Boston University School of Law

Why Do Gynecology Patients Suffer So Many Avoidable Injuries?

Four million Americans undergo gynecological surgeries each year, including many mothers after pregnancy. Thousands of bad outcomes lead to lifelong suffering and disabilities. Greater safety is possible.

The root cause lies in our framework for healthcare finance.

Framework

- Centers for Medicare and Medicaid Services (CMS) pays for surgeries.
- CMS relies on an AMA Commission to set Relative Valve Units (RVUs) for each procedure.
- Private insurers follow the RVUs.

Bias

- The AMA surveys physicians to self report time spent per procedure.
- Male surgeons provide biased (self-serving) times estimates.
- Gynecology (GYN) has fewer male surgeons than competing specialties.

Economics

- Insurers reimburse GYN procedures at lower rates.
- GYN surgeons receive lower incomes.
- Few physicians pursue fellowships specializing in GYN surgery.

Outcomes

- GYN surgeries are often performed by non-specialists.
- They do not do enough surgeries (volume) to get and stay proficient.
- GYN patients suffer adverse events more often.

The same surgery for men pays 34% more than when performed for women.

To set rates, the federal government relies on a secretive industry committee to set those rates, and the committee relies on junk science surveys, allowing self-interested and biased responses, contrary to objective measures.

Out of this junk process comes a skewed result. **You get what you pay for.**

Healthcare Providers

With distorted incentives, the industry has organized accordingly.

- Surgical training for Obstetrician Gynecologists (OB-GYNs) is truncated as compared to other surgical disciplines.
- OB-GYNs pursue a mix of better-paid work, rather than pursue advanced training and specialized experience.
- Most OB-GYNs perform particular surgeries only a few times per year, a context shown to magnify the risk of preventable injuries.

"The Federal government, and the private payors who follow its lead, spend more or less money for healthcare, depending directly on the sex of the patient."

Stock photo - posed by model.

STRUCTURAL DISCRIMINATION IN PRACTICE

Shelly Parfit, 42, began experiencing very heavy menstrual periods, pelvic pain, and a persistent back ache. She visited her OB-GYN Dr. Andrea Kozek, who recommended a hysterectomy, a surgical removal of the uterus. Dr. Kozek dedicates one day a month to performing such surgeries though she has not received advanced, specialized training as an OB-GYN with a general practice. Dr. Kozek has perhaps read about the remarkable safety achieved by high-volume, fellowship-trained surgeons, but if she were to focus her practice in this way, Dr. Kozek would have to sacrifice nearly a fifth of her salary. So she did the surgery herself.

Eight days after the surgery, Shelly presented to the emergency room with severe pain. A CT scan revealed that Shelly's ureter was damaged, presumably during the hysterectomy. Shelly was referred to a urologist and underwent several additional surgeries. She now has chronic pain, painful intercourse, and urinary incontinence. Her life will never be the same.

When Shelly asked about getting help for the additional medical bills, she was reminded that as part of the informed consent documentation, Dr. Kozek had disclosed ureteral damage as one of the many possible risks of surgery. Shelly spoke with a lawyer, but was told that litigation would be unsuccessful. If Shelly sued Dr. Kozek for medical malpractice, the doctor would truthfully say that she was just following the customary practice of other OB-GYN doctors. The law would thus normalize Shelly's injuries as the standard of care.

Cases like Shelly's are accidents in one sense, but in another sense, they are inevitabilities in a system of structural discrimination. It is an economic system that makes safety irrational.

We have made safety irrational.

Quality surgery requires a high-volume practice, but payment discrimination makes it too costly for many surgeons to make that sacrifice.

POTENTIAL REFORMS

The Secretary of the Department of Health and Human Services should reject the recommendations of the AMA committee and set fair reimbursement rates. Specifically:

- U.S. Centers for Medicare and Medicaid Services ("CMS") can eliminate many sex-specific reimbursement codes.
- Objective measures, rather than unreliable surveys, should be used to estimate physician work and ensure fair payments.
- The American Medical Association Relative Value Update Committee ("AMA RUC") must explicitly review and adjust relative value units ("RVUs") with an eye for sex equality.
- The AMA RUC should be subject to oversight and accountability.

When gynecological surgeries are reimbursed fairly, more physicians will specialize in this domain, volumes will increase, and patient safety will improve.

The Research Base

Robertson CT, Kupke A, King LP. Structural sex discrimination: Why gynecology patients suffer avoidable injuries and what the law can do about it. Emory LJ. 2024;74:43.

Penn M, Colley D, Koirala P, King L, Fitzgerald J. Price and Prejudice: Reimbursement of Surgical Care on Male Versus Female Anatomies. Journal of Women's Health. 2025 Feb 21.

King LP. The Pay Gap in Gynecologic Surgery and Its Effects on Training Quality. Journal of Gynecologic Surgery. 2022 Dec 1;38(6):397-9.

Watson KL, King LP. Double discrimination, the pay gap in gynecologic surgery, and its association with quality of care. Obstetrics & Gynecology. 2021 Apr 1;137(4):657-61.

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