYN residents was high—at 51.2%—and OB/GYN residents had high rates of other self-identified wellness problems as well.[95] An older study from 2004 that compared specialty burnout rates found that the general resident burnout rate was 50% compared with a rate of 75% in OB/GYN.[96] Medscape's yearly survey on physician burnout shows OB/GYN to be tied for second place with oncology, with a 53% burnout rate, second only to emergency medicine at 63%.[97] Such high burnout rates in OB/GYN require investigation. Residents who feel it wrong to inflict pain on patients during medical procedures can experience moral distress during painful OBGPs because they lack readily available and effective anesthetic options. This moral distress related to inflicting pain might be one contributor to high burnout rates in OB/GYN. Future work from our group will investigate how performing OBGPs without adequate anesthesia affects gynecology trainees and established clinicians.

Conclusion

This article synthesizes intersecting factors and systems of oppression that contribute to ongoing pain for a significant subpopulation of patients undergoing OBGPs. Reimbursement rates for OBPs vary, with gynecologic procedures being reimbursed at a lower rate than urologic and dermatologic procedures. Reimbursement affects what pain control can be offered in an office setting and thus how clinicians are trained. Moreover, gendered stereotypes in medicine contribute to acceptance of female pain in clinical practice. Finally, trainees learn to accept poor reimbursement of and poorly controlled pain in OBGPs through the hidden curriculum. Future directions include evaluating whether performing painful OBGPs engenders moral distress and burnout

and decreases empathy in gynecology trainees and established clinicians. Preventable pain during OBGPs should be confronted by addressing relevant structural and societal factors to ensure adequate pain control and comfort for all patients during OBGPs.

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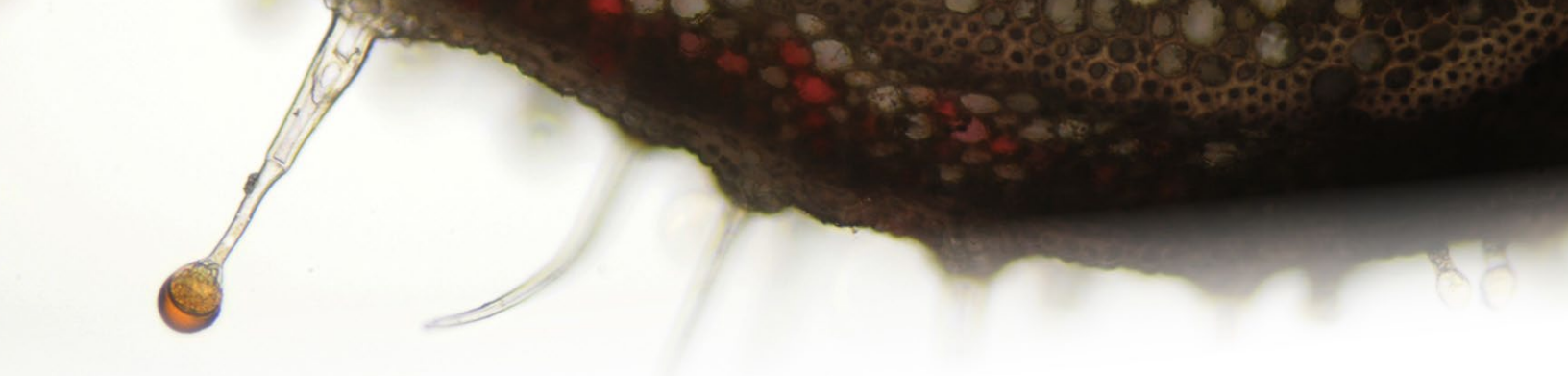

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HISTORY OF MEDICINE: PEER-REVIEWED ARTICLE

Abortion in the Nineteenth Century Through the Lens of Ann Lohman

Suzanne Minor, MD, Arianna Tapia, and Sarah E. Stumbar, MD, MPH

Abstract

Ann Lohman, a midwife in the 1800s also known as Madame Restell, deserves our attention following the US Supreme Court decision in *Dobbs v Jackson Women's Health Organization* in June 2022. As abortion regulations change, it is important that health care communities learn from past experiences. This article examines the historical context in which Lohman practiced and draws out key lessons to be applied today.

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Who Was Ann Lohman?

The 19th-century midwife Ann Lohman deserves our attention as clinicians practicing medicine following the 2022 US Supreme Court decision in *Dobbs v Jackson Women's Health Organization*, which overturned *Roe v Wade* and thus ended federal protections for the right to legal abortion.[1] In the 1800s in New York City, a similar time of legal flux for abortion, Lohman, under the name of Madame Restell, offered vital reproductive health care—including abortion services—to women for nearly 40 years. A controversial figure, she was publicly ridiculed as "notorious" and described as growing rich by the "practice of a nefarious business."[2]

During our current time of social and legal change, what allowed faculty and preclinical medical students at our Florida medical school to openly discuss the contentious topic of abortion was reading *My Notorious Life*,[3] a novel based on the life of Ann Lohman. This article examines the historical context in which Lohman practiced, including resolutions and advocacy of the newly minted American Medical Association (AMA) and laws criminalizing abortion. Additionally, the article details the evolution of the fields of midwifery and obstetrics and of medical practice and techniques for abortion. At a time when laws regulating abortion are again in flux, it is important that health care communities learn from their history and past experiences to inform current practice.

Lohman's Life

Some details about Lohman's life, such as date of birth, date of first marriage, and first husband's date of death, are unclear due to contradicting information in various primary

and secondary sources.[2,4,5,6] It is known that Ann, her first husband, Henry Summers, and daughter, Caroline, moved to the United States in 1831 from England.[2,4,6,7,8] After Ann was widowed in 1831 or 1833, she began to work as a seamstress.[5,6,7,8] She remarried in 1833, becoming Ann Lohman. Six years later, in 1839, Lohman listed her first advertisement as Madame Restell in the *New York Sun*.[2,5,6,7,8] Sources differ on where Lohman learned midwifery, with her first advertisement saying she learned it from her grandmother,[5] although others theorize she learned it from neighboring physician and pill compounder, Dr William Evans.[4,6] As Madame Restell, Lohman sold abortifacients and performed procedural abortions[2,8]—this article uses the term *abortion* to indicate medication or procedural termination of pregnancy.

As Lohman's practice became more successful and lucrative, competitors—Dr Ward, Mrs Mott, Mrs Bird, Dr Monroe, and Catherine Costello—joined the reproductive health care market by advertising abortifacients to treat "menstrual stoppage."[7] Neither Costello nor Lohman were physicians, although they advertised themselves as "female physicians." It is unknown whether Drs Ward and Monroe were trained physicians.[7] Lohman opened a boardinghouse where patients could give birth and could also pay an additional fee for her to facilitate adoption.[4] In this way, Lohman facilitated choices—abortion, birth, and adoption—for her patients.

Practicing during a time in which laws regulating abortion were changing, Lohman served a 1-year sentence from 1847 to 1848 for performing a procedural abortion.[2] She was arrested a second time and released in 1856.[2] The year following her second husband's death, Lohman was arrested for a third time for selling abortifacients.[2] Lohman died of suicide in 1878 at age 65, just prior to her scheduled trial.[2] Her story highlights the fear experienced by many current-day abortion providers as they navigate a volatile and often confusing legal landscape.

Early American Practices

In colonial America, midwives were prominent, respected community members who provided the majority of obstetric care.[9] Midwifery was primarily provided by women, although a midwifery school led by a male, Dr William Shippen, Jr, opened in 1762.[9] At the time, generalist medical care required no formal education and was provided by both men and women.[9] As medical schools began to open in the United States, starting in Philadelphia in 1765, male physicians slowly replaced midwives in attending to the care of upper-class patients, and women were relegated to the confines of providing midwifery services.[9]

Common law guided early American abortion practices. In the absence of modern-day pregnancy tests, pregnancy was not confirmed and fetal existence was not recognized before "quickening" (ie, feeling fetal movement).[10] At that time, prior to quickening, to be pregnant was to carry an "inert non-being" or a "potential for life rather than life itself," which was not a living soul.[10] That quickening was well accepted as marking the beginning of fetal existence in the United States was evident in the contrast between English laws (from which many American laws originated) criminalizing abortion prior to quickening and laws in the early 1800s in the United States that upheld the quickening doctrine—or the idea that fetal existence did not occur until this point in the pregnancy.[10] In 1812, the Massachusetts Supreme Court dismissed criminal abortion charges because the woman had not experienced quickening.[10] This decision set the legal precedent that stood through 1850: that an abortion before quickening was not criminal.[10] On the other hand, providing an abortion after quickening was illegal; in New

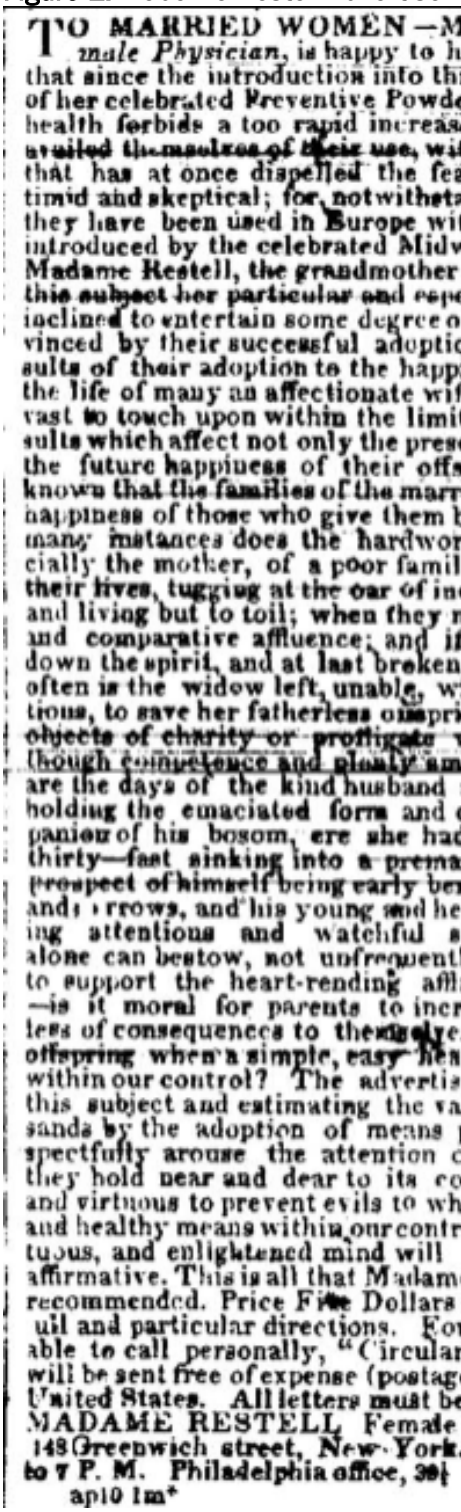
York State, abortion after quickening could be punished with a $100 fine and one year in prison.[8]

In early America, women presenting with amenorrhea were diagnosed with menstrual obstruction, which might be due to a number of causes, including pregnancy.[10] The treatment for menstrual obstruction was to bring on the woman's menses, which might have ended the pregnancy, just as a medication abortion does today. At the time, treatments for menstrual obstruction were considered appropriate medical practice.[10] Thus, physicians and midwives at that time could be considered to be following the principle of beneficence, in that they were providing the standard of medical care, and of nonmaleficence, in that many treatments for menstrual obstruction were no more dangerous than childbirth.

Treatments for menstrual obstruction included various pills and powders. In New York City, Lohman commercialized traditional remedies used by enslaved midwives and Native Americans that were discussed in midwifery medical guides and textbooks and taught in medical schools at the time.[10,11] Midwifery practices of enslaved African Americans consisted of application of "centuries-old African folk knowledge," including placing poultices of petroleum jelly and quinine at the cervix; douching with alum water, water from boiling rusty nails, or turpentine; and oral intake of quinine tablets, turpentine, or laxatives such as pennyroyal or papaya seeds.[11] Native Americans used black root and red cedar to induce abortion; red cedar was also known as savin or sabina and similarly used by colonial women.[12] Other oral abortifacients included pills made of "ergot, calomel, aloe, black hellebore, or ergot mixed with oil of tansy," which were called "female monthly regulating pills."[7] These treatments, which only worked some of the time, were deemed relatively safe by the clinical standards of that era.[10] Furthermore, some physicians considered violent purgatives and poisons to be dangerous to the woman and ineffective.[10]

In the 1830s, abortion marketing in penny papers emerged, offering treatment of "suppression, irregularity, or stoppage of the menses" or "female obstruction."[7] Lohman advertised surgical abortions, with one advertisement citing a cost of $20 for poor women and $100 for the wealthy.[8] Figures 1 and 2 are 1840s Lohman advertisements from the *New York Herald*; they show that while surgical abortion was legally precarious, it was openly advertised and sought out by women.[13,14] Surgical abortions consisted of dilation of the cervix or rupture of the amniotic sac, causing uterine contraction and fetal expulsion. A surgical abortion was not considered to be more dangerous than childbirth, as "a physically produced abortion handled by a competent physician was not a fearsome process."[10]

Figure 1. Madame Restell Advertisement in the *New York Herald*, April 13, 1840



TO MARRIED WOMEN—MADAME RESTELL, *Female Physician*, is happy to have it in her power to say that since the introduction into this country, about a year ago of her celebrated Preventive Powders for married ladies, whose health forbids a too rapid increase of family; hundreds have availed themselves of their use, with a success and satisfaction that has at once dispelled the fears and doubts of the most timid and skeptical; for, notwithstanding that for twenty years they have been used in Europe with invariable success, (first introduced by the celebrated Midwife and Female Physician Madame Restell, the grandmother of the advertiser, who made this subject her particular and especial study,) still some were inclined to entertain some degree of distrust, until become convinced by their successful adoption in this country. The results of their adoption to the happiness, the health, nay, often the life of many an affectionate wife and a fond mother, are too vast to touch upon within the limits of an advertisement—results which affect not only the present well-being of parents, but the future happiness of their offspring. Is it not but too well known that the families of the married often increase beyond the happiness of those who give them birth would dictate? In how many instances does the hardworking father, and more especially the mother, of a poor family, remain slaves throughout their lives, tugging at the oar of incessant labor, toiling to live and living but to toil; when they might have enjoyed comfort and comparative affluence; and if care and toil have weighed down the spirit, and at last broken the health of the father, how often is the widow left, unable, with the most virtuous intentions, to save her fatherless offspring from becoming degraded objects of charity or profligate votaries of vice? And even though conscience and gladly smile upon us, how often, alas! are the days of the kind husband and father embittered in beholding the emaciated form and declining health of the companion of his bosom, ere she had scarce reached the age of thirty—fast sinking into a premature grave—with the certain prospect of himself being early bereft of the partner of his joys and sorrows, and his young and helpless children of the endearing attentions and watchful solicitude which a mother alone can bestow, not unfrequently at a time when least able to support the heart-rending affliction! Is it desirable then—is it moral for parents to increase their families, regardless of consequences to themselves or the well being of their offspring when a simple, easy healthy and CERTAIN remedy is within our control? The advertiser feeling the importance of this subject and estimating the vast benefits resulting to thousands by the adoption of means prescribed by her, would respectfully arouse the attention of the married, by all that they hold near and dear to its consideration. Is it not wise and virtuous to prevent evils to which we are subject by simple and healthy means within our control? Every dispassionate, virtuous, and enlightened mind will unhesitatingly answer in the affirmative. This is all that Madame Restell recommends or ever recommended. Price Five Dollars a package, accompanied with full and particular directions. For the convenience of those unable to call personally, "Circulars" more fully explanatory, will be sent free of expense (postage excepted) to any part of the United States. All letters must be post-paid, and addressed to MADAME RESTELL, Female Physician. Principal office 148 Greenwich street, New-York. Office hours from 9 A. M to 7 P. M. Philadelphia office, 39½ South Eighth street.

ap10 1m*

Reproduced from the Library of Congress.[13]

Figure 2. Madame Restell Advertisement in the *New York Herald*, September 7, 1842

MADAME RESTELL,

FEMALE PHYSICIAN, Office and residence, 148 Greenwich street, between Courtland: nd Liberty streets, where she can be consulted with the strictest confidence on complaints incident to the female frame.

Madame Restell's experience and knowledge in the treatment of obstinate cases of female irregularity, stoppage, suppression, &c., is such as to require but a few days to effect a perfect cure. Ladies desiring proper medical attendance during confinement or other indisposition, will be accommodated during such time, with private and respectable board.

"Preventive Powders," for married ladies, whose delicate or precarious health forbids a too rapid increase of family, will be sent by mail to any part of the United States. Price $5 a package. All Letters (post paid) addressed to 'box 968, New York. Boston Office, No. 7 Essex street."

N. B.—Madame RESTELL would inform ladies residing out of the city, whose health would not admit of travelling, that she would devote her personal attendance upon them in any part of the United States within reasonable distance. s1 1m*r

FEMALE MONTHLY PILLS.

OWING to the celebrity, efficacy, and invariable success of Madame Restell's Female Monthly Pills in all cases of irregularity, suppression, or stoppage of those functions of nature upon which the health of every female depends, since their introduction into the United States, now about four years, counterfeits and imitations are constantly attempted to be palmed off for the genuine. Cheap common pills are purchased at twelve cents a box, put up in different boxes, and called—"Female Monthly Pills," with the object of selling them, if possible, at one or two dollars a box. Females are therefore cautioned against these attempts to impose upon them. It is sufficient here to state that all Female Monthly Pills are counterfeits, except those sold at Madame Restell's Principal Office, 148 Greenwich street, New York and 7 Essex street, Boston. Price $1. Madame Restell's signature is written on the cover of each box.

N. B.—They can be used by married or single, by following the directions enclosed inside of each box. Sold also by appointment at 294 Grand street, corner of Allen, New York.

s1 1m*r

Reproduced from the Library of Congress.[14]

Changing Abortion Regulations

In 1847, the AMA was founded at the National Medical Convention in Philadelphia, where it sought to establish itself and the medical profession by detailing medical training and professional licensure.[15] Medical school-trained physicians had "denounce[d] the amateurs"—including midwives and informally trained generalists—"who dominated the field" and explicitly sought to criminalize all abortion, which was, at that time, legal before quickening.[16] Lohman, as a midwife without formal training who performed abortions, was among those targeted by these efforts.

The AMA's motivations for criminalizing abortion were multipronged.[16] Women sought abortions from skilled practitioners, and, because many physicians lacked skill in performing abortions, physicians might gain control over abortion by criminalizing it.[16] With obstetrics evolving as a profession, midwives were viewed as competition who might decrease physician profit and societal standing.[7] The AMA also espoused the argument that abortion was immoral and violated medical ethics in adopting a resolution referring to it as "unwarrantable destruction of human life."[17] By depicting

abortion as evil, the AMA sought to uplift medicine as the standard of morality.[16] A visual representation of this perspective is Figure 3, an 1847 sketch of Lohman hovering over a creature with a baby in its mouth, which was published in the *National Police Gazette*.[18]

Figure 3. The Female Abortionist, *National Police Gazette*, March 13, 1847

Reproduced from Wikimedia Commons.[18]

In 1859, the AMA unanimously adopted Dr Horatio Storer's 4-page proposal, "Report on Criminal Abortion."[17] The report simultaneously recognized the social acceptance of abortion while deeming it immoral: "The heinous guilt of criminal abortion, however viewed by the community, is everywhere acknowledged by medical men."[17] Storer noted that physicians "are the physical guardians of women" and that abortion was "the wanton and murderous destruction of her child" and called on "governors and legislatures of several States, and, as representing the federal district, to the President and Congress" to carefully examine and revise the statutory and common law.[17] The

AMA formally espoused the idea that life begins at conception, rather than at quickening, and resolved to publicly protest abortion, lobby lawmakers to criminalize abortion, and enlist AMA-associated state medical societies in the cause.[17] The AMA's campaign resulted in the passage of over 40 anti-abortion statutes in state and territorial law codes between 1860 and 1880.[16] Today's increase in state-level abortion regulations is reminiscent of this period.

The AMA physicians declaring recommendations regarding the care of women's bodies did so without a woman's voice.[15,17] While the 1859 AMA "Report on Criminal Abortion" was about women's health care, there were no women authors. Similarly, the AMA campaign for abortion criminalization was led by men, especially Storer.[1] In the 1847 and 1859 AMA proceedings, physicians are always referred to as "men," whereas women are referenced as "wives" or "patients."[15,17] Today's new legislation regulating abortion is similarly written and championed by primarily male politicians who are not familiar with its medical or procedural aspects.

In 1873, Anthony Comstock, Postmaster General special agent and Society for the Suppression of Vice secretary, proposed the federal bill that later that year became the Comstock Law, which criminalized the use of mail to communicate information about preventing conception.[19] Comstock visited Lohman's office twice under an alias to learn about her practice and buy an abortifacent.[2] On his third visit, 5 years after the passage of the Comstock Law by Congress and 19 years after the AMA's "Report on Criminal Abortion," Comstock arrested Lohman for selling abortifacients.[2] The *New York Times* reported on April 1, 1878, that Lohman was "driven to desperation" and "came to a violent end by cutting her throat from ear to ear."[2] The Comstock Law is being considered as one possible way for legislators to regulate access to abortion pills today. Although the Comstock Law is federal policy, some city and county ordinances state that mailing or receiving abortion medications is illegal.[20]

Today

In 2020, Dr Meera Shah, chief medical officer of Planned Parenthood Hudson Peconic in New York State, wrote that "remaining silent about providing abortion care perpetuates the stereotype that abortion is unusual or deviant or that legitimate, skilled, intelligent doctors do not perform them."[21] Shah's words invite a comparison with the mid-19th-century delegitimization of abortion in AMA proceedings as unskilled medical care and the derogatory language used to describe those who performed abortions, epitomized by the 1878 *New York Times* article referring to Lohman as "mysterious," "notorious," and "nefarious" for practicing abortion.[2]

Abortion regulations are once again changing. The *Dobbs* decision has allowed individual states to recriminalize abortion.[1] Indeed, after the 2023 change to the US Food and Drug Administration Mifepristone Risk Evaluation Mitigation Strategy, which allows certified pharmacies to dispense mifepristone, 20 attorneys general posted communications to 2 major national pharmacy retailers citing the Comstock Act as criminalizing the mailing of abortifacients and asserting that their states could enforce the Comstock Act.[20] Thus, in the wake of the *Dobbs* decision, the Comstock Act is again the word of law, and conservative interpretation could lead to federal prosecution of those mailing abortifacients or even medications that may threaten pregnancies, such as methotrexate.[20]

In Texas, Senate Bill 8 bans abortions after fetal cardiac activity is detected (approximately 6 weeks gestational age) and Senate Bill 4 makes it a felony, punishable by jail time and a $10 000 fine, for a physician to medically terminate a pregnancy after 49 days gestational age.[22,23] A study that explored the effect on maternal morbidity of these 2 abortion restrictions implemented in 2021 found that women in Texas did not receive what was once standard of care,[22] indicating that physicians could no longer practice beneficence and justice. In Texas, physicians observed women for an average of 9 days until patients experienced severe complications that threatened their lives, such as hemorrhage and infection.[22] As a result, the Texas patients had nearly double the morbidity rate of women in states without abortion restrictions.[22]

In 2022, 160 years after its initial condemnation of abortion, the AMA adopted policies opposing abortion criminalization and supporting abortion access: "The AMA is steadfastly opposed to governmental interference in the practice of medicine, especially for well-established, medically necessary treatments. Patients and physicians need assurances that they won't be accused of crimes for medically necessary treatment … that medically necessary treatment can be criminalized speaks volumes about these misguided abortion laws."[24] The AMA's statement supports physicians practicing the standard of care, which is embedded in the ethical pillars of beneficence and nonmaleficence. Additionally, the AMA states that the decision to terminate a pregnancy "should be made privately within the relationship of trust between patient and physician."[25,26] In light of the *Dobbs* decision, the AMA is explicitly recognizing the sanctity and privacy of the patient-physician relationship, one which centers patient autonomy despite legal restrictions.

Lohman's story remains relevant as we experience a movement towards limiting women's bodily autonomy and access to reproductive care. Criminalization of abortion during Lohman's lifetime parallels the restrictions occurring in the present day. Considering the motivations for and impact of laws restricting reproductive care during Lohman's time provides a medium through which to further reflect on our current laws and their impact today.

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ART OF MEDICINE

Performing Clarity, Sincerity, and Endurance

Teddie Bernard

Abstract

Health beliefs about one's own future should be clearly expressed, sincere, and enduring to be taken seriously by clinicians when assessing risks and benefits in key health decisions. This cartoon considers how clinicians' expressions of doubt about those beliefs can undermine patient-clinician relationships and a patient's epistemic authority.

Figure. *Childless by Choice*

Media
Procreate.

Caption
When clinicians treat patients with a uterus with an intervention that poses fertility risks, shared decision-making requires clinicians to express respect for a patient's clear communication that they do not want to use their own bodies to procreate, do not want children, or some other view about how they relate their future selves to their procreative capacities. Clinicians' overemphasis on future pregnancy and fertility or continued expressions of doubt about the sincerity or endurance of a preference undermines a patient's epistemic authority in decision-making. The patient in this work has carefully staged what they want to say and clearly states their view with a garland of capital letters while dressed in a top hat and suit. Even with fireworks as background spectacle, their clinician still seems to find room for doubt about the patient's performative communication and their preferences and desires for their future self. Clinicians' expressions of doubt, especially when persistent, can also make patients feel unheard and dismissed and, perhaps, cause them to wonder, *Why do you think I've not thought about this? Why do I have to demonstrate the endurance or sincerity of my view?* This cartoon also asks, *What kind of show must patients, who can bear children but choose not to, perform for their clinicians in order to be taken at their word?*

Teddie Bernard graduated from the School of the Art Institute of Chicago with a bachelor's degree in fine arts in 2023. Their editorial comics and graphic journalism have been recognized by the Society for Professional Journalists (Mark of Excellence, 2023), the College Media Association (2023, 2022, 2021), the Illinois College Press Association (2024), and the Associated Collegiate Press (2021).

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ART OF MEDICINE

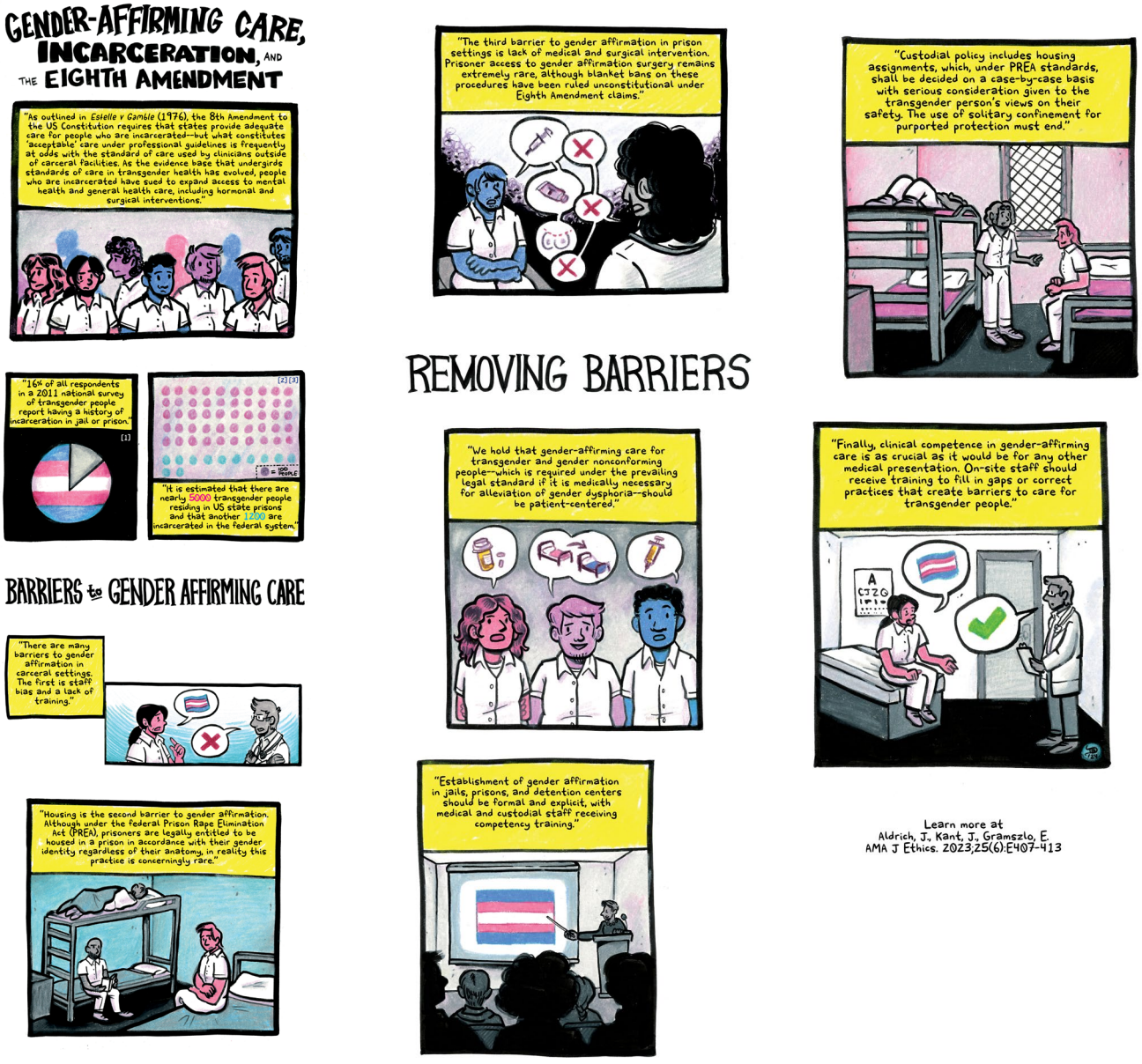
Visual Abstract of "Gender-Affirming Care, Incarceration, and the Eighth Amendment"

Teddie Bernard

Abstract

This visual abstract is based on an article from the June 2023 issue of the journal.

Figure. *Gender-Affirming Care, Incarceration, and the Eighth Amendment*



Media

Pen and colored pencil on Bristol board.

Teddie Bernard graduated from the School of the Art Institute of Chicago with a bachelor's degree in fine arts in 2023. Their editorial comics and graphic journalism have been recognized by the Society for Professional Journalists (Mark of Excellence, 2023), the College Media Association (2023, 2022, 2021), and the Associated Collegiate Press (2021).

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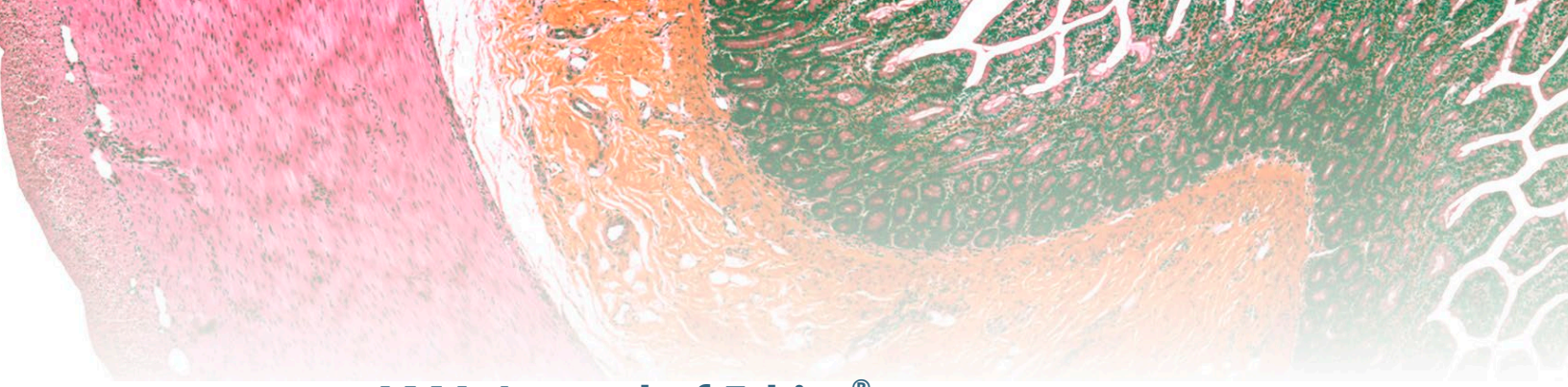

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LETTER TO THE EDITOR

Response to "Humanity and Inhumanity of Nonhuman Primate Research"

Emily R. Trunnell, PhD and Donya Mand, MD

Responding to Kaitlin R. Weed's "Humanity and Inhumanity of Nonhuman Primate Research" in the September 2024 issue of the journal, we argue that, contra the author's claim, use of nonhuman primates (NHPs) and other animals is unjustified and highlight reasons for growing opposition to using NHPs in biomedical or behavioral experimentation, testing, or research.

While the *presence* of NHPs and other animals in past research arguably was valid, their *necessity* in research—especially now—is not.[1] Despite the use of NHPs in research, approximately 95% of new drugs fail in clinical trials.[2] In 2019, 99% of Alzheimer's disease (AD) research trials showed no difference between the intervention drug and placebo.[3] Despite recent (but controversial) advancements[4,5]—specifically, the approval of several monoclonal antibody therapies—major discord continues to surround the models used to mimic current theories of AD etiology and pathology, prompting greater scrutiny of preclinical animal models.[6] Moreover, of hundreds of HIV vaccines developed and tested in NHPs, none are approved for humans.[7,8]

Despite strong insistence from some researchers that halting chimpanzee use in research would stall clinical progress,[9] in 2011 the Institute of Medicine Committee on the Use of Chimpanzees in Biomedical and Behavioral Research concluded that most experimental uses of chimpanzees were unnecessary.[10] Poor translation of conclusions drawn from research on other animals to humans, combined with the increasing availability of non-animal methods, has generated a scientific landscape that is continuing to move away from animal use, as demonstrated by the implementation of the US Food and Drug Administration's (FDA's) New Alternative Methods Program[11] and the adoption in 2023 of the FDA Modernization Act 2.0.[12] The aforementioned legislation gives the FDA the statutory authority to consider preclinical testing performed using non-animal methods, meaning animal tests are not required before drugs are advanced to human trials.[12]

Opposition to research on NHPs has merit. The Silver Spring Monkeys case mentioned in Weed's article resulted in changes to laws intended to improve care of laboratory-based animals, but some facilities that use primates still fail to uphold minimal standards of the Animal Welfare Act, resulting in some NHPs being denied veterinary care[13] and sustaining injuries[14] or dying[15] due to improper handling, monitoring, or facility

maintenance. Moreover, removal of primates from their native habitats threatens wild populations,[16] and transporting these NHPs to laboratories risks transmission of zoonotic diseases (which can also confound data collected from infected animals).[17]

The depiction of a content rhesus macaque in Weed's article offers a misleading view of NHPs in research, obscuring the reality that they suffer when they are denied dignity, respect, and opportunities to live their lives in their native habitats on their own terms. It's time we stopped thinking of NHP research as something of value and recognize it for what it is: a practice that future generations will—especially if current trends of using fewer NHPs in research continue—likely look back on with incredulity and regret.

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