Testimony in Opposition to
Senate Bill 243 An Act Prohibiting an Unauthorized Pelvic Examination on a Female Patient who is under Deep Sedation or Anesthesia or Unconscious
Public Health Committee
March 9, 2020

Senator Abrams, Representative Steinberg and members of the Public Health Committee, on behalf of the physicians and physicians in training of the Connecticut Section of the American College of Obstetricians and Gynecologists and the Connecticut State Medical Society, please accept this testimony in opposition to **Senate Bill 243 An Act Prohibiting an Unauthorized Pelvic Examination on a Female Patient who is under Deep Sedation or Anesthesia or Unconscious.**

When performed solely for educational purposes, with no expected health benefit to the patient, a pelvic exam under anesthesia (EUA) should require specific informed consent. This already occurs in health care settings, and the American College of Obstetricians and Gynecologists (ACOG) Committee Opinion 439 "Informed Consent" affirms that obtaining informed consent for medical treatment is an ethical requirement. Regarding pelvic EUA performed by medical learners, ACOG writes, *"Pelvic examinations on an anesthetized woman that offer her no personal benefit and are performed solely for teaching purposes should be performed only with her specific informed consent obtained before her surgery."*

Additionally, it is essential to distinguish between pelvic exams performed solely for educational purposes and those that are part of a woman's care at the time of surgery. The initial education about pelvic exams is most often provided to students using simulated patient interactions led by trained professionals. The intraoperative gynecologic exam specifically allows for assessment of uterine position, selection of appropriate surgical approach, and anticipation of potential intraoperative challenges such as the presence of scar tissue. This exam plays an essential role in the process of planning and performing safe gynecologic surgery.

An examination being performed for a diagnostic or therapeutic purpose (e.g., to determine in what manner to conduct surgery) is of an entirely different nature than one performed for training purposes. Such exams are hardly isolated to gynecologic procedures; on the contrary, it is a surgeon's responsibility to be familiar with the anatomy of the structures on or around which he or she is operating – whether be it a breast, a liver, a leg, or a uterus. As such, a pelvic examination is an inextricable component of nearly any gynecological procedure to which a patient has consented.

It is of vital importance that clinicians partner with patients to explain how aspects of a procedure relate to their medical care. This is the underlying tenet of informed consent and the foundation of trust upon which the doctor-patient relationship is built. We fully support the need for providers to have an *explicit* conversation as part of the consent process, addressing the importance of pelvic EUA as part of the procedure. However, it is our view that government attempts to mandate specifics of medical practices, especially regarding informed consent processes, can set ill-advised precedents. "Differentiating" pelvic examinations relegates

women's health care to a place outside the scope of normal health care and related standards of care. As seen in other areas of women's health that have been treated differently by the law, this can lead to marginalization and stigmatization of such care, which harms the very women we aim to serve.

In addition to impacting the provider patient relationship, we are concerned that the provision authorizing the Commissioner of Public Health to investigate physicians' compliance with this type of legislative initiative could impact physician participation in medical student education. Specifically, there is potential that such legislation could deter obstetricians and gynecologists from participating in medical education. Many physicians who participate in medical education are volunteers, and they sacrifice time and productivity to assist in medical education as a service to the community. The prospect of investigation and possible disciplinary action from the Department of Public Health on an aspect of medical care that is as individualized as patient informed consent, may be intimidating enough to discourage some from participating in medical education.

In 2017, the Committee on Public Health held a hearing on a shortage of clinical clerkships for medical students in Connecticut. The Committee also considered legislation to address the supply of clerkships; the issue was deemed serious enough to lead to extensive discussions among hospitals and schools of medicine that were convened by the Connecticut Hospital Association. It would be prudent to think carefully about measures that might aggravate the challenges in providing enough clinical experience to support plans for increased enrollment at medical schools in Connecticut.

As obstetrician-gynecologists, we believe that it is our duty to serve and respect our patients. As physicians, we are dedicated to caring for women. As medical educators, we teach and model professionalism to our learners. We believe the pelvic EUA and its consent process educate learners how transparent communication illustrates the respect and shared decision-making critical for the patient-physician relationship. We believe that patient care and medical education are not competing obligations but are synergistic to ensure best practices are continued.

We again thank the Committee for their time and attention to this important matter. We look forward to working with members of this committee to ensure that final legislation accomplishes our mutual goal.