RESOLUTION

Subject: Support Legislation Requiring Explicit Consent Before Pelvic Examinations Performed Under Anesthesia

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Referred to: Reference Committee

WHEREAS, medical Students in Kentucky are not explicitly barred from performing pelvic exams on anesthetized patients even when the patient has not explicitly consented to the exam and there is no medical indication[1,2]; and

WHEREAS, an Evidence Study conducted by the US Preventive Services Task Force and published by JAMA in 2017 found that there was “limited evidence” regarding the diagnostic accuracy of pelvic examinations in asymptomatic patients[3]; and

WHEREAS, the AMA Council on Ethical and Judicial Affairs, The Association of American Medical Colleges, and the Committee on Ethics of the American College of Obstetricians and Gynecologists (ACOG) have all published statements denouncing the practice of pelvic exams on anesthetized patients when specific informed consent has not been obtained[2]; and

WHEREAS, a 2010 survey of 102 women found that, while a majority (62%) of respondents would consent to medical students doing pelvic examinations if asked, 72% expected to be asked for consent before medical students undertook pelvic examinations under anesthesia, and only 19% were already aware that a medical student might do a pelvic examination in the operating room[4]; and

WHEREAS, eight states (California, Hawaii, Illinois, Iowa, Oregon, Virginia, Utah, and Maryland) have already passed legislation that prohibits unauthorized pelvic examinations, and at least nine other states (Connecticut, Minnesota, Missouri, Nebraska, New Hampshire, New York, Oklahoma, Washington, and Texas) are currently considering similar legislation[5]; now, therefore, be it

RESOLVED, that the Kentucky Medical Association support legislation that would require explicit patient consent before pelvic examinations performed under anesthesia.

References

[1] Kentucky Legislative Research Commission Search
[2] JAMA Forum: Teaching Pelvic Examination Under Anesthesia Without Patient Consent. *JAMA.* January 16, 2019.
[3] Periodic Screening Pelvic Examination: Evidence Report and Systematic Review for the US Preventive Services Task Force *JAMA.* 2017;317(9):954-966
[4] Wainberg S, et al. Teaching pelvic examinations under anaesthesia: what do women think? *J Obstet Gynaecol Can*. 2010;32(1):49-53. doi:10.1016/S1701-2163(16)34404-8
[5] HH. Med Students Are Doing Vaginal Exams on Unconscious, Non-Consenting Patients. *Vice*. June 2019.

RELEVANT AMA AND KMA POLICY

Office-Based Surgery Regulation H-475.984

Our AMA supports the following Core Principles on Office-Based Surgery:

- Core Principle #1: Guidelines or regulations for office-based surgery should be developed by states according to levels of anesthesia defined by the American Society of Anesthesiologists (ASA) excluding local anesthesia or minimal sedation. (American Society of Anesthesiologists. Continuum of depth of sedation. Available at: http://www.asahq.org/for-members/standards-guidelines-and-statement.aspx. Accessed July 2, 2013).

- Core Principle #2: Physicians should select patients for office-based surgery using moderate sedation/analgesia, deep sedation/analgesia or general anesthesia by criteria including the ASA Physical Status Classification System and so document. (American Society of Anesthesiologists. ASA physical status classification system. Available at: http://www.asahq.org/for-members/clinical-informaion/asa-physical-status-classification-syst em.aspx. Accessed July 2, 2013).

- Core Principle #3: Physicians who perform office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia should have their facilities accredited by The Joint Commission, Accreditation Association for Ambulatory Health Care (AAAHC), American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF), American Osteopathic Association (AOA), or by a state recognized entity, such as the Institute for Medical Quality (IMQ), or be state licensed and/or Medicare certified.

- Core Principle #4: Physicians performing office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia must have admitting privileges at a nearby hospital, or a transfer agreement with another physician who has admitting privileges at a nearby hospital, or maintain an emergency transfer agreement with a nearby hospital.

- Core Principle #5: States should follow the guidelines outlined by the Federation of State Medical Boards (FSMB) regarding informed consent. (Report of the Special Committee on Outpatient [Office-Based] Surgery. (Med. Licensure Discipline. 2002; 88:-160-174).

- Core Principle #6: For office surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia, states should consider legally privileged adverse incident reporting requirements as recommended by the FSMB and accompanied by periodic peer review and a program of Continuous Quality Improvement. (Report of the Special Committee on Outpatient (Office-Based) Surgery. Journal Medical Licensure and Discipline. 2002; 88:160-174).

- Core Principle #7: Physicians performing office-based surgery using moderate sedation/analgesia, deep sedation/analgesia or general anesthesia must obtain and maintain board certification by one of the boards recognized by the American Board of Medical Specialties, American Osteopathic Association, or a board with equivalent standards approved by the state medical board within five years of completing an approved residency training program. The procedure must be one that is generally recognized by that certifying board as falling within the scope of training and practice of the physician providing the care.

- Core Principle #8: Physicians performing office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia may show competency by maintaining core privileges at an accredited or licensed hospital or ambulatory surgical center, for the procedures they perform in the office setting. Alternatively, the governing body of the office facility is responsible for a peer review process for privileging physicians based on nationally recognized credentialing standards.

- Core Principle #9: For office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia, at least one physician who is credentialed or currently recognized as having successfully completed a course in advanced resuscitative techniques (e.g., ATLS, ACLS, or PALS), must be present or immediately available with age- and size-appropriate resuscitative equipment until the patient has met the criteria for discharge from the facility. In addition, other medical personnel with direct patient contact should at a minimum be trained in Basic Life Support (BLS).

- Core Principle #10: Physicians administering or supervising moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia should have appropriate education and training.