

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 502
(A-23)

Introduced by: Medial Student Section

Subject: Pain Management for Long-Acting Reversible Contraception and other
Gynecological Procedures

Referred to: Reference Committee E

1 Whereas, A U.S.-based prospective study of over 9,256 women known as the Contraceptive
2 CHOICE Project showed that increasing access to long-acting reversible contraceptives
3 (LARC) will lead to a decrease in both unintended pregnancies and annual healthcare costs¹;
4 and

5
6 Whereas, AMA policy H-75.987 supports a national goal of reducing unintended pregnancies
7 via counseling women of children bearing age on family planning and LARC use; and

8
9 Whereas, Intrauterine devices (IUDs) are between 99.6% and 99.9% effective as long-acting
10 reversible contraceptives and 99.9% effective as emergency contraceptives^{2,3}; and

11
12 Whereas, The 2017-2019 National Survey of Family Growth states that 10.4% of women age
13 15-49 in the United States use long-acting reversible contraceptives and use of LARCs has
14 risen five-fold in the last decade among women aged 15-44^{4,5}; and

15
16 Whereas, Without the use of analgesics or anesthesia, nearly 89% of women report
17 moderate to severe pain during placement of a tenaculum, which precedes insertion of an
18 intrauterine device (IUD), removal of lost IUDs, as well as endometrial biopsy, uterine
19 aspiration, colposcopy, and hysteroscopy⁶; and

20
21 Whereas, A 2014 study found that, on a scale of 100, the mean patient maximum pain upon
22 IUD insertion was 64.8 compared to 35.3 rated by the physician, highlighting a discrepancy
23 between patients' experienced pain and providers' assumption of pain⁷; and

24
25 Whereas, Studies report that physicians often underestimate female pain and treat female
26 pain less extensively than male pain; consequently, physicians are less likely to recommend
27 analgesics and are more likely to recommend psychological treatment for female pain than
28 for male pain⁸⁻¹³; and

29
30 Whereas, In addition to LARC insertion procedures, a substantial portion of other gynecologic
31 procedures are routinely performed in offices and in clinics, including colposcopy with biopsy,
32 loop electrosurgical excision procedure (LEEP), endometrial biopsy, uterine aspiration,
33 dilation and evacuation (D&E), saline infusion sonogram, and hysterosalpingogram, among
34 others under circumstances with limited validated options for analgesia¹⁴; and

35
36 Whereas, Local anesthesia, general anesthesia, and oral or intravenous sedation is
37 commonly used in vasectomy procedures for pain control and clear guidelines regarding use
38 of sedation or anesthesia for vasectomies are explicitly outlined in American Urological
39 Association clinical guidelines¹⁵; and

1 Whereas, Studies have shown that medical professionals hold false beliefs about Black
2 people feeling less pain, so that Black women stand to face compounded effects of racism
3 and sexism when seeking appropriate treatment for pain¹⁶; and
4

5 Whereas, Current research suggests that anticipated pain is correlated with increased
6 perceived pain throughout the duration of IUD insertion, especially in marginalized
7 populations¹⁷; and
8

9 Whereas, While studies have shown LARCs to be associated with high rates of satisfaction
10 following insertion, this level of satisfaction is negatively impacted by pain experienced during
11 the procedure¹⁸; and
12

13 Whereas, Negative experiences related to gynecologic procedures may lead to patients
14 delaying otherwise routine gynecologic care, which can lead to preventable healthcare
15 inequities surrounding undiagnosed gynecological cancers, endometriosis, infections,
16 thereby impacting a patient's quality of life and potentially resulting in preventable death¹⁹;
17 and
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19 Whereas, Multiple analgesic treatment regimens, including prophylactic NSAIDs, cervical
20 ripening, and topical cervical lidocaine, have been shown to prove inadequate analgesia prior
21 to IUD insertion, while intracervical lidocaine block and ketorolac injection have demonstrated
22 potential analgesic efficacy around the time of IUD insertion²⁰⁻²³; and
23

24 Whereas, Adequate management of postoperative pain after gynecologic procedures has
25 been associated with fewer postoperative hospital admissions²⁴; and
26

27 Whereas, The American College of Obstetricians and Gynecologists (ACOG) acknowledges
28 that, of the patients that undergo IUD insertion, “many report moderate to severe pain” and
29 that more research is needed to identify effective options to reduce pain for IUD insertion²⁵;
30 and
31

32 Whereas, ACOG specifically recommends that physicians consider analgesia or sedation for
33 women who are at higher risk for increased pain during IUD insertion, such as nulliparous
34 women, patients requiring cervical dilation, or patients who have had a past painful insertion
35 experience²⁵; and
36

37 Whereas, Our American Medical Association endorses training physicians on adequate pain
38 control and urges for informed consent for other in-office procedures such as policy H-69.945
39 “Neonatal Male Circumcision”, but does not have a policy that explicitly discusses pain
40 management for gynecological procedures; therefore be it
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42 RESOLVED, That our American Medical Association recognize the disparity in pain
43 management in gynecological procedures compared to procedures of similarly reported pain
44 and encourages discussion of pain control options, risks, and benefits with patients as a part of
45 the shared decision making process (New HOD Policy); and be it further
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47 RESOLVED, That our AMA support further research into evidence-based anesthetic and
48 anxiolytic medication options for long-acting reversible contraception procedures and other
49 gynecological procedures, including but not limited to colposcopy, endometrial biopsy, and
50 LEEP procedures. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 3/31/23

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RELEVANT AMA POLICY

Reducing Unintended Pregnancy H-75.987

Our AMA: (1) urges health care professionals to provide care for women of reproductive age, to assist them in planning for pregnancy and support age-appropriate education in esteem building, decision-making and family life in an effort to introduce the concept of planning for childbearing in the educational process; (2) supports reducing unintended pregnancies as a national goal; and (3) supports the training of all primary care physicians and relevant allied health professionals in the area of preconception counseling, including the recognition of long-acting reversible contraceptives as efficacious and economical forms of contraception.

Citation: Res. 512, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmation A-15; Appended: Res. 502, A-15; Reaffirmation I-16;

Pain Management H-410.950

Our AMA adopts the following guidelines on Invasive Pain Management Procedures for the Treatment of Chronic Pain, Including Procedures Using Fluoroscopy:

Interventional chronic pain management means the diagnosis and treatment of pain-related disorders with the application of interventional techniques in managing sub-acute, chronic, persistent, and intractable pain. The practice of pain management includes comprehensive assessment of the patient, diagnosis of the cause of the patient's pain, evaluation of alternative treatment options, selection of appropriate treatment options, termination of prescribed treatment options when appropriate, follow-up care, the diagnosis and management of complications, and collaboration with other health care providers.

Invasive pain management procedures include interventions throughout the course of diagnosing or treating pain which is chronic, persistent and intractable, or occurs outside of a surgical, obstetrical, or post-operative course of care. Invasive pain management techniques include:

1. ablation of targeted nerves;
2. procedures involving any portion of the spine, spinal cord, sympathetic nerves or block of major peripheral nerves, including percutaneous precision needle placement within the spinal column with placement of drugs such as local anesthetics, steroids, and analgesics, in the spinal column under fluoroscopic guidance or any other radiographic or imaging modality; and
3. surgical techniques, such as laser or endoscopic disectomy, or placement of intrathecal infusion pumps, and/or spinal cord stimulators.

At present, invasive pain management procedures do not include major joint injections (except sacroiliac injections), soft tissue injections or epidurals for surgical anesthesia or labor analgesia.

When used for interventional pain management purposes such invasive pain management procedures do not consist solely of administration of anesthesia; rather, they are interactive procedures in which the physician is called upon to make continuing adjustments based on medical inference and judgments. In such instances, it is not the procedure itself, but the purpose and manner in which such procedures are utilized, that demand the ongoing application of direct and immediate medical judgment. These procedures are therefore within the practice of medicine, and should be performed only by physicians with appropriate training and credentialing.

Invasive pain management procedures require physician-level training. However, certain technical aspects of invasive pain management procedures may be delegated to appropriately trained, licensed or certified, credentialed non-physicians under direct and/or personal supervision of a physician who possesses appropriate training and privileges in the performance of the procedure being supervised, and

in compliance with local, state, and federal regulations. Invasive pain management procedures employing radiologic imaging are within the practice of medicine and should be performed only by physicians with appropriate training and credentialing.

Citation: (BOT Rep. 16, A-13)

Coverage of Contraceptives by Insurance H-180.958

1. Our AMA supports federal and state efforts to require that every prescription drug benefit plan include coverage of prescription contraceptives.

2. Our AMA supports full coverage, without patient cost-sharing, of all contraception without regard to prescription or over-the-counter utilization because all contraception is essential preventive health care.

Citation: Res. 221, A-98; Reaffirmation A-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmation: I-17;

Modified: BOT Rep. 10, A-18;

Preconception Care H-425.976

1. Our AMA supports the 10 recommendations developed by the Centers for Disease Control and Prevention for improving preconception health care that state:

(1) Individual responsibility across the lifespan--each woman, man, and couple should be encouraged to have a reproductive life plan;

(2) Consumer awareness--increase public awareness of the importance of preconception health behaviors and preconception care services by using information and tools appropriate across various ages; literacy, including health literacy; and cultural/linguistic contexts;

(3) Preventive visits--as a part of primary care visits, provide risk assessment and educational and health promotion counseling to all women of childbearing age to reduce reproductive risks and improve pregnancy outcomes;

(4) Interventions for identified risks--increase the proportion of women who receive interventions as follow-up to preconception risk screening, focusing on high priority interventions (i.e., those with evidence of effectiveness and greatest potential impact);

(5) Inter-conception care--use the inter-conception period to provide additional intensive interventions to women who have had a previous pregnancy that ended in an adverse outcome (i.e., infant death, fetal loss, birth defects, low birth weight, or preterm birth);

(6) Pre-pregnancy checkup--offer, as a component of maternity care, one pre-pregnancy visit for couples and persons planning pregnancy;

(7) Health insurance coverage for women with low incomes--increase public and private health insurance coverage for women with low incomes to improve access to preventive women's health and pre-conception and inter-conception care;

(8) Public health programs and strategies--integrate components of pre-conception health into existing local public health and related programs, including emphasis on inter-conception interventions for women with previous adverse outcomes;

(9) Research--increase the evidence base and promote the use of the evidence to improve preconception health; and

(10) Monitoring improvements--maximize public health surveillance and related research mechanisms to monitor preconception health.

2. Our AMA supports the education of physicians and the public about the importance of preconception care as a vital component of a woman's reproductive health.

3. Our AMA supports the use of pregnancy intention screening and contraceptive screening in appropriate women and men as part of routine well-care and recommend it be appropriately documented in the medical record.

Citation: Res. 414, A-06; Reaffirmation I-07; Reaffirmed: CSAPH Rep. 01, A-17; Appended: Res. 401, A-19;

Neonatal Male Circumcision H-60.945

1. Our AMA: (a) encourages training programs for pediatricians, obstetricians, and family physicians to incorporate information on the use of local pain control techniques for neonatal circumcision; (b) supports the general principles of the 2012 Circumcision Policy Statement of the American Academy of Pediatrics, which reads as follows: "Evaluation of current evidence indicates that the health benefits of newborn male circumcision outweigh the risks and that the procedure's benefits justify access to this procedure for

families who choose it. Specific benefits identified included prevention of urinary tract infections, penile cancer, and transmission of some sexually transmitted infections, including HIV." and (c) urges that as part of the informed consent discussion, the risks and benefits of pain control techniques for circumcision be thoroughly discussed to aid parents in making their decisions.

2. Our AMA encourages state Medicaid reimbursement of neonatal male circumcision.

Citation: (CSA Rep. 10, I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: Res. 503, A-13)

E2.1.1 Informed Consent

Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making.

The process of **informed consent** occurs when communication between a patient and physician results in the patient's authorization or agreement to undergo a specific medical intervention. In seeking a patient's **informed consent** (or the **consent** of the patient's surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:

(a) Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.

(b) Present relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information. The physician should include information about:

(i) the diagnosis (when known);

(ii) the nature and purpose of recommended interventions;

(iii) the burdens, risks, and expected benefits of all options, including forgoing treatment.

(c) Document the **informed consent** conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the patient/surrogate has provided specific written **consent**, the **consent** form should be included in the record.

In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient's surrogate is not available, physicians may initiate treatment without prior **informed consent**. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain **consent** for ongoing treatment in keeping with these guidelines.

Issued: 2016

Pain as the Fifth Vital Sign D-450.956

Our AMA will: (1) work with The Joint Commission to promote evidence-based, functional and effective pain assessment and treatment measures for accreditation standards; (2) strongly support timely and appropriate access to non-opioid and non-pharmacologic treatments for pain, including removing barriers to such treatments when they inhibit a patient's access to care; (3) advocate that pain as the fifth vital sign be eliminated from professional standards and usage; and (4) advocate for the removal of the pain management component of patient satisfaction surveys as it pertains to payment and quality metrics.

Citation: BOT Rep. 19, A-16; Reaffirmation: A-19;

H-515.952 Adverse Childhood Experiences and Trauma-Informed Care Adverse Childhood Experiences and Trauma-Informed Care H-515.952

1. Our AMA recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization.

2. Our AMA supports:

a. evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs);

b. evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs;

c. efforts for data collection, research, and evaluation of cost-effective ACEs screening tools without additional burden for physicians.

d. efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting; and

e. funding for schools, behavioral and mental health services, professional groups, community, and government agencies to support patients with ACEs or trauma at any time in life; and

f. increased screening for ACEs in medical settings, in recognition of the intersectionality of ACEs with

significant increased risk for suicide, negative substance use-related outcomes including overdose, and a multitude of downstream negative health outcomes.

3. Our AMA supports the inclusion of ACEs and trauma-informed care into undergraduate and graduate medical education curricula.

Citation: Res. 504, A-19; Appended: CSAPH Rep. 3, A-21;

DRAFT