MIGS 26

55TH GLOBAL CONGRESS ON MIGS

BOSTON, MASSACHUSETTS
NOVEMBER 13-16, 2026

Syllabus

PG-14001

Rising Stars

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PG-14001: Rising Stars

Chair: Jeffrey J. Woo
Faculty: Diana Encalada Soto, Christine E. Foley, Esther S. Han, Whitney T. Trotter Ross, Youssef Youssef

Course Description

This postgraduate course highlights emerging leaders in minimally invasive gynecologic surgery who have demonstrated excellence in clinical care, research, education, global health, and professional leadership. Through a series of focused presentations, faculty will share practical strategies for lifelong surgical skill development, academic advancement, research collaboration, leadership growth, and expanding access to gynecologic surgical training worldwide. Attendees will gain insights to help navigate and accelerate their own professional development within gynecologic surgery.

Learning Objectives: *At the end of this course, the participant will be able to:* 1) Evaluate strategies for lifelong surgical skill acquisition, self-assessment, and continuous professional development throughout a career in minimally invasive gynecologic surgery; 2) Identify opportunities to advance academic and professional success through research funding, collaborative networking, global health engagement, and scholarly productivity; and 3) Apply principles of leadership, mentorship, and career development to foster growth as an educator, investigator, and administrative leader within gynecologic surgery.

Course Outline

8:00 am	Welcome, Introduction and Course Overview	J. Woo
8:05 am	Critical Self-Assessment and Life-Long Surgical Skill Acquisition	D. Encalada Soto
8:25 am	Training Gynecologic Surgeons in Low- and Middle-Income Countries	E. Han
8:45 am	Clinicians Engaged in Research-Securing NIH Funding	W. Trotter Ross
9:05 am	Growth and Success in Administrative Leadership	C. Foley
9:25 am	Research Collaboration through Professional Networking	Y. Youssef
9:45 am	Discussion Questions & Answers	All faculty
10:00 am	Adjourn	

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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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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
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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*

COURSE CHAIR

Jeffrey J. Woo, MD*

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).

Diana Encalada-Soto, MD – Stockholder: Intuitive Surgical
Christine E. Foley, MD*
Esther S. Han, MD*
Whitney T. Trotter Ross, MD - Advisory Board and Consultant: Roche
Youssef Youssef, 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.

The presentation content for course faculty, Drs. Encalada-Soto and Trotter Ross, has been peer reviewed and found to be fair, balanced, and free from commercial bias.

Critical Self-Assessment & Life-Long Surgical Skill Acquisition

What Thinking, Fast and Slow teaches us about building surgical judgment

Diana Encalada-Soto, MD
Minimally Invasive Gynecologic Surgery
University of South Florida Morsani College of Medicine

NOVEMBER 13–16, 2026 · BOSTON · #AAGL26

1

Disclosure

Stockholder – Intuitive Surgical

2

Objectives

At the end of this session, participants will be able to:

1. **Analyze** how System 1 and System 2 thinking shape intraoperative decisions in complex MIGS.
2. **Apply** critical self-assessment tools structured video review and feedback loops to accelerate surgical skill acquisition.
3. **Justify** staged surgical planning in complex endometriosis and fibroid cases as calibration, not limitation.

3

THE GAP

Wanting to do it isn't the same as being ready



You finished fellowship. You want the deep infiltrating endometriosis, the 1500-gram uterus, the Müllerian anomaly.

But readiness isn't a switch you flip on graduation day.

The dangerous part: the intuition to proceed feels exactly the same whether it's earned or borrowed.

> *"This talk is about the surgeon you can't see on the CV → the one who knows what they don't yet know.*

4

THE QUESTION

How do we get good at hard cases → safely?

Technical skill is the visible curriculum.

Judgment is the hidden one → and it's what decides whether a complex case goes well.

1	2	3
Know	Know	Know
when to proceed	**when to slow down**	**when to convert or refer**

5

THE FRAMEWORK

Two systems run every operation

SYSTEM 1

Fast, intuitive, effortless

- Pattern recognition built from reps
- "This feels routine"
- Trustworthy only when the reps are real
- "Muscle memory"

SYSTEM 2

Slow, deliberate, effortful

- Conscious, step-by-step reasoning
- "Wait — what am I assuming here?"
- Your safety net for anything unfamiliar

Expertise = a System 1 you've earned. Until then, complex cases must run on System 2.

6

THE TRAP

Borrowed confidence feels identical to earned confidence

From the inside, you can't tell the difference

which is exactly why early complex cases go wrong. The feeling of certainty is not evidence of readiness.



Feels the same

7

THE CORE RISK

Confidence and competence are different curves

Confidence climbs fast and early.

Competence climbs slowly, with reps and feedback. The gap between them → early in the curve →is where the risk lives.



8

IN THE MOMENT

Four biases that bite in the OR

1 Anchoring
Locking the plan before the anatomy speaks.

2 WYSIATI
Acting on what you see → forgetting the ureter and bowel you don't.

3 Sunk cost
Pushing a dissection because you're 90 minutes in.

4 Planning fallacy
Underestimating complexity, blood loss, and time.



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THE ANTIDOTE

Critical self-assessment is a discipline Not a personality trait.

The counter to a fast, overconfident System 1 is engineered slowness plus honest feedback. You can build it deliberately.

10

THE ASYMMETRY

Women are penalized twice: trained to doubt, then judged for hesitating

Trained to underestimate
In 8,149 operative assessments, women rated themselves below their attendings; men rated themselves above.[1]

Judged for hesitating
Then the caution that keeps a patient safe gets read as a lack of confidence in the room, in the referral pattern, on the panel.

MY OWN EXPERIENCE

For years I read my own hesitation as proof I wasn't ready. It was the discipline doing its job.

What changed was a system, not confidence: my own numbers, a colleague who tells me the truth, a written stop rule.

[1] Resident self-assessment vs attending assessment, 8,149 operative evaluations across three training programs; female residents underestimated and male residents overestimated performance at PGY2–6. Source: American Journal of Surgery, 2020.

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HOW SKILL IS BUILT

Valid intuition needs valid feedback

Intuition without feedback just calcifies error.

Five loops keep your System 1 honest → and none of them need a complication to start.

1 Video review
Watch your own cases → unedited.

2 Case review
Name the decision, not just the outcome.

3 Surgical coaching
A trained peer watching how you decide.

4 Mentorship
A second set of eyes on hard calls.

5 Outcome tracking
Measure results; don't trust memory.

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CASE REVIEW, UNPACKED

Four ways to review a case

EVERY CASE

Routine debrief

Two minutes at the end of the list: what did I decide, and why? No trigger needed.

SCHEDULED

Surgical coaching

A trained peer gives structured feedback on how you decide → a skill you can be trained in, through formal programs.

WHEN IT HAPPENS

Near-miss review

The case that almost went wrong. No harm, so no M&M → and the richest data you will get.

AFTER HARM

Honest M&M

The formal backstop. Necessary, and the most expensive place to learn a lesson.

Routine, cheap, no trigger required

Rare, costly, after the fact

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MY OWN CASE

Challenging case
Felt good tackling it

The case

Stage IV endometriosis.

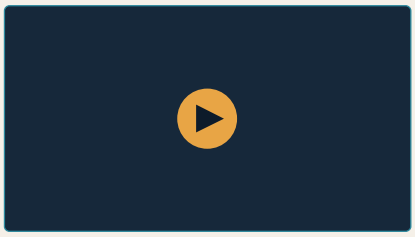
A prior laparoscopy had been converted to laparotomy by gyn-onc, with an enterotomy and a bladder injury.

What I did

Bladder resection, LAR with anastomosis, hysterectomy and BSO.

Completed minimally invasively, with colorectal surgery and urology.

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MY OWN CASE

We repaired the enterotomy I could see → the injury was through and through

What I missed

Palmer's point entry caused a small bowel enterotomy. Colorectal repaired it intraoperatively → no problem Right?.

Neither of us inspected the opposite wall. The injury was through and through. She went back to the OR the next day and recovered well.

The rule now: every enterotomy gets the opposite wall inspected before we move on. My colorectal colleague took the same lesson the loop only works if someone says it out loud.

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Watch for the reassessment, not the technique

THE CASE

Deep infiltrating endometriosis on bowel and bladder + plus significant fibroids

The honest question isn't whether you ***can*** keep going → it's whether you ***should***, today.

As you watch, ask what System 1 is pulling toward — and what makes System 2 step in.

17



18

WHAT JUST HAPPENED

Do it all now? or stage it?

SYSTEM 1 WANTED

- "I'm already in here → take the fibroids too."
- One anesthetic, one recovery: better for her
- Momentum, and the pull to finish everything

SYSTEM 2 CHECKED

- Endo on bowel and bladder is the priority → and the harder dissection
- A myomectomy now compounds time, blood loss, and risk
- Stage it → **not "can I?" but "should I, today?"**

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ANOTHER LENS →JOHN MAXWELL

Critical self-assessment is a law of growth

Kahneman names the cognitive trap. Maxwell names the habit that beats it → three of his 15 Laws of Growth map straight onto self-assessment:

1

Law of Awareness

Know yourself to grow yourself.

See your real skill level clearly the foundation of every safe complex case.

2

Law of Reflection

Learning to pause lets growth catch up.

The debrief is where reps become skill: watch the tape, name the decision.

3

Law of the Rubber Band

Keep the tension between where you are and where you could be.

Mind the confidence–competence gap — keep it productive, not dangerous.

20

THE LONG GAME

The curve never really flattens → unless you let it

A fellowship certificate is a starting line, not a finish. Expertise is deliberate reps plus feedback, sustained across a career.

1 **Fellowship** — 2 **Early practice** — 3 **Complex cases** — 4 **Mastery — ongoing**

The day you stop assessing critically is the day your skill curve goes flat.

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MONDAY MORNING

Three things you can start next week

1

Build a loop you can't dodge

Video your own cases and actually watch them back.

2

Force System 2 before hard cases

Ask out loud: "What would make me convert today?"

3

Separate confidence from competence

Track outcomes, not vibes. Let data calibrate you.

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Stay a student of your own hands.

The best complex surgeons aren't the most confident → they're the best calibrated.

Diana Encalada-Soto, MD, MHA, FACOG
Minimally Invasive Gynecologic Surgery · USF / Tampa General

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Acknowledgments

Thank you

All my mentors across my career, and the colleagues and trainees still ahead.

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3. Cooney CM, Aravind P, Lifchez SD, et al. Differences in operative self-assessment between male and female plastic surgery residents: a survey of 8,149 cases. Am J Surg. 2021;221(4):799–803.
4. Maxwell JC. The 15 Invaluable Laws of Growth: Live Them and Reach Your Potential. New York: Center Street; 2012.

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Training Gynecologic Surgeons in Under Resourced Communities

Esther S. Han, MD, MPH · Columbia University Medical Center

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1

Disclosure

I have no financial relationships to disclose.

2

Objectives

- Describe what I do
  - Focus on Capacity Building
- Describe how I do it
  - Minimally Invasively!
- Discuss how you can do it too
  - Compare different models







3

Guatemala City






4

Mwanza, Tanzania






5

Missions Trips

Team Schedules 2026

May 21st to 22nd Gastroenterology – Dr. Brian Brunson

May 21st to 22nd Podiatry- Dr. Robert Russell

May 25th to 27th Rheumatology – Dr. Greg Eudy

June 15th to 18th Endoscopy and Colonoscopy – Dr. Pooja Elias Group

July 20th to 24th Endocrinology – Dr. Avantika Waring

October 5th to 9th Ophthalmology – Dr. David Danse's Group

October 11th to 16th Plastic and General Surgery – Spanish Group

November 2nd to 5th Endoscopy and Colonoscopy – Dr. Michael Dougherty

November 9th to 20th Odontology – Dr. Cameron Qualey

November 30th to December 4th Pediatrics – Seattle Group




6

Capacity Building: Rural Guatemala






7

Logistically speaking…

Why should your hospital/division let you go?
- Appeal to the academic mission
- Trainees
- Research

Funding

Time

RVU's

8

Know who & what you have to work with






9

Didactics and Sim Sim Sim





10

Complex pathology







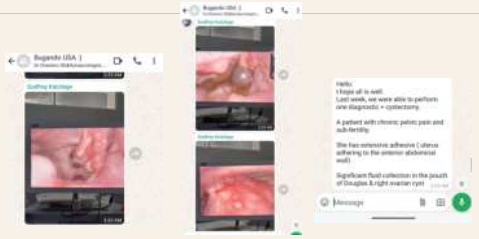
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Be flexible

12

The Rewards



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Clinicians Engaged in Research- Securing NIH Funding

Whitney Ross, MD, MSCI · WashU Medicine

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1

Disclosure

- Society of Gynecologic Surgeons (SGS) Executive Committee
- Advisory board member, Roche Pharmaceutical, October 2025
- Funding:
  - National Institute of Health, 1K23HD110710-01 and 1R21HD115568-01A1
  - Advanced Research Projects Agency for Health (ARPA-H), Sprint for Women's Health
  - Washington University Institute of Clinical and Translational Sciences (ICTS) KL2
  - Doris Duke Fund to Retain Clinical Scientists Scholarship
  - Society of Gynecologic Surgeons robotics award

2

Objectives

- Discuss research structure
- Describe funding mechanisms
- Summarize my journey
- Formulate action plans for getting engaged research



3



4

Example: 1 year of prospective study costs

- 50-patient study requiring a full-time research coordinator:
  - Research coordinator- $80,000
  - Regulatory oversight (10hrs/month)- $15,000
  - Participant compensation ($50/participant x 50 participants)- $2500
  - Statistician (100 hours)- $7,000
  - Software- REDCap, Qualtrix, Nvivo, SPSS, etc.- variable
  - Surgeon time (10% FTE)- $22,800
- Sum: $127,300
- Indirects
  - … $197,315

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Scrappy Research

- Invest your own time (when available)
- Mentor trainees (undergrad, med students, residents, fellows, allied health grad students)
- Pooled research staff support

6

Where to find money…

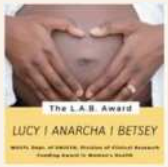
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Clinical Revenue or Institutional funds

- Division or Department allocated funds
  - Helpful for seed funding and getting pilot data
  - Fellow projects
  - Not feasible for smaller groups
- Institutional grants
  - Check out what's available, you might be surprised!
  - WashU examples:

Institute of Clinical and Translational Sciences
Just-In-Time (JIT) Core Usage Funding Program

WashU Research Seed Grants



8

Collaboration

- Basic or Translational partnerships
  - Basic scientists often need clinical partners to ground research and scientific questions to patient relavence
  - Patient samples for research


Kelly Wright


Nicole Donellan


Danielle Luciano

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Foundation Grants

- ABOG/AAOGF
- She+ Foundation, Foundation for Women's Health
- Sign up for funding newsletters/updates from organizations
- SGS:

CoRPS

FPRN Fellows' Pelvic Research Network

Systematic Review Group



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Federal Funding

- NIH (National Institute of Health)
  - Has different institutes with different scientific focuses (NICHD)
- ARPA-H (Advanced Research Program Agency for Health)
  - High risk, high reward focus
- PCORI (Patient Centered Outcomes Research Institute)
- DOD (Department of Defense) and VA (Veterans Affairs)
  - Millitary and veteran health focus

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NIH funding process



Peer Review Factors:
1. Importance of the research (Should it be done? Why?)
2. Rigor and Feasibility (Can it be done well? How?)
3. Expertise and Resources (Are the right people and physical resources in place?)

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NIH grant types- Alphabet Soup!

Grant type	Simple explanation
R01	Funds a substantial, defined research project
R21	Supports exploratory, innovative research
R03	Supports smaller, focused projects
K awards	Supports development of a research career, including protected time
U01	Supports collaborative research with substantial NIH involvement
SBIR/STTR	Small business grants


Suzie As-Sanie- R01, M01


Sara Till- K23, R01


Frank Tu- K23, R01


Erin Carey- SBIR


Amira Quevedo- K08

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Industry funding

- Investigator-initiated trials
- Being a site for a phase II trial
  - Example Elagolix or Relugolix
- Special funding calls
  - Pfizer Research Funding Program

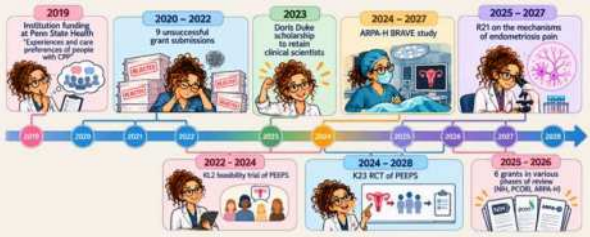
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Grateful Patients or Endowments

- Donations to a university for a specific research reason
- Endowments
- Don't have advice on this.. really amazing when it happens!

15

My journey



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Mentorship Team


Dineo Khabele, MD
WashU Gyn Onc


Graham Colditz, MD, DrPH
WashU Public Health


Debbie Frank, PhD
WashU Scientific Editor


Susie As-Sanie MD, MPH
Univ. Michigan MIGS


Joy Balls-Berry, PhD, MPE
WashU Neurology & Community Engaged Research


Ana Bauman, PhD, MA
WashU Implementation Science

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Teams


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Katie de Souza MD
Elise Bardawil MD

Hadas Nahman-Averbuch PhD, Adam Dourson PhD, Alana McMichael MHA, Joel Brown RN




Jasmine Jones


Latrice Dixon


Cynthia Munson


Kirsten Hoffman DPT, Sarah Buday PhD, Emily Yakel DPT, Emily Kaszyk DPT, Kate Mulligan MPH, Taylor Sheffield DPT

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Not every surgeon needs to write an NIH grant. But every surgeon can ask the questions—and contribute to the research—that moves our field forward.

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Start small and find friends

- Are you at an academic university?
  - See what resources you have in other silos
  - Sign up for funding newsletters/grant updates
  - Seek out basic scientist partners
- Not academic? No problem
  - SGS CoRPS and Systematic Review Group were designed for you
- Research isn't all or nothing
  - Pilot data and established teams are necessary to make the leap to alphabet soup

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Acknowledgments

- Images created with ChatGPT
- Thankful to my funders!

Institute of Clinical and Translational Sciences

NIH Eunice Kennedy Shriver National Institute of Child Health and Human Development

ARPA-H

DORIS DUKE FOUNDATION

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Growing and Succeeding in Administrative and Academic Leadership in Medicine

Christine Foley, MD
Division Chief, Complex Benign Gynecology
Beth Israel Deaconess Medical Center
Harvard Medical School

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1

Disclosures

- *I have no financial relationships to disclose*

2

Objectives

- *Describe the differences between academic and administrative leadership*
- *Discuss mentorship and sponsorship as critical steps in leadership*
- *Develop an action plan for the first 12 months at a new job*
- *Identify barriers to leadership and examine strategies to overcome these*

3

Why leadership skills matter in medicine

- Physicians increasingly lead clinical programs, departments, schools, and health systems, often with little formal preparation
- Trainees and early-career faculty report a need for systematic leadership development
- Leadership quality is linked to outcomes that matter: team well-being, engagement, and retention
- Leadership is a learnable skill set, not only a personality trait

Warren & Carnall, Postgrad Med J 2011; Blumenthal et al., Acad Med 2012; Shanafelt et al., Mayo Clin Proc 2015

4

Two Overlapping Pathways: Administrative and Academic

Administrative Leadership

- Program or clinic director, medical director, CMO
- Operations, budgets, quality, staffing
- Credibility through execution and stewardship
- Key skills: finance, change management, conflict resolution, operations

Academic Leadership

- Division chief, vice chair, chair, dean
- Research, education, faculty promotion
- Credibility through scholarship and teaching
- Key skills: mentoring, strategy, resource development

Synthesis; see Lucas et al., Acad Med 2018; Straus et al., Acad Med 2013

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Two Overlapping Pathways: Administrative and Academic

Administrative Leadership

- Surgical services
- Robotics committee
- Quality improvement or peer review
- Simulation (for multidisciplinary)
- Medical director

Academic Leadership

- Fellowship Leadership
- Residency rotation director
- Simulation (for GME)
- Undergraduate Medical Education - small group leader, course director etc

Synthesis; see Lucas et al., Acad Med 2018; Straus et al., Acad Med 2013

6

Academic Leadership Make Your Work Count!

CV Management

- During onboarding - update your CV to the institutional formatting
- Meet with a senior leader (Division Director, head of promotions / faculty development) to review CV within first 3 months
- Keep a live document on your desktop and update it immediately
- Meet regularly to discuss promotions
- Include everything!

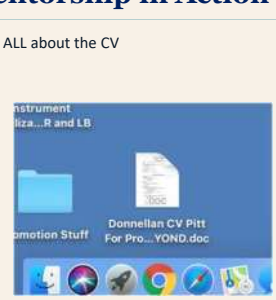


Synthesis; see Lucas et al., Acad Med 2018; Straus et al., Acad Med 2013

7

Mentorship in Action

- It is ALL about the CV





8

Academic Promotions

Why Get Promoted?

- Recognition from your home institution
- Recognition from national/international peers
- Increase in compensation
- More marketable in seeking new employment
- Get the credit you deserve!

Rank	Usual Duration of Appointment
Transitional Position (following completion of 3-year fellowship) • Instructor • Lecturer • Clinical Associate • Etc.	1 - 5 years
Assistant Professor	5 - 8 years
Associate Professor	5 - 10 years
Professor	Until resignation or retirement

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Action Items For Academic Leadership

- Update CV
- Meet with Division Director / Vice Chair of Faculty Development
- Explore your institutions' website – typically have recorded webinars for promotions / understanding tracks
- Make your interests known to increase chances of sponsorship

10

Equity: strengthening the leadership pipeline

The gap

- Gender differences in rank, retention, and leadership persisted in national faculty survey data
- Pipeline alone does not close the gap

What helps

- Leadership programs for under-represented groups (e.g., ELAM) were associated with advancement in rank and leadership roles
- Sponsorship, transparent promotion criteria, and bias-aware selection

Practice: if you lead, audit who gets nominated, sponsored, and appointed.

Carr et al., Acad Med 2018;93:1694-1699; Dannels et al., Acad Med 2008;83:488-495

11

Women in Academic Medicine

Group (women as % of total)	2013	2023	Change
All full-time faculty	38%	**45%**	+7 pts
Instructor	56%	**59%**	+3 pts
Assistant professor	44%	**49%**	+5 pts
Associate professor	34%	**43%**	+9 pts
Full professor	21%	**29%**	+8 pts
Division / section chiefs	24%	**34%**	+10 pts
Department chairs	15%	**25%**	+10 pts
Medical school deans	16%	**27%**	+11 pts

Representation falls at each step up the ladder: 45% of faculty, 29% of full professors, 25% of chairs.

Lautenberger & Dandar. The State of Women in Academic Medicine 2023-2024. AAMC; 2024 (AAMC Faculty Roster, Dec 31, 2023 snapshot)

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Administrative Leadership

Roadmap for Success

Meet with Division Director, Chair, QI Leaders

Identify opportunities to use your unique skills

- Examples: ERAS, SDD, Centers of Excellence

Only take on projects you have capacity for and are interested in

Learn the language of finance, reimbursement, strategy, operations (consider courses, PG courses, podcasts)

Know your worth, value, skills

Consider formal training



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Administrative Leadership

Examples:

Surgical services committee (early)

Robotics committee if interested

Quality Improvement / Peer Review

Specialty Clinic / Programmatic Development

Keep Track of EVERYTHING



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Mentorship: The Foundation

- A systematic review linked mentoring to career guidance, personal development, and research productivity
- Reported gaps: lack of available mentors, and limited institutional support for mentoring relationships
- Evidence quality is modest (largely self-reported), so benefits are associations, not proof of causation
- Practice: build a mentoring team (content, career, and peer mentors) rather than relying on one person

Sambunjak, Straus & Marusic, JAMA 2006;296:1103-1115

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Beyond mentorship: seek sponsorship

Mentor

- Advises and coaches
- Shares experience
- Supports skill development
- Can be at any seniority

Sponsor

- Advocates in rooms you are not in
- Nominates you for roles and visibility
- Uses own influence and capital
- Usually senior and well connected

Practice: make your accomplishments visible and specific so a sponsor can speak to them.

Ayyala et al., Acad Med 2019;94:94-100

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Beyond mentorship: seek sponsorship

Mentor

- Nicole Donnellan
- Star Hampton
- Kelly Wright

Sponsor

- Melissa Murphy – colorectal surgery, chief of surgery
- Christine Brousseau – ACOG

Important: If someone sponsors you, and you accept, performance is critical

Ayyala et al., Acad Med 2019;94:94-100

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Role of Professional Societies

- It is never too early to network nationally (and internationally!)
- Place to identify mentors / sponsors
- Involvement counts on CV
- Skill acquisition (PG courses, CME)

ACOG American College of Obstetricians & Gynecologists

AGL ELEVATING GYNECOLOGIC SURGERY

SGS

AMERICAN COLLEGE OF SURGEONS

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Core leadership competencies to build

Self

- Self-awareness
- Emotional intelligence
- Resilience and values clarity

Others

- Communication
- Feedback and coaching
- Conflict resolution
- Team building

Organization

- Vision and strategy
- Financial literacy
- Change management
- Systems thinking

Taylor, Taylor & Stoller, J Gen Intern Med 2008; Frich et al., J Gen Intern Med 2015

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A staged career roadmap

1

Early career

Build clinical or scholarly identity; find mentors; take on small projects (committee, curriculum, QI)

2

Mid career

Lead programs or divisions; join a leadership program; seek a sponsor; build budget skills

3

Senior career

Lead departments or institutions; shape strategy and culture; sponsor and develop others

Synthesis of Straus et al. 2013; Lucas et al. 2018; Ayyala et al. 2019

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Formal leadership development: what the evidence shows

Frich 2015

- 45 studies of physician programs
- Most emphasized skills and knowledge
- Less on personal growth and awareness

Straus 2013

- Systematic review in academic medical centers
- Programs generally reported positive outcomes
- Rigor of evaluation was limited

Lucas 2018

- National survey of academic health centers
- Mapped offerings and gaps
- Provides benchmarks for program design

Takeaway: programs are promising, but choose ones with clear curricula, practical projects, and peer networks.

Straus et al., Acad Med 2013;88:710-723; Frich et al., J Gen Intern Med 2015;30:656-674; Lucas et al., Acad Med 2018;93:229-236

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Limits of the evidence and common pitfalls

Evidence limits

- Mostly self-reported, short-term outcomes
- Few controlled designs
- Publication and selection bias

Career pitfalls

- Accepting roles without protected time or resources
- Neglecting scholarship or clinical credibility
- Going without a mentor or sponsor
- Ignoring your own well-being

Straus et al. 2013; Frich et al. 2015; Sambunjak et al. 2006

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A 12-month action plan

Months 1-3	Self-assess; meet with your leadership teams; identify 2-3 mentors; update CV; needs assessment at your new institution
Months 4-6	Consider an external leadership roll in professional society; join a local committee; take on one stretch project at home institution
Months 7-9	Identify a sponsor; make results visible; learn your value
Months 10-12	Review progress; set a 3-year role goal; begin mentoring someone

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Key takeaways

- Leadership is learnable: invest in competencies, not just titles
- Build a mentoring team and actively seek sponsorship
- Choose structured leadership programs, but expect modest, mostly short-term evidence
- Be accountable – quality over quantity
- Build equity into how you select, sponsor, and promote
- Don't take no as an answer ;)

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Research Collaboration through Professional Networking

Youssef Youssef, MD, FACOG · Cleveland Clinic, Cleveland, OH

NOVEMBER 13-16, 2026 · BOSTON · #AAGL26

1

Disclosure

- I have no financial relationships to disclose.

2

Objectives

- Describe how networks form across career stages
- Identify the motive behind each collaboration
- Apply skills worth collaborating with

3

RISING ~~STAR~~

4

"You're all over the place."



EEL Young Team · SRS / ASRM Electronic Education Committee · AAGL International Fellowship Committee

5

There was no network.

There was a need.

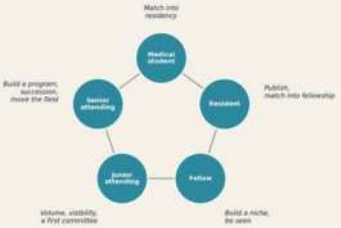
6

The network of medicine



7

Every edge is a need



8

“I should publish more” is not a why.

9

Networking is not a handshake.

It’s the set of people you’ve actually worked with.

10

When · With whom · Where · How

When
Before you need anything
The email you send when you want something is a request.

With whom
Sideways, not just up
Your co-fellows will be your co-authors for thirty years.

Where
Where the work is
Video sessions, PG courses, the committees nobody applies to.

How
Something small and finishable
“Can I be mentored by you” is unanswerable. “I’ll have it back in a week” is a yes.

11

A mentor talks to you.

A sponsor talks about you.

12

Nobody collaborates with enthusiasm.

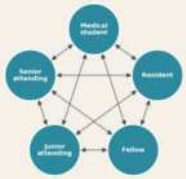
They collaborate with a skill.

- Video editing
- Databases (NSQIP)
- Systematic review & meta-analysis
- AI in medicine

Pick one. Then you're not asking to join a project — you're the reason it finishes.

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Collaboration is not a favor



It's how the work gets better.

14

1. **Know your need**
2. **Build a skill**
3. **Find your people**
4. **See the opportunity**
5. **Bring a plan**

It won't always work.

15

Be a sponsor

Put someone's name on a list

16

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/