AAGL 26

55TH GLOBAL CONGRESS ON MIGS

BOSTON, MASSACHUSETTS
NOVEMBER 13-16, 2026

Syllabus

PG-26007

Lead With Words: Communication Skills, Presentation Techniques and Audience Engagement

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Charles H. Koh, MD

SCIENTIFIC PROGRAM CHAIR
Nash S. Moawad, MD

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Michael Hibner, MD, PhD



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PG-26007: Lead With Words:
Communication Skills, Presentation Techniques and Audience Engagement

Chair: Attilio Di Spiezio Sardo
Co-Chair: Afchine Fazel
Faculty: Tony Carugno, Attilio Di Spiezio Sardo, Afchine Fazel, Sergio Haimovich

Course Description

Lead with Words: Communication Skills, Presentation Techniques & Audience Engagement is a fast-paced, practical 2-hour course designed for gynecologic surgeons who want to communicate with more clarity and impact—both in clinical encounters and in front of an audience. The course integrates evidence-informed communication frameworks with real-world surgical scenarios, then extends those same skills to the podium: how to structure a message, deliver it with confidence, handle questions, and keep an audience engaged. A distinctive component is the responsible use of AI as a skill accelerator. Participants will learn how to use AI tools to (1) refine patient explanations without adding jargon, (2) prepare difficult conversations (risks, complications, uncertainty, consent), (3) transform complex data into clear narratives, and (4) iterate presentations faster—improving slide logic, transitions, timing, and Q&A preparation. AI will be presented as a coach and rehearsal partner, not a substitute for clinical judgment, empathy, or professional authenticity.

Learning Objectives: *At the end of this course, the participant will be able to:* 1) Apply patient-centered communication strategies to facilitate shared decision-making, address patient emotions and expectations, and communicate clinical uncertainty and next steps while maintaining patient trust; 2) Demonstrate effective public speaking and presentation techniques to deliver clear, engaging scientific and clinical presentations, including development of a compelling narrative, effective slide design, audience engagement, and confident management of questions and interruptions; 3) Utilize artificial intelligence tools to develop and refine scientific and clinical presentations, including defining key take-home messages, structuring presentation content, improving slide clarity, and generating speaker notes and transitions; and 4) Apply AI-assisted rehearsal strategies to strengthen presentation delivery by generating practice questions and counter-questions and refining responses for clarity, confidence, and conciseness.

Course Outline

2:00 pm	Welcome, Introduction and Course Overview	A. Di Spiezio Sardo
2:05 pm	Academic Presentations: How to Prepare and Deliver to a Scientific Audience	A. Di Spiezio Sardo
2:30 pm	Patient Communication Under Different Clinical Circumstances	A. Fazel
2:55 pm	How to Design and Deliver an Idea Worth Sharing	J. Carugno
3:20 pm	AI Tools to Enhance Any Presentation	S. Haimovich
3:45 pm	Discussion Questions & Answers	All faculty
4:00 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
Jude Okohue, MD*
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*

COURSE CHAIR DISCLOSURE

Attilio Di Spiezio Sardo, MD, PhD*

COURSE CO-CHAIR DISCLOSURE

Afchine Fazel, MD, PhD*

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).

Jose Carugno, MD*
Attilio Di Spiezio Sardo, MD, PhD*
Afchine Fazel, MD, PhD*
Sergio Haimovich, MD, PhD*

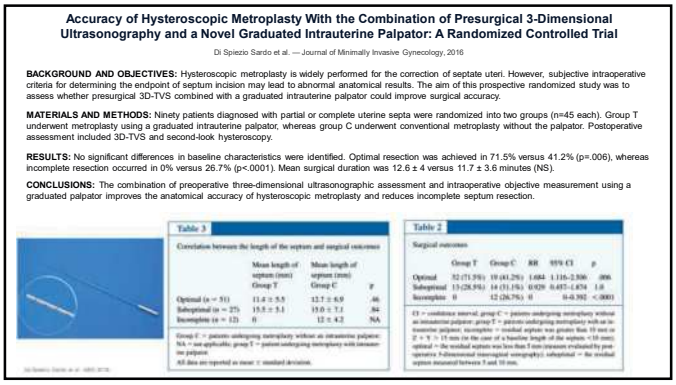
MITIGATION OF RELEVANT FINANCIAL RELATIONSHIPS

All relevant financial relationships have been mitigated.

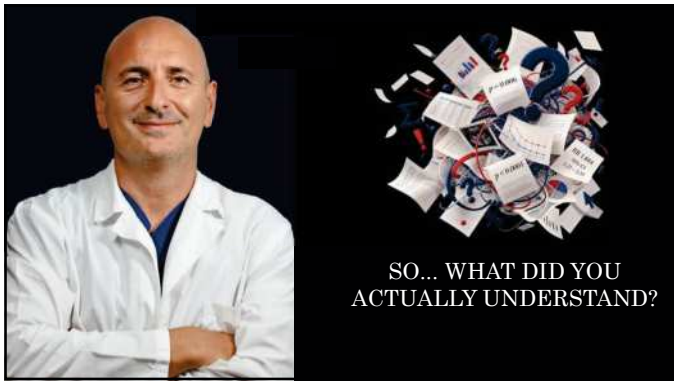
Drs. Lee, Lemos, Mikhail, and Chaudhari's planning decisions, as part of the Scientific Program Committee (SPC), were peer reviewed by other planners on the SPC who had disclosed no financial relationships with ineligible companies, and found to be fair, balanced, and free of commercial bias. Dr. Moawad's 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.


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ACADEMIC PRESENTATIONS:
How to Prepare and Deliver to a Scientific Audience
Attilio Di Spiezio Sardo
University of Naples Federico II

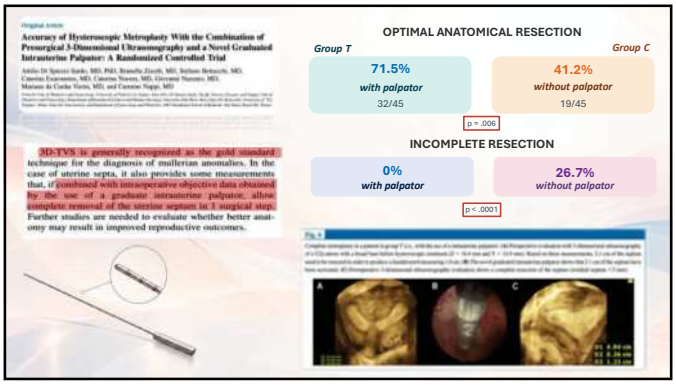
1


Accuracy of Hysteroscopic Metroplasty With the Combination of Presurgical 3-Dimensional Ultrasonography and a Novel Graduated Intrauterine Palpator: A Randomized Controlled Trial
Di Spiezio Sardo et al. — Journal of Minimally Invasive Gynecology, 2016
BACKGROUND AND OBJECTIVES: Hysteroscopic metroplasty is widely performed for the correction of septate uteri. However, subjective intraoperative criteria for determining the endpoint of septum incision may lead to abnormal anatomical results. The aim of this prospective randomized study was to assess whether presurgical 3D-TVS combined with a graduated intrauterine palpator could improve surgical accuracy.
MATERIALS AND METHODS: Ninety patients diagnosed with partial or complete uterine septa were randomized into two groups (n=45 each). Group T underwent metroplasty using a graduated intrauterine palpator, whereas group C underwent conventional metroplasty without the palpator. Postoperative assessment included 3D-TVS and second-look hysteroscopy.
RESULTS: No significant differences in baseline characteristics were identified. Optimal resection was achieved in 71.5% versus 41.2% (p=.006), whereas incomplete resection occurred in 0% versus 26.7% (p<.0001). Mean surgical duration was 12.6 ± 4 versus 11.7 ± 3.6 minutes (NS).
CONCLUSIONS: The combination of preoperative three-dimensional ultrasonographic assessment and intraoperative objective measurement using a graduated palpator improves the anatomical accuracy of hysteroscopic metroplasty and reduces incomplete septum resection.

2


SO... WHAT DID YOU ACTUALLY UNDERSTAND?

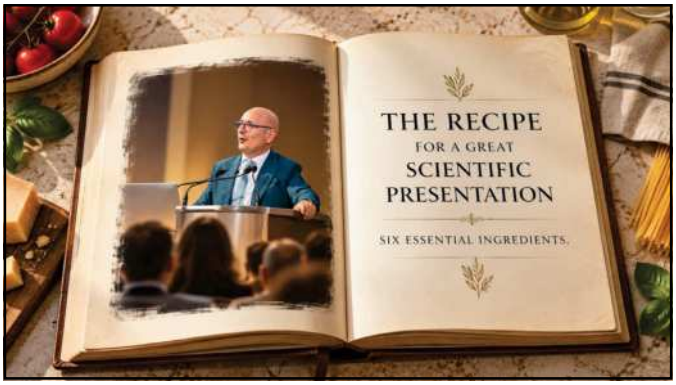
3


Accuracy of Hysteroscopic Metroplasty With the Combination of Presurgical 3-Dimensional Ultrasonography and a Novel Graduated Intrauterine Palpator: A Randomized Controlled Trial
3D-TVS is generally recognized as the gold standard technique for the diagnosis of mullerian anomalies. In the case of uterine septa, it also provides some measurements that, if combined with intraoperative objective data obtained by the use of a graduate intrauterine palpator, allow complete removal of the uterine septum in 1 surgical step. Further studies are needed to evaluate whether better anatomy may result in improved reproductive outcomes.
OPTIMAL ANATOMICAL RESECTION
Group T
71.5%
with palpator
32/45
Group C
41.2%
without palpator
19/45
p = .006
INCOMPLETE RESECTION
0%
with palpator
26.7%
without palpator
p < .0001

4


THE PROBLEM WAS NOT THE SCIENCE
BUT THE PRESENTATION

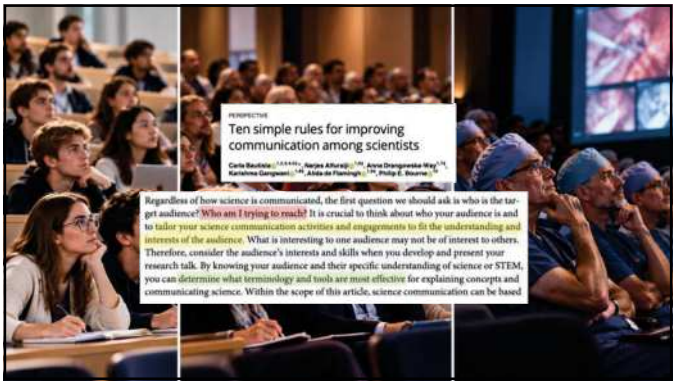
5


THE RECIPE
FOR A GREAT
SCIENTIFIC
PRESENTATION
SIX ESSENTIAL INGREDIENTS

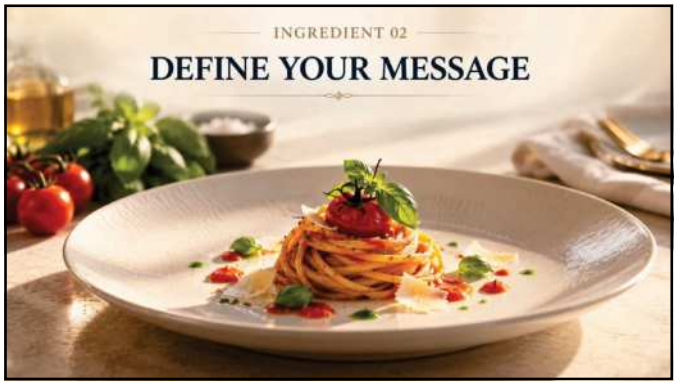
6


INGREDIENT 01
KNOW YOUR AUDIENCE

7


Ten simple rules for improving communication among scientists
Regardless of how science is communicated, the first question we should ask is who is the target audience? Who am I trying to reach? It is crucial to think about who your audience is and to tailor your science communication activities and engagements to fit the understanding and interests of the audience. What is interesting to one audience may not be of interest to others. Therefore, consider the audience's interests and skills when you develop and present your research talk. By knowing your audience and their specific understanding of science or STEM, you can determine what terminology and tools are most effective for explaining concepts and communicating science. Within the scope of this article, science communication can be based

8


INGREDIENT 02
DEFINE YOUR MESSAGE

9


DON'T START WITH YOUR SLIDES. START WITH YOUR MESSAGE.
What is the key finding?
Higher rates of optimal anatomical resection.
WHAT?
WHY?
What does it matter?
To improve precision and reduce incomplete septum resection.
Who is affected?
Women undergoing hysteroscopic metroplasty for a septate uterus.
WHO?
WHEN?
When is relevant?
When assessing whether septum resection is complete
WHERE?
Where can it be applied
In operative hysteroscopy during surgical treatment of a uterine septum.

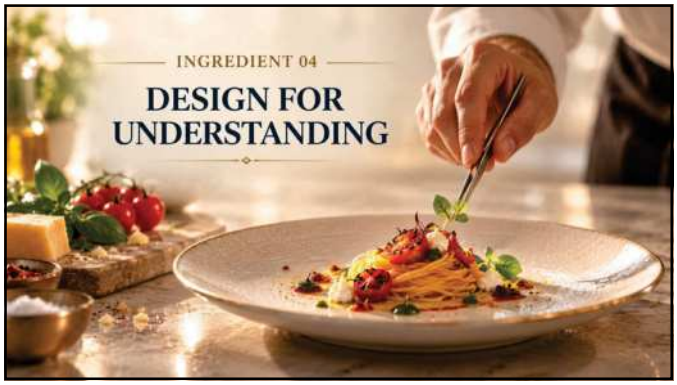
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INGREDIENT 03
BUILD A CLEAR STRUCTURE

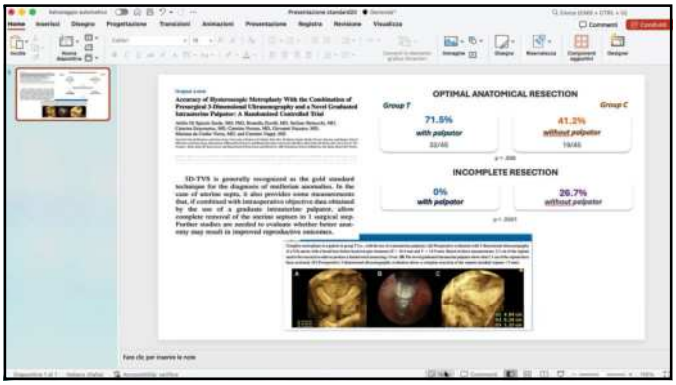
11


DON'T JUST SHARE DATA...TELL A STORY
Using narratives and storytelling to communicate science with nonexpert audiences
potentially more important. Research suggests that narratives are easier to comprehend and audiences find them more engaging than traditional logical-scientific communication (3, 4).
Common techniques to assist with the communication of phenomena beyond human scale include developing metaphors or other comparisons to link the phenomena to something understandable within human scale (93), such as describing nanotechnology as manipulating something "a million times smaller than the length of an ant" (94). Although useful, such compar-
However, when considering the communication of science to nonexpert audiences, a more appropriate mantra might be, "the plural of anecdote is engaging science communication."

12



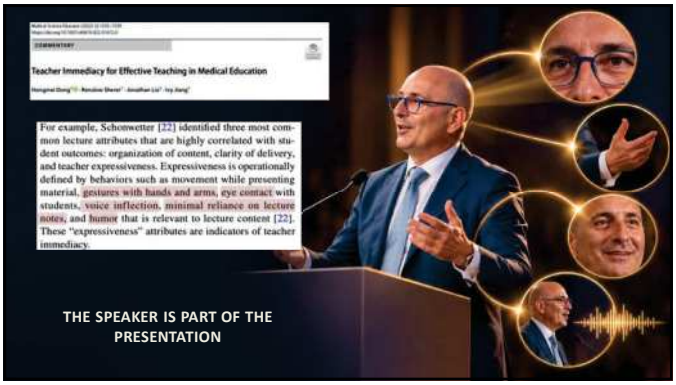
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14



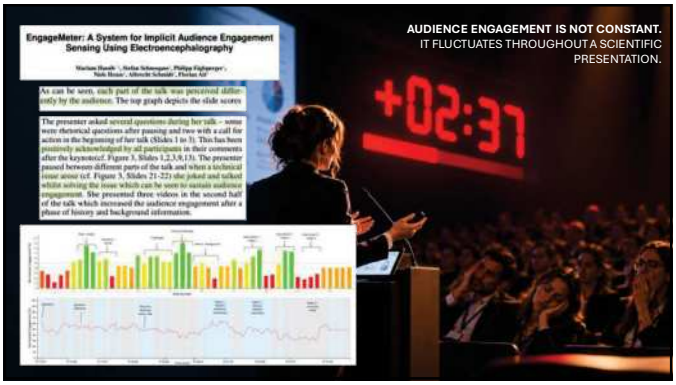
15



16



17



18



THANK YOU

Attilio Di Spiezio Sardo

University of Naples Federico II

19

Patient Communication Under Different Clinical Circumstances

Afshin FAZEL, MD, PhD
a.fazel@aphp.fr

NOVEMBER 13-16, 2026 · BOSTON · #AAGL26

1

Disclosure



Hôpital Lariboisière AP-HP

- "I have no financial relationships to disclose with this presentation"

Deputy Editor of JMIG



Judicial Expert
Paris Court of Appeal

ENDOSEARCH

2

Objectives

- • Identify communication needs across routine, urgent, and emotionally difficult clinical encounters.
- • Apply practical techniques for empathy, teach-back, and shared decision-making.
- • Demonstrate transparent communication after complications.
- • Adapt communication to trauma, language barriers, and patient preferences.

3

One patient. Different moments. Different needs.

- • Routine care: clarity, partnership, and expectations
- • Uncertainty or bad news: empathy, pacing, and support
- • Complications or conflict: transparency, accountability, and safety
- • Vulnerability or urgency: autonomy, accessibility, and focus

- Primeau et al., 2024; De Vries et al., 2014

4

What does the evidence actually show?

- • Communication skills training can improve clinician behaviors
- • Empathy and shared decision-making are associated with better communication
- • Teach-back may improve adherence and self-efficacy; certainty varies
- • Better communication processes do not always translate into proven clinical outcomes

- De Vries 2014; Lippke 2021; Vick 2026; oncology interventions 2025

5

A universal framework: CONNECT

- • Prepare: privacy, attention, eye level, and interpreter if needed
- • Ask: "What is your understanding so far?"
- • Listen and name emotion before giving more information
- • Explain in short chunks; check understanding with teach-back
- • Close with a shared plan, safety net, and follow-up

- AHRQ Patient & Family Engagement; Vick et al., 2026

6

The first 20 seconds can change the conversation

- LESS EFFECTIVE
- “Your ultrasound is normal. You don’t need surgery.”

- MORE EFFECTIVE
- “Before we review the scan, what concerns you most about your symptoms?”

7

Scenario 1: elective surgical consultation

- • Elicit goals: pain relief, fertility, recovery, and preferences
- • Explain alternatives, including no surgery when appropriate
- • Compare likely benefits, uncertainty, and material risks
- • Use plain language and ask what matters most to the patient
- • Confirm the decision is informed—not merely a signed form

- De Vries et al., 2014; oncology communication interventions 2025

8

Replace information overload with partnership

- LESS EFFECTIVE
- “These are the risks. Sign here if you agree.”

- MORE EFFECTIVE
- “Let’s compare the options, including not operating. Which trade-off feels most important to you?”

9

Scenario 2: unexpected serious diagnosis

- • Create a private setting; ask permission to discuss results
- • Give a brief warning shot: “I’m afraid the result is serious.”
- • State the news clearly, then stop talking
- • Acknowledge emotion before discussing treatment
- • Offer a concrete next step and a follow-up conversation

- Primeau et al., 2024; NOGGO survey, 2026

10

Evidence: what patients remember

- • 2024 systematic review: 28 studies, 976 cancer patients
- • Patients emphasized information, emotional support, and decision-making
- • 2026 gynecologic oncology survey: 249 respondents
- • 30.5% reported lack of empathy; 32.9% insufficient time
- • The setting, nonverbal behavior, and follow-up matter

- Primeau et al., 2024 (PMID 38918149); NOGGO 2026 (PMID 42041748)

11

When the patient cries: resist the rescue reflex

- LESS EFFECTIVE
- “Don’t worry. We have excellent treatments.”

- MORE EFFECTIVE
- “I can see this is overwhelming. I’m here with you. We can take this one step at a time.”

12

Scenario 3: postoperative complication

- • First address clinical safety and immediate care
- • Disclose known facts promptly; distinguish facts from uncertainty
- • Express empathy and regret without speculation or blame
- • Explain what is being done and when updates will come
- • Document accurately and follow institutional disclosure policy

- Clinical risk communication principles; local disclosure policy applies

13

Scenario 4: anger, mistrust, or disagreement

- • Regulate your own pace and tone; do not argue
- • Name the concern: “You feel you were not heard.”
- • Explore the unmet need and ask what would help now
- • Set respectful boundaries if behavior becomes unsafe
- • Offer a specific action and follow-up time

- Patient-centered communication and empathy literature

14

Scenario 5: intimate exams and trauma

- • Explain the exam and obtain ongoing consent
- • Offer choices: timing, support person, chaperone, positioning
- • Ask permission before each step; narrate only as preferred
- • Stop immediately if consent is withdrawn
- • Avoid assumptions about trauma history or identity

- Trauma-Informed Care for Obstetric and Gynecologic Settings, 2022

15

Scenario 6: urgent decisions, limited time

- • Lead with the immediate concern and recommended action
- • Explain key benefits, major risks, and alternatives succinctly
- • Check capacity and understanding; use an interpreter if feasible
- • Separate true urgency from avoidable pressure
- • Return for fuller explanation after stabilization

- Lippke et al., 2021; interpreter review, 2023

16

Language barriers: access is a safety skill

- • Use qualified medical interpreters whenever available
- • Speak directly to the patient, not to the interpreter
- • Use short segments; avoid idioms and jargon
- • Check understanding without making the patient feel tested
- • Document interpretation arrangements

- Interpreter services systematic review, 2023 (PMID 36816444)

17

Interactive challenge: 60-second response

- • Case: after hysterectomy, the patient says:
- • “Nobody told me this could happen. I no longer trust you.”
- • In pairs: formulate ONE validating sentence
- • Then ONE transparent next-step sentence
- • Debrief: acknowledge → explain → commit

- Applied simulation; not a validated script

18

Five phrases to take into your next clinic

- • “What matters most to you today?”
- • “What is your understanding of what is happening?”
- • “I can see why this is frightening.”
- • “Here is what we know—and what we do not yet know.”
- • “To check I explained this clearly, how would you describe our plan?”

- AHRQ teach-back; communication reviews

19

Acknowledgments

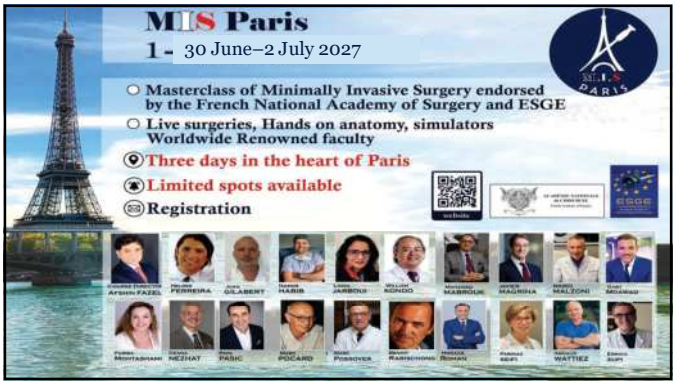
- Thanks to colleagues, patients, and educators contributing to better clinical communication.

20

References

- • De Vries AMM et al. Psychooncology. 2014;23:375–381. PMID: 24243790
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21



22

How to design and deliver an idea worth sharing

Jose Carugno, MD · University of Miami. Miami FL, USA

NOVEMBER 13-16, 2026 · BOSTON · #AAGL26

1

Disclosure

I have no financial relationships to disclose.

2

Objectives

- **Identify** the key psychological and emotional factors that determine audience engagement and attention retention during public speaking.
- **Demonstrate** techniques for crafting impactful openings, transitions, and conclusions that immediately capture and sustain audience interest.
- **Apply** effective verbal and non-verbal communication strategies—such as tone, pacing, body language, and eye contact—to enhance connection with listeners.
- **Utilize** storytelling, humor, and rhetorical devices appropriately to make presentations more memorable and persuasive.
- **Develop** a personalized framework for audience-centered speaking that aligns message delivery with audience expectations, setting, and purpose.

3

Storytelling.
Why are stories so powerful?



4



5



Underwater Surgeon!

6



Underwater Surgeon!
Who performs in-office hysteroscopy

7

The structure of a story

- Beginning (set up)
  - Explaining the situation. Seat number. Mid 30's
- Middle (struggle)
  - She is looking into my stuff (Rude)
- End (Solution)
  - Underwater surgeon. Funny ending

8

Capturing attention



9



Tone
Speed
Volume
The pause

10



11

Speed



12



13



Pause

The "power of the pause" is the act of creating space between a stimulus and a response **to foster clarity, enhance decision-making, and improve emotional intelligence.**

14

Slides

They are for the audience, not for you
Mantra: Less is more
(Is there an image that can replace text?)

15

Most common catastrophic mistakes

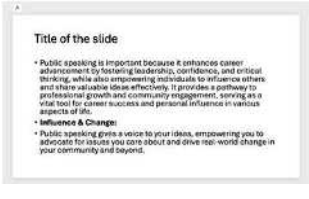
- **The speaker read the slides**
- Full sentences on the slides
- Text is too small, couldn't read it
- Hard to read because of poor font-color/background contrast
- Overly complex diagrams or charts
- Point out typos



16

Most common catastrophic mistakes

- The speaker read the slides
- **Full sentences on the slides**
- Text is too small, couldn't read it
- Hard to read because of poor font-color/background contrast
- Overly complex diagrams or charts
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17

Most common catastrophic mistakes

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- Full sentences on the slides
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18

Most common catastrophic mistakes

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- Full sentences on the slides
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19

Most common catastrophic mistakes

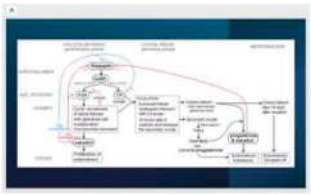
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20

Most common catastrophic mistakes

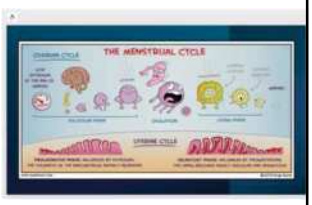
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- **Overly complex diagrams or charts**
- Point out typos



21

Most common catastrophic mistakes

- The speaker read the slides
- Full sentences on the slides
- Text is too small, couldn't read it
- Hard to read because of poor font-color/background contrast
- **Overly complex diagrams or charts**
- Point out typos



22

Most common catastrophic mistakes

- The speaker read the slides
- Full sentences on the slides
- Text is too small, couldn't read it
- Hard to read because of poor font-color/background contrast
- Overly complex diagrams or charts
- **Point out typos**

23

Most common catastrophic mistakes

- The speaker read the slides
- Full sentences on the slides
- Text is too small, couldn't read it
- Hard to read because of poor font-color/background contrast
- Overly complex diagrams or charts
- Point out typos
- **Animations**

24

Slides (Journal articles)

When citing articles:

Take the complex and make it simple

Take the simple and make it meaningful

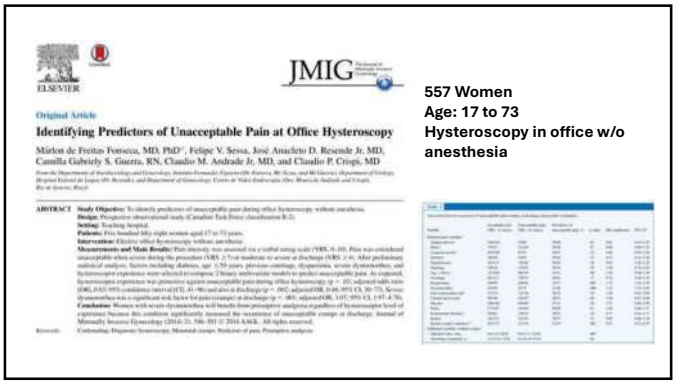
How:

Pick one or two points per slide

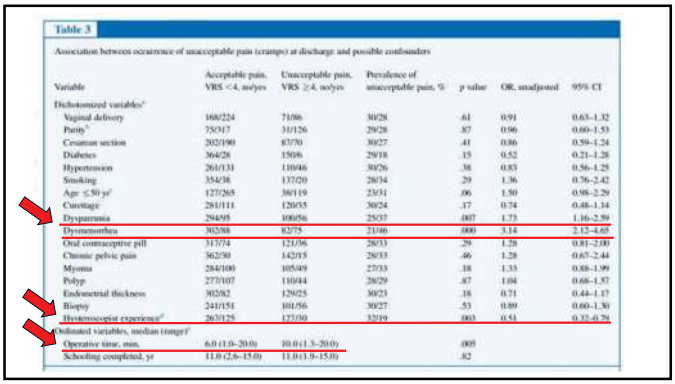
Avoid extensive numbers

Look for figures and tables

25



26



27

How to deliver



28



Bet…

29

March 15th

International Public Speaking day



30



31



32



33



Goals:

- ✓ Capture the people
- ✓ Don't lose anyone
- ✓ Make sure they enjoy the trip
- ✓ Make sure they remember the experience
- ✓ Make sure they come back

34



35

How to start

- The classic start
  - Good morning
  - I am…. and my talk is going to be
- The technician start
- The nervous start



36

How to start

- The classic start
  - Good morning
  - I am…. and my talk is going to be
- **The technician start**
- The nervous start



37

How to start

- The classic start
  - Good morning
  - I am…. and my talk is going to be
- The technician start
- **The nervous start**



38

How to start

- **The best start**
  - **Small talk**
  - **Strong fact**
  - **Humor**
  - **Story telling**
  - **Be yourself**



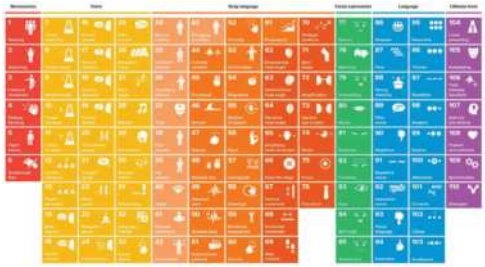
39

What makes an effective communicator?



40

110 Skills of Effective Communicators



David Phillips. The toastmasters Podcast

41

Nervousness

Voice

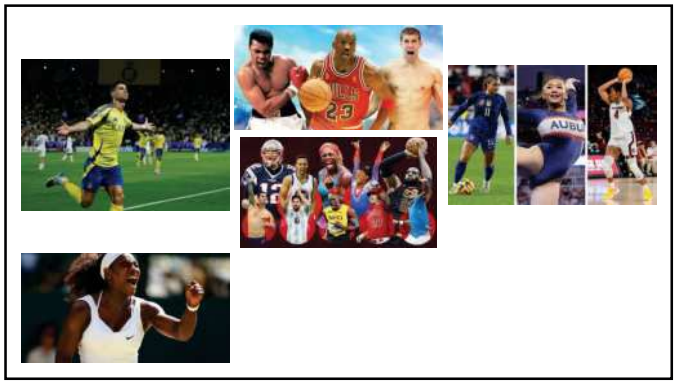
Body Language

Facial Expression

Verbal Language

Ultimate Level

42



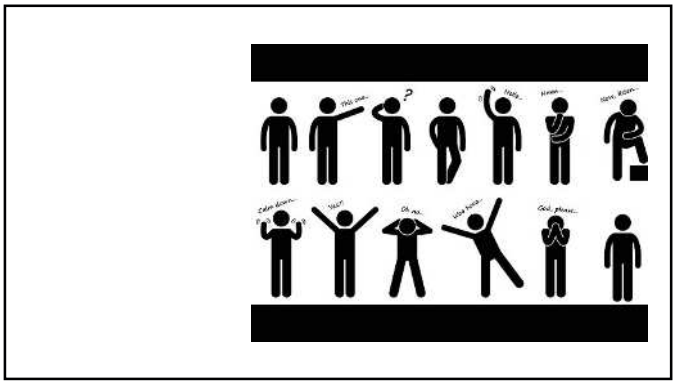
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44



45



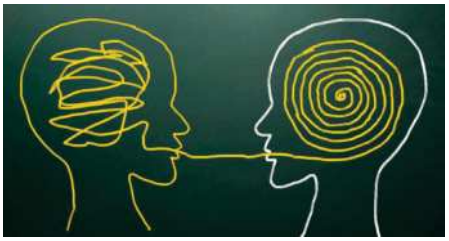
46



47



48



Language

49

Ultimate skills

- Be authentic
  - The value of "I don't know"
- Enjoy the experience
  - Love presenting
  - Be present and enthusiastic
- Practice, practice, practice



50



51

The 7 rules of Effective Speakers

1. Be yourself (Integrate humor. Speak in a conversational style)
2. Show up to give… not to take (It is about them not you)
3. Make eye contact
4. Speak slowly
5. Turn nervousness into excitement.
6. Pick 2 or 3 core messages only
7. Enjoy the ride

52

Tips to become a better communicator/speaker

1. Record yourself and watch it
2. Watch and learn from the experts (Barack Obama, Steve Jobs)
3. Ask for feedback
4. Find analogies to drive your points and lines to remember them
5. Practice, practice, practice.

53

Core Principles of Public Speaking

1. Do not lie
2. Be yourself (Develop your style)
3. Respect your audience
   - Prepare for your talk
   - Read the audience and tailor your talk
4. Respect the event
   - Stay within your topic
   - Stay within the time allocated to you
5. Enjoy the experience

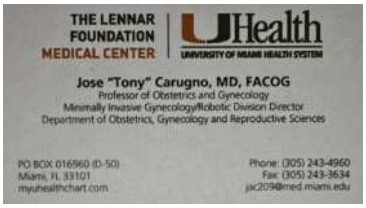
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References



55

Thank you



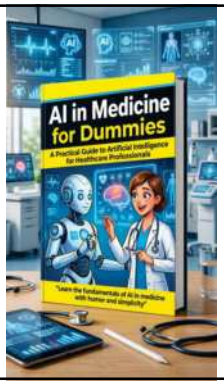
jac209@med.miami.edu

56

Please connect:

1. To the chat with the QR we will use it for sharing the results of your exercises during the course
2. From your Laptop, to any AI, it is free. (ChatGPT, Gemini, Copilot, Claude, etc.)
3. Also, look in your laptop for a medical PDF, you will need it

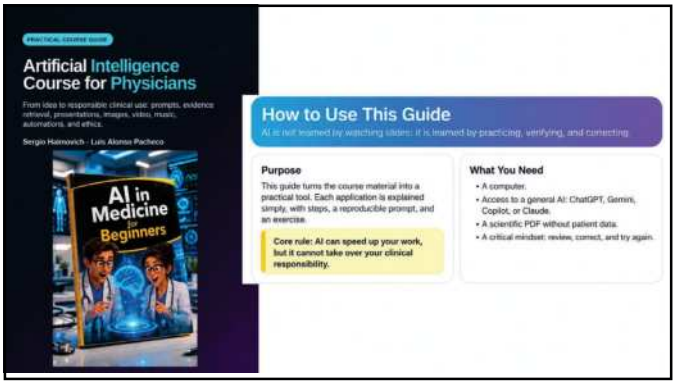
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2



3



4



5



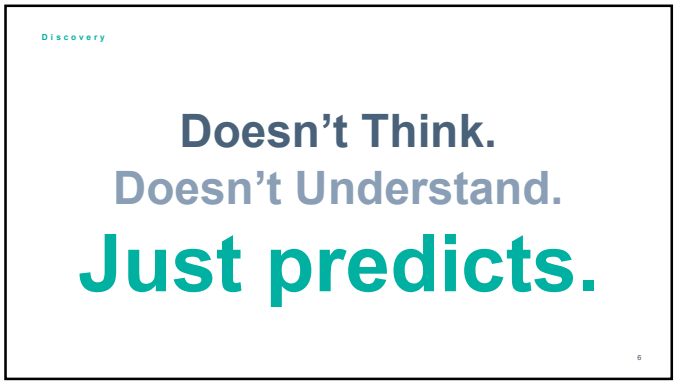
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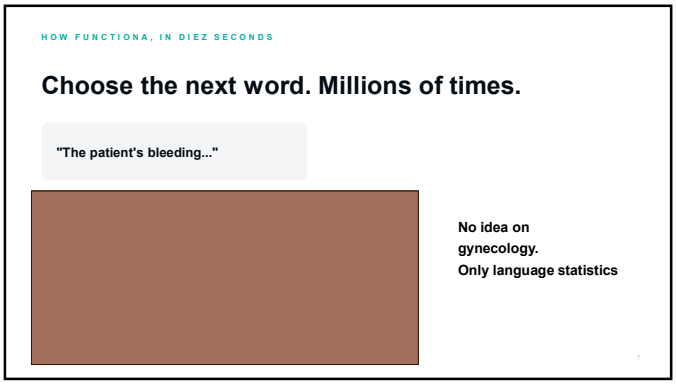
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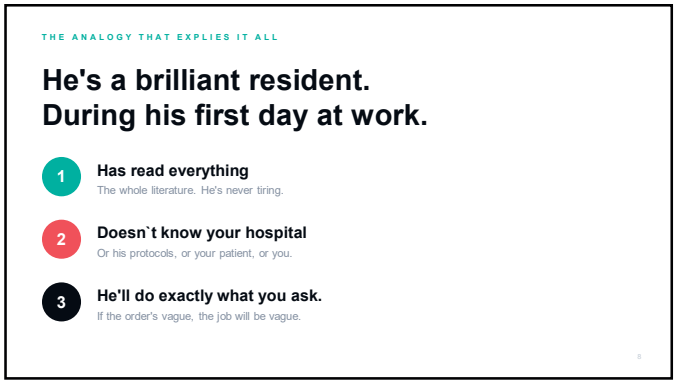
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25



26



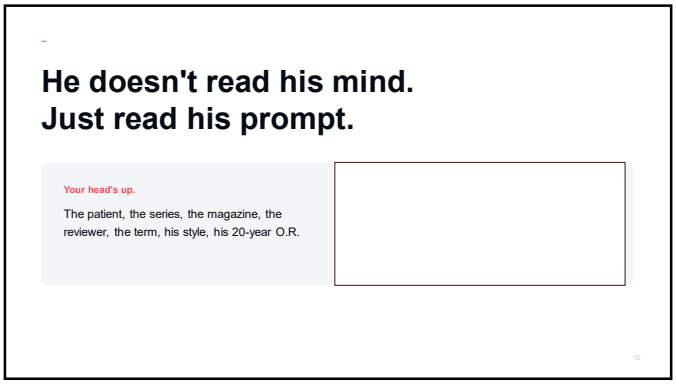
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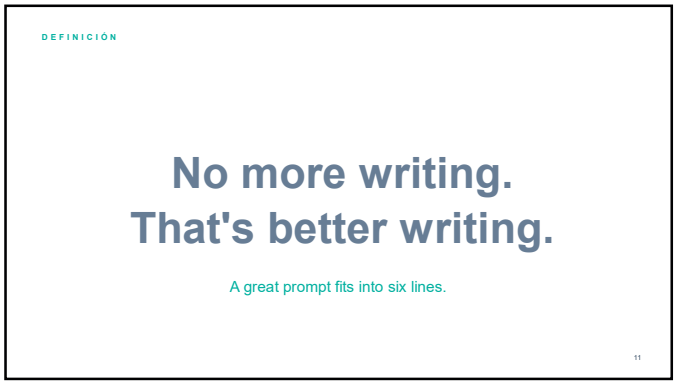
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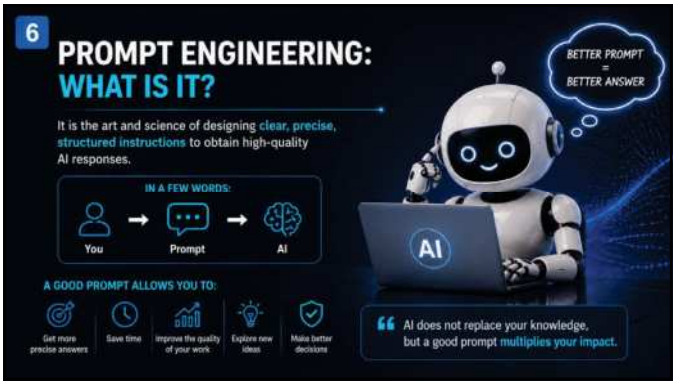
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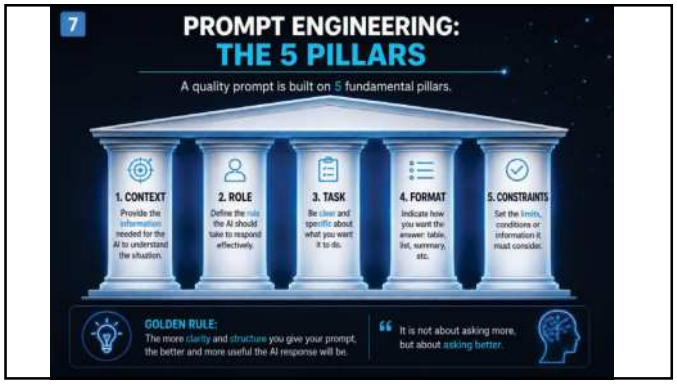
31



32



33



34



35

SCALPEL

How to Write Prompts That Cut Through Ambiguity

Precision starts before the answer

AI PROMPTING FOR HEALTHCARE PROFESSIONALS



01

36

Vague Prompt. Vague Result.

AI cannot reliably solve what you have not clearly defined.

"Make a presentation about adhesions."

Missing role, audience, scope, format, and evidence rules.



02

37

Seven Letters. One Method.

S	C	A	L	P	E	L
Set the Role	Context	Action	Limits	Parameters	Expected Output	Loop & Validate

Miss one step, and precision is lost.

SCALPEL turns a vague request into a controlled instruction.



03

38

S — Set the Role

Define who should think before defining what to do.

"Act as an expert gynecologist in hysteroscopy and intrauterine surgery."

Role changes the knowledge, language, and priorities of the answer.



04

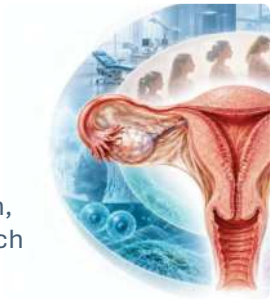
39

C — Context

Without context, AI fills the gaps.

"For a 20-minute session for Latin American gynecologists..."

Context answers: for whom, where, why, and under which conditions.



05

40

A — Action

Use one precise verb for one precise task.

Analyze	Compare
Summarize	**Design**
Translate	Draft

"Design a 12-slide presentation on intrauterine adhesions."



06

41

L — Limits

What AI must not do is equally important.

"Do not invent references.
Do not alter data.
Do not exceed 12 slides."

Limits protect accuracy, scope, and clinical credibility.



07

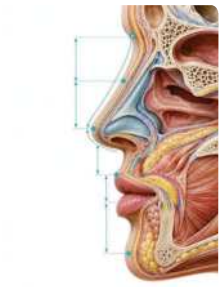
42

P — Parameters

Specify how the answer should sound, look, and fit.

Language	Audience
Tone	Length
Style	Technical level

"In English, scientific tone, concise messages, anatomical-atlas visuals."



08

43

E — Expected Output

Do not just request an answer. Design the delivery.

"Deliver a table with diagnosis, evidence, recommendation, and references."

A defined **format** makes the result easier to use and verify.



09

44

L — Loop & Validate

The first answer is a draft, not the destination.

Review

Correct

Refine

"Before delivering, verify consistency, accuracy, and unsupported claims."



10

45

Build the Prompt

VAGUE

"Create a presentation about intrauterine adhesions."

Too many decisions remain undefined.

SCALPEL

Act as a hysteroscopy expert. Create a 12-slide English presentation for gynecologists. Use concise evidence-based messages, atlas-style visuals, and speaker notes. Do not invent references. Deliver editable slides.

The structure makes the instruction executable.



11

46

Precision Is a Structure

Before you send a prompt, use SCALPEL.

A precise prompt needs a SCALPEL, not a guess.



12

47

Temperature (What does it really do?)

Temperature	Behaviour
0.0	Deterministic, always the same result
0.1–0.2	Stable, Scinetific Mode
0.5	Balanced
0.7–0.9	Creative
1.0+	Unestable, prone to hallucinations



For medicine, law and research:

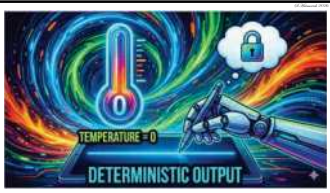
Never use >0.2

48

When you write

"**TEMPERATURE=0**"

You're telling the model:



Don't improvise.

Don't especulate.

Give the most statistically correct answer.

49

State critical constraints

This prevents typical AI errors.

Examples:
- **Do not invent data.**
- **Do not cite papers unless certain.**
- **Do not add emotional tone.**
- **Avoid assumptions beyond given information.**



Example prompt clause:
"Do not fabricate numbers or authors; explicitly state if evidence is uncertain."

50

Hallucinations: the main danger

LLMs prefer to invent rather than say "I don't know".

By default:

If data is missing → it fills the gap.



Prevention:

```
If information is missing or uncertain,
explicitly state that. Do not infer or guess.
```

52

Prompt practice



80

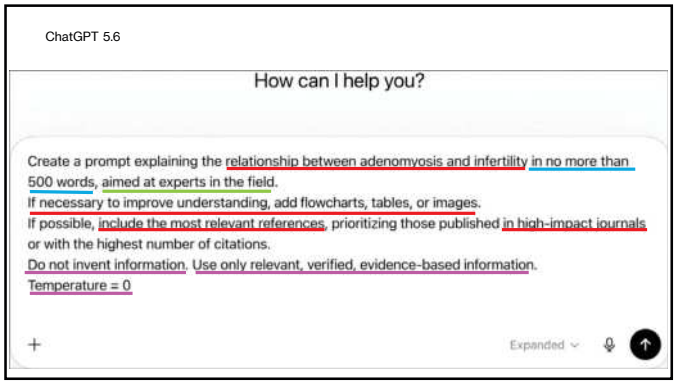
Exercise

Ask IA to explain "Adenomyosis and Infertility"

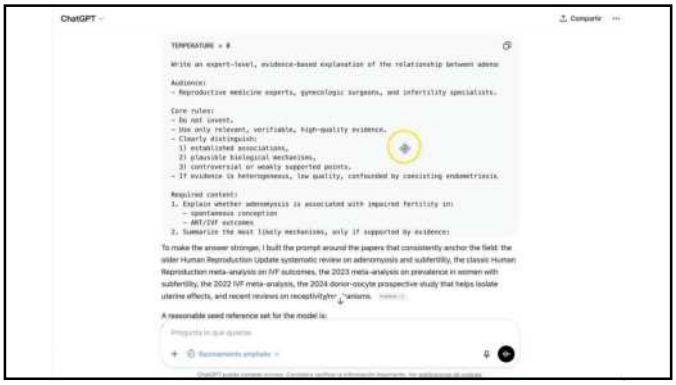
(That final result be a word or PDF file)

Use what you have learned with regard to prompt engineering

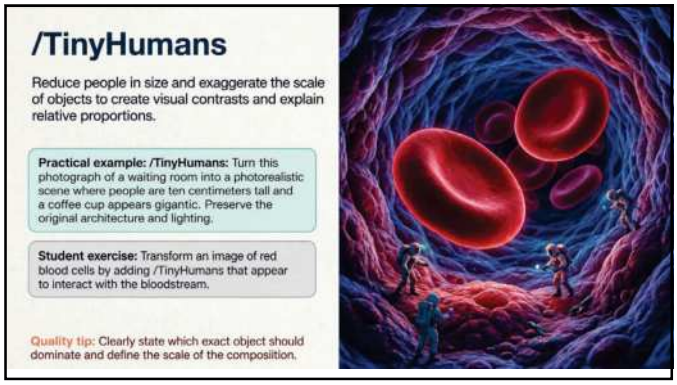
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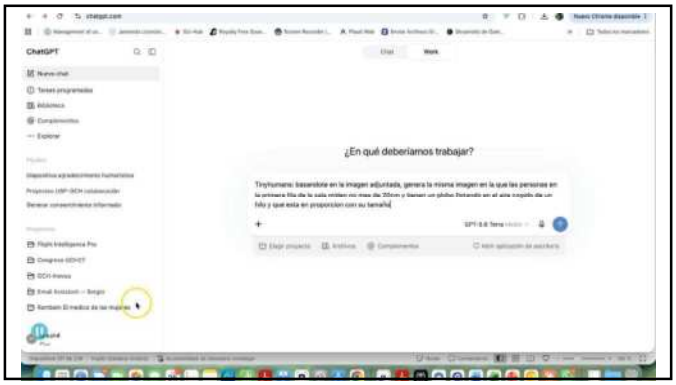
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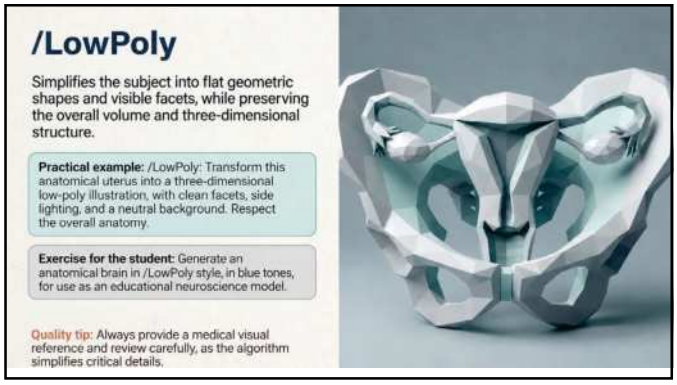
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100



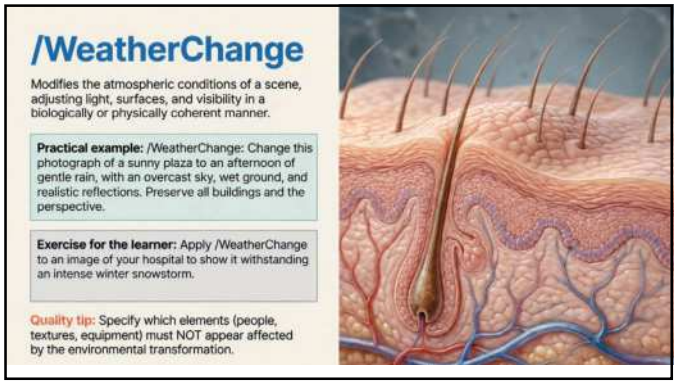
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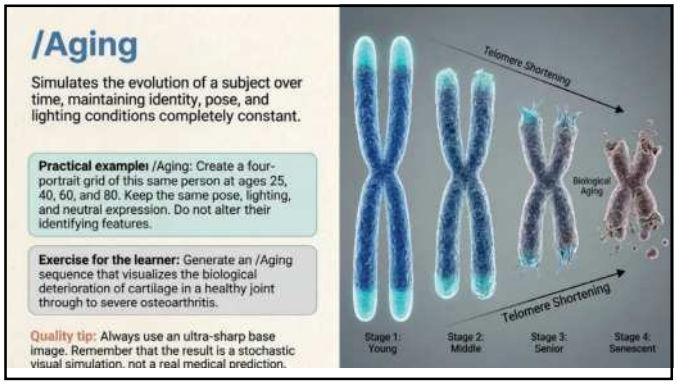
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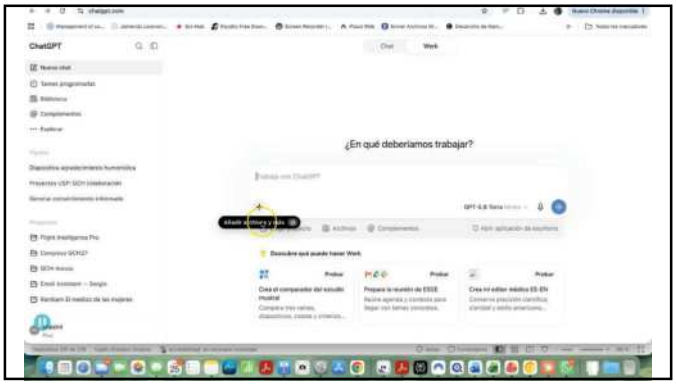
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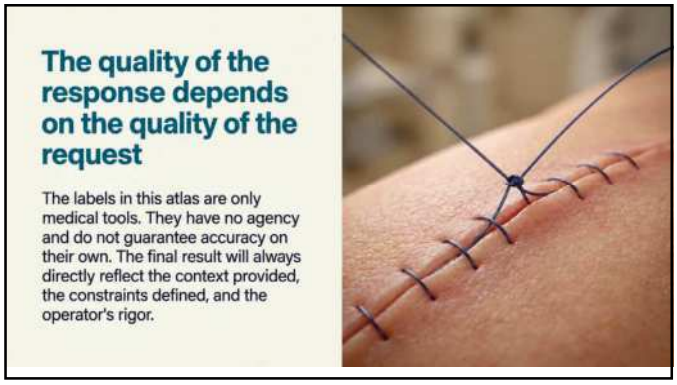
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107



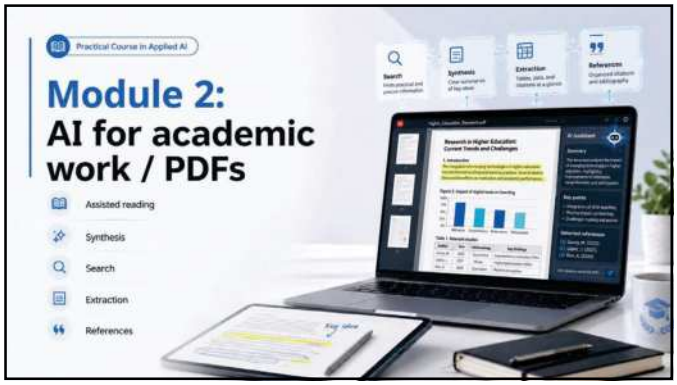
108



109



110



115

We start with the practice...



116

PERPLEXITY

OUR TOPIC: ABNORMAL UTERINE BLEEDING

1. Scientific Text



117

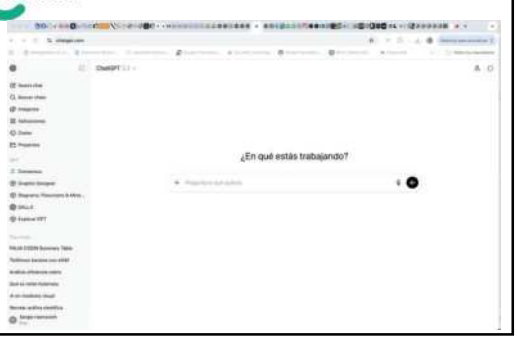
OpenEvidence

118

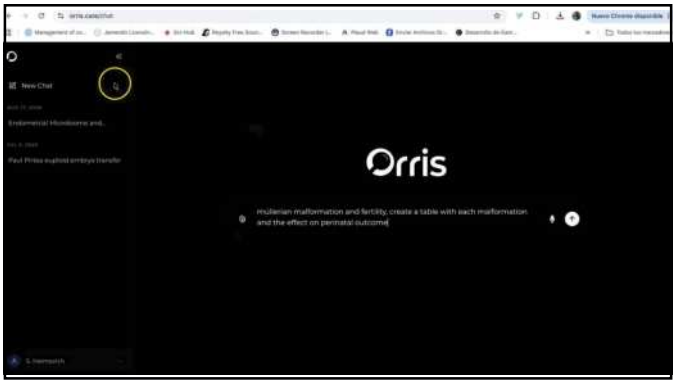
Consensus

consensus

2. Table/Chart



119



120

Exercise:

Plaese, create with Consensus a table that sums up the concept of Isthmocele, thinks about his target, what an aspect of the isthmocele you want to represent, etc.

121



122

PDF ANALYSIS



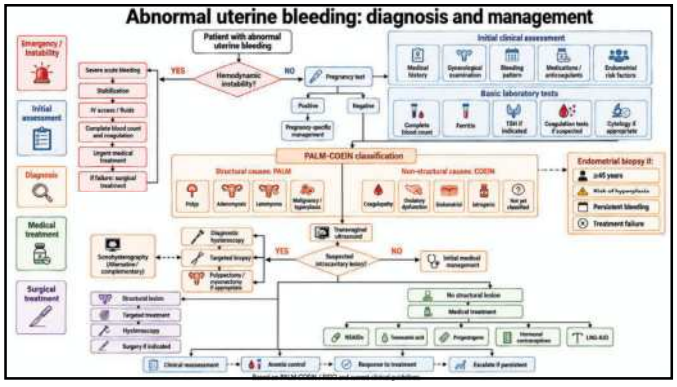
123

FLOW DIAGRAMS

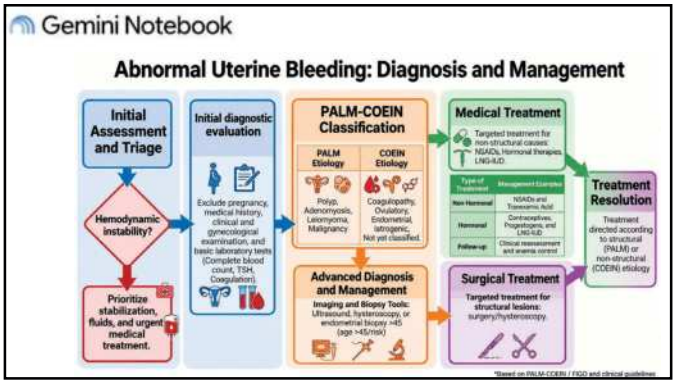
Text to:
Diagram
Flow Chart



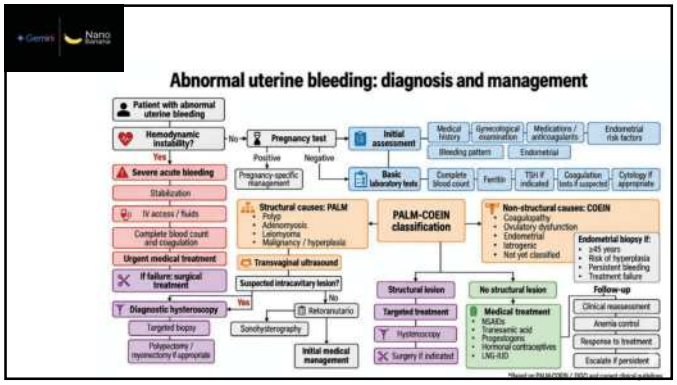
124



125



126



127

Upload a PDF file of a publication and creates a table from the contents or ask the AI to summarize it into 10 bullets.

128



129



130

Gemini - Nano Banana

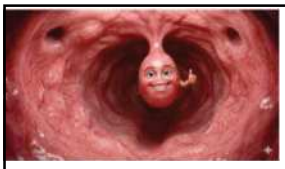


131

ChatGPT Image 2



132



Nona Banana



GPT Image 2

133



They just took this photo during my presentation, but I appear too dark and cannot be seen clearly. Enhance the image so that only I am brighter, without altering the surroundings, while preserving my facial features.

134



135

Exercise

Create an image prompt for **Nano Banana** or **GPT Image 2** showing a caravel sailing along a red river toward a flowering uterus.

136



137

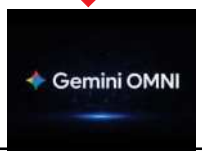


138

text to video

- Video Apps





139

A video inside the colisseum where romulus and remus are brestfeeding from a she wolf, and behind 3 gentlemen are approaching with a sign in wich you can read HARTUS



140



Hyperrealistic cinematic video, ancient Roman **Colosseum** at golden hour, vivid saturated colors, strong realism, ultra-detailed textures, epic and majestic atmosphere. The camera faces the center of the arena. In the middle of the arena, a realistic Roman she-wolf is calmly breastfeeding **Romulus and Remus**, portrayed as human infants in a classical mythological style, respectful and visually powerful.

From the background, walking forward with dignity and confidence, come **three elegant gentlemen** side by side. One is dressed in **deep royal red**, one in **rich emerald green**, and one in **golden yellow**. Their clothing is refined, noble, and timeless, with subtle Roman-inspired elegance but not costume-like. They are carrying together a **large sign** toward the center of the scene.

The sign must be clearly visible and easy to read. On it, in **very large bold letters**, the word:

HARTUS

The text must be **exactly spelled HARTUS**, with **no mistakes, no extra words, no distorted letters, no mirrored text**.

Style: hyperrealistic, highly illuminated, dramatic sunlight, warm golden beams, cinematic depth, realistic stone textures, dust in the air, subtle movement in fabric, premium visual quality, 4K film look, stable composition, clean focal hierarchy.

Camera direction: begin with a wide establishing shot of the Colosseum, then slowly move closer toward the she-wolf and twins, revealing the three gentlemen approaching from behind with the sign, ending in a strong centered frame where the word **HARTUS** is perfectly legible.

141

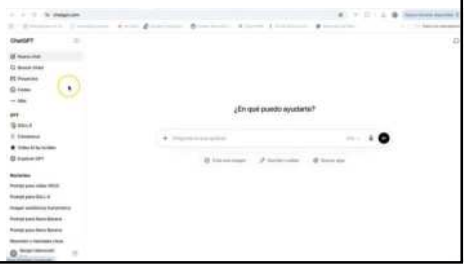


142

Video AI invideo AI

Text to:
text + voice + video

1. **Requests the script prompt**
2. **Create video**

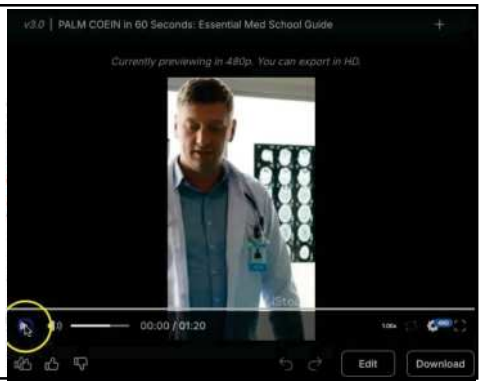


143

Video AI invideo AI

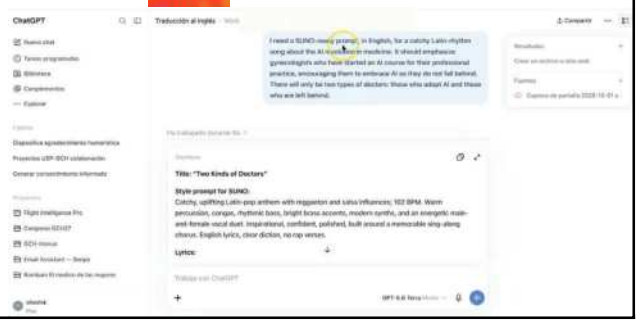
Text to:
text + voice + video

1. **Ask the script prompt**
2. **Create the video**

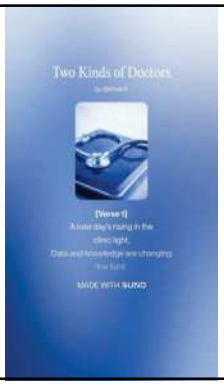


144

Text to Music



145



146



147

Preparing a Presentation



148

IA-driven innovations in the design of academic presentations for gynecologists



From boring slides to clear teaching,
visual and enhanced by IA

149

Because this is important for clinics

The challenge

- Medical presentations are often too textual and overwhelming.
- The time pressure limits design development.
- **Lack of training in visual communication.**

The opportunity

- Better presentations improve understanding
- Cleaner teaching leads to better clinical decisions.



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What do we mean by IA for presentation design?

A. Text

• Language models (LLM) structured content and simplified medical language for different audiences.

IA Image

Generate **diagrams**, **anatomical illustrations**, and visual metaphors

Diagram Generator

• Platforms such as Gamma and NotebookLM create complete presentations from schemes.

IA Video

• It creates brief and lively explanations and educational content.

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The role of the Clinic: IA is co-designer, No Replace

Your Role is essential

- Define the studies purposes and the clinical targets
- Permorm the narrative and his leading thread.
- **Check all scientific content and data**
- • apply clinical judgment and professional experience.

The A's support role

- **Expand the structured content**
- Enhance visual clarity and design
- Generates initial purifiers and design
- **Translates and adapts contents**



Critical principle: • The responsibility for patient accuracy, ethics and safety always lies with the patient.

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Example Prompt for Structuring a a Talk

"Here is my publication on hysteroscopic myomectomy. Create a 15-slide outline for a 15-minute talk for OB/GYN residents, highlighting clinical relevance and minimizing complex statistics. Focus on surgical technique, patient selection, and outcomes."

01 **Specify your audience**

Residents, attendings, or patients require different depth

02 **Define time constraints**

Slides per minute ratio (typically 1-1.5 slides/minute)

03 **Clarify learning goals**

What should the audience remember and apply?

Your audience will remember max 30% of what you say, you must decide what is that 30% before

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Drafting Content While Maintaining Scientific Rigor Rigor

AI Can Help You:

- **Simplify** complex medical language for trainees or patients
- **Transform** dense paragraphs into 3-4 **clear bullet** points
- Generate **analogies** and **visual metaphors**
- Suggest **clinical examples** and **case scenarios**



You Must Always:

- **Verify** all data, statistics, and references manually
- **Check** for AI hallucinations or inaccuracies
- **Ensure** clinical recommendations align with current guidelines

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Visual Design Principles for Clinicians



One Main Idea Per Slide

Resist the urge to cram. Each slide should convey a single, clear message.

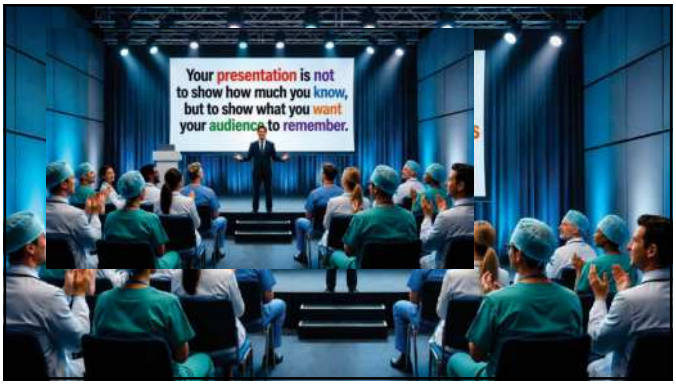
Large Fonts, High Contrast

Readable from the back of the room. Minimum 24pt body text, 36pt+ headings.

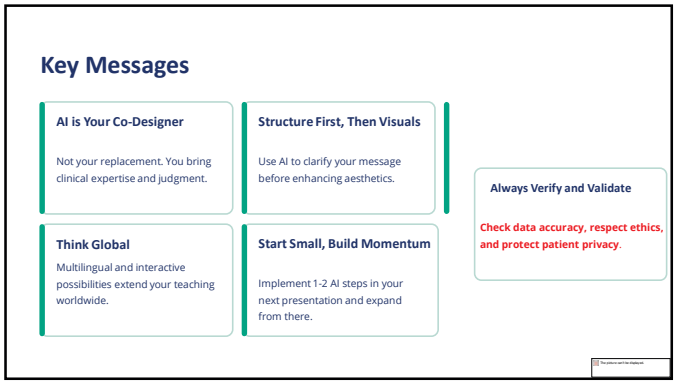
Minimal Text, Maximum Impact

Use diagrams, icons, and images instead of lengthy paragraphs.

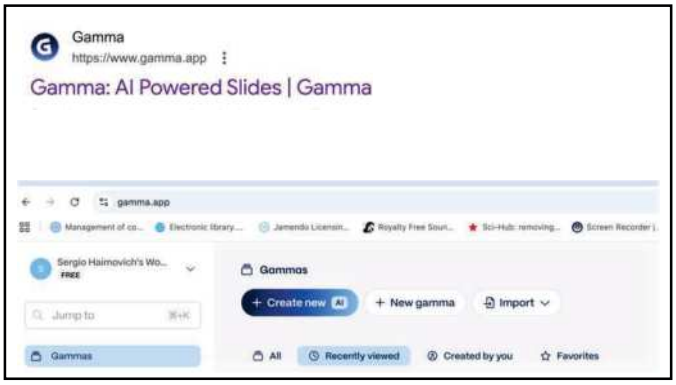
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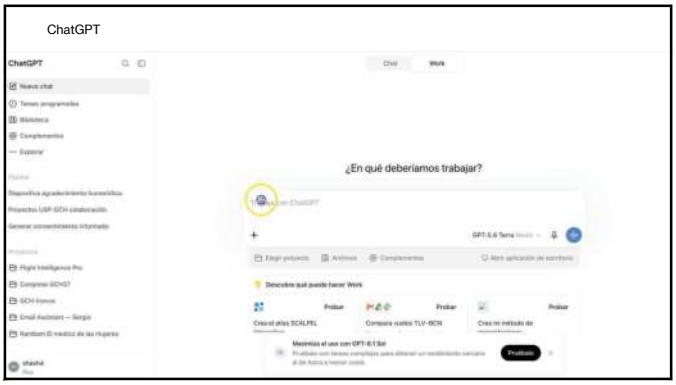
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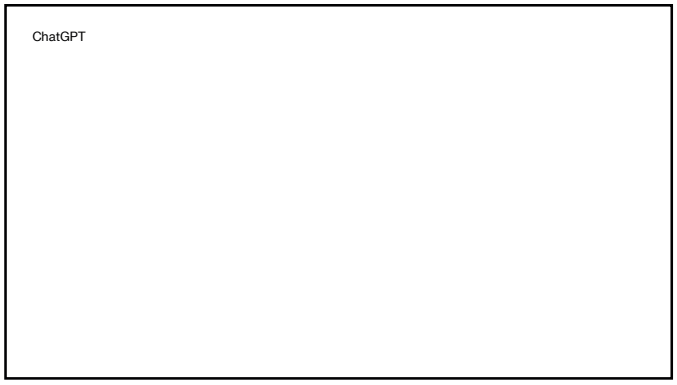
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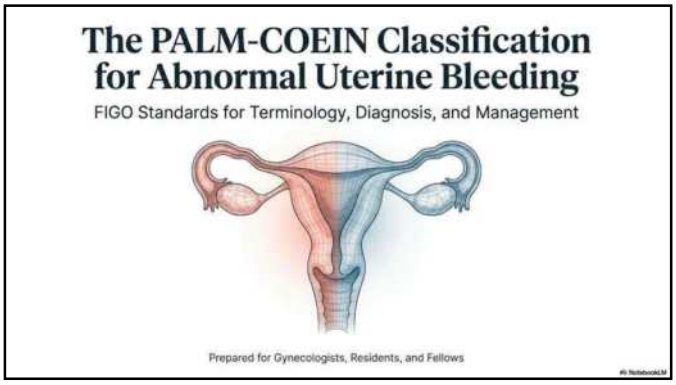
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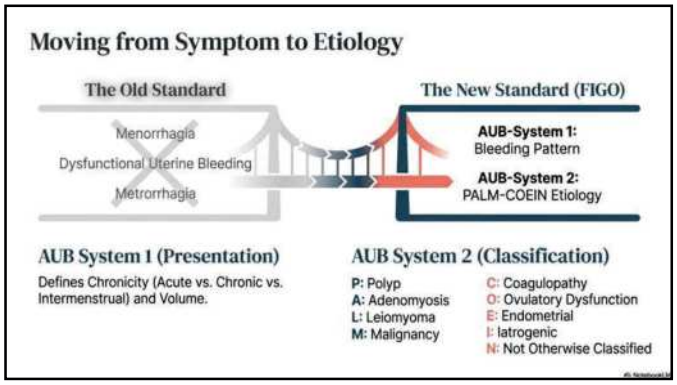
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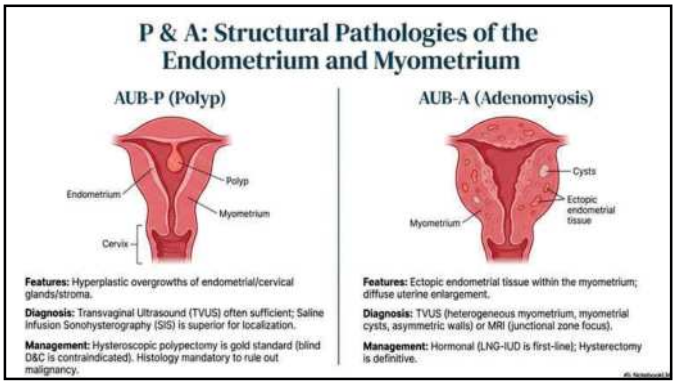
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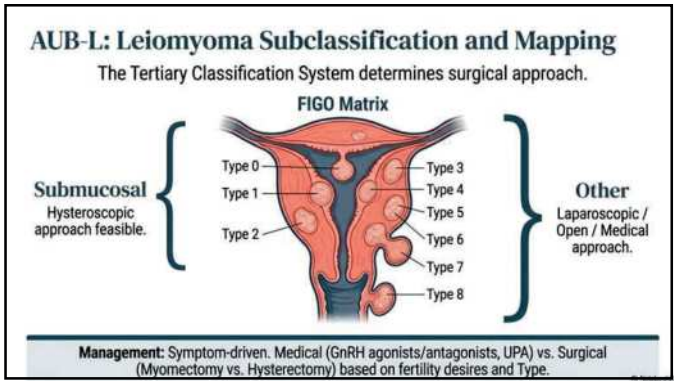
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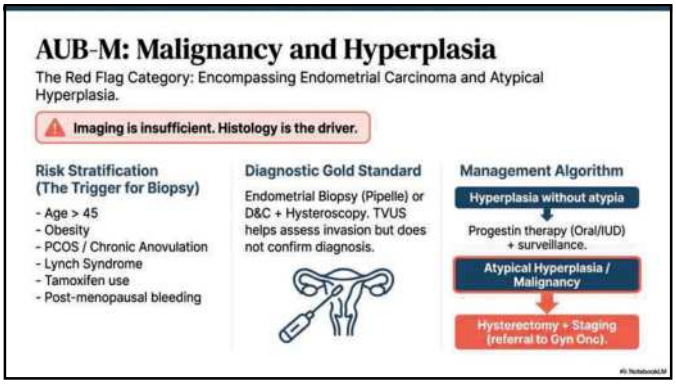
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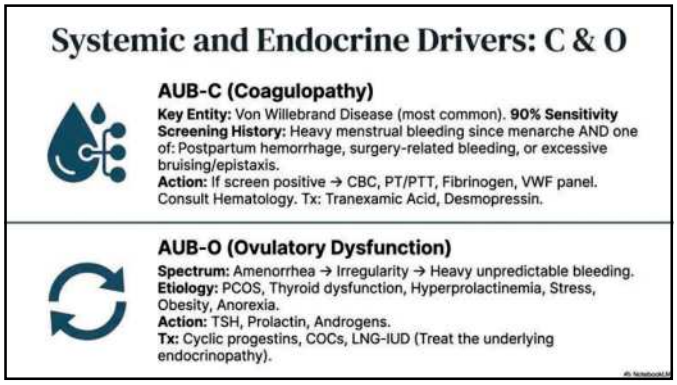
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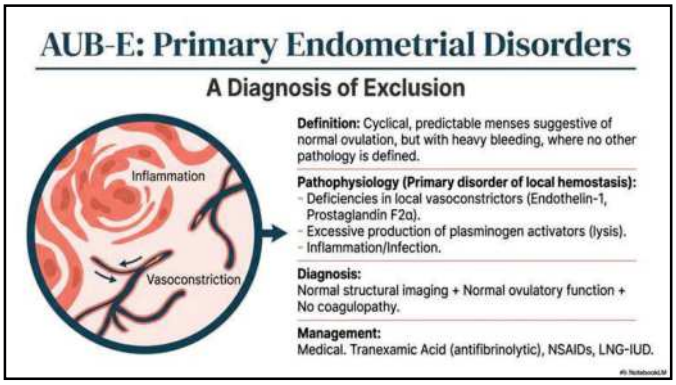
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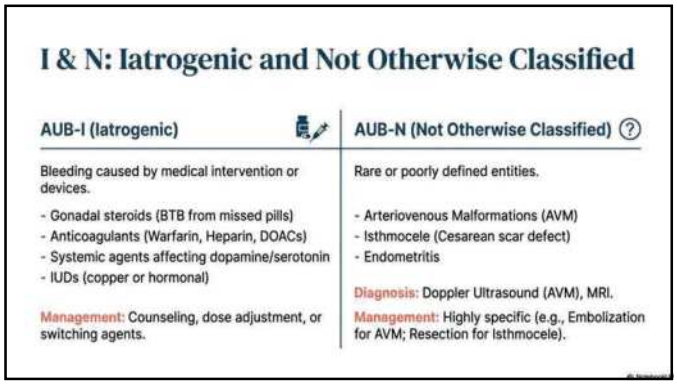
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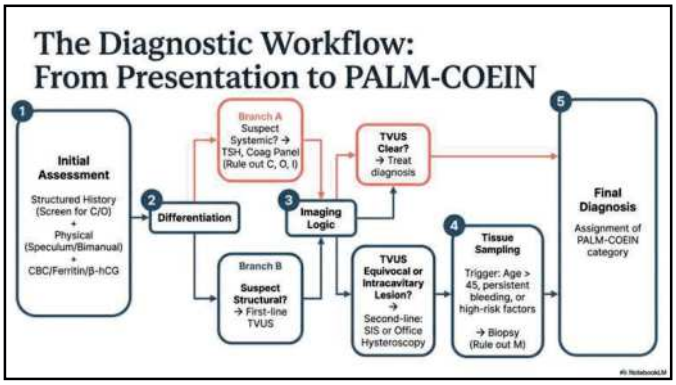
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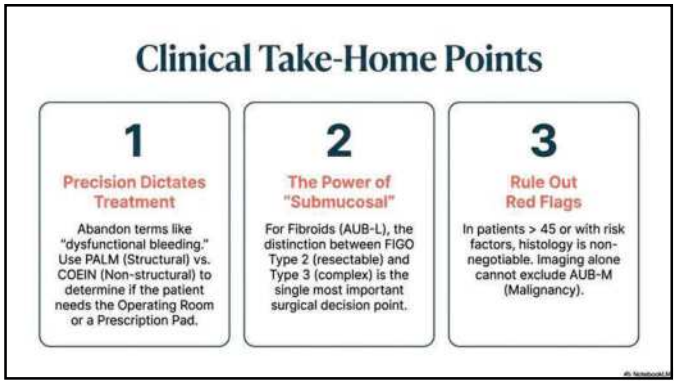
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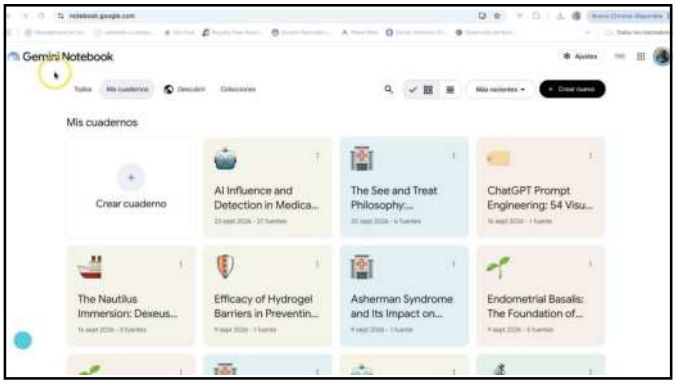
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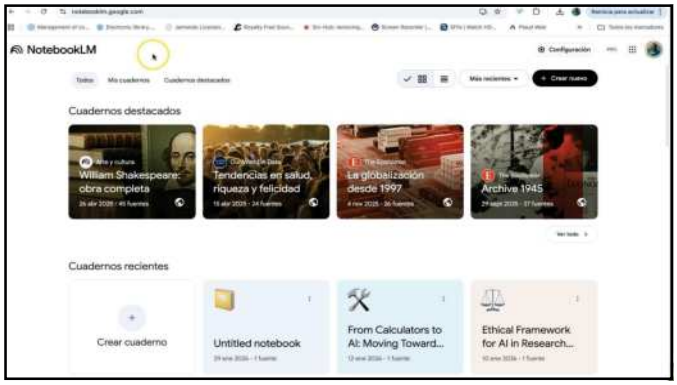
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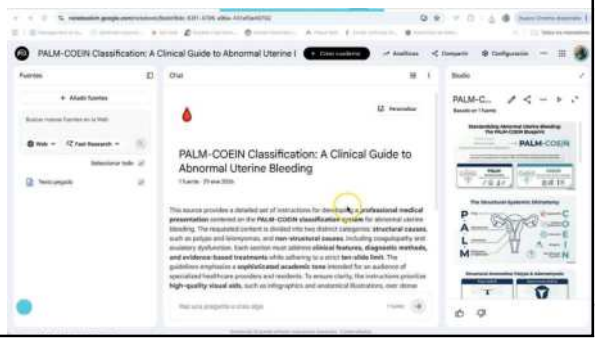


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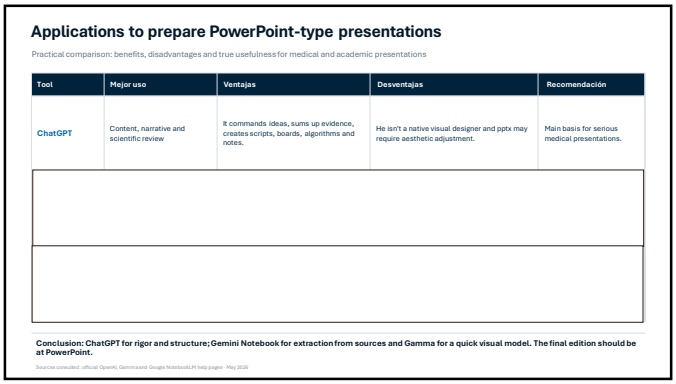


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NoteBookLM editable con Claude



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Applications to prepare PowerPoint-type presentations

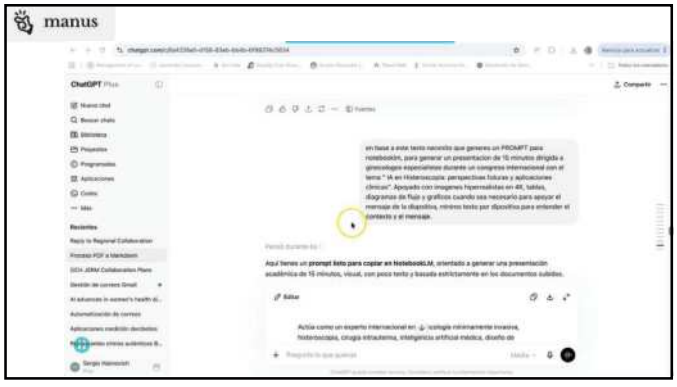
Practical comparison: benefits, disadvantages and true usefulness for medical and academic presentations

Tool	Mejor uso	Ventajas	Desventajas	Recomendación
ChatGPT	Content, narrative and scientific review	It commands ideas, sums up evidence, creates scripts, boards, algorithms and notes.	He isn't a native visual designer and pptx may require aesthetic adjustment.	Main basis for serious medical presentations.

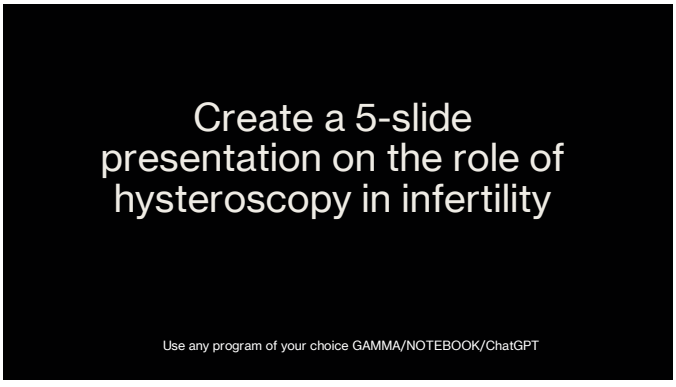
Conclusion: ChatGPT for rigor and structure; Gemini Notebook for extraction from sources and Gamma for a quick visual model. The final edition should be at PowerPoint.

Sources consulted: official OpenAI, Gemini and Google NotebookLM help pages · May 2026

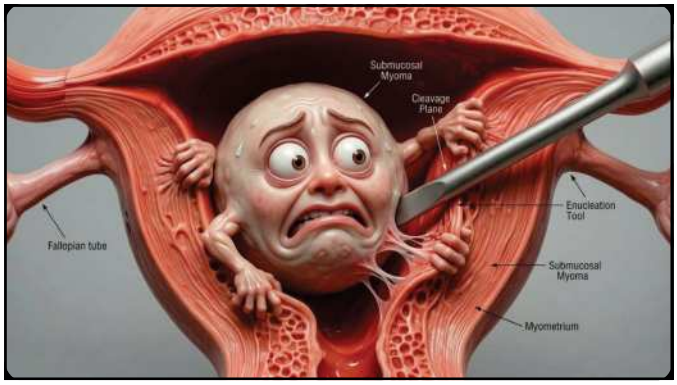
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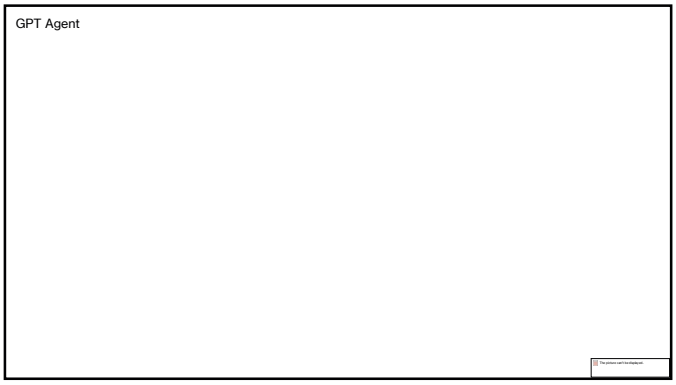
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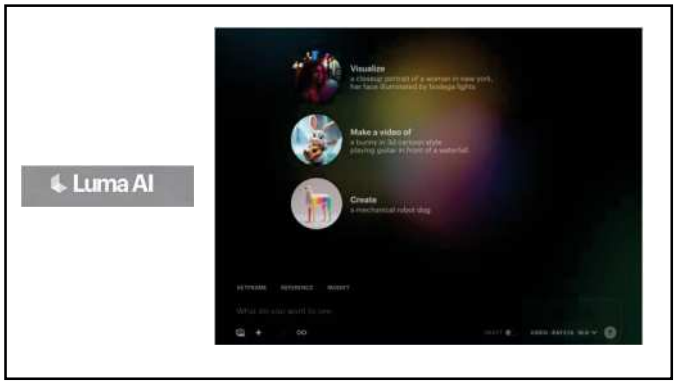
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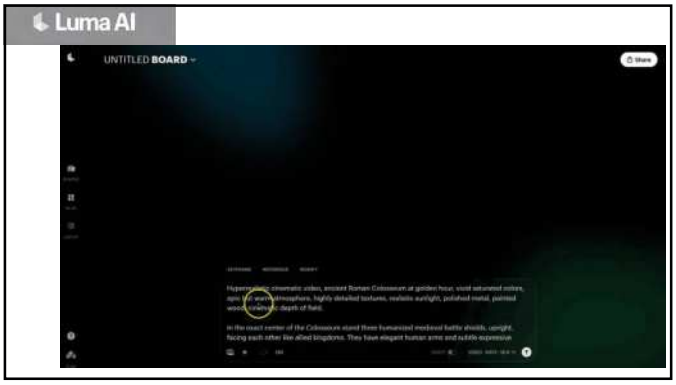
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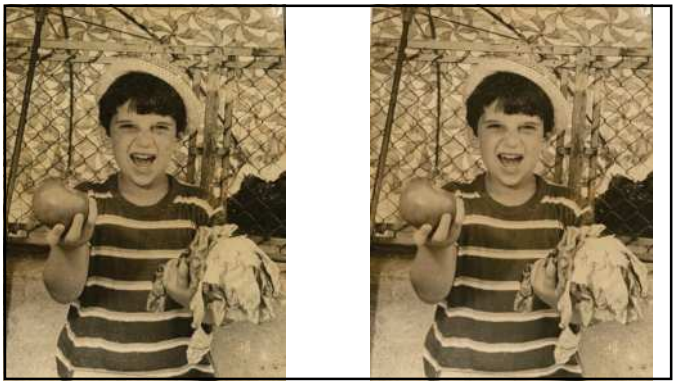
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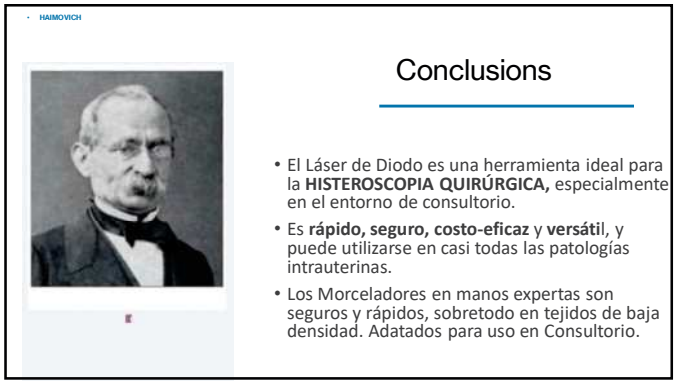
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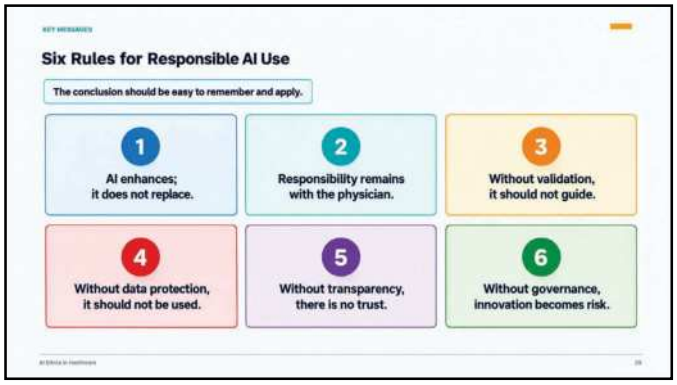
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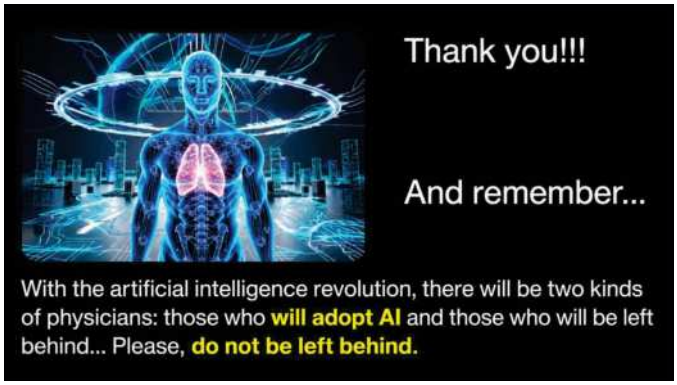
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Six Rules for Responsible AI Use
The conclusion should be easy to remember and apply.
1
AI enhances; it does not replace.
2
Responsibility remains with the physician.
3
Without validation, it should not guide.
4
Without data protection, it should not be used.
5
Without transparency, there is no trust.
6
Without governance, innovation becomes risk.

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The question is not whether we will use AI.
The question is whether we will use it well.
Ethics does not hinder innovation: it makes it safer.

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Thank you!!!
And remember...
With the artificial intelligence revolution, there will be two kinds of physicians: those who will adopt AI and those who will be left behind... Please, do not be left behind.

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CULTURAL AND LINGUISTIC COMPETENCY & IMPLICIT BIAS

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

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

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

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

Important Definitions:

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

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

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

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

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

CLC & IB Online Resources:

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