



Instructional Course Lecture Moderator Instructions

What is a Instructional Course Lecture and how does it work?

This one-hour educational session combines **didactic lectures with audience discussion** and focuses on established principles, techniques, and evidence-based practices in orthopaedics. ICLs often highlight practical **pearls and pitfalls** and should include time for audience questions and discussion.

Faculty Limit: 4 total — 1 moderator + up to 3 faculty.

Handout: A course handout is required and must be submitted by the moderator.

Your Role as Moderator

As moderator, you are responsible for coordinating the session, communicating with your faculty, and ensuring the course is organized, balanced, and stays within the allotted 60 minutes.

Before the Annual Meeting

- Communicate with your faculty and ensure everyone understands the session format, assigned topic, and time allotment.
- Coordinate presentation topics to create a cohesive course and avoid unnecessary overlap or redundancy.
- Develop a session outline that includes faculty topics, presentation times, and time for audience questions and discussion.
- Review session content for balance, bias, and commercialism.
- Ensure presentations support the course learning objectives and incorporate evidence-based information.
- Plan for adequate audience discussion and Q&A.
- Collect, review, and submit the required course handout by the designated deadline.

Handout Requirement

A handout is **required** for all ICL Lectures and may only be submitted by the moderator.

The moderator is responsible for collecting faculty materials and reviewing the completed handout before submission.

The handout should:

- Support the key educational content and takeaways from the course.
- Include relevant references and/or a bibliography.
- Reflect the overall content of the session.

Detailed **handout requirements, formatting guidelines, review criteria, submission instructions, and deadlines** will be provided separately.

During Your Session

The moderator leads the overall session and helps ensure a smooth, engaging educational experience.

1. Introduce the Session

Welcome attendees, briefly introduce the course topic and faculty, and set expectations for the session.

2. Keep Presentations on Schedule

Monitor presentation times and help faculty stay within their assigned time allotments so the entire course remains within **60 minutes**.

3. Facilitate Discussion

Encourage audience participation and facilitate discussion between faculty and attendees throughout the session when appropriate.

4. Lead Q&A

Allow adequate time for audience questions and discussion. Q&A may take place after individual presentations, throughout the course, or as a dedicated segment at the end.

5. Close the Session

Keep the course on schedule and conclude within the allotted 60 minutes.

Maintaining Balance & Managing Disclosures

As moderator, you are responsible for helping ensure the session remains **fair, balanced, evidence-based, and free of commercial bias**.

- Be alert to bias or commercialism from both faculty and participants.

- Avoid promotion of a specific company's product, device, or treatment.
- When discussing products or treatment options, encourage balanced consideration of available alternatives.
- Clearly identify emerging or new content that is not yet supported by established evidence.
- Address potential conflicts or bias during the discussion when necessary.

Faculty disclosures will be displayed at the start of the session. If a disclosure does not display properly, direct attendees to the disclosure information available through AAOS Annual Meeting resources.

Day-of Reminders

- Arrive early and confirm your faculty are present and prepared.
- Keep presentations within their assigned time limits.
- Encourage audience participation and discussion.
- Help transition smoothly between faculty presentations.
- Keep discussion focused on the course objectives and evidence-based content.
- Protect adequate time for audience Q&A.
- Ensure the session concludes within the allotted **60 minutes**.

Questions?

For questions regarding your ICL Lecture, please contact the AAOS Education team.

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ICL Lecture Handout Sample:

AAOS 2026 Annual Meeting

How to Stay Out of Trouble in Your First 100 DA Hips

AAOS ICL 261

Tuesday, March 3 | 3:30 PM-4:30 PM

Moderators: Joshua C. Rozell MD & William Hamilton, MD

Introduction

William Hamilton, MD: How To Teach DAA THA to Residents and Fellows | 10 minutes

Alexander L. Neuwirth, MD: Indications for DAA THA and Early Practice Tips | 10

minutes **Christopher D. Skeeahan, MD:** Acetabular Preparation for the DAA THA | 10

minutes **Joshua C. Rozell, MD:** Femoral Exposure and Preparation in DAA THA | 10

minutes

All faculty: Q&A | 15 minutes

Objective 1: Appropriate indications for DA THA and which patients to avoid early in practice

Objective 2: How to manage acetabular complications and troubleshooting exposure during DA THA

Objective 3: How to do appropriate femoral releases to improve exposure and safely instrument the femur during DA THA

How to Effectively Teach Residents and Fellows DAA THA

William Hamilton, MD

Narrative Summary:

Over the past 2 decades, the usage of the direct anterior approach (DAA) to the hip for total hip arthroplasty (THA) has grown dramatically. In the mid 2000's, only 5-10% of surveyed AAHKS members utilized the approach, and this has grown to over 65% by 2024.

The early adopters of this approach were largely self-taught. While there were surgeon champions teaching the approach in courses sponsored by societies and industry, these were largely limited to 1-2 days of didactic and cadaveric training, occasionally accompanied by surgeon visitations to observe the approach in live surgery. This limited exposure left these early adopters to mostly learn the approach by trial and error, slowly mastering the technique over years. This led to an era with higher complication rates, and a notion that the approach was more dangerous with higher complication rates.

Once this generation of early adopters mastered the approach, it led to an era where these surgeons could teach their residents and fellows how to do the surgery in a steady and stepwise fashion. This allowed for the instructor to carefully and deliberately take the trainee through a process of learning all the critical steps of the approach, learning the tips and tricks to avoid complications, and doing so in an environment where the instructor was there to limit complications and avoid pitfalls before they occur. This provides an environment where trainees can “skip” some of the early complications of the early adopters, leading to a safe implementation of the approach in practice.

Presentation Outline:

1. Challenges for the Educator
 - a. Popularized by William Halstead, the apprenticeship model is the predominant form of education in the US (Cameron, 1997)
 - i. This is now augmented with cadaver labs, improving quality of multimedia and surgical simulations via virtual reality
 - b. Not all master surgeons are master educators
 - c. Most surgeons receive no formal training in how to properly educate (Goldberg, 2019)
 - d. Many master surgeons fail to remember the early challenges of learning the approach, leading to a “*knowledge paradox*”; described as “the more you know, the less you can clearly explain”
 - e. The “*threshold concept*” means that once the boundary of understanding has been crossed, it is challenging to remember a time when the concept was not understood. (Burson, 2006)
2. Graduated Autonomy
 - a. Also a crucial tenet of Halstead's approach (Dolmans, et al)

- b. Teacher must guide trainee from supervised to independent practice
 - c. Surgical learning requires learning the task from beginning to end, starting with simple and transitioning to complex.
 - d. Teaching progresses from simple anatomy and principles of retractor placement and positioning to more complex concepts and maneuvers
 - e. This diminishing support, or *scaffolding*, continues until independence
 - f. The process of graduated autonomy is challenging - disrupting a surgeon's workflow
 - g. The teacher must have comfort and understanding on how to calmly manage complications when they arise
3. Graduated autonomy- HOW TO (Pirruccio, et al, 2020)
- a. Prioritize patient care
 - b. Assess trainees baseline skill
 - c. Assess trainees understanding of the own strengths and weaknesses and ability to self-assess and correct
 - d. Identify an assistant that can help the trainee when the trainee is given opportunity for independent surgery
 - i. This can help trainees' confidence that they are "operating alone", while protecting the patient from harm because the assistant is a proxy for the teacher and can prevent mishaps
 - e. Avoid temptation of "Minimally Invasive" surgery- better termed "minimal visualization" surgery, which can limit trainees understanding of the anatomy and lead to problems in the long run. Visualization can be gradually decreased as mastery progresses
4. Challenges of the Resident and Fellow
- a. They start as a blank slate
 - b. Background study, using array of educational materials is paramount to safe transition into the operating room
 - c. Need to learn:
 - i. anatomy to identify proper intervals
 - ii. supine positioning and how that relates to implant positioning
 - iii. newer implants- pros and cons
 - iv. often use of fluoroscopy
 - v. use of orthopedic table
 - vi. tenets of proper exposure
 - vii. technology being rapidly introduced into practice
 - viii. Getting acquainted with support staff in OR- which are critical AND frequently change
5. Mitigating Challenges of DAA Education
- a. Dunning-Kruger effect: "the less you know, the less you are able to recognize how little you know your limitations" (Pafitanis, 2020)

- b. The skills that engender competence in a particular domain are often the very skills necessary to evaluate competence in that domain (Kruger, 1999)
- c. Trainees' confidence becomes artificially inflated as they master one portion of the procedure- potentially leading to complications in other portions
- d. Countermeasures to limit complications:
 - i. Self-study to precede the OR
 - ii. Careful observation and study by trainee- not just "holding hook", but listening, learning, taking notes, and rehearsing in ones mind
 - iii. Patient selection- avoid highly complex cases at first
 - iv. Experienced assistant
 - v. Engage the entire surgical team to build camaraderie
 - vi. Revisit your instructor or different teaching surgeon to "learn new tricks"

Selected References:

[8] Cameron, JL. William Stewart Halstead. Our Surgical Heritage. Ann Surg 1997; 225:445-58

[8] Goldberg, H, et al: When I say the knowledge paradox. Med Educ 2019;53:13-4

[8] Burson, et al: Skilled or unskilled, but still unaware of it. J Pers Soc Psychol 2006;90:60-77

[8] Dolmans, DH et al: Twelve tips for implementing whole task curricula. Med Teach 2013;35:801-5

[8] Pirruccicchio, K et al: Safely implementing the direct anterior total hip arthroplasty. JAAOS 2020;28(22): 930-6

[8] Pafatinis G, et al: The Dunning Kruger effect: Revisiting the Valley of Despair. J Plast Reconst Aesthet Surg 2020;73:783-808

[8] Kruger, J Dunning, D: Unskilled and unaware of it. J Pers Soc Psychol 1999;77:1121-34

- [8] Hamilton, WG, and Dattilo, JR: Challenges in Anterior Approach Education. In Anterior Hip Replacement, eds Matta and Sah. Springer, 2022. p 79

Anterior Hip Replacement: Indications and Early Practice Tips

Alexander Neuwirth, MD

Outline

- Overview of the anterior approach
- Indications and contraindications
- Technical pearls and pitfalls
- Early complication avoidance

Key Facts

- The direct anterior approach (DAA) provides true intermuscular and internervous access between the tensor fascia lata and sartorius, minimizing soft-tissue trauma.
- Cautious Indications: Severe contracture, complex deformity, morbid obesity, compromised soft tissue envelope, bony anatomy phenotypes.
- Advantages include early functional recovery, ease of fluoroscopic assessment, clinical assessment of leg lengths.
- Limitations include steeper learning curve, exposure difficulty in muscular or obese patients, and higher early wound complication risk if not performed meticulously.

Pearls

- Patient positioning
- Capsulotomy
- Femoral exposure
- Retractor placement
- Fluoroscopy

Special Considerations

- Learning curve: Complication rates drop significantly after ~50 cases; mentorship or cadaveric training recommended before independent practice.
- Patient selection: Straightforward soft tissue and bony anatomy, BMI <40
- Wound care pearls