"It's Just a Pinch": Conceptualizing Inadequate Pain Management for Women's Healthcare as Sex Discrimination

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Abstract

There is a pain gap: Doctors prescribe pain management for procedures that cisgender men undergo, but often not for those intended for female anatomy. Studies consistently show that intrauterine device ("IUD") insertions cause intense pain, but doctors continue to refuse to prescribe pain management. The same is true for a litany of procedures: hysteroscopies, mammograms, egg retrievals. Women's healthcare repeatedly fails to address pain. This comes as no surprise, given that gynecology developed from forced experimentation on Black women. The pain gap reinforces a culture of misogynistic subordination, worsens women's health outcomes, and threatens broader public health. In short, the pain gap is a sex discrimination problem that causes real harm.

Section 1557 of the Affordable Care Act prohibits discrimination in medicine "because of sex" and should be used to combat this sex discrimination problem. Discrimination law is the most appropriate tool to combat this harm: Alternatives, like tort law, fail to appreciate the group-based harms at play and systematically discount women and people of color. Instead, litigants can argue the pain gap is sex discrimination under formal, anti-stereotyping, or substantive equality theories. Of these theories, substantive equality is the strongest theoretical underpinning to argue sex discrimination because it is more likely to accurately and consistently identify the pain gap as discrimination, does not erase women's unique experiences, and can better respond to religious challenges. The preference of American courts for formal or anti-stereotyping theories should not dissuade a substantive approach. Although Section 1557 is an underdeveloped area of law, it allows litigants to argue for a substantive equality analysis in cases involving the pain gap.

Lauren Capps thought she went in for a routine Pap smear, but as soon as the speculum went in, she experienced severe pain and started screaming.[1] Instead of changing course—altering the insertion or utilizing pain medication—the doctor told Capps "she had a 'beautiful cervix'" and asked

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[1] Rae Nudson, *Gynecology Has a Pain Problem Our Discomfort is Routine. What If It Didn't Have to Be?*, N.Y. Mag.: The Cut (June 1, 2022), https://www.thecut.com/2022/06/pain-in-gynecology-practice-exams.html [https://perma.cc/J2AL-DRY3].

to continue the procedure.[2] Feeling pressured, Capps said yes: She left the appointment "sore," "bleeding," and "feeling violated."[3]

Stories like Capps's are unfortunately common. Medical professionals regularly perform intrauterine device ("IUD") insertions, egg retrievals, mammograms, Pap smears, hysteroscopies, and other procedures for female anatomy with little to no pain management,[4] despite data[5] and anecdotes[6] demonstrating that these procedures can be exceptionally painful. One woman said that getting her IUD inserted "felt like a knitting needle was piercing my womb."[7] For procedures unique to women's health, the medical system fails to offer pain management options and often refuses women when they request it.[8] Women's pain is dismissed and distrusted.[9] As one woman explained, "To live through a medical procedure in the 21st century in which the expectation was that I could tolerate acute pain seemed surreal."[10]

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[2] *Id.*

[3] *Id.*

[4] *See, e.g.*, *id.* (overviewing pain management practices in gynecology); Laken Brooks, *Painful Gynecologist Visits Can Be Traumatic Instead of Healing*, Forbes (Nov. 6, 2021, at 11:50 PM), https://www.forbes.com/sites/lakenbrooks/2021/11/06/painful-gynecologist-visits-can-be-traumatic-instead-of-healing/ [https://perma.cc/V4KS-9XZD] (summarizing anecdotes about gynecology visits and noting patients claimed pain medication was often not offered).

[5] *See, e.g.*, Adrian Nowak, Karolina Chmaj-Wierzchowska, Agnieszka Lach, Adam Malinger & Maciej Wilczak, *Evaluation of Pain During Hysteroscopy Under Local Anesthesia, Including the Stages of the Procedure*, J. Clinical Med., Nov. 21, 2024, at 1, 2 (noting that hysteroscopy can be so painful that the operation needs to be abandoned before completion, which happens in 1.3–5.2% of cases); Chito P. Ilika, George U. Eleje, Michael E. Chiemeka, Frances N. Ilika, Joseph I. Ikechebelu, Valentine C. Ilika, Emmanuel O. Ugwu, Ifeanyichukwu J. Ofor, Onyecherelam M. Ogelle, Osita S. Umeononihu, Johnbosco E. Mamah, Chinedu L. Olisa, Chijioke O. Ezeigwe, Malarchy E. Nwankwo, Chukwuemeka J. Ofojebe, Chidinma C. Okafor, Onyeka C. Ekwebene, Obinna K. Nnabuchi & Chigozie G. Okafor, *Effects of Speculum Lubrication on Cervical Smears for Cervical Cancer Screening: A Double Blind Randomized Clinical Trial*, PLOS One, May 24, 2024, at 1, 8 (finding that approximately 79% of patients receiving a standard, no lubrication Pap smear reported a pain score of 5 or higher out of 10); Hannat Akintomide, Nataliya Brima, Robert D. E. Sewell & Judith M. Stephenson, *Patients' Experiences and Providers' Observations on Pain During Intrauterine Device Insertion*, 20 Eur. J. Contraception & Reprod. Health Care 320, 321 (2015) (finding 17% of IUD insertion patients reported severe pain).

[6] *See, e.g.*, Nudson, *supra* note 1.

[7] Teresa Carr, *At the OB-GYN, Pain Control Is Possible—But Often Overlooked*, Undark (Dec. 12, 2023), https://undark.org/2023/12/13/gynecology-iud-pain/ [https://perma.cc/7R2D-JP48] ("It's not always a 'it hurts here' kind of a pain . . . . Sometimes it's a 'I just feel really sick and I feel like something is wrong' kind of a pain, sort of like labor feels." (quoting OB-GYN Maureen Baldwin)).

[8] *See id.*; *see also* Brooks, *supra* note 4 (listing ways doctors fail to provide pain management).

[9] *See, e.g.*, Carr, *supra* note 7; Nudson, *supra* note 1; *see also* Lindsey Bever, *From Heart Disease to IUDs: How Doctors Dismiss Women's Pain*, Wash. Post (Dec. 13, 2022, at 6:00 AM), https://www.washingtonpost.com/wellness/interactive/2022/women-pain-gender-bias-doctors/ [https://perma.cc/26R2-ZZRE].

[10] Nudson, *supra* note 1.

Women's medical pain is a sex equality problem requiring a sex equality solution. The antidiscrimination provision of the Patient Protection and Affordable Care Act ("ACA")[11] provides a statutory opening to argue that inadequate pain management in women's healthcare is impermissible sex discrimination. Substantive equality is the strongest legal theory to make this argument, though there are potential arguments to be made under formal equality and anti-stereotyping models as well.[12] Part I begins by introducing pain management disparities for women's healthcare and its origins in race and sex discrimination. Part II goes on to explain the harms of the pain management gap, including subordination, negative health outcomes, and erosion of trust. Next, Part III argues for using discrimination law to combat the pain gap. Finally, Part IV identifies how the pain gap can be theorized as discrimination under formalist, anti-stereotyping, or substantive frameworks. Ultimately, the Note finds that substantive equality is the most promising theoretical framework for addressing medical discrimination.

I. Definitions and Background

Although sex discrimination is a problem in medicine generally,[13] the analysis in this Note is specifically concerned with inadequate pain management in procedures intended for bodies assigned female at birth. This is the pain gap: Medical professionals prescribe pain management for procedures received by cisgender men, but often not for analogous procedures exclusive to female anatomy.[14] Medical professionals will often perform these female anatomy procedures on cisgender women, but also on intersex and nonbinary people, as well as transgender men[15] and women.[16] For example, medical professionals may recommend mammograms for transgender women who take hormones.[17]

The medical system consistently underprovides pain management for women's procedures. Less than 5% of doctors offer local anesthesia for IUD insertion despite evidence that it is effective in combating pain from the

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[11] 42 U.S.C. § 18116(a).

[12] *See infra* Part IV for discussion.

[13] *See* Bever, *supra* note 9.

[14] *See* Nudson, *supra* note 1.

[15] *See What Gynecologists Need to Know About Caring for Transgender Patients*, Cleveland Clinic, https://web.archive.org/web/20230331035730/https://consultqd.clevelandclinic.org/what-gynecologists-need-to-know-about-caring-for-transgender-patients/ [https://perma.cc/A7CA-5XWW].

[16] *See* Madeline B. Deutsch, *Screening for Breast Cancer in Transgender Women*, UCSF Transgender Care (June 17, 2016), https://transcare.ucsf.edu/guidelines/breast-cancer-women#:~:text=Screening%20mammography%20is%20the%20primary,not%20recommended%20in%20transgender%20women [https://perma.cc/S9V5-GQRQ].

[17] *See id.*

procedure.[18] Similarly, although it is well-documented that colposcopies—a diagnostic procedure that uses a magnifying device to screen the cervix for cancer—can cause pain, providing any pain management for the procedure "remains uncommon."[19] Although pain management is often not provided for procedures necessary for women's health, it *is* provided for similar procedures that impact male bodies.[20] In identifying the pain gap, this Note argues that the law requires changes in medical care to rectify pain gap discrimination, but the Note does not purport to suggest how exactly medical care must change. A variety of healthcare solutions to the disparity in pain management exist: Addressing the pain gap may require prescribing pain medications, using local anesthetics, redesigning procedures and tools, accurately disclosing pain risks to women, or improving physician training.[21] Medical professionals should, in compliance with discrimination law, identify appropriate means of rectifying the pain gap.

Understanding the pain gap requires understanding its history. The pain gap arises out of racialized male domination and female subordination, which has a history specific to gynecology. Gynecology was not born out of concern for women, but out of wealthy, white men's desire to control reproduction and amass power.[22] James Sims, "the 'father of modern gynecology,'" developed the field through the forced experimentation and torture of enslaved Black women.[23] The transatlantic slave trade assigned value to Black women based on "their fecundity," or fertility, with appraisals for enslaved women "linked to their ability to reproduce."[24] "Enslaved mothers [were] called 'breeders'" because, when they had children, those children were born into enslavement under American law.[25] As such, enslavers

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[18] Teddy Rosenbluth, *Health Officials Urge Doctors to Address IUD Insertion Pain*, N.Y. Times (Aug. 7, 2024), https://www.nytimes.com/2024/08/07/health/iud-insertion-pain.html [https://perma.cc/AQ6Z-AFDP].

[19] Miis Akel, Dhruv Ratra, Maggie Wright, Crystal Barroca, Amy A. Abdou, Paul Kaldas, Shreya Bhatt, Aleymi Perez, Sahil Shah & Sergio Hernandez Borges, *Anesthesia Usage and Pain Management in Colposcopy: A Scoping Review of Efficacy and Approaches*, Cureus, Sept. 28, 2024, at 1, 2.

[20] *See* Med. Student Section AMA, Resol. 502 (A-23), Pain Management for Long-Acting Reversible Contraception and Other Gynecological Procedures 1 (2023) (comparing vasectomies to IUDs and noting pain management is common for vasectomies—the procedure men get); Saurabh Sethi & Rebecca Joy Stanborough, *Does a Colonoscopy Hurt?*, Healthline (Jan. 30, 2020), https://www.healthline.com/health/is-a-colonoscopy-painful [https://perma.cc/SG89-7GVP] (explaining that patients are "completely sedated for the entire procedure" when they get colonoscopies, a diagnostic test that inserts a camera into the colon).

[21] Nudson, *supra* note 1 (providing examples of these solutions).

[22] *See* Brynn Holland, *The 'Father of Modern Gynecology' Performed Shocking Experiments on Enslaved Women*, History (Jan. 31, 2025), https://www.history.com/articles/the-father-of-modern-gynecology-performed-shocking-experiments-on-slaves [https://perma.cc/3HDT-KH4J]; *see also* Anushay Hossain, The Pain Gap 150 (2021).

[23] Holland, *supra* note 22; *see also* Hossain, *supra* note 22, at 149-51.

[24] Daina Ramey Berry, The Price for Their Pound of Flesh: The Value of the Enslaved, from Womb to Grave, in the Building of a Nation 24 (2017).

[25] *Id.* at 24-25.

considered enslaved women of reproductive age valuable because the birth of enslaved children increased their "property."[26] Sims profited from this mentality by selling his gynecological services to white plantation owners.[27] He claimed that, with gynecology, he could "patch[] up enslaved workers so they could produce—and reproduce—for their masters again. Otherwise, they were useless to their owners."[28]

Gynecology is built on this corrupt foundation.[29] And providers today continue to systematically discount women's pain.[30] In a 2013 study, the mean maximum pain score reported by patients for IUD insertion was 64.8 on a 100-point scale, while the mean maximum pain score estimated by providers was only 35.3.[31] Another study found that when researchers showed doctors videos of men and women in pain, the doctors underestimated women's pain and were less likely to prescribe them pain medication as compared to men.[32] And despite these issues, little scientific study and funding is directed towards improving women's healthcare.[33] The National Institute of Health, for example, did not require most studies it funded to consider sex as a biological variable until 2016.[34] Structurally and historically, women's healthcare is not built to address women's pain because it started from the assumption of women's inferiority.

When women try to complain about this inequality, they are dismissed.[35] When women tell healthcare professionals they are in pain, they

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[26] *Id.* (explaining how enslaved Black women were treated like livestock).

[27] Holland, *supra* note 22.

[28] *Id*.

[29] *Id.*

[30] Carr, *supra* note 7.

[31] Karla Maguirea, Kathleen Morrell, Carolyn Westhoff & Anne Davis, *Accuracy of Providers' Assessment of Pain During Intrauterine Device Insertion*, 89 Contraception 22, 23 (2013).

[32] Lanlan Zhang, Elizabeth A, Reynolds Losin, Yoni K. Ashar, Leonie Koban & Tor D. Wager, *Gender Biases in Estimation of Others' Pain*, 22 J. Pain 1048, 1054-55 (2021).

[33] *See* Hossain, *supra* note 22, at 53-61; *see also* Charley Burlock, *Getting an IUD Doesn't Have to be Painful. Here's What Your Doctor May Not Be Telling You.*, Oprah Daily (Sept. 10, 2024, at 12:04 PM), https://www.oprahdaily.com/life/health/a61939474/iud-insertion-pain-relief/ [https://perma.cc/9VUZ-XH6W].

[34] *See* Bever, *supra* note 9.

[35] *See id.* ("[A] number of studies support the claim that women in pain often are not taken as seriously as men.").

> [W]omen who visited emergency departments with chest pain waited 29 percent longer than men to be evaluated for possible heart attacks. An analysis of 981 emergency room visits showed that women with acute abdominal pain were up to 25 percent less likely than their male counterparts to be treated with powerful opioid painkillers. Another study showed that middle-aged women with chest pain and other symptoms of heart disease were twice as likely to be diagnosed with a mental illness compared with men who had the same symptoms.

Id. (first citing Darcy Branco, Jerway Chang, Nina Talmor, Priya Wadhera, Amrita Mukhopadhyay, Xinlin Lu, Siyuan Dong, Yukun Lu, Rebecca A. Betensky, Saul Blecker, Basmah Safdar & Harmony R. Reynolds, *Sex and Race Differences in the Evaluation and Treatment of Young*

are told they are making it up, being dramatic, or they are simply ignored.[36] The medical system calls them "hysterical."[37] Studies have found that women, as compared to men, are less likely to have their pain adequately managed; women are less likely than men to be prescribed pain medication after abdominal surgery, as well as less likely to have their pain managed adequately for metastatic cancer and AIDs.[38] A survey of nurses found that they felt that "women, as compared to men, were less sensitive to pain, more tolerant of pain, less distressed as a result of pain, and more likely to report pain and express pain through nonverbal gestures."[39] Anushay Hossain, a cisgender woman, told her doctor during a 33-hour-long labor that she was in severe pain. But the doctor dismissed her concerns, saying she couldn't be in pain—she was already receiving the maximum epidural.[40] It turned out Hossain was right: She was not receiving pain medication, as her epidural had slipped out.[41] By the time doctors caught the mistake, Hossain was in so much pain that she was shaking and needed emergency surgery.[42] Women's reports of pain are often disregarded.[43]

Black women face particularly severe mistreatment:[44] A 2024 study found that Black women seeking obstetric care reported doctors dismissing their concerns, conducting nonconsensual experimentation, coercing them, humiliating them, ignoring their symptoms, and even intentionally causing

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Adults Presenting to the Emergency Department with Chest Pain, J. Am. Heart Ass'n, May 4, 2022, at 1, 5; then citing Esther H. Chen, Frances S. Shofer, Anthony J. Dean, Judd E. Hollander, William G. Baxt, Jennifer L. Robey, Keara L. Sease & Angela M. Mills, *Gender Disparity in Analgesic Treatment of Emergency Department Patients with Acute Abdominal Pain*, 15 Acad. Emergency Med. 414, 416 (2008); and then citing Nancy N. Maserejian, Carol L. Link, Karen L. Lutfey, Lisa D. Marceau & John B. McKinlay, *Disparities in Physicians' Interpretations of Heart Disease Symptoms by Patient Gender: Results of a Video Vignette Factorial Experiment*, 18 J. Women's Health 1661, 1665 (2009)).

[36] Bever, *supra* note 9.

[37] *Id.* ("Research shows men in chronic pain tend to be regarded as 'stoic' while women are more likely to be considered 'emotional' and 'hysterical' and accused of 'fabricating the pain.'" (citing Anke Samulowitz, Ida Gremyr, Erik Eriksson & Gunnel Hensing, *"Brave Men" and "Emotional Women": A Theory-Guided Literature Review on Gender Bias in Health Care and Gendered Norms Towards Patients with Chronic Pain*, 2018 Pain Rsch. & Mgmt., Feb. 25, 2018, at 1, 5)). The word "hysteria" originates from the Greek word for uterus. Cecilia Tasca, Mariangela Rapetti, Mauro Giovanni Carta & Bianca Fadda, *Women and Hysteria in the History of Mental Health*, 8 Clinical Prac. & Epidemiology Mental Health 110, 111 (2012); *see also* Rick Harrison, *It's Time to Take Women's Health Seriously*, 19 Women's Health Rsch. Yale: Innovations Women's Health 10, 10 (Fall 2021), https://medicine.yale.edu/news-article/its-time-to-take-womens-health-seriously/ [https://perma.cc/TGA4-Z5KB].

[38] *See* Diane E. Hoffmann & Anita J. Tarzian, *The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain*, 29 J.L., Med. & Ethics 13, 17 (2001).

[39] *Id.* at 18.

[40] *See* Bever, *supra* note 9.

[41] *See id.*

[42] *Id.*

[43] *See id.*

[44] Nudson, *supra* note 1 (sharing history and anecdotes of Black women's mistreatment when seeking gynecological care).

pain.[45] Across a range of medical procedures and treatments, Black women are documented to be less likely than white women to receive adequate pain management.[46] As such, it is no surprise that "[t]he management of pain is one of the largest disparities we see between Black people and White people in the American health-care system."[47] Recent surveys show that many medical students still (incorrectly) believe that Black people are more tolerant of pain than white people.[48] Many of these prejudices have roots in the antebellum period, when scientists tried to establish inherent biological differences between Black and white people to "bolster[] society's view that enslaved people were fit for little outside forced labor and provid[e] support for racist ideology and discriminatory public policies."[49] The myth "that [B]lack people were impervious to pain" was "seized upon by pro-slavery advocates."[50] This idea was quickly extended to gynecology; Sims did not use anesthesia when experimenting on Black women because of "his misguided belief that Black people didn't experience pain like white people did."[51] Today, when

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[45] Dorian S. Odems, Erica Czaja, Saraswathi Vedam, Na'Tasha Evans, Barbara Saltzman & Karen A. Scott, *"It Seemed Like She Just Wanted Me to Suffer": Acts of Obstetric Racism and Birthing Rights Violations Against Black Women*, SSM – Qualitative Rsch. Health, Sept. 19, 2024, at 1, 3.

[46] *See, e.g.*, Nevert Badreldin, William A. Grobman & Lynn M. Yee, *Racial Disparities in Postpartum Pain Management*, 220 Am. J. Obstetrics & Gynecology S206 (2019) ("Hispanic and [non-Hispanic, Black] women experience disparities in pain management in the postpartum setting that cannot be explained by less perceived pain."); Danielle Perro, Annalise Weckesser & Veronique Griffith, *Endometriosis: Black Women Continue to Receive Poorer Care for the Condition*, The Conversation (Mar. 30, 2023, at 10:58 AM), https://theconversation.com/endometriosis-black-women-continue-to-receive-poorer-care-for-the-condition-200663 [https://perma.cc/N6J5-J9A7] (noting Black women are "50% less likely to be diagnosed with endometriosis compared to white women" and "health professionals, in the US at least, are less likely to provide [B]lack women with pain medication during and after childbirth" (first citing O. Bougie, Ma I. Yap, L. Sikora, T. Flaxman & S. Singh, *Influence of Race/Ethnicity on Prevalence and Presentation of Endometriosis: A Systemic Review and Meta-Analysis*, BJOG, Apr. 26. 2019, at 1104, 1111; then citing Laurent G. Glance, Richard Wissler, Christopher Glantz, Turner M. Olser, Dana B. Mukamel & Andrew W. Dick, *Racial Differences in the Use of Epidural Analgesia for Labor*, Anesthesiology, Jan. 2007, at 19, 23; and then citing Badreldin et al., *supra* note 46, at S206)); Mayisah Rahman, Connor King, Rosie Saikaly, Maria Sosa, Kristel Sibaja, Brandon Tran, Simon Tran, Pamella Morello, Se Yeon Seo, Yi Yeon Seo & Robin J. Jacobs, *Differing Approaches to Pain Management for Intrauterine Device Insertion and Maintenance: A Scoping Review*, Cureus, Mar. 8, 2024, at 1, 9 (finding Black women more likely than white women to experience pain during IUD insertion and noting this disparity could be due in part to lack of "effective pain control for various demographic populations").

[47] Bever, *supra* note 9 (quoting Professor Tina Sacks).

[48] Kelly M. Hoffman, Sophie Trawalter, Jordan R. Axt & M. Norman Oliver, *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites*, 113 Proc. Nat'l Acad. Sci. Psych. & Cognitive Sci. 4296, 4299-300 (2016).

[49] Linda Villarosa, *Myths About Physical Racial Differences Were Used to Justify Slavery—And Are Still Believed by Doctors Today*, N.Y. Times Mag. (Aug. 14, 2019), https://www.nytimes.com/interactive/2019/08/14/magazine/racial-differences-doctors.html [https://perma.cc/JYZ5-3VQC].

[50] *Id.*

[51] Holland, *supra* note 22.

Black women try to correct this injustice and advocate for pain management, they are often stereotyped as aggressive or drug-seeking.[52] This prejudice produces both untreated pain and fear of doctors among Black women who face the increased criminalization of their reproduction.[53]

II. The Harms

Inadequate pain management in women's healthcare causes harm. The pain itself is unacceptable. There is no excuse for forcing women to bear pain that is "completely unnecessary and preventable."[54] "How is this not violence against women?"[55] The torture of women—in the home, in sex, in work, in media,[56] and in the doctor's office—is too often a consequence of a world that eroticizes women's suffering in service of male dominance.[57] The harm of the pain gap goes beyond the pain itself, though. Subjecting women to unnecessary medical pain (A) subordinates women, (B) damages their health outcomes, and (C) threatens public health.

A. Subordination

"[S]ubordination is about power, its definition and distribution."[58] It "is a question of hierarchy: who is on top and who is on the bottom [of the] . . . existing social hierarchy."[59] Inadequate pain management subordinates women—upholding a social hierarchy where men dominate women—by endorsing biological essentialism, stereotyping women as liars, silencing them, and placing low value on their suffering as well as devaluing their credibility in reporting it.

Failing to address pain subordinates women by naturalizing their suffering.[60] It falsely paints biology, rather than gender hierarchy, as the source

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[52] *See* Amanda Holpuch, *Black Patients Half as Likely to Receive Pain Medication as White Patients, Study Finds*, The Guardian (Aug. 10, 2016, at 7:18 PM), https://www.theguardian.com/science/2016/aug/10/black-patients-bias-prescriptions-pain-management-medicine-opioids [https://perma.cc/P2SC-JFVP].

[53] See generally Michelle Goodwin, Policing the Womb (2020) for a discussion on the criminalization of pregnancy, particularly the racialized targeting of Black women through the War on Drugs.

[54] Burlock, *supra* note 33.

[55] *Id.*

[56] *See generally* Catharine A. MacKinnon, Sex Equality (3rd ed. 2016) [hereinafter Sex Equality] (explaining that women are battered in the home, raped, sexually harassed in the workplace, and abused in pornography).

[57] *See* Catharine A. MacKinnon, Toward a Feminist Theory of the State 130 (1989) [hereinafter Feminist Theory].

[58] Catharine A. MacKinnon, *Substantive Equality, in* Butterfly Politics 110, 118 (2017) [hereinafter *Substantive Equality*].

[59] *Id.* at 118-19.

[60] *Cf.* Sex Equality, *supra* note 56, at 910-11 (making this argument about the Court assuming women's "rapability" while discussing Dothard v. Rawlinson, 433 U.S. 321 (1977)).

of women's harm.[61] A biological essentialist argument would claim that women's healthcare is more painful because women's bodies are different—more sensitive, perhaps[62]—but a Pap smear is not painful because of biology.[63] It is painful because a male-dominated society has repeatedly refused to prioritize women's health and wellbeing sufficiently to address the pain the procedure inflicts.[64] Gendered medical pain results from biological essentialism that subordinates women by telling them to blame biology instead of misogyny for their suffering.[65]

Inadequate pain management also demonizes women as untrustworthy liars.[66] There is a "pervasive aura of distrust around women's accounts of their pain" that "has been enfolded into medical attitudes over centuries."[67] Systems of power label women as untrustworthy because they are supposedly emotional, hormonal, or master manipulators, leading doctors to dismiss women's complaints of pain.[68] It is beneficial for male dominance to undermine women's credibility; it is harder to challenge power if your complaints of inequality can be dismissed as just another lie.[69]

Silencing women via the pain gap is yet another important tool for subordination. Consider the similarities between women's medical treatment and rape. Both are tools of subordination that tell women their experiences of harm do not matter. In the medical context, women are told that treatments are not violative as long as they consent to them, even if consent was not informed and involuntary.[70] Compare a woman forced to get her IUD

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[61] *Cf.* Catharine A. MacKinnon, *A Feminist Defense of Transgender Sex Equality Rights*, 34 Yale J.L. & Feminism 88, 91 (2023) [hereinafter *Transgender Sex Equality*] (making similar argument on trans rights).

[62] *See* Bever, *supra* note 9 (noting biological explanations for pain differences).

[63] *See* Nudson, *supra* note 1 (recounting how Pap smear pain can vary based on who provides the treatment, indicating pain is not inevitable).

[64] *See* Hossain, *supra* note 22, at 53-61.

[65] *Cf. Transgender Sex Equality*, *supra* note 61, at 91 (making similar argument on trans rights).

[66] *See* Elinor Cleghorn, *Medical Myths About Gender Roles Go Back to Ancient Greece. Women Are Still Paying the Price Today*, Time (June 17, 2021, at 5:46 PM), https://time.com/6074224/gender-medicine-history/ [https://perma.cc/Y427-MKXZ].

[67] *Id.*

[68] *Id.*

[69] *Cf.* Sex Equality, *supra* note 56, at 877 (discussing how undermining women's credibility is used to maintain hierarchy in the context of rape).

[70] *See* Lisa Napoli, *The Doctrine of Informed Consent and Women: The Achievement of Equal Value and Equal Exercise of Autonomy*, 4 Am. U. J. Gender, Soc. Pol'y & L. 335, 339 (1996) ("When consent is sought, women must often overcome gender-based stereotypes that impact on a doctor's decision to perform a procedure and on the doctor's disclosure of information concerning that procedure. As a result, important risks and benefits associated with a woman's options for care are frequently never revealed."); *cf. Failures of Informed Consent and the Impact on Women's Health*, Patient Safety Learning (Mar. 8, 2023), https://www.patientsafetylearning.org/blog/failures-of-informed-consent-and-the-impact-on-womens-health [https://perma.cc/H3UK-BU3J] (discussing how women felt violated after consenting to procedures they did not realize would involve severe pain).

inserted without sedation because her insurance will not cover sedation,[71] with a woman who acquiesces to sex with her landlord because she cannot afford eviction.[72] Both women consented, as the law understands the term,[73] but both were violated. Likewise, when a woman experiences pain during a medical procedure but is told that pain is normal and that she should stop complaining,[74] the coercive situation echoes sexual assaults where women are told that they are simply experiencing "rough sex."[75] Both women's injuries have been dismissed. They are at most placated and told to get over it. The pain gap dismisses women's experiences of harm and signals to her and to society that women are lesser humans because their pain does not matter.

Perhaps the clearest demonstration of the parallels between rape and women's medical treatment is when doctors sexually assault patients. Victims often report that they initially struggle to identify whether their doctor's behavior was an appropriate medical exam or sexual assault.[76] But medical care should look and feel nothing like rape. The medical establishment entrenches gender hierarchy and sexualized subordination by naturalizing pain, demonizing women, and silencing them.

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[71] *See* Danielle Roncari, *Get the Facts About IUD Insertion + Pain Management*, TUFTS MED. (Aug. 20, 2024), https://www.tuftsmedicine.org/about-us/news/get-facts-about-iud-insertion-pain-management#:~:text=A:%20At%20Tufts%20Medical%20Center,entire%20cost%20of%20the%20sedation [https://perma.cc/7E4V-B37T] ("A patient's health insurance plan may or may not cover the entire cost of the sedation."); Jessie Van Amburg, *Here's What the CDC's New IUD Pain Management Recommendations Mean in Practice*, SELF (Aug. 20, 2024), https://www.self.com/story/iud-insertion-pain-relief-cdc-guidelines [https://perma.cc/H3UK-BU3J] ("[S]edation may not be covered by insurance or might have a higher out-of-pocket cost, depending on your plan.").

[72] *See* Catharine MacKinnon, *Rape Redefined*, 10 HARV. L. & POL'Y REV. 431, 443 (2016) [hereinafter *Rape Redefined*] ("Consent in sexual assault law is consistent with economic . . . hierarchical threats, so long as severe physical injury (rape itself is usually not considered a physical injury) or life . . . are not threatened."); *cf.* Deborah Zalesne, *The Intersection of Socioeconomic Class and Gender in Hostile Housing Environment Claims under Title VIII: Who is the Reasonable Person?*, 38 B.C. L. REV. 861, 861 (1997) ("Sexual harassment is predicated on the imbalance of power. Landlords typically have significant power over their tenants, including the power to . . . evict a tenant . . . .").

[73] See generally *Rape Redefined, supra* note 72, at 443 for a discussion of how consent is understood under the law.

[74] *See* Bever, *supra* note 9.

[75] *Rape Redefined*, *supra* note 72, at 461.

[76] *E.g.*, Meena Duerson & Meridith Edwards, *A Doctor Cared for Generations of Families. Now Dozens of Women Say He Also Abused Them*, CNN (Sept. 20, 2024, at 11:35 ET), https://www.cnn.com/2024/09/15/us/oregon-doctor-survivors-abuse-claims/index.html [https://perma.cc/93P9-7DGB] (noting that woman who was sexually abused by doctor "had no idea" that he was not providing proper medical care and that she "thought this was normal"); Jessica Miller, *94 Women Allege a Utah Doctor Sexually Assaulted Them. Here's Why a Judge Threw Out Their Case*, SALT LAKE TRIB. (Feb. 22, 2023, at 6:00 AM), https://local.sltrib.com/94-utah-women-sue-obgyn-for-sexual-assault-judge-tosses-case/?_gl=1*1wuc6oh*_ga*MTAwMTE2MjI5MC4xNjkxMDg5Nzg1*_ga_DC2TJEE08T*MTcxOTUyMjI4OS43NC4xLjE3MTk1MjYxODguNjAuMC4w [https://perma.cc/GUB2-M5BZ] (including testimonial from woman who was sexually assaulted by doctor that she "felt disgusted and violated," but was then unsure if conduct was assault or proper medical practice).

B. Health Outcomes

Health outcomes are compromised by providing poor pain management for women. Straightforwardly, it may be harder to conduct medical procedures if women are in pain. A natural response to pain is to flinch or move,[77] which can make it difficult for doctors to get clear images or complete examinations. When women shift out of discomfort during a mammogram, it is harder to get an accurate X-ray.[78] Pain-driven movement may be hazardous during procedures like egg retrievals, where doctors use sharp instruments within the patient's body.[79]

Normalizing pain also makes it harder for both doctors and patients to identify when a procedure has gone awry.[80] A nurse at a Yale fertility clinic was stealing fentanyl and replacing it with saline, but it took years for Yale to realize they were performing in vitro fertilization ("IVF") egg retrievals without pain medication because, even under the clinic's standard procedures, "[s]ometimes a patient would be in so much pain that she would be kicking."[81] Normalizing painful medical care undermines the alarm function of pain, which can warn all parties involved when there is a new medical issue.[82]

Unnecessary medical pain is particularly dangerous due to its impact on preventative care. Women who experience painful medical care are less likely to pursue future care.[83] Surveys have found that 35–46% of women experience pain so significant during mammograms that they plan to delay or refuse future scans.[84] Procedures like mammograms and cervical

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[77] *"Ouch, that hurts!" The Science of Pain*, Nat'l Inst. Health MedlinePlus Mag. (May 23, 2023), https://magazine.medlineplus.gov/article/ouch-that-hurts-the-science-of-pain#:~:text=When%20a%20part%20of%20your,wrong%20here%2C%20pay%20attention!%E2%80%9D [https://perma.cc/GL22-KY3W]; Brooks, *supra* note 4 (noting some women writhe when they get Pap smears due to pain).

[78] *See Mammogram*, Cleveland Clinic (Oct. 17, 2024), https://my.clevelandclinic.org/health/diagnostics/4877-mammogram [https://perma.cc/GL22-KY3W].

[79] *E.g.*, Susan Burton, *The Retrievals: The Clinic*, N.Y. Times Serial Prod., at 12:37 (June 25, 2025), https://www.nytimes.com/2023/07/27/podcasts/serial-the-retrievals-yale-fertility-clinic.html?showTranscript=1 [https://perma.cc/RN2D-7Z54] (noting sudden movement due to pain is dangerous for egg retrievals).

[80] Nudson, *supra* note 1.

[81] Burton, *supra* note 79, at 00:10:48.

[82] *See id.*

[83] *See, e.g.*, Lindsey Bever, *Their IUD Procedures Were Painful. Now They're Scared to Have it Removed*, Wash. Post (Aug. 13, 2024), https://www.washingtonpost.com/wellness/2024/08/13/iud-removal-pain/ [https://perma.cc/Y4C9-FYWN] (interviewing women avoiding getting their IUDs removed due to pain of the initial procedure).

[84] Nudson, *supra* note 1 (citing Cathrine Hoyo, Kimberly S. H. Yarnall, Celette Sugg Skinner, Patricia G. Moorman, Denethia Sellers & LaVerne Reid, *Pain Predicts Non-Adherence to Pap Smear Screening Among Middle-Aged African American Women*, 41 Preventative Med. 439 (2005)).

screenings are critical for detecting cancer[85] while it is still treatable.[86] As OB/GYN Ashley Hill explains, "I have met in my career quite a few people who were hurt during a pelvic exam . . . . And they never came back. And they developed cervical cancer or some other problem that could have been prevented . . . ."[87] By failing to manage women's pain, the medical system drives women away from the very care that could save their lives.

C. Eroding Trust and Public Health

Dismissing women's pain is bad for women's health outcomes, but also public health goals at large. When doctors fail to warn women about the potential pain of procedures or fail to believe them when they report pain, women's trust in the medical system erodes.[88] This is especially true for Black women, who already reasonably hold significant distrust[89] of a medical system built on the experimentation and exploitation of Black bodies.[90] When women do not trust their doctors, they may defer or avoid seeking help.[91] And because women often make family health decisions, especially

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[85] Nancy L. Baezinger, *Painful Reality: Inappropriate Provider Management of Pain as a Determinant of Health Care Avoidance*, 22 Creative Nursing 151, 155 (2016).

[86] Elizabeth Selvin & Kate M. Brett, *Breast and Cervical Cancer Screening: Sociodemographic Predictors Among White, Black, and Hispanic Women*, 93 Am. J. Pub. Health 618, 618 (2003).

[87] Nudson, *supra* note 1.

[88] *E.g.*, Leah Pierson, *Disclosing Pain: The Case for Greater Transparency*, Petrie-Flom Ctr.: Bill of Health (Oct. 5, 2021) (noting "[c]linicians across medical settings commonly euphemize or understate pain—a practice that has concerning implications for patient trust, consent, and care quality"), https://petrieflom.law.harvard.edu/2021/10/05/pain-transparency-medicine/ [https://perma.cc/EV8Q-4THD]; Bever, *supra* note 83 (quoting patient who now feels general "mistrust" toward gynecology after her clinician failed to warn her that IUD insertion may be painful and also sharing the view of Professor Nichole Tyson that "[m]ost patients fare better when their health-care providers are transparent about the procedures, the possibility of pain and any available pain control options"); Elizabeth Hintz & Marlene D. Berke, *When Doctors Don't Believe Their Patients*, UConn Today (May 21, 2025), https://today.uconn.edu/2025/05/when-doctors-dont-believe-their-patients/# [https://perma.cc/7Q4H-PGMT] (noting that "centuries of gender bias in medicine" means "the repeated experience of being dismissed by clinicians erodes [women's] sense of trust in the health care system. They might hesitate to seek medical attention in the future, fearing they will once again be dismissed").

[89] *See Most Black Americans Believe U.S. Institutions Were Designed to Hold Black People Back*, Pew Rsch. Ctr. 32 (2024), https://www.pewresearch.org/wp-content/uploads/sites/20/2024/06/RE_2024.06.15_Black-Americans-and-US-Institutions_REPORT.pdf [https://perma.cc/VBM2-FEH7] (58% of Black women "say the U.S. health care system was designed to hold Black people back a great deal or fair amount").

[90] The "Father of American Gynecology" experimented on enslaved Black women. Dierdre Cooper Owens, Medical Bondage: Race, Gender, and the Origins of American Gynecology 1-6 (2017). Black men, women, and children were infected with syphilis during the infamous Tuskegee experiment. Elizabeth Nix, *Tuskegee Experiment: The Infamous Syphilis Study*, History (May 28, 2025), https://www.history.com/news/the-infamous-40-year-tuskegee-study [https://perma.cc/9M7Y-VT4Z].

[91] *E.g.*, Bever, *supra* note 83 (interviewing women who now are hesitant to seek IUD care out of mistrust); *cf.* Ariel Washington & Jill Randall, *"We're Not Taken Seriously": Describing the Experiences of Perceived Discrimination in Medical Settings for Black Women*, 10 J. Racial

for their children, women's distrust of the medical system has broader public health implications.[92] Anthropologist Johanna Richlin suggests that women's mistreatment in the medical system has contributed to decreased rates in pediatric vaccination.[93] Women are skeptical of trusting vaccine information when their own medical appointments have involved being "touched without consent, yelled at, disbelieved or threatened."[94] Undermining women's already fraught and fragile trust in the medical system is damaging for women and society at large.

III. Why Discrimination Law?

Recognizing the harm that the pain gap produces and its relationship to sex equality, the next question is how that violation can be legally theorized.[95] Though tort medical malpractice[96] is a potential avenue for litigating the pain gap,[97] a discrimination approach is more adequate.[98] Before conceptualizing the discrimination claim, Section III.A of this Note addresses the drawbacks of using tort.[99]

A. Tort Law

Women can sue in tort for medical malpractice if they show that a provider was negligent and deviated from "the professional standard of care."[100] Unfortunately, the "legal standard for medical malpractice currently protects

& Ethnic Health Disparities 883, 887 (2022) (noting that medical mistrust can lead patients to "reducing the number of visits, being hesitant to trust medical advice, and turning to community members for medical advice.").

[92] *See* U.S. Dep't of Lab., General Facts on Women and Job Based Health 1, https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/women-health-care-jobs-fact-sheet.pdf [https://perma.cc/DRX7-X7FT] (noting that women make many family health decisions).

[93] Johanna Richlin, *Vaccine-Skeptical Mothers Say Bad Health Care Experiences Made Them Distrust the Medical System*, The Conversation (Mar. 11, 2024, at 8:28 AM), https://theconversation.com/vaccine-skeptical-mothers-say-bad-health-care-experiences-made-them-distrust-the-medical-system-217433 [https://perma.cc/ZX4J-S383].

[94] *Id.*

[95] *See generally* Catharine A. MacKinnon, Sexual Harassment of Working Women 51 (1979) [hereinafter Sexual Harassment] (making same argument for sexual harassment).

[96] Other areas of the law, including criminal law (medical battery) and constitutional law (right to medical privacy) may also ground pain gap crimes, but like tort, they are less appropriate than discrimination. *Cf. id*. at 164-74 (making similar argument for sexual harassment).

[97] *E.g.*, Complaint at *25-28, Mendi Blue v. Yale, No. 24-6068022-S (Conn. Super. Ct. Bridgeport, Jan. 18, 2024) (alleging medical malpractice negligence for clinic's failure to ensure that fentanyl was admitted to patients for IVF egg retrievals).

[98] *Cf.* Sexual Harassment, *supra* note 95, at 164-74 (making similar claim for sexual harassment).

[99] *Cf. id.* (using similar structural argument for sexual harassment).

[100] Maytal Gilboa, *Biased but Reasonable: Bias Under the Cover of Standard of Care*, 57 Ga. L. Rev. 489, 494-95 (2023).

the common practice of discounting women and their reports of their symptoms."[101] Care can be discriminatory and meet the standard of care because acceptable behavior is set at the status quo:[102] A doctor can fail to provide pain management and meet the standard of care as long as other doctors also fail under the same circumstances.[103] Medical malpractice law does not consider sex inequality.[104] "If the standard of care in the US is bad, it's hard to prove that the bad care you received was a deviation from the standard. . . . A lot of times, it *is* the standard."[105] The more entrenched sex inequality is, the more likely discriminatory behavior is to meet the standard of care.[106] This is a substantial obstacle for pain gap claims, where the *general* practice is often not to provide pain management.[107] If the standard of care is to not manage women's pain, a given woman cannot establish that her doctor failed to meet the standard of care by not managing her pain.[108] The doctor did meet the standard, but the standard itself is discriminatory, so the patient has no medical malpractice claim.[109]

In addition to these doctrinal obstacles, tort is a politically poor fit for addressing the pain gap.[110] Tort law explicitly values women as less than men: "[T]ort damages are typically estimated based on the victim's loss of future earning capacity, and the earning capacity of women and minorities is, on average, lower than that of [w]hite men. Negligence toward [w]hite men is therefore more costly than negligence toward women and minorities."[111] As such, sex equality cannot be expected from a field of law premised on women's second-class status.[112] Furthermore, tort misses the group-based

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[101] Cecilia Plaza, *Miss Diagnosis: Gendered Injustice in Medical Malpractice Law*, 39 Colum. J. Gender & L. 91, 93 (2020).

[102] *See* Gilboa, *supra* note 100, at 496; Cecilia Plaza, *In It for the Long Haul: The American Legal System's Failure to Protect Patients with Persistent Covid-19 Symptoms from Gender Discrimination in Healthcare*, 18 J. Health & Biomedical L. 33, 69 (2022).

[103] *See* Plaza, *supra* note 101, at 69-70.

[104] *See id.*

[105] Courtney Rozen, *Women Harmed by Doctors, Then Failed by US Civil Rights Watchdog*, Bloomberg L. (Aug. 28, 2024, at 11:04 AM), https://news.bloomberglaw.com/health-law-and-business/women-harmed-by-doctors-then-failed-by-us-civil-rights-watchdog [https://perma.cc/L8YH-88ZE] (emphasis added) (quoting civil rights attorney Indra Lusero).

[106] *See* Plaza, *supra* note 101, at 69.

[107] *See, e.g.*, Deanna Hartog & Madeline Morcelle, *Reproductive Health Care Pain Points: Raising The Standard of Care for Managing Pain from IUD Insertion and Removal*, Nat'l Health L. Program (Dec. 12, 2023), https://healthlaw.org/reproductive-health-care-pain-points-raising-the-standard-of-care-for-managing-pain-from-iud-insertion-and-removal/ [https://perma.cc/DL8L-SA3P] (explaining that "[t]he standard of care for pain management during IUD insertion and removal and other gynecological procedures [is] underdeveloped . . .").

[108] *Cf.* Plaza, *supra* note 101, at 93 (explaining obstacles with standard of care frameworks generally).

[109] *Id.*

[110] *Cf.* Sexual Harassment, *supra* note 95, at 171-74 (making same argument for sexual harassment).

[111] Gilboa, *supra* note 100, at 520-21.

[112] *Cf.* Sexual Harassment, *supra* note 95, at 158-61 (making same argument for sexual harassment).

harm of inadequate pain management.[113] Tort law focuses on remedying individual harm from individual bad actors, but the pain gap is much more than that. It is a "group injury" in the sense that much of it addresses female-specific medical disregard and all of it is based on the women's sex, often exacerbated by race, subordinating all the women affected as women.[114] "Tort law considers individual and compensable something which is fundamentally social and should be eliminated."[115]

B. Discrimination Law

Discrimination, on the other hand, has the potential to expose the pain gap for what it is: a social, group-based harm.[116] The statutory prohibition on sex discrimination in healthcare is found in the nondiscrimination provision of the ACA,[117] referred to as § 1557.[118] The Section prohibits discrimination on the "basis of sex"[119] by "any health program or activity, any part of which is receiving Federal financial assistance."[120] To assert a § 1557 claim, a plaintiff would need to demonstrate that the inadequate provision of pain management for women's healthcare was because of sex. There are three main ways to "legally theorize" the pain gap as discrimination on the basis of sex: formal equality, anti-stereotyping, and substantive equality.[121]

Section 1557 offers a potential statutory hook for a pain gap discrimination claim. It was the first federal statute to explicitly prohibit sex discrimination in healthcare.[122] Scholars initially predicted the provision would bring radical reform to medical discrimination.[123] Section 1557 applies

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[113] *Compare id.* at 171-74 (arguing tort misses group-harm in sexual harassment), *with supra* Section II.A. Subordination (identifying group-based subordination harm of the pain gap).

[114] *Compare* Sexual Harassment, *supra* note 9593, 171-74 (arguing tort misses group-harm in sexual harassment), *with supra* section II.A. Subordination (identifying group-based subordination harm of the pain gap).

[115] Sexual Harassment, *supra* note 95, at 172.

[116] *Cf. id.* at 172-74 (marking same argument for sexual harassment).

[117] Elizabeth Sepper, *The ACA's Nondiscrimination Rule: Kudos and Critiques*, Petrie-Flom Ctr.: Bill of Health (Nov. 9, 2015), https://blog.petrieflom.law.harvard.edu/2015/11/09/the-acas-nondiscrimination-rule-kudos-and-critiques/ [https://perma.cc/NK9P-PUDG] (explaining that the provision "broke new ground in prohibiting sex discrimination in healthcare for the first time.").

[118] Anna Kirkland & Mikell Hyman, *Civil Rights as Patient Experience: How Healthcare Organizations Handle Discrimination Complaints*, 55 Law & Soc'y Rev. 273 (2021).

[119] 42 U.S.C. § 18116(a) (citing Title IX for its definition of prohibited discrimination, which bans discrimination "on the basis of sex. . . ." 20 U.S.C. § 1681(a)).

[120] *Id.* Federal funding is defined to include federal insurance.

[121] *Cf. Transgender Sex Equality*, *supra* note 61, at 92 (analyzing these three models for transgender rights).

[122] Sepper, *supra* note 117.

[123] *E.g.*, Sidney D. Watson, *Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity*, 55 How. L.J. 855, 855 (2012); Valarie K. Blake, *An Opening for Civil Rights in Health Insurance After the Affordable Care Act*, 36 B.C. J.L. & Soc. Just. 235, 235 (2016); Kirkland & Hyman, *supra* note 118, at 274. Some argue the provision has not brought forth the revolution anticipated. *E.g.*, Rozen, *supra* note 105 (arguing administrative enforcement

to essentially every healthcare entity in the country,[124] from providers[125] to insurers.[126] The Section provides for both a private right of action and Health and Human Services administrative enforcement.[127] Litigators can attach various sex discrimination theories to § 1557 in order to combat the pain gap.

IV. Legally Theorizing the Pain Gap as Sex Discrimination

The pain gap can be theorized as § 1557 discrimination on the basis of sex under three models: formal equality, anti-stereotyping, and substantive equality. While all three are arguable, substantive equality is the most promising theory. This analysis emphasizes legal theory over specific doctrinal issues in imagining § 1557 claims for two reasons. First, pain gap discrimination can manifest in different ways, from an individual doctor declining to mention pain management during a consultation, to an insurance company declining to cover pain management for women's procedures.[128] Different fact patterns will require slightly different doctrinal arguments. By focusing on theory, we can establish a baseline foundation for later specific cases. Second, one of the main doctrinal hurdles to § 1557 claims is navigating the

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of Section has been ineffective); Kirkland, *supra* note 118, at 274-75 (arguing little has changed on the ground post-ACA § 1557). Section 1557 also faces other threats, including challenges to the ACA. See generally Abbe R. Gluck, Mark Regan & Erica Turret, *The Affordable Care Act's Litigation Decade*, 108 Geo. L.J. 1472 (2020) for an overview of ACA legal challenges. Section 1557 has also been limited by the Supreme Court's bar on emotional damages under the statute. *See* Cummings v. Premier Rehab Keller, P.L.L.C., 596 U.S. 212, 230 (2022).

[124] Section 1557 applies to all healthcare entities that receive federal funding, 42 U.S.C. § 18116(a), which essentially means all American healthcare. *See* Watson, *supra* note 123, at 872-78, 880; Blake, *supra* note 123, at 237.

[125] Provider refers to an entity like a hospital or medical practice, not an individual doctor. There is no individual liability under § 1557 for sex discrimination. *E.g.*, Rule v. Braiman, No. 1:23-cv-01218, 2024 WL 4042135, at *12-13 (N.D.N.Y. Sept. 9, 2024).

[126] This is important for the efficacy of a potential pain gap claim, where harm can be generated by a single discriminatory entity. A provider offering pain management for a procedure may make little difference to the patient if that pain management is not covered by insurance and vice versa. *See* Roncari, *supra* note 71.

[127] *See* Nondiscrimination in Health Programs and Activities, 89 Fed. Reg. 37522, 37529 (May 6, 2025) (to be codified at 42 C.F.R. pts. 438, 440, 457, 460; 45 C.F.R. pts. 80, 84, 92, 147, 155, 156) (noting that § 1557 includes both a private right of action and administrative enforcement). The private right of action is especially important, given the variation in agency enforcement across administrations and the limited capacity of agencies. Lindsey Dawson, Laurie Sobel, Kaye Pestaina, Jennifer Kates, Samantha Artiga & Alice Burns, *The Biden Administration's Final Rule on Section 1557 Non-Discrimination Regulations Under the ACA*, KFF (May 15, 2024), https://www.kff.org/affordable-care-act/issue-brief/the-biden-administrations-final-rule-on-section-1557-non-discrimination-regulations-under-the-aca/ [https://perma.cc/G6PW-6C4C] ("The final rule closely mirrors a proposed rule issued by the Biden administration in July of 2022 and is, in many ways, a reversal of the final rule issued by the Trump Administration in June of 2020, which itself was a significant departure from the Obama Administration regulations issued in 2016."); *see* Rozen, *supra* note 105.

[128] *E.g.*, Nudson, *supra* note 1.

doctrines of disparate impact and treatment.[129] Courts are evenly split as to whether the Section permits a private right of action for disparate impact.[130] But impact and treatment doctrine should not be viewed as an inevitable obstacle.[131] The formal equality approach is concerned with distinguishing impact from treatment,[132] but anti-stereotyping and substantive legal theories question the validity of the distinction[133] or avoid it by cabining themselves as disparate treatment claims.[134] Starting with theory is a critical first step for establishing a strong legal argument before becoming enmeshed in doctrines that may be more or less relevant or helpful, depending on the theorized framework.[135] Although there are other equality theories, this Note focuses on these three theoretical approaches because of their establishment in jurisprudence and in feminist scholarship.

A. Formal Equality

A formal equality theory argues that differing policies in pain management for men's and women's procedures are facial sex classifications that treat similarly situated people differently. Formal equality requires "same

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[129] *E.g.*, Doe v. BlueCross BlueShield of Tenn., Inc., 926 F.3d 235, 238-43 (6th Cir. 2019) (discussing disparate impact versus treatment under § 1557); Doe v. CVS Pharm., Inc., 982 F.3d 1204, 1211-12 (9th Cir. 2020) (same).

[130] *Compare CVS*, 982 F.3d at 1211-12 (allowing private disparate impact claim), *with BlueCross*, 926 F.3d at 238-43 (barring those claims), *and* York v. Wellmark, Inc., No. 4:16-cv-00627-RGE-CFB, 2017 WL 11261026, at *18 (S.D. Iowa Sept. 6, 2017) (same), *aff'd*, 965 F.3d 633 (8th Cir. 2020). The Supreme Court was supposed to weigh in on this issue, but the case before them was settled. Kanchana Sthanumurthy, Comment, *Punitive and Unequal Pregnancies: How Drug Testing Pregnant Women Violates Disparate Impact Provisions Under § 1557 of the Affordable Care Act*, 33 Geo. Mason U. Civ. Rights L.J. 325, 339-40 (2023) (discussing *CVS*, 982 F.3d 1204, *cert. granted in part*, 141 S. Ct. 2882 (2021), *and cert. dismissed*, 142 S. Ct. 480 (2021)).

[131] Catharine A. MacKinnon, *Substantive Equality: A Perspective*, 96 Minn. L. Rev. 1, 7 (2011) [hereinafter *A Perspective*] (arguing there is no legal requirement for the distinction); Sexual Harassment, *supra* note 95, at 192 (noting that "[t]he Supreme Court distinctions between disparate treatment . . . and disparate impact").

[132] *Cf.* Sexual Harassment, *supra* note 95, at 192-93 (noting the "differences" approach, as applied by the American Supreme Court, is concerned with impact versus treatment).

[133] *E.g.*, *id.* at 174-208 (only discussing impact/treatment for "differences" model, not for the "equality" model); *A Perspective*, *supra* note 131, at 7 (noting substantive equality does not focus on impact versus treatment); *id.* at 8 (noting that sexual harassment is a well-recognized form of sex discrimination that is based in substance and not treatment/impact); Zachary R. Herz, Note, Price*'s Progress: Sex Stereotyping and Its Potential for Antidiscrimination Law*, 124 Yale L.J. 396, 410-11 (2014) (arguing sex stereotyping theory is not neatly impact or treatment).

[134] *E.g.*, *A Perspective*, *supra* note 131, at 8 (noting sexual harassment is substantive but is often treated by formalist courts as disparate treatment); City of L.A., Dept. of Water & Power v. Manhart, 435 U.S. 702, 707 & n.13 (1978) (citing "disparate treatment" language when outlining prohibition of stereotyping); Herz, *supra* note 133, at 410-11 (arguing anti-stereotyping is often framed as disparate treatment).

[135] *Cf.* Margaret E. Johnson, Emily Gold Waldman & Bridget J. Crawford, *Title IX & Menstruation*, 43 Harv. J.L. & Gender 225, 263-64 (2020) (arguing that legal and feminist theory "provide[] a broad set of tools" that are necessary for establishing the groundwork for specific doctrinal arguments).

treatment of similar persons."[136] Adequate pain management is provided by the medical system for men's treatments but not for comparable women's treatments. For example, vasectomies are simple, outpatient reproductive health procedures, just as IUD insertions are.[137] Pain management for vasectomies is extensive and common policy.[138] Vasectomy pain is so effectively managed that there is now a "VasMadness" phenomenon, where men get vasectomies during March Madness so they can watch the basketball tournament while they rest.[139] By contrast, standard practices in the medical field mean that women are prescribed little to no pain management for IUD insertion,[140] even though approximately 50% of women report experiencing "intense pain" during the procedure.[141] Likewise, sedation is not consistently prescribed for hysteroscopies (an endoscopic examination of the uterus), even though it is standard practice for other endoscopic procedures, such as colonoscopies, that men undergo.[142] A third of women who undergo

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[136] Sex Equality, *supra* note 56 at 5.

[137] *Cf.* Med. Student Section Am. Med. Ass'n, *supra* note 20, at 1 (comparing vasectomies to IUD insertions). *Compare id.*, *with Vasectomy*, Johns Hopkins Med., https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/vasectomy#:~:text=Vasectomy%20is%20almost%20always%20done,go%20home%20the%20same%20day [https://perma.cc/TT4E-QLTK].

[138] Med. Student Section Am. Med. Ass'n, *supra* note 20, at 1 ("Whereas, local anesthesia, general anesthesia, and oral or intravenous sedation is commonly used in vasectomy procedures for pain control and clear guidelines regarding use of sedation or anesthesia for vasectomies are explicitly outlined in American Urological Association clinical guidelines.").

[139] Anne Roderique-Jones, *There's A Safe, Effective Contraceptive Method For Men—But They're Not Using It*, Self (Nov. 8, 2016), https://www.self.com/story/vasectomy-safe-effective-contraceptive-men-not-using-it [https://perma.cc/MD6M-MWD9].

[140] *See* Lindsey Bever, *IUD Placement Can Be Painful. These Women Used Their Phones To Record It.*, Wash. Post (Mar. 25, 2024), https://www.washingtonpost.com/wellness/2024/03/25/tiktok-iud-birth-control-pain/ [https://perma.cc/EC6E-WC3U]. In 2024, the CDC did update their guidance to encourage pain management of IUD insertions, but an initial study of the recommendation's impact found that 95% of patients in 2025 still did not receive lidocaine or opiods. Nina B. Masters, Karen Gilbert Farrar, Brianna M. Goodwin Cartwright, Patricia J. Rodriguez, Duy Do & Nicholas L. Stucky, *Evaluating Changes in Lidocaine and Opioid Administration on the day of IUD Insertion, 2018-2025*, Contraception (forthcoming) (manuscript at 3, 7).

[141] Elaine A. Lopes-Garcia, Elenice V. Carmona, Ilza Monteiro, & Luis Bahamondes, *Assessment of Pain and Ease of Intrauterine Device Placement According to Type of Device, Parity, and Mode of Delivery*, 28 Eur. J. Contraception Reprod. Health Care 163, 165 (2023).

[142] Burlock, *supra* note 33. *Compare* Comm. on Gynecologic Practice, Am. Coll. of Obstetricians & Gynecologists, The Use of Hysteroscopy for the Diagnosis and Treatment of Intrauterine Pathology, at e143 (2020), https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2020/03/the-use-of-hysteroscopy-for-the-diagnosis-and-treatment-of-intrauterine-pathology.pdf [https://perma.cc/H2ZD-2XFN] (listing most common pain management procedures for hysteroscopies and not including sedation), *with* Shaina Drummond, *Colonoscopy*, Am. Soc. Anesthesiologists (Mar. 24, 2024), https://madeforthismoment.asahq.org/preparing-for-surgery/procedures/colonoscopy/ [https://perma.cc/75UB-UT56] ("Almost all colonoscopies . . . are performed with patients under a level of sedation or anesthesia that prevents them from feeling anything.").

hysteroscopies rate their pain as 7 or above out of 10.[143] The medical system treats similarly situated men and women differently based on sex, so the formal equality theory should apply to medical discrimination.[144]

This argument, however, assumes that courts view these procedures and patients as similarly situated. "[T]raditionally equality is a sameness and sex or gender is a difference."[145] In *Geduldig v. Aiello*,[146] the Supreme Court found in a formalist opinion that pregnancy is "a 'difference' that can validly ground different treatment" under the Constitution.[147] Excluding pregnancy from a disability insurance program was considered constitutional since the Court ruled the program did not discriminate "because of gender but merely remove[d] one physical condition—pregnancy—from the list of compensable disabilities."[148] Pregnancy was not considered facial sex discrimination.[149] Given this precedent, a court may see differences in pain management across medical procedures to be validly premised on differences in the physical condition of men and women.[150] Still, advocates should try to distinguish pain management from *Geduldig*'s facts when possible. While pregnancy is unique to female internal anatomy,[151] both men and women require potentially painful medical treatments.[152] Therefore, a formalist comparison is possible.[153] Furthermore, pain management cases are distinguishable from *Geduldig* because, although not all women experience pregnancy,[154] many procedures that can cause pain, such as mammograms and Pap smears, are recommended for all women in certain age groups.[155]

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[143] Hayley Jarvis, *'Like Ripping My Insides' - Fears Hysteroscopy Guidelines Not Enough*, BBC (Sept. 19, 2024), https://www.bbc.com/news/articles/c7498yvvjvgo [https://perma.cc/8U7H-ZP5T].

[144] *See* SEX EQUALITY, *supra* note 56, at 7.

[145] *Id.* at 22.

[146] 417 U.S. 484 (1971).

[147] SEX EQUALITY, *supra* note 56, at 311 (analyzing *Geduldig*, 417 U.S. 484).

[148] *Geduldig*, 417 U.S. at 496 n.20.

[149] SEX EQUALITY, *supra* note 56, at 314-15 (analyzing *Geduldig*, 417 U.S. at 496 n.20).

[150] *Cf.* Johnson et al., *supra* note 135, at 264-67 (making this argument for menstruation).

[151] *See* KC Clements, *Can Men Get Pregnant?*, HEALTHLINE (July 12, 2024), https://www.healthline.com/health/transgender/can-men-get-pregnant [https://perma.cc/BB3Z-T2WM] (explaining that, given the current state of technology, generally those "with a uterus and ovaries can get pregnant").

[152] *See supra* Part I for explanation of painful treatments for men and women.

[153] *See* SEX EQUALITY, *supra* note 56, at 7.

[154] In 2016, 14% of American women ages 40 to 44 had never given birth. Gretchen Livingston, *They're Waiting Longer, but U.S. Women Today More Likely to Have Children Than a Decade Ago*, PEW RSCH. CTR. (Jan. 18, 2018), https://www.pewresearch.org/social-trends/2018/01/18/theyre-waiting-longer-but-u-s-women-today-more-likely-to-have-children-than-a-decade-ago/ [https://perma.cc/C2WW-F6WV].

[155] *See American Cancer Society Recommendations for the Early Detection of Breast Cancer*, AM. CANCER SOC'Y (Dec. 19, 2023), https://www.cancer.org/cancer/types/breast-cancer/screening-tests-and-early-detection/american-cancer-society-recommendations-for-the-early-detection-of-breast-cancer.html [https://perma.cc/AK3V-95H2] (recommending mammograms for all women over 40 years of age); *Cervical Cancer Screening*, AM. COLL. OF

This means that there is a tighter fit between women and the class of people who get these procedures than there is between women and the class of pregnant people, which underscores that these pain management disparities are sex-based.[156]

Geduldig highlights that formal equality "is of limited utility for analyzing some of the other issues raised by sex-specific biological processes."[157] A formalist may argue that pain management varies between men's vasectomies and women's IUD insertions due to the different procedures and anatomy involved; unalike cases are treated unalike, so there is no discrimination.[158] But *Geduldig* exemplifies formal equality's convoluted logic. Currently, those born without a uterus do not receive IUDs.[159] This formalist trap treats procedures "suffered only by women"[160] as immune from discrimination because society lacks a male comparator.[161] Why cisgender men should have to possess uteruses before medical abuse of women's uteruses can be legally addressed as unequal—indeed, facially so—is never considered in this model.[162]

The trap of formal equality exemplifies the model's endemic flaws. First, formal equality is inconsistent.[163] Changing the abstract framing can make two similarly situated individuals no longer seem alike,[164] and vice versa.[165] Formalist abstractions can lead to equality outcomes, as seen in *Reed v. Reed*,[166] but they can also be used to undermine equality.[167] Second, formal equality is especially poor at addressing systemic inequalities.[168] The greater the inequality, the more it resembles a difference, implying that

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Obstetricians & Gynecologists (May 2023), https://www.acog.org/womens-health/faqs/cervical-cancer-screening [https://perma.cc/VF7Q-JWWD] (recommending Pap smears for all women over 21 years of age).

[156] *Cf. Geduldig*, 417 U.S. at 496 n.20 (declining to find sex discrimination on basis of different treatment of pregnant people because "it does not follow that every legislative classification concerning pregnancy is sex-based").

[157] *See* Johnson et al., *supra* note 135, at 266.

[158] *Cf. Geduldig*, 417 U.S. at 496 n.20 (applying analogous logic to pregnancy).

[159] *Cf.* Sex Equality, *supra* note 56, at 476-77 (questioning the logic of not considering pregnancy to be facial discrimination).

[160] *Geduldig*, 417 U.S. at 500 (Brennan, J., dissenting).

[161] *See* Sex Equality, *supra* note 56, at 314-16.

[162] *Cf. Geduldig*, 417 U.S. at 496 n.20 (stating "that only women can become pregnant" and going on to say "lawmakers are constitutionally free to include or exclude pregnancy from the coverage of legislation").

[163] *See Transgender Sex Equality*, *supra* note 61, at 92.

[164] *Id.*

[165] *See, e.g.*, *supra* pp. 326 for IUD/Vasectomy example.

[166] 404 U.S. 71, 76 (1971) ("[A]ll persons similarly circumstanced shall be treated alike." (quoting Royster Guano Co. v. Virginia, 253 U.S. 412, 415 (1920))).

[167] *See Geduldig*, 417 U.S. at 496 n.20.

[168] Sex Equality, *supra* note 56, at 8-9.

differential treatment is permissible under the law.[169] This perpetuates existing discrimination.[170]

National Organization for Women-New York City (NOW-NYC) v. United States Department of Defense[171] demonstrates failed formal equality reasoning under § 1557. In *NOW-NYC*, the Department of Defense (DoD) maintained a policy to provide coverage for IVF only to couples who could demonstrate a direct correlation between infertility and military service.[172] NOW-NYC sued under § 1557 and argued DoD's policy was facial discrimination "[b]y applying a unique, onerous requirement to gender-specific healthcare for those of child-bearing capacity."[173] Only those with a uterus can receive IVF.[174] Therefore, the court should have identified the additional requirements regarding IVF insurance coverage as facially sex-based.[175] Instead, the court held that the IVF rule was "gender-neutral and applie[d] to both male and female service members."[176] The decision made a classic formalist error. The rule may technically apply to men and women, but in *actuality*, it harms only women because cisgender men cannot biologically receive IVF.[177]

The Department of Health and Human Services ("HHS") rulemaking interprets § 1557 to bar discrimination based on reproductive capacity,[178] which could direct a formalist court to identify discrimination in pain management despite anatomical differences.[179] But the HHS rule has been repeatedly challenged[180] and likely carries little weight under current administrative law.[181] Even if a formal equality court finds "sameness" between procedures for women and men, a problem remains: Formal equality erases

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[169] *Id.* at 12-13, 23-24; *cf. e.g.*, Lemons v. City of Denver, No. 76-W-1156., 1978 U.S. Dist. LEXIS 18332, *10 (D. Colo. Apr. 17, 1978) (declining to find impermissible discrimination because sex segregated labor means entire fields of women workers are paid less than male fields).

[170] Sex Equality, *supra* note 56, at 12-13.

[171] 755 F. Supp. 3d 350 (S.D.N.Y. 2024), *appeal filed*, No. 25-71 (2d Cir. Jan. 10, 2025).

[172] *Id.* at 357.

[173] *Id.* at 365.

[174] *In Vitro Fertilization (IVF)*, Mayo Clinic (Sept. 1, 2023), https://www.mayoclinic.org/tests-procedures/in-vitro-fertilization/about/pac-20384716 [https://perma.cc/XD2A-YNHR] (explaining a uterus is currently required for IVF).

[175] *NOW-NYC*, 755 F. Supp. 3d 350 at 364-65 (recounting this argument from plaintiff's brief).

[176] *Id.* at 365.

[177] *Cf.* Sex Equality, *supra* note 56, at 315 n.4 (making same argument for pregnancy broadly).

[178] 45 C.F.R. § 92.101(a)(2); *see* Sepper, *supra* note 117.

[179] *See* Sepper, *supra* note 117.

[180] Challenges have focused on the rule's inclusion of gender identity as part of sex discrimination. *E.g.*, Florida v. Dep't of Health & Hum. Servs., 739 F. Supp. 3d 1091, 1096 (M.D. Fla. 2024).

[181] *See, e.g.*, Loper Bright Enters. v. Raimondo, 603 U.S. 369, 412 (2024).

fundamental differences.[182] There may be concrete differences between women's healthcare needs and other procedures that justify different treatment. Pain management may be of greater importance in some women's healthcare because much of the female reproductive system is internal.[183] Thus, medical care (and pain) may be especially visceral for these procedures because they happen inside the body.[184] Approaches to pain management may also need to differ for women because women are more likely to have been raped,[185] and sexual assault trauma can make certain reproductive health procedures especially physically painful and anxiety-provoking.[186] Although the logic of formal equality can identify some discrimination, the framework is limited and may confine women's pain management to a "same"—but still inadequate—position, simply because male bodies may not have the same needs, problems, or capacities.[187]

B. Sex Stereotyping

Alternatively, the anti-stereotyping approach identifies sex discrimination by acknowledging the role stereotyping plays in women's pain management. Pain management for women's health is insufficient in part due to stereotypes that women are overdramatic and exaggerate pain.[188] Black women face an added layer of stereotyping, with many medical professionals falsely believing they feel less pain than white women.[189] Sex stereotypes contribute to the pain gap, and, according to *Price Waterhouse v. Hopkins*,[190] sex stereotyping in employment is sex discrimination.[191] By analogy,

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[182] *See id.* at 478-79 (Kagan, J. dissenting).

[183] Carr, *supra* note 77 ("It's not always a 'it hurts here' kind of a pain . . . . Sometimes it's a 'I just feel really sick and I feel like something is wrong' kind of a pain, sort of like labor feels." (quoting OB-GYN Maureen Baldwin)).

[184] *Id.*

[185] Holly Kearl, The Facts Behind The #MeToo Movement: A National Study On Sexual Harassment And Assault 14 (2018), https://www.nsvrc.org/sites/default/files/2021-04/full-report-2018-national-study-on-sexual-harassment-and-assault.pdf [https://perma.cc/K2ZE-ER5F].

[186] *E.g.*, Brigette Leeners, Ruth Stiller, Emina Block, Gisela Gorres, Bruno Imthurn & Werner Rath, *Effect of Childhood Sexual Abuse on Gynecologic Care as an Adult*, 48 Psychosomatics 385, 389 (2007) (finding increased "psychology strain" for child sexual abuse survivors when visiting the gynecologist); Yvette Brend & Stephanie Dubois, *Women Have Sucked Up the Pain of Birth Control Devices For Decades, But Do They Have To?*, CBC Radio (Aug. 25, 2023), https://www.cbc.ca/radio/whitecoat/iud-pain-birth-control-1.6480281 [https://perma.cc/W9KX-BF8Y] (suggesting sedation during IUD insertion may be best for sexual assault survivors).

[187] *Cf.* Sex Equality, *supra* note 56, at 479-80 (making this argument for pregnancy).

[188] Bever, *supra* note 9.

[189] *Id.*

[190] 490 U.S. 228 (1989).

[191] *Id.* at 250-51 (finding sex stereotyping as indicative of discrimination under Title VII). Section 1557 uses the sex discrimination standard of Title IX, 42 U.S.C. § 1811(a). Title IX often looks to Title VII for defining sex discrimination. *E.g.*, Gebser v. Lago Vista Indep. Sch.

inadequate pain management in women's healthcare due to sex stereotypes can be regarded as impermissible discrimination on the basis of sex.[192]

A sex stereotyping theory can be used to address sex inequality in women's healthcare, but it has limits. One such limit is that sex stereotyping claims focus on individuals, usually outliers.[193] Additionally, the framework is poor for conceptualizing systemic, class-wide discrimination where "the stereotype has been made real."[194] This limitation has several repercussions. First, sex stereotyping claims will likely be more effective for women who differ from the stereotype than for those who do not.[195] A woman who loudly advocates for pain management and is denied will have a stronger anti-stereotyping claim than the demure woman who hesitates to advocate for herself due to the socialized gender hierarchy,[196] even though both women have experienced poor healthcare due to sex inequality. Second, like formal equality, anti-stereotyping can obscure genuine differences that should be considered when assessing discrimination. For example, women's health procedures may require more pain management than similar procedures for men, not because women are being stereotyped as "delicate,"[197] but because there are actual relevant differences.[198] Lastly, sex stereotyping theory relies on evidence, including, but not limited to, remarks. "[S]tray remarks" are insufficient to establish discriminatory sex stereotyping.[199] However, patients will often not have any remarks to cite, let alone specific comments directly tied to both sex and the denial of pain management.[200] A medical provider may not have mentioned pain management at all.[201]

Dist., 524 U.S. 274, 281-82 (1998) (citing Meritor Sav. Bank, FSB v. Vinson, 477 U.S. 57 (1986) (Title VII case)).

[192] *Cf.* Johnson et al., *supra* note 135, at 269-71 (making similar argument for menstruation).

[193] *Transgender Sex Equality*, *supra* note 61, at 93.

[194] *Id.*

[195] *Id.*

[196] *See* Hossain, *supra* note 22, at 193-94; *e.g.*, Susan Salanger, *I Spoke to Over 40 Women About Their Medical Experiences. They Offered a Disturbing Warning.*, Huffington Post (July 2, 2022, at 07:00 AM), https://www.huffpost.com/entry/women-medical-experiences-poor-care_n_62b36883e4b0cf43c85f446e [https://perma.cc/EX3E-P5M8] (suggesting some women "take too passive a role with their doctors, perhaps from a culturized reluctance to challenge authority").

[197] Kristina Marusic, *People Still Believe Women Belong in the Kitchen and Men Belong at the Office*, Women's Health (Mar. 10, 2016, at 1:42 PM), https://www.womenshealthmag.com/life/a19934409/gender-stereotypes-study/ [https://perma.cc/DF62-2U9Z].

[198] *See supra* Section IV.A for discussion of potential real differences.

[199] *Price Waterhouse*, 490 U.S. at 251-52.

[200] See generally Kerri Lynn Stone, *Taking in Strays: A Critique of the Stray Comment Doctrine in Employment Discrimination Law*, 77 Mo. L. Rev. 149 (2012), for a critique of how "stray remarks" is too high of a bar for plaintiffs.

[201] Carr, *supra* note 77 (noting doctors may not even mention the possibility of pain); *see also* Nudson, *supra* note 1.

Doe v. Independent Blue Cross[202] exemplifies the strengths and weaknesses of the anti-stereotyping model. In this case, Jane Doe, a transgender woman, sued her insurance company for denying coverage of her gender-affirming facial reconstruction.[203] The insurance company denied coverage on the grounds that Doe's face was within the "broad range of normal for the female gender."[204] The district court held that "a reasonable jury could find that [the insurance company] relied on gender stereotyping language in denying Doe coverage," so the court ruled for Doe, saying "summary judgment [for the defendant wa]s inappropriate" at that time.[205]

Stereotyping theory allowed the *Blue Cross* court to identify sex discrimination,[206] but the claim worked because Doe's facts avoided anti-stereotyping pitfalls. Transgender individuals,[207]—by their very existence in a sex and gender-essentialist society—challenge the stereotypical gender binary.[208] Therefore, Doe—as a woman who defies the traditional societal stereotype of what it means to be a woman—was able to leverage a stereotype theory. Doe also possessed evidence of specific stereotyping remarks connected to the harm she suffered, enabling her to meet the evidentiary requirements of anti-stereotyping.[209] Many women harmed by sex discrimination in pain management will be unable to demonstrate that they defy stereotypes or will struggle to produce evidence of stereotyping.

C. Substantive Equality

Finally, there is the substantive equality approach to the pain gap. The substantive model centers the hierarchy of "dominance and subordination."[210]

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[202] 2024 WL 233216 (E.D. Pa. Jan. 22, 2024).

[203] *Id.* at *1.

[204] *Id.* at *1-2.

[205] *Id.* at *2.

[206] *Id.*

[207] The Supreme Court has recently shown hostility to trans rights, in particular, trans healthcare rights. *E.g.*, United States v. Skrmetti, 145 S. Ct. 1816, 1832 (2025) (rejecting argument that youth gender affirming care ban was sex-based and rejecting suspect-class status for transgender individuals). *Skrmetti*'s harm might be cabinable. *E.g.*, *id.* (emphasizing that the legislation at issue was youth-focused); Katie Eyer, *The Limits of Anti-Classification Doctrine in U.S. v. Skrmetti*, Regul. Rev. (July 14, 2025), https://www.theregreview.org/2025/07/14/eyer-the-limits-of-anti-classification-doctrine-in-u-s-v-skrmetti/ [https://perma.cc/XF9M-32UU] (suggesting holding might be limited to gender-affirming care). But it is important for litigators to keep this recent backslide of trans rights in mind while advocating within the current landscape.

[208] *See, e.g.*, EEOC v. R.G. &. G.R. Harris Funeral Homes, Inc., 884 F.3d 560, 576 (6th Cir. 2018), *aff'd sub nom*; Bostock v. Clayton County, 590 U.S. 644 (2020) ("[A]n employer cannot discriminate on the basis of transgender status without imposing its stereotypical notions of how sexual organs and gender identity ought to align."); *see generally* Alexandra R. Johnson, Note, *Curious Continuity: How Bostock Preserves Sex-Stereotyping Doctrine*, 23 Dukeminier Awards J. 235, § I.A (2024) (providing an overview of LGBT sex stereotyping theory and case law).

[209] Doe v. Indep. Blue Cross, 2024 WL 233216, at *1 (E.D. Pa. Jan. 22, 2024).

[210] *Substantive Equality*, *supra* note 58, at 118.

Its "goal is to legally confront real social inequalities and conditions in order to end them."[211] The substantive equality theory identifies inequality by assessing the group-based, "social relation of rank ordering" as "higher and lower, more and less, top and bottom, better and worse, clean and dirty, served and serving, appropriately rich and appropriately poor, superior and inferior, dominant and subordinate, justly forceful and rightly violated or victimized, commanding and obeying . . . ."[212] In contrast to formal equality, substantive equality does not blindly require identical treatment for all groups; instead, it requires an approach that considers and remedies existing hierarchy to ensure equality.[213]

A substantive equality approach to the pain gap would consider how pain management disparities arise out of gender hierarchy conditions,[214] namely via the objectification of women,[215] devaluation of women's lives,[216] destruction of women's credibility,[217] eroticization of power,[218] and denial of resources.[219] Substantive equality identifies how the pain management gap arises out of this larger social context, where women's suffering is normalized and sexualized; women are seen as objects intended to be tortured.[220] As Professor Catharine MacKinnon has argued, "at the core of misogyny is the notion that women are born masochists who naturally desire to be forced into sex."[221] The pain gap is born from the misogynistic assumption that women are meant to experience forced pain.[222] Additionally, the substantive equality approach considers how failing to provide adequate pain management for women's healthcare generates concrete harms.[223] Failing to provide

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[211] *Id.* at 119.

[212] *A Perspective*, *supra* note 131, at 11.

[213] *See id.* at 11.

[214] *See* Sex Equality, *supra* note 56, at 35 (noting substantive equality "is predicated on history," meaning it considers historical inequalities).

[215] *Compare Substantive Equality*, *supra* note 58 at 119 (identifying dehumanization as inequality), *with supra* Part I. (exploring how the othering of Black people, in part by claiming they did not feel pain, was used to maintain slavery).

[216] *Compare Substantive Equality*, *supra* note 58, at 119 (identifying "second-class" status as inequality), *with supra* Section II.A. (arguing inadequate pain management signals that women are subordinate to men).

[217] *Compare Sex Equality*, *supra* note 56, at 877 (explaining common trope of lying women), with *supra* Section II.A. (arguing women are treated as liars in pain management).

[218] *Compare* Feminist Theory, *supra* note 57, at 130 (arguing female submission is eroticized under conditions of gender hierarchy), with *supra* Section II.A. (comparing denial of pain management to rape).

[219] *Compare Substantive Equality*, *supra* note 58, at 119 (identifying denial of resources as element of inequality), *with* Hossain, *supra* note 22, at 54-63 (arguing that the systemic failure to direct resources towards researching women's health contributes to the medical pain gap), *and* Burlock, *supra* note 33 ("Women's health is underfunded and understudied.").

[220] *See Rape Redefined*, *supra* note 72, at 459-61.

[221] *Id.* at 461.

[222] *Id.*

[223] *See Substantive Equality*, *supra* note 58, at 119 (stating substantive equality focuses on "concrete" harm).

women with sufficient pain management supports male dominance in its "denigration, humiliation, disregard, [and/or] degradation" of women based on their status as women.[224] Refusing to believe women and dismissing their pain as insignificant[225] labels women "as less than human, less than a full member of society, a second-class citizen."[226] Inadequate pain management tortures women, potentially leading to their deaths.[227] Substantive equality appreciates these harms and understands that systems of power[228]—such as gender, race, and class—impact the treatment of women in the medical system.[229] Substantive equality identifies pain management practices as impermissible discrimination by considering how they arise out of and sustain female subordination.

Substantive equality avoids the flaws of formal equality and anti-stereotyping. In contrast to formal equality, substantive equality is not abstract, arbitrary, or indeterminate.[230] While formal equality can overly erase differences, substantive equality considers relevant, real differences.[231] Unlike the sex stereotyping approach, the substantive equality model is group-based and is not limited to protecting non-stereotypical individuals.[232] Substantive equality avoids difficult evidentiary issues like the wrongdoer's "intent" because it does not begin by assuming that the world is equal.[233] Formalist equality and anti-stereotyping both struggle to adequately address intersectionality.[234] But substantive equality fundamentally considers how hierarchies interact by acknowledging that all women, substantively, are members of multiple groups, many of which are disadvantaged and marginalized.[235] Accounting for multiple axes of discrimination is critical given how

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[224] *See id.*

[225] *See supra* Part I.

[226] *Substantive Equality*, *supra* note 58, at 119.

[227] *See supra* Section II.B.

[228] *Cf. Rape Redefined*, *supra* note 72, at 442 (arguing that a substantive equality approach to rape law would consider how various systems of power impact women's ability to say no to sex they do not want).

[229] Nudson, *supra* note 1.

[230] *See Substantive Equality*, *supra* note 58, at 119 (contrasting the concreteness of substantive equality with formalist abstractness); *A Perspective*, *supra* note 131, at 5 (critiquing formal equality's indeterminateness).

[231] *Substantive Equality*, *supra* note 58, at 112 ("You always have to say, we are really the same as you, when in fact the very things that make one 'different' in their terms are what make one 'unequal' in our terms.").

[232] *Transgender Sex Equality*, *supra* note 61, at 93.

[233] *A Perspective*, *supra* note 131, at 8.

[234] Kimberlé Crenshaw, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics*, 1989 U. Chi. Legal F. 139, 140, 156 (critiquing formal equality (i.e., the "single-axis" approach) and anti-stereotyping for failing to account for Black women).

[235] *Substantive Equality*, *supra* note 58, at 121 (noting how intersecting hierarchies are substantive).

gendered medical disparities interact with racist, ableist, classist, homophobic, and transphobic hierarchies.[236]

1. Addressing Religion Claims

Substantive equality is also better equipped to deal with § 1557's religious challenges. The Religious Freedom Restoration Act ("RFRA")[237] presents a potential obstacle for a § 1557 pain gap claim. However, this obstacle is limited and may be overcome. RFRA has been used several times to limit § 1557 and the ACA more broadly, with objections raised to gender-affirming care and contraception.[238] Yet, RFRA does not apply to many pain gap claims: For example, religious objections to procedures like mammograms appear to be rare.[239] Even where RFRA claims could be raised, such claims would object to the procedure itself, not the pain management. A party might conceivably claim a religious objection to contraception like an IUD,[240] but the issue in that claim is whether the IUD should be provided in the first place. It seems unlikely that one would argue their religion supports sadistic insertion, or the belief that if an IUD is inserted, the procedure should hurt. The issue theorized here is what pain management methods medical professionals utilize when the procedures *do* take place.

Furthermore, a substantive equality approach would not allow a religious argument to overcome the sex equality concerns at issue.[241] Substantive equality theory would consider how "all too often women's rights give way

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[236] Hossain, *supra* note 22, at 55-56 ("'[T]he American healthcare system does not value all lives equally . . . . It is a system that values white, male, wealthy, straight, cisgender, able-bodied, neurotypical individuals above all others.'") (quoting mental health advocate Melody Moezzi).

[237] 42 U.S.C. § 2000bb–1.

[238] *E.g.*, Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682, 736 (2014) (contraception); Florida v. Dept. Health & Hum. Servs., No. 8:24-cv-1080-WFJ-TGW (M.D. Fla. July 3, 2024) (gender affirming care).

[239] *Cf.* Benedikt Kretzler, Hans-Helmut König, Linéa Brandt, Helene Rabea Weiss, & André Hajek, *Religious Denomination, Religiosity, Religious Attendance, and Cancer Prevention. A Systematic Review*, 15 Risk Mgmt. & Healthcare Pol'y 45, 45, 54 (2022) (finding that religious denomination and religiosity did not clearly link uptake of mammograms). Some studies have suggested that Muslim women may be less likely to pursue mammograms, but this seems to be less about objections to the procedure itself, and more about a failure of the medical establishment to accommodate those individuals. Aasim I. Padela, Milkie Vu, Hadiyah Muhammad, Farha Marfani, Saleha Mallick, Monica Peek, & Michael T. Quinn, *Religious Beliefs and Mammography Intention: Findings from a Qualitative Study of a Diverse Group of American Muslim Women*, 25 Psycho-Oncology 1175, 1175, 1179-80 (2016) (noting Muslim women are less likely in the United States to get mammograms, but suggesting they may be more likely to get the scans if they could ensure a female doctor).

[240] *Cf. Burwell*, 573 U.S. at 701-02 (featuring RFRA objection to IUDs). Denying IUD access is its own equality problem. *See* Elizabeth Sepper, *Gendering Corporate Conscience*, 38 Harv. J. L. & Gender 193, 208-12 (2015) (identifying sex equality issues in *Burwell*).

[241] *See* Sepper, *supra* note 240, at 212 (identifying sex equality issues in *Burwell*).

in the face of religious justifications for sex discrimination."[242] A substantive equality analysis would prevent courts from "neglect[ing] the gendered effects of their decisions and the gendered assumptions in their analysis," which have overwhelmingly occurred in the absence of substantive equality arguments.[243]

2. The Challenge of Arguing Substantive Equality in the United States

The greatest obstacle for a substantive equality theory is that the American legal system generally operates with formal equality principles.[244] American case law has been dominated by the formalist principles of *Geduldig*,[245] but substantive equality logic has made brief appearances in American jurisprudence. For example, the United States Supreme Court in *United States v. Virginia (VMI)*[246] held that sex classifications that "create or perpetuate the legal, social, and economic inferiority of women" violate the Equal Protection Clause.[247] The Court's opinion focused on hierarchy, i.e., substantive equality.[248] *VMI* is the most substantive Supreme Court case,[249] but other opinions also employ some substantive methodology. In *California Federal Savings & Loan Association v. Guerra*,[250] Justice Marshall considered the realities[251] of pregnancy discrimination in determining that Title VII[252] prohibits adverse treatment of pregnancy. There, the Court permitted a pregnancy-only unpaid leave provision, enabling women to have children and keep their jobs as men do.[253] And the Court's holding in *Loving v. Virginia*[254] struck down a state ban on interracial marriage in the name of condemning "White Supremacy."[255] By focusing on hierarchical reality

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[242] Karima Bennoune, *The Law of the Republic Versus the 'Law of Brothers:' A Story of France's Law Banning Religious Symbols in Public Schools*, *in* Human Rights Advocacy Stories 178 (Deena R. Hurwitz et al. eds., 2009).

[243] Sepper, *supra* note 240, at 212.

[244] *Substantive Equality*, *supra* note 58, at 111.

[245] *See* Dobbs v. Jackson Women's Health Org., 597 U.S. 215, 216 (2022) (citing Geduldig v. Aiello, 417 U.S. 484, 496 n. 20 (1974)).

[246] 518 U.S. 515 (1996).

[247] *Id.* at 534.

[248] Catharine A. MacKinnon, *A Love Letter to Ruth Bader Ginsburg*, 31 Women's Rts. L. Rep. 177, 182-83 (2010) (identifying substantive elements in decisions like *VMI*).

[249] *Cf. id.* (arguing that Justice Ginsburg applied substance in decisions like *VMI*, not pure gender neutrality).

[250] 479 U.S. 272 (1987).

[251] *See, e.g.*, *id.* at 289 (identifying pregnancy as a "social phenomenon" that disadvantages women economically and in the workforce (quoting Gen. Elec. Co. v. Gilbert, 429 U.S. 125, 159 (1976) (Brennan & Marshall, JJ., dissenting), *superseded by statute*, Pregnancy Discrimination Act, Pub. L. No. 95-555, 92 Stat. 2076 (1978), 42 U.S.C. § 2000e(k))).

[252] As amended by the Pregnancy Discrimination Act. 42 U.S.C. § 2000e(k).

[253] *Cal. Fed.*, 479 U.S. at 280.

[254] 388 U.S. 1 (1967).

[255] *Id.* at 7; *see A Perspective*, *supra* note 131, at 3 ("[T]he substance of the statute was recognized in *Loving* . . . .").

and social systems of power, these opinions employed substantive equality thinking.[256] The logic of these cases can be extended to the pain gap: Failure to provide adequate pain management traps women in inferiority and stems from the experimentation on enslaved women that was rooted in white supremacy.[257] Though these cases remain the exception in the United States, the substantive equality model has gained ground elsewhere, most notably in Canada.[258] Applications of substantive thinking, both at home and abroad, demonstrate the feasibility of a substantive equality model, and cases from American courts provide precedential hooks for arguing a substantive equality theory.

But should a pain management claim be brought under a substantive equality model if formalist thinking is so predominant? Formal equality and anti-stereotyping have had their legal successes, but they have also repeatedly failed women in law and in reality.[259] Applying these theories in the context of the pain management gap could very well fail women again,[260] whether through formal equality failing to see sameness in the face of different anatomy, or anti-stereotyping limiting its protection to only some women who are outliers.[261] Arguing for equality under logic structures that assume

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[256] *See* Sex Equality, *supra* note 56, at 35.

[257] *See supra* Part I.

[258] *A Perspective*, *supra* note 131, at 10 (citing Andrews v. Law Society of British Columbia, [1989] 1 S.C.R. 143 (Can.)). While it is true that the United States Supreme Court is often described as having "adamant opposition . . . to the citation of foreign law," ignoring the success of substantive equality in foreign jurisdictions would be a misguided. Although not common, there have been civil rights cases in the United States that cite to foreign and international law. Adam Liptak, *U.S. Court Is Now Guiding Fewer Nations*, N.Y. Times (Sep. 17, 2008), https://www.nytimes.com/2008/09/18/us/18legal.html [https://perma.cc/XZX8-U5BL] (citing Roper v. Simmons, 543 U.S. 551 (2005); Lawrence v. Texas, 539 U.S. 558 (2003)). Professor Mark Tushnet, referring to the work of Professor Vicki Jackson, claims "the US Supreme Court has a long tradition of referring to non-US law in interpreting the US Constitution." Mark Tushnet, *The* Charter*'s Influence Around the World*, 50 Osgoode Hall L.J. 527, 543 (citing Vicki C. Jackson, Constitutional Engagement in a Transnational Era, at ch. 4 (2010)). Experts have described the United States's focus on domestic cases as a mistake that limits the impact of American jurisprudence, stunts growth, and undermines international democratic progress. *Id.* Several former Supreme Court Justices, including Sandra Day O'Connor and Ruth Bader Ginsberg have argued that foreign law should at least be given notice, even if it is not binding. Liptak, *supra*. The fact that substantive equality has been adopted in Canada—a country with historically close ties to the United States and a jurisdiction that is considered one of the most influential constitutional law regimes in the world—means it is especially prudent to note this adoption. Justin Ling, *The Long History of U.S.-Canada War Plans*, Foreign Pol'y (May 9, 2025, at 3:00 PM), https://foreignpolicy.com/2025/05/09/plans-canada-war-trump/ [https://perma.cc/9MMT-U96E] ("For the past century, the United States and Canada have been the best of friends . . . ."); *see* Tushnet, *supra* note 258, at 529 (arguing Canada has supplanted the United States for constitutional law influence).

[259] *A Perspective*, *supra* note 131, at 15-16 (providing examples); *see also Transgender Sex Equality*, *supra* note 61, at 92-93; Crenshaw, *supra* note 234, at 140, 155-56.

[260] *See, e.g.*, Dobbs v. Jackson Women's Health Org., 597 U.S. 215, 236 (2022) (claiming "regulation of abortion is not a sex-based classification," and "[t]he regulation of a medical procedure that only one sex can undergo does not trigger heightened constitutional scrutiny").

[261] *See* discussion *supra* Section IV.B.

and support women's subordination is not in the best interest of women.[262] It entrenches the unequal status quo.[263] Few cases have been litigated under § 1557, seemingly none of which argue discriminatory pain management in women's healthcare. This absence creates an opportunity: Since § 1557 jurisprudence is a relatively nascent area of law, advocates can build case law based on ambitious, feminist arguments that seriously contemplate women's unequal reality rather than attempting to apply existing, flawed antidiscrimination doctrine that has never truly reflected women's unequal situation, despite many tries. Pessimists can argue that substantive equality "can't win and won't work," so "don't try. The law isn't for [women]."[264] But it seems unproductive to give up before even trying.[265] The inadequacy of pain management for women's healthcare is an inequality problem. It seems prudent to "recogniz[e] substance—the reality of inequality—as what it is."[266]

In fact, the District Court for Minnesota applied substantive equality to § 1557 in *Rumble v. Fairview Health Services*.[267] Jakob Tiarnan Rumble, a transgender man, went to the hospital in severe pain with a fever and inflamed genitals.[268] He was repeatedly met with hostility, misgendered, and dismissed.[269] When a doctor finally saw Rumble, the doctor made degrading sexual comments while "forcefully jab[bing]" his fingers into Rumble's genitals, even as Rumble cried and begged the doctor to stop.[270] In finding that Rumble had pleaded sufficient facts to survive the hospital's motion to dismiss the § 1557 claim,[271] the court analyzed hierarchy:

> Generally, the two parties in a doctor-patient relationship are not on equal footing, as a doctor normally has significantly more experience and expertise in his position of authority. . . . When any individual permits a doctor to conduct a genital exam, the patient is in a physically vulnerable position, which the doctor controls.[272]

In emphasizing authority and vulnerability, the *Rumble* court considered how power influenced the facts. *Rumble* could have more explicitly addressed the role *gender* hierarchy played in this interaction—a male

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[262] *See Substantive Equality*, *supra* note 58, at 124.
[263] *Id.* at 115.
[264] *Id.* at 125.
[265] *Id.*
[266] *A Perspective*, *supra* note 131, at 27.
[267] 2015 WL 1197415 (D. Minn. Mar. 16, 2015).
[268] *Id.* at *2-5.
[269] *Id.*
[270] *Id.* at *4-5.
[271] *Id.* at *17.
[272] *Id.* at *16.

doctor violently inspecting a transgender man's labia.[273] But the opinion still made substantial progress in identifying that "inequality" relies on "the social relation of rank ordering."[274] *Rumble* demonstrates that a substantive equality § 1557 claim is possible.

IUD insertion is perhaps the paradigmatic example of the pain gap.[275] While the facts in *Rumble* raise distinct issues, particularly in the marginalization of trans people,[276] there are parallels to be drawn. When Molly Hill went to get her IUD inserted, she was told "it would be uncomfortable, but she was not prepared for 'horrific' pain."[277] Hill begged her doctor to stop the procedure, crying and screaming for it to stop, but the doctor continued anyway, saying, "We're almost done."[278] Hill was traumatized by the pain and felt deeply violated by the experience.[279] Hill and Rumble were both put through horrific pain at the hands of their doctors, even as they begged their doctors to stop. Their doctors proceeded despite their pleas. These patients were vulnerable—not only because of their gender identities, but also because of their positions as patients who had to give doctors intimate access to their bodies for medical purposes. Mirroring the substantive equality logic of *Rumble*, it should be possible to assert an impactful pain gap claim under § 1557.

Conclusion

The field of medicine is plagued by a pain gap inflicted on women. Procedures intended for female bodies do not involve adequate pain management, and this lack of pain management is a sex inequality problem. The pain gap does not originate from women's bodies; it arises from gender hierarchy—attitudes and practices that predicate social stratification on allegedly natural conditions—and generates harm by violating women, threatening their health, and compromising public health.

Discrimination law offers a potential path forward. Section 1557 can be used to argue that the pain gap constitutes discrimination on the basis of sex. Substantive equality offers a strong legal theory on which to base this argument, avoiding the drawbacks of alternative, somewhat antiquated theories

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[273] See generally Esperanza Fonseca, *A Socialist, Feminist, and Transgender Analysis of "Sex Work,"* Medium (July 27, 2020), https://proletarianfeminist.medium.com/a-socialist-feminist-and-transgender-analysis-of-sex-work-b08aaf1ee4ab [https://perma.cc/8UKM-KQ7H] for discussion of sexual violence against trans people.

[274] *A Perspective*, *supra* note 131, at 11.

[275] Bever, *supra* note 9.

[276] *See generally The Struggle of Trans and Gender-Diverse Persons*, United Nations Hum. Rts., https://www.ohchr.org/en/special-procedures/ie-sexual-orientation-and-gender-identity/struggle-trans-and-gender-diverse-persons [https://perma.cc/5QY8-VN9L] (overviewing the particular discrimination trans people face).

[277] Bever, *supra* note 9.

[278] *Id.*

[279] *Id.*

like formal equality and anti-stereotyping. Advocates could attempt to bring § 1557 pain gap claims, building this doctrine in the courts. Litigating these cases has the potential to improve the lives of female patients, motivate medical professionals to develop new treatment options, and strengthen our public health infrastructure. It is past time to end the misogynistic pain gap. Women deserve better.