ELSEVIER

JMIG The Journal of Minimally Invasive Gynecology

Presidential Address

The Future of Our Specialty: Elevating Gynecologic Surgery

It is an honor to be here today. I want to give you a little insight into who I am, how I got here, and what we are going to be working on over the next few years.

I was born and raised in Iceland by my grandparents, a simple blue-collar upbringing. My grandparents had never really been to school and did not understand my studies, but fortunately I did well. Once I came home with a grade of 9.5 out of 10 and my grandfather asked me why I had not answered all of the questions. He thought that I had not answered all of the questions and that was why I missed points. They were very good people, and I had a happy childhood. I always wanted to be a doctor for some reason and participated with the national karate team as well. I went to medical school in Iceland and then travelled to the United States. There was another Icelandic person that did the same thing about 1 000 years ahead of me. His name was Leifur Eiríksson (Leif Eriksson). He discovered North America about 500 years before Christopher Columbus. There is a statue of him in Boston on Commonwealth Avenue, because it is thought that he may have come all the way down to Boston during his discovery of this new land that they called *Vinland* because it was full of vines and grapes. Once in America, I ended up at Baylor College of Medicine, of the Texas Medical Center, the world's largest life sciences destination. When I arrived, I thought that laparoscopic surgery was kind of nonsensical, clumsy, and took forever to complete. I referred to them as *foreveroscopies* and did not understand why we just did not open everybody. In my second year, I realized three things. One, I saw Dr. Carl Giesler perform a total laparoscopic hysterectomy in 30 minutes, which was really incredible because I had only seen hysterectomies done in 3 to 4 hours. Second, I worked with Dr. Rob Zurawin at Baylor, who introduced me to the world of minimally invasive surgery as well as the American Association of Gynecologic Laparoscopists (AAGL). Three, I attended the AAGL Resident Workshop in Dallas, Texas, as a second-year resident and saw what can be done with laparoscopy. These three things inspired me to actively pursue laparoscopic surgery. And so, I went on to a Minimally Invasive Gynecological Surgery Fellowship at Baylor for two years while earning a Master of Public Health at Harvard. I remember my chair at the time, Joe Leigh Simpson, was not very happy with my decision, as he felt I was veering off the standard path. Nevertheless, he was extremely supportive, and I owe him a lot of gratitude. After that, I went back to Iceland for a couple of years and was later recruited to the Brigham and Women's Hospital, my dream job, 11 years ago. Bob Barbieri, Brigham and Women's Hospital Obstetrics and Gynecology and Reproductive Biology Chair, had a very clear vision. He realized the need to develop a minimally invasive gynecologic surgical program and recruited me to start that division. In addition, I started a fellowship program two years later and assembled a great team. My current partners Drs. Sarah Cohen and Mobolaji Ajao, as well as our current fellow of the Fellowship of Minimally Invasive Gynecologic Surgery, Dr. Nisse Clark, are outstanding. Dr. Cohen heads our robust clinical research program.

I believe that the secret of success is to surround yourself with outstanding people who have talents that make up for your own deficiencies, and I have done that. As Dr. Advincula just mentioned, I was recently promoted to full Professor at Harvard and would never have imagined when I was in Iceland and medical school that I would be promoted to a Professor at Harvard. I think that we sometimes box ourselves in a little bit too much and do not allow ourselves to dream as much as maybe we should.

Occhiolism

I would like to introduce you to the word *occhiolism*, meaning the awareness of the smallness of your perspective. When I was twelve years old, I realized that the structure of an atom is very similar to the structure of our solar system. There is a big core and things floating around it on structured paths. At that time, I imagined that perhaps we were actually living on the electron in an atom in a cell in a big

1553-4650/$ — see front matter
https://doi.org/10.1016/j.jmig.2018.01.002

animal. I mention this because I now get to publish this theory of mine in a peer-reviewed scientific journal, so thank you very much to Tommaso Falcone for that. I also think we need to have a big perspective, and all these petty arguments about different things are really not important because we are just floating in space and very tiny little specks in the universe. It is important to stop focusing on the little things and value different perspectives. You may ask yourselves, if we are actually floating on an electron in the middle of some big animal somewhere, does what we do really matter? I think so, and so does Jon Snow (of Game of Thrones).

Essentials in Minimally Invasive Gynecologic Surgery

So, the first really important initiative is the Essentials in Minimally Invasive Gynecology Surgery (EMIGS) test, a validated high stakes examination in gynecologic surgery. People have been talking about it, but we are actually getting closer to the finish line with this test. This is extremely important because the test enables us to set a minimum standard for what surgeons should know and protects patients. Most surgeons are very competent; however, there are some surgeons who should not be operating on patients. This validated test allows for remedial training options that will elevate our game collectively, a goal for our organization. Collaborating with the American Board of Obstetrics and Gynecology to mandate this test for graduates and obstetrics and gynecology (OB/GYN) residents would allow the profession as a whole to benefit. The test can also be used for hospitals to set minimum standards for providing operating privileges. The good news is that this test is moving forward, and the cognitive test has already been validated. So look for the rollout of the complete test soon.

Outcomes Database

Another initiative is a prospective surgical outcomes database to collect data on patient outcomes and surgeon experience. Dr. Marie Paraiso will spearhead this effort. Our group recently published data on hysterectomy, and we found that all of the hysterectomy data before that were skewed because they were missing a huge chunk of cases being done in outpatient surgery centers. Because these surgeries were not accounted for, it was thought that hysterectomy rates had gone down to 400 000 per year. However, over 100 000 cases are being done in outpatient surgery centers, leading to inaccurate data. This is a call to arms. We need to increase publishing and research. More importantly, we must stop being modest about what we contribute as minimally invasive gynecological surgeon specialists because in the eyes of policymakers and hospital administrators and frankly some OB/GYNs, we are just generalists who know how to do a laparoscopic hysterectomy. That is just not true anymore. For example, we are currently preparing a manuscript based on the study of patients who underwent laparoscopic surgery and an incomplete resection for endometriosis elsewhere by board certified OB/GYNs and were sent to us to treat and remove the endometriosis laparoscopically. This was accomplished 100% of the time with no conversions to laparotomy as an example of the value that a referral center for minimally invasive gynecological surgery can provide.

The database could also be helpful to document devices. I currently have a startup company so am sensitive to encouraging innovation. Better data collection would allow us to catch any potential problems that can arise from these devices before they create significant harm or waste thousands of dollars.

International Outreach

International outreach is very important, but you also have to think about what you are trying to accomplish. Going in and operating up a storm for a week and then leaving does not really impact the people there much at all. So the AAGL has been planning, for a long time, to create a sustainable program where members will donate time so there is someone there consistently for a period of six to twelve months, helping to train the local physicians and teach them to be self-sufficient. This is starting in Malawi but can be rolled out in other sites as well.

Coding and Reimbursement

We must take a more active role in coding and reimbursement because, as you may or may not know, anybody can suggest a new code, The American College of Obstetricians and Gynecologists (ACOG) has been doing that for the most part for OB/GYNs, but sometimes our interests do not align with ACOG. Endometriosis is a good example. There is one reimbursement code for endometriosis (58662). Sorry my international friends, but that is the only code. For example, we performed a fulguration of endometriosis taking probably three or four seconds and performed another case of a dilated ureter with a 5-cm nodule requiring bowel resection and extensive adhesiolysis. These cases have the same code, same reimbursement. Does that make any sense? I don't think so. Although this may seem self-serving because I do these hard cases, it is not; it really is the right thing to do, to change the reimbursement structure for this type of surgery because the current status quo is limiting access to care. Providers who do a lot of these cases end up going out of network because if they do 3 or 4 cases and reimbursement stays the way it is now, it does not really work. These patients are not able to get the care that they need. The current system is really encouraging bad surgery indirectly. Obviously, providers are not trying to be malicious, but they get paid the same. For example, the surgeries of the patients who were referred to us for incomplete endometriosis surgery were billed and paid for by insurance companies, and then the patients come back