# AAGL 26

55TH GLOBAL CONGRESS ON MIGS

BOSTON, MASSACHUSETTS
NOVEMBER 13-16, 2026

# Syllabus

## PG-26193

Teaching in the OR: Advancing Surgical Judgment, Autonomy, and Team-Based Learning


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# Table of Contents

Course Program: Course Description, Learning Objectives, Course Outline ..... 3

Financial Disclosures ..... 4

Course Overview
M. Billow ..... 5

Teaching Surgical Judgment In the or: Balancing Autonomy, Safety, and Decision-Making
M. Billow ..... 6

Teaching in Dual-Console Environments: Simulation, Debriefing, and Platform-Based Coaching
L. Valentine ..... 13

Innovating Intraoperative Teaching: Rethinking How We Teach Complex Pelvic and Vaginal Surgery
R.Kho ..... 17

Learner to Leader: Building a Teaching Identity Early in Faculty Life
M. Alzamora ..... 18

Cultural and Linguistic Competency & Implicit Bias ..... 24

**PG-26193: Teaching in the OR: Advancing Surgical Judgment, Autonomy, and Team-Based Learning**

**Chair:** Megan Billow
**Co-Chair:** Lindsey Valentine
**Faculty:** Maria Alzamora, Megan Billow, Rosanne Kho, Lindsey Valentine

**Course Description**

Intra-operative teaching is one of the most influential and underdeveloped skills in gynecologic surgery. Faculty are expected to model judgment, maintain safety, lead teams, and support learner autonomy, often under time pressure and clinical uncertainty. Yet most surgical educators receive little formal guidance on how to teach effectively in the OR. This postgraduate course provides a structured, cross-platform approach to surgical teaching, drawing on expertise from vaginal, laparoscopic, and robotic surgery as well as across the faculty career arc. Through practical frameworks and real-world scenarios, faculty will explore how to teach surgical decision-making, give actionable feedback, teach under stress, and maintain psychological safety during complex or high-stakes cases. Topics will include how to teach restraint, how to use simulation and digital tools to improve readiness and feedback, and how early-career faculty can develop a personal teaching identity. Emphasis will be placed on innovation in teaching technique and leveraging diverse educational models to improve consistency, outcomes, and learner development. Designed for surgeons who actively supervise trainees or early-career colleagues, this course equips attendees with the tools to lead safe, high-functioning, learning-centered ORs.

**Learning Objectives:** *At the end of this course, the participant will be able to:* 1) Apply structured strategies to teach surgical judgment and autonomy in real time; 2) Model effective intraoperative teaching across surgical platforms; and 3) Implement feedback techniques that support learner growth and psychological safety.

**Course Outline**

| | | |
|---|---|---|
| 10:30 am | Welcome, Introduction and Course Overview | M. Billow |
| 10:35 am | Teaching Surgical Judgment In the or: Balancing Autonomy, Safety, and Decision-Making | M. Billow |
| 11:00 am | Teaching in Dual-Console Environments: Simulation, Debriefing, and Platform-Based Coaching | L. Valentine |
| 11:25 am | Innovating Intraoperative Teaching: Rethinking How We Teach Complex Pelvic and Vaginal Surgery | R. Kho |
| 11:50 am | From Learner to Leader: Building a Teaching Identity Early in Faculty Life | M. Alzamora |
| 12:15 pm | Discussion Questions & Answers | All faculty |
| 12:30 pm | Adjourn | |

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**Disclosure of Relevant Financial Relationships**

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

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

Disclosure information and acknowledgment of any commercial support are provided to learners before the activity to promote transparency and maintain the independence and integrity of the education.

Asterisk (*) denotes no financial relationships with ACCME-defined ineligible companies to disclose.

**PLANNER DISCLOSURES**

**The following members of AAGL have been involved in the educational planning and/or review of this course (listed in alphabetical order by last name).**

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Adrian Balica, MD*
Jamal Mourad, DO – Proctor: Intuitive Surgical
Jude Okohue, MD*
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Jean Uy-Kroh, MD*
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
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Megan Wasson, DO*
Michael Hibner, MD, PhD*
Jose "Tony" Carugno, MD*
Angela Chaudhari, MD - Consultant: Tag/Dream Medical, Johnson & Johnson; Speakers Bureau: Johnson & Johnson
Linda D. Bradley, MD, Medical Director*
Linda Michels, Executive Director, AAGL*

**COURSE CHAIR DISCLOSURE**

Megan Billow, DO*

**COURSE CO-CHAIR DISCLOSURE**

Lindsey Valentine, 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).**

Maria Alzamora, MD*
Megan Billow, DO*
Rosanne Kho, MD*
Lindsey Valentine, MD*

**MITIGATION OF RELEVANT FINANCIAL RELATIONSHIPS**

**All relevant financial relationships have been mitigated.**

Drs. Lee, Lemos, Mikhail, and Chaudhari's planning decisions, as part of the Scientific Program Committee (SPC), were peer reviewed by other planners on the SPC who had disclosed no financial relationships with ineligible companies, and found to be fair, balanced, and free of commercial bias. Dr. Moawad's financial relationships ended 12/2024, thus mitigating them. For most of his AAGL Professional Education Committee service, Dr. Mourad had no financial relationships to disclose. He recently disclosed a new relationship as a Proctor for Intuitive Surgical. Since then, he has not participated in activities involving control or influence over accredited educational content; therefore, no additional mitigation was necessary.

AAGL POSTGRADUATE COURSE

# Teaching in the OR: Advancing Surgical Judgment, Autonomy, and Team-Based Learning

Megan R. Billow, DO · Cleveland Clinic
Rosanne M. Kho, MD · University of Arizona College of Medicine
Lindsey Valentine, MD · Cleveland Clinic
Maria Alzamora, MD · Cleveland Clinic

NOVEMBER 13-16, 2026 · BOSTON · #AAGL26

1

FACULTY

## Four surgeons. One framework.

| Megan R. Billow, DO | Lindsey Valentine, MD | Rosanne M. Kho, MD | Maria Alzamora, MD |
|---|---|---|---|
| COURSE CHAIR | CO-CHAIR | FACULTY | FACULTY |
| Quality and Patient Safety Officer, Gynecologic Surgery<br>Associate Program Director, Complex Benign Gynecology Fellowship, Cleveland Clinic | Associate Program Director, Complex Benign Gynecology Fellowship, Cleveland Clinic | Chair, Department of Obstetrics and Gynecology, University of Arizona College of Medicine – Phoenix | Graduating Complex Benign Gynecology Fellow; Complex Benign Gynecology Staff, Cleveland Clinic |
| **Developing surgical judgment** | **Teaching through the console** | **Making vaginal surgery teachable** | **From learner to educator** |

2

2

BEFORE WE START

## What is your teaching style?

10 questions.
Three minutes. Answer fast.
What you do — not what you should.

A reflection, not a validated instrument.

3

3

## Disclosure

- **Megan Billow:** *I have no financial relationships to disclose.*
- **Lindsey Valentine:** *I have no financial relationships to disclose.*
- **Maria Alzamora:** *I have no financial relationships to disclose.*
- **Rosanne Kho:** *I have no financial relationships to disclose.*

4

4

## Objectives

- **Apply** structured teaching strategies to develop surgical judgment and progressive autonomy in real time.
- **Demonstrate** effective intraoperative teaching across surgical platforms.
- **Use** focused feedback to guide learner improvement and support psychological safety.

5

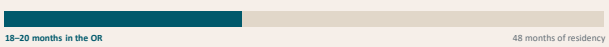
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SURGICAL TRAINING IN OB/GYN

# 18–20

## months of surgical training.

Out of a 48-month residency.



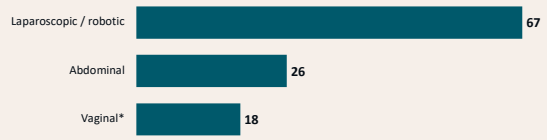

Wright KN, Truong M, Siedhoff MT. J Gynecol Surg. 2022;38(6):375–378.

7

6

SURGICAL TRAINING IN OB/GYN

## Mean hysterectomies per 2024 graduate.




**ACGME minimum: 85 across routes. Minimums do not establish competence.**

Ruhotina et al., OBGO Open 2026, Table 2: 1,469 U.S. graduates, surgeon role only, cumulative means, labels rounded. *Vaginal includes LAVH; laparoscopic includes robotic. ACGME Case Log Information, March 2025: minimums count surgeon and teaching-assistant roles.

8

7

THE BREADTH OF SURGICAL PRACTICE

## The field keeps expanding.

| | |
|---|---|
| **100+** | new endometriosis diagnosis codes |
| **2** | fibroid ablation approaches with Category I CPT codes |
| **8** | routes and access configurations |

**Our teaching must prepare surgeons for a bigger field.**

10

8

SURGICAL TRAINING IN OB/GYN

## Every case is a pivotal step toward independence.

9

9

THE ROOM YOU TEACH IN

## We get it.

| | |
|---|---|
| **External pressure** | The clock, the schedule, patient satisfaction, personal life. |
| **Internal pressure** | Your standards, your name on the outcome. |
| **The noise** | Alarms, phones, questions, decision fatigue — attention is never whole. |

**The hardest case of the day is also the one you have to teach.**

11

10

RELEVANCE

## Skilled surgeons are not automatically skilled teachers.

Expertise goes silent.

We default to our own training.

We teach with a patient on the table.

**A competence problem, not a motivation problem.**

12

11

LECTURE 1

# Teaching surgical judgment in the OR.

Balancing autonomy, safety, and decision-making – with all faculty

**Megan R. Billow, DO**
Quality and Patient Safety Officer, Gynecologic Surgery ·
Associate Program Director, Complex Benign Gynecology Fellowship · Cleveland Clinic

13

12

## Objectives

- **Identify** your default teaching profile and the strengths and limitations of all five profiles.
- **Evaluate** learner readiness, cognitive load, and operative risk to guide supervision.
- **Apply** different teaching profiles as learner needs and case complexity change.
- **Develop** focused debriefs that connect observed performance to a specific goal for the next case.

13

IDENTITY

## Who am I as a teacher?

Name the style you already use.

14

YOUR RESULT

## Where this room sits.

| Demonstrator | Director | Facilitator | Reflective Mentor | Entruster |
|---|---|---|---|---|
| __% | __% | __% | __% | __% |

**No profile is superior. The spread is the point.**

15

THE FIVE PROFILES

## Master all five. Flex with the moment.

| | |
|---|---|
| **Demonstrator** | Shows and narrates. |
| **Director** | Directs in real time. |
| **Facilitator** | Prompts thinking. |
| **Reflective Mentor** | Observes, then debriefs. |
| **Entruster** | Sets limits, steps back. |

**Tendencies you choose between — not fixed types.**

16

THE FIVE PROFILES

## The Demonstrator

*"Watch how the traction opens the plane."*

| FITS WHEN | WATCH FOR | FLEX WHEN |
|---|---|---|
| Unfamiliar anatomy or a new maneuver.<br>No usable mental model yet. | You answer before they reason.<br>The demo becomes the operation. | They already have the model.<br>Ask first: what do you see? |

**Name the move you are making. The learner cannot read your intent.**

17

THE FIVE PROFILES

## The Director

*"Move your left hand laterally. Open there. Now seal and divide."*

| FITS WHEN | WATCH FOR | FLEX WHEN |
|---|---|---|
| No clear task model yet.<br>Load is high, or risk is rising. | Hands busy, mind passive.<br>Direction becomes dependence. | They can run a whole segment.<br>Command, then cue, then question. |

**Name the move you are making. The learner cannot read your intent.**

18

THE FIVE PROFILES

## The Facilitator

*"What has changed? Which landmark is gone? What is now at risk?"*

| FITS WHEN | WATCH FOR | FLEX WHEN |
|---|---|---|
| Judgment is the target, not technique. | Questions add load at the worst moment. | They are overloaded or underprepared. |
| Between steps, once risk has fallen. | Under stress it reads as interrogation. | Instruct now, discuss after. |

**Name the move you are making. The learner cannot read your intent.**

20

19

THE FIVE PROFILES

## The Reflective Mentor

*"Finish the dissection. Then we review exposure and one change."*

| FITS WHEN | WATCH FOR | FLEX WHEN |
|---|---|---|
| You need unprompted performance. | Waiting too long to step in. | They need structure or a hard limit. |
| Assessment and progression calls. | Silence read as approval. | Set the boundary before the segment. |

**Name the move you are making. The learner cannot read your intent.**

21

20

THE FIVE PROFILES

## The Entruster

*"Continue while the ureter stays identified. If the plane stains, you stop."*

| FITS WHEN | WATCH FOR | FLEX WHEN |
|---|---|---|
| Novice, underprepared, or overconfident. | Preference posing as a safety standard. | Anatomy demands adaptation. |
| Safety thresholds must be explicit. | Compliance without the reasoning. | Tie limits to safety, not preference. |

**Name the move you are making. The learner cannot read your intent.**

22

21

THE FRAMEWORK

## You know your default. Now read the learner.

23

22

THE FRAMEWORK

## Four moves, every case.

| | |
|---|---|
| **01 Preview** | Who is in front of me? |
| **02 Perform** | What am I seeing? |
| **03 Pause** | Keep going, or step in? |
| **04 Debrief** | What is the next goal? |

**Diagnose. Adapt. Debrief.**

24

23

01

PREVIEW · BEFORE THE CASE

## Who is in front of me?

Skill. Load. Readiness.

25

24

PREVIEW · THE LEARNER

PREVIEW PERFORM PAUSE DEBRIEF

## Six learners. Six first moves.

| | | FIRST MOVE |
|---|---|---|
| Prepared planner | Comes prepared | Facilitator |
| Experiential | Learns by doing | Entruster |
| Feedback-driven | Wants the debrief | Director |
| Reflective | Processes afterward | Facilitator |
| Autonomy-seeking | Wants to lead | Entruster |
| Overloaded | Freezes, over-grips | Director |

Behaviors, not types. The same learner changes by 4 pm.

26

25

PREVIEW · THREE MINUTES

PREVIEW PERFORM PAUSE DEBRIEF

## Three minutes changes the entire case.

| | |
|---|---|
| GOAL | "What are you working on today?" |
| PLAN | "Talk me through the next step." |
| RISK | "Where does this go wrong?" |
| LIMIT | "Here is where I take over." |

One question each. Diagnose, do not quiz.

27

26

02

PERFORM · DURING THE CASE

## Readiness is not decided once.

Watch. Adjust. Repeat.

28

27

PERFORM · REASSESS

PREVIEW PERFORM PAUSE DEBRIEF

## Watch for four things.

| | |
|---|---|
| Orientation | Landmarks — without prompting? |
| Anticipation | Risks of the next move — seen? |
| Capacity | Hands and judgment — together? |
| Communication | Uncertainty — spoken out loud? |

Adjust supervision to what you see.

29

28

PERFORM · READ THE SIGNALS

PREVIEW PERFORM PAUSE DEBRIEF

## Diagnose. Do not assume.

| | |
|---|---|
| Notices | Do they see the change — or do I say it? |
| Adapts | Do they change the move — or repeat it? |
| Readiness | Can they do this step today? |
| Load | Are they at their limit? |

A repeated failed move means the model is wrong, not the hands.

30

29

03

PAUSE · THE DECISION POINT

## When to keep going.

Struggle builds judgment — until it stops.

31

30

PAUSE · CONTINUE WITH SUPERVISION

PREVIEW PERFORM PAUSE DEBRIEF

## Stay out of the way when…

The learner names the problem.

Exposure holds.

Attempts are purposeful.

There is room to reassess.

**If these hold, wait.**

32

31

PAUSE · STOP RULES

PREVIEW PERFORM PAUSE DEBRIEF

## Name the stop before you start.

Plane is gone — we stop dissecting.

Ureter is close — energy goes down.

We cannot see — exposure comes first.

**Restraint is judgment.**

33

32

PAUSE · AFTER THE TAKEOVER

PREVIEW PERFORM PAUSE DEBRIEF

## Taking over is teaching. Say why. Say when it comes back.

**One sentence for the finding that moved you. One for what earns the step back.**

34

33

04

DEBRIEF · AFTER THE CASE

## The case ends when the next goal is set.

Their view first. Then yours.

35

34

DEBRIEF · CLOSE THE LOOP

PREVIEW PERFORM PAUSE DEBRIEF

## Six questions. Two minutes.

| | |
|---|---|
| **Set** | “What did we agree to work on?” |
| **How** | “How did that go?” |
| **Concerns** | “What worried you?” |
| **Strength** | One thing done well. |
| **Change** | One thing to change. |
| **Next** | What they own next. |

**Their view first. Then yours. The next goal becomes the next preview.**

36

35

05

APPLY · LAPAROSCOPY

## Where does the profile have to flex?

Two hands. One flat view. Fixed ports.

37

36

LAPAROSCOPY · THE CONSTRAINTS

PREVIEW PERFORM PAUSE DEBRIEF

## Six constraints of the platform.

| | |
|---|---|
| Orientation | Distorted planes, no depth. |
| Ergonomics | Fixed posture, grip fatigue. |
| Instruments | Rigid tools, limited motion. |
| Exposure | Ports dictate the angles. |
| Eye, hand, foot | Screen, hands, pedals at once. |
| Tissue, energy | Filtered feel, unforgiving energy. |

**Find the constraint. Adapt the profile.**

38

37

LAPAROSCOPY · WHEN THE DISSECTION STALLS

PREVIEW PERFORM PAUSE DEBRIEF

## Match the response to the barrier.

| | |
|---|---|
| The anatomy | Fibrosis, distorted landmarks. Director: reset orientation. |
| The learner | Cannot justify the plane, repeats. Facilitator: "What is stopping progress?" |
| The load | Overloaded, decisions slow. Director: narrow the task. |

**Reduce the load before you judge the learner.**

39

38

PERFORM · WATCH

PREVIEW PERFORM PAUSE DEBRIEF

## Three moments. One Fellow.

| | |
|---|---|
| Clip 1 | The fellow is struggling. Watch first. Do not coach yet. |
| Clip 2 | The decision point. Continue, or step in? |
| Clip 3 | The takeover. Why now — and what did I say? |

**What would you have said — and when?**

40

39

CLIP 4

PREVIEW PERFORM PAUSE DEBRIEF

CLIP 4

## First year Fellow

Watch for: which profile the moment calls for.

41

40

VIDEO · CLIP 4 · APRIL 2026, FIRST-YEAR FELLOW

PREVIEW PERFORM PAUSE DEBRIEF

INSERT VIDEO

Insert > Video > This Device, then size to fill this frame.

42

41

CLIP 5

PREVIEW PERFORM PAUSE DEBRIEF

CLIP 5

## Adjusting mid-case.

Watch for: the signal that made me switch.

43

42

VIDEO · CLIP 5 · ADJUSTING MID-CASE

PREVIEW PERFORM PAUSE DEBRIEF

INSERT VIDEO

Insert > Video > This Device, then size to fill this frame.

44

43

CLIP 6

PREVIEW PERFORM PAUSE DEBRIEF

CLIP 6

# Handing it back.

Watch for: what they owned by the end.

45

44

VIDEO · CLIP 6 · HANDING IT BACK

PREVIEW PERFORM PAUSE DEBRIEF

INSERT VIDEO

Insert > Video > This Device, then size to fill this frame.

46

45

ADVANCED ENDOMETRIOSIS · RETROPERITONEAL DISSECTION

PREVIEW PERFORM PAUSE DEBRIEF

## Five signals for entrustment.

| | |
|---|---|
| **Explains the strategy** | Names entry, plane, endpoint. |
| **Maintains orientation** | Tracks ureter and vessels. |
| **Controls the dissection** | Holds exposure; adjusts traction. |
| **Recognizes changing risk** | Pauses when fibrosis obscures. |
| **Communicates limits** | Flags uncertainty early. |

**This learner. This segment. This anatomy.**

47

46

ENTRUSTER LANGUAGE

PREVIEW PERFORM PAUSE DEBRIEF

“

***You lead to the boundary we agreed. Pause if you lose orientation.***

**One sentence: autonomy, boundary, and pause condition.**

48

47

KEY TAKEAWAYS

## Take these into the OR on Monday.

| | |
|---|---|
| **Know your default.** | Recognize your profile. Build all five. |
| **Adapt to the case.** | Match autonomy to readiness, load, and risk. |
| **Make feedback actionable.** | One specific goal for the next case. |
| **Believe in the learner.** | Teach them from where they are. |

49

48

I am glad you are here.
I believe in you.
I am your coach.
You can do these advanced-stage endo cases.
Yes, you can.

Next: the same four moves at the console, in the vaginal field, and in early practice.

50

49

LECTURE 2

# Teaching in dual-console environments.

Simulation, debriefing, and platform-based coaching.

**Lindsey Valentine, MD**
Associate Program Director, Complex Benign Gynecology Fellowship · Cleveland Clinic

51

50

## Disclosure

- **Lindsey Valentine, MD:** *"I have no financial relationships to disclose."*

51

## Objectives

- Identify teaching challenges unique to robotic surgery, including physical separation and competing console tasks.
- Apply teaching strategies that maintain active supervision while advancing learner autonomy at the console.
- Evaluate learner readiness and cognitive load to adapt teaching profiles and console autonomy.
- Use simulation and structured feedback to develop and maintain robotic skills.

52

ROBOTIC SURGERY · THE FEAR

## What worries you most about handing over the console?

| | | |
|---|---|---|
| **Patient safety** | **Inability to intervene quickly** | **Communication breakdowns** |
| **Loss of control** | **Trainee errors** | **Efficiency versus autonomy** |

54

53

ROBOTIC SURGERY · THE CHALLENGES

## What is actually different about robotics?

| Instrumentation | Separation | Dual role |
|---|---|---|
| New technology. | Distance delays rescue and relies on communication. | The learner controls more. |

**The profile has to flex to the platform.**

55

54

CHALLENGE 1 · INSTRUMENTATION

## Solve problems before the OR.

| | | |
|---|---|---|
| **01** Docking | **02** Console controls | **03** Energy activation |
| **04** Tissue handling | **05** Spatial awareness | **06** Economy of motion |

**Simulation. Evidence: faster tasks, fewer errors.**

56

55

CHALLENGE 2 · PHYSICAL SEPARATION

## Teach through words and shared vision.

| | |
|---|---|
| **Confirm early** | Audio works; everyone can hear. |
| **Be concise** | Short instructions cut cognitive load. |
| **Telestrate** | Arrows build a shared reference. |
| **Close the loop** | Confirm it was heard correctly. |
| **Narrate the why** | The principle, not just the motion. |

**Not "pull harder" — "add countertraction until the plane opens."**

57

56

CHALLENGE 2 · PHYSICAL SEPARATION

## Remain an active supervisor and coach.

**Watch the field, not the instrument.**

58

57

CHALLENGE 2 · WHAT TO WATCH FOR

## Eight signals from across the room.

| | | | |
|---|---|---|---|
| **01** Exposure | **02** Drifting off plane | **03** Change in tissue tension | **04** Instruments out of view |
| **05** Camera left behind | **06** Same step retried | **07** Silence at the console | **08** Rushed movements |

59

58

DUAL CONSOLE

## A tool for dynamic teaching.

| | | | |
|---|---|---|---|
| **Direct** Coach out loud. | → **Demonstrate** Show the principle. | → **Return** They repeat it. | → **Entrust** They carry on. |

**Evidence: trainees complete more steps and operate longer.**

60

59

CHALLENGE 3 · THE DUAL ROLE

## Assistant and primary surgeon at once.

| | | |
|---|---|---|
| **Camera** | **Retraction** | **Dissection** |
| **Energy** | **Instruments** | **Bedside team** |

**The learner is holding all of it. What can you carry?**

61

60

CHALLENGE 3 · THE DUAL ROLE

“

*What are we asking them to think about? What can we take off their plate?*

**Ask it repeatedly, every case.**

62

61

CHALLENGE 3 · MATCHING SUPPORT

## Early learner. Advanced learner.

| Early learner | Advanced learner |
|---|---|
| Narrow the objective. | Remove support. |
| Carry the rest. | Ask for the plan. |

**Flex from Director toward Entruster.**

63

62

SIMULATION · SKILL MAINTENANCE

## Simulation is not just for beginners.

| Gaps in exposure | Where it helps |
|---|---|
| OB rotations | Pre-case warm-up |
| Night float | New procedure prep |
| Research blocks | Return after absence |
| Long case gaps | Other OR skills |

**Learn → Warm up → Maintain → Refresh → Recover → Advance**

64

63

SIMULATION · FEEDBACK

“

*Perfect practice makes perfect.*

**Feedback from faculty, video, peers, crowd, and AI.**

65

64

ROBOTIC SURGERY · THREE QUESTIONS

## Three questions for every robotic educator.

| 01 | 02 | 03 |
|---|---|---|
| What do I want them to learn? | What can I take off their plate? | What style does this learner need now? |

**Ask them before every robotic case.**

66

65

ROBOTIC SURGERY · CLOSE

“

*There is great opportunity in moving from providing operative experience to intentionally designing the learning experience.*

**Design the experience. · Thank you — questions.**

67

66

LECTURE 3

# Rethinking how we teach complex and vaginal surgery.

Innovating intraoperative teaching.

**Rosanne M. Kho, MD**
Chair, Department of Obstetrics and Gynecology · University of Arizona College of Medicine – Phoenix

68

67

## Disclosure

- **Rosanne M. Kho, MD** — *I have no financial relationships to disclose.*
- No commercial support was received for this presentation.
- Content reflects peer-reviewed education literature and institutional experience.

68

## Objectives

- Analyze barriers to effective teaching and learning in vaginal surgery.
- Apply exposure strategies that establish a shared view of the operative field.
- Demonstrate targeted instructional techniques that clarify key maneuvers and anticipate technical challenges.
- Evaluate learner performance and operative risk to adapt supervision and advance surgical autonomy.

69

VAGINAL SURGERY · THE CONSTRAINTS

## Six constraints, one teaching problem.

One view
Deep, narrow field
Assistant fatigue
Touch before sight
Awkward ergonomics
Fewer cases

**If the learner cannot see the field, autonomy is limited.**

71

70

VAGINAL SURGERY · FALLING VOLUME

## Volume no longer carries the curriculum.

| | |
|---|---|
| **35 → 19** | vaginal hysterectomies per graduating resident, 2002 → 2012 |
| **28%** | feel prepared for vaginal hysterectomy |
| **> 80%** | perform fewer than five vaginal cases per year |
| **~ 1 in 2** | say exposure influences route choice |

**Teaching must become deliberate.**

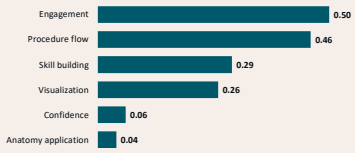
Sources: Kho 2015; Gressel 2020; Halder 2025.

72

71

EXOSCOPE DURING VAGINAL HYSTERECTOMY

## A shared view raises engagement.




**Engagement**
improved with the camera
**Physical demand**
reduced with the camera
**Overall workload**
40.4 vs 47.5 — no difference (p = .14)
**Procedural flow**
perceived as improved

**Engagement improved. Workload did not rise.**

Woodburn, Orlando, Barba, et al. J Minim Invasive Gynecol. 2026 (epub ahead of print) · 39 surveys, 21 with camera.

73

72

VAGINAL SURGERY · FOUR CHANGES, NO NEW EQUIPMENT

## The shared view starts with setup.

| Retract once | Surgeon sits | Light the field | Clear sightlines |
|---|---|---|---|
| Free both assistants. | Bring the field to eye level. | Light where you are looking. | Remove what blocks the view. |

**The goal is not a camera. It is a shared view.**

74

73

VAGINAL SURGERY · GIVE A SPATIAL REFERENCE

## Demonstrate the target, not the operation.

| | |
|---|---|
| 01 | Place the reference — show depth, angle, and bite. |
| 02 | Name the why — state what you include, and avoid. |
| 03 | Return the step — remove your clamp; they repeat it. |
| 04 | Correct in place — one observable cue. |

**Failure mode: leaving the clamp on. The trainee has the final move.**

75

74

VAGINAL SURGERY · EXPOSURE

## Your assisting is the learner's exposure.

| | |
|---|---|
| Own retraction | Anticipate the next position. |
| Create traction | Present the plane. |
| Bring it down | Descensus before dissection. |
| Name the view | Say what only you can see. |
| Stage instruments | Protect the learner's flow. |

**Expert exposure lets a beginner operate.**

76

75

VAGINAL SURGERY · DEMONSTRATION TO ENTRUSTMENT

## Six teaching moves, and their risks.

| | |
|---|---|
| Demonstrator | Show one move. Risk: you finish it. |
| Director | Give a command. Risk: they follow, not think. |
| Coach | Cue one step. Risk: too many cues. |
| Facilitator | Ask at pauses. Risk: questions mid-bite. |
| Entruster | Set a boundary. Risk: no exposure, no autonomy. |
| Reflective Mentor | Debrief and target. Risk: no next step. |

**One case can hold the full teaching range.**

77

76

VAGINAL SURGERY · SAME LEARNER, DIFFERENT MOMENT

## Calibrate autonomy to what you see.

| | |
|---|---|
| Knows the sequence | Entrust a whole step. |
| Acts before explaining | Let them keep moving. |
| Asks how they did | Name the standard. |
| Reflects afterward | Debrief at the sink. |
| Wants the whole case | Set hard stops. |
| Freezes or over-grips | Reset exposure. |

**Check exposure before ability.**

78

77

VAGINAL SURGERY · HIGH-RISK MOMENTS

## Predict the three high-risk moments.

| | |
|---|---|
| Entry | Too deep; bladder plane. "Distal. Tent. Palpate. Then sharp." |
| Clamp | Large or lateral bites. "Hug the uterus. Small bites. Cut to the sealer." |
| Suture | Lost needle; crossed ties. "Shoulder–elbow–wrist. Straight for uterosacrals; curved for rounds." |

**Predict the pitfall. Coach before rescue.**

79

78

VAGINAL SURGERY · AUTONOMY IN INCREMENTS

## Entrust a step, not the whole case.

| | |
|---|---|
| 01 | Position and expose |
| 02 | Posterior entry |
| 03 | Uterosacral pedicles |
| 04 | Bladder reflection |
| 05 | Uterine vessels |
| 06 | Round and utero-ovarian pedicles |
| 07 | Cuff closure |

**Set the boundary before positioning.**

80

79

VAGINAL SURGERY · CLOSE

## Three moves for Monday.

**01**

Fix exposure. Position, light, and share the field.

**02**

Shadow, then return. Demonstrate the target; hand it back.

**03**

Predict the pitfall. Coach before the mistake.

**Diagnose the learner. Match the move. Close the loop.**

81

80

LECTURE 4

# From learner to leader.

Building a teaching identity early in faculty life.

**Maria Alzamora, MD**
Graduating Complex Benign Gynecology Fellow · Complex Benign Gynecology Staff · Cleveland Clinic

82

81

## Disclosure

- **Maria Alzamora, MD:** *"I have no financial relationships to disclose."*

82

## Objectives

- Analyze challenges in the transition from surgical trainee to educator.
- Evaluate how prior learning experiences and responses to pressure shape your teaching profile.
- Apply strategies that support psychological safety while maintaining high expectations.
- Develop an intentional teaching approach that adapts to learner readiness and operative demands.

83

TEACHING IDENTITY

## Turning the framework on yourself.

**Judge yourself honestly. Name your default under pressure. Build range, then choose.**

85

84

WHAT FELLOWSHIP TAUGHT ME

## What my best teachers taught me.

**01**
Adapting instruction to the learner.

**02**
Psychological safety with high expectations.

**03**
Composure during complications.

**Three lessons. Three attendings. Three profiles.**

86

85

LESSON ONE · ADAPT TO THE LEARNER

# 01

## One attending. Two profiles. One case.

**Demonstrator**
Exact hand placement, narrated step by step.

**Entruster**
Given the case, and room to find my own rhythm.

**The same attending moved between both, within a single case.**

87

86

LESSON TWO · THE FACILITATOR PROFILE

# 02

## Psychological safety, with high expectations.

**Present**
Watching closely enough to catch a mistake early, once trust was established.

**Precise**
Timely, specific correction on exactly what I was already capable of.

**A safe space to fail. A high bar.**

88

87

LESSON THREE · THE DIRECTOR PROFILE

## Composure under pressure.

**Assessed**
Took in the situation.

→ **Named it**
Said it out loud.

→ **Informed**
Told staff directly.

→ **Escalated**
Called for help.

→ **Continued**
Stayed in scope.

**Her tone did not change.**

89

88

EARLY FACULTY LIFE

## The challenges of early career.

**01**
Imposter syndrome. Uncertainty about your readiness for the role.

**02**
Proximity. Often only a few years further along than the learner.

**03**
Pressure to be efficient. Teaching takes time that competes with operative pace.

**04**
Still developing. Growth that does not end when training does.

90

89

NAMING THE GAP

# Name the gap.

**The style you intend, and the one that feels fastest under pressure.**

91

90

CASE · BRISK BLEEDING, MID-CASE

## Recognize the instinct. Flex it.

INSTINCT

**Demonstrator**

Take over. Stop the bleeding myself.

DELIBERATE FLEX

**Director**

Stay at the field. Give direct, focused instructions.

**The skill is not suppressing the instinct. It is noticing it fast enough to choose.**

92

91

CASE · A CAPABLE FELLOW, HESITATING

## A different case. A different flex.

INSTINCT

**Director**

Narrate every micro-step, because it feels faster.

DELIBERATE FLEX

**Entruster**

Step back. Let them lead the segment.

**Sometimes the flex is toward more control. Sometimes toward less.**

93

92

TEACHING IDENTITY

## Flexing is a decision, not a personality.

**01**

Your default profile is a starting point, not a fixed trait.

**02**

Name the instinct before the case, so you can choose against it.

**03**

Flex up or down — more control when risk rises, less when readiness allows.

**04**

Close the gap between the teacher you intend to be and the one in the room.

94

93

CLOSE

## The surgeon as the teacher.

**01**

Diagnose the learner. Read readiness before you read the case.

**02**

Match the move. Demonstrate, direct, facilitate, mentor, or entrust.

**03**

Close the loop. Two decisions, one target, every case.

95

94

CLOSE

## Teaching is a privilege and responsibility. Make every surgery count.

96

95

RESOURCES

## Take this home.

TAKE THE QUIZ

Your teaching profile in about four minutes.

GET THE TOOLKIT

Ten reference cards, including scripts by route.

97

96

TOOLKIT · CARD 1 OF 10

## The five teaching profiles

| | |
|---|---|
| **Demonstrator** | Show the move first, narrating what to look for. Best for a first exposure. |
| **Director** | Concise direction in the moment, one instruction at a time. Best when risk is rising. |
| **Facilitator** | Ask before telling; let the learner name the next step. Best when they are close. |
| **Reflective Mentor** | Debrief after: two decisions, one target. Best after any case, every time. |
| **Entruster** | Hand over the step and stay quiet. Best when readiness has been shown. |

97

TOOLKIT · CARD 2 OF 10

## Demonstrator — shows and explains

Teaches by making expert knowledge, operative judgment, visual cues, and technical performance visible: explain what matters, demonstrate the maneuver, then return responsibility once the learner has a usable mental model.

IN THE OR

*"Watch how changing the direction of traction moves the ureter away from the dissection. The cue is the tissue plane opening here. You will take the next segment."*

**STRENGTHS**

- Creates a clear technical and cognitive model
- Useful for unfamiliar anatomy and new maneuvers
- Makes hidden expert perception and reasoning visible
- Can restore safety and orientation efficiently

**WATCH FOR**

- May answer before the learner reasons independently
- May take over too early, or demonstrate too long
- Learners may imitate movements without the cues
- Observation can become passive, not active, learning

98

TOOLKIT · CARD 3 OF 10

## Director — directs each action in real time

Teaches by supplying the immediate operative sequence, instrument movements, and corrections while the learner physically performs the case. The faculty member may retain much of the cognitive control.

IN THE OR

*"Move your left hand laterally. Rotate the camera. Open there. Maintain traction. Now seal and divide."*

**STRENGTHS**

- Provides immediate and precise guidance
- Maintains flow and safety during unfamiliar tasks
- Helps translate strategy into physical action
- Useful briefly for novices, overload, or rising risk

**WATCH FOR**

- Physical participation without cognitive autonomy
- Continuous direction raises load and dependence
- Completion may overestimate independent competence
- You never learn what the trainee can plan alone

99

TOOLKIT · CARD 4 OF 10

## Facilitator — develops thinking through questions

Teaches by using focused questions and prompts to reveal the learner's mental model and to develop interpretation, anticipation, judgment, and adaptive decision-making.

IN THE OR

*"What has changed? Which landmark can you no longer see? What structure is now at risk, and how should that alter your plan?"*

**STRENGTHS**

- Reveals what the learner sees and anticipates
- Develops surgical judgment and adaptive expertise
- Encourages agency and active problem-solving
- Separates a technical problem from a reasoning one

**WATCH FOR**

- Too many questions can increase cognitive load
- May feel interrogative or punitive under stress
- Ineffective if foundational knowledge is absent
- Questioning must not delay a safety intervention

100

TOOLKIT · CARD 5 OF 10

## Reflective Mentor — watches, then targets feedback

Teaches by minimizing interruption during a coherent operative segment, directly observing technical and cognitive performance, then giving focused feedback to improve the next attempt.

IN THE OR

*"Complete the right-sided dissection unless a safety condition changes. Afterward we will review your exposure, your recognition of the plane, and one change for the opposite side."*

**STRENGTHS**

- Shows what the learner can do without prompting
- Supports authentic workplace assessment
- Avoids correcting harmless stylistic differences
- Enables behavior-based feedback and progression

**WATCH FOR**

- May wait too long to intervene
- Silence can read as approval or disengagement
- Delayed feedback becomes vague or disconnected
- Requires explicit boundaries and feedback timing

101

TOOLKIT · CARD 6 OF 10

## Entruster — defines expectations and boundaries

Teaches by establishing preparation requirements, performance standards, critical landmarks, safety boundaries, and stopping criteria — what must be true for learner responsibility to continue safely.

IN THE OR

*"You may continue the pelvic sidewall dissection while the ureter remains identified. If the plane becomes uncertain, or energy would cross an undefined plane, you stop."*

**STRENGTHS**

- Creates clarity, consistency, and predictability
- Makes safety thresholds and intervention criteria explicit
- Useful for novices, underprepared learners, overconfidence
- Supports transparent entrustment decisions

**WATCH FOR**

- May confuse personal preference with a safety standard
- Can teach compliance without underlying reasoning
- May become rigid when anatomy requires adaptation
- Learners may hide uncertainty or withhold alternatives

102

TOOLKIT · CARD 7 OF 10

## Pearls — laparoscopy

Two hands, one flat view, fixed ports. The constraints of the route decide which profile you need, moment to moment — name the constraint, then flex.

HAND OVER IN RUNGS

*Camera and horizon → retraction and countertraction → blunt dissection in a known plane → energy on a defined pedicle → sharp dissection at the target → suturing and knot tying.*

**THE CONSTRAINTS**

- Ergonomics
- Few degrees of freedom; the tool fights the wrist
- The non-dominant hand must work, not just hold
- Port angles are set before the case, not recovered
- Target, ports, and camera must hold a triangle
- A flat view removes depth; the assistant owns the horizon

**SAY THIS**

- *"Watch the traction — the ureter moves off the plane."*
- *"Your left hand is idle. Countertraction there."*
- *"Camera is off the horizon. Level it, then cut."*
- *"Setup problem, not your hands. I fix it, you continue."*
- *"You own the camera. Say when you lose the plane."*
- *"Two decisions: the port choice, and asking for help."*

103

TOOLKIT · CARD 8 OF 10

## Pearls — at the console

Distance, a dual console, and a trainee holding the whole field. You cannot reach in, so every boundary has to be spoken before the step begins.

THE DUAL-CONSOLE LOOP

*Direct — coach out loud. Demonstrate — show the principle. Return — they repeat it. Entrust — they carry on. Trainees complete more steps and operate longer when the loop is used.*

**WHAT CHANGES**

- You cannot take the field back quickly
- The trainee holds the whole operative view
- Coaching is verbal only — silence reads as absence
- Harder to see what the learner is perceiving
- Safety limits need a spoken threshold, not a look
- Simulation and warm-up carry more of the load

**SAY THIS**

- *"You have the sidewall while the ureter stays in view."*
- *"If the plane gets uncertain, you stop and tell me."*
- *"Talk me through it — I cannot see your hands."*
- *"I take this vessel, then hand straight back."*
- *"Next twenty minutes are yours. I speak at a limit."*
- *"Two decisions, one target — let us do that now."*

104

TOOLKIT · CARD 9 OF 10

## Pearls — vaginal surgery

A deep, narrow field the learner may never see. Exposure decides how much you can hand over — and volume has fallen, so the teaching has to be deliberate.

SHARE THE VIEW

*Camera or exoscope raised engagement and reduced physical demand, with no rise in overall workload (40.4 vs 47.5, p=.14). If they cannot see it, they cannot learn it.*

**WHAT THE ROUTE DEMANDS**

- Exposure gates autonomy: no exposure, no handover
- The learner may never actually see the field
- Retraction and positioning are teaching acts
- One case can hold the full teaching range
- Cue one step at a time — never question mid-bite

**SAY THIS**

- *"You have the colpotomy if exposure holds."*
- *"Name the landmark you can see right now."*
- *"Exposure problem, not dissection. Reset the retractor."*
- *"I place this stitch where you see it; you place two."*
- *"Get the view back and the step is yours again."*
- *"Afterward: two decisions, one target."*

105

TOOLKIT · CARD 10 OF 10

## Selected evidence


1. **Collins A, Brown JS, Newman SE.** Cognitive apprenticeship: teaching the crafts of reading, writing, and mathematics. In: Resnick LB, ed. Knowing, Learning, and Instruction. Lawrence Erlbaum; 1989.
2. **Gardner AK, et al.** Faculty development for the operating room: effectiveness of an intraoperative teaching course for surgeons. Ann Surg. 2017.
3. **Sandhu G, et al.** Progressive entrustment to achieve resident autonomy in the operating room. J Surg Educ. 2017. PMID: 27163961.
4. **Nieboer P, et al.** Strategies of supervisors to entrust and regulate autonomy during surgical procedures. 2022. PMID: 32224741.
5. **Haji FA, et al.** Measuring cognitive load: performance, mental effort and simulation task complexity. Med Educ. 2015. PMID: 26152493.
6. **Tokuno J, Haji FA, et al.** Measurement and management of cognitive load in surgical education: a systematic review. Surg Endosc. 2023.
7. **Williams RG, et al.** Practice guidelines for operative performance assessments. Ann Surg. 2016. PMID: 26967627.
8. **Ahmed M, et al.** Operation debrief: a SHARP improvement in performance feedback in the operating room. Ann Surg. 2013. PMID: 23478533.


106

## References


- Woodburn KL, Orlando MS, Barba NB, Garcia-Filion P, Vargas Maldonado D, Gebhart J, Kho RM. Measuring the impact of an exoscopic camera system on learner mental workload in vaginal surgery. J Minim Invasive Gynecol. 2026 Feb 5 (epub ahead of print). PMID: 41654081.
- Halder GE, Ferrando CA, Rogers R, et al. The survey of barriers for vaginal access surgery study. J Minim Invasive Gynecol. 2025;32:438-446.
- Hobson DTG, Meriwether KV, Gaskins JT, et al. Learner satisfaction and experience with a high-definition telescopic camera during vaginal procedures: a randomized controlled trial. Female Pelvic Med Reconstr Surg. 2021;27:105-111.
- Gressel GM, Potts JR, Cha S, et al. Hysterectomy route and numbers reported by graduating residents in obstetrics and gynecology training programs. Obstet Gynecol. 2020;135:268-273.
- Levy BS. Vaginal hysterectomy with basic instrumentation. OBG Management. 2015;27(10):28-37.
- Kho RM. Transforming vaginal hysterectomy: 7 solutions to the most daunting challenges. OBG Management. 2014;26(8):29,34-37.
- Wright KN, Truong M, Siedhoff MT. Residency training in gynecologic surgery: where do we go from here? J Gynecol Surg. 2022;38(6):375-378.
- Ruhotina M, Cai F, Burns RN. O&G Open. 2026. [complete article title, volume, pages]


107

## References (continued)


- 1. Collins A, Brown JS, Newman SE. Cognitive apprenticeship: teaching the crafts of reading, writing, and mathematics. In: Resnick LB, ed. Knowing, Learning, and Instruction. Hillsdale, NJ: Lawrence Erlbaum; 1989:453-494.
- 2. Gardner AK, Timberlake MD, Dunkin BJ. Faculty development for the operating room: an examination of the effectiveness of an intraoperative teaching course for surgeons. Ann Surg. 2019;269(1):184-190.
- 3. Sandhu G, Magas CP, Robinson AB, Scally CP, Minter RM. Progressive entrustment to achieve resident autonomy in the operating room: a national qualitative study with general surgery faculty and residents. Ann Surg. 2017;265(6):1134-1140.
- 4. Nieboer P, Huiskes M, Crossen F, Stevens M, Bulstra SK, Jaarsma DADC. The supervisor's toolkit: strategies of supervisors to entrust and regulate autonomy of residents in the operating room. Ann Surg. 2022;275(1):e264-e270.
- 5. Haji FA, Rojas D, Childs R, de Ribaupierre S, Dubrowski A. Measuring cognitive load: performance, mental effort and simulation task complexity. Med Educ. 2015;49(8):815-827.
- 6. Tokuno J, Carver TE, Fried GM. Measurement and management of cognitive load in surgical education: a narrative review. J Surg Educ. 2023;80(2):208-215.
- 7. Williams RG, Kim MJ, Dunnington GL. Practice guidelines for operative performance assessments. Ann Surg. 2016;264(6):934-948.
- 8. Ahmed M, Arora S, Russ S, Darzi A, Vincent C, Sevdalis N. Operation debrief: a SHARP improvement in performance feedback in the operating room. Ann Surg. 2013;258(6):958-963.


108

## References (continued)


- 9. Roberts NK, Williams RG, Kim MJ, Dunnington GL. The briefing, intraoperative teaching, debriefing model for teaching in the operating room. J Am Coll Surg. 2009;208(2):299-303.
- 10. Stalmeijer RE, Dolmans DHJM, Wolfhagen IHAP, Muijtjens AMM, Scherpbier AJJA. The Maastricht Clinical Teaching Questionnaire (MCTQ) as a valid and reliable instrument for the evaluation of clinical teachers. Acad Med. 2010;85(11):1732-1738.
- 11. van der Leeuw R, Lombarts K, Heineman MJ, Arah O. Systematic evaluation of the teaching qualities of obstetrics and gynecology faculty: reliability and validity of the SETQ tools. PLoS One. 2011;6(5):e19142.
- 12. Boerebach BCM, Arah OA, Busch ORC, Lombarts KMJMH. Reliable and valid tools for measuring surgeons' teaching performance: residents' vs. self evaluation. J Surg Educ. 2012;69(4):511-520.
- 13. Boerebach BCM, Lombarts KMJMH, Arah OA. Confirmatory factor analysis of the System for Evaluation of Teaching Qualities (SETQ) in graduate medical training. Eval Health Prof. 2016;39(1):21-32.
- 14. Meyerson SL, Teitelbaum EN, George BC, Schuller MC, DaRosa DA, Fryer JP. Defining the autonomy gap: when expectations do not meet reality in the operating room. J Surg Educ. 2014;71(6):e64-e72.
- 15. Accreditation Council for Graduate Medical Education. Case Log Information: Obstetrics and Gynecology, March 2025; and ACGME Defined Category Minimum Numbers for General Surgery Residents.
- AAGL / CMS. FY 2023 ICD-10-CM update; IHCP 2017 code update (CPT 58674); AAGL 2023 CPT update (CPT 58580).


109

# 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/