Episode: *Author Interview: "What Does Our Tolerance of Poor Management of Patients' Pain Have to Do With Reimbursement Inequity for Office-Based Gynecologic Procedures?"*

Guest: Nishita Pondugula, MS and Louise P. King, MD, JD
Host: Tim Hoff
Transcript: Cheryl Green

Access the podcast.

[bright theme music]

[00:00:03] TIM HOFF: Welcome to another episode of the Author Interview series from the *American Medical Association Journal of Ethics*. I'm your host, Tim Hoff. This series provides an alternative way to access the interesting and important work being done by Journal contributors each month. Joining me on this episode is Nishita Pondugula, a fourth-year medical student at Yale School of Medicine in New Haven, Connecticut, and Dr Louise P. King, an assistant professor of obstetrics, gynecology, and reproductive biology at Harvard Medical School and a surgeon within the Division of Minimally Invasive Gynecologic Surgery at Brigham and Women's Hospital in Boston, Massachusetts. They're here to discuss their article, coauthored with Parmida Maghsoudlou and Dr Vardit Ravitsky, "*What Does Our Tolerance of Poor Management of Patients' Pain Have to Do With Reimbursement Inequity for Office-Based Gynecologic Procedures?,*" in the February 2025 issue of the Journal, *Pain Management in Non-Labor and Delivery OBGYN Procedures*. Thank you both for being here. [music fades]

DR LOUISE KING: Thank you so much.

NISHITA PONDUGULA: Thanks so much for having me. It's great to be here.

[00:01:06] HOFF: So, what is the main ethics point that you and your coauthors are making in this article?

PONDUGULA: Yeah. So, we've seen multiple reports of poorly controlled pain in gynecology, and our own experience of training and practice confirms this to be true. In our work for this article, we sought to define the root cause, and we started with the premise that poorly controlling pain in an office setting during gynecologic outpatient procedures is unethical. We start here because we know that pain is better controlled in settings that treat a majority of male patients, for example, urology, or wealthier patients, which dermatology is a good example of that. This is an example of distributive injustice. Why is it that women and persons with uteri or ovaries are not afforded the same pain control options as men or patients seeing dermatologists? This really highlights identity-based discrimination, which is likely magnified based on multiple identities held by affected groups in the gynecologic population, which is not only by gender, but also race, ethnicity, and sociodemographics, all of which impact having less access to adequate pain control.

In light of the lack of financial incentives, there's been very little research into optimal pain management strategies in gynecology outside of local anesthesia that's easily done in the office. While money shouldn't be everything, without adequate billing structures, we aren't able to build a system to provide better care and really address pain in the office-based setting in gynecology. Without that system in place, we can't advocate for better billing. It's a typical cart and horse problem.

[00:02:43] HOFF: And so, what should health professions students and trainees specifically be taking from this article?

PONDUGULA: So, I think fundamentally, it's so important to pay attention to your patients, whether it be pain, like with this issue, or any other harms they're experiencing, and do your best to advocate for them. Try to learn of the larger structural forces that limit the individual clinician and get engaged. Try to change the systems to prioritize offering the best care for all of our patients. Ensure all patients you interact with are aware of options for their care, including asking for care in operating room settings if that's the best option for pain control currently available.

Related to our topic specifically, gynecology needs to be adequately funded equitably compared to its peer surgical specialties to improve the health and care for patients of all backgrounds and genders. Doing so is justified to allow for greater resources that could be used to systemically improve pain management options during office-based gynecologic procedures. Many of us don't really like talking about financial aspects of medicine because that's not why we chose to go into the field. But practically, this is often what limits our abilities to care for patients in the ways we hope to.

[00:03:56] HOFF: And finally, if you could add something to your article that you didn't have the time or space to fully explore, what would that be?

KING: Thanks for asking me this question. There's mounting bipartisan support for an overhaul to the current reimbursement system that would impact how we fund gynecology, and so how we prioritize adequate pain control. The Centers for Medicare and Medicaid Services, or CMS, oversees the system that assigns relative value units, RVUs, to each procedure code that we use any time that we bill for procedures that we do. CMS, in turn, gets recommendations from the American Medical Association and from a specific RVU update committee, also called the RUC. The current focus of reform is that primary care is underfunded as compared to procedural disciplines like surgery and obstetrics and gynecology. That's a super accurate critique, and we very much welcome reform. But as they're looking into reform, we hope that legislators will look to increase funding not only to primary care, but also to longstanding areas that are underfunded, most notably pediatrics and obstetrics and gynecology.

We all exist in a world of for-profit medicine, and without adequate and equitable funding, we're unable to compete for resources for our patients. Solutions would include more equity in the allocation of RVUs and funding to level the playing field. In addition, movement towards value-based as opposed to fee for service-based reimbursements would be helpful. This is a highly complex area of legislation and policy making. We

hope that legislators will continue to engage with medical experts, along with others, as they look toward solutions to the inequities in our health care system. [theme music returns]

[00:05:43] HOFF: Thank you so much for being on the podcast today, and thanks to you and your coauthors for your contribution to the Journal this month.

PONDUGULA: Thank you so much, Tim.

KING: Thank you so much.

HOFF: To read the full article, as well as the rest of this month's issue for free, visit our site, journalofethics.org. We'll be back soon with more *Ethics Talk* from the *American Medical Association Journal of Ethics*.