SYLLABUS

PLENARY 1:
Laparoscopy

Be a Surgical “Multiplier” in MIGS
Inspire Brilliance Through Teamwork

Scientific Program Chair
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Marie Fidela R. Paraiso, MD

48TH Global Congress on MIGS
November 9-13 Vancouver, B.C., Canada
Professional Education Information

Target Audience
This educational activity is developed to meet the needs of surgical gynecologists in practice and in training, as well as other healthcare professionals in the field of gynecology.

Accreditation
AAGL is accredited by the Accreditation Council for Continuing Medical Education (ACCME) 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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As a provider accredited by the Accreditation Council for Continuing Medical Education, AAGL must ensure balance, independence, and objectivity in all CME activities to promote improvements in health care and not proprietary interests of a commercial interest. The provider controls all decisions related to identification of CME needs, determination of educational objectives, selection and presentation of content, selection of all persons and organizations that will be in a position to control the content, selection of educational methods, and evaluation of the activity. Course chairs, planning committee members, presenters, authors, moderators, panel members, and others in a position to control the content of this activity are required to disclose relevant financial relationships with commercial interests related to the subject matter of this educational activity. Learners are able to assess the potential for commercial bias in information when complete disclosure, resolution of conflicts of interest, and acknowledgment of commercial support are provided prior to the activity. Informed learners are the final safeguards in assuring that a CME activity is independent from commercial support. We believe this mechanism contributes to the transparency and accountability of CME.

Anti-Harassment Statement
AAGL encourages its members to interact with each other for the purposes of professional development and scholarly interchange so that all members may learn, network, and enjoy the company of colleagues in a professional atmosphere. Consequently, it is the policy of the AAGL to provide an environment free from all forms of discrimination, harassment, and retaliation to its members and guests at all regional educational meetings or courses, the annual global congress (i.e. annual meeting), and AAGL-hosted social events (AAGL sponsored activities). Every individual associated with the AAGL has a duty to maintain this environment free of harassment and intimidation.

AAGL encourages reporting all perceived incidents of harassment, discrimination, or retaliation. Any individual covered by this policy who believes that he or she has been subjected to such an inappropriate incident has two (2) options for reporting:

1. By toll free phone to AAGL’s confidential 3rd party hotline: (833) 995-AAGL (2245) during the AAGL Annual or Regional Meetings.
2. By email or phone to: The Executive Director, Linda Michels, at lmichels@aagl.org or (714) 503-6200.

All persons who witness potential harassment, discrimination, or other harmful behavior during AAGL sponsored activities may report the incident and be proactive in helping to mitigate or avoid that harm and to alert appropriate authorities if someone is in imminent physical danger.

For more information or to view the policy please go to:
# Table of Contents

## Course Description

## Disclosure

## Transcervical Radiofrequency Ablation of Symptomatic Uterine Fibroids: 2-Year Results of the Sonata Pivotal Trial
C.E. Miller

## Internal Iliac Artery Ligation in Laparoscopic Myomectomy
M.T. Siedhoff

## Laparoscopic Assisted Posterior Transverse Abdominis Plane (TAP) Block
S. Kim

## Resection of Cystic Adenomyosis
J. Gisseman

## Laparoscopic-Assisted Hysteroscopic Resection of Cesarean Scar Ectopic
P. Urbina

## The Retroperitoneal Approach to a Broad Ligament Fibroid
L.K. Newcomb

## Creation of a Neovagina: A Modified Davydov Approach
A.P. Sanders

## Infrarenal Para-Aortic Lymphadenectomy via Laparoendoscopic Single-Site Approach
L. Chen

## Tips & Tricks: Minimally Invasive Removal of Transabdominal Cerclage
R.B. Smith

## Surgical Approach to a Large Cervical Fibroid
E.M. Lee

## Cultural and Linguistics Competency
Plenary 1: Laparoscopy
Moderator: Amy N. Brown, Arleen H. Song

Description
This session presents high-quality studies concerning common laparoscopic techniques and procedures to improve patient outcome and better treat complex diseases. Techniques described include ways for: tissue extraction, resection of deep infiltrating endometriosis, removal of myoma, and excision of retroperitoneal cysts.

Objectives
Learning Objectives: At the conclusion of this activity, the participant will be able to: 1) Discuss current data concerning a variety of issues encountered on a daily basis in the operating suite; and 2) develop surgical techniques and strategies for successful completion of laparoscopic surgery.

<table>
<thead>
<tr>
<th>Time</th>
<th>Presentation Title</th>
<th>Discussant</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:00</td>
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</tr>
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</tr>
<tr>
<td>11:30</td>
<td>Resection of Cystic Adenomyosis</td>
<td>J. Gisseman</td>
</tr>
<tr>
<td>11:40</td>
<td>Laparoscopic-Assisted Hysteroscopic Resection of Cesarean Scar Ectopic</td>
<td>P. Urbina</td>
</tr>
<tr>
<td>11:50</td>
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<td>L.K. Newcomb</td>
</tr>
<tr>
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</tr>
</tbody>
</table>
PLANNER DISCLOSURE
The following members of AAGL have been involved in the educational planning of this workshop (listed in alphabetical order by last name).
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Anuschirawan Yazdani
Stock Ownership: Virtus Health
Content Reviewer has nothing to disclose.

Asterisk (*) denotes no financial relationships to disclose.
Objectives

- Characterize the two-year clinical outcomes of transcervical fibroid ablation (TFA)
- Describe the durability of TFA at two years

Intended Use and Safety Considerations

**Intended Use**
The Sonata System is intended for diagnostic intrauterine imaging and transcervical treatment of symptomatic uterine fibroids, including those associated with heavy menstrual bleeding.

**Contraindications**
- Current pregnancy
- Active pelvic infection
- Known or suspected gynecologic malignancy or premalignant disorders such as atypical endometrial hyperplasia
- Presence of an intrauterine device (IUD) unless removed prior to the introduction of the Sonata Treatment Device

**Patient Selection Considerations**
Safety and effectiveness with regard to fertility and fecundity after the use of the Sonata System have not been established.

**Anticipated Postoperative Events and Potential Risks**
- Abdominal pain/cramping
- Back pain
- Constipation
- Dizziness/fatigue
- Headache
- Fever
- Malaise
- Nausea/vomiting
- Vaginal spotting/bleeding
- Vaginal sloughing
- Bowel or bladder perforation
- Cervical/vaginal laceration or tear
- Dysmenorrhea
- Electrical shock
- Hematometra
- Hemorrhage
- Infections: local and systemic infection
- Retention of device fragment
- Skin burn from dispersion of RF energy
- Thrombotic events
- Unintended injury to the uterus, cervix, or vagina

**To learn more about the Sonata System, visit**
http://gynesonics.com/sonata-system
Sonata Can Partially/Completely Ablate All Non-Pedunculated Uterine Fibroids

The Sonata System is designed to ablate or partially ablate the target fibroids in the FIGO Leiomyoma Subclassification System.

SONATA 24-Month Follow-up
- 125 of 147 women (85%) returned for follow-up at 24 months
- Overall treatment satisfaction at 2 years was 94%
- The mean percentage of missed work time, overall work impairment, and activity impairment significantly decreased at follow-up
- Through 2 years, surgical reintervention for heavy menstrual bleeding was performed in 9.6% of patients
- One singleton pregnancy occurred (elective R C/S) with a normal peripartum outcome

Improvement in SSS and HR-QoL Maintained Through 24 Months

Improvement in EQ-5D Maintained Through 24 Months

Conclusions
- TFA treatment with the Sonata system provides significant clinical improvement through 2 years post-ablation, with a low incidence of surgical reintervention
- Other favorable outcomes included a rapid return to work and substantial improvements in quality of life, symptom severity, work productivity and activity levels

Acknowledgments
- Khadra M. Osman, MD; Fort Lauderdale Women Care, Ft. Lauderdale, FL, United States
References


Internal Iliac Artery Ligation in Laparoscopic Myomectomy

Presenter: Matthew T. Siedhoff, MD, MSCR
Division of Minimally Invasive Gynecologic Surgery, Cedars Sinai Medical Center
Los Angeles, CA

Video Objective: Vessel ligation, typically the uterine artery, has been described as a preventative measure for bleeding in laparoscopic myomectomy. The internal iliac, or hypogastric artery, a vessel that obstetricians are familiar with ligating in the setting of postpartum hemorrhage, can also be used in laparoscopic myomectomy. In this video, we will review existing literature on vessel ligation in laparoscopic myomectomy, and then demonstrate internal iliac artery ligation as a prophylactic measure, as well as one to treat acute intraoperative hemorrhage.

Setting: Tertiary care academic hospital

Interventions: Laparoscopic myomectomy

Conclusion: Internal iliac artery ligation can be used to prevent and treat bleeding during difficult laparoscopic myomectomy
Laparoscopic Assisted Posterior Transverse Abdominis Plane (TAP) Block

Presenter: Soorin Kim, MD
Yale, New Haven Hospital, New Haven, CT

**Video Objective**: This video demonstrates a laparoscopic assisted transverse abdominis plane (TAP) block as an alternative to the traditional anesthesiology-driven ultrasound-guided TAP block to reduce postoperative pain.

**Setting**: Our patient is a 49 year old with endometriosis, abnormal uterine bleeding, and fibroids, who undergoes a total laparoscopic hysterectomy.

**Interventions**: Following removal of the specimen and closure of the vaginal cuff, we inject a mixture of liposomal bupivacaine and regular bupivacaine between the transverse abdominis and internal oblique muscles. We use external and internal anatomic landmarks such as the iliac crest, latissimus dorsi muscle, and the transverse abdominis muscle to target the Triangle of Petit when placing the injection under direct visualization. This supplies analgesia to the parietal peritoneum, skin, and muscles along T8 through L1 dermatomes. The patient did not require any postoperative opioid based medications.

**Conclusion**: The laparoscopic assisted TAP block is a safe, effective, and quick strategy to reduce pain after minimally invasive gynecologic surgery.
Resection of Cystic Adenomyosis

Presenter: Jordan Gisseman, MD
Obstetrics and Gynecology, San Antonio Military Medical Center
San Antonio, TX

**Video Objective:** To describe a case of cystic adenomyosis and demonstrate the resection of adenomyotic cysts.

**Setting:** A 21 year-old nulligravid patient presents for worsening chronic pelvic pain for 3-4 years which is only partially responsive to oral contraceptives.

**Interventions:** Ultrasound and MRI images confirmed the diagnosis of cystic adenomyosis, and the patient underwent robotic-assisted laparoscopic resection and removal of cystic adenomyosis.

**Conclusion:** Cystic adenomyosis is a rare disorder that requires excision for complete resolution of symptoms. It is necessary to have a high index of suspicion in young patients with dysmenorrhea that does not resolve with hormonal therapy. It is also important for gynecologists to review ultrasound and MRI images themselves and in conjunction with radiologists experienced in pelvic imaging to reduce misdiagnosis.
Laparoscopic-Assisted Hysteroscopic Resection of Cesarean Scar Ectopic

Presenter: Princess Urbina, MD
Obstetrics and Gynecology, The George Washington University School of Medicine and Health Sciences
Washington, DC

Video Objective: In this video, we attempted to mitigate the risk of hemorrhage during a hysteroscopic resection of a cesarean scar ectopic through temporary laparoscopic ligation of the uterine pedicles and utero-ovarian arteries.

Setting: The patient is a 28 y/o G4P2011 at 5 weeks gestation with history of a prior cesarean delivery who presented to the emergency department with vaginal bleeding. Transvaginal ultrasound findings showed an empty endometrial canal, however, a gestational sac and yolk sac were seen implanted within the myometrium at the lower uterine segment. These findings were consistent with a cesarean scar ectopic pregnancy, for which the patient received combined medical and surgical management.

Interventions: Diagnostic and operative laparoscopy were performed to obtain temporary occlusion of the uterine and utero-ovarian arteries, followed by operative hysteroscopy to resect the cesarean scar pregnancy tissue.

Conclusion: Temporary occlusion of the uterine and utero-ovarian arteries seems to be an effective and safe technique in reducing blood loss and should be strongly considered prior to operative management of cesarean scar pregnancies.
The Retroperitoneal Approach to a Broad Ligament Fibroid

Presenter: Laura K Newcomb, MD
Minimally Invasive Surgery, University of Pittsburgh Medical Center, Magee Womens Hospital
Pittsburgh, PA

Video Objective: To demonstrate a strategic retroperitoneal approach that gynecologic surgeons can employ when encountered with an obscuring broad ligament fibroid.

Setting: Academic medical center.

Interventions: This patient is a 38-year-old G3P3 with menorrhagia and dysmenorrhea secondary to uterine fibroids. Her ultrasound was significant for an 8.5 cm right broad ligament fibroid. She desired definitive management of her symptoms in the form of a total laparoscopic hysterectomy and bilateral salpingectomy. The location of the right broad ligament fibroid obscured visualization of the traditional approach to the uterine artery at the level of the internal os, thus it was necessary to secure the uterine blood supply at its origin off the internal iliac artery. The retroperitoneal space was opened, and the pararectal and paracervical spaces were identified in order to complete this step. The course of the ureter ran in close proximity to the lateral aspect of the fibroid, necessitating mobilization of the ureter laterally. This allowed the fibroid to be safely dissected and the procedure to be safely completed.

Conclusion: This video displays a strategic method for accessing and dissecting the retroperitoneal space in order to safely complete a hysterectomy in a patient with an obstructing broad ligament fibroid. Using this technique, hemostasis is ensured by locating and securing the uterine artery at its origin off the internal iliac artery, and the safety of the ureter is maintained by mobilizing this structure laterally.
Creation of a Neovagina: A Modified Davydov Approach

Presenter: Ari P. Sanders, MD
Obstetrics and Gynecology, Mount Sinai Hospital & Women's College Hospital
Toronto, ON, Canada

**Video Objective:** This video presents a stepwise approach to the creation of a neovagina through a modified laparoscopic Davydov approach.

**Setting:** This procedure is most commonly performed for vaginal agenesis. First line treatment is self-dilation with multidisciplinary support. When first line treatment fails, a surgical approach to neovaginal creation is the Davydov procedure. This video illustrates the steps of a modified laparoscopic Davydov procedure for the creation of a neovagina in a patient with Mayer-Rokitansky-Küster-Hauser Syndrome.

**Interventions:** The modified laparoscopic Davydov procedure is comprised of five steps: 1) define the anatomy (± salpingectomy), 2) create the neovaginal space, 3) line the neovagina with peritoneum, 4) dissect the pelvic sidewall, and 5) suture the neovagina over the stent. The modified laparoscopic approach involves round ligament preservation (instead of transection) for added vaginal support. It also involves transection of the utero-ovarian ligaments (instead of preservation) to keep ovaries in their anatomical location. More extensive pelvic sidewall dissection helps avoid tension on sidewall structures.

**Conclusion:** The Davydov procedure has high rates of sexual satisfaction and should be considered for the surgical creation of a neovagina.
Infrarenal Para-Aortic Lymphadenectomy Via Laparoendoscopic Single-Site Approach

Presenter: Lin Chen, MS
Gynecology, West-china second university Hospital
Chengdu, China

Video Objective: To perform the procedure of Laparoendoscopic Single-Site surgery (LESS) for infrarenal para-aortic nodal dissection and demonstrate the feasibility and safety of infrarenal para-aortic lymphadenectomy via LESS

Setting: A 59-year old female who has no special past history presented an university and tertiary care hospital with abnormal uterus bleeding after menopause. The bimanual examination was no special. The laboratory test was normal, exceptionally, the CA-125 level of 181.6 U/ml (normal <35 U/ml) and CA19-9 level of 1228.4U/ml (normal 30.9 < U/ml). The MRI revealed a 3.6×3.3×2.2 cm uneven enhancement mass at the left uterus cornua with invasion more than half of the myometrium. The pathology was well-differentiated endometrial adenocarcinoma by D&C. The clinical diagnose was endometrial carcinoma with deep myometrium invasion (high-risk)

Interventions: The comprehensive staging surgery was performed by an experienced gynecologist via LESS approach. The comprehensive staging surgery was successfully completed, and the video mainly show the para-aortic lymph nodes dissection up to level of left renal vein. The operation time of the para-aortic lymphadenectomy was 100 min. There were no intra- and post-operative complications. The histopathology was well-differentiated endometrial adenocarcinoma with deep myometrium invasion but the bilateral adnexa, the 17 pelvic nodes and the 18 para-aortic nodes were negative. The FIGO stage was IB

Conclusion: The para-aortic lymphadenectomy up to the level of infrarenal vein is feasible via LESS. The LESS approach can provide easier access to the upper abdominal regions comparing with traditional laparoscopy and facilitate the high level para-aortic lymphadenectomy, with the advantage of faster recovery, shorter hospital day, lesser postoperative pain and incisional mobility and better cosmetic result.
Tips & Tricks: Minimally Invasive Removal of Transabdominal Cerclage

Presenter: Rachael B Smith, DO
Minimally Invasive Gynecologic Surgery, University of Arizona College of Medicine – Phoenix
Phoenix, AZ

Video Objective: To present surgical tips and tricks for the minimally invasive removal of transabdominal cerclage and surgical technique during transabdominal cerclage placement that facilitates easier removal.

Setting: Three patients are presented that underwent uncomplicated robotic transabdominal cerclage placements in pregnancy. The first patient subsequently had a laparotomy for cerclage removal due to second trimester preterm labor at an outside hospital. This case prompted this tips and tricks surgical video to educate surgeons regarding minimally invasive removal of transabdominal cerclage. The second patient underwent an uncomplicated laparoscopic removal of transabdominal cerclage in the setting of preterm labor at 18 weeks. The third case had a term cesarean delivery although her cerclage was not removed at that time. She underwent a robotic transabdominal cerclage removal without complication. Apart from the laparotomy, all placement and removal procedures were performed at an academic medical center by one primary surgeon.

Interventions: In this surgical video, we present surgical tips and tricks for placement and removal of transabdominal cerclage in a minimally invasive fashion using conventional laparoscopic and robotic approaches. Tips described in this video include the “needleless” approach with creation of an avascular tunnel for cerclage placement as well as considerations for anterior versus posterior knot placement. Regarding cerclage removal, we present techniques such as undermining the cerclage tape anteriorly and posteriorly as well as blunt dissection in the previously created avascular tunnel to facilitate removal. Additionally, we present tricks for improved visualization and to delineate anatomic borders around a gravid uterus during these cases.

Conclusion: The removal of transabdominal cerclage is often performed at time of cesarean delivery. However, in cases of intrapartum and postpartum removal, a minimally invasive approach is effective utilizing these surgical tips and tricks.
Surgical Approach to a Large Cervical Fibroid

Presenter: Eung-Mi Lee, MD, MBA
Obstetrics and Gynecology, Boston University School of Medicine
Boston, MA

Video Objective: The objective of this video is to outline a unique approach to removal of a large intracervical fibroid during hysterectomy.

Setting: The patient is a 49 year-old para 3 who presented with pelvic pain, pressure and increased abdominal girth. She was found to have a 20 week size uterus with a large intracervical fibroid on exam. Her cervix was dilated to 4 cm and effaced on exam and the fibroid was palpable. MRI demonstrated a large multi-fibroid uterus, with a dominant 10 centimeter cervical fibroid and a dominant 9 centimeter broad ligament fibroid. She desired definitive management of her symptoms.

Interventions: After extensive surgical planning, a hysterectomy was performed in a three-staged approach. Stage one included dissection of the broad ligament fibroid and ligation of the uterine arteries. Stage 2 of the procedure involved a vaginal myomectomy, in which the cervical fibroid was dissected after use of Duhrssen's incisions on the cervix. The uterine manipulator was then secured using 0 prolene suture. In the last stage of the procedure, the hysterectomy was completed laparoscopically and the entire specimen removed vaginally. The patient had an uncomplicated postoperative course and surgical pathology was consistent with benign leiomyoma.

Conclusion: In this video we outline one unique and feasible approach to hysterectomy when there is a large cervical fibroid. When considering surgical approaches, it is important to remember that there may be distortion of the usual anatomy due to fibroids. Through use of Duhrssen's incisions, we were able to use an obstetrical surgical technique to aide in the removal of a large intracervical fibroid.
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.