ACOG Releases Updated Guidelines for Pain Management

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Across Washington State, women have filed complaints with the Washington Medical Commission citing inadequate treatment of pain. These concerns are not isolated or anecdotal. A substantial and growing body of academic research confirms that women particularly Black, Indigenous, Latina/x, and other women of color routinely face bias and substandard care when reporting pain[6,7,8,9].This systemic issue extends across healthcare settings and specialties, resulting in women being underdiagnosed[10,11,12] undertreated[13], and ultimately harmed[14,15]. When patients feel unheard or dismissed[16], they are more likely to delay or avoid future care[17,18], including preventive service leading to worsening health outcomes[19] and further entrenching disparities[20] in health equity[21,22].

Numerous research studies have validated the extensive presence of pain bias against women. A 2024 study analyzing over 21,000 emergency department discharges in the U.S. and Israel found that women were significantly less likely than men to receive analgesics, even when reporting similar pain levels, and providers frequently failed to record their pain scores[23]. A foundational 2001 research titled, *The Girl Who Cried Pain*, revealed that women report more frequent and severe pain than men but are consistently treated less aggressively due to enduring stereotypes portraying them as overly emotional or exaggerating symptoms[24]. These biases are compounded by racial disparities: Black and Hispanic women face greater obstacles to receiving adequate pain relief. A 2019 study found that postpartum Black and Hispanic women were prescribed fewer opioids than their White counterparts, despite reporting higher pain levels[25]. Similarly, a retrospective study of over 81,000 childbirth admissions in New York found that Black and Hispanic women were less likely to receive epidural analgesia than White women, even after adjusting for clinical and insurance factors[26]. Collectively, these studies confirm that the dismissal of women's pain especially among women of color is not incidental, but systemic and persistent across clinical settings.

In response to these well-documented disparities, the American College of Obstetricians and Gynecologists (ACOG) released updated guidelines in 2025 for pain management in gynecologic ambulatory care.

These updates are especially critical for outpatient reproductive health and primary care providers. ACOG now explicitly recognizes that minimizing or dismissing procedural pain is not only clinically harmful but reflects implicit bias within healthcare systems. The organization calls for trauma-informed, equity-centered care, especially during procedures such as IUD insertion or removal, endometrial biopsy, cervical dilation, and colposcopy with biopsy.

ACOG recommends that providers proactively assess and validate patients' pain, offer a range of evidence-based and patient-centered pain management options, and use bias-aware, trauma-informed communication. Pain management strategies should include NSAIDs prior to procedures, topical anesthetics such as lidocaine, paracervical blocks, misoprostol for cervical softening, IV sedation or anesthesia when indicated, and non-pharmacologic supports such as support person or comfort measures. These practices must be accompanied by thorough documentation of patient preferences and pain management plans.

To address underlying bias, ACOG urges providers to engage in self-reflection to identify disparities in their own clinical decisions, utilize standardized pain assessment tools to reduce subjectivity, build time for patient questions and shared decision-making, and avoid assumptions about what pain patients should tolerate based on race, gender, age, or reproductive history.

Providers play a critical role in helping close the gap observed in pain management. Listening to patients, validating their experiences, and offering personalized pain management are not only markers of clinical quality standard but a core foundation of excellent patient-provider relationships[27]. Implementing these practices can directly reduce disparities and lead to improved outcomes for women across Washington.

> "When patients feel unheard or dismissed, they are more likely to delay or avoid future care including preventive service leading to worsening health outcomes and further entrenching disparities in health equity".

ED Report : Unlicensed Practice of Medicine

1 RCW 18.71.021.

2 Included are exemptions for licensed of dentistry, osteopathic medicine, nursing, and podiatric medicine, among others where there is a separate practice act and license requirement.

3 RCW 18.71.011.

4 RCW 18.130.190. There is a porton of this statute that also allows other bodies and individuals to maintain a civil action for injunctive relief that has rarely, if ever, been relied upon to address the issue of unlicensed practice.

5 In 2015, the United States Supreme Court entered a decision in a case involving the Federal Trade Commission and the North Carolina Board of Dental Examiners. While the ruling might actually be somewhat different if it were argued now, the majority based part of its ruling on a legal doctrine called the state action doctrine. A detailed discussion of the majority and dissent reasoning would be lengthy. This is not the right venue for the Commission to do anything other than recognize the factors present in the majority's opinion and be mindful of them.

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