Panel Session 5:
Objective Measurements

PROGRAM CHAIR
Malcolm G. Munro, MD

Frank W. Jansen, MD, PhD
James K. Robinson III, MD, MS

Steven F. Palter, MD
Dries Twijnstra, MD, PhD
Professional Education Information

Target Audience
This educational activity is developed to meet the needs of residents, fellows and new minimally invasive specialists in the field of gynecology.

Accreditation
AAGL is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The AAGL designates this live activity for a maximum of 1.75 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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The healthcare industry is undergoing a fundamental shift toward reimbursement strategies that reward value rather than volume. Hospitals and other care providers are eager to increase care quality while reducing costs, but the practical challenges of transitioning to value-based reimbursement are daunting.

By definition, value-based reimbursement, also called value-based payment, involves paying for quality, taking clinical markers into account and ultimately producing better population-based outcomes. Until now, few payers or providers have had to consider, let alone manage, such a broad range of concerns. Bringing those elements into one system requires new ways of thinking, organizing and partnering.

**Learning Objectives:** At the conclusion of this course, the clinician will be able to: 1) Discuss the shift in volume-based care (fee for service) to a value-based reimbursement; and 2) determine how centers of excellence will establish and distinguish themselves in the market.

**Course Outline**

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</tr>
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<td>Welcome, Introductions and Course Overview</td>
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</tr>
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<td>J.K. Robinson</td>
</tr>
<tr>
<td>3:45</td>
<td>QUality Indicator for Surgica l Performance in Minimally Invasive Surgery (QUSUM)</td>
<td>F.W. Jansen/D. Twijnstra</td>
</tr>
<tr>
<td>4:05</td>
<td>Center of Excellence in Minimally Invasive Gynecology (COEMIG)</td>
<td>S.F. Palter</td>
</tr>
<tr>
<td>4:25</td>
<td>Essentials in Minimally Invasive Gynecology (EMIG)</td>
<td>M.G. Munro</td>
</tr>
<tr>
<td>4:45</td>
<td>Questions &amp; Answers</td>
<td>All Faculty</td>
</tr>
<tr>
<td>5:00</td>
<td>Adjourn</td>
<td></td>
</tr>
</tbody>
</table>
PLANNER DISCLOSURE
The following members of AAGL have been involved in the educational planning of this workshop and have no conflict of interest to disclose (in alphabetical order by last name).
Art Arellano, Professional Education Manager, AAGL*
Amber Bradshaw
Speakers Bureau: Myriad Genetics Lab
Other: Proctor: Intuitive Surgical
Erica Dun*
Frank D. Loffer, Medical Director, AAGL*
Linda Michels, Executive Director, AAGL*
Johnny Yi*

SCIENTIFIC PROGRAM COMMITTEE
Arnold P. Advincula
Consultant: Intuitive
Royalty: CooperSurgical
Sarah L. Cohen*
Jon l. Einarsson*
Stuart Hart
Consultant: Covidien
Speakers Bureau: Boston Scientific, Covidien
Kimberly A. Kho
Contracted/Research: Applied Medical
Other: Pivotal Protocol Advisor: Actamax
Matthew T. Siedhoff
Other: Payment for Training Sales Representatives: Teleflex
M. Jonathon Solnik
Consultant: Z Microsystems
Other: Faculty for PACE Surgical Courses: Covidien

FACULTY DISCLOSURE
The following have agreed to provide verbal disclosure of their relationships prior to their presentations. They have also agreed to support their presentations and clinical recommendations with the “best available evidence” from medical literature (in alphabetical order by last name).
Frank W. Jansen*
Malcolm G. Munro
Steven F. Palter
Consultant: Boston Scientific Corp. Inc., Sony
James K. Robinson, III
Consultant: Bayer Healthcare Corp.
Dries Twijnstra*

Asterisk (*) denotes no financial relationships to disclose.
Crowd Sourced Assessment of Technical Skill (CSATS)

James K. Robinson, MD, MS, FACOG
Director, Minimally Invasive Gynecologic Surgery

MedStar Washington Hospital Center
Washington, DC

• Consultant: Bayer Healthcare Corp.

OBJECTIVES

• Explore a better understanding of the history of crowdsourcing.
• Discuss and understand how CSATS works.
• Describe the familiarity with the evidence supporting the use of CSATS.
• Apply for continuing medical education credits through CSATS.

Crowd Sourcing:
A Brief History

“Many hands make light work”
– John Heywood (1497-1580)

Power of the Crowd

The History / Genesis of Crowdsourcing


fold it
Solve Puzzles for Science
Other Notable Examples

Objective Assessment Tools
As I present the next 3 tools, ask yourself whether surgical expertise is a necessary pre-requisite to accurately answering the questions and assigning an objective score

Objective Structured Assessment of Technical Skills (OSATS)
• Initially described in 1997 as an objective approach to assessing the open surgical skills of general surgery residents.
• 7 Domains measured on a 5 point scale
  - Respect for tissue
  - Time and motion
  - Instrument handling
  - Flow of operation
  - Use of assistant
  - Knowledge of procedure

Global Operative Assessment of Laparoscopic Skills (GOALS)
• Initially described in 2005 as global objective assessment tool for technical skills specific to laparoscopy in General Surgery Residents.
• 5 Domains measured on a 5 point scale
  - Depth Perception
  - Bimanual dexterity
  - Efficiency
  - Tissue handling
  - Autonomy
Global Evaluative Assessment of Robotic Skills (GEARS)

- Initially described in 2012 as global objective assessment tool for technical skills specific to robotics in urology residents.
- 6 domains measured on a 5 point scale
  - Depth perception
  - Bimanual dexterity
  - Efficiency
  - Force sensitivity
  - Autonomy
  - Robotic control


Participant Survey

Question 1
Text anonymous answers to . . .

- How often do you video record your surgeries?
  a) Always
  b) Most of the time
  c) Only when I think there will be an interesting portion of the case I can use in a presentation
  d) Rarely
  e) Never

Question 2
Text anonymous answers to . . .

- Do you regularly review your own videos to assess for areas of improvement?
  a) Yes
  b) No
  c) N/A I never record my surgeries

Question #3
Text anonymous answers to . . .

- Do you believe regular objective review of video performance would be helpful in guiding your long-term surgical skill and growth?
  a) Yes
  b) No
Can the power of crowdsourcing be combined with current and emerging objective evaluation tools to help fill an identifiable need in primary and continuing surgical education, evaluation, feedback, skill development, and meaningful quality measures?

Crowd Sourced Assessment of Technical Skills

- Health Care Technology Company
- Co-Founder – Thomas Lendvay, MD
  - Pediatric Robotic Urologist
  - University of Washington
- Extension of Medical Educational Research

How C-SATS Works

The Early Data

Assessments of a single surgeon doing dry lab tasks.
- 500 naive crowd workers vs 10 surgical experts.
- Equivalent assessments

Video 1: Performance dashboard
https://www.youtube.com/watch?v=QGo1KZ3bhw

Video 2: Review of comments and scores with corresponding video segments
https://www.youtube.com/watch?v=gZvMHON4Bw

On-Going Projects

- Education
  - Incorporation into residency programs
  - Linking CSAT scores to ACGME milestones
- Credentialing and Surgical Privileging
  - Integrated medical networks
    - Streamlined credentials
    - Evaluation of new hires
    - Link CSATS scores to surgical outcomes to help with referral networks and coverage

Assessments of a single surgeon doing dry lab tasks:
- Suturing tasks: crowd workers vs expert.
  - Same skill order.
  - Excellent inter-rater reliability


Video Review and Evaluation

- Up to 20 CME hours available
- Ability to compare yourself to other surgeons

Continuing Medical Education

Practice Improvement

Stage 1
- Submit 3 video clips.
- Review performance assessment report.
- Discover opportunities for improvement.

Stage 2
- Submit 3 additional videos.
- Receive feedback on your progress.

Stage 3
- Submit 3 more videos.
- Receive a final performance assessment report.
- Reflect on the improvement process.

20 possible CME

Audience assessment of 2 1 minute surgical videos with comparison to the crowd

Surgical Coaching

- Atul Gawande, MD in Personal Best
- All elite athletes and musicians have coaches to guide their growth
- As the health care culture focuses more on quality, we as surgeons are charged to be self-aware.
- C-SATS offers an anonymous, cost effective, and efficient approach to surgical coaching

REFERENCES

Quality Indicator for Surgical Performance in Minimally Invasive Surgery - QUSUM

Panel Session 5: Objective Measurements
November 18, AAGL Global Congress, Las Vegas

Dries Twijnstra, MD, PhD
Fellow MIGS, Leiden University Medical Center, The Netherlands
Head Research Group: Professor FW Jansen, MD, PhD

Objective slide
1. Recognize benchmarks in good quality indicators
2. Apply quality indicators in laparoscopic hysterectomy (LH)
3. Discuss quality of care

Why the hassle?
Minimally Invasive Surgery ≠ Minimal risk

Ranking the stars!

Quality indicators: three domains
1. Outcome: eg postoperative quality of life
2. Structure: eg volume case-load, OR equipment
3. Process: eg evidence based guidelines
### Requirements/Quality Indicators

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relevance</td>
<td>Relevant aspect quality of care?</td>
</tr>
<tr>
<td>Evidence</td>
<td>Validated indicator? Relation to outcome of procedure?</td>
</tr>
<tr>
<td>Feasibility</td>
<td>Data readily available?</td>
</tr>
<tr>
<td>Controllable</td>
<td>Can we improve the outcome?</td>
</tr>
<tr>
<td>Case-mix</td>
<td>Correction possible?</td>
</tr>
</tbody>
</table>

**References:**
- Driessen et al., Trends in the implementation of advanced minimally invasive gynecologic surgical procedures in The Netherlands. JMIG (2015) j.jmig.2015.01.026

### Complications

- Sine qua non
- Univocal definition
- Learning curve
- Late adverse events

### Volume

- High-volume surgeons
- Lower mortality rate

...skills equally important!

**References:**
- Birkmeijer JD, NEJM 2003.
- Birkmeijer JD, NEJM 2013.

Better outcomes in MIGS skills equally important! Which cut-off?

### Type of approach

<table>
<thead>
<tr>
<th>Preference</th>
<th>Case-mix</th>
<th>Indication</th>
</tr>
</thead>
</table>

***Conversion***

- 4% (0-19) in LH
- Univocal definition
- Strategic or reactive
- Indication
- Case-mix

**References:**
- Driessen et al., Trends in the implementation of advanced minimally invasive gynecologic surgical procedures in The Netherlands. JMIG (2015) j.jmig.2015.01.026
Cumulative summation analysis

Instant feedback!

Quality indicators in laparoscopic hysterectomy

<table>
<thead>
<tr>
<th></th>
<th>Relevance</th>
<th>Evidence</th>
<th>Feasibility</th>
<th>Controllable</th>
<th>Case mix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volume</td>
<td>±</td>
<td>+</td>
<td>+</td>
<td>±</td>
<td>-</td>
</tr>
<tr>
<td>Approach</td>
<td>±</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Complication</td>
<td>+</td>
<td>+</td>
<td>±</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Conversion</td>
<td>+</td>
<td>+</td>
<td>±</td>
<td>±</td>
<td>±</td>
</tr>
<tr>
<td>QUSUM</td>
<td>+</td>
<td>±</td>
<td>+</td>
<td>+</td>
<td>+</td>
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</table>
Center of Excellence in Minimally Invasive Gynecology

The Value and Benefit of the COEMIG Designation

Disclosure
Consultant: Boston Scientific Corp. Inc., Sony

Objective
Discuss the value and benefits of COEMIG designation

Mission for the COEMIG Designation
Steven F. Palter, M.D.
Gold Coast IVF
COEMIG Program Director
Long Island, New York

Identified Challenges
• Identifying excellence for patients and providers
• Cost
• Outcomes
• Lack of adoption of MIS
• Lack of universal performance standards
• Lack of consistent and valid outcomes data

Identified Challenges
• Identifying excellence for patients and providers
• Costs
• Outcomes
• Lack of adoption of MIS
• Lack of universal performance standards
• Lack of consistent and valid outcomes data
COEMIG

Purpose

Enhance adoption of MIS by demonstrating improved outcomes and cost savings that result from a quality initiative.

COEMIG

Purpose

- Improving patient safety
- Improving quality of care
- Expand patient awareness of MIS
- Establish best practices
- Allow informed decisions

COEMIG

Administration

- Independent administration = SRC
  - Administrator of COE programs for surgical specialties
  - Bariatrics
  - Gynecology
  - Hernia

COEMIG

Program Development

- AAGL Board of Directors
- Charge to CGE to develop program
- COEMIG
  - Standards Committee
  - Review Committee
  - Outcomes Committee

COEMIG

Program Leadership

- Steven F. Palter, M.D.
  - Program director
- Under the auspices of CGE
- Under the direction of the AAGL Board

COEMIG

Program Eligibility

- Institution
  - Experience
  - Facilities and equipment
  - Designated surgical team and support staff
  - Continuing education
  - Clinical pathways
  - Provide outcomes data
**COEMIG**

**Program Eligibility**

- Surgeon
  - Experience
  - Board certified or Active candidate by ABOG or equivalent
  - Continuing education
  - Provide outcomes data

**COEMIG**

**United States**

Gold: Applicants
Blue: Provisional (pre site inspection)
Yellow stars: Designees

**COEMIG**

**International**

**COEMIG Participation to Date**

<table>
<thead>
<tr>
<th>Applications</th>
<th>Hospitals</th>
<th>Surgeons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved for designation</td>
<td>16</td>
<td>197</td>
</tr>
<tr>
<td>Approved for integration</td>
<td>16</td>
<td>300</td>
</tr>
<tr>
<td>Total Participation</td>
<td>176</td>
<td>566</td>
</tr>
</tbody>
</table>

**COEMIG**

- Conceived by us
- Developed by us
- For us
- To enhance safety and patient care

**Thank you**
Consultant:
- Aegea Medical, Bayer Healthcare Corp.,
- Boston Scientific Corp. Inc., Gynesonics,
- Hologic, Idoman Teoranta

Roadmap
- Introduction
- Is there a problem with resident education in minimally invasive gynecologic surgery?
- Rationale for the EMIG program
- Description of the EMIG program
- Conclusions

Roadmap
- Introduction
- Is there a problem with resident education in minimally invasive gynecologic surgery?
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What is Minimally Invasive Gynecologic Surgery (MIGS)?

- Laparoscopic surgery
  - Standard without microprocessor assistance
  - With microprocessor (“robotic”) assistance
- Hysteroscopic surgery
- Vaginal surgery
- Other

Approaches to Improving Surgical Quality Where to start?

<table>
<thead>
<tr>
<th>Context</th>
<th>Overall Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postgraduate training</td>
<td>Cognitive knowledge</td>
</tr>
<tr>
<td>Mentorship</td>
<td>Manual/Physical Skills</td>
</tr>
<tr>
<td>CME</td>
<td>Simulated environment</td>
</tr>
<tr>
<td>Fellowship Training</td>
<td>Surgical environment</td>
</tr>
<tr>
<td>Residency Training</td>
<td>Integration and application at surgery</td>
</tr>
</tbody>
</table>

Approaches to Improving Surgical Quality How to measure?

<table>
<thead>
<tr>
<th>Overall Components</th>
<th>Determination of Competency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive knowledge</td>
<td>Validated “written” examination</td>
</tr>
<tr>
<td>Manual/Physical Skills</td>
<td>Validated evaluation of manual skills</td>
</tr>
<tr>
<td>- Simulated environment</td>
<td>- Surgical environment</td>
</tr>
<tr>
<td>- Integration and application at surgery</td>
<td>Assessment of integration of skills in the safe performance of surgical procedures...but how?</td>
</tr>
</tbody>
</table>

Roadmap

- Introduction
- Is there a problem with resident education in minimally invasive gynecologic surgery?
- Rationale for the EMIG program
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- Conclusions

Original Research (Obstet Gynecol 2015;126:559-68)

Preparedness of Obstetrics and Gynecology Residents for Fellowship Training

Sarah R. Gomisjapili, MD, David W. Due, MD, Michael Gay, MD, Janell Steiner, MD, Kevin Oman, MD, Lucien Benardello, MD, Erika Valea, MD, Louis Hester, MD, Siri, MD, and Tyler M. Meile, MD

RESULTS: One hundred thirty directors completed the survey for a response rate of 60%. Responses

% First Year Fellows Able to Perform:
- Vaginal Hysterectomy = 20%
- Basic Hysteroscopic Procedures = 34%
- Laparotomic Hysterectomy = 46%

CONCLUSION: Graduating residents may be underprepared for advanced subspecialty training, necessitating an evaluation of the current structure of resident and fellow curriculum.

“These results suggest that general Ob/Gyn residency is ineffective in preparing fellows for advanced training in gynecologic oncology and should prompt a revision of the goals and objectives of resident education to correct these deficiencies.”

David W. Due, MD, Michael Gay, MD, Janell Steiner, MD, Sarah R. Gomisjapili, MD, Lucien Benardello, MD, Erika Valea, MD, Louis Hester, MD, Siri, MD, and Tyler M. Meile, MD
Survey of North American Gyn/Ob residency education program directors n=135/259

- THE PROBLEM: Currently, there is no standardized evidence-based laparoscopy program to teach gynecology residents laparoscopic surgery, resulting in considerable variability among residency training programs.

- A SOLUTION: Develop a standardized laparoscopy curriculum involving cognitive knowledge, technical skills, and nontechnical skills using an evidence-based approach utilizing a consensus method and the opinions of interested program directors.

Roadmap

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SAGES – ABS
Society of American Gastrointestinal and Endoscopic Surgeons
American Board of Surgery

Module I – Preoperative Considerations
- Laparoscopic Equipment
- Energy Sources
- OR Setup
- Patient Selection / Preoperative Assessment
- Preoperative Assessment

Module II – Intraoperative Considerations
- Anaesthesia & Patient Positioning
- Port Placement Establishment & Tissue Placement
- Physiology of Perioperative Care
- Exiting the Operation

Module III – Basic Laparoscopic Procedures
- Diagnostic Laparoscopy
- Biopsy
- Laparoscopic Suturing
- Hemostasis & Hemostats

Module IV – Postoperative Care and Complications
- Postoperative Care
- Postoperative Complications

Module V – Manual Skills Training
- Manual Skills Practice
- Manual Skills Training: FLS Trainer assembly
- Peg Transfer
- Percision Cutting
- Lifting Loop
- Suture with Extracorporeal knot
- Suture with Intracorporeal knot

SAGES – FLS
Supporting/Validating Literature

1. Bead/peg transfer
2. Circle cut
3. Pretied loop ligation
4. Intracorporal tie and knot
5. Extracorporal tie and knot
SAGES – ABS
Society of American Gastrointestinal and Endoscopic Surgeons
American Board of Surgery

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Approaches to Improving Surgical Quality
How to measure?

EMIG “Stakeholders”
- AAGL
- Postgraduate Physicians
- Fellows
- Residents
- Other Societies: ACOG, ASRM, Others
- Industry
- Payors
- Patients

EMIG Development Schematic

Cognitive Test Development Process
- Psychometrics:
  - The branch of psychology that deals with the design, administration, and evaluation of tests which measure psychological variables such as knowledge, skills, abilities, attitudes, and personality traits.
- April 2010: contracted with a test development consulting firm
- Ph.D., psychometrician assigned to project
Cognitive Test Development Process

- Subnet Matter Experts (SMEs)
- Community of Test Takers and Clinicians
- Subnet Matter Experts (SMEs)
- Community of Test Takers and Clinicians

Validated Cognitive Test

Important issues:
- Validity
- Reliability
- Legal defensibility


EMIG Development

10-Step Test Development Process

- Test definition — Stakeholders; 8 Groups
- Job task analysis — 13 SMEs; 12 subjects; 88 objectives
- Test blueprint — Survey of 300 gynecologic surgeons
- Item (question) writing — 42 SMEs, Writing training
- Psychometric, Sensitivity & Grammar edit
- Technical review — accuracy, clarity, distractors
- Beta testing — 100 test takers in the target audience
- Item/Exam analysis — items to discard; exam properties
- Passing score study — define minimal level
- Finalize the test — 2 versions; score beta

Completed and available November 2012

EMIG Development Schematic

Cognitive Test
- Started 2010
- Rigorous validated process
- Completed 2012

Curriculum
- Started 2012
- 95 Authors
- To be completed in 2015

Manual Skills
- Started 2014
- Laparoscopy
- Hysteroscopy
- Validation 2015-6

Curriculum Development Process

- Used outline originally developed by the Hysteroscopy and Laparoscopy Curriculum Taskforces in conjunction with the EMIG test development process
- Content written: 22 chapters, 300 pages, authored by 95 former Fellows
- Reviewed by the JMIG Editorial Board
- Convert written content using instructional design principles to e-learning mobile portal

EMIG Development Schematic

Cognitive Test
- Started 2010
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Manual Skills
- Started 2014
- Laparoscopy
- Hysteroscopy
- Validation 2015-6
Manual Skills

EMIG Development

10-Step Test Development Process

• Important issues:
  • Validity
  • Reliability
  • Legal defensibility

• Based upon professional testing standards and legal guidelines (e.g., The Standards for Educational and Psychological Testing [American Psychological Association, American Educational Research Association, & National Council on Measurement in Education, 1974; 1999])

EMIG – AAGL

Essentials in Minimally Invasive Gynecology
Laparoscopic Training and Testing Platform (in development)

Based in Part on the validated SAGES Laparoscopic Training and Testing Platform but with a unique infrastructure designed for gynecologic surgery

1. Laparoscope navigation
2. Bead transfer
3. Circle cut
4. Suturing
  1. Intracorporeal tie and knot
  2. Extracorporeal tie and knot
  3. Running suture

Approaches to Improving Surgical Quality

What is EMIG addressing?

Overall Components

Determination of Competency

NOT directly addressed

Roadmap

• Introduction
• Is there a problem with resident education in minimally invasive gynecologic surgery?
• Rationale for the EMIG program
• Description of the EMIG program
• Conclusions
Approaches to Improving Surgical Quality

EMIG: Remaining Challenges

- EMIG Skills Validation
  - Rigorous, scientific process
- Continuous reassessment and revision of the curriculum and cognitive test
- Addressing other important surgical skills
  - Energy based devices
    - SAGES FUSE program
  - Anatomy
  - Dissection skills
  - Adverse event management – e.g., major vascular injury
  - Others

References


Essentials in Minimally Invasive Gynecology

Malcolm G. Munro MD, FACOG, FRCS(c)
David Geffen School of Medicine at UCLA
Kaiser Permanente Los Angeles Medical Center
CULTURAL AND LINGUISTIC COMPETENCY

Governor Arnold Schwarzenegger signed into law AB 1195 (eff. 7/1/06) requiring local CME providers, such as the AAGL, to assist in enhancing the cultural and linguistic competency of California’s physicians (researchers and doctors without patient contact are exempt). This mandate follows the federal Civil Rights Act of 1964, Executive Order 13166 (2000) and the Dymally-Alatorre Bilingual Services Act (1973), all of which recognize, as confirmed by the US Census Bureau, that substantial numbers of patients possess limited English proficiency (LEP).

California Business & Professions Code §2190.1(c)(3) requires a review and explanation of the laws identified above so as to fulfill AAGL’s obligations pursuant to California law. Additional guidance is provided by the Institute for Medical Quality at http://www.imq.org.

Title VI of the Civil Rights Act of 1964 prohibits recipients of federal financial assistance from discriminating against or otherwise excluding individuals on the basis of race, color, or national origin in any of their activities. In 1974, the US Supreme Court recognized LEP individuals as potential victims of national origin discrimination. In all situations, federal agencies are required to assess the number or proportion of LEP individuals in the eligible service population, the frequency with which they come into contact with the program, the importance of the services, and the resources available to the recipient, including the mix of oral and written language services. Additional details may be found in the Department of Justice Policy Guidance Document: Enforcement of Title VI of the Civil Rights Act of 1964 http://www.usdoj.gov/crt/cor/pubs.htm.

Executive Order 13166, “Improving Access to Services for Persons with Limited English Proficiency”, signed by the President on August 11, 2000 http://www.usdoj.gov/crt/cor/13166.htm was the genesis of the Guidance Document mentioned above. The Executive Order requires all federal agencies, including those which provide federal financial assistance, to examine the services they provide, identify any need for services to LEP individuals, and develop and implement a system to provide those services so LEP persons can have meaningful access.

Dymally-Alatorre Bilingual Services Act (California Government Code §7290 et seq.) requires every California state agency which either provides information to, or has contact with, the public to provide bilingual interpreters as well as translated materials explaining those services whenever the local agency serves LEP members of a group whose numbers exceed 5% of the general population.

If you add staff to assist with LEP patients, confirm their translation skills, not just their language skills. A 2007 Northern California study from Sutter Health confirmed that being bilingual does not guarantee competence as a medical interpreter. http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2078538.