MIGS 26

55TH GLOBAL CONGRESS ON MIGS

BOSTON, MASSACHUSETTS
NOVEMBER 13-16, 2026

Syllabus

PG-14009

Research Resources: Elevating Gynecologic Science Through Funding and Publication

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Charles H. Koh, MD

SCIENTIFIC PROGRAM CHAIR
Nash S. Moawad, MD

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Michael Hibner, MD, PhD



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PG-14009: Research Resources: Elevating Gynecologic Science Through Funding and Publication

Chair: Lara Harvey
Co-Chair: Yana Aznavour
Faculty: Yana Aznavour, Lara Harvey, Mateo Leon, Veronica Lerner

Course Description

In this course, instructors will provide a practical overview of key research databases and how to effectively leverage them for high-quality scholarly work in gynecology. Participants will refine essential skills in manuscript development, with a focus on structuring, writing, and navigating the submission process to achieve successful publication within the field of gynecologic research. In addition, the course will offer a foundational understanding of the National Institutes of Health grant process as it relates to gynecology and women's health, including key components of grant applications, review criteria, and strategies for developing competitive proposals. Together, these sessions are designed to equip participants with the core tools needed to advance academic productivity and research success in gynecology.

Learning Objectives: *At the end of this course, the participant will be able to:* 1) Identify major databases and registries containing variables pertinent to complex benign gynecology and compare the strengths and limitations of working with these data sources; 2) Apply best practices in scientific writing and utilize techniques to optimize written communication and increase the likelihood of manuscript acceptance; 3) Describe the perspectives of major funding agencies when evaluating research funding decisions; 4) Identify available research funding vehicles from private to federal sources; and 5) Apply strategies to optimize research funding applications in the field of complex benign gynecology.

Course Outline

10:15 am	Welcome, Introduction and Course Overview	L. Harvey
10:20 am	Inside the Editorial Machine: Tips and Tricks for Authors	V. Lerner
10:45 am	Increasing the N: Using Databases to Produce Impactful Research	L. Harvey
11:10 am	Funding Translational Research in Gynecology: Lessons from Venture Capital Fundraising and the NIH RADx ACT ENDO Challenge	Y. Aznavour
11:35 am	The Importance of Targeted Funding and Inclusivity in Gynecologic Research	M. Leon
12:00 pm	Discussion Questions & Answers	All faculty
12:15 pm	Adjourn	

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Disclosure of Relevant Financial Relationships

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Disclosure information and acknowledgment of any commercial support are provided to learners before the activity to promote transparency and maintain the independence and integrity of the education.

Asterisk (*) denotes no financial relationships with ACCME-defined ineligible companies to disclose.

PLANNER DISCLOSURES

The following members of AAGL have been involved in the educational planning and/or review of this course (listed in alphabetical order by last name).

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COURSE CHAIR DISCLOSURE

Lara Harvey, MD*

COURSE CO-CHAIR DISCLOSURE

Yana Aznavour, MD, PhD - Contracted Research, Employed Relationship and Stockholder: Endometrics

FACULTY DISCLOSURES

The following faculty have agreed to support their presentations and clinical recommendations with the best available evidence from the medical literature (in alphabetical order by last name).

Yana Aznavour, MD, PhD - Contracted Research, Employed Relationship and Stockholder: Endometrics
Lara Harvey, MD*
Mateo Leon, MD*
Veronica Lerner, MD – Consultant: Applied Medical

MITIGATION OF RELEVANT FINANCIAL RELATIONSHIPS

All relevant financial relationships have been mitigated.

Drs. Lee, Lemos, Mikhail, and Chaudhari's planning decisions, as part of the Scientific Program Committee (SPC), were peer reviewed by other planners on the SPC who had disclosed no financial relationships with ineligible companies, and found to be fair, balanced, and free of commercial bias. Dr. Moawad's financial relationships ended 12/2024, thus mitigating them. For most of his AAGL Professional Education Committee service, Dr. Mourad had no financial relationships to disclose. He recently disclosed a new relationship as a Proctor for Intuitive Surgical. Since then, he has not participated in activities involving control or influence over accredited educational content; therefore, no additional mitigation was necessary. As Co-Chair, Dr. Aznavour's relationship with Endometrics is not considered a relevant financial relationship as Endometrics has not yet submitted a pre-market application to the FDA; therefore, does not meet the definition of an ACCME-defined ineligible company and does not require mitigation.

The presentation content for course faculty, Drs. Aznavour and Lerner, has been peer reviewed and found to be fair, balanced, and free from commercial bias.

Decoding the Editorial Machine: An Author's Insider Guide to Successful Publishing

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MIGS/CBG and Urogynecology
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1

Disclosures

- Consultant: Applied Medical
- Former Editorial Board member for *Obstetrics and Gynecology*
- Peer review mentor for *Obstetrics and Gynecology*
- Associate editor *for Simulation in Healthcare*
- Associate chair CORPS

2

Objectives

- Understand best practices in scientific writing
- Optimize impact in publication
- How to get your paper accepted

3

My Journey

- Residency: research project with MFM fellow
- Fellowship: clinical
- 1st Attending job: clinical->academic
  - Mentorship->educator track



4

Why?

- Dissemination of work
- Advancement of the field
- Fellowship/collaboration
- Internal fulfillment
- Role modeling
- Future workforce



5



Bringing Colposcopy into Focus: A Multidisciplinary Curriculum for Residents

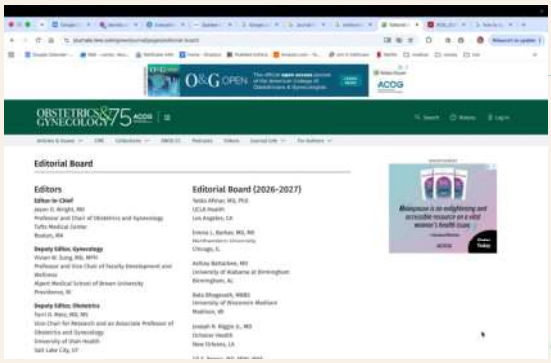


6

Why peer review? #1: Learn from peers



7



8

Inside the editorial machine

- Submission->formatting screen
- Editor-in-chief screen

9

Inside the editorial machine

- Submission->formatting screen
- Editor-in-chief screen
- Associate/managing editor
- Peer review
  - At least one editorial board member
  - Often one new "test" reviewer
  - Content expert





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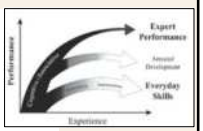
Inside the editorial machine

- Submission->formatting screen
- Editor-in-chief screen
- Associate/managing editor
- Peer review
  - At least one editorial board member
  - Often one new "test" reviewer
  - Content expert
  - Statistics review
- Associate editor decision
- Editor-in-chief decision

11



Peer reviewer
-asked for feedback on reviews
-asked for mentorship on stats
-pay attention to reviewer metrics
-recognized as top reviewer->ED board invite



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Inside the editorial machine

- Peer review/Editorial board membership
  - List of key articles on how to review different submission types
  - Join ED board calls and meetings
  - Journal operations
  - Networking at meetings and in between

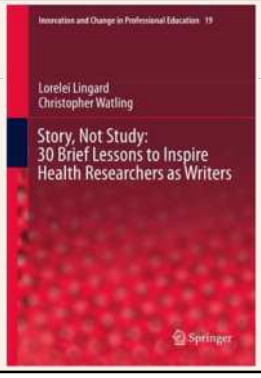
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Examples of articles on how to review

14

Gap/hook

15



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Templates

17

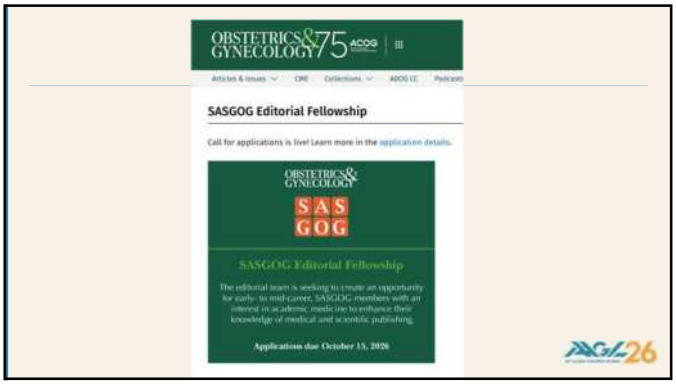


Peer reviewer
->ED Board
->Mentor in a peer review mentorship program

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20

Templates

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Where to publish?

22

My Journey

- Simulation in Healthcare ED Board->Associate Editor

23

Paper #42, Reviewer #2...



Chaoui J, Vann E, **Lerner V**, Pachipala K, Ratan RB, Advincula A, Saab SS. Beyond "Good Hands": Simulation Training and Objective Assessment of Medical Students' Suturing and Knot Tying Skills in the Obstetrics and Gynecology Clerkship. J Surg Educ. 2026 Aug 4;83(10):104091. doi: 10.1016/j.jsurg.2026.104091. Epub ahead of print. PMID: 42551298.

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Mentorship/Collaboration

- SGS research engine: CORPS

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History

- Established in 2012 by recent FPRN® graduates
- Multi-center research **for early-career, unfunded researchers**
- Productive 14 years
  - 18 papers published
  - Multiple presentations at national societies
  - 1 roundtable
  - IUJ Challenging Cases Series – 7 published
- **Collaboration with SGS in 2019**
  - Natural extension for graduating FPRN® members
  - SGS strong track record of research

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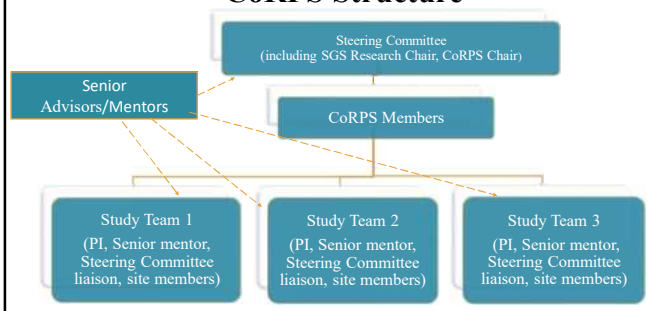
Key senior mentors: THANK YOU!

- **Dr. R Rogers**
- **Dr. K Meriwether**
- **Dr. C Iglesia**
- **Dr. C Grimes**
- **Dr. G Cundiff**



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CoRPS Structure



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Expectations of new members

- Attend meetings
- Give feedback on
  - CONCEPT PROPOSALS (short ideas) and
  - PROTOCOLS (long, thought-out)
- Participate in at least 1 study within 2 years of joining
- Expect to run 1 study and participate in 1 study

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Not a member of CoRPS? Join today!

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CoRPS SGS
WhatsApp group
Scan or upload this QR code using the WhatsApp camera to join this group

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Using databases to create impactful GYN research

Lara Harvey, MD, MPH · VUMC

NOVEMBER 13-16, 2026 · BOSTON · #AAGL26

1

Disclosures

I have no financial relationships to disclose.

Slide editing credit to Henry Harvey



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2

Why databases?

- **Few major journals publish single-institution data**
- **"Correlate less-common adverse events with modifiable and previously unidentified risk factors, identify adjustable provider- or hospital-level variables associated with readmissions or complications, and compare resource utilization for common interventions across diverse geographic regions or practice settings" Grauer et al**
- **Helpful for rare outcomes**

Grauer JN, Leopold SS. Editorial: large database studies--what they can do, what they cannot do, and which ones we will publish. Clin Orthop Relat Res. 2015 May;473(5):1537-9. doi: 10.1007/s11999-015-4223-z. Epub 2015 Feb 28. PMID: 25724835; PMCID: PMC438534

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3

Database pitfalls

- GIGO
- Data input design-> will it capture your question?
- Specific populations -> risk of over or under estimation of searched event
- Low data granularity
- Same question "asked" of different databases may yield different results
- "With bigger data, random signals may denote statistical significance, and precision may be incorrectly inferred because of narrow confidence intervals" Kaji et al
- "Interpretations of observational studies should only lead to descriptions of associations between variables, not to conclusions of causality." Kaji et al

Grauer JN, Leopold SS. Editorial: large database studies--what they can do, what they cannot do, and which ones we will publish. Clin Orthop Relat Res. 2015 May;473(5):1537-9. doi: 10.1007/s11999-015-4223-z. Epub 2015 Feb 28. PMID: 25724835; PMCID: PMC4385344.

Kaji AH, Rademaker AW, Hyslop T. Tips for Analyzing Large Data Sets From the JAMA Surgery Statistical Editors. JAMA Surg. 2018;153(6):508–509. doi:10.1001/jamasurg.2018.0647

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4

What to be aware of:

- **What data goes in ? ICD codes? CPT codes?**
- **Who is putting the data in? Automated? Manual entry?**
- **Impact of missing data?**
- **Prospective or retrospective**
- **Time horizon?**
- **Cost?**
- **Prior pitfalls?**
- **STROBE guidelines**

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5

Statistical considerations

"Since studies based on secondary analyses of large data sets are by definition observational, ***it would be preferred if there were less emphasis placed on statistical hypothesis testing and the reporting of P values***. As per the American Statistical Association, a description of effect estimates (odds ratios, risk ratios, etc.) and the 95% CI is more informative than reporting P values."

Kaji AH, Rademaker AW, Hyslop T. Tips for Analyzing Large Data Sets From the *JAMA Surgery* Statistical Editors. *JAMA Surg*. 2018;153(6):508–509. doi:10.1001/jamasurg.2018.0647

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6

Clear research question:

- P - Population: The target patient group, demographic profile, or clinical condition.
- I - Intervention: The specific treatment, test, or procedure being evaluated.
- C - Comparator: The alternative treatment, placebo, or standard care used for comparison.
- O - Outcome: The specific health results, measurements, or clinical endpoints.
- T - Timing: The duration of treatment or the schedule for follow-up.
- S - Setting: The real-world environment or clinical location where the care occurs.

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What databases exist?

- Agency for Healthcare Research and Quality Healthcare Cost and Utilization Project databases: National Inpatient Sample, State Inpatient Databases, and Kids' Inpatient Database
- Surveillance Surgeons National Database, Epidemiology, and End Results Program
- Medicare Claims Data
- Military Health System Tricare Encounter Data
- Veterans Affairs Surgical Quality Improvement Program
- National Surgical Quality Improvement Program
- Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program
- National Cancer Database
- National Trauma Data Bank
- Society for Vascular Surgery Vascular Quality Initiative
- The Society of Thoracic

Haider AH, Bilimoria KY, Kibbe MR. A Checklist to Elevate the Science of Surgical Database Research. JAMA Surg. 2018;153(6):505–507. doi:10.1001/jamasurg.2018.0628

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8

JAMA Surgery Guide to Statistics and Methods



- https://jamanetwork.com/journals/jamasurgery/pages/statistics-and-methods

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9

JAMA Surgery Checklist for Surgical Database Research

- Haider AH, Bilimoria KY, Kibbe MR. A Checklist to Elevate the Science of Surgical Database Research. JAMA Surg. 2018;153(6):505–507. doi:10.1001/jamasurg.2018.0628

- Have a solid research question and clear hypothesis. Consider using the FINER (Feasible, Interesting, Novel, Ethical, Relevant) or PICO (Patient, Population, or Problem; Intervention, Prognostic Factor, or Exposure; Comparison or Intervention; Outcome) criteria to develop these.
- Ensure compliance with the institutional review board and data use agreements.
- Conduct a thorough literature review. Use a reference management program for ease in manuscript development.
- Make sure this is the best data set available and that it has the appropriate variables to answer your research question.
- Clearly define the inclusion criteria, exclusion criteria, and outcome variables. Use a flow diagram to describe final patient selection.
- Identify potential confounders and use risk adjustment to minimize bias. Consider using a directed acyclic graph to represent potential associations. Avoid use of causal language in reporting results of these observational studies.
- Ensure that the data variables have not changed over time. If so, account for this.
- Ensure that competing risks are identified and addressed.
- Ensure that data issues, such as missing data, are discussed and that any sensitivity analyses or imputations performed are reported in a clear and cohesive way.
- Ensure that your article has a clear take-home message that addresses how your research advances current knowledge and has important policy or clinical implications.

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Medicare Claims Data

- (https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/FilesForOrderGenInfo/index.html)

The Centers for Medicare and Medicaid Services (CMS) administers Medicare, the primary US health insurance program for people aged 65 years and older and people who qualify for Social Security Administration disability benefits.

-1987

-Hundreds to thousands $ to access

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11

National Surgical Quality Improvement Program (NSQIP) and Pediatric NSQIP

https://www.facs.org/quality-programs/data-and-registries/acs-nsqip/

- Began in 2004
- Trained data abstractors
- 700 currently active hospitals
- Captures more than 1 million incident cases annually.
- Institutional annual subscription fee of approximately $10,000 to $80,000 per year
- 30 days post-op

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Veterans Affairs Surgical Quality Improvement Program (VASQIP)

-Templated after NSQIP

-1991

-RN collected preoperative, intraoperative, and 30-day outcome variables

-Between 1991 and 2006, VA facilities saw a 47% drop in postoperative mortality and a 43% drop in morbidity.

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Military Health System Tricare Encounter Data

-9 million beneficiaries nationwide

-maintained by the Military Health System Data Repository (MDR)

-Direct and purchased care

-~ 20% of the covered population is active-duty, while 80% consists of civilian dependents and retiree

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Healthcare Cost and Utilization Project National Inpatient Sample (NIS)

- (http://www.hcup-us.ahrq.gov/).

- largest collection of administrative, longitudinal health care data in the United States.
- 1988
- collaborative effort between state data organizations, hospital associations, private data organizations, and the federal government

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Questions?

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Funding Translational Research in Gynecology

Lessons from Venture Capital Fundraising and the NIH RADx ACT ENDO Challenge

Yana Aznavour, MD, PhD

NOVEMBER 13-16, 2026 · BOSTON · #AAGL26

1

Disclosure

- CEO & Founder: Endometrics
- Member, AAGL Research Committee

2

Objectives

- Describe the non-dilutive and dilutive funding pathways available to women's health innovators, using venture fundraising experiences and the NIH RADx ACT ENDO Challenge as case studies.
- Compare the strategic trade-offs (speed, dilution, diligence focus, and credibility signal) between venture financing and federal non-dilutive funding for an early-stage femtech company.
- Apply a practical framework for positioning a translational research program to investors and federal reviewers.

3

The Funding Gap in Women's Health Innovation

<1%

of private healthcare investment goes to companies focused exclusively on women's health

World Economic Forum / BCG, 2026 Women's Health Investment Outlook

65x

less NIH funding per patient for endometriosis than for Crohn's disease — $16M vs. $90M in 2022, despite 47x the patient population

AMA Journal of Ethics, 2025

Non-dilutive and dilutive capital aren't alternatives => Run them in parallel, and let each one strengthen the other.

4

Case Study: Funding an Emerging Gynecologic Diagnostic Technology

Accelerator Participation
Accessing mentorship, research infrastructure, and investor networks.

Venture Capital Funding
Securing private investment to fund technology development and clinical validation.

FDA Pre-Submission
Early regulatory feedback to refine the analytical and clinical validation plan.

NIH Funding
Developing a risk mitigation plan and milestone-based work plan, with progress assessed across technology, clinical, regulatory, and commercialization pillars.

Payer Innovation Program
Understanding payer evidence needs, reimbursement strategy, and clinical utility early in development.

5

NIH opportunities

Grants

R21 / R01, SBIR / STTR, NICHD mechanisms

- Peer-reviewed by a standing study section, hypothesis-driven
- Multi-year, staged funding (exploratory to established)
- SBIR / STTR built for company-led translational work
- Requires a full proposal and preliminary data up front

Challenge Competitions

Prize-based programs like NIH's RADx initiative

- Judged by federal program staff and external reviewers
- Compressed timeline around defined milestones
- Built to accelerate a specific public-health need
- Non-dilutive, often faster than a grant cycle

6

Venture Capital opportunities

Early-Stage Investors

Individual and pre-institutional capital: the first checks in

- Angels – clinicians and operators investing personal capital, small checks, often the fastest yes
- Friends, family & crowdfunding – small checks, most flexible terms
- Pre-seed / seed funds – $25K–$500K, thesis-driven, decide in weeks
- Look for: founder conviction, early clinical signal, a credible first customer

Institutional & Strategic Investors

Series A and beyond: capital that expects scale

- Series A / B venture funds – larger checks, formal diligence, board seats
- Corporate VC & strategics — pharma, diagnostics, and payer-backed funds seeking pipeline or distribution fit
- Growth & crossover investors — later-stage, valuation-driven, exit-focused
- Look for: reimbursement pathway, market sizing, a credible path to scale

7

Venture Capital vs NIH

Dimension	Venture Capital	NIH / RADx
Speed	Can close in weeks to months	Fixed competition and review cycle
Dilution	Equity given up, plus board seat	Non-dilutive (no equity)
Diligence focus	ROI, market size, team, moat	Scientific rigor, regulatory pathway
Credibility signal	Investor conviction in the return	Federal, peer-reviewed credibility

8

A Stronger Venture Narrative

3 questions you should answer before pitching to investors

Why This

The clinical problem is specific. The test or intervention changes a concrete decision.

Why Now

A scientific, regulatory, market, or care-delivery shift makes translation newly feasible.
"Awareness is increasing" is usually not enough.

Why You

Unique evidence, access, and execution capability. The moat is the accumulation of hard-to-recreate assets.

9

Not every good science becomes a good product

01 **Great data is not a product.** Investors probe whether a finding survives translation into a reimbursable product.

02 **Product-market fit is not optional.** Define who orders your product, what decision it changes, and why today's standard of care isn't already "good enough"

03 **The bar isn't "is this interesting science?"** – it's whether a clinician would change practice because of the result.

The question that reframes everything: if this result didn't exist, what would a physician do differently tomorrow?

10

Key Takeaways

1. **Women's health has historically been underfunded relative to its burden of disease.** Clinicians who understand the funding landscape are better positioned to champion, evaluate, and accelerate the innovations their patients need.
2. **Federal recognition brings value beyond funding.** Competitive awards can increase visibility, attract collaborators and investors, and help advance a technology toward clinical validation.
3. **Funding strategy is part of clinical innovation, whatever form it takes.** Good science doesn't reach patients without appropriate funding.
4. **Non-dilutive funding is underused by clinician-innovators.** Most clinicians know R01/R21 grants; far fewer know challenge competitions exist as a separate, often faster track built around a defined public-health need.
5. **Venture capital is increasingly active in women's health.** Knowing who funds what stage matters whether you're founding, advising, or seeking funding for your own research.
6. **A "good idea" isn't the same as a fundable product.** The rigor that gets a paper published doesn't automatically answer the questions investors and federal reviewers ask: who adopts this, what does it change in practice, and why isn't today's standard of care already good enough.

11

A Practical Playbook

Write the Intended Use

Who is the patient? Who acts on the result? What decision changes?

Map the Top Risks

Technical · clinical · regulatory · adoption · economics

Choose One Value Inflection

Define the milestone that materially changes the next financing conversation

Build the Minimum Evidence Plan

Endpoint, threshold, cohort, timeline, cost, IP owner

Match the Capital Source

Grant / challenge · VC · strategic · internal / revenue

Run 5 Conversations with Key Stakeholders

Use repeated questions as data; rewrite the story around unresolved risk

12

Acknowledgments

- Endometrics team & Advisory Board
- NIH RADx ACT ENDO Review Board

13

References

- World Economic Forum / Boston Consulting Group. 2026 Women's Health Investment Outlook.
- AMA Journal of Ethics. NIH Funding Disparities in Endometriosis Research. 2025.

Let's discuss!

yb@endometrics.us

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The Importance of targeted Funding and inclusivity in gynecologic research

Mateo Leon MD
Senior Associate Consultant
Associate Program Director- Complex Benign Gynecology Fellowship
Mayo Clinic- Jacksonville,FL

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1

Disclosure

- No disclosures

2

NIH National Institutes of Health
Turning Discovery Into Health

20 billion per year



1%

3

NIH RESEARCH GRANTS (R SERIES

KEY GRANT TYPES:

- R01 — R01 RESEARCH PROJECT GRANT
- R21 — R21 EXPLORATORY/ DEVELOPMENTAL GRANT
- R03 — R03 SMALL GRANT
- R15 — R15 ACADEMIC RESEARCH ENHANCEMENT AWARD

Most extended funding period for independent researchers

NIH → ? → ACOG

4



2000 | 2005
R01
2010 | 2015

5

R01 Grants from RePORTER

⇩

Publications stemming from grant

⇩

Screening of GYN- ACOG Practice Bulletins and Committee Opinions

⇩

If R01 PI referenced → Citation was cross-referenced with RePORTER

6

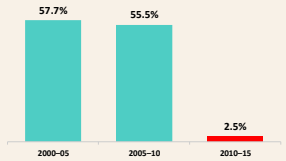
Characteristics of Research Project Grants

R01 Grants	2000	2005	2000 vs 2005 (% change/P)	2010	2005 vs 2010 (% change/P)	2015	2010 vs 2015 (% change/P)
Total Number	27,187	31,271	15.0%	32,182	2.9%	24,966	-22.4%
Total Funding ($)	7,511,262,698	10,892,225,932	45.0%	12,249,092,655	12.5%	10,129,566,707	-17.3%
Gyn Topic	24 (0.1)	33 (0.1)	37.5%	57 (0.2)	72.7%	36 (0.1)	-36.8%
Funding for Gyn							
Total Funding in Gyn (%)	7332588 (0.1)	11563612 (0.1)	57.7%	17977051 (0.1)	55.5%	18432168 (0.2)	2.5%
Mean (SD) per grant	305525 (121714)	350412 (193425)	0.288	315387 (170887)	0.375	512005 (322637)	0.002
Median (IQR) per grant	277808 (235099-314223)	317366 (268403-354800)	0.070	314450 (225750-381799)	0.691	418359 (316034-589918)	0.001

7

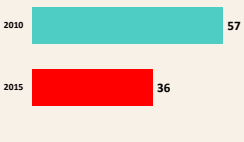
After 2010, funding stalled as grants fell

FUNDING GROWTH BY PERIOD



−5.2% real after inflation, 2010–15

ACTIVE GYNECOLOGIC R01 GRANTS



−36.8% 57 grants → 36

The decline reversed a decade of grant growth.

Two signals moved together after 2010: funding momentum disappeared while the number of funded grants contracted.

8

Total Funding per Specialty

Year	Gynecology	Obstetrics	Urology
2000	$7,332,588	$21,292,084	$12,964,289
2005	$11,563,612	$23,989,876	$20,832,246
2010	$17,977,051	$35,923,163	$35,587,855
2015	$18,432,168	$109,202,694	$43,112,751
Total	$55,305,419	$190,407,817	$112,497,141

50 to 70% less funding

17% compared to obstetrics
42% compared to urology

9

5,663 publications
$55,305,419

Publications in ACOG guidelines

ACOG Guidelines	2000	2005	2010	2015	
Publications Referenced	9 (1.7)	4 (0.6)	11 (0.4)	10 (0.7)	**34 (0.6%) referenced**
Publications linked with Recommendations	2 (0.4)	2 (0.3)	3 (0.1)	4 (0.3)	**11 (0.2%) linked with rec**

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Publications linked with recommendations

ACOG Gynecologic Practice Bulletin Publication	Principal Investigator	Year
Std Risks And Latino Adolescents' Sexual Networks	Padian, Nancy S	2000
Treatment Evaluation In Premenstrual Syndrome Patients	Freeman, Ellen W	2000
Vulvar Vestibulitis Trial: Desipramine-Lidocaine	Foster, David Charles	2005
Mechanisms Of Anterior Vaginal Wall Support Failure	Delancey, John O.L	2005
Risk Factors As Predictors Of Ectopic Pregnancy	Barnhart, Kurt T	2010
Mechanisms Of Anterior Vaginal Wall Support Failure	Delancey, John O.L	2010
Ec Method: Determinants For Copper Iud Use And Future Unintended Pregnancy	Turok, David	2010
Pelvic Floor Disorders Network Duke University Clinical Site	Visco Anthony G	2015
Biomarkers Of Infertility	Steiner, Anne Zweifel	2015
Using Comparative Effectiveness Analyses To Optimize Cervical Cancer Screening	Sawaya, George F	2015
Characterization & Prevention Of Chemotherapy-Induced Damage To Ovarian Reserve	Oktay, Kutluk H	2015

11

The Cost of a Practice-Changing Publication

The limited Number of Publications referenced in ACOG Guidelines underscores the pressing need to prioritize funding on topics that directly influence national guidelines!

$55,305,419 → 5,663→ 11 ACOG recommendations

$5,027,656
R01 funding required per publication linked to an ACOG recommendation

12

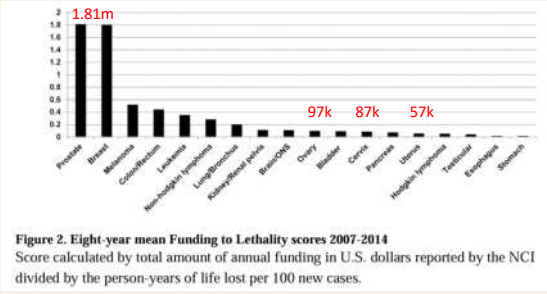


Figure 2. Eight-year mean Funding to Lethality scores 2007-2014
Score calculated by total amount of annual funding in U.S. dollars reported by the NCI divided by the person-years of life lost per 100 new cases.

*Spencer et al. Disparities in the allocation of research funding to gynecologic cancers by Funding to Lethality scores. Gynecol Oncol. 2019

13

Personal Perspectives

Reconciling the Literature on Sex-Based Disparities in Reimbursement

Asha B. McClurg, MD, MSCR, Louise P. King, MD, JD, and Christopher Robertson, JD, PhD

Benoit et al. 2016
50 matched CPT code pairs • 2015 Medicare

72%
higher work RVUs for male-coded

84%
reimbursed at higher rates

Male-coded procedures paid more in the large majority of anatomically matched pairs

Polan & Barber 2021
12 CPT code pairs • NSQIP

+26%
Female-coded

+13%
Male-coded

RVU growth over two decades — yet male-specific procedures still pay more in most pairs

Paired CPT codes differ only by patient sex — the procedures themselves are functionally alike

14

Discrimination Gap

Same paired-CPT approach — narrower matching on the left, broader and longitudinal on the right

Hathaway et al. 2024
9 strictly matched pairs • same valuation date, global period, approach

6 of 9
favored female-coded

Strict matching erases the work RVU difference — high internal validity, but it may miss systemic effects

Penn et al., 2025
55 pairs / 110 procedures • 2003–2023

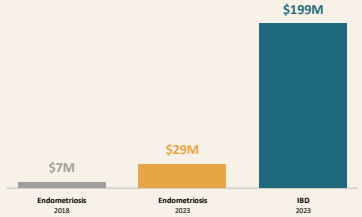
~30%
higher RVUs assigned to male-specific procedures, on average

Two decades of partial improvement — the gap narrowed but never closed

15

Endometriosis: a Fraction of the Funding

Annual NIH research funding



14%
Endometriosis funding as a share of IBD funding in 2023

10% vs 1.3%
Prevalence: endometriosis in reproductive-age women vs. IBD in the population

NIH categorical spending, 2018 and 2023 [12,13]. Despite 4x growth since 2018, endometriosis funding remains a fraction of IBD funding.

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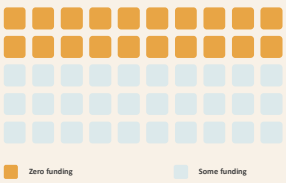
Research Project Grants in Gynecology

R01 Grants	2000	2005	2000 vs 2005 (% change/P)	2010	2005 vs 2010 (% change/P)	2015	2010 vs 2015 (% change/P)
Number of states with R01, n (%)	16 (32%)	19 (38%)	0.529	22 (44%)	0.542	17 (34%)	0.305
Publications from R01 in Gyn (number)	527	632	19.9%	3108	391.8%	1396	-55.1%

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40% of States Got Nothing

Each square = one state, 2000–2015



20 of 50
states received no gynecologic R01 funding

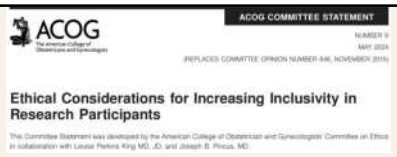
Geographic concentration of research capacity limits the physician-scientist pipeline in women's health.

18

Racial, Ethnic, and Demographic representation matters

- One of the requirements of the NIH Revitalization Act is the inclusion of minority groups in RCTs
- To mitigate documented racial and ethnic disparities in women's health care by enrolling participants of color in proportion to disease prevalence in their communities
- Certain demographics are underrepresented in RCTs
- When trial participants do not reflect the demographics of the affected population, the generalizability of the results is limited

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ACOG COMMITTEE STATEMENT

ACOG

Ethical Considerations for Increasing Inclusivity in Research Participants

- "Researchers and funding organizations should be aware of historical examples of exclusion and should strive for recruitment inclusivity. It is only by the inclusion of people who can become pregnant, could have become pregnant, are lactating, or identify as women in thoughtfully designed research studies that we can ultimately protect these populations"

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Conclusion

- There was a relative decline in both the number of grants and NIH funding allocated to gynecology. This trend is notable considering the already minimal proportion of R01 grants designated for this field.
- The paltry number of publications referenced in ACOG guidelines underscores the need to fund on topics which influence national guidelines.
- Within the field of women's health, most of the federal grant funding has been allocated to obstetric-related research.
- Efforts should be taken to prioritize inclusivity and ensure the research participation of women from diverse ethnic, socioeconomic, and geographical backgrounds.

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CULTURAL AND LINGUISTIC COMPETENCY & IMPLICIT BIAS

The California Medical Association (CMA) outlines standards for Cultural Linguistic Competency and Implicit Bias in CME. The goal of the standards is to support the role of accredited CME in advancing diversity, health equity, and inclusion in healthcare. These standards are relevant to ACCME-accredited, CMA-accredited, and jointly accredited providers located in California. AAGL is ACCME-accredited and headquartered in California.

CMA developed the standards in response to California legislation (Business and Professions (B&P) Code Section 2190.1), which directs CMA to draft a set of standards for the inclusion of cultural and linguistic competency (CLC) and implicit bias (IB) in accredited CME.

The standards are intended to support CME providers in meeting the expectations of the legislation. CME provider organizations physically located in California and accredited by CMA CME or ACCME, as well as jointly accredited providers whose target audience includes physicians, are expected to meet these expectations which began on January 1, 2022. AAGL has been proactively adopting processes that meet and often exceed the required expectations of the legislation.

CMA CME offers a variety of resources and tools to help providers meet the standards and successfully incorporate CLC & IB into their CME activities, including FAQ, definitions, a planning worksheet, and best practices. These resources are available on the CLC and IB standards page on the CMA website.

Important Definitions:

Cultural and Linguistic Competency (CLC) – The ability and readiness of health care providers and organizations to humbly and respectfully demonstrate, effectively communicate, and tailor delivery of care to patients with diverse values, beliefs, identities and behaviors, in order to meet social, cultural and linguistic needs as they relate to patient health.

Implicit Bias (IB) – The attitudes, stereotypes and feelings, either positive or negative, that affect our understanding, actions and decisions without conscious knowledge or control. Implicit bias is a universal phenomenon. When negative, implicit bias often contributes to unequal treatment and disparities in diagnosis, treatment decisions, levels of care and health care outcomes of people based on race, ethnicity, gender identity, sexual orientation, age, disability and other characteristics.

Diversity – Having many different forms, types or ideas; showing variety. Demographic diversity can mean a group composed of people of different genders, races/ethnicities, cultures, religions, physical abilities, sexual orientations or preferences, ages, etc.

Direct links to AB1195 (CLC), AB241 (IB), and the B&P Code 2190.1:

Bill Text – AB-1195 Continuing education: cultural and linguistic competency.
Bill Text – AB-241 Implicit bias: continuing education: requirements.
Business and Professions (B&P) Code Section 2190.1

CLC & IB Online Resources:

Diversity-Wheel-as-used-at-Johns-Hopkins-University-12.png (850×839) (researchgate.net)
Implicit Bias, Microaggressions, and Stereotypes Resources | NEA
Act, Communicating, Implicit Bias (racialequitytools.org)
https://www.contemporaryobgyn.net/view/overcoming-racism-and-unconscious-bias-in-ob-gyn
https://pubmed.ncbi.nlm.nih.gov/34016820/
https://hr.ucdavis.edu/departments/learning/certificate/implicit-bias
https://pmc.ncbi.nlm.nih.gov/articles/PMC7011228/