The Artemis

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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.

President's Message, Op Ed

Melissa Rodriguez,
DMSc, PA-C

Welcome to the first-ever Journal for the Association for PAs in Obstetrics and Gynecology (APAOG). We are delighted to support Obstetrics and Gynecology (OBGYN) PAs' academic and clinical pursuits and those planning to enter the field. Our profession has grown since the 1960s, and we need to find ways to adapt and continue to provide the best medical care with increased autonomy and dedication. We also need to evolve in providing leadership, mentorship, and administrative support to our practicing PAs, PA students, and pre-PAs. Thankfully, as our profession evolves, we can see the need for appropriately trained PAs to care for women, fill clinical shortages throughout the country, and improve patient outcomes. We are blessed to have the training, knowledge, and versatility to provide that care.

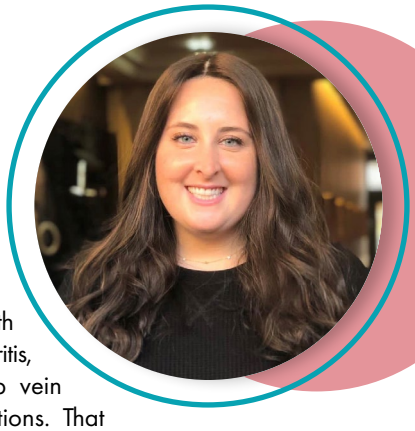
Despite their robust training in all medical and surgical care components, we must address and resolve inappropriate barriers to PAs wanting to practice in obstetrics, gynecology, and their subspecialties. These barriers are unnecessary as they create turf wars that are impractical and only impact access to care for women in all geographical settings. We must persevere to provide the necessary care throughout women's lifespans to improve their health. There are provider shortages throughout our nation, shortage projections of 22,000 OB/GYN physicians by 2030, and an ever-increasing shortage of midwives who provide care to a low-risk obstetric population. PAs can fill the void and improve the health of our women.

We understand it takes a multi-pronged approach to tackle our barriers. We will provide the necessary education, documents, and support to achieve our goals, but it takes a village, our village. Let's pool our resources, do our part, and open the doors for all PAs. Artemis is the opportunity to publish research, show our worth, and share our knowledge and experience. Let's do this together. APAOG is the only organization supporting PAs in all fields of obstetrics, gynecology, and their subspecialties. We will continue collaborating with other women's health organizations to improve the overall health of our patients. Let's show our support, experience, worth, and value to women.

Melissa Rodriguez, DMSc, PA-C

The PA Perspective

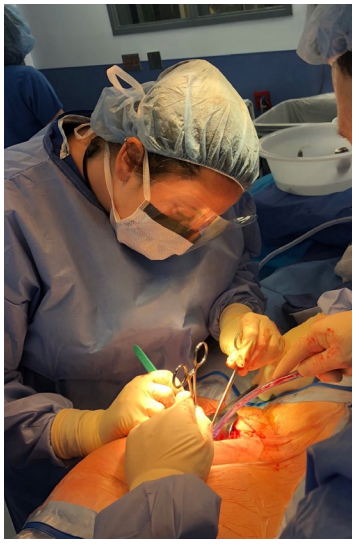
Melanie Jacobs,
MMS, PA-C

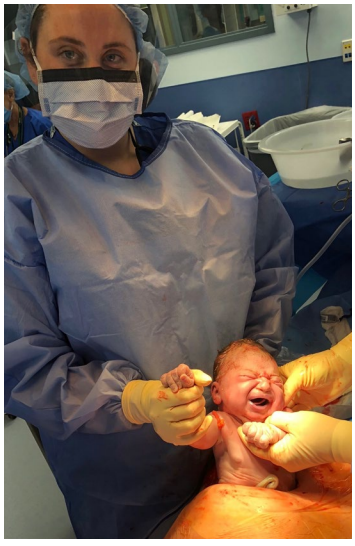


Working as a PA on the labor and delivery floor of a 1,000+ bed tertiary care teaching facility is often busy and exciting, and sometimes challenging! I decided to specialize in Obstetrics and Gynecology to provide care for women, specifically throughout pregnancy, as it can be a vulnerable and impactful time in their lives. One aspect of my current job includes treating women during the intrapartum period. As such, I triage patients, evaluate them throughout various stages of labor, perform vaginal and cesarean deliveries, and manage postpartum complications.

On a typical weekday there are around 4-6 scheduled cesarean delivery cases. I arrive at work at 6:30am and admit the first scheduled case for the day. From there I go directly to the daily morning "sign out." Signout starts with some form of learning or lecture at 7:00am. This varies depending on the weekday: Monday is journal club, Tuesday is maternal fetal medicine (high risk obstetrics) lecture, Thursday is electronic fetal heart tracing rounds, and Friday is another journal review. Wednesdays are unique, as there are department grand rounds and the residents have didactics until midday, therefore 2-3 PAs exclusively run the labor floor until they return. Overall, the learning lasts about 30 minutes and then the night team thoroughly signs out the patients to the day team.

The labor and delivery unit I work on has 15 labor, 3 triage bays and 4 antepartum beds, as well as 3 full service operating rooms and a PACU all on the same floor. After we finish the sign out, the trajectory of the day all depends on what patients present and who is laboring on the floor. The daily tasks range from seeing patients in triage to co-managing patients labor to being in the operating room. When it comes to triaging patients, the PAs play a key part in seeing and assessing the patients. Most common presenting complaints are in term or preterm labor, ruptured membranes and/or vaginal bleeding and hypertensive disorders in pregnancy. Evaluations include performing sterile vaginal exams, pelvic speculum exams, and obstetric bedside ultrasounds. Very often pregnant patients also present for non-obstetric complaints and I evaluate and diagnose patients with asthma exacerbations, gastroenteritis, cholecystitis, nephrolithiasis, deep vein thrombosis and urinary tract infections. That is a unique part of my job, I work in a specialized field of medicine however I also may encounter and manage patients for a wide range of disorders and illnesses unrelated to pregnancy.





The care center I work for has a full resident teaching program and on any given day the labor floor is managed by three residents, 2-3 PAs, multiple attendings, and a certified nurse midwife. In addition to seeing patients in a triage setting, as a PA I also aid in the management of labor. This includes performing cervical exams, placing cervical ripening balloons, intrauterine pressure catheters, fetal scalp electrodes, and performing vaginal deliveries. I help push with the patients, deliver the babies, and suture to repair any vaginal or perineal lacerations. Oftentimes we manage patients who have high risk complicated pregnancies and may have to evaluate patients for postpartum hemorrhage, chorioamnionitis/endometritis, or postoperative wound infections. I may be in the operating room for 2-3 cesarean sections in one day or it may be less frequent. It all depends on the amount of patients and floor staff on that day.

I personally appreciate the full service of care that PAs provide on the labor and delivery floor and that we are very hands-on providers. Ultimately every day brings a unique set of patients, cases and hands-on learning. As a PA in this role, I have a wide scope of practice and am utilizing advanced clinical skills to care for these women. I believe my job is comprehensive, hands-on and personally rewarding. I recognize many PAs in Ob/Gyn work in the outpatient gynecologic setting and there are less job opportunities for obstetric inpatient PAs, as such I am very grateful for my current work and job role and appreciate the unique opportunity I have.

Melanie Jacobs, MMS, PA-C

Melanie Jacobs, MMS, PA-C is currently an inpatient PA specializing in Obstetrics and Gynecology at Mount Sinai Hospital in New York City. She works on labor and delivery, as well as the gynecology and gynecology oncology service teams. Melanie is a graduate from the Wake Forest University School of Medicine PA Program. She received a Bachelor of Science degree from the University of Michigan in Biopsychology and Cognitive Neuroscience, and originally became interested in women's health while working as a medical assistant at a holistic gynecology practice in Ann Arbor, Michigan. Melanie currently serves as the Secretary for the Association of Physician Assistants in Obstetrics and Gynecology (APAOG) and the Director of Publicity for Physician Assistants for Global Health (PAGH). She also sits on the Medical Advisory Board for The Mansaray Foundation, an non-profit organization dedicated to reducing maternal mortality and morbidity in Sierra Leone, Africa.

Inclusivity in Healthcare

Sexual Orientation and Gender Identity Inclusivity: Foundational Considerations

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Abstract

This article discusses foundational knowledge relevant to clinically practicing and administrative P.A.s responsible for the sexual and reproductive health care of sexual and gender minority (SGM) patients across the lifespan. It is a selected introduction to the topic, with applicability in obstetrics and gynecology, adolescent medicine, family medicine, internal medicine, rural health, emergency medicine, urology, plastic surgery, urgent care, and subspecialty GYN oncology and surgery.

Introduction

The health needs of the SGM population were assumed to be similar to the cisgender and heterosexual population until the 1980s when the landmark National Lesbian Health Care Survey (NLHCS) first cited health disparities among cisgender, sexual minority women.1 The U.S. Department of Health and Human Services and associated federal agencies now include sexual orientation and gender identity (SOGI) in their public health efforts,2-4 and there is a growing, relevant body of data to inform clinical practice.4,5

Even with the availability of clinically relevant information, studies have found limited education and training on SGM health received by medical professional students.6 Licensed medical professionals continue to express a lack of preparation and discomfort caring for SGM patients, and SGM health disparities remain.6,7 In 2015, 98.1% of P.A. programs reported teaching nonjudgmental history-taking regarding same-sex relationships. Up to 41% did not address transgender health, 38% either did not cover SGM health topics or covered them only slightly well, and 46% felt SGM health topics were not important or only somewhat important.8 A survey of SGM people found that 90% would disclose their SOGI to their healthcare provider. However, 80% of providers surveyed stated it would be inappropriate and uncomfortable to ask about a patient's sexual orientation or gender identity.9 Thirty years after the first NLHCS, PA education standards began requiring accredited programs to prepare their graduates to care for patients with consideration of SOGI and social determinants of health (SDOH).10 As lifelong learners, P.A.s who graduated prior to this accreditation standard taking effect may rely on articles, such as this one, to support their practice.

Who are sexual and gender minorities?

Sexual and gender minority populations are defined by SOGI and, in some circumstances, gender expression (SOGIE).11 However, popular culture employs different definitions from science-based terminology. P.A.s and others in science-based professions are expected to understand what is and what is not a science-based construct. SGM communities are heterogeneous. Taking an intersectional perspective allows recognition of the interrelated influence of SOGI, race, ethnicity, age, socioeconomic status, religiosity, national origin, kinship networks, dis/ability, and geographic location.12 Gender minorities are found in all fifty states and the District of Columbia. Sexual minorities are found in 99% of counties throughout the United States.13

Sexual Diversity

"The world is not to be divided into sheep and goats. Not all things are black, nor all things white. It is a fundamental principle of taxonomy that nature rarely deals with discrete categories. Only the human mind invents categories and tries to force facts into separated pigeon-holes. The living world is a continuum in each and every one of its aspects. The sooner we learn this concerning human sexual behavior the sooner we shall reach a sound understanding of the realities of sex."14 (Kinsey et al., 1948)

Sexual orientation is not a measurable construct. It is a descriptive term that represents three distinct and interrelated concepts: sexual attraction, sexual behavior, and sexual identity (sometimes referred to as sexual orientation identity). In the vernacular of popular culture, sexual orientation is used as a proxy for sexual identity, and other times as a proxy for sexual behavior. There is incomplete concordance between attraction, behavior, and identity, reflected by the incidence/prevalence noted in Tables 1, 2, and 3 [TABLE 1, TABLE 2, TABLE 3]. To illustrate incomplete concordance, studies have found:15

- Among sexually active women who report ever having sexual activity with women, 52.6% identified as straight, 28.3% bisexual, and 19.1% lesbian.16
- Among sexually active women who reported sexual activity with women in the past year, 23.5% identified as straight, 42% identified as bisexual, and 46% identified as lesbian. 16
- 77-91% of lesbian-identified women report ever having a male sexual partner.15
- 8% of lesbian-identified women report having sex with a male sexual partner in the previous year.16

For context,

- 73% of men who reported sexual activity with men identified as heterosexual (more likely to be foreign-born, married, racial and ethnic minority, and lower SES)
- 9.4% of men who identified as heterosexual had had sex with a man in the previous year (more likely to be a racial and ethnic minority, of lower socioeconomic status, foreign-born, and not use a condom).17

Gender Diversity

"Unfortunately, nature seems unaware of our intellectual need for convenience and unity, and very often takes delight in complication and diversity."18 (Santiago Ramón Y Cajal, Nobel lecture, 1906)

Gender identity is an innate sense of self that may be congruent or incongruent with designated sex at birth (DSAB), sometimes referred to as assigned sex at birth (ASAB).11 World Health Organization's International Classification of Diseases 11th Revision (ICD-11) characterizes gender incongruence as an insistent, consistent, and persistent incongruence between an individual's experienced gender and designated sex.19 Transgender is a descriptor for gender identity or expression that is discordant with DSAB, while cisgender describes concordance between gender identity and DSAB.20

In 2013, the American Psychiatric Association affirmed the longstanding opinion of the World Professional Association for Transgender Health, that gender diversity is a "common and culturally-diverse human phenomenon [that] should not be judged as inherently pathological or negative" while removing gender identity disorder from the DSM-5.21,22 In 2019, the World Health Organization introduced gender incongruence in the ICD-11 to ensure that access to care continued while removing the classification from the section on mental disorders to underscore that gender diversity is not psychopathology.19 Although diagnostic and classification criteria in the DSM-5 (gender dysphoria) and ICD-11 (gender incongruence) vary, both demonstrate that gender diversity is a variation in human identity and that gender nonconformity is not in itself a mental disorder. 19,23,24

The prevalence of gender diversity is estimated at 25 million people worldwide.25 This is likely a gross under-estimation, although direct study methods have been field-tested for inclusion in national public health surveys.15 However, the U.S. is a restrictive environment, and the form taken by sex and gender results from whether the environment is permissive or repressive.26 In the U.S., 0.73% (149,750) adolescents and 0.6% (1.4 million) adults are estimated to be transgender,27 while 4% of secondary school children in New Zealand report a gender identity as something other than their DSAB.28

Gender identity develops as early as 2-4 years of age, but it may occur at any stage of life.29 82.6% of transgender adults in the U.S. were aware that they "felt different" from their DSAB before 12 years of age. Most transgender adults surveyed report expressing their gender in hiding during childhood - for example, cross-dressing in private and noting profound psychological pain and suffering associated with the lack of affirmation.30

Sex

Sex noted within the medical record may reflect legal sex - as found on identity documents which may be amended, or the sex the patient's health insurance has on file as a way to avoid rejection of insurance claims. Both are relevant in the care of gender-diverse patients, as is designated sex at birth (DSAB). Some electronic health records allow all three of these variables to be documented.15

Why is SOGI important?

All patients want their medical providers to deliver high-quality, patient-centered healthcare communicated in a respectful and affirming manner.31,32 However, SGM adults are less likely to access care and more likely to delay care (LGB 29%, T 30%) than cisgender, heterosexual adults (17%).33 SGMs report increased expectations of provider bias and discrimination, and reports of verbal harassment, physical or sexual assault with greater incidence noted among SGM people of color and people with disabilities. The resulting delay in access to care causes SGM patients to be diagnosed at later and thus more deadly stages of illness and disease34. In addition, when providers employ the philosophy of "treating all patients the same" and apply the dominant cisgender and heterosexual paradigm to all patients including SGM patients, the result may be an incorrect assumption of risk that contributes to disparate health outcomes.31,32,34

When does SOGI matter?

In addition to enhancing patient-PA rapport, allowing patients to have their SOGI affirmed during the clinical encounter is essential to patient-centered sexual and reproductive health care.12,34

Patient Assessment

History taking

Addressing patients with inclusive and affirming language is foundational to providing patient-centered care to SGM patients. To approach your patient with cultural humility, consider adding your pronouns to your introduction, and ask your patient how they would like to be addressed to allow for disclosure of chosen name and pronouns (i.e., I'm the OB/GYN PA, Jane Doe, my pronouns are she/they. How would you like to be addressed?)Gender-neutral language is an appropriate interim solution prior to your patient's disclosures. For example, replacing husband/wife with spouse, son/daughter with child, penis/vagina with genitals.35

In one study, 7% of sexual minorities and 36% of gender minorities have preferred terms for their anatomy. Most commonly in male and N.B., AFAB patients, breast was replaced with chest, penis was replaced with dick, and vagina was replaced with front hole. Often, replacement phrases were used by one individual (e.g., replaced vagina with coin purse). 36

Patient Intake

Electronic health records that meet meaningful use criteria will have

fields for patient SOGI in addition to sex.15,37,38 There may also be fields for chosen names and pronouns.

A common approach within the patient intake involves asking patients to define their gender as male, female, or transgender. This approach is not recommended as it will fail to identify two-thirds of transgender patients whose gender identity is male and female. Best practices for patient intake involve asking two separate questions and contrasting them - gender identity and designated sex at birth - and may result in over 60% more identification of transgender patients from the single question approach.15 In a nationwide study of P.A.s, 37.2% reported their patient intake utilized the best practice, two-question approach.39

Before initiating history taking, begin by reinforcing the patient's right for topics including SOGI to be discussed confidentially and timed whenever the patient would like. Confidentiality is particularly important to adolescent patients who may come from a restrictive family environment where disclosure could put them at risk. LGBT youth represent <10% of the population and represent 40% of homeless youth. The P.A. needs to be explicit that appropriate medical care, education/counseling, and anticipatory guidance are most effective when patient-centered.40

Avoid using DSAB as a proxy for a patient's reproductive and sexual anatomy in transgender patients and patients born with differences of sexual development known as intersex conditions. Instead, the best practice is to conduct an organ inventory within the past medical and surgical history.41

Consider affirming adolescent patients' sexual attraction and gender identity. In addition to enhancing patient-P.A. rapport, this information is essential to provide appropriate patient-centered sexual and reproductive health care, education, and counseling prior to the debut of sexual activity. Sexual minority adolescents experience a 2-7 times greater incidence of unplanned pregnancies,42 and young transgender women of color experience a greater incidence of HIV acquisition.12

Clinical Documentation

As the scientific community's understanding of sex and gender gains nuance, new ways of communicating those complexities are necessary. Employing the best practice two-question approach to gender identity and DSAB is also effective in documentation and case presentations. To illustrate, Jane Doe may be referred to as a 21-year-old female, assigned male at birth, or AMAB. This approach also allows for a N.B. identity, such as John Doe is a 21-year-old N.B., AMAB who uses they/them pronouns.15

How to improve your practice

Prior to introducing system-level SOGI demographic data collection in electronic health records (EHR), health outcomes and patient satisfaction of SGM patients were mainly captured in research and were otherwise invisible to inform the practice improvement of individual administrators and providers. At the Institute of Medicine and the Joint Commission's recommendation,15,35 SOGI data collection was added to the EHR meaningful use criteria in 2015.37,38 Inclusion of SOGI demographic data collection in the EHR moved SGM health into quality improvement metrics and allows administrators and clinicians to identify areas for practice improvement and merit-based incentive payment systems. Quality measures such as Press Ganey patient satisfaction survey now include variables on sexual orientation and gender identity.43

Individualized quality improvement opportunities are available to assist P.A.s in improving their professional practices involving SGM patients. On such AAPA-accredited CME is Outside the Box that provides P.A.s with 40 category 1 CME credits. This performance improvement CME involves reviewing ten random charts, answering a few simple questions to identify where practice can be improved, and then changing that professional practice behavior using educational tools provided.39

Conclusion

"Knowing is not enough; we must apply. Willing is not enough; we must do." (Goethe)

Two professional practices that are foundational to providing patient-centered care are attaining clarity in science-based terminology about SOGI and addressing patients with inclusive and affirming language.

The field of SGM health is developing more quickly than ever before. To illustrate: the CDC recently assessed their public health surveillance systems' data collection on SOGI in disease notification, periodic prevalence surveys, and registry/vital records,2 and the U.S. Preventive Services Task Force recently published a commitment to updated methods differentiating anatomy, DSAB, and gender identity, allowing for recognition of sex and gender in evidence-based recommendations.44

Future articles will address the applicability and relevance of SOGI to clinical decision-making in sexual and reproductive health.

Resources

1. *American Academy of Nephrology PAs. QI-CME for P.A.s* http://aanpa.org/outsidethebox.html
2. *LBGT PA Caucus* www.lbgtpa.org
3. *World Professional Association of Transgender Health (WPATH).* www.wpath.org
4. *Gay and Lesbian Medical Assocation.* www.glma.org
5. *National LGBT Cancer Network* www.cancer-network.org
6. *Transgender Fertility* https://transfertility.co/

Table 1. % of U.S. adults by sexual orientation identity45

Sexual orientation identity	% U.S. adults
straight	86.9%
gay/lesbian	2.0%
bisexual	7.5%
Something else	3.6%

Table 2. % of U.S. adults by same-sex sexual activity45

Sexual Activity (same-sex)	% among men*	% among women*
Lifetime	7.3%	20.8%
Within the last 12 months	3.2%	5.9%

**Note that this citation does not account for nonbinary.*

Table 3. % of U.S. adults by sexual attraction45

Sexual Attraction	% among men*	% among women*
Only opposite sex	76.8%	90.6%
Mostly opposite sex	14.2%	4.7%
Equally to both	4.8%	1.1%
Mostly same sex	1.4%	0.8%
Only same sex	1.5%	1.9%
Not sure	1.3%	0.9%

Source of Tables: Special tabulation by National Center for Health Statistics, CDC. National Survey of Family Growth. Published Nov 8, 202

Table 4. Best and Promising Practices

- Allow patients to disclose their sexual identity and use the 2-question approach during patient intake by collecting gender identity and designated sex at birth
- Introduce yourself to the patient with your chosen pronouns and ask how the patient would like to be addressed
- When initiating patient assessment, start by reinforcing the patient's right to confidentiality and your willingness to discuss topics including SOGI whenever the patient would like
- Rather than using DSAB as proxy for anatomy, conduct an organ inventory within the past medical history
- Ask patients what genders their sexual partners are, instead of asking if they're sexually active with men, women, or both
- Query adolescent patients about sexual attraction to inform anticipatory guidance
- After vaginoplasty, keep in mind cancers associated with the donor tissue (e.g., sigmoid colon, peritoneum, and penile skin)46

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Clinical Pearls

The Patient Encounter

Melissa Rodriguez,
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What does it matter whether I stand by a patient or sit by them? It turns out that patient perception of provider attention, quality, and engagement is highly effected by how we approach them. Several studies have documented the effect of standing versus sitting with patients, including a recent assessment by Merel et al.1 As most PAs learn, we can better connect with our patients if we remove the pretentious barriers of titles, formal names, and behaviors. We are taught to identify ourselves by first name to remove that barrier of formality. Additionally, there is a power struggle that occurs during visits. A patient is vulnerable, sitting in a poorly fitting gown, on an uncomfortable bed or examination table, and expecting to have her privacy shattered. Imagine, in comes the medical provider, well-dressed, with a crisp white coat, and towering over her. She is expected to confide in this provider but she barely wants to speak. And so she doesn't. Instead, she nods her head and agrees to the comments, although internally she knows she will not take the medications or advice. This is not the kind of care we PAs provide. We sit, we listen, we make them feel comfortable enough to share their goals and what they are wiling to try. Our most important role is to provide patient care, not provider dictated care. Therefore, take a seat, create a comfortable atmosphere, and provide the best care possible.

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En Caul

Why I Practice in Women's Health

Julie Grandinetti,
PA-C

Growing up I was surrounded by the medical field, specifically women's health. My grandfather was a physician for over 50 years, in obstetrics and gynecology, and my mother was a labor & delivery registered nurse. When looking back at pictures taken of my grandfather delivering newborns and listening to my mother tell stories of the women and their families she cared for on labor and delivery, my decision was made, to one day pursue a career in healthcare. Although I had respect for the role of a physician and registered nurse, I felt uncertain in determining my specific career path. It was during the time I shadowed & communicated more with providers in the medical field, I learned about the role of a physician assistant. Immediately, I knew this would be the right career for me & it was perfectly positioned between my grandfather as a physician and my mother as a registered nurse. Since then, I have never looked back.

Now almost 3 years into my career as a physician assistant practicing in obstetrics & gynecology, I have a great amount of positive patient encounters to reflect on; however, there is one that will always remain with me & reminds me of why I continue to practice in women's health. Recently, I started a new position with a larger healthcare system in Pennsylvania. My days during the week are spent caring for women in an outpatient office setting as well as providing care to patients on the labor and delivery unit. Although working in an outpatient setting was newer to me, I felt a sense of excitement for this opportunity. I was looking forward to start developing continuity & deeper relationships with my patients.

It was a very busy morning full of a wide variety of obstetric & gynecological visits. During my lunch break, I started to prepare my chart for the next patient & look through her history. She was coming in for a second trimester routine prenatal visit. This was her third pregnancy, unfortunately her first two were complicated by early spontaneous miscarriages. The patient was already seen for her first prenatal visit, which did confirm a normal healthy growing intrauterine pregnancy. Once the patient presented & was ready, I walked into the room to start the visit. Although the smiles of the patient & her husband were hidden behind their masks, their warmth & enthusiasm were immediately palpable. After sitting down & discussing all the details of her pregnancy, the patient admitted she was very anxious. As it has been almost 6 weeks since her first prenatal visit, she has been eager to hear her baby's heartbeat today. I confirmed that we will listen for the fetal heart tones with a doppler to confirm viability. The patient laid back & I placed the doppler on her lower abdomen to listen for the heartbeat. We all listened intently. After a few moments, a lusty rapid heartbeat made its presence. Immediately, the patient burst out in tears of joy. Her husband remained by her side, also tearful, and soaked in the noise of the tiny but strong heartbeat. It was a moment, conceivably so small & routine, that suddenly became so large & special. All three of us listened for several minutes, discussing our excitement. Afterwards, I gave the patient a tight hug & congratulated her on her rainbow pregnancy.

Reflecting on that moment, brings me so much gratification in my decision to pursue a career in women's health. This is a moment I experience every day with my patients, confirming fetal heart tones & providing guidance. Nevertheless, with this patient & in that moment, everything around me stopped & focused on the beauty of obstetrics. Right then, I was reminded of why I will always continue to practice as a physician assistant in women's health.

Julie Grandinetti, PA-C

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