AGA26

55TH GLOBAL CONGRESS ON MIGS

BOSTON, MASSACHUSETTS
NOVEMBER 13-16, 2026

Syllabus

General Session I

HONORARY CHAIR
Charles H. Koh, MD

SCIENTIFIC PROGRAM CHAIR
Nash S. Moawad, MD

PRESIDENT
Michael Hibner, MD, PhD



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GS0I: General Session I - Opening Ceremony

Faculty: Fernando Heredia, Michael Hibner, Charles H. Koh

MedTalk I #255 The New Patients....and the New Doctors
Presenter: Fernando Heredia

Description: This MedTalk dives into a clinical reality many of us are facing—one that's changing how care is requested, offered, and delivered. We're meeting "new patients": women empowered by unprecedented access to information—much of it shaped by social media. That empowerment can be powerful. But it can also be risky when misinformation (or deliberate deception) turns a smartphone into a shortcut to diagnoses, treatments, and even surgeries that were never truly needed. And we're also becoming "new doctors": clinicians navigating a landscape where visibility can be mistaken for expertise. Where a few successful cases can be amplified into authority. Where marketing, paid "certifications," and online popularity can distort what excellence really looks like. And where we increasingly inherit complex cases—patients previously operated on by pseudo-experts, with predictable technical challenges and poorer outcomes. In this MedTalk, I explore how we can stay grounded between both extremes of the doctor–patient paradigm—protecting trust, prioritizing evidence, and keeping medicine human in an age of algorithms.

Learning Objectives: *At the end of this course, the participant will be able to:* 1) Understand the emerging clinical landscape both for patients and physicians: Describe how social-media–driven information is changing how patients request, interpret, and decide on care—highlighting the risks of misinformation, manipulation, and unnecessary treatments; 2) Examine the impact on physicians and care quality: Analyze how "visibility-based medicine" (branding, paid marketing, pseudo-certifications, popularity) can be mistaken for expertise, shaping expectations and contributing to complex referrals and poorer outcomes after suboptimal procedures; and 3) Build a practical framework to stay grounded: Provide principles and actionable strategies to balance empowerment with evidence—strengthening shared decision-making, protecting trust, and keeping care ethical and human in the age of algorithms.

Course Outline

4:30 pm	Opening Ceremony	
4:35 pm	FAAGL Noteworthy Awards	
4:50 pm	MedTalk I: The New Patients....and the New Doctors	F. Heredia
5:05 pm	Honorary Chair Award	C. Koh
5:15 pm	Presidential Address	M. Hibner
5:35 pm	Induction of the 2027 President	N. Moawad
5:45 pm	Adjourn	

ADA Statement: In accordance with the Americans with Disabilities Act (ADA), please contact CMEsupport@aagl.org should you require any special assistance.

Disclosure of Relevant Financial Relationships

As an ACCME-accredited provider, AAGL is responsible for ensuring that accredited education is fair, balanced, free of commercial bias, and supports safe, effective patient care. AAGL maintains control over all aspects of educational planning, content, faculty selection, delivery, and evaluation.

All individuals in a position to control educational content are required to disclose financial relationships with ACCME-defined ineligible companies within the past 24 months. AAGL identifies and mitigates all relevant financial relationships before individuals assume their respective roles. Educational content is also subject to independent peer review by individuals without relevant financial relationships.

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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Nash Moawad, MD, MS, Chairman – Consultant (ended 12/2024): Medtronic, Womed, Integra Life Sciences
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Linda D. Bradley, MD, Medical Director*
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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).

Fernando Heredia, MD – Consultant: Johnson & Johnson, Merck & Co./MSD; Speakers Bureau: AstraZeneca, Johnson & Johnson, KLS Martin, Merck & Co./MSD; Travel Expenses: KLS Martin, Medtronic, Merck & Co./MSD
Michael Hibner, MD, PhD*
Charles H. Koh, MD – Royalty: CooperSurgical, Karl Storz

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.

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


THE NEW PATIENTS
&
THE NEW DOCTORS
FERNANDO HEREDIA MD
FULL PROFESSOR OBSTETRICS & GYNECOLOGY
UNIVERSIDAD DE CONCEPCIÓN - CHILE

1


Disclosures
1 I am not receiving an honorarium for this presentation.
2 I have no conflicts of interest regarding this presentation.
3 This represents my personal opinion and is based on bioethical guidelines and regulations from countries other than the United States, as well as the opinions of sociologists, psychologists, and colleagues of all ages concerned about this matter.

2


Social Media
para médicos
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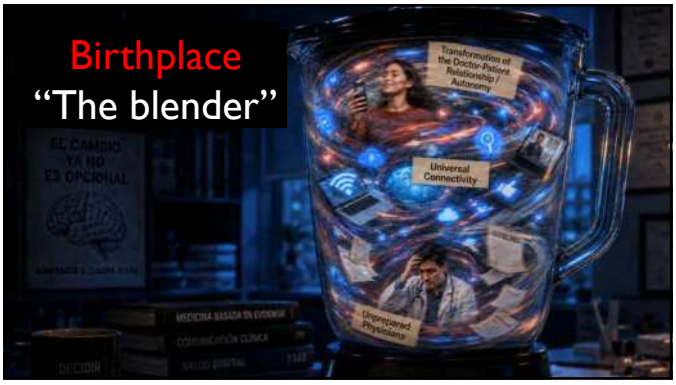
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ONE DAY,
A MONSTER APPEARED

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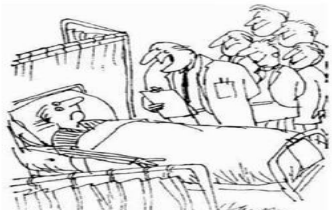

Birthplace
"The blender"
Transformation of the Doctor-Patient Relationship / Autonomy
Universal Connectivity
Unprepared Physicians

5


Birthplace
"The blender"
Transformation of the Doctor-Patient Relationship / Autonomy
Universal Connectivity
Unprepared Physicians

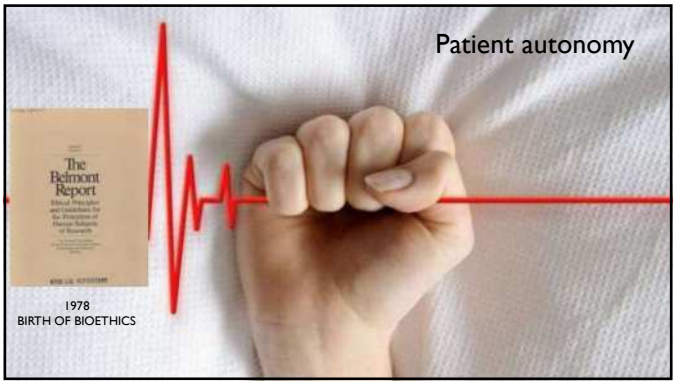
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PATERNALISTIC DOCTOR PATIENT RELATIONSHIP



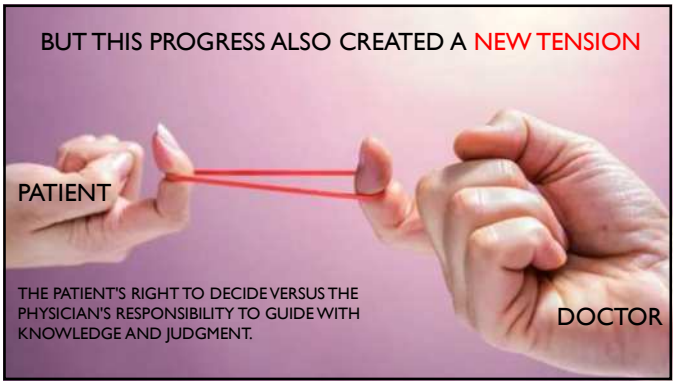
"When **WE** want your opinion, **WE´LL** give it to you"

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8

BUT THIS PROGRESS ALSO CREATED A NEW TENSION

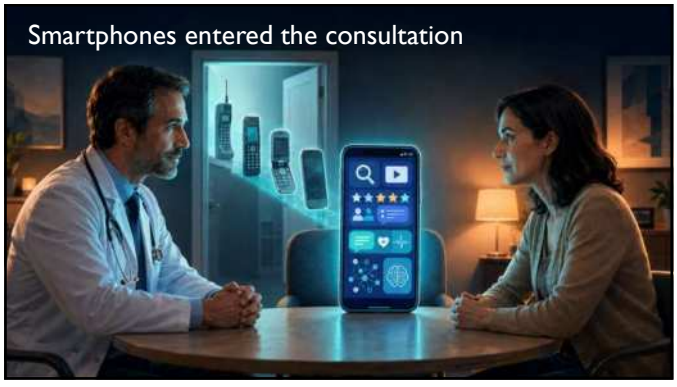


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THE SEED TOOK ROOT IN THE USUAL SEARCH ENGINES



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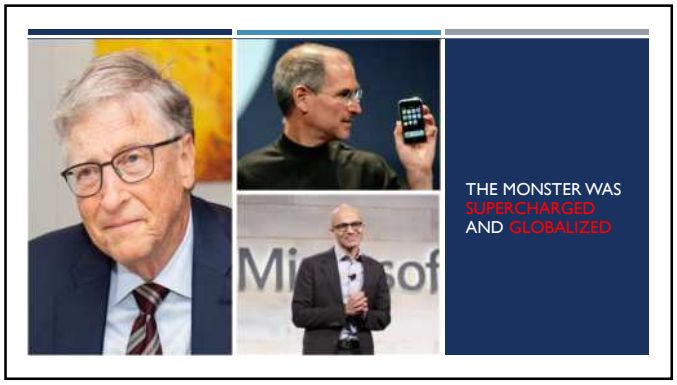
THEN GLOBAL PLATFORMS …. THEN AI ….





These extraordinary innovations connected the world and democratized information

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AND WHEN THE ALGORYTHM ENTERS MEDICINE
WE MUST ASK

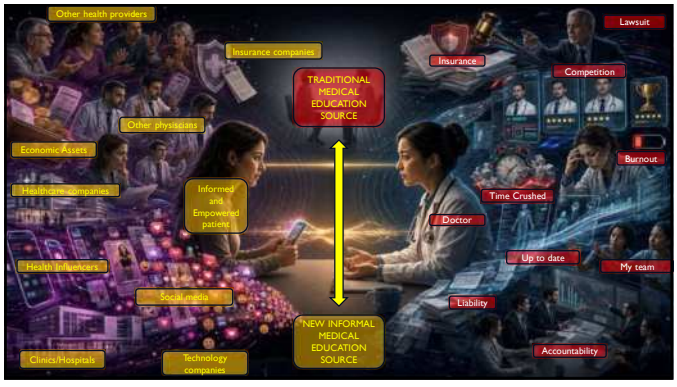
- What NEW factors influence the doctor-patient relationship today?
- Based on WHAT information do patients make decisions TODAY?
- How do patients choose their doctors TODAY?
- WHO FEEDS the information that our patients receive through the algorithm?



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MEDICAL INFORMATION IS NOW WIDELY AVAILABLE… BUT WHAT IS THE QUALITY OF THE INFORMATION AVAILABLE?

19

"DOCTOR, YOU SHOULD KNOW THAT I HAVE BEEN INVESTIGATING!"

Patients compulsively seek out, find, chew, and swallow these "DIGITAL DORITOS", and their perceptions regarding their medical conditions or ailments are shaped by these "NUGGETS OF MEDICAL KNOWLEDGE" of frankly uncertain origin.



20



THIS IS MEDICAL ACCULTURATION TRANSFORMED INTO A DIGITAL CONSUMABLE. THE ALGORITHM "OPENS THE BAG AND KEEPS OFFERING ONE MORE".



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HOW DID WE CHOOSE > 20-25 YEARS AGO?





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THEN INSURANCE COMPANIES NARROWED THE MENU…





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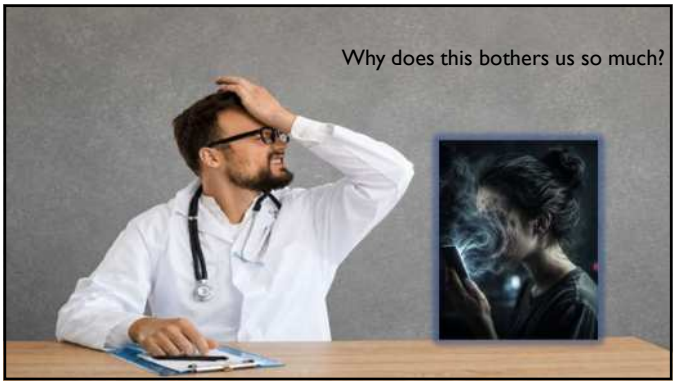
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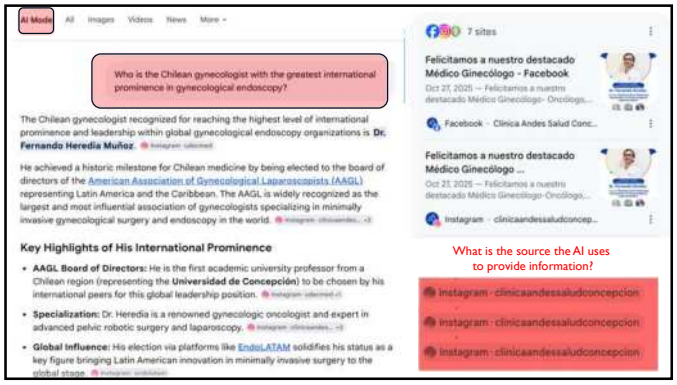
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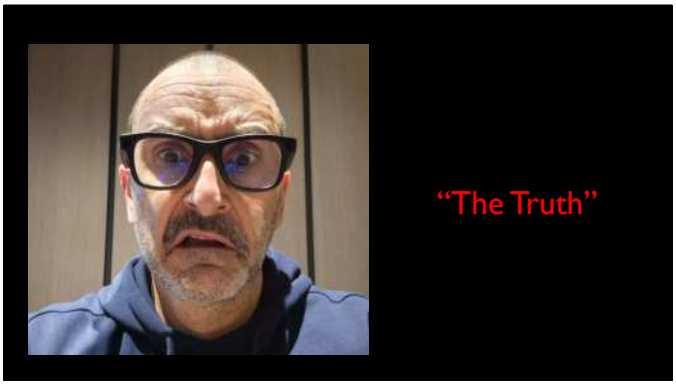
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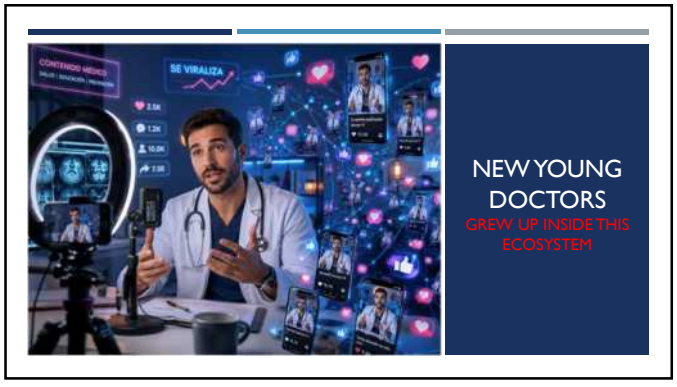
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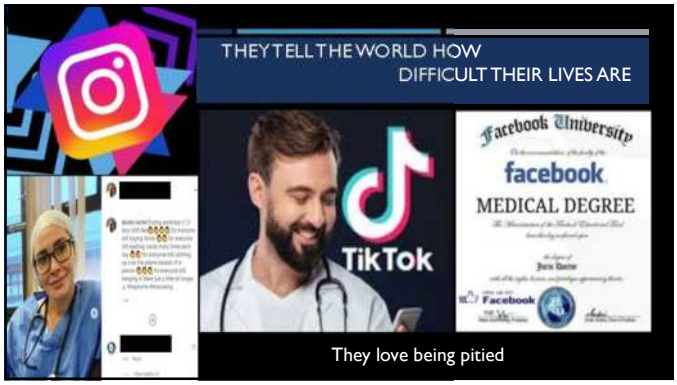
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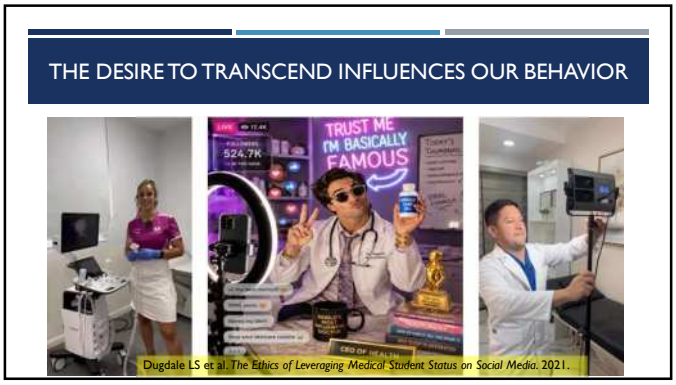
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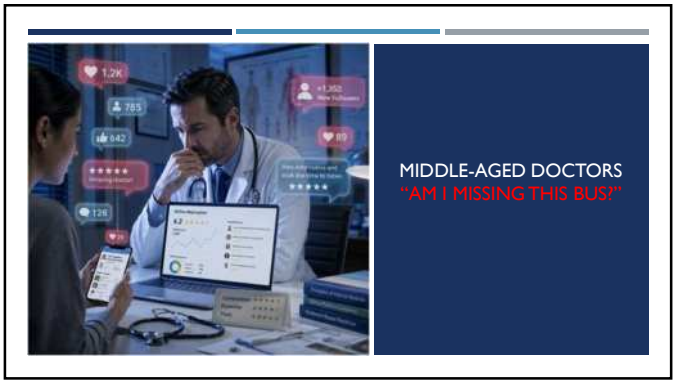
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AND THE OLDER DOCTORS?



Not immune to anxiety

56

AND THE OLDER DOCTORS?



57

"TY-REX SURGEONS" ARE BLOOMING IN SOCIAL MEDIA



Ng IK, Thong C, Tan LF, Teo DB. The rise of medical influencers: The pros and the cons. J R Coll Physicians Edinb.

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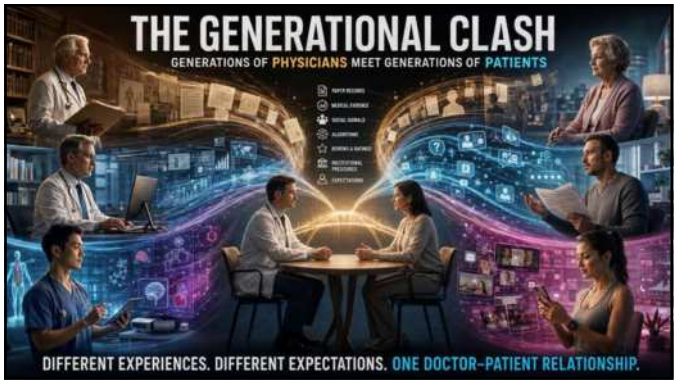
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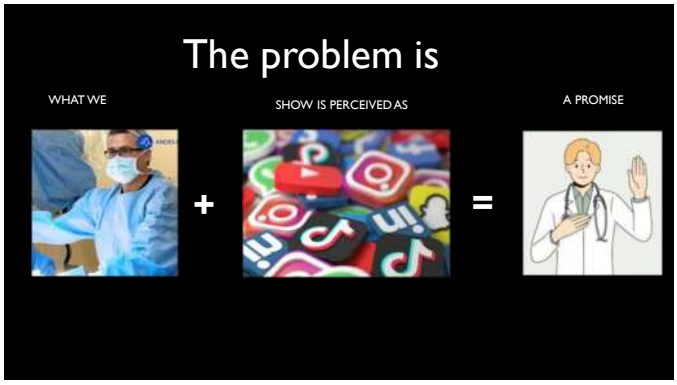
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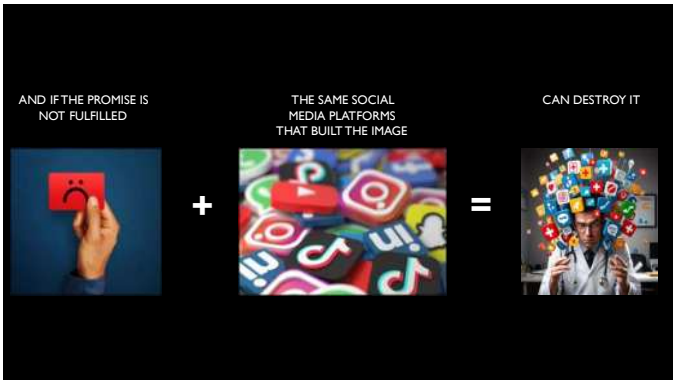
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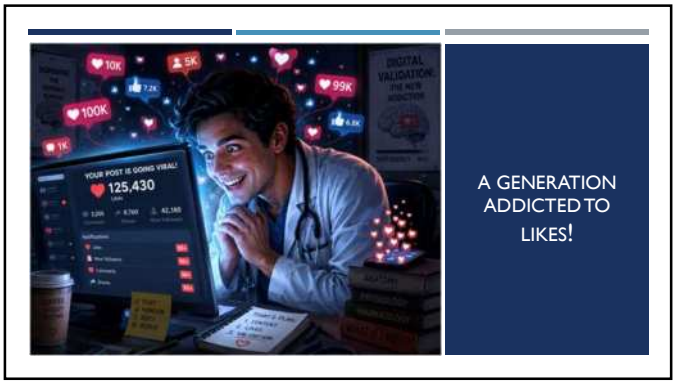
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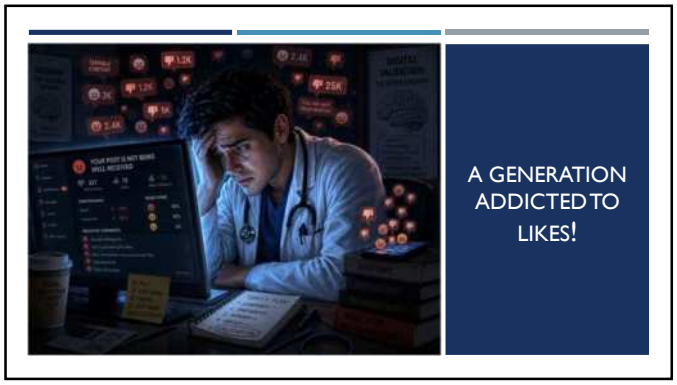
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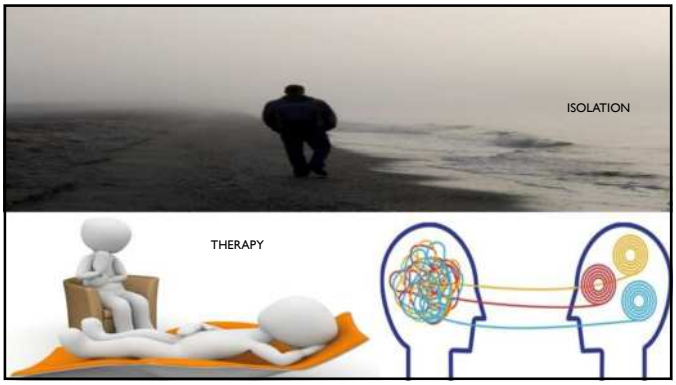
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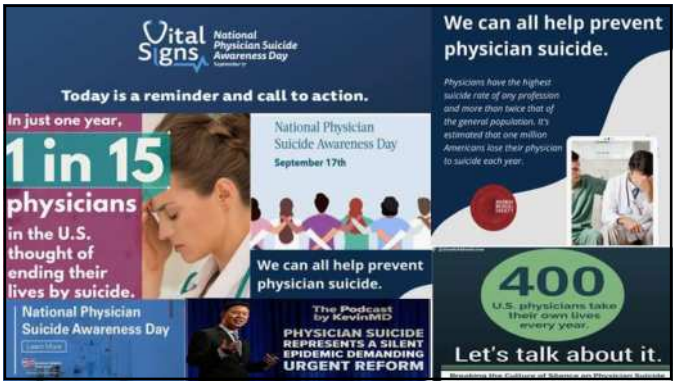
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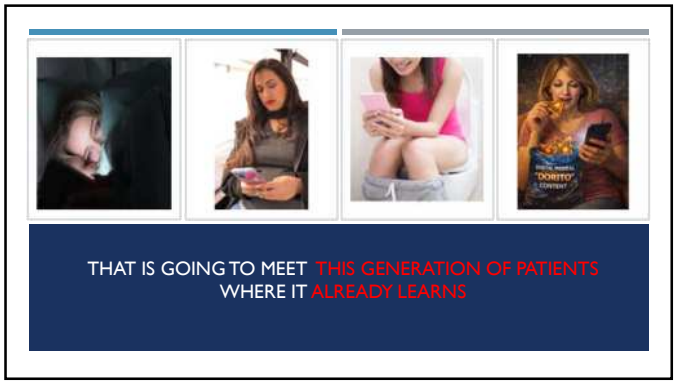
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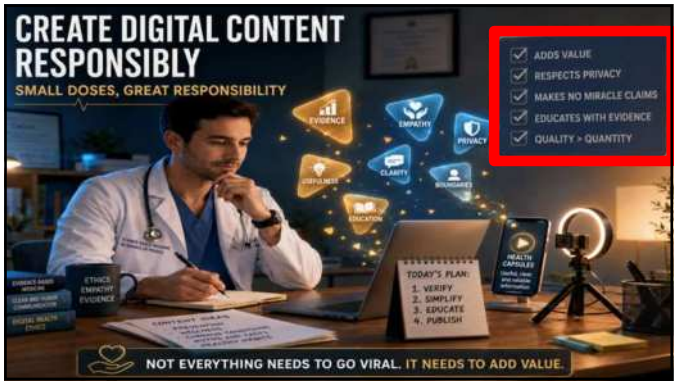
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1977

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In 1977 -

I moved to USA with my young family - to take a job as Assistant Professor in OBGYN at the Medical College of Wisconsin



8

Soon another exciting development occurred -

9

The advent of

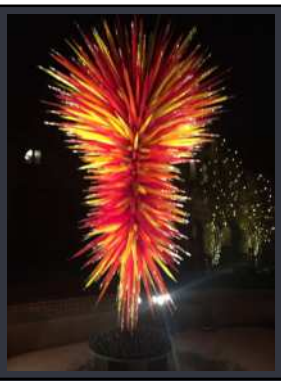
laparoscopic surgery

10

….the advent of

Laparoscopic

Surgery



11

Why was laparoscopy appealing to me?

12

Panoramic vision

Magnification just by moving laparoscope nearer tissue

Less denovo adhesion formation

What surgeries could benefit form this wonderful access?!!

It was a superior medium waiting to be tapped.

Goal:

true Micro surgical tubal anastomosis using 8/0 suture

Replicate all aspects of open microsurgery, but only vary the route of access

Skin Incision ?

13

What were the challenges?

Questions we asked

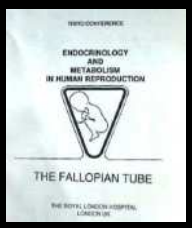
- Adequate magnification ?
- How to suture with 8/0
- How to manage CO2 loss - thin instruments
- How to stent the tube during anastomosis
- What was non-negotiable was the exact replication of the open micro surgical technique

14



For reproducible controlled micro suturing - contralateral style abandoned, ipsilateral method created

15



The audience?

The list of who's who in microsurgery

Including

Robert Winston

Victor Gomel

Ivo Brosens

Maurice Bruhat

.....

World's First Laparoscopic Microsurgical Tubal Anastomosis 8/0 suture

Presented in London, 1992
Charles Koh M.D. Grace Janik M.D.

16

AMERICAN/CANADIAN FERTILITY SOCIETY -

MONTREAL 1993

1ST. PRIZE VIDEO AWARD

"laparoscopic microsurgery"

Charles H Koh MD Grace M Janik MD



17

"The attribute of minimally invasive surgery is abused unless the new access is combined with microsurgical techniques"

I.A.BROSENS. 15th World Congress on Fertility and Sterility, Montpellier,France, 17-22 Sept.1995



Crude laparoscopic Neosalpingostomy

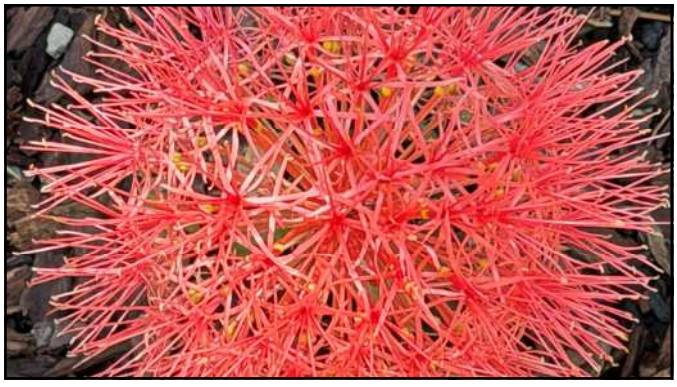


Classical Microsurgical Neosalpingostomy



Laparoscopic Microsurgical Neosalpingostomy

18



22



1989



- Patient for TAH - nulliparous with no descent
- I thought why not do upper pedicles with bipolar and then do easy vaginal hysterectomy ?
- I read about Harry Reich performing a laparoscopic hysterectomy
- LAVH was born.

23

What were the impediments to performing the whole hysterectomy by laparoscopic route?

24





ABDOMINAL HYSTERECTOMY

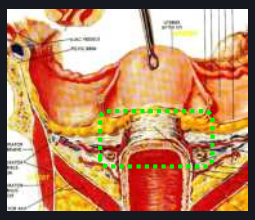
Palpation and Pinch

LAPAROSCOPY -

We lost our fingers!

25

RING OF 'FEAR' or 'FIRE'



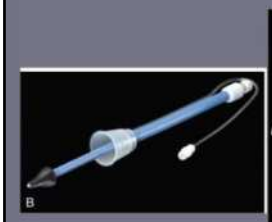


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What if a cup can replace touch with vision?

27

Metal HSG cup used to cut against.





28

- Good mobilization
- Anterflex uterus without damaging vagina fourchette



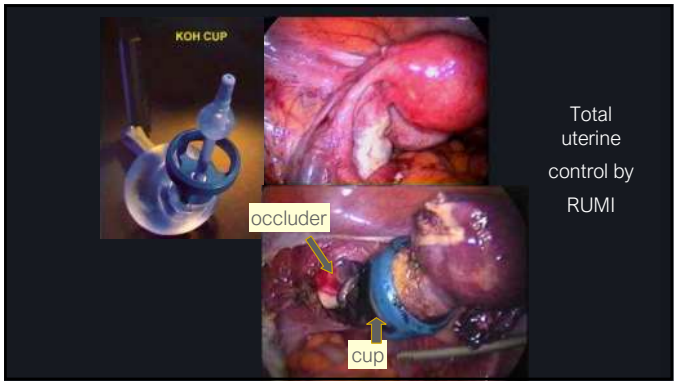
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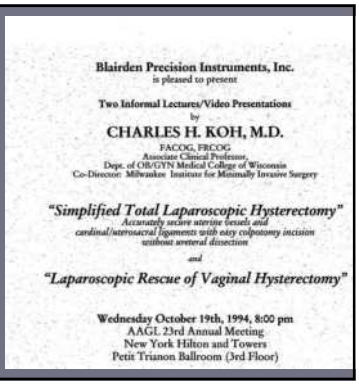
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Milestones

- 1994-1998 Evening lectures at AAGL
- 1996 product approved by FDA
- International meetings, live surgery plus lectures 1996 on -



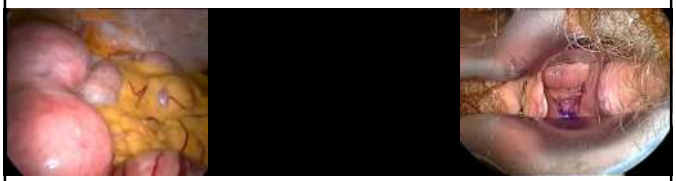
Blairden Precision Instruments, Inc.
is pleased to present
Two Informal Lectures/Video Presentations
by
CHARLES H. KOH, M.D.
FACOG, FRCOG
Associate Clinical Professor,
Dept. of OB/GYN Medical College of Wisconsin
Co-Director: Milwaukee Institute for Minimally Invasive Surgery
"Simplified Total Laparoscopic Hysterectomy"
Accurately secure uterine vessels and cardinal/uterosacral ligaments with easy colpotomy incision without ureteral dissection
and
"Laparoscopic Rescue of Vaginal Hysterectomy"
Wednesday October 19th, 1994, 8:00 pm
AAGL 23rd Annual Meeting
New York Hilton and Towers
Petit Trianon Ballroom (3rd Floor)

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Revelation -
KOH Cup as GPS
to guide the surgery.

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The new microsurgery should be a universal and total solution not only for all tubal problems, but also for surgical challenges emerging in the millenium.

Laparoscopic Microsurgery is that tool

Koh C, Janik G. Laparoscopic Microsurgery: current and future status Current Opinion in Obstetrics and Gynecology 1999,11:401-407

37

Deep Infiltrating Endometriosis-

The art of the possible -

….and the refusal to accept the limits of the possible….

Nash Moawad 2026

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How to prepare yourself?

39

DIE vs IVF

….the eye does not see

what the mind does not know



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2000

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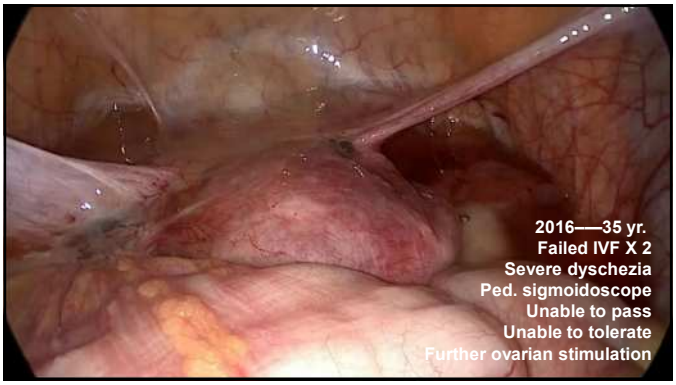
consecutive IVF cases with no embryo transfer outcome after REEFP surgery

	IVF, cancelled ET	REEFP RSC	IVF after REEFP	outcome
BR	2	2002	3	LB
BA	1	2004	1	no preg
JU*	2	2000	0	LB*
ST	2	2000	1	LB
ML	3	2004	1	LB
BF	3	2003	3	ongoing
IND*	6	2004	0	LB*

* spont. LB

- IVF - DIE - no further increase in PR after 2-3 cycles , Ballester 2012

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….Underwent 3rd. IVF

6 months after surgery

- able to tolerate ovarian hyperstimulation

without pain……

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SERENDIPITY

SENSIBILITY

SENSE

46

"The next great innovation in MIGS may not begin in a laboratory. It may begin tomorrow, in your operating room, when you recognize a problem and refuse to accept that there cannot be a better way."



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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/