AAGL 26

55TH GLOBAL CONGRESS ON MIGS

BOSTON, MASSACHUSETTS
NOVEMBER 13-16, 2026

Syllabus

PGSIG-849

Differentiating Robotic Platforms for Gynecology

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SCIENTIFIC PROGRAM CHAIR
Nash S. Moawad, MD

PRESIDENT
Michael Hibner, MD, PhD



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PGSIG-849: Differentiating Robotic Platforms for Gynecology

Chair: Uchenna C. Acholonu, Jr.
Co-Chair: Maureen Cernadas
Faculty: Uchenna C. Acholonu Jr., Maureen Cernadas, Jin Hee Kim

Course Description

The Robotics SIG created this course to serve as an unbiased, descriptive exploration of three robotic systems available for gynecologic surgery.

Learning Objectives: *At the end of this course, the participant will be able to:* 1) Compare the similarities and differences between three robotic systems currently in use for gynecologic surgery; 2) Evaluate the advantages and disadvantages of each of the three systems; and 3) Identify factors that may help determine which robotic system might be the best fit for an individual surgical practice.

Course Outline

8:00 am	Welcome, Introduction and Course Overview	U. Acholonu
8:10 am	Da Vinci 5 By Intuitive	J. Kim
8:40 am	Hugo By Medtronic	M. Cernadas
9:10 am	Dexter By Distalmotion	U. Acholonu
9:40 am	Discussion Questions & Answers	All faculty
10:00 am	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.

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

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COURSE CHAIR DISCLOSURE

Uchenna C. Acholonu Jr., MD, MBA*

COURSE CO-CHAIR DISCLOSURE

Maureen Cernadas, 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).

Uchenna C. Acholonu Jr., MD, MBA*
Maureen Cernadas, MD*
Jin Hee Jeannie Kim, 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.

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Differentiating Robotic Platforms for Gynecology: DV5 by Intuitive

Jin Hee "Jeannie" Kim, MD
Associate Professor, Gynecologic Specialty Surgery
Fellowship Director, Minimally Invasive Gynecologic Surgery
Columbia University Medical Center / New York-Presbyterian Hospital
AAGL 2026 PGSIG-849

Columbia University Medical Center

1

Disclosure

None

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Objectives

- Review the evolution of the robot Standard to DV5 and review the most recent updates
- Understand the advantages and disadvantages of the DV5
- Determine which newer features might be the best fit for your practice

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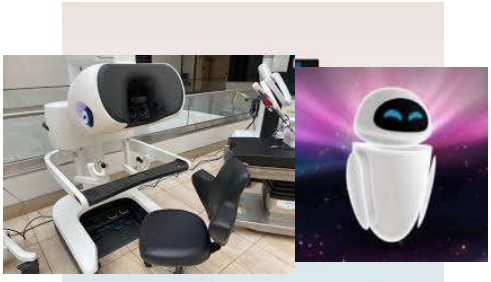
History

2005 FDA approval for GYN robotic surgery
- side docking, 4 arms
- arm clasp to trocar
- 8mm camera
- 30 degree rotation
- multi-quadrant surgery
- port hop



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DV5 in 2024



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Some new features on the DV5

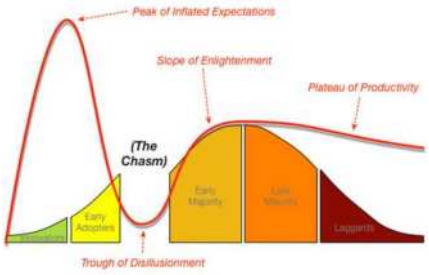
Advanced ergonomic adjustments: a flexible viewer for more degrees of freedom[1] and to maintain neutral neck posture



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Roger's 5-step technology-adoption lifecycle



1. Awareness
2. Interest
3. Evaluation
4. Trial
5. Adoption

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Advantages of robotics in benign gynecologic surgery

Curr Opin Obstet Gynecol 2016, 28:304 – 310

Mireille Truong, Jin Hee Kim, Stacey Scheib, and Kristin Patzkowsky

LOVE IT

- Feasibility, safety, equivalent clinical outcomes to laparoscopy, better than laparotomy
- Ergonomics
- Visualization
- Dexterity, range of motion

HATE IT

- Cost
- Learning curve
- Operative time initially

SAFETY & EFFICIENCY
MINIMIZE LAPAROTOMY

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The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

SGS SOCIETY OF GYNECOLOGIC SURGEONS

COMMITTEE OPINION

Number 628 • March 2015
(Reaffirmed 2017)

Committee on Gynecologic Practice
Society of Gynecologic Surgeons

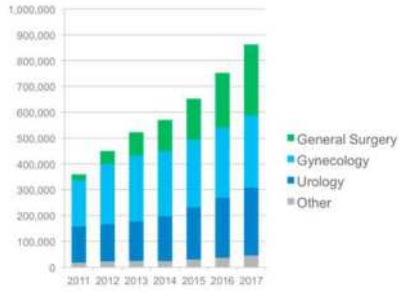
The American Urogynecologic Society endorses this document. This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Robotic Surgery in Gynecology

ABSTRACT: The field of robotic surgery has developed rapidly, and its use for gynecologic conditions has grown exponentially. Surgeons should be skilled at abdominal and laparoscopic approaches for a specific procedure before undertaking robotic approaches. Surgeon training, competency guidelines, and quality metrics should be developed at the institutional level. Robot-assisted cases should be appropriately selected based on the available data and expert opinion. As with any surgical procedure, repetition drives competency. Ongoing quality assurance is essential to ensure appropriate use of the technology and, most importantly, patient safety. Adoption of new surgical techniques should be driven by what is best for the patient, as determined by evidence-based medicine rather than external pressures. Well-designed randomized controlled trials or comparably rigorous nonrandomized prospective trials are needed to determine which patients are likely to benefit from robot-assisted surgery and to establish the potential risks.

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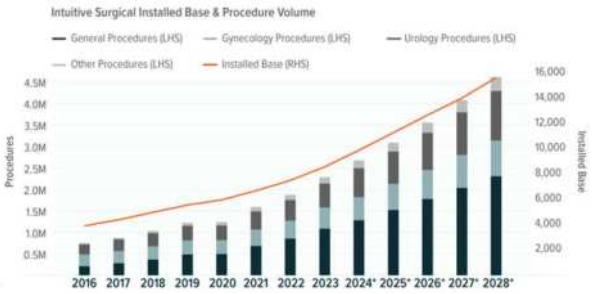
Global adoption of robotic surgery by specialty



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Surgical robot adoption



Sources: Intuitive Surgical Annual Reports 2017-2023. Bloomberg, L.P. (n.d.). ISRG: Intuitive Surgical Inc. Data as of November 1, 2024.

*Forecast

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Top issues for healthcare providers

Significant opportunity remains in MIS

Patient safety and quality

Access to care

Workforce challenges

Financial challenges

Patient **outcomes** can be profoundly better.

Reduced OR variability makes MIS **more efficient** for expert teams and **easier to learn** for novice teams.

Harnessing the power of actionable **data insights** supports the pursuit of better outcomes.

Better and more predictable outcomes can reduce the **total cost of care**.

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Driven by continuous innovation



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Surgical senses · Operational efficiency · Objective insights · Intelligently integrated

- A Monitor
- B Laparoscopic camera
- C Light source
- D Insufflator
- E Video recorder
- F Fluorescent imaging
- G Endoscope



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Surgical senses · Operational efficiency · Objective insights · Intelligently integrated

Features included in the DV5

Up to **$462,000+** value of hardware and software integration



A la carte Xi component	Cost
Integrated Table Motion software	$75,000
E-200 generator	$25,000
Third-party insufflator*	$35,000
Xi Handheld camera	$17,000
Laparoscopic tower	$100,000
Simulator hardware	$100,000
Intuitive Hub	$40,000
My Intuitive+ subscription	N/A



Da Vinci 5 integrated component	
Integrated Table Motion software	Included
E-200 generator	Included
Insufflator	Included
Handheld camera	Included
Integrated tower	Included
Simulator	Included
Integrated video capture	Included
My Intuitive+ subscription (after year 1)	$40,000

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Updates: enhanced surgical senses



Force Feedback is first-of-its-kind technology. Surgeons with varying experience delivered up to 43% less force on tissue.[1]



The da Vinci vision system delivering our most realistic 3D image with better color and resolution,[2] and set up to evolve over time.



Improved ergonomic system— an immersive console offering even more comfort[3] to aid in career longevity.

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Operational efficiency through surgeon autonomy and workflow



Greater surgeon autonomy[1] through component integration and control at surgeons' fingertips.



Streamlined workflow with an easy-to-learn system, a universal user interface for care teams, and dynamic assistance integrated into the system to automate tasks.



Reduced procedure times[2] with potential to increase throughput.

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Features designed for operational efficiency



Perform multi-arm targeting with any number of robotic arms docked, before or during the procedure.*



A software-enabled ruler makes linear measurements on the surgical scene based on points selected by the surgeon.*



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Use of AI and machine learning



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My Intuitive+

Objective insights and personalized action



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Halsted's 7 Principles



Gentle handling of tissue
Scrupulous hemostasis
Minimize tissue tension
Accurate tissue apposition
Elimination of dead space
Strict aseptic technique
Preservation of blood supply

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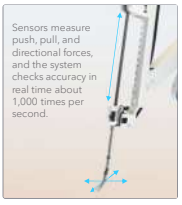
William Stewart Halsted, John H. Stocksdale, http://ihm.nlm.nih.gov/images/B14034, Public Domain

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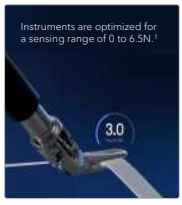
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Surgical senses Operational efficiency Objective insights Intelligently integrated

Sensors measure push, pull, and directional forces, and the system checks accuracy in real time about 1,000 times per second.

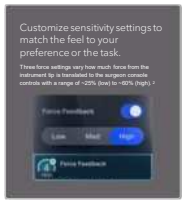


Instruments are optimized for a sensing range of 0 to 6.5N.[1]



Customize sensitivity settings to match the feel to your preference or the task.

These force settings vary how much force from the instrument tip is translated to the surgeon console controls with a range of ~25% (low) to ~65% (high).[2]



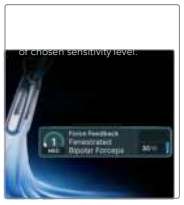
23

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Surgical senses Operational efficiency Objective insights Intelligently integrated

Enables surgeons to feel push/pull forces at the instrument tip.





Experience Force Feedback across a range of actions.

Six Force Feedback-enabled instruments for multiple tasks, including dissecting, retracting, and suturing.[1]

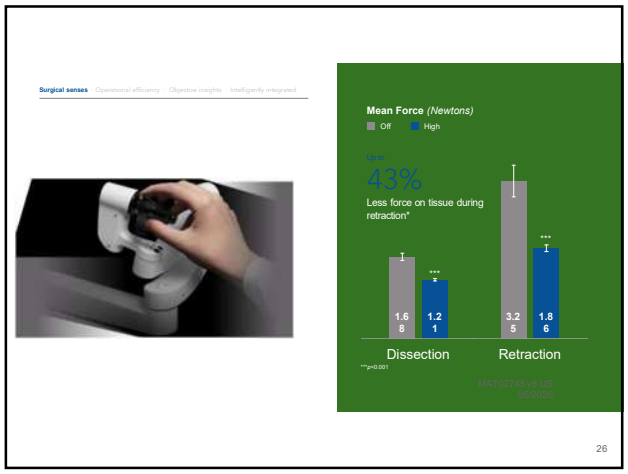


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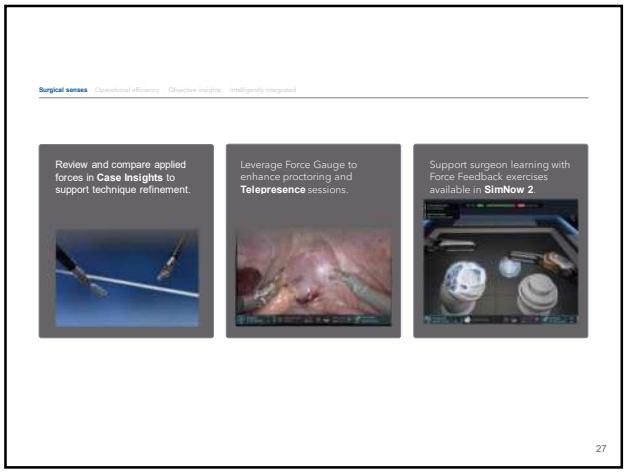
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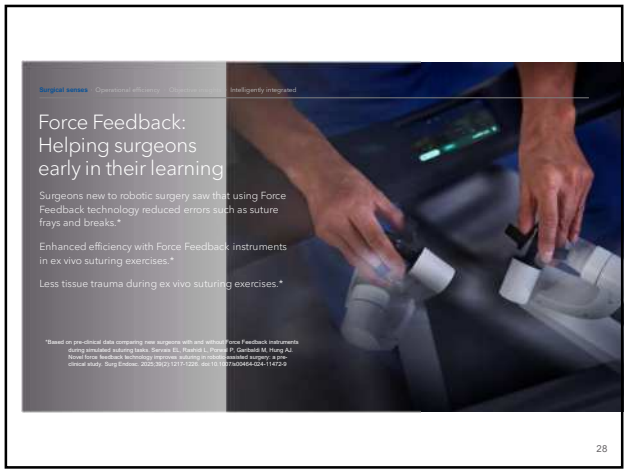
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Improved ergonomics

Surgical senses · Operational efficiency · Objective insights · Intelligently integrated

100%
of surgeons reported less neck and lower back pain when using da Vinci 5 for simulated procedures.*

Advanced ergonomic adjustments accommodate a wide range of body types.



Designed to help with greater career longevity and better quality of life outside the OR.

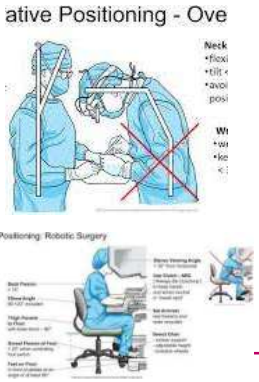


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*Based on a preclinical human factors study comparing 13 surgeons' use of da Vinci 5 to da Vinci Xi.

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Surgical ergonomics



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Greater surgeon autonomy

Surgical senses · Operational efficiency · Objective insights · Intelligently integrated

Greater surgeon autonomy

100%
of surgeons surveyed agreed they had a strong sense of control and confidence when using da Vinci 5.*

Console head-in menu controls integrated components, such as insufflation and energy.



In-console video replay allows for real-time case video review without leaving the viewer.



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*Based on a preclinical human factors study comparing 11 surgeons and 22 care team members' use of da Vinci 5 to da Vinci Xi.

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Improved streamlined workflow

Surgical senses · Operational efficiency · Objective insights · Intelligently integrated

Similar patient cart design to da Vinci Xi for consistent experience with key setup tasks.



Enhanced guided tool change intended to allow bedside assistants to quickly and confidently change instruments.





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Early surgeon experience showing median console time savings compared to da Vinci Xi

Surgical senses · Operational efficiency · Objective insights · Intelligently integrated

See more examples →

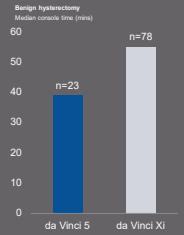


Dr. Devin Garza (Gynecology)
St. David's North Austin Medical Center

Da Vinci system training
2007

Lifetime da Vinci volume
> 3,400 cases

16 minutes saved
29% savings



» Analysis methodology:
Surgeon console time is from da Vinci system log data. The data analysis compared single-console da Vinci Xi procedures against single-console da Vinci S procedures done by the same surgeon at the same facilities. System log data date range is from January 2023–December 2, 2024

» Considerations:
The complexity of the case cannot be deciphered from the da Vinci system log data. Information about concomitant procedures that could influence the console time cannot be extrapolated from the da Vinci system log data. As such, this data presentation should be considered as informational only and not conclusive.

INTUITIVE

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Surgical senses · Operational efficiency · Objective insights · Intelligently integrated

Telepresence

Collaborate remotely anytime, anywhere

Telepresence enables real-time case observation, collaboration, and mentoring

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Telepresence

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*Hinata N, Miyake H, Kurahashi T, et al. Novel Telementoring System for Robot- assisted Radical Prostatectomy: Impact on the Learning Curve. Urology. 2014;83(5):1088-1092. https://doi.org/10.1016/j.urology.2014.01.010

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Telecollaboration experience

- May help decrease learning curves
  Increase knowledge of procedures
- Possible cost saving from instance guidance and cost of readmission
- Increase access to care/health equity



Experience the OR like never before, with expanded OR views and improved audio bringing remote surgeons into the heart of the action*



Clear real-time communication from remote observers to the operating surgeon with live cursor*



MAT0273 05/2026 38

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Scheduled pre-operatively in My Intuitive

My Intuitive users can create one-time or recurring sessions using a remote participant's name and email address.



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Value of telepresence for experienced surgeons using da Vinci

Intuitive Telepresence provides real-time collaboration, saving valuable OR time

Travel time by car (one-way)
~30 minutes

Travel time by telepresence
Instant

Cost savings due to instant guidance
~$870[1]
Estimated cost saved per case

Estimated cost of readmission, if needed
$19,852[2]
Hiatal hernia readmission

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How do you get better? Keep track: Analytics





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Surgical senses · Operational efficiency · **Objective insights** · Intelligently integrated

Case Insights

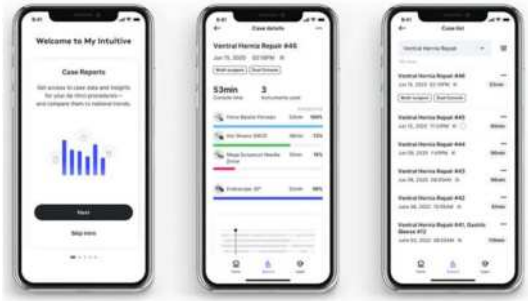


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Myintuitive App



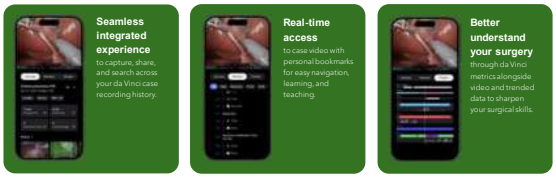
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Case Insights

Objective insights that help surgeons elevate their skills.

Review case video in real-time with seamless navigation to key moments and explore da Vinci metrics to learn, teach and refine surgical performance



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Video capture

Take advantage of automated video capture and bookmarking.

Easily share case images and videos with peers or patients.

Delve into your searchable repository of historical case recordings.



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Real-time access

Access your case video on both mobile and web platforms.

Navigate quickly to key case moments and personal bookmarks.

Conduct timely case review for enhanced learning and teaching.



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Better understand your surgery

Discover your personal da Vinci metrics (i.e., force) alongside your procedure video.

Review your da Vinci metrics over total case volume to identify personal trends and outliers.

Harness ML-segmented video that provides quick and easy navigation for targeted review.

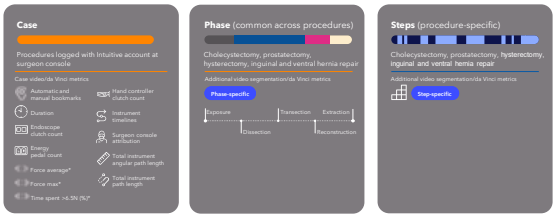


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Case Insights

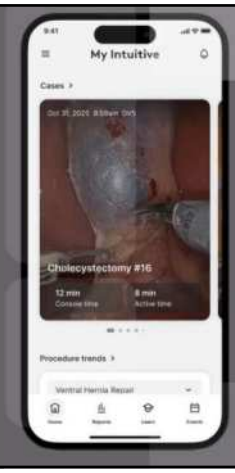
Access your procedure video and da Vinci metrics in the Case Insights web application.



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Case Insights mobile demo



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Case Insights

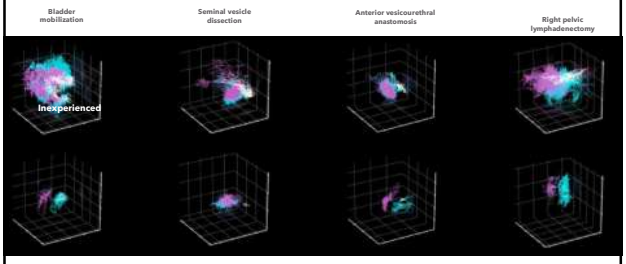
Web application demo



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Novice vs expert

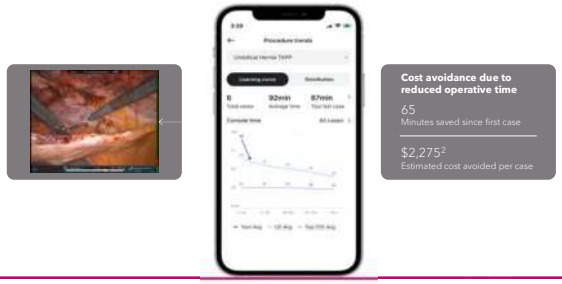


Columbia University College of Physicians and Surgeons — Dominant instrument — Nondominant instrument — Camera

Hung AJ, et al. Development and Validation of Objective Performance Metrics for Robot-Assisted Radical Prostatectomy: A Pilot Study. J Urol. 2018 Jan;199(1):296-304.

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Video-based coaching can help improve technical performance and efficiency



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Clanahan, J.M., Gerull, W.D., Williamson, A.J.H. et al. Video-based coaching improves trainee robotic technical performance. Global Surg Educ 4, 57 (2026

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Available VR systems

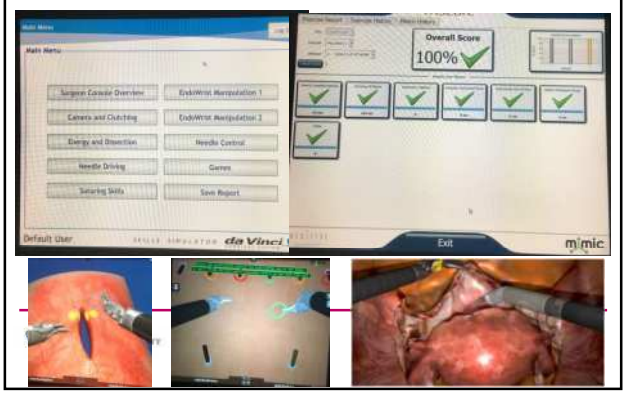
- da Vinci Skills Simulator (dVSS): Intuitive
- Mimic dV-Trainer (dV-Trainer): Mimic Technologies
- Robotic Surgical Simulator (RoSS): Simulated Surgical Systems LLC
- Sim-Surgery Educational Platform (SEP): SimSurgery
- RobotiX Mentor: Simbionix



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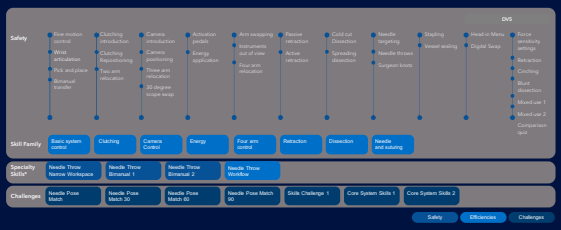
Tasks and scoring on VR



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SimNow 2 Learning Framework

Complete a self-led curriculum that includes safety exercises and efficiency evaluations



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SimNow2 demo



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Conclusion

- Updates to the DV5 system include:
  - Insufflation
  - Energy
  - Handheld camera, endoscope
  - Ergonomics
  - Surgeon control
  - Multi-arm targeting, eject
  - Force feedback
  - Video capture
  - Telepresence
  - Simulation
  - Case insights
- Important to understand these newer features to see the advantages and disadvantages that may exist

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References

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Thank you!







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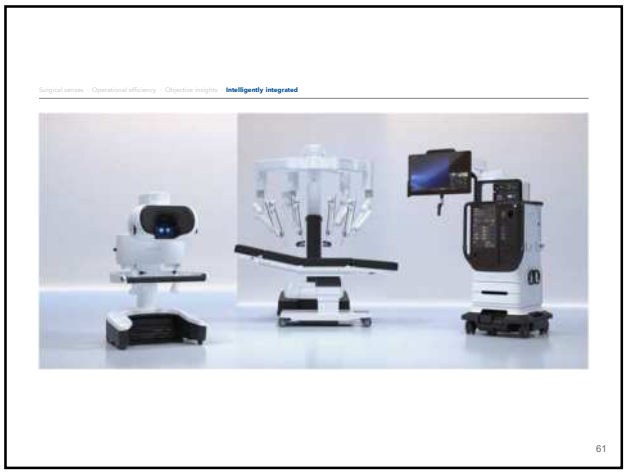
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CME Question

Which is NOT an updated feature of the DV5 compared to the old models?

A. Telepresence
B. Force Feedback
C. Improved ergonomics
D. Iphone charger
E. Integration of gas and electrosurgery settings under surgeon control
F. All of the above

60


Surgical senses · Operational efficiency · Objective insights · Intelligently integrated
61

61

Medtronic's Hugo™ Robotic-assisted Surgery (RAS) System

Maureen Cernadas, MD, FACOG, FACS

1

- There has been a **rapid increase** in number of patients having minimally invasive surgery
- Robotic surgery has been in the forefront to perform **minimally invasive surgery**
- Metronics offers a robotic system aimed to be more **accessible, efficient and affordable**

2

History of Hugo

- **Jul 2021** — **First gynecologic procedures** were performed using the Hugo Robotic-assisted surgery system (Drs. S. Zebede and J. Lopez- Panama City, Panama)
- **Mar 2022** — Hugo RAS received **European approval for gynecologic and urologic** procedures
- **Dec 2025** — Hugo RAS received **FDA clearance for urologic procedures**

3

History of Hugo, cont.

- **Jun 2025** — **Start of "Embrace Gynecology"**, an investigational device exemption U.S. clinical study
  - Evaluate the safety and effectiveness of HUGO RAS systems in gynecologic surgery
  - First surgeries (total hysterectomies) were successfully completed (Drs. S. Crafton and E. Miller, Pittsburgh, PA)
  - By June 2026, the Embrace Gynecology study completed enrollment of 70 patients across 5 US hospitals
- **Feb 2026** — **1st U.S. case performed** after FDA clearance - robotic prostatectomy (Dr. Kaouk, Cleveland Clinic)
- **Jun 2026** — Medtronic submitted **filings to the FDA** to expand the Hugo RAS system into **general and gynecologic procedures** in the U.S.

4

Studies

- "The first 60 cases of robotic sacrocolpopexy with the novel HUGO RAS system: feasibility, setting and perioperative outcomes"—G. Panico et al, in Italy, 2023—concluded "effectiveness both in objective and subjective outcomes, with minimal intra and post-operative complications.
- "The new surgical robot HUGO RAS for total hysterectomy: a pilot study"—Monterossi et al, Rome, Italy, 2022—single-center prospective study of a series of total hysterectomies from March 2022-June 2022—showed that the "HUGO RAS showed high reliability, similar to other robotic devices".
- "The new robotic system HUGO RAS for gynecologic surgery: First European experience from Gemelli Hospital"—Gioe et al, Rome, Italy—study to address the safety and feasibility of the HUGO RAS system concluded "the system for gynecologic surgery is safe with good results in terms of surgical efficiency and perioperative outcomes".

5



6

Hugo™ Robotic-assisted Surgery (RAS) System Components

1. Hugo RAS arm cart assembly (3 or 4 arm carts)
2. Hugo RAS open surgeon console
3. Hugo RAS tower
   - Vision system
   - Energy device
4. Touch Surgery Ecosystem



Source: Metronics

7

Modular Arms



- Individual mobile arm carts
- Arms can be moved around room to fit each surgery
- Extensive range of motion for multi-quadrant surgery
- Adjustable height

Source: Metronics

8

Open Surgeon Console



- 3D definition console
- Allows better communication with room staff
- Trainee can watch the same console as the surgeon and observe surgeons hand movements

Source: Metronics

9

Tower



- Karl Storz 3D HD endoscope and image
- Can switch between 2D and 3D
- Valley Lab energy platform (can be used with all Medtronic energy-based devices)
- Central processing unit of the system
- Easy to use interactive display
- EUA 15 insufflation and smoke evacuation system

Source: Metronics

10

AI-powered Touch Ecosystem



- Video management + analytics platform
- Simplifies: recording, analysis and sharing of surgical videos
- Automatically blurs video outside of the body in real time to protect sensitive information and maintain patient/staff privacy
- Allows live streaming of procedure for virtual learning
- End-to-end encryption

Source: Metronics

11

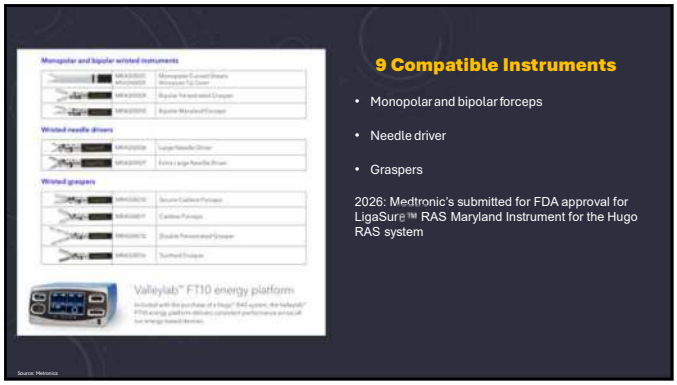
AI-enabled video analysis

- Allows for post-operative review
- Assesses performance- the surgeon can see their benchmarks and trends
- Helps with teaching and learning
- Helps with efficiency and performance improvement

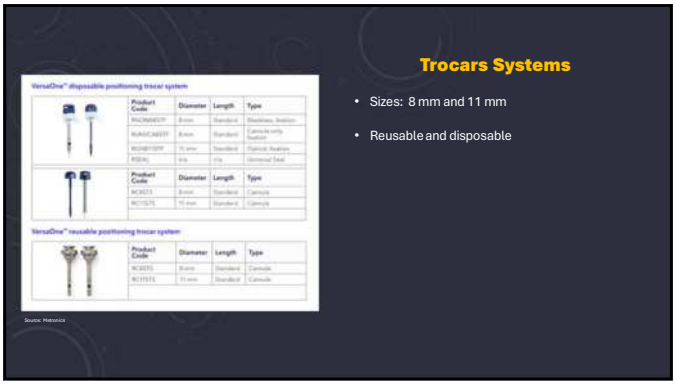
TouchSurgery Free App

- Download from App store
- 200 + simulations across 17+ specialties
- Provides interactive learning
- Prepare, practice and teach surgical procedures

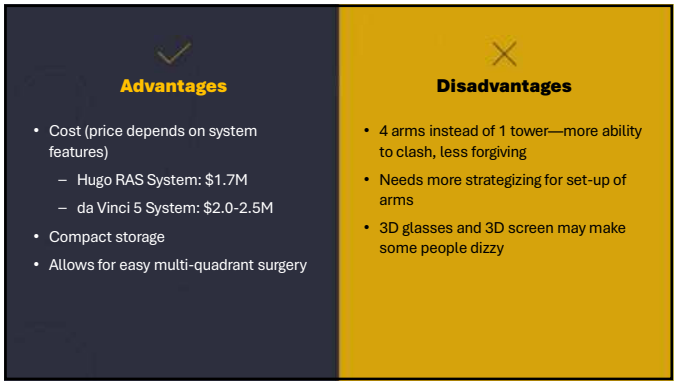
12


Monopolar and bipolar wristed instruments
Wristed needle drivers
Wristed graspers
Valleylab™ FT10 energy platform
9 Compatible Instruments
• Monopolar and bipolar forceps
• Needle driver
• Graspers
2026: Medtronic's submitted for FDA approval for LigaSure™ RAS Maryland Instrument for the Hugo RAS system

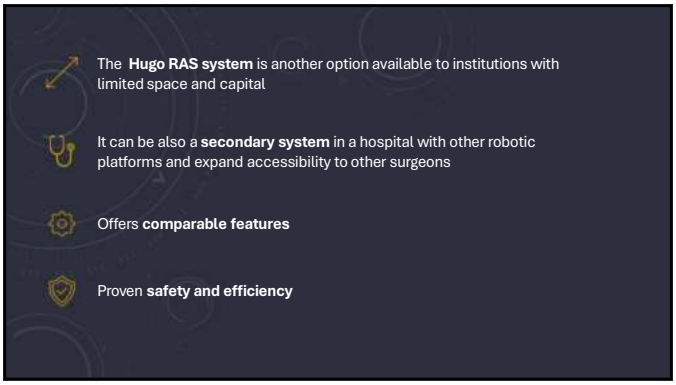
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Trocars Systems
• Sizes: 8 mm and 11 mm
• Reusable and disposable

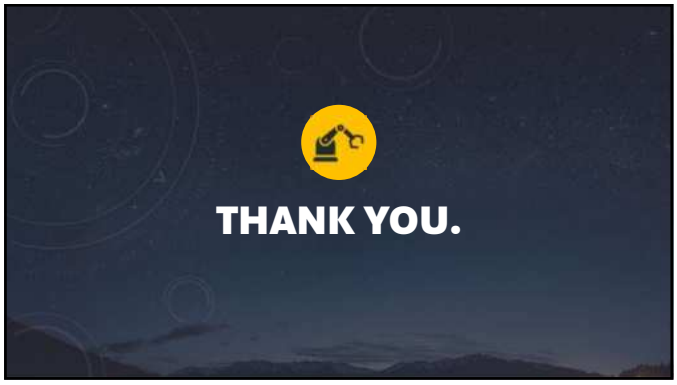
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Advantages
• Cost (price depends on system features)
– Hugo RAS System: $1.7M
– da Vinci 5 System: $2.0-2.5M
• Compact storage
• Allows for easy multi-quadrant surgery
Disadvantages
• 4 arms instead of 1 tower—more ability to clash, less forgiving
• Needs more strategizing for set-up of arms
• 3D glasses and 3D screen may make some people dizzy

15


The Hugo RAS system is another option available to institutions with limited space and capital
It can be also a secondary system in a hospital with other robotic platforms and expand accessibility to other surgeons
Offers comparable features
Proven safety and efficiency

16


THANK YOU.

17

Distalmotion

DEXTER



UCHENNA ACHOLONU, JR, MD MBA
NORTHWELL HEALTH

1

Disclosures

- I have no financial disclosures.

2

Distalmotion



Robotics Lab of the Swiss Federal Institute of Technology in Lausanne (2012)

3

Distalmotion

Mission – "…to empower access to the benefits of robotic surgery. By removing operational barriers to surgical robotics, we are on a journey to ensure more surgeons in more sites of care can provide more patients with best-in-class minimally invasive surgery."

150 people. Self described startup culture.

4

Dexter

- Soft tissue robot, approved by the Conformite Europeenne (CE) in 2020 for Urology, Gynecology, and Gen Surg.
- Approved in US for Isc inguinal and ventral hernia repair, cholecystectomy, benign TLH/BSO, sacrocolpopexy.
- Age 22+.
- First clinical case 2021.



5

Convenience

Mobility is emphasized.
Small and mobile components
Can fit through standard 30-32" wide
Can be set up in a room 120 ft^2
Standard power outlets



6

Versatile

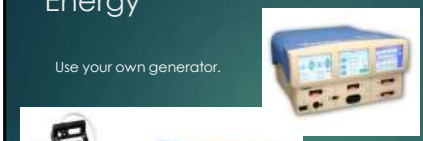
Open architecture

- Endoscope arm is compatible with 5-10 mm endoscopes. Can be mounted to a cart or to the OR bed.
- Surgeon or institution preferred camera, light source, energy generator, insufflation device, trocars, and monitors.
- Open to advances in component instrumentation

7

Energy

Use your own generator.







8

Energy



9

Hand controls





10

Patient cart arm





11

Docking





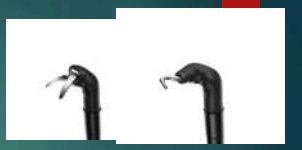
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13

Instrumentation

Single-use, fully wristed instruments
Monopolar and bipolar instruments.






14

Instruments

- Cables for movement are wrapped under the insulation sheath.
  - Pitch (up/down)
  - Yaw (left/right)
  - Actuation (open/close)

15

Energy

- No harmonic instruments.
- No advanced bipolar

but…





16

Undocking

- Easy, not a burden.
- Can switch back and forth from robot to Isc easily.
- Can introduce hand held instrument like harmonic or third-generation bipolar (LigaSure).



17

Endoscope arm




18



19

Advantages

- Small, mobile components.
- Cost of robotic system
  - Stripped down to robotic essentials
    - Keep your own energy, scope, trocars, monitors, etc
- Surgeon is always bedside and console ready
  - Back and forth
  - Can adjust manipulator and go back to console
  - Can easily use trocars for other handheld instruments.
- Startup excitement

20

Limitations

- 4th arm
- Minimal AI integration
- More instruments
  - Tinaculum
  - Larger needle driver
  - Advanced bipolar
- No hand clutch
- Hand control may take time to get used to.
- Not approved for patients < 22 yo
- Smaller company, fighting uphill battle

21

Summation

- Mechanical benefits of robotics.
- Sterile console
  - Operator is not isolated from bedside
  - Good for working with learners.
- To add myomectomy would need tenaculum and stronger needle driver.
- Needle driver w/scissor would be nice.
- Would be helpful to be able to rotate the camera, especially if using an angled scope.
- Can easily port hop to different trocars.
- Price for the system likely significantly lower than more popular robotic systems.
  - Instrument costs are comparable, but these are single use, ergo new every time.
  - Service contract less costly
  - Break-even point is closer to 7 cases (instead of 12 for more common system)
- Well-suited for ASC setting. Good tool for the right setting.
- Well-suited for generalist cases. Good tool for the right surgery.

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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/