MIGS 26

55TH GLOBAL CONGRESS ON MIGS

BOSTON, MASSACHUSETTS
NOVEMBER 13-16, 2026

Syllabus

PG-14004

The Anatomy of a Complication:
Avoiding, Recognition, & Repair

HONORARY CHAIR
Charles H. Koh, MD

SCIENTIFIC PROGRAM CHAIR
Nash ?*Moawad, MD

PRESIDENT
Michael Hibner, MD, PhD



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PG-14004: The Anatomy of a Complication: Avoiding, Recognition, & Repair

Chair: Joseph L. Hudgens
Faculty: Amanda Ecker, Joseph L. Hudgens, Samar Nahas, Megan Wasson

Course Description

This course will focus on one of the greatest challenges in complex pelvic surgery with an emphasis on strategies to avoid complications, recognizing complications when they occur, and repair techniques and including appropriate intra-operative consultation. This course will focus on four types of the most challenging complications that pelvic surgeons face including: Ureteral & Urologic injuries, Bowel injuries, Vascular complications, and prevention and management of thermal injuries.
This course will focus not just on the understanding of how to prevent and why a complication may occur, but also strategies to improve recognition, appropriate intra-operative consultation, repair, as well as follow-up management.

Learning Objectives: *At the end of this course, the participant will be able to:* 1) Identify appropriate diagnostic tests to identify ureteral and urologic injuries and develop strategies for appropriate consultation and repair; 2) Identify bowel injuries and apply techniques for appropriate repair; and 3) Identify risk factors for vascular and thermal injuries and deploy strategies to mitigate these risk utilizing surgical dissection techniques.

Course Outline

8:00 am	Welcome, Introduction and Course Overview	J. Hudgens
8:05 am	Going With the Flow: Prevention, Recognition, and Repair Strategies for Ureteral and Urologic Injuries	J. Hudgens
8:30 am	Seeing Red: Strategies for the Prevention and Repair of Vascular Injuries	S. Nahas
8:55 am	Don't Be Shocked: Understanding Electro-Surgical Dissection Techniques to Mitigate Thermal Injuries	M. Wasson
9:20 am	Bossing the Bowel: Bowel Injury Prevention, Recognition, and Repair	A. Ecker
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.

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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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Linda Michels, Executive Director, AAGL*

COURSE CHAIR DISCLOSURE

Joseph L. Hudgens, 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).

Amanda M. Ecker, MD*
Joseph L. Hudgens, MD*
Samar Nahas, MD, MPH*
Megan Wasson, DO*

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.

Going with the Flow: Prevention, Recognition, & Repair Strategies for Ureteral and Urologic Injuries

Jay L. Hudgens M.D.

Associate Professor & Vice Chair of Gynecology
Division Director of General Obstetrics & Gynecology
Director of Sentara-EVMS Center for Advanced Gynecologic Surgery

Department of Obstetrics & Gynecology
Eastern Virginia Medical School

1

Disclosures

- No financial disclosures

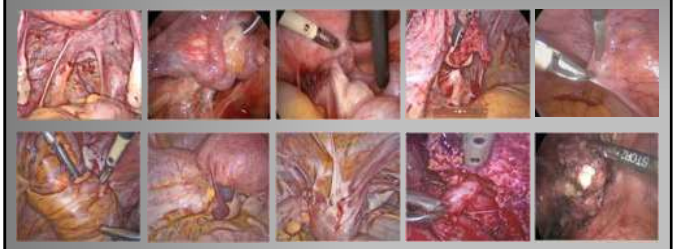
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Objectives

- Review the relative Urologic Anatomy encountered in pelvic surgery and how to avoid injuries
-
- Review strategies to recognize when injuries occur
- Review principles for repairing urologic injuries

3

What is the Plan????



4

How to Avoid Complications

Preparation and planning

5

How to Avoid Complications

Dissect parallel to the ureter

Dissect Parallel to the bladder

Stay out of bleeding

6

How to Avoid Complicating Complications

Recognize the injury

Repair the injury

Make sure you are friends with urology

7

Incidence of Urologic Injury?

Reconstructive Urology

The Impact of Minimally Invasive Surgery on Major Iatrogenic Ureteral Injury and Subsequent Ureteral Repair During Hysterectomy: A National Analysis of Risk Factors and Outcomes

Vignesh T. Packiam, Andrew J. Cohen, Joseph J. Pariser, Charles U. Nottingham, Sarah F. Faris, and Gregory T. Bales

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Incidence of Urologic Injury?

Urinary Tract Injury in Gynecologic Laparoscopy for Benign Indication
A Systematic Review

Jacqueline M. K. Wong, MD, Pietro Bortoletto, MD, Jocelyn Tolentino, MD, MPH, Michael J. Jung, MD, MHA, and Magdy P. Milad, MD, MS

90 STUDIES

140,444 SURGERIES

458 (0.33%) INJURIES

Wong JMK, Bortoletto P, Tolentino J, Jung MJ, Milad MP. Urinary Tract Injury in Gynecologic Laparoscopy for Benign Indication: A Systematic Review. Obstet Gynecol. 2018 Jan;131(1):100-108.

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Incidence of Urologic Injury?

458 INJURIES

BLADDER INJURIES 344 (0.24%)

85% RECOGNIZED

URETERAL INJURIES 114 (0.08%)

40% RECOGNIZED

Wong JMK, Bortoletto P, Tolentino J, Jung MJ, Milad MP. Urinary Tract Injury in Gynecologic Laparoscopy for Benign Indication: A Systematic Review. Obstet Gynecol. 2018 Jan;131(1):100-108.

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Incidence of Urologic Injury?

	No. of Surgeries	Bladder	Ureteral	Total
TLH	86,683	91 (0.1%)	31 (0.04%)	122 (0.1%)
LAVH	24,257	187 (0.8%)	50 (0.2%)	247 (1.0%)
Endometriosis Excision	4275	0 (0.0%)	17 (0.4%)	17 (0.4%)

Wong JMK, Bortoletto P, Tolentino J, Jung MJ, Milad MP. Urinary Tract Injury in Gynecologic Laparoscopy for Benign Indication: A Systematic Review. Obstet Gynecol. 2018 Jan;131(1):100-108.

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Incidence of Urologic Injury?

Table 1. Baseline Characteristics of Women Undergoing Hyste… …nign Indications at Nonfederal Facilities in the State of California (200… …l Rate of a Genitourinary Injury

1.8%

Total Cohort (N=296,130)	Injury (n=5,455 [1.8])	OR (95% CI)	P
Age (y, mean=47.43)	47.42	NA	.66
Approach*			
Abdominal (n=109,188)	2,219 (2.0)	Ref	Ref
Laparoscopic (n=77,415)	1,281 (1.7)	0.82 (0.76-0.87)	<.00
Vaginal (n=62,860)	924 (1.5)	0.72 (0.67-0.78)	<.001
LAVH (n=36,348)	607 (1.7)	0.82 (0.75-0.90)	<.001

Dallas KB, Rogo-Gupta L, Elliott CS. Urologic Injury and Fistula After Hysterectomy for Benign Indications. Obstet Gynecol. 2019 Aug;134(2):241-249.

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Incidence of Urologic Injury?

5,455 INJURIES

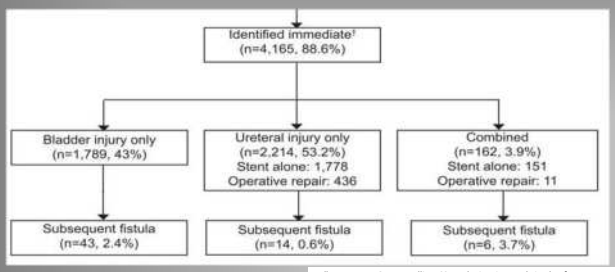
IDENTIFIED N=4,701 (86.2%)

UNIDENTIFIED N=754 (13.8%)

Dallas KB, Rogo-Gupta L, Elliott CS. Urologic Injury and Fistula After Hysterectomy for Benign Indications. Obstet Gynecol. 2019 Aug;134(2):241-249.

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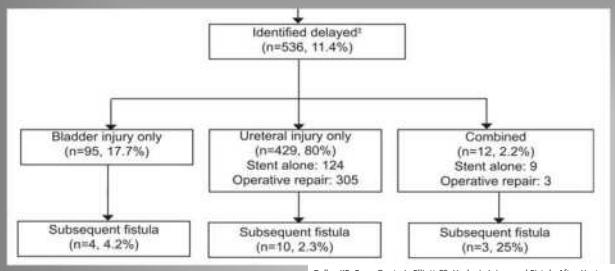
Incidence of Urologic Injury?



Dallas KB, Rogo-Gupta L, Elliott CS. Urologic Injury and Fistula After Hysterectomy for Benign Indications. Obstet Gynecol. 2019 Aug;134(2):241-249.

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Incidence of Urologic Injury?



Dallas KB, Rogo-Gupta L, Elliott CS. Urologic Injury and Fistula After Hysterectomy for Benign Indications. Obstet Gynecol. 2019 Aug;134(2):241-249.

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Incidence of Ureteral Injury?

Reconstructive Urology

The Impact of Minimally Invasive Surgery on Major Iatrogenic Ureteral Injury and Subsequent Ureteral Repair During Hysterectomy: A National Analysis of Risk Factors and Outcomes

Vignesh T. Packiam, Andrew J. Cohen, Joseph J. Pariser, Charles U. Nottingham, Sarah F. Faris, and Gregory T. Bales

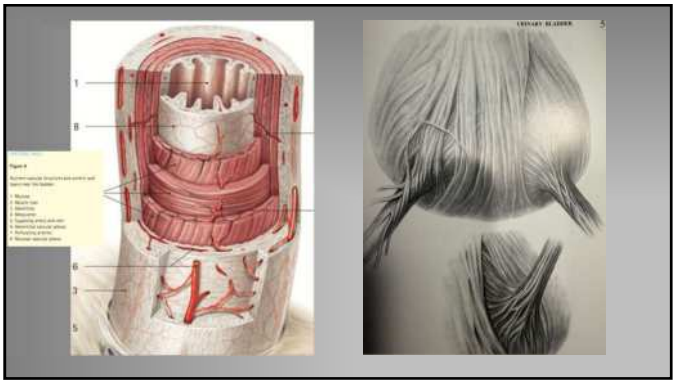
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Incidence of Urologic Injury

	TAH	MIH	p Value
Number	28,408 (29%)	51,293 (53%)	.001
Ureteral Injury Rate	0.18% (n=50)	0.48% (n=245)	.001
Immediate Repair	n=40 (80%)	n=214 (87.3%)	n/a

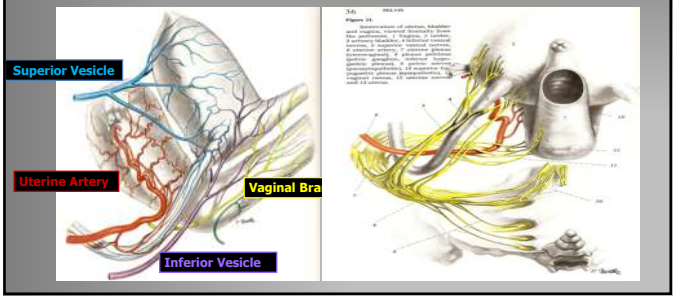
Packiam VT, Cohen AJ, Pariser JJ, Nottingham CU, Faris SF, Bales GT. The Impact of Minimally Invasive Surgery on Major Iatrogenic Ureteral Injury and Subsequent Ureteral Repair During Hysterectomy: A National Analysis of Risk Factors and Outcomes. Urology. 2016 Dec;98:183-188. doi: 10.1016/j.urology.2016.06.041.

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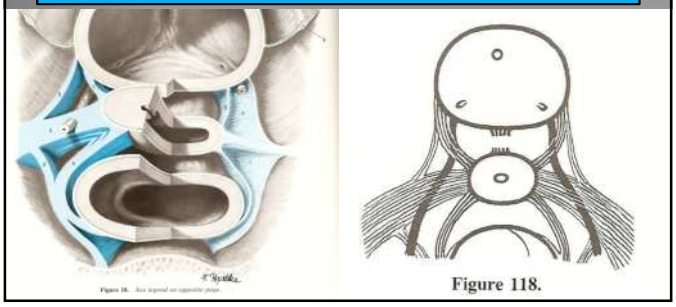
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Bladder& Ureteral ANATOMY

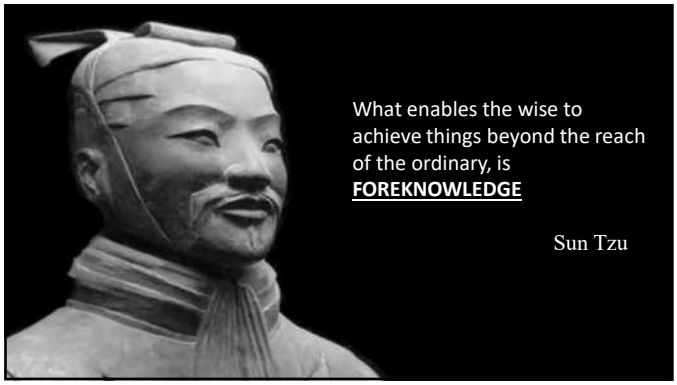


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ParAMETRIAL ANATOMY



20



What enables the wise to achieve things beyond the reach of the ordinary, is **FOREKNOWLEDGE**

Sun Tzu

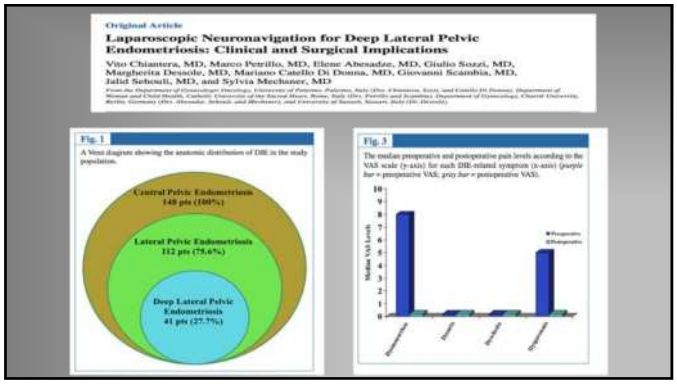
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Planning to Avoid Complications

Imaging

- -Ultrasound
- -MRI
- -CT Urogram
- -Cystoscopy

22



Original Article

Laparoscopic Neuronavigation for Deep Lateral Pelvic Endometriosis: Clinical and Surgical Implications

Vito Chiantera, MD, Marco Petrillo, MD, Elena Abesadze, MD, Giulio Sozzi, MD, Margherita Deiscole, MD, Mariano Catello Di Donna, MD, Giovanni Scambia, MD, Jalid Sehouli, MD, and Sylvia Mechsner, MD

Fig. 1

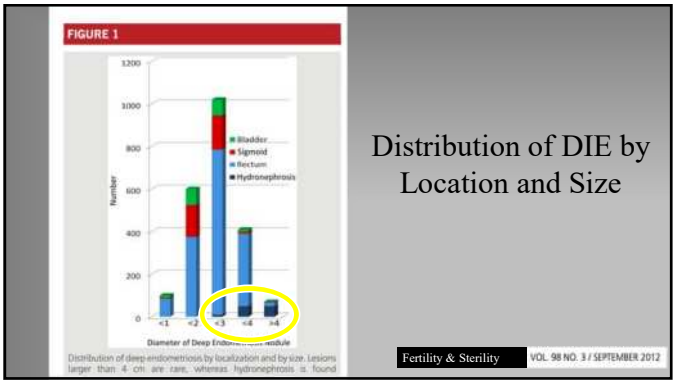
Central Pelvic Endometriosis 148 pts (100%)

Lateral Pelvic Endometriosis 112 pts (75.6%)

Deep Lateral Pelvic Endometriosis 41 pts (27.7%)

Fig. 3

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Distribution of DIE by Location and Size

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Clinical Scenarios

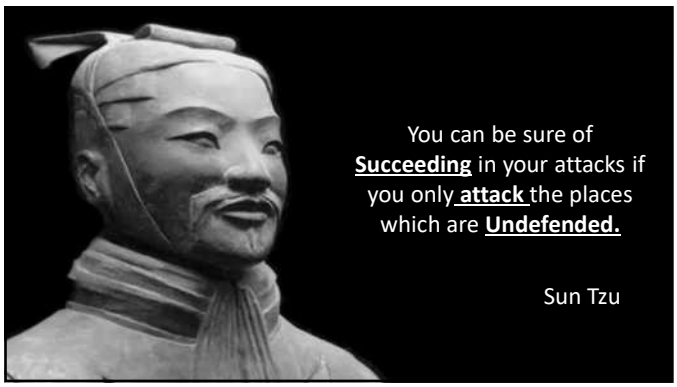
- Ovarian/Sigmoid Adhesions/Endometriosis
- Parametrial Endometriosis
- Obilterated Anterior Cul de Sac
- Bladder Endometriosis

25

Dissection Principles

- Ureterolysis
- Development of the para-vesicle spaces
- Development of the Vesicovaginal Space

26



You can be sure of **Succeeding** in your attacks if you only **attack** the places which are **Undefended.**

Sun Tzu

27

Recognizing Injures

Intra-operative Vs. **Post operative**

28

Recognizing Injures

Intra-operative

-Direct Visualization & Cystoscopy

-IV & Retrograde Dyes

-Retrograde Pyelography (IVP)

Vs.

Post operative

-CT Urogram with Delayed Excretory Phase

- Serum Creatanine/BUN & Fluid Creatanine

-IVP

-Tampon/Vaginal Dye Test

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Recognizing Injures

30

Grades of Bladder Injuries

Grade 1: contusion, intramural hematoma, or partial thickness laceration

Grade 2: extraperitoneal bladder wall laceration <2 cm

Grade 3: extraperitoneal >2 cm or intraperitoneal <2 cm bladder wall laceration

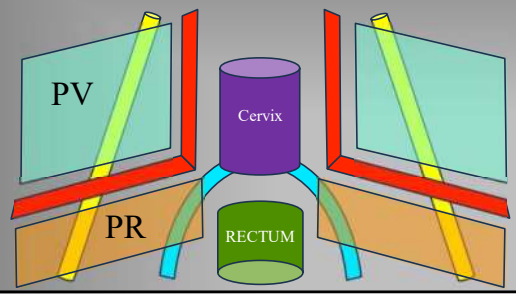
Grade 4: intraperitoneal bladder wall laceration >2 cm

Grade 5: intra- or extraperitoneal bladder wall laceration involving the trigone or bladder neck

Glaser LM, Milad MP. Bowel and bladder injury repair and follow-up after gynecologic surgery. Obstet Gynecol. 2019;133:313–322.

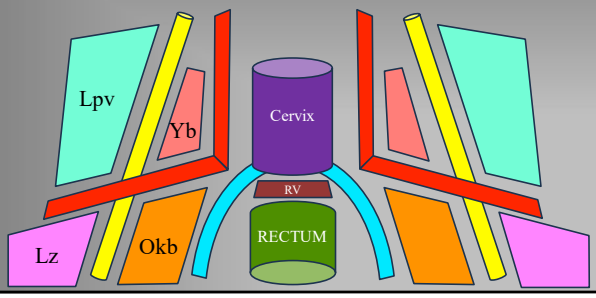
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POSTERIOR COMPARTMENT ANATOMY



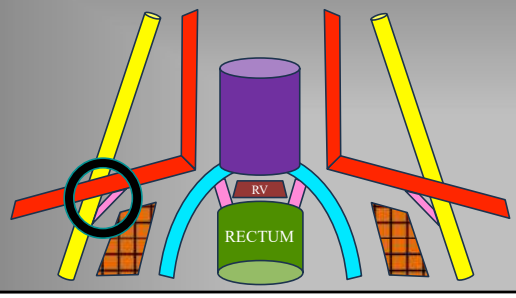
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POSTERIOR COMPARTMENT ANATOMY



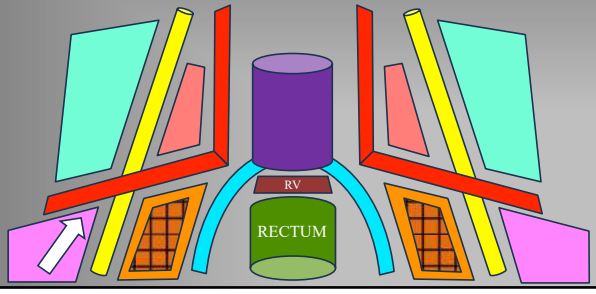
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POSTERIOR COMPARTMENT ANATOMY



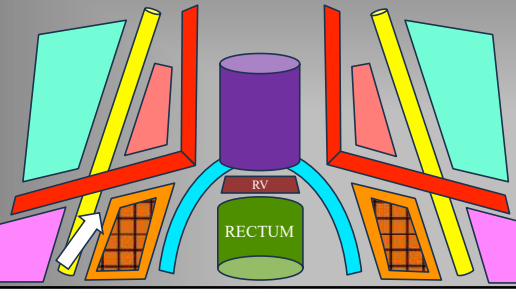
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POSTERIOR COMPARTMENT ANATOMY

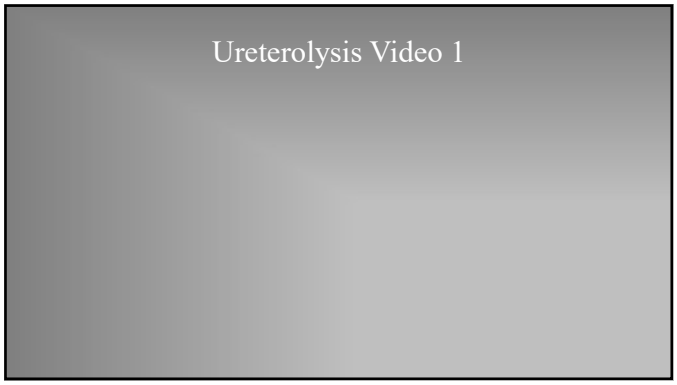


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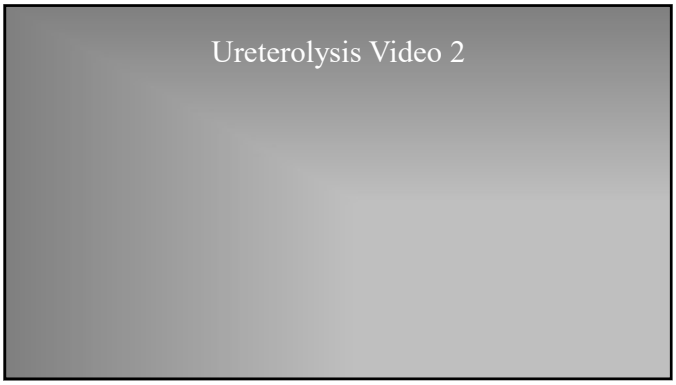
POSTERIOR COMPARTMENT ANATOMY



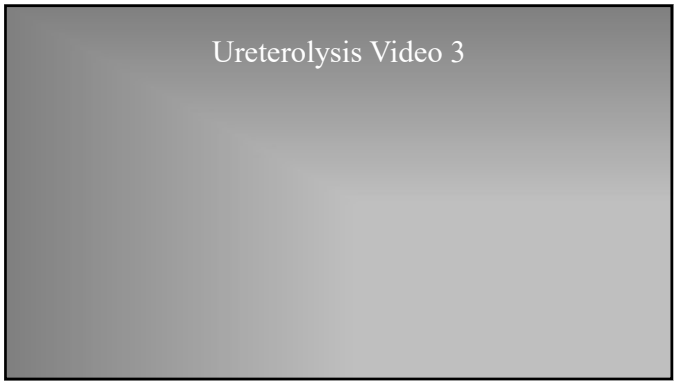
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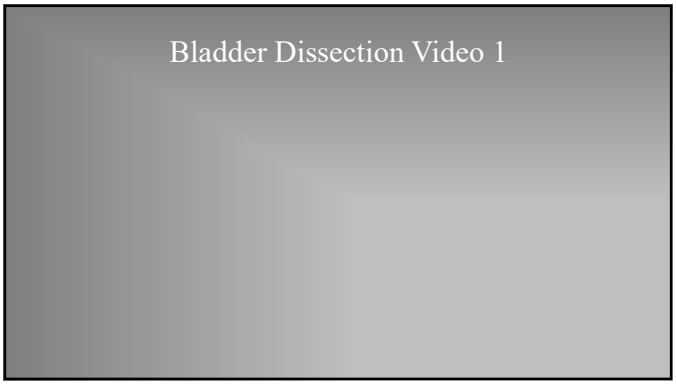
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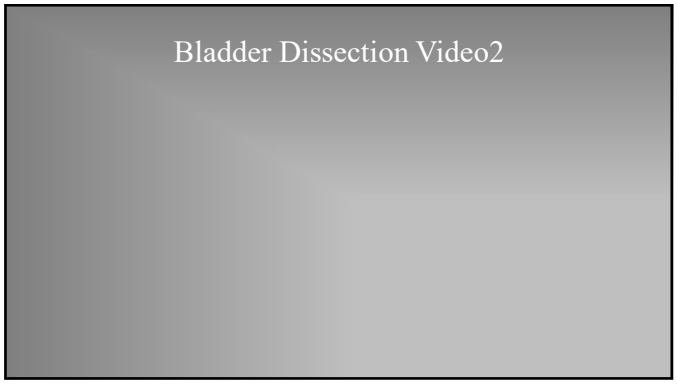
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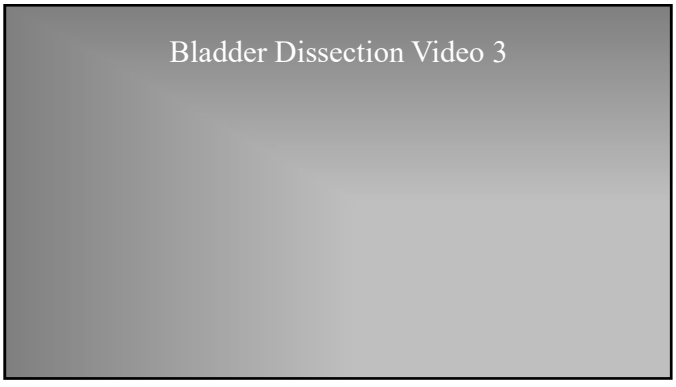
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Bladder Dissection Video 3

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Bladder repair Video 1

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Bladder repair Video 2

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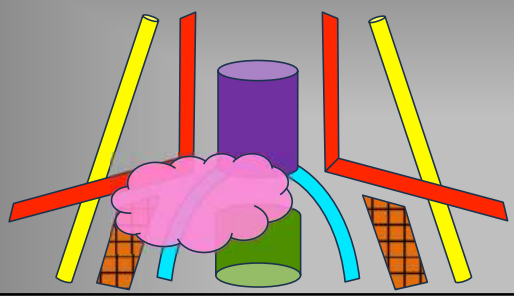
Ureteral repair Video 1

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Ureteral repair Video 2

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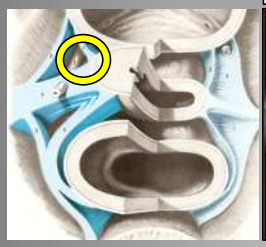
Parametrial Extension



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Yubuki's Space (Medial Para-vesicle)

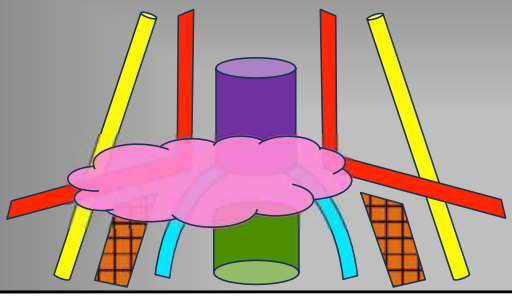
Right Side of Patient



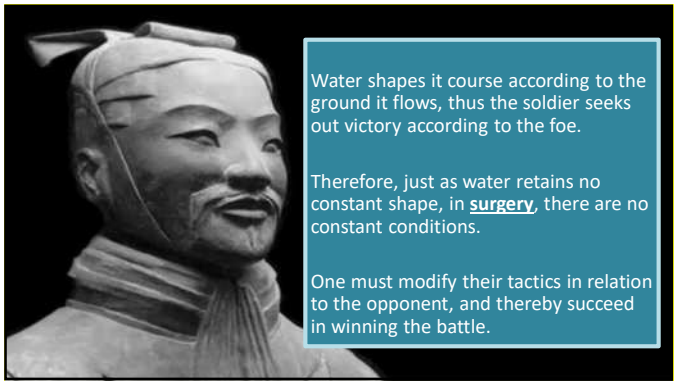


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Parametrial Extension to Ureter



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Water shapes it course according to the ground it flows, thus the soldier seeks out victory according to the foe.

Therefore, just as water retains no constant shape, in **surgery**, there are no constant conditions.

One must modify their tactics in relation to the opponent, and thereby succeed in winning the battle.

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Thank You

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Don't Be Shocked: Understanding Electro-Surgical Dissection Techniques to Mitigate Thermal Injuries

Megan Wasson, DO, FACOG, FACS
Department Chair and Professor
Department of Medical and Surgical Gynecology
Mayo Clinic in Arizona

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1

Disclosure

- *I have no financial relationships to disclose.*

2

Objectives

- Illustrate different energy sources
- Understand pros and cons of available energy sources
- Summarize safe techniques for energy use

3

Energy Related Injuries

- Have you had an energy related injury?

4

Energy Related Injuries

- Have you had an energy related injury?
- Have you known a colleague with an energy related injury?

5

Energy Related Injuries

- Incidence of laparoscopic injures 0.1%-0.5%.[1]
- 18% of surgeons experienced insulation failure or a capacitive coupling injury. [2]
- 54% knew of a colleague who had a patient with an energy related injury.[2]

[1] Nduka CC, Super PA, Monson JR, Darzi AW. Cause and prevention of electrosurgical injuries in laparoscopy. *Journal of the American College of Surgeons* 1994; 179(2): 161-80.
[2] Tucker RD. Laparoscopic electrosurgical injuries: survey results and their implications. *Surgical laparoscopy & endoscopy* 1995; 5(4): 311-7.

6

Terminology?

- Cautery
- Electrocautery
- Electrosurgery

7

Cautery

- Passive transfer of heat to tissue



8

Electrosurgery

- Electrical current applied to tissue



9

"I predict that electrosurgery will continue to grow in usefulness, indeed to be found indispensable to every surgical procedure."

William Clark 1930

10

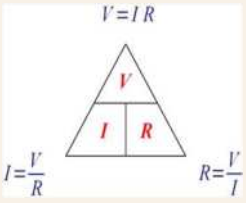
Properties of Electricity

Voltage — The pressure force required to push electrons *(volts)*

Current — • The rate at which electrons flow *(amperes)*

Power — The energy (amount of work) produced over time *(watts)*

Impedance — • Resistance to the flow of current *(Ohms)*



11

Cut vs. Coag

12

Waveforms

Cut Current	Coag Current
• High Frequency	• Low Frequency
• Low Voltage	• High Voltage

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Cut

- Continuous waveform
- Low voltage
- High current density
- Focused in small area

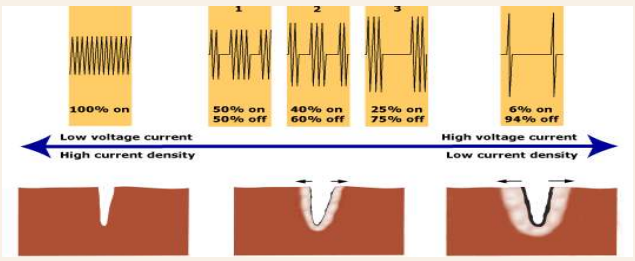
14

Coagulation

- Interrupted waveform
- High voltage
- Low current density
- Dispersed over large area

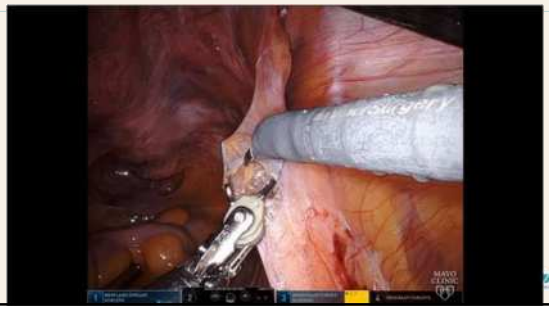
15

Cut Blend Coag



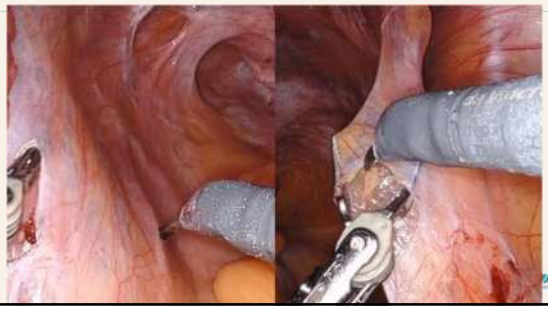
16

Cut versus Coagulation: Incising Peritoneum



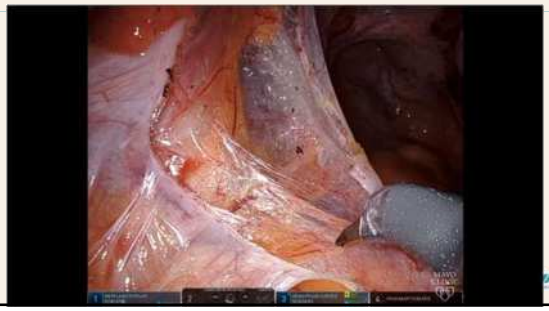
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Cut versus Coagulation: Incising Peritoneum



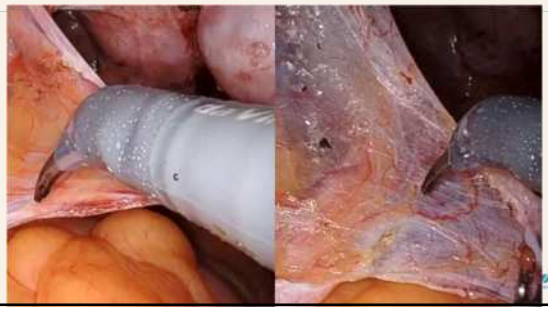
18

Cut versus Coagulation: Dissecting Retroperitoneum



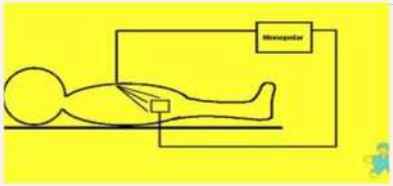
19

Cut versus Coagulation: Dissecting Retroperitoneum



20

Monopolar Electrosurgery



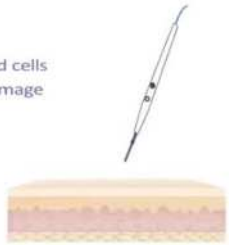


Active Electrode-Surgical Site
Dispersive Electrode-Peripheral Site
Current flows through Body Between Electrodes

21

Vaporization

- Tissue divided by rapidly heated cells
- Deep injury with min lateral damage
- NON-CONTACT
- "Cut" waveform
  - Low voltage
  - High current



22

Fulguration

- Superficial and wide "coagulum"
- NON-CONTACT
- "Coag" waveform
  - High Voltage
  - Low Current



23

Desiccation

- Deep, penetrating tissue effect
- CONTACT
- Either waveform



24



25

Tissue Effect

- Current density
- Time
- Electrode size
- Tissue conductivity
- Current waveforms

26

Shortcomings of Monopolar Electrosurgery

- Need for a dispersive electrode
- High power settings
- Stray current injuries
- Inability to seal vessels > 1–2 mm



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Surgical Complications with Monopolar Electrosurgery

- Dispersive Electrode Injuries
- Alternate site burns
- Stray energy burns

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Dispersive Electrode Injuries

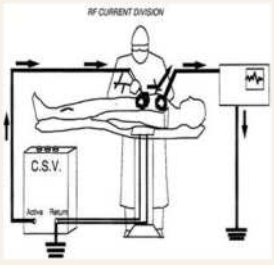
- Incorrectly attached electrode
  - Scars
  - Metal
- Partial detachment
- No impedance monitoring



29

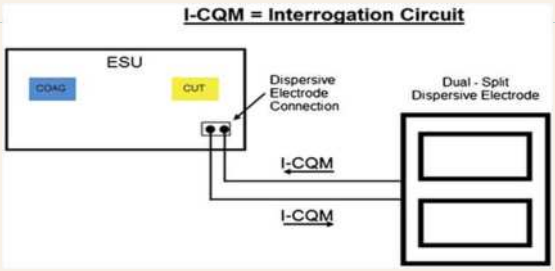
Alternate Site Burns

- EKG leads
- Dispersive pads
- → Contact Quality Monitoring (CQM) circuitry and dual-section dispersive electrodes



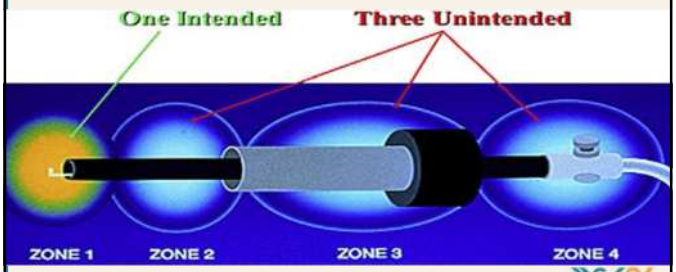
30

Contact Quality Monitoring System



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Stray Energy Burns



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Direct Coupling

- Convert a forceps into a coagulation device



33

Direct Coupling

- Convert a forceps into a coagulation device
- Inadvertently contact instrument with monopolar electrosurgery

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Direct Coupling

- Convert a forceps into a coagulation device
- Inadvertently contact instrument with monopolar electrosurgery
  - → injury

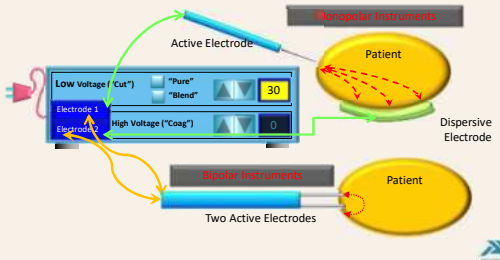
35

Capacitive Coupling

- Transfer of Energy via Current Displacement
- Increased risk
  - Monopolar instrumentation
  - Modulated high voltage waveforms
  - Open circuit activation
  - Single port

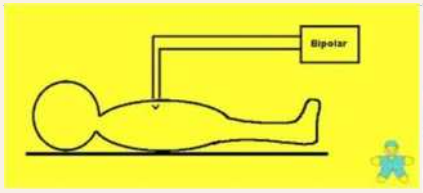
36

Monopolar versus Bipolar Instrumentation



37

Bipolar Electrosurgery





Active and dispersive electrodes in the instrument
Current flow confined to tissue between electrodes

38

Bipolar Electrosurgery

Electrical Current Does NOT Pass Through Patient → Power Settings Lower → No Need Remote-Dispersive Electrode → NO Capacitance-Coupling → Less Variation Operational parameters

39

Vessel Sealing Technology

2 major categories:

- ✓Advanced bipolar
- ✓Ultrasonic instruments

40

Creation of Heat

ESU: Electrical Energy → Mechanical Energy → Thermal Energy

41

Bipolar Electrosurgery

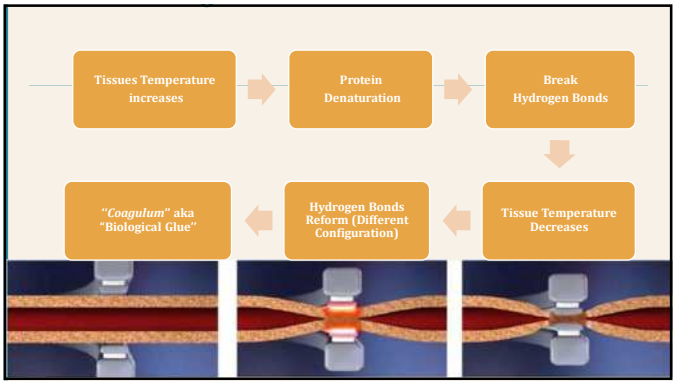
Alternating Current → Oscillates Intracellular Molecules → Intracellular Friction → Tissue Effect

42

Ultrasonic Energy

Oscillating Shaft → Friction Force → Extracellular Heating → Intracellular Heating

43



44

Advanced Vessel Sealing Devices

- Double Burn?

45

Advanced Bipolar Technology

- Low voltage, continuous "CUT" waveform
- Electrical energy is pulsatile ➔ allowing for tissue cooling
- Computer-controlled tissue feedback response systems
- Cutting capabilities
- Poor dissecting abilities

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Bipolar Instrumentation Comparison

Device		Lateral Thermal Injury (mm)	
Category	Product	Distal	Proximal
		Mean ± SD	Mean ± SD
Generic		1.721 ±0.945	1.934± 0.604
Proprietary	Ligasure™	2.128 ± 1.116	2.294 ± 0.693
	EnSeal®	1.671 ± 0.435	1.860 ± 0.858
	PlasaKinetics™	1.301 ± 0.445	1.898 ± 0.474

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Bipolar Instrumentation Comparison

Device	Lateral Tmax (°C)
Ligasure™	55.5
EnSeal®	58.9
PlasaKinetics™	64.5

48

Bipolar Instrumentation Comparison

Device	Burst Pressure (mmHg)
Ligasure™	386
EnSeal®	255
PlasaKinetics™	290

49

Bipolar Instrumentation Comparison

Device	Vessel Diameter (mm)	Seal Time (seconds)	2-mm Lateral Temperature (°C)	Plume	Burst Pressure (mmHg)
Ligasure™	7	10.0	55.5	12.5	386
EnSeal®	7	11.1	58.9	21.6	255
PlasaKinetics™	7	19.2	64.5	74.1	290

50

Ultrasonic Devices

- Harmonic ACE (Ethicon) 7mm
- AutoSonix (Covidien)
- Sonocision (Covidien) 5mm
- SonoSurg (Olympus)

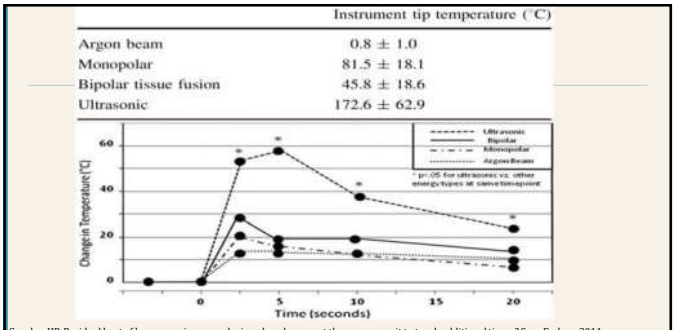


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Ultrasonic Generator Setting

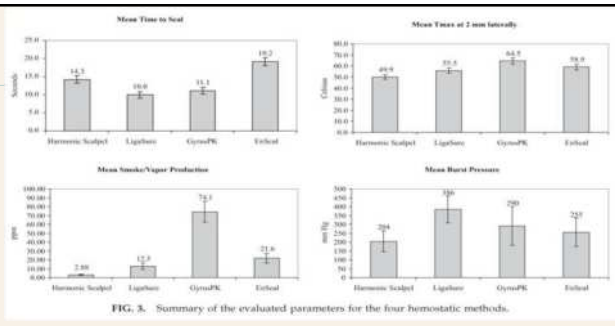
	Max	Min
Oscillations	Large	Small
Tissue transection	Rapid	Slow
Lateral Thermal Spread	Less	More
Vessel sealing	Inferior	Superior

52



Govekar HR Residual heat of laparoscopic energy devices: how long must the surgeon wait to touch additional tissue? Surg Endosc. 2011

53



Prospective comparison of four laparoscopic vessel ligation devices.
Lamberton GR[1], Hsi RS, Jin DH, Lindler TU, Jellison FC, Baldwin DD. J Endourol. 2008 Oct;22(10):2307-12.

54

Safety First

- Inspect Insulation
- Use Lowest Power Setting
- Don't Activate
  - Open Circuit
  - Close to Other Instrument

55

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- Harold KL, Pollinger H, Matthews BD, Kercher KW, Sing RF, Prett B, Lipford EH. Comparison of thermal spread after ureteral ligation with the Laparo-Sonic ultrasonic shears and the Ligasure system. *Surg Endosc* 2003;17:1228-30.

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Bossing the Bowel: Managing Laparoscopic Bowel Injury

Amanda Ecker, MD · Oregon Health Sciences University

NOVEMBER 13-16, 2026 · BOSTON · #AAGL26

1

Disclosures

I have no financial relationships to disclose

2

Objectives



PREVENTION



RECOGNITION



REPAIR

3

Prevalence

- Incidence of bowel injury ranges 0.13-0.14% [1,2]
- Elevated in complex cases (endo, adhesions, etc…)
- Unrecognized injury is the main contributor to laparoscopy-related mortality (3.6%)[3]

Mantra: "The only surgeon who never has a bowel injury is the one who doesn't operate"

4

Prevention

Identify high risk patients before OR

- Comprehensive surgical history
- Additional imaging if warranted
- Co-surgeon if very high concern

Choosing entry point

- Open Hasson entry when umbilical adhesions suspected
- Alternate entry point

5

Prevention

Dissection techniques

- Cold cutting near bowel wall
- Obey natural tissue planes
- Utilize surgical para-rectal space
- Consider hydrodissection

Energy Hygiene

- Shortest duration of energy applied
- Use the lowest effective energy setting
- Be cognizant of electrosurgical instruments

6

Dissection Video

7

Intraoperative Assessment

- Proctoscopy/Rigid Sigmoidoscopy AKA air-leak testing
- Transrectal dye testing
- ICG

Find it early!

8

ICG Video

9

Postoperative Assessment

- Low threshold for imaging with ongoing/worsening pain at 3-10 days postop
- Classic triad: unexplained persistent tachycardia, abdominal pain out of proportion to exam, leukopenia or low-grad fever

10

Tips and Tricks for Repair

Consider the following:

- Defect size relative to lumen diameter
- Surrounding tissue margins
- Microvascular supply
- Feculent contamination

Call general surgery if needed and DON'T FEEL BAD!

11

Tips and Tricks for Repair

- Repair should be parallel to bowel long axis
- Consider angle stitches
- Use at least two layers for the repair
  - Mucosa/Submucosa – Running or interrupted 3-0 or 4-0 absorbable suture
  - Seromuscular layer – Interrupted Lembert sutures with 3-0 or 4-0 silk, vicryl or PDS
- Cover with fat

12

Bowel Repair Video

13

Take-Home Pearls

- "An ounce of prevention is worth a pound of cure"
- Respect the thermal footprint
- If in doubt, test it out!
- Master the Lembert suture

14

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3 – Van der Voort M, Heijnsdijk E, Gourma D. Bowel injury as a complication of laparoscopy. *BJS*. 2004;91 (10):1253-1258. https://doi.org/10.1002/bjs.4716
4- Eisner I, Wadhwa R, Downing K, et al. Prevention and management of bowel injury during gynecologic laparoscopy: an update. *Current Opinion in Obstetrics & Gynecology*. 2019;31(4):245-250.
5- Elbiss H, Abu-Zidan F. Bowel injury following gynecological laparoscopic surgery. *Afr Health Sci*. 2017;17(4):1237-1245.

15

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/