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What Does Our Tolerance of Poor Management of Patients' Pain Have to Do With Reimbursement Inequity for Office-Based Gynecologic Procedures?

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Abstract

Office-based gynecologic procedures (OBGPs) are reimbursed at lower rates than similar office urology and dermatology procedures. But there is a broader "hidden curriculum" in health professions training that perpetuates clinicians' and organizations' acceptance of these patterns of poor reimbursement, disincentivizes research on improving OBGP pain management, and exacerbates tolerance of poor control of patients' OBGP pain. This article suggests strategies for equitable reimbursement that would also likely motivate better, more equitable OBGP pain control.

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Office-Based Gynecologic Procedures

Office-based procedures confer many advantages over those requiring an operating room (OR), including lower costs, easier scheduling, decreased administrative barriers, and lower potential risks.[1,2] However, several studies have shown that office-based gynecologic procedures (OBGPs) cause significant poorly controlled pain for some patients. For example, in a study of the top 100 TikToks related to intrauterine devices (IUDs) as of April 2022, Wu et al found that 96.8% of 31 videos on patient experiences of IUD insertion or removal highlighted pain and side effects.[3] Importantly, patients might be less likely to make TikToks about positive IUD experiences, and positive experiences likely would receive fewer views. Although positive experiences were less likely to have been captured in this study of the top 100 TikToks related to IUDs, it highlights a public perception of pain during OBGPs, which is important for clinicians to address and is supported by other clinical studies. Specifically, patient testimonials have revealed a disconnect between the significant pain experienced during procedures (typically IUD insertion or loop electrosurgical excision procedures) and the minimization of pain during prior counseling.[4,5] Reports have highlighted that though some clinicians perceive hysteroscopy as a low-pain procedure, patients frequently report severe pain.[6]

The American College of Obstetricians and Gynecologists Committee Opinion Number 672 acknowledges the difficulty of adequate pain control for IUD insertion in the office.[7] The opinion does not mention moderate sedation in the office or anesthesia in the OR as an option.[7] Clinicians providing OBGPs typically have limited or no access to surgical block time,[8] making OR scheduling difficult. Few practices have capacity for in-office moderate sedation, which requires a mid-level practitioner, additional space, and the ability to recover patients from moderate sedation, and is not accounted for by Current Procedural Terminology or Relative Value Unit (RVU) codes. For procedures routinely performed in the office, costs of in-office moderate sedation or scheduling them as OR procedures are not covered by many insurers.

This article canvasses factors contributing to poor pain control for OBGPs. We highlight the importance of reimbursement and compare office-based procedure (OBP) reimbursement rates for similar procedures in gynecology, urology, and dermatology; explore social expectations and stereotypes that contribute to acceptance of pain experienced by gynecologic patients; and consider how these practices are modeled by teachers and internalized by learners during hidden curriculum training, likely engendering trainees' moral distress and burnout and eroding their empathy. Together, these factors contribute to unethical reinforcement and acceptance of poor pain management for gynecologic patients.

Comparing OBP Reimbursements

Like gynecology practices, dermatology and urology practices perform many OBPs and serve as insightful comparators.[9] Urology pain management for OBPs includes local anesthetics as first-line pain control, oral sedation (eg, benzodiazepines) for persisting pain or anxiety, nitrous oxide,[10] and, finally, general anesthesia if the patient declines an office procedure.[11,12,13,14,15,16,17,18] For dermatology, common pain management approaches include local anesthesia—commonly field block, nerve block, wing block, and direct infiltration.[19,20,21,22,23,24] As in urology, in dermatology if local anesthesia is insufficient, procedural sedation remains an option to ensure a relatively painless dermatologic procedure.[24] Mohs microsurgery, a surgical procedure to remove visible lesions on the skin, is performed by dermatology subspecialists in their office. If the lesions are large, local anesthesia might be insufficient pain control; these cases are then referred to specialized surgical oncologists to perform complete removal of the lesion in the operating room.[23] In both urology and dermatology, procedural pain control and adequately responsive anesthesia are deemed important during OBPs. Direct comparison of pain levels experienced by patients undergoing gynecologic, dermatologic, and urologic procedures has not been done and would be difficult to achieve, given the subjective nature of pain perception and differences between visceral and cutaneous pain. Nevertheless, the lack of pain control options afforded gynecologic patients starkly contrasts with the myriad and tailored options afforded urologic and dermatologic patients.

A comparison of reimbursement rates across the 3 specialties highlights that gynecology is systematically underfunded relative to urology and dermatology. RVUs set by the Centers for Medicare and Medicaid Services (CMS) determine reimbursement rates for various medical encounters and interventions in terms of the value of a service or procedure relative to all services and procedures. RVUs are calculated by a committee within the American Medical Association and then reviewed and typically accepted by CMS. They reflect the physician's work (both time and intensity), the practice's expenses, and liability protection. RVUs for procedures for women tend to be lower than

RVUs for similar procedures for men and for dermatologic procedures.[25,26,27] This inequity likely suggests a variety of factors at play, including misogyny as it relates to both the persons treated and clinicians, as most obstetrician- gynecologists (OB/GYNs) are women. In short, we suggest that reimbursement inequity expresses devaluation of "women's work."[28]

We believe correcting billing inequity would empower clinicians and others to create methods for better pain control in office settings. As proof of concept, we explore changes in reimbursement, research, and practice related to office hysteroscopy. In 2017, the CMS RVU for office hysteroscopy increased by 237% to incentivize moving this procedure from OR to office.[29,30] Prior to 2017, studies showed that the most common reason for office hysteroscopy procedural failure was pain.[31,32,33]1/29/2025 9:58:00 AM Following this reimbursement change, a number of studies investigating pain management interventions for office hysteroscopy were published,[34,35,36,37,38,39,40] and several subsequent studies have evidenced improvement in pain control for these procedures.[37,38,39,41,42,43] In-office performance of hysteroscopy and other procedures like endometrial ablation has likely increased since 2017, given better pain control and development of new, less painful modalities for these procedures.[6,30,44] Thus, changes in reimbursement for in-office hysteroscopy have prompted changes in practice and innovative technology that have resulted in better and appropriate pain control for patients.

This case in point supports our hypothesis that appropriate and equitable reimbursement for OBGPs can translate into better pain control through novel technology. While raising reimbursement rates for OBGPs is only one factor in improving pain control, it is ethically justified and perhaps required. However, cultural and professional changes are still necessary to ensure that pain complaints by gynecologic patients are not dismissed or minimized in our capitalistic health care system.

Income-Based, Gendered, and Racialized Pain Norms

Persistence of OBGP pain partly reflects discrimination, as revealed by comparing patient populations in gynecology, urology, and dermatology. Gynecologists care for people with uteri (as well as many women and gender/sexual minorities without uteri) of diverse socioeconomic status (SES).[45] In contrast, several dermatology studies have found that outpatient dermatology care is less accessible for those with Medicaid than those with private insurance.[46,47] Indeed, high cost of care was found to be the top barrier to dermatologic care.[48] One study found that every $10 000 increase in median household income was associated with a 2.3 day reduction in wait times at dermatology clinics, suggesting greater systemic efficiency for patients of higher SES.[49] Another study found that dermatology practices are more likely to be located in wealthier zip codes.[50] Finally, income, insurance status, and education—measures of SES—were all found to contribute to disparities in melanoma survival.[51] Together, these studies suggest that dermatology disproportionately cares for patients of higher SES.[47,48,51] And a prevailing belief is that people of low SES feel less pain than people of high SES.[52]

Sexual discrimination might also help explain the persistence of OBGP pain. The urology patient population is generally assumed to be majority male—with female patients facing concerning disparities.[53,54,55] While urology patient demographics in terms of gender are difficult to come by, one study investigating the gender distribution of patients in surgical case logs by gender of urologist found that, among 558 female urologists, 54.5% of their patients were female, while among 6 058 male urologists, only 32.5% of

their patients were female.[53] And women's pain is routinely underestimated compared to men's. Studies show that people expect men to be less likely to report pain and more likely to withstand greater pain than women.[56,57] Consistent with this view, studies have shown that observers are more likely to rate males' pain as greater than that of females, raising concern for dismissal of female pain due to gendered stereotypes,[58,59] particularly of women as hysterical or emotional and as more likely to present with psychogenic pain, which many clinicians are biased against.[60,61] However, studies of sexual differences in physical perception of pain are controversial and have mixed results.[62,63] Despite being more likely to have their pain dismissed, women have a higher burden of medical conditions associated with pain.[62,63] Gendered and income-based stereotypes likely contribute to the paucity of offers made and research done to control the pain of gynecologic patients.

Lack of adequate pain control and the failure to believe a patient's expression of their own pain are exacerbated for persons of color. A 2016 study showed that approximately 50% of White medical trainees believed Black people felt less pain than White people.[64,65] Furthermore, a 2019 study found that Black and Latinx patients experienced more severe pain than White and Asian patients, yet patients from all 3 minoritized groups were prescribed less pain medication after cesarean delivery than White patients.[66] These inequitable practices have been attributed to racist ideology, including "obstetrical hardiness"—the troubling but still-prominent idea that Black women are relatively unaffected by expected pains of labor and childbirth—and the false beliefs in Black hyperfertility, the Black "primitive pelvis," the absence of endometriosis in Black patients, and lessened sensitivity of Black women's vaginal tissues.[67,68]

Lack of adequate pain control for OBGPs thus highlights intersectional systems of oppression, including classism, sexism, and racism, which contribute to poor reimbursement for OBGPs and a medical culture that perpetuates and normalizes pain in gynecologic patients.[69,70] Options to address inequitable reimbursement for OBGPs include a broader transformation of the US health care system—a consideration worthy of more robust analysis—and creating equitable reimbursement rates for OBGPs, which would enable and encourage clinicians to utilize a broader range of pain management options and tools to ensure comfort for their patients.

Finally, patients with histories of sexual trauma and interpersonal violence ought to be met with greater sensitivity, including with adequate pain management. In a 2016-2017 survey, 19.6% of US women reported sexual violence by an intimate partner, while 7.6% of men reported the same.[71] However, pain persists to a greater degree in the gynecologic setting than in the urologic setting despite a higher prevalence of sexual trauma in predominantly female gynecologic patients. Although it is important to care appropriately for all individuals with sexual trauma, the greater prevalence of sexual violence in women than men highlights the relatively greater need for trauma-informed care in gynecologic settings, which necessitates equitable reimbursement to support appropriate and adequate pain control.[72]

Hidden Curriculum in Training

The structural inequity trends described above contribute to norms for OBGPs that are taught to trainees. Education involving "lessons learned that are embedded in culture and are not explicitly intended"[73] is called the hidden curriculum.[73,74,75] Studies have shown that gender and racial bias can be prominent in health professions' so-called hidden curricula.[67,76,77,78,79] Oral "traditions" that pass along ethically troubling

stereotypes perpetuate bias that influences patients' care.[67,79] Hidden curricula not only affect patients but contribute to distress, burnout, and decreased empathy in medical trainees.[73,80,81,82] More generally, clinician burnout and moral distress have been associated with decreased empathy,[73,80,83,84,85,86,87] and compromised empathy can muddle clinicians' perceptions of what patients deserve from them, which can compromise pain management quality.

Specifically, in OB/GYN, the hidden curriculum has been identified as contributing to mistreatment of trainees. Studies have shown that medical students report rates of mistreatment in OB/GYN clerkships as high as 25%,[88] which have been attributed to stressful settings, high acuity situations common in labor and delivery, and communication breakdown.[89] Following the Association of Professors of Gynecology and Obstetrics' efforts to emphasize the hidden curriculum's positive consequences and minimize its negative ones,[90] the culture of OB/GYN training will change. One study of a workshop for OB/GYN faculty to address negative elements of the hidden curriculum, such as mistreatment and neglect, found that most faculty were more aware of negative elements and committed to changing their interactions with trainees after the workshop.[91] However, the hidden curriculum's influence on pain control during OBGPs should be further studied. Establishment of equitable reimbursement for OBGPs would afford attending physicians and trainees alike the option of centering patient comfort during procedures and thus encourage a culture that refuses to accept routine, poorly controlled pain.

Moral distress, which occurs in situations in which clinicians are prevented from taking action to do good or prevent harm due to institutional constraints, has yet to be studied in trainees performing OBGPs.[92,93] Medical trainees are particularly vulnerable to moral distress,[94] which has been observed in residents executing end-of-life care decisions with which they disagree.[85] As of 2017, the rate of burnout among OB/GYN residents was high—at 51.2%—and OB/GYN residents had high rates of other self-identified wellness problems as well.[95] An older study from 2004 that compared specialty burnout rates found that the general resident burnout rate was 50% compared with a rate of 75% in OB/GYN.[96] Medscape's yearly survey on physician burnout shows OB/GYN to be tied for second place with oncology, with a 53% burnout rate, second only to emergency medicine at 63%.[97] Such high burnout rates in OB/GYN require investigation. Residents who feel it wrong to inflict pain on patients during medical procedures can experience moral distress during painful OBGPs because they lack readily available and effective anesthetic options. This moral distress related to inflicting pain might be one contributor to high burnout rates in OB/GYN. Future work from our group will investigate how performing OBGPs without adequate anesthesia affects gynecology trainees and established clinicians.

Conclusion

This article synthesizes intersecting factors and systems of oppression that contribute to ongoing pain for a significant subpopulation of patients undergoing OBGPs. Reimbursement rates for OBPs vary, with gynecologic procedures being reimbursed at a lower rate than urologic and dermatologic procedures. Reimbursement affects what pain control can be offered in an office setting and thus how clinicians are trained. Moreover, gendered stereotypes in medicine contribute to acceptance of female pain in clinical practice. Finally, trainees learn to accept poor reimbursement of and poorly controlled pain in OBGPs through the hidden curriculum. Future directions include evaluating whether performing painful OBGPs engenders moral distress and burnout

and decreases empathy in gynecology trainees and established clinicians. Preventable pain during OBGPs should be confronted by addressing relevant structural and societal factors to ensure adequate pain control and comfort for all patients during OBGPs.

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