MIGS 26

55TH GLOBAL CONGRESS ON MIGS

BOSTON, MASSACHUSETTS
NOVEMBER 13-16, 2026

Syllabus

General Session III

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GS03: General Session III

Faculty: Gabrielle Whitmore, Stephen Trzeciak

MedTalk III: 288 - You Don't Know What You Don't Know: Expanding Awareness to Restore Autonomy and Access
Presenter: Gabrielle Whitmore

Description: Despite advances in minimally invasive gynecologic surgery, patients with endometriosis and uterine fibroids continue to face prolonged diagnostic delays, fragmented care, and limited autonomy in treatment decision-making. A major contributor is not a lack of surgical innovation—but a lack of awareness. As clinicians, we often underestimate how much patients, referring providers, and even colleagues do not know they do not know. This talk reframes awareness as a clinical intervention. Using real-world examples, the session explores how MIGS surgeons can move beyond the exam room to become catalysts for education, advocacy, and access. Attendees will learn how to engage their local communities through patient-centered educational forums, leverage social media responsibly for evidence-based education, and build intentional partnerships with PCPs, APPs, and midwives to bridge gaps between symptom recognition and specialty care. The presentation emphasizes scalable, time-efficient approaches that are feasible for both early-career and senior faculty, whether practicing in academic centers or community settings. By improving awareness upstream, surgeons can help restore patient autonomy, shorten time to diagnosis, and ensure equitable access to high-quality gynecologic care.

Learning Objectives: *At the end of this course, the participant will be able to:* 1) Review key gaps in awareness that delay diagnosis and limit patient autonomy in endometriosis and fibroid care; 2) Apply practical strategies to engage communities through educational forums and digital platforms to improve public understanding of gynecologic disease; and 3) Strengthen referral pathways by collaborating with primary care providers (PCPs), advanced practice providers (APPs), and midwives to improve timely access to specialty care.

Learning Objectives: *After attending this session, the participant will be able to:* 1) Compare leading mechanistic models of endometriosis pathogenesis, including metabolic/decidualization dysfunction, inflammatory and immune pathways, neuroangiogenesis, and endocrine/progesterone resistance mechanisms; 2) Explain how these mechanisms may contribute to pain, infertility, lesion persistence, recurrence, treatment response, and the mismatch between visual disease burden and patient symptoms; 3) Identify how mechanistic insights should influence surgical counseling, operative expectations, postoperative suppression, recurrence prevention, and multidisciplinary care; and 4) Recognize the limitations of a purely lesion-centered model of endometriosis and integrate biologic, inflammatory, hormonal, metabolic, neurologic, and patient-centered perspectives into comprehensive care.

Course Outline

4:30 pm	FAAGL Awards	
4:45 pm	MedTalk III: 288 - You Don't Know What You Don't Know: Expanding Awareness to Restore Autonomy and Access	G. Whitmore
5:00 pm	Video on Empathy	
5:05 pm	Keynote Address: “Compassionomics: The Revolutionary Scientific Evidence that Caring Makes a Difference”	S. Trzeciak
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).

PROFESSIONAL EDUCATION COMMITTEE

Harold Wu, MD* - Chairman
Adrian Balica, MD*
Jamal Mourad, DO – Proctor: Intuitive Surgical
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Steven Radtke, MD*
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Linda Bradley, MD, AAGL Medical Director*
Linda Michels, AAGL Executive Director*
Linda Bell, AAGL Admin Support*
Nancy Williams, COO, CME Consultants*

SCIENTIFIC PROGRAM COMMITTEE

Nash Moawad, MD, MS, Chairman – Consultant (ended 12/2024): Medtronic, Womed, Integra Life Sciences
Amani Harris, MD*
Ted Lee, MD – Advisory/Consultant: Johnson & Johnson, Regeneron Pharmaceuticals
Nucelio Lemos, MD, PhD – Speakers Bureau: Pfizer, Inc., Medtronic; Advisory Board: Knight Therapeutics, Vecfer Pharma
Mario Malzoni, MD*
Emad Mikhail, MD – Consultant: Johnson & Johnson
Hannah Palin, MD*
Megan Wasson, DO*
Michael Hibner, MD, PhD*
Jose "Tony" Carugno, MD*
Angela Chaudhari, MD - Consultant: Tag/Dream Medical, Johnson & Johnson; Speakers Bureau: Johnson & Johnson
Linda D. Bradley, MD, Medical Director*
Linda Michels, Executive Director, AAGL*

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).

Stephen Trzeciak, MD, MPH*
Gabrielle T. Whitmore, MD*

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.

You Don't Know What You Don't Know:

Expanding Awareness to Restore Autonomy and Access

Gabrielle Whitmore, MD · University of Colorado Anschutz

NOVEMBER 13-16, 2026 · BOSTON · #AAGL26

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You Don't Know What You Don't Know:

Expanding Awareness to Restore Autonomy and Access

Gabrielle Whitmore, MD · University of Colorado Anschutz

NOVEMBER 13-16, 2026 · BOSTON · #AAGL26

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Disclosure

I have no financial relationships to disclose

4

Objectives

- Review key gaps in awareness that delay diagnosis and limit patient autonomy in endometriosis and fibroid care
- Apply practical strategies to engage communities to improve public understanding of gynecologic disease
- Strengthen referral pathways



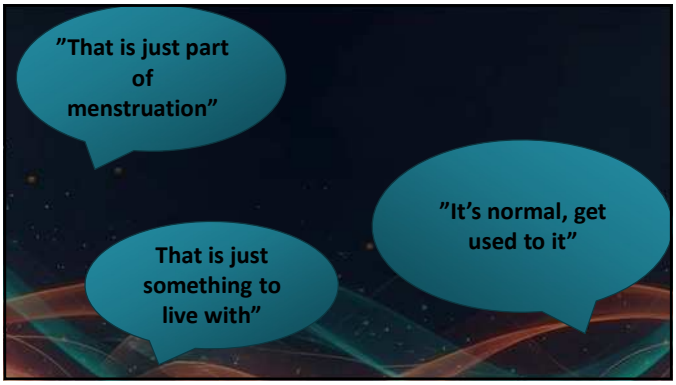
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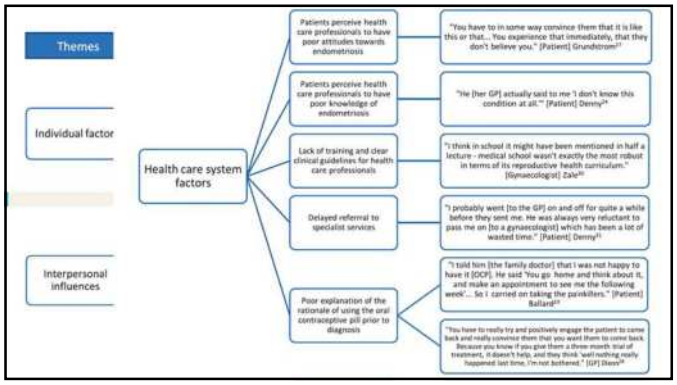
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Awareness Gap

7


”That is just part of menstruation”
”It’s normal, get used to it”
That is just something to live with”

8


Themes
Individual factor
Interpersonal influences
Health care system factors
Patients perceive health care professionals to have poor attitudes towards endometriosis
Patients perceive health care professionals to have poor knowledge of endometriosis
Lack of training and clear clinical guidelines for health care professionals
Delayed referral to specialist services
Poor explanation of the rationale of using the oral contraceptive pill prior to diagnosis
"You have to in some way convince them that it is like this or that... You experience that immediately, that they don't believe you." [Patient] Grundstrom[27]
"He [her GP] actually said to me 'I don't know this condition at all.'" [Patient] Denny[29]
"I think in school it might have been mentioned in half a lecture - medical school wasn't exactly the most robust in terms of its reproductive health curriculum." [Gynaecologist] Zale[30]
"I probably went [to the GP] on and off for quite a while before they sent me. He was always very reluctant to pass me on [to a gynaecologist] which has been a lot of wasted time." [Patient] Denny[31]
"I told him [the family doctor] that I was not happy to have it [OCP]. He said 'You go home and think about it, and make an appointment to see me the following week'... So I carried on taking the painkillers." [Patient] Ballard[32]
"You have to really try and positively engage the patient to come back and really convince them that you want them to come back. Because you know if you give them a three-month trial of treatment, it doesn't help, and they think 'well nothing really happened last time, I'm not bothered.'" [GP] Dixon[33]

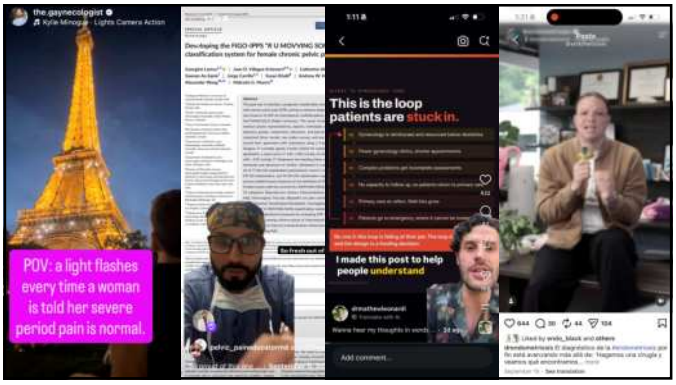
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Step #1:
Patient Education

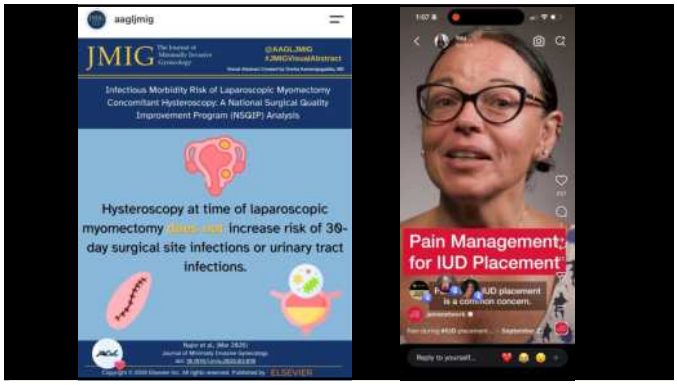
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POV: a light flashes every time a woman is told her severe period pain is normal.
This is the loop patients are stuck in.
I made this post to help people understand

12



13



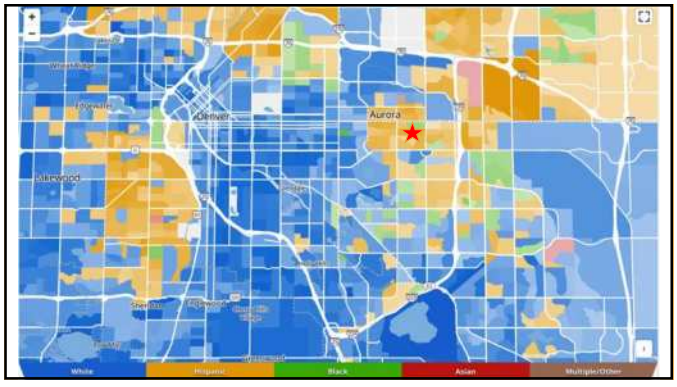
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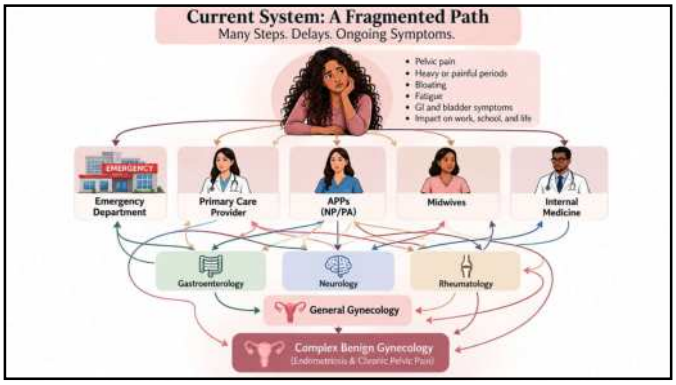
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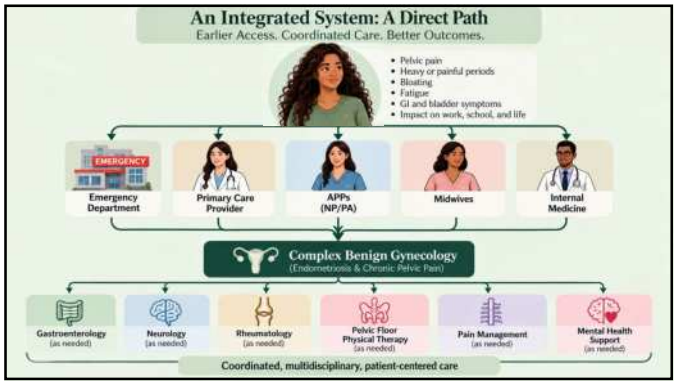
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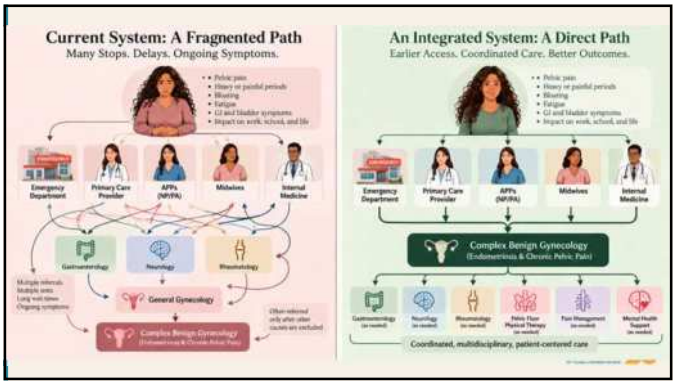
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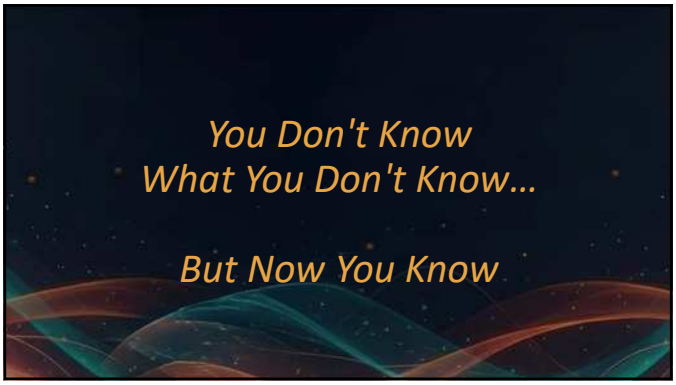
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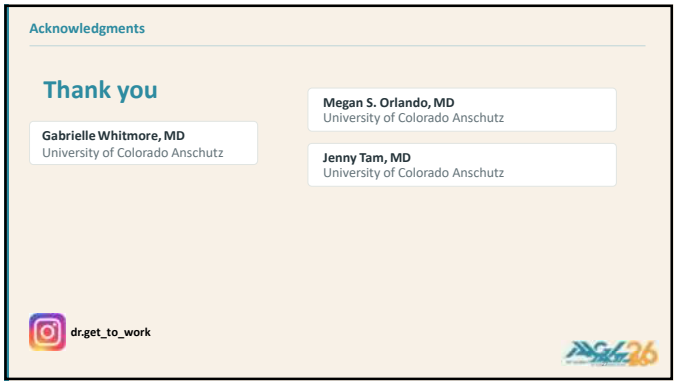
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DISMISSAL
DELAY
AWARENESS
EDUCATION
RECOGNITION
ACCESS
SUPPORT

25


You Don't Know
What You Don't Know...
But Now You Know

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Acknowledgments
Thank you
Gabrielle Whitmore, MD
University of Colorado Anschutz
Megan S. Orlando, MD
University of Colorado Anschutz
Jenny Tam, MD
University of Colorado Anschutz
dr.get_to_work

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Compassionomics

The Science of Human Connection

Stephen Trzeciak, MD, MPH
Edward D. Viner Endowed Chief of Medicine
Cooper University Health Care
Professor & Chair of Medicine
Cooper Medical School of Rowan University
Camden, New Jersey, USA

1

As seen in The New York Times

When Your Technical Skills Are Eclipsed, Your Humanity Will Matter More Than Ever

When Doctors Use a Chatbot to Improve Their Bedside Manner



© Joanne Joo for The New York Times

I'm a Doctor. ChatGPT's Bedside Manner Is Better Than Mine.

2

Disclosures

I have no relationships with commercial interests

I donate my book proceeds to the Cooper Foundation

I receive payments for speaking engagements

I have no "magical thinking"

I am (very much) a work in progress

3

How We Got Here

4



5



6



7



8

Does compassion *really* matter?

9

Definition

Compassion is an emotional *response* to another's pain or suffering involving an authentic desire to *help.*

Empathy + Action = Compassion

10

Physiological

Patient self-care — **Clinical Effects** — **Quality of care**

Psychological

11

Empathy is related to clinical competence in medical care

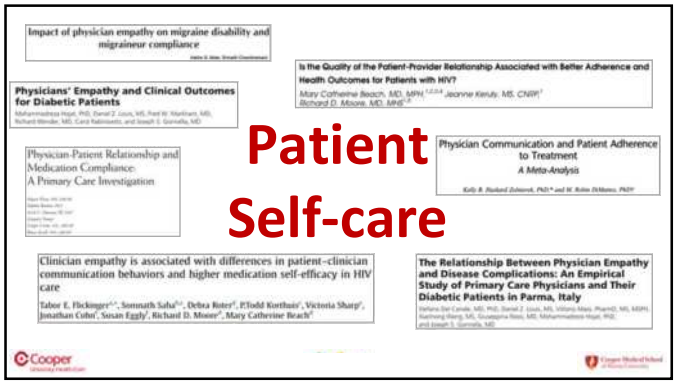
Association of Perceived Medical Errors With Resident Distress and Empathy
A Prospective Longitudinal Study
JAMA

Burnout and Medical Errors Among American Surgeons

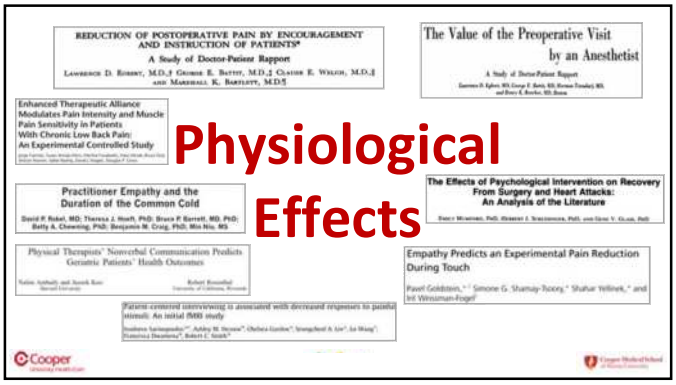
Quality of Care

Burnout and Self-Reported Patient Care in an Internal Medicine Residency Program

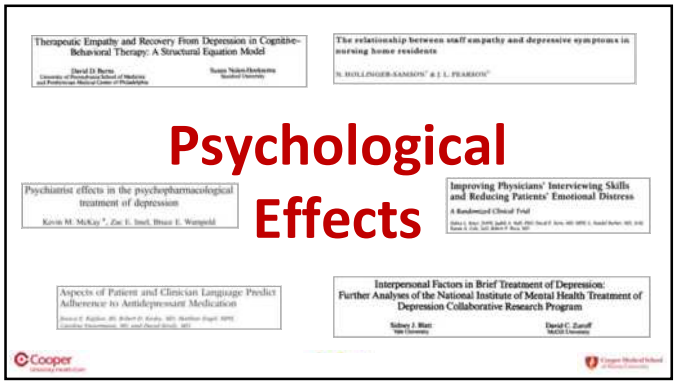
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17



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Definition

Hope is the *belief* that the future will be better than today, *and we play a vital role in making it so.*

Hope = Belief + Action

19

The Compassion Mindset

1. Compassion is *evidence-based* medicine
2. Change is *possible*
3. It's about *time*

20

Change *IS* Possible



Dweck 2006

21



22

40 Seconds

23



24

Compassion is a powerful beneficial therapy for the *giver, too.*

25

n=1

26

What do patients and families *remember?*



Bus Crash



Luke Fildes

27

Contact Me

@DoctorThopeeffect

Substack: The Hope Effect

28

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/