

# Double Discrimination, the Pay Gap in Gynecologic Surgery, and Its Association With Quality of Care

Katie L. Watson, JD, and Louise P. King, MD, JD

In this commentary, we describe historical and other influences that drive “double discrimination” in gynecologic surgery—lower pay in the area of surgery that boasts the largest proportion of female surgeons and is focused on female patients and explore how it results in potentially lower quality care. Insurers reimburse procedures for women at a lower rate than similar procedures for men, although there is no medically justifiable reason for this disparity. The wage gap created by lower reimbursement rates disproportionately affects female surgeons, who are disproportionately represented among gynecologic surgeons. This contributes to a large wage gap in surgery for women. Finally, poor reimbursement for gynecologic surgery pushes many obstetrics and gynecology surgeons to preferentially perform obstetric services, resulting in a high prevalence of low-volume gynecologic surgeons, a metric that is closely tied to higher complication rates. Creating equity in reimbursement for gynecologic surgery is one important and ethically required step forward to gender equity in medicine for patients and surgeons.

(*Obstet Gynecol* 2021;137:657–61)

DOI: 10.1097/AOG.0000000000004309

Justice Ruth Bader Ginsburg is mourned as a hero by many. In 2007, we were both moved by Justice

*From the Departments of Medical Social Science, Medical Education, and Obstetrics & Gynecology, Feinberg School of Medicine, Northwestern University, Chicago, Illinois; and Reproductive Bioethics, Center for Bioethics, Harvard Medical School, Boston, Massachusetts.*

*Each author has confirmed compliance with the journal's requirements for authorship.*

*Corresponding author: Louise P. King, MD, JD, Center for Bioethics, Harvard Medical School, Boston, MA; e-mail: lperkinsking@bwh.harvard.edu.*

## Financial Disclosure

*The authors did not report any potential conflicts of interest.*

© 2021 by the American College of Obstetricians and Gynecologists. Published by Wolters Kluwer Health, Inc. All rights reserved.

ISSN: 0029-7844/21

Ginsburg's powerful dissent in Lilly Ledbetter's pay discrimination case. Ms. Ledbetter was a supervisor in a Goodyear plant, and a jury found in her favor after she showed that the plant paid her male counterparts more than her. Goodyear appealed, arguing that Ms. Ledbetter filed too long after her pay rate was set to have her case heard, and the Supreme Court agreed.

Justice Ginsburg—the only woman on the Court at the time—wrote the dissent. She and three other Justices concluded that each discriminatory paycheck should instead reset the statute of limitations for filing a complaint, and thus the Court should consider the merits of the claim. Justice Ginsburg explained, “[p]ay disparities often occur, as they did in Ledbetter's case, in small increments; cause to suspect that discrimination at work develops only over time. Comparative pay information, moreover, is often hidden from the employee's view... Small initial discrepancies may not be seen as meet for a federal case, particularly when the employee, trying to succeed in a nontraditional environment, is averse to making waves.”<sup>1</sup> As Justice Ginsburg said from the bench when reading her dissent aloud, “In our view, the court does not comprehend, or is indifferent to, the insidious way in which women can be victims of pay discrimination.”<sup>2</sup>

As we mourn Justice Ginsburg's passing from our vantage points as a gynecologic surgeon and ethicist (L.P.K.) and as a bioethics professor specializing in women's health (K.L.W.), who both began their careers as public interest lawyers, fidelity to her legacy compels us to point out a similarly insidious way women endure pay discrimination in medicine and the harmful effect that has on their patients.

## WAGE GAP

Congress passed the Equal Pay Act in 1963, yet women in the United States are still typically paid only 82% of men's wages.<sup>3</sup> In medicine it is worse, with female physicians and surgeons being paid only 71% of what their male counterparts are paid.<sup>4</sup>



The wage gap in gynecologic surgery is particularly troubling, because it presents a unique case of what we conceive of as “double discrimination”—lower pay in an area of surgery that boasts the largest proportion of female surgeons, and that serves primarily female patients. (In this Commentary we use the terms female and woman to ensure a focus on the gendered nature of historic and current discrimination. However, it's important to recognize that all gynecologic surgeons, whether they identify as female, male, or non-binary, are affected by these findings, and that lower reimbursement in gynecologic surgery and possible lower-quality care affects all people with female sex organs including male-identifying and non-binary patients.)<sup>5</sup>

The Centers for Medicare & Medicaid Services set rates, and insurers then reimburse procedures for women at a lower rate than similar procedures for men, although there is no medically justifiable reason for this disparity. An analysis of 2015 Current Procedural Terminology codes that compared work and total relative value units (RVUs) for 50 pairs of anatomically similar, sex-specific procedures found that female procedures were undervalued. To wit, 84% (42) of the male procedures were compensated at a higher rate than the paired female procedures; on average, the male-specific surgeries were reimbursed at a 28% higher rate than the paired female-specific surgeries.<sup>6</sup> This sex disparity in billing rates is not supported by any reference to complexity; in fact, an argument can be made that anatomically similar female surgeries may be more difficult given diseases such as endometriosis and higher rates of prior surgeries related in part to cesarean deliveries. Moreover, this billing disparity is not news—a similar finding was published in 1997.<sup>7</sup>

Patient gender is the first piece of this double-discrimination, and surgeon gender is the second. The wage gap created in part by lower reimbursement rates disproportionately affects female surgeons because women are disproportionately represented among gynecologic surgeons (in one study, 48% vs range less than 1–19% in other surgical disciplines).<sup>8</sup> Compensation is a complex entity related to multiple factors, but there is no denying that the starting point for compensation for gynecologic surgeons falls far behind that of urologic surgeons.

## QUALITY GAP

Gender discrimination in reimbursement is unacceptable and unethical. However, even more alarming is the way this sex disparity in billing may result in harm to female patients. Over time, lower reimbursement

rates have played a part in developing and maintaining a workforce of low-volume gynecologic surgeons who likely do not perform as well as high-volume surgeons would. This is in part because poor reimbursement for gynecologic surgery is one factor that pushes many obstetrics and gynecology surgeons to preferentially perform obstetric services. To understand how this could be the case, it helps to understand the history of gynecologic surgery.

Gynecologic surgeons today receive less training in residency and have lower-volume practices than general surgeons. This was not always the case. Historically, gynecologic surgery was performed by surgeons trained in general surgery. That changed when gynecology merged with obstetrics in the 1930–1940s. Critics at the time of the merger, such as Dr. Joe Vincent Meigs, a noted pelvic surgeon, contended, “that all who open the belly should have the broad surgical skills required for handling all problems encountered there, regardless of organ system involved.”<sup>9</sup> They objected to the truncation of surgical training from 5 years to 18–24 months and the devotion of only 15% of any eventual practice to surgery.

Those in favor of the merger argued that the new field would address, “the whole of femininity and reproduction”<sup>9</sup> and would preserve a “special relationship” between women and their obstetricians.<sup>10</sup> Another motivation may have been an effort to capture market share and create a controlled referral process for gynecologic surgery,<sup>9</sup> which is unique—most patients are referred for surgery by primary care professionals, but gynecologic surgeons frequently identify surgical issues and essentially refer to themselves. The continuity this affords is a positive. However, there may be an oversight function served by primary care professionals that is lacking.

The language used in support of merger was at times patronizing, with one supporter in 1968 stating, “[t]he true woman's physician [was] actually, other than her husband, the most important man in her life.”<sup>10</sup> Yet, from those questionable origins comes what is beautiful and unique about the specialty—notably a deep sense of care for patients across many decades of their lives and a dedication to comprehensive care. We see this each day in interactions with patients in clinic and on the labor and delivery floor. It is evident in the advocacy of obstetrician–gynecologists for women's issues in medicine and society through the American College of Obstetricians and Gynecologists. And it is this deep sense of care in the ethical core of obstetrics and gynecology that calls for a profound change in practice in response to disparities identified in this article.<sup>11</sup>



A shortened training model and limited surgical practice persist as the norm, and the criticisms made at the time of the merger remain valid. Despite extensive changes in surgical techniques with the advent of laparoscopy, no additional years have been added to obstetrics and gynecology residency in the United States, and studies have shown that graduating obstetrics and gynecology residents may be unprepared to independently practice surgical gynecology.<sup>12,13</sup> Although change would be difficult to implement, failing to implement it is tantamount to saying that female patients deserve less well-trained surgeons than male patients.

After residency, surgical skills deteriorate because ob-gyns operate infrequently—approximately 1–2 days in the operating room per month. A systematic review and meta-analysis of 14 studies concluded that the link between volume and quality that is well-documented in many other fields of surgery also exists in gynecologic surgery: low-volume gynecologic surgeons (defined as those doing fewer than 12 of a particular procedure per year) have significantly higher rates of bowel and urinary tract injury.<sup>14,15</sup> Gynecologic surgeons account for the majority of ureteral injuries (64–82%); urologic surgeons, who have more surgical training and volume, account for approximately 11–30%.<sup>16</sup>

This relationship between volume and quality in gynecologic surgery was explored by the Kaiser Health System. Over a 7-year period, after clinicians were tracked into either obstetrics or gynecology, surgical outcomes improved for all hysterectomy patients<sup>17</sup> and racial disparities in access to minimally invasive hysterectomy care dissipated.<sup>18</sup> This solution is not possible outside of a large system willing to subsidize gynecologic-only practice, because current low reimbursement rates mean that few ob-gyns can devote themselves primarily to surgery.<sup>19</sup>

Many ob-gyns, whether in training or in practice, describe moral distress when confronted with the natural sequelae of our current system. Women present for second opinions after being told that minimally invasive surgery is not an option when it is.<sup>20</sup> Other women present after surgery and require repeat surgical interventions that may not be as successful as those that could have been offered at the outset.<sup>11,21</sup> The evidence here is anecdotal at best because few studies have evaluated these questions. Designing such a study would be difficult because many of these patients are seeking consultations at multiple hospitals or self-referring to new health care professionals.

The initial creation of three subspecialties (gynecologic oncology, maternal–fetal medicine, and reproductive endocrinology and infertility) in the 1970s was meant to address these issues.<sup>9</sup> Notably, both gynecologic oncologists and reproductive endocrinologists at that time were highly trained surgeons. Reproductive endocrinologists operated on leiomyomas, adhesions, and endometriosis, taking on complex cases. With the advent of in vitro fertilization, many reproductive endocrinologists no longer focus on complex surgery. Female pelvic medicine and reconstructive surgery has been added as an Accreditation Council for Graduate Medical Education fellowship, along with nonaccredited fellowships in minimally invasive gynecologic surgery and adolescent gynecology, to partially address the need for further training. Fellowships in surgical disciplines are exceptionally competitive, demonstrating a desire by trainees to achieve enhanced surgical skill sets. Even so, further reform is needed to ensure prompt referral and access to appropriately trained high-volume surgeons.

Some might argue that the training difference between gynecologic surgeons and other surgeons justifies lower reimbursement levels. However, this stance ignores how lower reimbursement likely lowers the quality of women's surgical care by disincentivizing practitioners from pursuing higher surgical volume practice. Moreover, studies comparing billing codes between urology and gynecologic oncology, disciplines with similar years of training, have shown that the reimbursement differential endures, indicating a sexist discriminatory effect.<sup>5,8</sup>

Finally, it is important to note the other potential negative downstream effects of lower reimbursement rates for gynecologic surgery. Funding and support in most large hospital systems are driven primarily by revenue, which in turn is driven by reimbursement. Thus, with less reimbursement comes less funding for administrative support, for nursing support, and for pilot studies, leading to less major funding for research.<sup>22</sup>

All of these factors combine to relegate both women's gynecologic health and the work of female surgeons to a status of secondary import to that of men.

## REMEDIES

Several solutions to the training problem have been proposed, including splitting gynecology from obstetrics, initiating training with general surgery, or tracking residents and surgeons to obstetrics or gynecology to increase surgical training and



volume.<sup>23</sup> Another solution is fellowship training. A recent study showed that 2 years of fellowship training in gynecologic surgery is potentially equivalent to 19 years in practice.<sup>24</sup> Yet, implementation of training and workforce changes without addressing sex differences in reimbursement does not address the unethical discrimination inherent in reimbursement patterns. Moreover, low-volume gynecologic surgery likely will remain the norm because reimbursement will continue to incentivize a focus on obstetric care. Women's surgical care will continue to be unjustifiably devalued, and double discrimination will continue. Therefore, the American College of Obstetricians and Gynecologists should partner with allies to advocate for sex parity in reimbursement rates for gynecologic surgery. If this internal solution is not pursued, or if it is not successful, gynecologic surgeons, their patients, or state attorneys general should turn to legal remedies.

Although the pay gap in gynecologic surgery violates the spirit of the Equal Pay Act, the part of it that is attributable to disparities in reimbursement rates may not violate the letter of that law, which is focused on discriminatory decision making by employers. Although insurers set the payment associated with those RVUs, they are not considered employers under this law. Instead, a legal challenge to sex-discriminatory billing codes would probably have to be framed as governmental action in setting Medicare and Medicaid rates that violates the Equal Protection clause of the Constitution, or as private insurers' violation of Section 1557, the nondiscrimination provision of the Affordable Care Act.

Women's access to equal pay is improving. After Ms. Ledbetter lost her case against Goodyear, Congress turned Justice Ginsburg's dissenting position into law by passing the Lilly Ledbetter Fair Pay Act, and women in many professions previously dominated by men are speaking up against gender-disparate pay. For example, in 2019, the U.S. Women's Soccer Team sued the U.S. Soccer Federation for paying female players less than male players, and their lawsuit inspired their fans to chant, "Pay them! Pay them!"<sup>25</sup> We believe that, if the patients of gynecologic surgeons knew about the gendered pay disparity we describe, they would do the same. It might be easy to deride surgeons' calls for increases in billing as self-serving, but the devaluation of women's surgical care results in a profound injustice to patients and moral distress to surgeons.<sup>11</sup> If surgical care for women were reimbursed at a level commensurate with similar care for men nationwide, it is likely that many disparities in the care of female patients, as well

as in the pay and advancement of female physicians, could be reduced.

## REFERENCES

1. Ledbetter v Goodyear Tire & Rubber Company. 550 US 618, 645 (2007).
2. Barnes R. Over Ginsburg's dissent, court limits bias suits. Accessed December 16, 2020. <https://www.washingtonpost.com/wp-dyn/content/article/2007/05/29/AR2007052900740.html>
3. The wage gap: the who, how, why, and what to do. Accessed December 16, 2020. <https://nwl.org/resources/the-wage-gap-the-who-how-why-and-what-to-do/>
4. Asgari MM, Carr PL, Bates CK. Closing the gender wage gap and achieving professional equity in medicine. *JAMA* 2019; 321:1665–6. doi: 10.1001/jama.2019.4168
5. Heisler CA, Mark K, Ton J, Miller P, Temkin S. Has a critical mass of women resulted in gender equity in gynecologic surgery? *Am J Obstet Gynecol* 2020;223:665–73. doi: 10.1016/j.ajog.2020.06.038
6. Benoit MF, Ma JF, Upperman BA. Comparison of 2015 Medicare relative value units for gender-specific procedures: gynecologic and gynecologic-oncologic versus urologic CPT coding. Has time healed gender-worth? *Gynecol Oncol* 2017;144:336–42. doi: 10.1016/j.ygyno.2016.12.006
7. Goff BA, Muntz HG, Cain JM. Comparison of 1997 Medicare relative value units for gender-specific procedures: is Adam still worth more than Eve? *Gynecol Oncol* 1997;66:313–19. doi: 10.1006/gyno.1997.4775
8. Dossa F, Simpson AN, Sutradhar R, Urbach DR, Tomlinson G, Detsky AS, et al. Sex-based disparities in the hourly earnings of surgeons in the fee-for-service system in Ontario, Canada. *JAMA Surg* 2019;154:1134–42. doi: 10.1001/jamasurg.2019.3769
9. Zetka JR. Establishing specialty jurisdictions in medicine: the case of American obstetrics and gynaecology. *Social Health Illn* 2011;33:837–52. doi: 10.1111/j.1467-9566.2011.01341.x
10. Zetka JR. The making of the women's physician in American obstetrics and gynecology: re-forging an occupational identity and a division of labor. *J Health Soc Behav* 2008;49:335–51. doi: 10.1177/002214650804900307
11. King LP. A Reluctant critic: why gynecologic surgery needs reform. *Hastings Cent Rep* 2019;49:10–3. doi: 10.1002/hast.1001
12. Einarsson JI, Sangi-Hagheykar H. Perceived proficiency in minimally invasive surgery among senior ob/gyn residents. *J Soc Laparoendosc Surg* 2009;13:473–8.
13. Klebanoff JS, Marfori CQ, Vargas MV, Amdur RL, Wu CZ, et al. Ob/gyn resident self-perceived preparedness for minimally invasive surgery. *BMC Med Educ* 2020;20:185. doi: 10.1186/s12909-020-02090-9
14. Mowat A, Maher C, Ballard E. Surgical outcomes for low-volume vs high-volume surgeons in gynecology surgery: a systematic review and meta-analysis. *Am J Obstet Gynecol* 2016; 215:21–33. doi: 10.1016/j.ajog.2016.02.048
15. Glaser LM, Brennan L, King LP, Milad MP. Surgeon volume in benign gynecologic surgery: review of outcomes, impact on training, and ethical contexts. *J Minim Invasive Gynecol* 2019;26:279–87. doi: 10.1016/j.jmig.2018.09.775
16. Gild P, Kluth LA, Vetterlein MW, Engel O, Chun FKH, Fisch M. Adult iatrogenic ureteral injury and stricture—incidence and treatment strategies. *Asian J Urol* 2018;5:101–6. doi: 10.1016/j.ajur.2018.02.003



17. Abel MK, Kho KA, Walter A, Zaritsky E. Measuring quality in minimally invasive gynecologic surgery: what, how, and why? *J Minimally Invasive Gynecol* 2019;26:321–6. doi: 10.1016/j.jmig.2018.11.013
18. Zaritsky E, Ojo A, Tucker LY, Raine-Bennett TR. Racial disparities in route of hysterectomy for benign indications within an integrated health care system. *JAMA Netw Open* 2019;2:e1917004. doi: 10.1001/jamanetworkopen.2019.17004
19. Rayburn WF. The obstetrician-gynecologist workforce in the United States: facts, figures, and implications 2011. Accessed December 16, 2020. <https://www.ncbi.nlm.nih.gov/nlmcatalog/?term=The+obstetrician-gynecologist+workforce+in+the+United+States+%3A+facts%2C+figures%2C+and+implications+2011>
20. Angel K. The hardest part of my laparoscopic hysterectomy: finding a surgeon with the skills to do it. Accessed December 16, 2020. <https://thriveglobal.com/stories/the-hardest-part-of-my-laparoscopic-hysterectomy-finding-a-surgeon-with-the-skills-to-do-it/>
21. King LP. Lena Dunham’s lesson for doctors. Accessed December 16, 2020. <https://www.thehastingscenter.org/lena-dunhams-lesson-doctors/>
22. Oliveira DFM, Ma Y, Woodruff TK, Uzzi B. Comparison of national institutes of health grant amounts to first-time male and female principal investigators. *JAMA* 2019;321:898–900. doi: 10.1001/jama.2018.21944
23. Siedhoff MT, Truong MD, Wright KN. Gynecologic surgery tracking in obstetrics and gynecology residency. *Curr Opin Obstet Gynecol* 2020;32:298–303. doi: 10.1097/gco.0000000000000640
24. Arora C, Menzies A, Han ES, Lee M, Lauer JK, Hur HC, et al. Comparing surgical experience and skill using a high-fidelity, total laparoscopic hysterectomy model. *Obstet Gynecol* 2020;136:97–108. doi: 10.1097/aog.0000000000003897
25. Lieber R. As US women’s soccer team clinches World Cup, fans demand “pay them.” Accessed February 13, 2021. <https://www.motherjones.com/media/2019/07/us-womens-soccer-team-world-cup-equal-pay/>

## PEER REVIEW HISTORY

Received October 9, 2020. Received in revised form December 14, 2020. Accepted December 17, 2020. Peer reviews and author correspondence are available at <http://links.lww.com/AOG/C216>.

