The Artemis

The Journal of the Association of PAs in Ob-Gyn

ISSUE 10 • SPRING • 2025

Mission

The Artemis is the peer-reviewed clinical journal of the Association for PAs in Obstetrics and Gynecology (APAOG). Its mission is to support the advancement of PAs by publishing current information and research on clinical, health policy, and professional issues for PAs in obstetrics, gynecology, sexual, and reproductive health subspecialties across the lifespan. We honor the variation of expression of gender and sex across the spectrum and will continue to create an inclusive space.

Cervical Cancer Screenings Inaccuracies Based on Minnesota Community Measures

Brittany A. Strelow, DMSc, P.A.-C., M.S. & Danielle J. O' Laughlin, P.A.-C., M.S

Affiliations: Division of Community and Internal Medicine, Geriatrics, and Palliative Medicine; Mayo Clinic Physician Assistant Program, Mayo Clinic, Rochester, MN

Abstract

To provide comprehensive and quality patient care, health care institutions, primary care teams, and providers use metrics to ensure preventative health services are met. To adequately meet patient care needs, these metrics must be readily available, updated frequently, and easy to act on. If the metrics are not accurate this can lead to patient confusion, decreased trust, and hesitancy to perform preventative health measures.

The Minnesota Community Measurement's Detailed Report-Cervical Cancer Screening found that the average cervical cancer screening rate for all medical groups in Minnesota was 75%. A large Midwest medical institution measured below average at 65%, and the Internal Medicine (IM) division reported lower rates at 60%. Our preliminary study was to determine if the non-complaint rates were accurate within the electronic health record (EHR).

Of the 2,083 women aged 50-65 identified in the IM department and MN Community Measures identified as overdue for cervical cancer screenings, only 736 were accurately eligible in the EHR

In analysis of the data, we found inaccuracies in the EHR included, how documentation of the hysterectomy type was done, discrepancy in the documentation of outside records, and health modifiers for prior abnormal pap smears to be the cause of most of the incorrect data.

Our initial cervical cancer screening rate in women ages 50-65 based on MN Community Measures was 49.8% (2066/4149). Following a review of EHR and fixing electronic discrepancies, our cervical cancer screening rate in this age group improved to 82.2% (3413/4149).

continued on next page

Introduction

To provide comprehensive and quality patient care, health care institutions, primary care teams, and providers use metrics to ensure preventative health services are met. Metrics are often provided through the electronic health record (EHR), or local, state, or national registries. Primary care teams analyze preventative health services to ensure high-quality health care is provided. To adequately meet patient care needs, these metrics must be readily available, updated frequently, and easy to act on.

Care teams have used individual, care team, quality improvement, and research efforts to find new and innovative ways to make preventative health measures understandable and obtainable. To do this, the metrics must be accurate. If the metrics are not accurate this can lead to patient confusion, decreased trust, and hesitancy to perform preventative health measures.

Cervical cancer screening, a preventative health measure aimed to detect early cervical cancer in hopes of preventing complications and death, is recommended for women in the United States with a cervix between the ages of 21 and 65.

The Minnesota (MN) Community Measurement's Detailed Report—Cervical Cancer Screening found that the average cervical cancer screening rate for all medical groups in MN was 75%. At our institution we measured below average at 65%.

According to these measures, the internal medicine (IM) department at a large Midwest medical institution had a 60% cervical cancer screening rate which fell below the goal of 82%. 2,083 out of 4,149 patients, ages 50-65, had the highest overdue rates. Our preliminary study was to determine whether the MN Community Measures overdue rates for IM were accurate based on the EHR.

Methods

Study Design: A retrospective study used EHR and MN Community Measures data. The study aimed to identify women who had not completed cervical cancer screening, focusing on identifying any women who may have been misclassified as needing cervical cancer screening.

Study Population: Women aged 21-65 eligible for cervical cancer screening were identified within the IM department, which resulted in 43,213 individuals eligible for cervical cancer screening based on MN Community Measures. Of these, 19,746 did not have cervical cancer screening completed. Age ranges identified showed women aged 50-65 yielded the highest number of women overdue for cervical cancer screening. This age range of 50-65 was further analyzed, identifying 2,083 women not having cervical cancer screening completed. Women were excluded who were not eligible for cervical cancer screening, on an alternate screening schedule due to a previous abnormal Pap smear result, had a history of hysterectomy, and/or permission for chart review denied.

Data Collection: Data collection was performed through a retrospective chart review within the EHR. If the patient health modifier was accurate, it was noted in the EHR. The following additional information was collected on each patient to identify discrepancies: prior hysterectomy status and pap smear results.

Data Analysis: The collected data was analyzed to identify any discrepancies in patients showing they had not completed cervical cancer screening.

Results

Of the 2,083 IM women aged 50-65 identified as overdue for cervical cancer screening according to the MN Community Measures, only 736 were accurately eligible in the EHR. The MN Community Measures misidentified 1,347 individuals as needing cervical cancer screening.

In reviewing the MN Community Measures and our EHR, six trends were identified in the data (Figure 1).

Trend 1: 438/2083 (21%) both the health modifier (HM) and the MN Community Measures correctly identified patients as up to date on cervical cancer screening.

Trend 2: 948/2083 (45%) HM showed they had completed cervical cancer screening; MN Community Measures showed they had not. Therefore, they are not due for cervical cancer screening.

Trend 3: 408/2083 (20%) HM showed they had not completed cervical cancer screening (frequency of pap smears not accurate in the EHR); MN Community Measures said they had completed. Therefore, the patient was due for cervical cancer screening.

Trend 4: 33/2083 (2%) both the HM and MN Community Measures showed they were overdue.

Trend 5: 176/2083 (8%) both the HM and MN community Measures showed that cervical cancer screening did not apply. Therefore, the patient was exempt from cervical cancer screening.

Trend 6: 80/2083 (4%) both the HM and MN Community Measures were unknown; therefore, there was no indication for cervical cancer screening.

continued on next page

Results Continued...

We further analyzed the data to determine what discrepancies were causing the data to be inaccurate. We looked at whether a hysterectomy had been done to see if this was contributing to errors in the EHR regarding cervical cancer screening requirements. Of those who were identified as needing cervical cancer screening, 201 were found in the EHR to have had a prior hysterectomy and 25 were found in review of billing data to have had a prior hysterectomy. Thirty-one individuals were found to have abnormal pap smears in the EHR, and 12 in review of billing data showed abnormal pap smear.

Our initial cervical cancer screening rate in women ages 50-65 based on MN Community Measures was 49.8% (2066/4149). Following a review of EHR and fixing electronic discrepancies, our cervical cancer screening rate in this age group improved to 82.2% (3413/4149).

Discussion

MN Community Measures of overdue cervical cancer screening rates were inaccurate in the EHR. A variation of hysterectomy codes was being used in review of the EHR. Some codes being used showed patients still had a cervix and needed cervical cancer screening; however, in reviewing surgical notes, it was identified these were inaccurate. Patients populated correctly into the MN Community Measures once the EHR was updated with the correct hysterectomy. Patients with outside records of cervical cancer screening were updated in the record. Patients with abnormal pap smears were identified and had their health modifier updated to ensure they continued to get screenings at appropriate times based on their history.

IM now has a cumulative cervical cancer screening rate of 82.26% for ages 50-65 after accounting for discrepancies. Our goals of achieving more accurate records and higher screening percentages was accomplished. Additional work needs to be done to rectify and have the correct patient identified to have cervical cancer screening completed.

References

1. *Cervical Cancer Screening Reference 2017 [PDF]. (n.d.). Mayo Clinic*
2. *Detailed Report – Cervical Cancer Screening. (n.d.). Retrieved from http://www.mnhealthscores.org/medical-group-measure-detail/cervical-cancer-screening/#/results*
3. *Final Recommendation Statement: Cervical Cancer: Screening. (n.d.). Retrieved from https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/cervical-cancer-screening*
4. *HPV-Associated Cancer Statistics | CDC. (n.d.). Retrieved from https://www.cdc.gov/cancer/hpv/statistics/index.htm*
5. *Inside Knowledge About Gynecologic Cancer. (n.d.). Retrieved from https://www.cdc.gov/cancer/knowledge/provider-education/cervical/recommendations.htm*
6. *Berseth, D. E., Blair, D., Bruxvoort, K. R., Gehrig, P. S., Gullickson, P. R., Helland, D., LaBudde, D. L.,. Storlie, K. A. (2015). Improvement in rate of Cervical Cancer Screening Rates in Bloomer/Colfax Clinics. Unpublished Manuscript.*
7. *Chaundhry, R., Gibbons, L. E., MacLaughlin, K. L., Rahman, P. A., & Stroebel, R. J. (2010). Improving Cervical Cancer Screening in a Primary Care Practice Using a Population Informatics-Based System. Unpublished Manuscript.*
8. *Adlin-Barnard, M. S., Akfaly, A., Berkseth, L., Byrd, J. D., Cosiquien, J., Cosiquien, R., Driggs, K. L.,. Woldum, L. A. (2015). Cervical Cancer Screening Improvement- NWWI. Unpublished Manuscript.*

Ethics Statement: Patient consent for publication: Not required

Ethics Approval: This study does not involve human participants

Contributors All authors contributed equally.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests: None declared

Provenance and peer review Not commissioned; externally peer reviewed.

Addressing Pain Associated with IUD Insertions: Current Practice and a Future Direction

Heather Mills, PA-S

Introduction

Despite being one of the most effective forms of birth control with over a 99% efficacy rate intrauterine devices (IUDs) remain underutilized, with only 14.3% of reproductive-age patients worldwide choosing intrauterine contraception.[1-3] The American College of Obstetrics and Gynecology (ACOG) and the American Academy of Pediatrics (AAP) advocate for IUDs as first-line contraception for all reproductive-aged individuals.[2] Given this, why are more patients not taking advantage of the peace of mind that comes with this long-acting contraceptive?

Pain and fear of pain with insertion is the largest barrier to increasing the use of IUDs.[1,2,4-6] Lack of patient education also contributes to the negative perceptions surrounding IUD insertions. By improving contraceptive education for our patient populations, addressing issues of fear and anxiety, and providing positive experiences during insertions, the stigma associated with IUDs can be reduced, ultimately leading to more women being protected from unwanted or unplanned pregnancies.

The IUD Insertion Process and Factors Associated with Pain

IUD insertion begins by performing a speculum exam to assess for evidence of active genital infections. If the exam is benign with a normal appearing cervix, then the general procedure involves cervical stabilization with a single toothed tenaculum, uterine sounding, and IUD placement through the cervical os. While the procedure is brief, significant pain and discomfort can be experienced during the process, with the highest reported pain levels occurring during the placement of the tenaculum, uterine sounding, and/or insertion of the IUD.[1,2]

Several factors have been found to play a role in the amount of pain experienced during IUD insertions. These include nulliparity, higher levels of education, no history of vaginal deliveries, and a history of dysmenorrhea.[2] Arguably the biggest factor in pain experienced with IUD insertions is nulliparity or never having a vaginal delivery.[1, 7] Studies that have evaluated pain scores between nulliparous vs multiparous women have shown lower pain scores in multiparous women.[1] Women with higher levels of anticipated pain before insertion are more likely to experience greater pain during IUD insertion.[4,5] Hunter, et al. found patients with previous vaginal or gynecological exams, previous or current sexual activity, previous or current pregnancy, or history of sexually transmitted infections did not predict higher levels of anticipated pain.4 The key to decreasing experienced pain during IUD insertions may be to identify patients with higher anticipated pain and educating them about the procedure.[4] It has been reported that providers performing the insertion underestimate levels of pain by half compared to the experienced pain of the patient.[7]

Hunter, et al. categorized those with an anticipated pain score of less than the median of 63 on a Visual Analog Scale (VAS) of 0-100 as having low anticipated pain and those with a score of 63 or greater as having high anticipated pain.[4] Participants aged 14-17 had an average anticipated pain score of 69, indicating high anticipated pain, whereas older participants, 18-22, had an average anticipated pain score of 59, indicating low anticipated pain.[4] While this was not reported as statistically significant in their research, it is still noteworthy to consider additional means of pain control and education to reduce anticipated and experienced pain in this population. Higher anticipated pain before the procedure predicted actual experienced pain at every step of the insertion process amongst women of all ages included in the study.[4]

The only statistically significant predictor of higher levels of anticipated pain identified by Hunter, et al. was higher levels of anticipated pain in black women compared to white women.[4] Black women reported an average score of 68 for anticipated pain while white women had an average score of 51.4 The significant difference in pain score between races was not believed to be biologically based, but rather related to the lived experiences of black women within the health care system. Black women experience higher rates of maternal and fetal mortality during childbirth and encounter higher rates of sexually transmitted diseases. [4] Another cause for higher levels of anticipated pain in black and Hispanic women stems from an increased rate of adverse childhood events compared to white women that may carry a mental and physical toll through to adulthood. [4] Research has shown there is an overall underreporting of pain in minority groups, which contributes to inadequately treated pain during gynecologic procedures.[4]

continued on next page

Pharmacological Tools for Decreasing Pain

Multiple pharmacologic and non-pharmacologic methods have been evaluated to reduce pain; however, no single method has consistently proven its efficacy over time.[2,5,8] The most common methods cited in literature and utilized in clinical practice include the use of oral nonsteroidal anti-inflammatory drugs (NSAIDs) before the procedure, various types and routes of anesthetics like lidocaine, as well as timing insertion up with menstruation, when the cervix is already somewhat dilated.[1, 2, 5]

De Oliveria, et al. conducted a randomized study comparing the effects of 550 mg of oral naproxen taken 30 minutes before the procedure to a 6 mL, 2% lidocaine intracervical block administered five minutes before the procedure.[2] Women who received 550 mg naproxen reported statistically significant higher pain scores overall and naproxen was found to be the least effective in reducing pain during placement of the tenaculum.[2] Prophylactic administration of 800 mg of ibuprofen has also been shown to be ineffective in reducing pain throughout the procedure.[7] Another oral medication that has been used for pain control is tramadol. A 50-mg dose of tramadol has been proven to reduce VAS pain scores during and immediately after IUD insertion.[5] However, routine use of tramadol has been discouraged in recent years due to its narcotic properties and addiction concerns.[5] Intramuscular ketorolac (Toradol) given before the procedure, lowered pain scores 15 minutes after the procedure but provided no relief during insertion.[7]

Various forms of anesthetics have also been studied for reducing pain. Lidocaine is favored for its numbing effects and excellent safety profile. One of the most effective options for reducing pain during placement of the tenaculum, as well as during and after IUD insertion, is topical lidocaine-prilocaine (EMLA cream), which is applied directly to the cervix.[1, 2, 5, 7] The cream reportedly helps with the most painful steps of the procedure: tenaculum placement, uterine sounding, and IUD insertion.[7] De Oliveria, et al reported the study group that received the intracervical block reported lower pain scores.[2,6] However, current evidence does not support routine use of blocks for IUD insertions due to accessibility of providers trained in this approach and inserting the block itself would cause patients pain.[2, 8] The effectiveness of 10% topical lidocaine spray is also noteworthy. In a double-blind study compared to a control group, four puffs of 10% lidocaine spray had statistically significant lower pain scores during the most painful steps of the procedure listed above.[1,5] After application of the lidocaine spray, a three-minute waiting period was required for the lidocaine to take effect. Studies referenced in this review experimented with varying waiting times before starting procedure, and also found significantly lower pain scores.[1] Mepivacaine, a local anesthetic closely related to lidocaine, reported statistically significant lower pain scores and an overall more pleasant experience compared to placebo in a study of nulliparous patients.[8] A pilot study by Envall, et al. used 1% mepivacaine paracervical block with positive effects, with a repeat study where an increased mepivacaine concentration to 2% was used with further reductions in pain. These studies provide supporting evidence that manipulation of dosage and/or concentration with non-oral routes can affect the level of pain control achieved.

Non-Pharmacological Tools for Decreasing Pain

Unfortunately, non-pharmacological pain reduction interventions are scarce and have limited supporting data. Strategies like timing insertion with the menstrual cycle, inhaling lavender, and use of nitrous oxide gas have not shown significant reductions in pain.[5] Using a "slow" placement method reported an average pain score of 44 during placement of the tenaculum, compared to a score of 32 with the cough method, where the patient coughs as the provider places the tenaculum.[7] Ultrasound-guided IUD insertion is an optional technique for women with a mispositioned cervix or uterus or when assistance with cervical dilation is needed.[9] Compared to blind insertions, ultrasound guidance has been shown to reduce procedure time, significantly lower patient-reported pain scores, and improve overall patient experience.[9,10] Despite these benefits, it is not currently the standard of care, and not all providers are trained or have access to this method.

Research has shown that inhaling lavender before the procedure can significantly decrease anxiety, although it does not show a statistically significant reduction in pain.[5] Playing music is a strategy that has also been studied with women in labor and suggests it may be an effective approach for decreasing pain and anxiety with gynecological procedures.[5] Counseling on the effectiveness of IUDs, the insertion and removal process, risks, benefits, effects on menstruation and fertility serves as another important strategy for decreasing anxiety.[4]

Future Direction

For IUDs to be properly placed, the uterus, cervix, and vaginal canal must be aligned. This is accomplished most often using a single-tooth cervical tenaculum attached to the cervix to allow for traction, which is known to cause bleeding and is one of the more painful steps of the procedure.[6] As a result of this, a new suction device has been developed to stabilize the cervix during IUD insertions, minimizing physical trauma and pain associated with a traditional tenaculum (Figure 1).[6] Yaron, et al. found a 94% success rate for IUD insertions with the suction device. Both groups had three participants whose insertions failed due to anatomical issues.[6] The suction device group reported statistically significant lower pain scores compared to the control group during the cervical grasping and traction stages.[7] Nulliparous women showed the greatest difference in pain scores between the two groups and experienced less pain with the suction cervical stabilizer. Parous women reported lower pain scores than nulliparous women overall.[6]

continued on next page

The suction device did have 18 spontaneous releases of the 48 subjects and some with multiple releases required switching to the single tooth tenaculum.[6] This study was conducted early in the development of the device and issues with the prototype were considered when finalizing the design. Overall, the satisfaction rates among both providers and patients were nearly unanimous, with the suction device group reporting higher satisfaction compared to the control group. There were several mild adverse effects that occurred in the suction device group. These included difficulty removing the suction device in a timely manner, causing bruising and bleeding, one vasovagal reaction due to multiple spontaneous releases, and leg numbness which they attributed to the vasovagal reaction.[6] Occurrences of bleeding were statistically significantly lower in the suction group compared to the control group, where 89% suction stabilizer group had no bleeding compared to only 40% not bleeding with the tenaculum control.[6] Ecchymosis occurred more frequently in the suction group and was contributed to a flaw in the prototype. No further studies have yet been reported on the outcomes of the improvements since the prototype, with results from a recent clinical trial at Indiana University completed in April 2024 still pending.[11] The suction device, known in clinical use as Carevix©, may be a promising option for women, especially nulliparous, to have a more pleasant experience with IUD insertions and other gynecological procedures in the future. Currently the device is cleared by the US Food and Drug Administration (FDA) but not widely available at the time of this article being written.

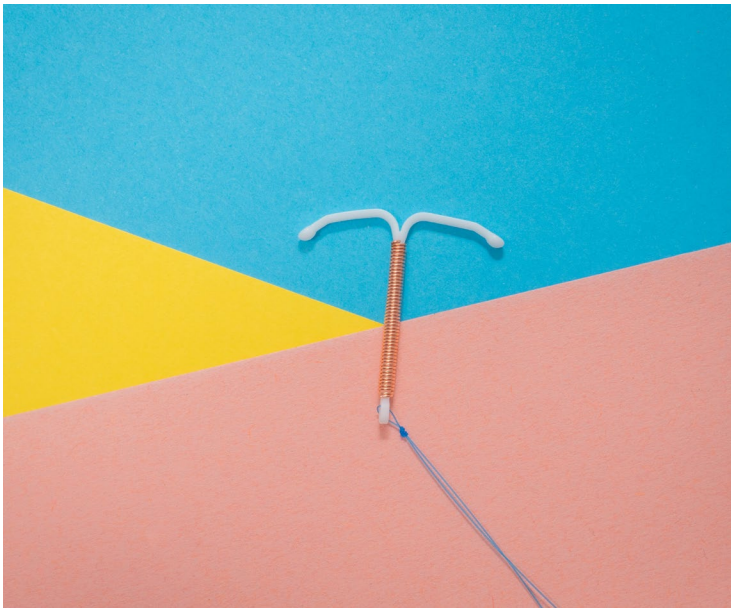
Conclusion

Multiple approaches have been evaluated for pain control during IUD insertions, but no single method has consistently proven to be the standard of care. Oral NSAIDs such as ibuprofen and naproxen are not effective during insertion but may help with post-procedural discomfort. Local anesthetics like lidocaine sprays and creams have demonstrated benefit, particularly during the most painful steps. Non-pharmacologic tools alone are less effective apart from ultrasound guided IUD insertions. Combining non-pharmacological with pharmacological options, such as using the cough method with a local cervical anesthetic, may enhance outcomes. [7] The suction cervical stabilizer (Carevix©) has shown early promise as an alternative to the tenaculum, offering lower pain scores and fewer complications. As these tools evolve and become more available, improving patient education and pain control may reduce barriers to IUD use and ultimately prevent more unplanned pregnancies

condition, its incidence is likely underreported due to misdiagnosis or lack of patients seeking care.[6] Although the exact cause of this disease is unknown, various agents have been discussed as possible perpetrators. Chronic irritation of the female anogenital region should be avoided.[11] Given the correlation between LS and autoimmune conditions, it may be beneficial to study whether symptoms of LS improve with the treatment of the comorbidity. Further research is needed to determine the exact cause of lichen sclerosus to provide information on how to avoid these agents. Until the causes can be identified, medical professionals should focus on screening and diagnosing lichen sclerosus in symptomatic and asymptomatic patients to initiate early treatment.

References

1. *Panichyawat N, Mongkornthong T, Wongwananuruk T, Sirimai K. 10% lidocaine spray for pain control during intrauterine device insertion: A randomised, double-blind, placebo-controlled trial. BMJ Sexual & Reproductive Health. 2020;47(3):159-165. doi:10.1136/bmjsrh-2020-200670*
2. *de Oliveira ECF, Baêta T, Brant APC, Silva-Filho A, Rocha ALL. Use of naproxen versus intracervical block for pain control during the 52-mg levonorgestrel-releasing intrauterine system insertion in young women: a multivariate analysis of a randomized controlled trial. BMC Womens Health. 2021;21(1):377. Published 2021 Oct 29. doi:10.1186/s12905-021-01521-z*
3. *Yacobson I, Wanga V, Ahmed K, et al. Clinical outcomes of intrauterine device insertions by newly trained providers: The echo trial experience. Contraception: X. 2023;5:100092. doi:10.1016/j.conx.2023.100092*
4. *Hunter TA, Sonalkar S, Schreiber CA, Perriera LK, Sammel MD, Akers AY. Anticipated pain during intrauterine device insertion. Journal of Pediatric and Adolescent Gynecology. 2020;33(1):27-32. doi:10.1016/j.jpag.2019.09.007*
5. *Nguyen L, Lamarche L, Lennox R, et al. Strategies to mitigate anxiety and pain in intrauterine device insertion: A systematic review. Journal of Obstetrics and Gynaecology Canada. 2020;42(9). doi:10.1016/j.jogc.2019.09.014*
6. *Yaron M, Legardeur H, Barcellini B, Akhoundova F, Mathevet P. Safety and efficacy of a suction cervical stabilizer for intrauterine contraceptive device insertion: Results from a randomized, controlled study. Contraception. 2023;123:110004. doi:10.1016/j.contraception.2023.110004*
7. *Rahman M, King C, Saikaly R, et al. Differing Approaches to Pain Management for Intrauterine Device Insertion and Maintenance: A Scoping Review. Cureus. 2024;16(3):e55785. Published 2024 Mar 8. doi:10.7759/cureus.55785*
8. *Envall, Niklas et al. Mepivacaine instillation for pain reduction during intrauterine device placement in nulliparous women: a double-blinded randomized trial. American Journal of Obstetrics & Gynecology, 2024;231(5), doi.org/10.1016/j.ajog.2024.05.038*
9. *Lisa L. Bayer, et al. Best practices for reducing pain associated with intrauterine device placement. American Journal of Obstetrics and Gynecology, 2025. https://doi.org/10.1016/j.ajog.2025.01.039.*
10. *Ahmed M. Abdelraheem, et al. Efficacy and Safety of Ultrasound Guided versus Blind Technique for Office Insertion of Intrauterine Contraceptive Device in Women with Previous Cesarean Section; A Randomized Controlled Clinical Trial. Journal of Evidence-Based Women's Health Society, Published 2024 April 30. doi:10.21608/ebwhj.2024.275927.1312*
11. *ClinicalTrials.gov. A randomized, single-blinded, multicenter study comparing the efficacy and safety of CAREVIX™ cervical stabilizer vs. tenaculum. Updated March 7, 2024. Accessed March 17, 2025. https://clinicaltrials.gov/study/NCT06193590*



continued on next page

Renew Your Membership for 2025!

It's time to renew your APAOG membership in order to keep access to your members benefits. Current members can login to our website and renew online. If you need assistance, please reach out to our office. Don't forget, members receive a discounted price when registering for the annual conference.

Join APAOG Today!

APAOG is the professional association representing Obstetrics and Gynecologic (OBGYN) Physician Associates in the United States. We support PAs practicing obstetrics, gynecology, and all its subspecialties by advancing the role of PAs to serve our patients throughout their lifespan. We provide a network to better engage on various topics and serve our community better. Our priority is to promote equitable care through education, research, advocacy, inclusivity, and leadership.

A glimpse into what is included...

- Free on-demand CME webinars to educate professionals on current healthcare needs and advancements.
- Board and committee leadership opportunities for professional growth.
- User friendly website that includes current news, provider FAQ, clinical resources and so much more.
- Career Center with resources (such as resume review) and job postings for new and current professionals.
- Members-only forum for discussion on any topic of interest.

Membership Categories

The membership year runs from January through December.
Dues are not prorated.

Fellow • Fellow 3-Year • Affiliate • Associate • Student • Group

ACOG Discount Membership Offer

The American College of Obstetricians and Gynecologists needs your help to provide a strong voice for the specialty. Join APAOG as a Fellow, Associate or Affiliate member and reap the benefits of ACOG! Upon joining or renewing with APAOG, you will be able to join ACOG at the discounted rate.

APAOG PODCAST

We welcome you to listen to the APAOG Podcast. The shows' host and creator, Morgan Bechtle has successful produced three full season with the fourth season launched in May 2025. Morgan will explore the science and practice of medicine as it relates to women's health in the past, present, and future. In this series, we'll break down the most common conditions seen in practice, as well as those covered on the PANCE/PANRE. You'll hear first-hand accounts from practicing PA's, NPs, and OBGYNs. And we'll go back in time to hear the stories of individuals who have contributed so much to improving the lives of women and shaping the field into what it is today. So whether you are a PA student looking to ace your women's health EOR or a practicing PA who wants to review the top WH conditions in preparation for the PANRE, or simply someone wanting to learn more about the ins and outs of women's health, this is the podcast for.

2025 EPISODES

LISTEN HERE

PODCAST ARCHIVE

PROVIDE FEEDBACK

Op Ed: Infertility is a Medical Condition, Not a Lifestyle Choice

Taylor Betheil, PA-S, Kean University

Infertility is not a decision- it's a medical condition. However, millions of couples are denied access to fertility treatments because of the exorbitant costs. It's time for insurance companies to step up and cover these essential services.

Infertility Is a Medical Condition

Infertility is not a choice. Conditions such as polycystic ovary syndrome, endometriosis, premature ovarian failure, and male factor infertility are just a few of the medical diagnoses that can prevent conception. Furthermore, cancer treatments, autoimmune disorders, and genetic conditions can also lead to infertility, making the need for medical intervention unavoidable for many.

Unlike other serious medical conditions, infertility is often excluded from standard insurance coverage. This leaves patients to face the financial burden alone, perpetuating the damaging misconception that seeking medical help to conceive is optional. While infertility may not be life-threatening, the psychological toll it takes can be. Would anyone suggest that treating diabetes, heart disease, or cancer is a matter of personal choice? Why is infertility treated so differently?

A Call to Action

Infertility is a disease, not a privilege. Denying medical care based on outdated perceptions of fertility treatments as "elective" is both unjust and harmful. We must demand change through policy reform, expanded insurance coverage, and increased awareness to ensure that everyone, regardless of income, has a fair chance at building a family. Parenthood should never be a luxury, and it's time we start treating it as the fundamental human right that it is.

ASSOCIATION OF
PHYSICIAN ASSOCIATES IN
OBSTETRICS & GYNECOLOGY

Contact Us

563 Carter Court
Suite B
Kimberly, WI 54136

Phone: 920-560-5620 /
800-545-0636

Fax: 920-882-3655

Email: APAOG@badgerbay.co

Follow Us

Quick Links

- Prenatal Care Workshop
- PA Practice
- Career Center
- Member Forum
- Events Calendar
- Students Center
- Member Benefits
- APAOG Website

Board of Directors

Adrianna Kiafoulis, DMSc, MSPAS, PA-C,
President, AAPA HOD Rep

Melanie Lucks, MMS, PA-C, *Immediate Past-President*

Nancy Vanaphan, MS, DMSc, PA-C, *Vice President*

Rachel Galanos, PA-C, *Secretary*

Mari Chadwick, DMSc, MPAP, PA-C, *Treasurer*

Alannah Zheng, MSPA, PA-C, CLC, *Director-At-Large*

Julia M. Burkhardt, MS, PA-C, *Director-At-Large*

Jennifer Carson, PA-S1, *Student Representative*

Alexandra Klinkowski, PA-S, *Student Representative*

Committee Chairs

Melissa Rodriguez, DMSc, PA-C,
Education Co-Chair (Conference Planning)

Ester Avero, MCMSc, PA-C, *Education/ Professional Practice*

Mariah Leroux, MHS, PA-C, *Public Relations*

Nisha McKenzie, PA-C, *Membership*

Morgan Bechtle, PA-C, *Publications Co-Chair (Podcast)*

Heather Adams, MPAS, PA-C, DFAAPA,
Publications Co-Chair (Artemis)

Submit an Article for our Summer 2025 Issue!

Fellow PAs,

The Artemis was created in 2022 by APAOG and has successfully released ten quarterly journals thus far. The goal for Artemis is to encourage scholarly work for PAs in ob-gyn and provide support for them to grow their skill and confidence. Therefore, we accept a variety of submissions, including, but not limited to, student capstone projects, art/poems, case reports, and clinical anecdotes. We understand that other journal articles have a rigorous submission process and therefore aim to be inclusive towards all types of authors. If you are interested in submitting an article for the next release, you can find more information on our website: www.apaog.org/Authors-and-Info. In addition, please always feel welcome to reach out to our office with any questions at APAOG@badgerbay.co.

We look forward to hearing from you!

Adrianna Kiafoulis, DMSc, MSPAS, PA-C