



The Fellowship Council Specific Fellowship Type Curricula and Program Requirements November 2018

Surgeon Role Guidelines

Only First Assistant and Primary Surgeon designated cases count towards the minimum case requirements.

- 1. For laparoscopic and open procedures, the fellow should designate themselves as the Primary Surgeon if they performed the majority of the procedure, as First Assistant if they performed a significant but less than 50% of the key portion of the procedure, as Teaching Assistant if they guided a more junior trainee through the procedure, and as an Observer if they did not personally perform any critical portion of the procedure.*
- 2. For robotic cases, fellows should designate themselves as Primary Surgeon if they spent greater than 50% of the procedure as the operating surgeon at the console, as First Assistant if they spent less than 50% of the time at the console as operating surgeon, and as an Observer if they did not spend any significant time at the console (e.g. served as the bedside assistant or observer at the console).*

Program Requirements

Each Fellowship Council program must demonstrate compliance with the following requirements:

- 1. Integration of an articulated curriculum with goals and objectives*
- 2. Written quarterly evaluation of the fellow*
- 3. Quarterly operative assessment of the fellow*
- 4. Evidence of scholarly activity. Fellows must submit at least one clinical and/or research project during the fellowship to a National or Regional Society meeting or journal. The research project need not be accepted for presentation by the conference or for publication in the journal to which it was submitted.*
- 5. The fellowship program should be designed such that transition to independent practice is emphasized.*

For additional information on program requirements, refer to the Guidelines for Fellowship Council Accredited Fellowships in Surgery at: <https://fellowshipcouncil.org/about/program-guidelines/>

Advanced Colorectal --An advanced fellowship in colorectal surgery will not substitute for an ACGME-accredited colorectal residency and will not allow the fellow to apply for entry to the examination process provided by the American Board of Colon and Rectal Surgery. Fellowships can provide broad based colorectal training intended for international candidates who are not certified or eligible for certification by the American Board of Surgery. These fellowships should include all aspects of colorectal diseases including endoscopy, surgical resection, anorectal disease and should provide MIS exposure. Alternatively, fellowships can be developed for candidates who have completed an ACGME-accredited general surgery and possibly an ACGME-accredited colorectal surgery residency, who desire focused further training in a specific area such as: pelvic floor disorders, MIS techniques, inflammatory bowel disease or oncologic surgery. A minimum of 100 complex colorectal operative cases should be performed during the fellowship. All fellowships must have an educational program that includes teaching conferences. Preoperative and postoperative care of the complex colorectal patient must be included in the program.

Advanced GI -- An advanced GI fellowship consists of broad-based training in complex gastrointestinal and abdominal operations. The intent of such fellowships should be to train the general surgeon to do advanced and complex cases in various areas of the gastrointestinal tract and abdominal wall. The fellow should be exposed to and participate in at least 150 advanced cases in the areas of bariatrics, advanced minimally invasive surgery, HPB, flexible endoscopy, complex laparoscopic ventral hernia repair*, and/or advanced colorectal surgery. For the purpose of this designation, "advanced" or "complex" GI operations refers to those procedures not generally performed in sufficient numbers to achieve competency within the context of General Surgery residency. Although it will be presumed that such fellowships will not meet the criteria for any of the specifically categorized areas of GI Surgery within the Fellowship Council, it is encouraged that the fellowship concentrate in two or three focused areas (e.g. HPB and foregut surgery, or bariatric and flexible endoscopy). This focus should allow for clarity of purpose and intent in the description of the training program, as well as the requisite exposure to the technical, cognitive and practice/systems issues to confer a level of competence in such disciplines. The programs must provide a minimum of one year, in-depth experience in the pre- and postoperative management of patients who have complex gastrointestinal abdominal pathology as well as acquisition of technical skills within these areas. Exposure to techniques in those domains with both open and minimally invasive approaches is highly encouraged and expected. *Hernia cases can be included in the cases as defined in Advanced GI MIS.

Advanced GI MIS -- An advanced GI MIS fellowship consists of broad based training in MIS surgery which may include exposure to minimally invasive bariatric surgery. The number of bariatric cases, however, do not necessarily need to meet the requirements set forth by the ASMBS and only 75 of these minimally invasive bariatric cases may count towards the minimum case requirements for accreditation as an advanced GI MIS program. The minimum number of advanced MIS cases required is 150, and excludes basic MIS procedures. These excluded procedures include laparoscopic cholecystectomy, appendectomy, and diagnostic laparoscopy. Of note, ventral hernia repair should not represent a preponderance of the cases. Single incision and robotic basic MIS procedures as defined above will no longer be included as advanced MIS procedures.

REVISED: Advanced GI MIS -- Programs will be expected to adhere to the new Advanced GI MIS criteria beginning in Year 3 (2020-2021 fellowship year). The FC Accreditation Committee will take into account that the fellow in 2020-2021 has not completed an entire year in the new criteria when examining any “perceived” deficits from the new criteria.

Case Log Minimums

65 Defined Category MIS Cases^{1,2}

- 20 Foregut
- 25 Bariatric
- 10 Inguinal Hernia
- 10 Ventral Hernia

85 Additional Complex MIS Cases^{1,3}

150 Total Complex MIS Cases

¹ Only complex (not basic) MIS Cases will count for credit. A “Complex MIS Case” is defined as any

laparoscopic or thoracoscopic operation with the exception of a cholecystectomy, appendectomy, or diagnostic laparoscopy as these are considered “basic MIS cases.” Complex MIS cases done robotically or with a SILS technique will count for credit; however, basic MIS cases done robotically or via a SILS approach will still be treated as basic MIS cases. MIS inguinal and ventral hernias are considered complex MIS cases and there is no limit regarding how many hernia cases may be counted for credit in addition to the defined hernia category minimums.

² All Defined Category MIS Cases must be performed using an MIS approach and the fellow must serve as either the Primary Surgeon (PS) or Teaching Assistant (TA) for all of these cases.

³ For the 85 additional Complex MIS Cases:

- Up to 15 complex foregut, bariatric, or hernia cases may be performed using an open approach and will count for credit towards these 85 cases.
- The fellow must serve as either PS or TA in at least 60 of these 85 cases. The fellow may serve as First Assistant (FA) in up to 25 of these 85 cases.
- These 85 cases may consist of any complex MIS case type, including either the defined category case types (foregut, bariatric, or hernia) or other case types (colorectal, hepatobiliary, solid organ, thoracic, etc.).

Flexible Endoscopy

50 Upper or Lower Endoscopies

- Can be diagnostic or therapeutic
- Endoscopies performed as part of a logged MIS case (e.g. EGD performed during fundoplication) will count for endoscopy credit

Advanced GI MIS/Bariatric -- An Advanced GI MIS/Bariatric fellowship consists of a mixture of bariatric surgery training and broad advanced MIS training. In order to be dually accredited as a GI MIS/Bariatric program, the bariatric experience must meet the requirements for a pure bariatric fellowship (*See guidelines for Bariatrics*), and must also provide exposure to broad based advanced MIS training as evidenced by performance of an additional 75 non-bariatric advanced MIS cases. Basic MIS procedures do not count towards these minimum requirements, and these excluded procedures include laparoscopic cholecystectomy, appendectomy, and diagnostic laparoscopy. Of note, ventral hernia repair should not represent a preponderance of the cases. Single incision and robotic basic MIS procedures as defined above will no longer be counted as advanced MIS procedures. Up to 75 of the 100 minimally invasive bariatric procedures can be credited towards the required 150 MIS procedures, with an additional 75 non-bariatric MIS cases comprising the remainder of the minimum case requirements. Thus, the minimum total number of cases required for Advanced GI MIS/Bariatric accreditation ranges from 175-225 cases.

Please note: These criteria will be valid through the 2019-2020 fellowship year.

Advanced Thoracic -- An Advanced Thoracic fellowship is an additional year of training for surgeons already completing or intending to complete an ACGME-approved cardiothoracic fellowship or equivalent. Completion of this fellowship does not fulfill eligibility for board certification. The emphasis is on minimally invasive techniques. At least 100 cases, not counting bronchoscopy or mediastinoscopy, are required, and at least 40 major cases – esophagectomy + anatomic lung resection – are required. At least 50 of the total cases and at least 20 of the major cases should be minimally invasive approach. Robotic procedures are permitted according to the Fellowship Council Surgeon Role Guidelines. Additionally, 25 bronchoscopies are also required; however these do not count toward the 100 minimum case requirement. Benign esophageal surgery is optional. Advanced endoscopic procedures including endobronchial ultrasound, navigational bronchoscopy, airway obstruction management, and advanced flexible endoscopic procedures including endoscopic mucosal resection, radiofrequency ablation, and stenting, are encouraged. Principles of thoracic oncology, patient selection, and perioperative management should all be strongly emphasized.

Bariatrics -- A Bariatric fellowship provides exclusively or predominantly bariatric surgical training. The institution sponsoring the fellowship must be certified by the American College of Surgeons Bariatric Surgery Center Network, or be actively engaged in the application process. Fellows finishing bariatric fellowships should have completed the minimum number of cases required to allow them to be "certified" as a bariatric surgeon at the completion of their training. Current ASMBS guidelines require a minimum of 100 cases with 51 as Primary Surgeon, and must include a combination of restrictive procedures (bands and sleeves) and malabsorptive procedures. 50 of the 100 cases must be bariatric operations that include an anastomosis (eg: RNY Gastric Bypass or Duodenal Switch with BPD), 10 restrictive cases (e.g. sleeve gastrectomy operations and/or adjustable gastric banding procedures), and at least 5 revisional procedures. The 35 undesignated cases can include internal hernias, band removals, band repositioning, etc. A simple port change is not acceptable towards the 100 case count. 80% of the primary bariatric surgeries must be performed using minimally invasive techniques. As an additional point of clarification, the ASMBS currently does not make any distinction between laparoscopic and robotic procedures. Fellows must have demonstrable experience in the preoperative evaluation and assessment as well as postoperative follow-up and assessment of patients.

Flexible Endoscopy-- A flexible endoscopic fellowship is a fellowship that should focus on the treatment of patients and diseases that require advanced endoscopic techniques. The fellowship should provide experience in advanced upper and lower endoscopic procedures. The training should include a broad based comprehensive experience in diagnostic and therapeutic upper and lower endoscopy. The fellowship should satisfy the SAGES guidelines for training and credentialing in flexible endoscopy (<http://www.sages.org/publications/guidelines/granting-of-privileges-for-gastrointestinal-endoscopy/>). The focus should be on advanced and therapeutic endoscopy. A minimum of 100 therapeutic endoscopic procedures, for which the fellow is the Primary Surgeon, is required to be accredited as a Flexible Endoscopy fellowship.

HPB -- A HPB fellowship program provides a concentrated exposure to patients with both benign and malignant pancreatic, biliary, and liver diseases. While absolute numbers of operative cases have not yet been defined for a specific disease, a minimum of 100 total major operative HPB cases are required, and the fellow must act in the Primary Surgeon role for at least 70 of these major cases. A minimum of 25 major liver, 15 complex biliary, and 25 major pancreas cases are required. The remaining 35 major operative HPB cases may be within any of these categories. Within the liver unit, at least 20 of these procedures must be either hemi-liver resections, trisectionectomies, right posterior sectionectomies, central hepatectomy, and/or in situ donor hemi-hepatectomy. Within the pancreas unit, at least 20 cases must be pancreaticoduodenectomies. Basic HPB cases which do not count towards these minimum requirements include cholecystectomy, liver and pancreas biopsy (any technique). Liver transplant, donor hepatectomy, and donor pancreatectomy may account for up to 20% of each category, with a maximum of 20% of total requirements. The programs must provide a minimum of 1 year of in-depth experience in the pre and post operative management of patients with simple and complex HPB pathology as well as the acquisition of technical skills for performing complex HPB operations. Principles of management of patients with malignant and benign conditions in a multi-disciplinary fashion is required. Experience with ablation techniques, intra-operative ultrasonography, hepatic hilar dissection, and minimally invasive HPB surgery techniques are required. Please see the Appendix to the HPB curriculum for additional information regarding allowable unbundling of HPB procedures.