AGENDA

Call to Order

Approve the Minutes of the January 11, 2015 GISAC Meeting

Introduction of New Director on the GISAC
  • O. Joe Hines, M.D.

Introduction of Guest
  • Brian J. Dunkin, M.D.

Future Key Dates

Old Business - Advanced Training in Gastrointestinal Surgery
  • Fellowship Council Activities: Update
    o FC Match Statistics
    o FSF Funding Summary

  • Flexible Endoscopy Curriculum (FEC) and APDS
    o Implementation and Feedback
    o APDS PowerPoint

  • Complex Gastrointestinal Surgery Fellowships and SSAT Initiative
    o 2015 SSAT Presidential Address - Fabrizio Michelassi, M.D.

  • SAGES/SSAT Curriculum in Upper Gastrointestinal (Foregut) Surgery
New Business

- Reflections on the Retreat
  Dr. Hunter/All

- Review Definition of General Surgery
  Dr. Hunter

- ABMS Recognition of Additional Training
  o RCPSC Discipline and Specialty Recognition
  TAB 7 p. 106

- Competency-Based Training in:
  o HPB Surgery
  TAB 9 p. 110
  o Bariatric Surgery
  o Colorectal Surgery

- Where Do MIS Fellowships Fall?
  o Should All Be Subsumed in Advanced GI Fellowships?
  o Should Some Be General Surgery Fellowships?
  Dr. Hunter/All

- Review of SCORE General Surgery Curriculum for Gastrointestinal Surgery
  TAB 10 p. 112

Adjournment

Dr. Hunter

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* Newly-Elected GISAC Member, Beginning 7/1/15 (None)

** Newly-Elected Director, Beginning 7/1/15
Call to Order

John G. Hunter, MD, Chair of the GISAC, called the meeting to order at 12:30 PM. Also present were Kevin E. Behrens, MD; Mark C Callery, MD; Robert D. Fanelli, MD; Tyler G. Hughes, MD; David W. Mercer, MD; Ninh T. Nguyen, MD; Daniel J. Scott, MD; Nathanial J. Soper, MD; Lee L. Swanstrom, MD; Mark A. Talamini, MD; and Mark L. Welton, MD.

Approval of the Minutes of the June 21, 2014 Meeting

The Minutes of the June 21, 2014 meeting were unanimously approved without modification.

Introduction of New Member

Daniel J. Scott, M.D., the Program Director from Southwestern, a minimally invasive and endoscopic surgeon, was welcomed. Danny represents the Fellowship Council to the GISAC.

Future Key Dates

June 28, 2015, Philadelphia, PA
January 10, 2016, Four Seasons Hotel, Miami, Florida

Fellowship Council Activities

Drs. Scott and Swanstrom brought the GISAC up to date on the activities of the Fellowship Council and the Fellowship Foundation, the funding arm of the Fellowship Council. The match process for fellowships was moved up by several months, into the end of the resident’s fourth year of training. The match data are contained in Attachment 1. The industry support of fellowships continues to fall, such that positions in accredited fellowships will be funded at $35,000/fellow in 2015-2016, and may drop to approximately $20,000/fellowship in the future, if the current methodology of even sharing across all accredited fellowships remains in place (Attachment 2). Despite this decrease in fellowship funding, there appears to be no decrease in the number of fellowships participating in GI/MIS fellowships through the Fellowship Council.
Fellowships in Gastrointestinal (GI) Surgery

The GISAC discussed the evolution of the ABS involvement in fellowships. At the retreat this morning, there was a strong consensus that the ABS support a General Surgery redesign that includes a four-year General Surgery core, followed by additional training in a specialty area, including GI surgery and its several “permutations”. It was also the desire of the retreat attendees that the ABS become involved in offering certificates of added qualifications in areas not covered by ACGME-accredited surgical specialty fellowships, IF the American Board of Medical Specialties (ABMS) confirms that component boards (e.g., the ABS) are allowed the opportunity to grant such certificates. Fundamental to such an effort would be assurance, at the level of the ABS, of quality in the curricula, evaluation, faculty, facilities, and experience. While there is no desire for the ABS to get into the “accreditation business”, it is the general consensus that examination and certification of the candidates would be of little interest if the other elements were not in place.

In anticipation of this, the GISAC has asked its component societies to supply curricula in Bariatric Surgery, HPB Surgery, GI/UGI Surgery, and Colorectal Surgery. It is recognized that some such curricula are to be developed (UGI/GI - Attachment 3), and some curricula have been in use for several years (HPB - Attachment 4) to several decades (CR Surgery). A desire to move towards competency-based curricula was restated.

A discussion of the August fellowship summit in Philadelphia was carried out. The six elements felt to be necessary for ABS participation were discussed and felt to be the correct items. Some confusion about the roles of SAGES and the Fellowship Council were clarified, as the Fellowship Council serves as the coordinating and accrediting body for the fellowships it oversees, but the member societies (SAGES, AHPBA, SSAT, ASCRS, ASBMS) are responsible for developing fellowship curricula. Errors in the minutes from this fellowship summit where SAGES and SSAT representatives were recorded as Fellowship Council representatives will be corrected.

Tracking of Flexible Endoscopy Curriculum (FEC)

The FEC and the requirement for completion has been in place for 18 months, but it is not clear how many programs have the process of FEC completion figured out for their residents. It was discussed that the APDS might be a good group to query to determine if “best practices” for completing this curriculum exist, and, if so, to bring them back to the next GISAC meeting. The tracking template (Attachment 5) was discussed. It was suggested that the required items (250 cases by the end of the second year) be monitored and, if an individual were deficient, he/she and the program would be given a warning that would need to be fixed within six months of the completion of the second year (mid-third year) or the individual would not be able to progress to the fourth year. At this point, no ‘hard stops’ were desired for each stage of FEC completion in the midst of residency until it could be better determined how the FEC would be completed.

August 1, 2016 Fellowship Start Date and July 2016 Qualifying Examination

A discussion of the new fellowship start date ensued. All fellowships represented by the Fellowship Council and its component societies were joining the delayed start to fellowships. The only items that came up for discussion were the first year, where overlap might be a
problem, and J-1 visa issues. It appears that about 75% of fellowships are planning to go without a fellow for one month, and 25% had asked the 2015-2016 fellow to stay for an extra month.

Communication with the Fellowship Council

A request for data on fellow case logs (in aggregate) made by the ABS leadership to the Fellowship Council has been completed (Attachment 6). These data show that cases performed by residents where fellowships exist do not fall below median for complex cases, but do fall below median for simple cases (e.g., appendectomy, cholecystectomy). The explanation for this was believed to be fewer simple cases done at institutions with fellowships.

Flexibility in Surgery Training (FIST)

The list of programs requesting application of the flexibility rule for senior residents was inspected and confirmed without further comment.

Reflections on the Retreat

A thorough discussion of the process and substance of the retreat was then carried out. The GISAC was very supportive of the early creation of the groups and question assignment, and requested that it could be done even earlier next year. As well, methodologies for sharing thoughts (e.g., Google docs) should become standard across all groups.

As well, the GISAC felt that it was important to work in parallel on the several issues that were brought forth at the retreat, feeling that ongoing attention to the fellowship certification discussion should not be shelved in favor of General Surgery residency redesign (four plus something).

Adjournment

With no further business, the meeting was adjourned at 4:00 PM.

Respectfully submitted,

John G. Hunter, M.D.
Chair, Gastrointestinal Surgery Advisory Council
# Match Statistics

**Program Statistics**

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</table>
Attachment 2: Fellowship Foundation Funding

2011-2012 (variable amounts given - cap was $62,500)
Total Number of Individual Institutions that applied: 119
Total Number of Applications: 135
Total Fellowship positions applied for: 208
Total Fellowship positions awarded: 145
Positions not funded: 63

2012-2013 (variable amounts given - cap was $62,500)
Total Number of Individual Institutions that applied: 92
Total Number of Applications: 125
Total Fellowship positions applied for: 167
Total Fellowship positions awarded: 147
Positions not funded: 20

2013-2014 (variable amounts given - cap was $62,500)
Total Number of Individual Institutions that applied: 91
Total Number of Applications: 120
Total Fellowship positions applied for: 168
Total Fellowship positions awarded: 149
Positions not funded: 19
2014-2015 (variable amounts given - cap was $50,000)

Total Number of Individual Institutions that applied: **92**

Total Number of Applications: **114**

Total Fellowship positions applied for: **158**

Total Fellowship positions awarded: **113**

Positions not funded: **45**

2015-2016 (variable amounts given - cap was $35,000)

Total Number of Individual Institutions that applied: **95**

Total Number of Applications: **128**

Total Fellowship positions applied for: **176**

Total Fellowship positions awarded: **115**

Positions not funded: **61**

2016-2017 - we won't know exact until all the applications are in, but we are estimating approximately 100 programs at $20,000.
Dear Dr. ,

The Fellowship Council has developed a joint Upper GI Surgery Task Force with representatives from SAGES and SSAT. As you may know, the pathways for training in HPB and Bariatric Surgery are fairly homogenous while the Advanced GI and Advanced GI/MIS fellowships are more heterogeneous in nature. As the Fellowship Council and its representative member societies engage in discussions with the American Board of Surgery regarding the future path for formal recognition of training in these pathways, it has become evident that defining our vision for what encompasses the components of GI Surgery and recommendations for how that training may be recognized is critically important. As the content of Advanced GI fellowships really are represented by two of our member societies, SAGES and SSAT, we have asked for the appointment of a joint task force to evaluate this issue and bring forward recommendations.

The purpose of the Fellowship Council Upper GI Surgery Task Force will be to provide the following to the Fellowship Council Board by June 1, 2015:

1. Develop a framework to define the sub-elements and/or pathways of excellence which might be considered under an umbrella of GI surgery. If the task force feels that this should be broader than just Upper GI Surgery then the Fellowship Council welcomes those recommendations and will seek the appointment of representatives from other relevant societies.

2. Within each of these pathways of excellence within the field of GI Surgery, the general composition of training content should be described. This is not expected to be formal curricula or assessment, but rather the case content domain and any other specific training which you feel should be included for each pathway.

Once agreement is reached on the domains and associated training content for each pathway of excellence or sub-element of GI Surgery training, specific curricula, training program requirements, and recommended assessment rubrics should be developed. A timeline for this work and additional committee members needed for completion can be defined upon approval of the recommendations outlined above in 1) and 2).

The duties and responsibilities of the Task Force therefore are as follows:

- Participation via email/phone as necessary to determine final recommendations for the Fellowship Council Board. **We would like to schedule the first conference call for January 2015.**
- Potential in-person meetings at the SAGES Annual Meeting or during Digestive Disease Week

The members of the task force include:

<table>
<thead>
<tr>
<th>SAGES</th>
<th>SSAT</th>
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<tr>
<td>Aurora Pryor, MD-SAGES Representative to</td>
<td>Matthew Hutter, MD-SSAT Representative</td>
</tr>
<tr>
<td>the FC Board and Co-Chair of this Task</td>
<td>to the FC Board and Co-Chair of this Task</td>
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<tr>
<td>Lee Swanstrom, MD</td>
<td>Nathaniel Soper, MD</td>
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<td>John Mellinger, MD</td>
<td>Ken Murayama, MD</td>
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<td>Daniel Scott, MD</td>
<td>Michael Zenilman, MD</td>
</tr>
<tr>
<td></td>
<td>Rebecca Minter, MD-FC President</td>
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Each committee and task force serves as a vital part of the underpinning on which the future of the Fellowship Council is forged. Participation is a critical function for the Council and requires a commitment in time and effort. The Fellowship Council office will be in touch with you regarding the first task force conference call.

Please provide the following information to Vanessa Cheung in the Fellowship Council office at Vanessa@fellowshipcouncil.org by Friday, January 2, 2015:

- Email address: _______________________________________________
- Phone number: _______________________________________________
- Assistant Name: ______________________________________________
- Assistant email address: _______________________________________
- Assistant phone number: _______________________________________

Your contribution of time and energy are important to the Council’s efforts and we are looking forward to your participation.

Sincerely,

Rebecca Minter, MD
President
The Fellowship Council
Attachment 4: HPB Fellowship Curriculum (first page). Full curriculum to be found on AHPBA website.

The Fellowship Council
And
The American Hepato-Pancreatico Biliary Association

Advanced GI Surgery Curriculum for
Hepato-Pancreatic & Biliary Surgery Fellowship

1. Introduction

- The purpose of Fellowship education in HPB Surgery is to provide a structured educational and training experience necessary to achieve expertise in HBP Surgery
- This curriculum provides:
  - HPB Surgery Program Directors with a basis for instruction and evaluation of Fellows
  - Fellows with a guide to the study of HBP Surgery and defines the essential areas of knowledge and technical skills that need to be mastered.

2. Curriculum Structure

This Curriculum for Hepato-Pancreatic & Biliary Surgery Fellowship should be considered within the broader context of the core curriculum for the Advanced GI Surgery Fellowship. This document, as produced and maintained by The Fellowship Council details the core requirements common to all Fellowships in Advanced GI Surgery, including those denoted as providing advanced training in:

- Minimally Invasive Surgery (MIS) (SAGES)
- Bariatric Surgery (ASMBG)
- Hepato-pancreatic & biliary surgery (AHPBA)
- Flexible endoscopy (SAGES)
- GI Surgery (SSAT)

It is intended that each of the respective National Societies will be responsible for establishing and maintaining a Curriculum that describes the specific goals, and detailed objectives that are relevant to their sub-specialty fellowship, and that these curricula be included in the curriculum for Advanced GI Surgery Fellowship.
ADVISORY COUNCILS
GASTROINTESTINAL SURGERY ADVISORY COUNCIL

TRACKING OF FLEXIBLE ENDOSCOPY CURRICULUM (FEC)

The GISAC is asked to review and comment on the proposed reporting rubric for requirements in residency. Where the ABS has PGY-year recommendations or requirements, those are noted. All items are required to be completed by application to the Qualifying Examination. Please particularly comment on what consequences there will be for the individual resident who (A) does not complete 250 cases in the first two years, or (B) falls behind the recommended schedule of completion of the FEC.

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Attachment 6: FC data on resident and fellow case logs at institutions with FC accredited fellowships.

To be added.
GASTROINTESTINAL SURGERY ADVISORY COUNCIL (GISAC)

FUTURE KEY DATES

JAN 10-11, 2016  Retreat and Semi-Annual Meeting of the GISAC
                 Four Seasons Hotel, Miami, FL

JUN 26-27, 2016  Retreat and Semi-Annual Meeting of the GISAC
                 Philadelphia, PA

The GISAC is asked to note the above dates.
## Match Statistics

**Program Statistics**

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## Match Statistics

### Program Statistics

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### Applicant Statistics

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#### Applicant Statistics: USA

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</tr>
<tr>
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#### Applicant Statistics: OTHER

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<tr>
<td>Unmatched Applicants</td>
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</tr>
</tbody>
</table>
FELLOWSHIP COUNCIL FUNDING SUMMARY

2011-2012 (variable amounts given-cap was $62,500)
Total Number of Individual Institutions that applied: 119
Total Number of Applications: 135
Total Fellowship positions applied for: 208
Total Fellowship positions awarded: 145
Positions not funded: 63

2012-2013 (variable amounts given-cap was $62,500)
Total Number of Individual Institutions that applied: 92
Total Number of Applications: 125
Total Fellowship positions applied for: 167
Total Fellowship positions awarded: 147
Positions not funded: 20

2013-2014 (variable amounts given-cap was $62,500)
Total Number of Individual Institutions that applied: 91
Total Number of Applications: 120
Total Fellowship positions applied for: 168
Total Fellowship positions awarded: 149
Positions not funded: 19
2014-2015 (variable amounts given-cap was $50,000)

Total Number of Individual Institutions that applied: 92

Total Number of Applications: 114

Total Fellowship positions applied for: 158

Total Fellowship positions awarded: 113

Positions not funded: 45

2015-2016 (variable amounts given-cap was $35,000)

Total Number of Individual Institutions that applied: 95

Total Number of Applications: 128

Total Fellowship positions applied for: 176

Total Fellowship positions awarded: 115

Positions not funded: 61

2016-2017 (cap was $20,000*)

Total Number of Individual Institutions that applied: 97

Total Number of Applications: 118

Total Fellowship positions applied for: 159

Total Fellowship positions awarded: 130

Positions not funded: 29

* The Foundation for Surgical Fellowship’s goal is to sustain as many fellowships as possible at the minimum amount ($20K) suggested by the Fellowship Council. Thus for 2016/17, we are funding more positions than the two prior years, but at a lower award level.
Implementing the Flexible Endoscopy Curriculum (FEC) into Your Residency Program

Surgical Education Week
APDS Workshop
April 22, 2015

Andrew Kastenmeier, MD
Assistant Professor
Division of General Surgery
Medical College of Wisconsin
SAGES Resident Education Committee

SAGES Flexible Endoscopy Committee

- **Resident Education Committee**
  - **Brent Matthews**
    - Carolinas Medical Center
  - **Matthew Goldblatt**
    - Medical College of Wisconsin
  - **John Mellinger**
    - Southern Illinois University

- **Flexible Endoscopy Committee**
  - **Brian Duncan**
    - Houston Methodist
  - **Ted Truss**
    - Dartmouth-Hitchcock
  - **Jeff Marks**
    - UH Case
Follow-Up

• APDS Listserve
  ▫ Questions about FEC and FES
  ▫ Solutions
  ▫ Where to find posted materials

• Contact Andrew Kastenmeier
  ▫ akastenm@mcw.edu
  ▫ Questions, solutions, materials
  ▫ We are interested in feedback
Objectives

1. Understand the requirements of the Flexible Endoscopy Curriculum (FEC)

2. Understand the options for providing didactic and simulation components of curriculum

1. Understand the mechanisms for tracking resident progress through the curriculum

2. Understand how the FEC will evolve in the future
FLEXIBLE ENDOSCOPY CURRICULUM
FOR
GENERAL SURGERY RESIDENTS

http://www.absurgery.org/xfer/abs-fec.pdf
The Basics . . .

- FEC is different from FES
  - Flexible Endoscopy Curriculum (FEC)
  - Fundamentals of Endoscopic Surgery (FES)
Flexible Endoscopy Curriculum (FEC)

- New training **REQUIREMENT** formally introduced in March, 2014 by the American Board of Surgery (ABS)
  - A stepwise endoscopy curriculum with cognitive and technical requirements *throughout residency*
    - Includes recommended cognitive resources
    - Includes recommended technical resources (limited)
    - Includes *validated* clinical assessment tools
    - Provides a timeline for completion

- Applicable to residents completing training in 2018 and after
Why FEC? . . .

1. Flexible endoscopy skills are inherent to gastrointestinal surgery which is the domain of nearly every general surgeon

1. Flexible endoscopy has been found to comprise a large if not predominant component of many American surgeons’ practices

1. Surgeons are depended on to provide flexible endoscopy services in many areas - especially smaller communities

Why FEC?

4. Some credentialing committees and GI societies have viewed surgical residency as insufficient training for these procedures

5. Total case numbers alone do not ensure competency - more is needed and we can provide more complete training

Flexible Endoscopy Curriculum (FEC)

- What are the core requirements in the curriculum?
  - Cognitive (didactic) education
  - Technical (simulation) education
  - Clinical experience
    - Required flexible endoscopy case numbers
    - Validated Flexible Endoscopic Skill Assessment Tool (GAGES)
  - Fundamentals of Endoscopic Surgery (FES) certification
  - Tracking resident progress through the curriculum
LEVEL I
(Typically completed in PGY-1 or -2)

Cognitive Milestones: Basic understanding of GI diseases and endoscopic GI anatomy

Materials:
Recommended materials for this level are found in Appendix A

Technical Milestones: Simulation or clinical tutorial exposure with an emphasis on basic scope manipulation including one-handed wheel deflection, control of suction, irrigation, and insufflation, and passage of instruments through the working channel

Equipment:
1. Inanimate trainers used with real endoscopes
2. Virtual reality endoscopy simulators (if available)

Recommended equipment for this level are found in Appendix A
Cognitive Resources

SCORE

1. Esophagogastroduodenoscopy Module (http://www.surgicalcore.org/modulecontent/130707)
   a. Indications and contraindications
      i. http://www.surgicalcore.org/chapter/25204#25212
      ii. http://www.surgicalcore.org/chapter/180195#180197
   b. Pertinent anatomy
      i. http://www.surgicalcore.org/chapter/25204#25216
      ii. http://www.surgicalcore.org/chapter/180195#180199

2. Colonoscopy Module (http://www.surgicalcore.org/modulecontent/130830)
   a. Indications and contraindications
   b. Pertinent anatomy
      i. http://www.surgicalcore.org/chapter/180195#180202
**Technical Resources**

1. Inanimate trainers used with real endoscopes
   a. ACS/APDS Phase I Surgical Skills Curriculum
      i. [http://www.facs.org/education/surgicalskills.html](http://www.facs.org/education/surgicalskills.html)

2. Computer-based simulator training
HELP!

- How do I convert the FEC document into a curriculum at my program?
Initial Steps

• Assign someone to design and manage the endoscopy curriculum

• Document the current endoscopy education that your residents receive
  ▫ Didactic
  ▫ Simulation
  ▫ Clinical education
  ▫ Which rotations and which PGY-level?
Initial Steps

• Find ways to add in the missing pieces to achieve meet all of the requirements
  ▫ Utilize any rotations where endoscopy is relevant
  ▫ Utilize dedicated education time

• Review curriculum on a regular basis to make changes and additions
PGY-2 residents participate in a 1 month GI rotation

Some clinical endoscopy experience during PGY-3,4,5 on:
- Colorectal
- Trauma
- Critical care
- VA general surgery
- Minimally invasive surgery

CAE computer-based endoscopy simulator
- PGY-1,2 residents are required to complete the modules on the simulator
- Simulator broke last year

Dedicated educational time for PGY-1 and PGY-2 residents
- 4 consecutive days every 2 months

Dedicated education time for PGY-3,4,5 residents
- Half day every month
Deficiencies within our program:

- Lacking a formal endoscopy curriculum
- Lacking a didactic component
- Simulation experience needs expansion/replacement
- Needs an assessment tool for clinical cases
- Needs a mechanism of tracking progress
Addressing the Didactic Curriculum
Didactic Curriculum

- Start by utilizing SCORE
  - Create a reading assignment with the suggested FEC resources

www.surgicalcore.org
Why SCORE?

- Supported by the ABS
- Content is all in one place
- Nearly every general surgery residency has access
- Ability to link outside content
- Most of the FEC curriculum is based on SCORE content
- **Ability to track completion**
SCORE

• Requires someone in your program to create and update the SCORE assignment

• Requires someone in your program to assign it to the resident(s)

• Requires someone to interrogate SCORE to verify completion of the assignment

• Does not guarantee mastery of the didactic materials
Additional Aspects to Consider

- Each program must provide a context for completing the assignment
  - During a certain clinical rotation
  - Prior to a dedicated surgical education day/week
  - Prior to a dedicated skills session
  - Prior to completion of the academic year
Expanding the Didactic Curriculum

- Online content can be linked to a SCORE assignment
  - Textbook chapters (online or PDF)
  - Up-to-date modules
  - Videos
    - SAGES Video Atlas of Endoscopy (SAGES TV)
    - Published guidelines
      - ASGE practice guidelines (free content)
- Journal articles or journal clubs
- Lectures
- Require residents to give a presentation
- Computer-based simulator didactics
Simulation Experience

• “The ABS is not mandating the use of any particular resource and encourages programs to take advantage of the resources for endoscopic training already present at their institution; purchase of a simulator is not necessary.”

• “Training programs should have flexible endoscopy simulation (inanimate, animate or computer –based) available as part of its skills training.”
Simulation Experience

Translation:

- An expensive, computer-based simulator is NOT required and is NOT necessary

- Some type of hands-on experience in which residents practice utilizing a flexible endoscope and performing endoscopy skills is mandatory
Simulation

• Purpose
  ▫ To gain familiarity with equipment
    • Equipment set-up
    • Equipment use
    • Equipment troubleshooting
  ▫ Acquiring individual skills to perform aspects of a procedure
    • Scope insertion, navigation, tip deflection, lesion identification, retroflexion, loop reduction, instrument manipulation, etc.
Simulation and Proficiency

- Experience vs proficiency
- Objective endpoints for simulation tasks that are correlated with:
  - Expert proficiency metrics for a given skill
  - Clinic performance
  - Performance on high-stakes testing (FES)
Endoscopy Simulation Options

1. Clinical tutorial

   1. Inanimate
      ▫ Homemade box trainers
      ▫ Purchased physical models

   2. Animate
      ▫ Explants
      ▫ Animal lab

3. Computer-based or virtual reality
Clinical Tutorial

- Endoscopy tower set-up
- Endoscope set-up
- Equipment trouble-shooting
- Introduction to using the endoscope

- GI lab or operating room equipment
- Requires faculty and/or nurse educator

**Tracking:** skill sign-off sheet
Simulation

• **Inanimate Physical Models**
  - Homemade models
  - Purchased models
Homemade Models

- ACS/APDS Surgical Skills Curriculum
  https://www.facs.org/education/program/apds-resident
  - Requires creating an account
Homemade Models

- Phase I: Module 15 (Upper Endoscopy)
  - A document detailing how to organize a skills session
    - Objectives
    - Suggested stations (didactic and skills)
    - Skills to be practiced
  - A document detailing how to build a low-cost upper endoscopy physical model
Upper Endoscopy Model

- **Intubation Model**
  *We use Laerdal.

- **Pink Plastic Tablecloth**

- **Zip Ties**
  *Available at Home Improvement Store*
Homemade Models

• Phase I: Module 16 (colonoscopy)
  ▫ A document detailing how to organize a skills session
    • Objectives
    • Suggested stations (didactic and skills)
  ▫ A document detailing how to build low-cost colonoscopy physical models
    • Navigation model
    • Withdraw model
Colonoscopy Withdrawal Model

- Thin pink vinyl table cloth
- 1" x 6' Self seal pipe insulation tube
- ¼" peg board (24"x36")
- Alphabet rubber stamp set
- Red permanent stamp ink
- Esmark
- Seran wrap
- Fabri-Tak Quick dry adhesive glue or similar product
- 11" Zip ties
Colonoscopy Withdrawal Model

Use fabric glue to adhere the two tubing edges back together.

Place tape on the pipe tubing to keep it closed and allow the glue to dry.
Colonoscopy Withdrawal Model

Place the remainder of the model on the peg board in a gentle curved position and secure with zip ties in various areas. Cut a small hole in the Esmark to allow the scope to enter at the proximal end of the model. When using the model, place a piece of non-skid rubber type fabric (shelf liner) to keep the model in position.
Colonoscopy Withdrawal Model

Colonoscope view of the model

Colonoscope Withdrawal Instructions for residents:
Insert colonoscope into foam model. Once at the very end, begin to slowly withdraw scope and examine every surface and fold looking for lesions (letters). When a lesion is identified, note its appearance on a paper log and continue until the scope is removed.
Colonoscopy Navigation Model
(Ham Cam)

To make the “Ham Cam” you will need the following items:

- Peg board (24” x 29”)
- Zip ties (11” length)
- Hamster tubing (pet supply store)
- Wood blocks (2.5”x6”)
- Long screws
- Power drill with hole saw attachment
- Kidney basin
- Esmark
- Clear rubber tubing (ID: 3/4”)
Colonoscopy Navigation Model (Ham Cam)
A Proficiency-Based Skills Training Curriculum for the SAGES Surgical Training For Endoscopic Proficiency (STEP) Program

Victor Wilcox Jr, MD, *, † Ted Trus, MD, ‡ Nilson Salas, MD, *, † Jose Martinez, MD, § and Brian J. Dunkin, MD *, †

- Describes 3 physical models
  - 2 inexpensive homemade models
  - 1 purchased physical model

- Introduces proficiency targets for 3 physical models

- PubMed PMID: 24797841
Upper Endoscopy Model

FIGURE 1. Trus upper endoscopy model.
Endoscopic Targeting Model

**FIGURE 3.** The MITIE flexible endoscopy targeting model
Physical Models for Purchase

- CM-15 Colonoscopy training model
- Kyoto Kagaku and Olympus (Japan)
Physical Models for Purchase

Primary level Case

Primary level

Case 1
Introductory level 1
Simple layout appropriate for first-time trainees.

Case 2
Introductory level 2
Still a simple layout, but with a longer sigmoid colon than in Case 1. An essential training step before moving on to actual patients.

Case 3
Straighten out the "Alpha" loop
Still a simple layout, but with a naturally formed "Alpha" loop in a longer sigmoid colon.
With insertion, the colonoscope naturally forms an "alpha" loop, and advances toward the splenic flexure.

Secondary level

Case 4
Redundant sigmoid colon,
"N" loop formation and long transverse colon
A challenging layout, with a difficult-to-shorten sigmoid colon and a drooping transverse colon.

Case 5
Redundant sigmoid colon and "alpha" loop formation
An "alpha" loop is formed by the redundant sigmoid colon, therefore, passing through the sigmoid colon by shortening method is extremely challenging.

Advanced level

Case 6
"Reverse alpha" loop formation
Because of the significantly redundant sigmoid colon, a "reverse alpha" loop is formed by insertion of the colonoscope.

Colon layout can be changed.
# A Proficiency-Based Skills Training Curriculum for the SAGES Surgical Training For Endoscopic Proficiency (STEP) Program

## Table 4. Recommended Proficiency Metrics for Trainees

<table>
<thead>
<tr>
<th>Model</th>
<th>Time (s)</th>
<th>Errors</th>
<th>Repetition</th>
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<tbody>
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<td>133</td>
<td>N/A</td>
<td>2 consecutive</td>
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<tr>
<td>CM-15 Colonoscopy model</td>
<td>325</td>
<td>N/A</td>
<td>2</td>
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<tr>
<td>MITIE Flexible Endoscopy</td>
<td>273</td>
<td>≤3</td>
<td>2</td>
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<tr>
<td>Targeting model</td>
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</table>

Simulation

- Explants
- Animal
Explants and Animal Labs

• Advantages
  ▫ Appearance and feel of tissue
  ▫ Basic or advanced skills
  ▫ Explants are relatively inexpensive

• Disadvantages
  ▫ Require a facility that will allow use of animal tissue
  ▫ Requires a special session to be organized
    • Not readily available like a physical model or a computer based model
Simulation

- Computer-Based or Virtual Reality
Simulation

- Computer-Based or Virtual Reality
  - Advantages
    - Many skill sets addressed
    - Tracking of utilization and performance
    - Lends itself to validation of proficiency
    - Built in didactic modules, case scenarios
    - Accessibility compared to explant/animal models
    - Cost-sharing between departments
Simulation

• Computer-Based or Virtual Reality
  ▫ Disadvantages
    • Cost, maintenance, replacement
    • Faculty member to design the requirements
      • Intro to equipment
      • Select skills modules and endpoints
      • Easy to overlook mentored feedback
Simulation

• Mentored feedback
  ▫ Requires faculty time to provide instruction

• Context for task completion
  ▫ During a clinical rotation
  ▫ During a skills session
  ▫ By the end of the year
Methods of Didactic Curriculum Tracking

- Verify completion of task online (SCORE)
- Verify attendance and/or participation
- Verify computer-based didactic completion
- * Written summary of material
- * Written test
- * Presentations by the residents
- * Discussion or oral examination
Methods of Tracking Simulation

• Verify participation
  ▫ Skills sessions, surgical boot camp, mentored feedback sessions

• Verify task completion
  ▫ Required number of repetitions on a sim task
  ▫ Sign-off (observed) skills

• Skills testing
  ▫ Assessment tool (GAGES)
  ▫ Proficiency targets
Examples:

• Thank you to UH Case (Jeff Marks)
• Thank you to SIU (John Mellinger)
• Matt Goldblatt –MCW PD
UH Case

LEVEL 1: Intro to endoscopy (BASICS) - CH 1-6
EGD - indications/contraindications/anatomy - CH 16
Colonoscopy - ind/cont/anatomy - CH 17

(utilizing Principles of Flexible Endoscopy for Surgeons textbook)

Level I - done during Holden (general surgery rotation) month as an intern. Residents will have to schedule 30 minutes with Dr Marks at some point in the month - 20 minutes of oral/written examination to confirm familiarity with the subject material and 10 minutes to demonstrate proficiency with endobubble on the simbionix trainer. Residents will also participate in animate lab training with flexible endoscopy explant model.
GUIDELINES FOR PRACTICE

1. Attend the Endoscopy Surgical Skills Lab.
   a. Read the syllabus that is provided (ACS/APDS Phase I Skills Curriculum Modules 15 and 16).
   b. Practice with focusing on the mechanics of manipulation of the control wheels and endoscope handling, including navigation, recognition of pathology and, targeting pathology with the passage of instruments.
   c. Complete 2 repetitions of the SIU Endo exam model
   d. Complete 2 repetitions of the SIU Ham Cam model
   e. Log on to the Simbionix Endoscopy simulator. Complete 2 repetitions of each task on the PGY I Endoscopy Curriculum module on the Simbionix simulator (Endobasket, Endobubble, and one case each from both upper and lower GI modules)

INSTRUCTIONS FOR VERIFICATION FOR PROFICIENCY TESTING

- At or after the completion of PGY I Boot Camp, complete the 5 Endoscopy guidelines for practice outlined above by June 1st.
Flexible Endoscopy Curriculum (FEC)

Medical College of Wisconsin
PGY-1

1. PGY-1 residents e-mailed MCW FEC information
2. Introduction to the Flexible Endoscopy Curriculum (FEC) during curriculum #2 (September)
3. Complete PGY-1 SCORE Assignment prior to curriculum #3 (November)
   a. FEC SCORE Assignments
      i. Level 1
4. Complete PGY-1 SCORE Assignment prior to curriculum #5 (April)
   a. FEC SCORE Assignments
      i. Level 2
   b. ASGE Guideline Articles
5. Presentation of assigned ASGE Role of Endoscopy Article at curriculum #5 (April)
   a. Powerpoint
   b. 10 minutes
6. Clinical Tutorial during curriculum #3 (November):
   a. Tour of the GI lab
      i. Introduction to appropriate cleaning and maintenance of the endoscopic equipment
   b. Introduction to the endoscopic equipment
      i. Tower and endoscope setup
         1. Sign-off skill
      ii. Identification of endoscope parts
         1. Sign-off skill
Flexible Endoscopy Curriculum (FEC)
Medical College of Wisconsin
PGY-1

Resident: __________________________

☐ DATE:__________ Attended the Introduction to Flexible Endoscopy Curriculum (FEC) during curriculum #2 (September).

☐ DATE:__________ Completed PGY-1 SCORE Assignment prior to curriculum #3 (November).

☐ DATE:__________ Completed PGY-1 SCORE Assignment prior to curriculum #5 (April).

☐ DATE:__________ Completed presentation of assigned ASGE Role of Endoscopy Article at curriculum #5 (April).

☐ DATE:__________ Attended tour of the GI lab with introduction to endoscope processing.

☐ DATE:__________ Successfully completed tower and endoscope setup exam.

☐ DATE:__________ Successfully completed identification of endoscope parts exam.
Evaluating Clinical Performance

- Required case numbers
- Clinical assessment tool
Validated Assessment Tools for Clinical Performance

- Global Assessment of Gastrointestinal Endoscopic Skills (GAGES)
  - GAGES-UE (upper endoscopy)
  - GAGES-C (colonoscopy)
# GAGES - UPPER GI ENDOSCOPY SCORESHEET

## Global Assessment of Gastrointestinal Endoscopic Skills

### Intubation of the Esophagus

<table>
<thead>
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<th>Score</th>
<th>Description</th>
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<tbody>
<tr>
<td>5</td>
<td>Able to independently (successfully) intubate esophagus without patient discomfort</td>
</tr>
<tr>
<td>4</td>
<td>Requires detailed prompting and cues</td>
</tr>
<tr>
<td>3</td>
<td>Unable to properly intubate requiring take over</td>
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### Scope Navigation

Reflects navigation of the GI tract using tip deflection, advancement/withdrawal and torque.

### Ability to Keep a Clear Endoscopic Field

Utilization of insufflation, suction and/or irrigation to maximize mucosal evaluation.

### Instrumentation (if applicable; leave blank if not applicable)

Random biopsy: targeting is assessed by asking the endoscopist to take another biopsy from the identical site. Targeted instrumentation: evaluation is based on ability to direct the instrument to the target.

### Quality of Examination

Reflects attention to patient comfort, efficiency, and completeness of mucosal evaluation.

### Overall Score:

[ ]
GAGES

- Instructor evaluates resident
- Resident self-evaluation

- Can also be used as an assessment tool on for simulation tasks
  - Physical models
  - Animal lab
  - Computer-based simulation exercises
Fundamentals of Endoscopic Surgery (FES)

- 2 components to the test (knowledge and skill)

- A web-based multiple choice exam for evaluating cognitive knowledge and judgment
  - 80 question written exam

- A virtual reality platform to evaluate fundamental technical and psychomotor skills
  - 5 simulation exercises
    1. Navigation
    2. Loop reduction
    3. Targeting
    4. Mucosal evaluation
    5. Retroflexion
Fundamentals of Endoscopic Surgery (FES)

- Must pass to be eligible for boards
- Requirement starts with residents completing training in 2018
- Didactic modules are on-line (free)

http://www.fesprogram.org/
More FEC Examples

• UH Case
  ▫ Jeff Marks

• Southern Illinois University
  ▫ John Mellinger

• Medical College of Wisconsin
LEVEL 3: CH 7-12, REVIEW CH 19
LEVEL 4: CH 13-15, 21-22

(utilizing Principles of Flexible Endoscopy for Surgeons textbook)

Levels III and IV will be completed during the 1st and 2nd endoscopy months respectively during the PGY-3 year. The subject material will be reviewed with Dr. Marks throughout the months as well as GAGES scoring during procedures.

Level V will be completed during colorectal as a PGY-4. This includes taking the FES test by the end of the month. Hopefully by this point residents will have completed their case requirement and be able to complete the curriculum entirely. FES testing will be in either PGY-4 or PGY-5 year.
GUIDELINES FOR PRACTICE

1. Read the FES cognitive modules pertinent to basic patient management.
   a. Read modules 2, 3, and 4 in the FES curriculum on indications and contraindications, perioperative patient management, and principles of sedation.
      i. http://www.fundamentals-didactics.com
2. Review basic endoscopic procedural technique and common pathologies
   a. Review the Accutouch Endoscopy Simulator teaching videos and pathology slides.
   b. EGD set up, technology, and technique video
      i. http://www.surgicalcore.org/videoplayer/510000113
   c. Colonoscopy technique video
      i. http://www.surgicalcore.org/videoplayer/510000114
3. Accomplish the following skills training requirements
   a. Complete all of the Upper Endoscopy II tasks on the Simbionix simulator
   b. Complete all of the Lower Endoscopy II tasks on the Simbionix simulator
   c. Complete 25 required colonoscopy clinical procedures with GAGES tool evaluation on each.
   d. Complete 15 required upper endoscopy clinical procedures with GAGES tool evaluation on each.

INSTRUCTIONS FOR VERIFICATION FOR PROFICIENCY TESTING

- Complete the guidelines for practice by June 1st of your PGY III year.
Endoscopy Verification of Proficiency Module
SIU Surgical Skills Lab
PGY IV-V

OBJECTIVES: By the end of this module the resident will meet proficiency level of endoscopic procedures.

GUIDELINES FOR PRACTICE

1. Achieve the RRC clinical Endoscopy requirement of 50 colonoscopy patients.
2. Achieve the RRC clinical Endoscopy requirement of 35 upper endoscopy patients.
3. Complete the GAGES tool evaluations on clinical cases until you have reached the score of 18 in 5 of your attempts with both upper and lower endoscopies.

INSTRUCTIONS FOR VERIFICATION FOR PROFICIENCY TESTING

- After the completion of the PGY IV-V guidelines for practice, and completion of all the FES didactic modules (http://www.fundamentals-didactics.com), you are ready to take the Fundamentals of Endoscopic Skills test (FES).
- Pass FES (requirement to take ABS Qualifying Exam beginning with 2018 graduating class).
Flexible Endoscopy Curriculum (FEC)

Medical College of Wisconsin
PGY-4

1. Complete PGY-4 SCORE Assignment prior to completion of MIGS rotation
   a. Includes repeating FES didactic modules
2. Presentation during MIGS rotation
   a. Arrange with Dr. Kastenmeier
   b. Topics
      i. Barrett’s Esophagus
      ii. Esophageal Cancer
      iii. Peptic Ulcer Disease
      iv. Benign Esophageal Neoplasm
      v. Esophageal Perforation
   c. Powerpoint
   d. 40 minutes
3. GAGES-UE on MIGS service
   a. Complete 5 and include a self-assessment
   b. Intraoperative or in GI Lab
      i. GI Lab is Thursday afternoon with Dr. Kastenmeier or Dr. Goldblatt
4. Take FES exam prior to completion of the academic year
   a. Program coordinator will send out a reminder during the spring of the year to sign up for the exam.
Thank You

- **APDS Listserve**
  - Questions about FEC and FES
  - Solutions
  - Where to find posted materials

- **Contact Andrew Kastenmeier**
  - akastenm@mcw.edu
  - Questions, solutions, materials
  - SAGES and ABS are interested in feedback
Supporting Literature


RESOURCES

- **FEC**
  - Includes GAGES-UE, GAGES-C
- **FES**
  - [http://www.fesprogram.org/](http://www.fesprogram.org/)
- **Why FES?**
- **SCORE**
  - [http://www.surgicalcore.org/](http://www.surgicalcore.org/)
- **ACS/APDS Surgical Skills Curriculum**
  - [https://www.facs.org/education/program/apds-resident](https://www.facs.org/education/program/apds-resident)
Dear Friends and Colleagues,

I am deeply grateful for the opportunity and honor to serve as your President. Over the past 12 months, the leadership of our Society has been involved in a comprehensive analysis of our challenges and opportunities.

The issues that we’ve discussed include increasing our support for research in gastrointestinal disorders; crafting effective outreach programs to attract practicing surgeons from the United States and abroad to our society; vetting the feasibility of an additional scientific meeting outside of DDW; and exploring the potential for verification of Centers of Excellence in Digestive Care.

And certainly at the top of our list – presenting both great challenges and great opportunities – is the future of advanced GI Surgery training.

In this field, changes are being discussed that would have consequences on all post-residency fellowships: The American Board of Surgery is considering ways to integrate fellowship training in the continuum of surgical education. The American Board of Medical Specialties is contemplating whether to confer certificates of additional qualification to individuals who successfully complete an accredited non-ACGME fellowship. How these changes would affect GI Surgery training is unknown. But we do know that there is a great opportunity for our Society to contribute to the discussion and help shape the future of advanced GI surgery fellowship training.

It is this area – the past, present and how we would like to see the future – that I’ll address today.

I will begin by reminding all of us about the common bond which unites us - the appreciation and love for GI surgery – and I will follow with a summary of the past and current
changes in the landscape of GI surgery training. Finally, I want to focus on the challenges and opportunities we, as the Society for Surgery of the Alimentary Tract, face...and I will conclude by offering a blueprint for the future.

We all recognize that, in our careers, we have been the beneficiaries of advanced GI surgery training from master surgeons and great mentors who have influenced and shaped who we are today.

So let me take just a moment to recognize and pay respect to three past members of our Society who shaped my development.

Dr. John Ranson: John was a Past President of this Association and was an attending surgeon at NYU during my residency. John stressed the importance of evidence-based medicine long before this concept was accepted and became common place.

Dr. David Skinner: David was Chairman of Surgery at the University of Chicago in the 70’s and 80’s. David gave me my first academic job and mentored me for the next twenty years. Poignantly, he did so even the very last time I saw him, less than a week before his sudden and unexpected death.

Dr. George Block: George was attending surgeon at the University of Chicago. George refined my technical skills and taught me how to earn the confidence and the trust of a patient without which the sacred patient-physician bond, on which a surgical procedure rests, cannot exist.

I feel very fortunate to have been taught and mentored by these master surgeons. These were master surgeons who felt equally comfortable with an esophagectomy or a pouch procedure, an hepatectomy, or a pancreatic resection. Not only were they master surgeons,
they also added new knowledge to their respective fields of interest and expertise. Can we duplicate this experience today?

I feel that it is incumbent upon us to provide high-quality training for the next generation of GI surgeons. Such training responds to the needs of our trainees and to the public’s request for specialized care. In this moment of needed changes, I am here today to demonstrate to you that no one better than the members of the SSAT can lead this transformation.

The issue of training in gastrointestinal surgery has been debated by several past presidents of our Society.

In his 1992 Presidential address entitled “Is Fellowship Training in Alimentary Tract Surgery Necessary?”, Dr. John Cameron stated that there was a real need for such fellowships. And indeed he was proven right by the multiple fellowships that subsequently developed in GI surgery.

Dr. Cameron also suggested there was a need for “a national group or body” to oversee and guide quality control of all training programs...and he turned to the SSAT to take on that role. But the fear of possible fragmentation of Surgery as a discipline as we knew it then probably played a role against following Dr. Cameron’s advice.

The following decade witnessed many independent but convergent changes. Laparoscopic surgery emerged as an innovative technology and fellowship training programs in laparoscopic surgery proliferated with 40 fellowships started by 1998.

During these early years, the program directors of many of these fellowships met to share experiences and explore options for improving advanced GI Surgery training. This led to
the informal creation in 1997 of the Minimally Invasive Surgery Fellowship Council. Four years later, the Fellowship Council incorporated into the Council of Fellowship Directors.

Yet, there were concerns that these fellowships were mostly based on a new technique...laparoscopy, rather than a comprehensive and cognitive curriculum.

These concerns were expressed by Dr. Carlos Pellegrini in his 2000 Presidential Address, in which he stated that these new fellowships gave disproportionate importance to “Technique” over the cognitive aspects of “Discipline”.

In addition, Dr. Pellegrini expressed concern about the proliferation of informal, heterogeneous, unsanctioned, not-accredited fellowships. To this end, Dr. Pellegrini established a Tri-Society Council, which brought together the SSAT, SAGES, and AHPBA. The Tri-Society Council developed guidelines and set goals for fellowship training, including added exposure to complex GI and Hepato-pancreato-biliary conditions, competence with endoscopy, skills in laparoscopy, and appreciation of the multidisciplinary care required by the GI patients. In 2004, the Tri-Society Council and the MIS Fellowship Council merged into a single organization -- The Fellowship Council.

The SSAT is one of five sponsoring surgical societies of the Fellowship Council and our members hold key leadership roles within it. Dr. Rebecca Minter is the current President and Dr. Rohan Jeyarajah is the current Vice President. Dr. Matt Hutter is our SSAT representative and he is a member of the Board of Directors. All three are SSAT members.

One of the most important functions of the Fellowship Council is to accredit fellowship programs that meet established criteria of education and experience for fellows. Currently, the Fellowship Council oversees some 220 accredited fellowship positions in more than 150 programs.
Obviously a lot of progress has been achieved since Dr. Cameron’s Presidential Address. But, as my kids would ask, “Are we there yet?” I do not think so.

The issues related to fellowship training are tied to the questions about restructuring surgical residency, inasmuch as most people feel that post-residency fellowships need to be recognized as part of overall surgical training.

In recognition of the contrast between the rigidly structured five year training in general surgery and the ever increasing number of graduated general surgery residents embracing specialized training with post-residency fellowships, the American Board of Surgery and the RRC for Surgery in 2011 began allowing general surgery residency programs some flexibility in training, with as many as 12 of the 36 months of senior residency spent in a single content area as long as all requirements were met by the end of residency. It was envisioned that this added flexibility would favor Early Specialization Training, with trainees able to track to their area of subspecialty interest sooner than traditional residency training would allow. Preliminary results from a pilot study implementing this added flexibility indicate overall satisfaction by the residents with this new training option. Understanding the full potential of this new flexibility rule could ultimately result in understanding how to better integrate residency and fellowship training in the continuum of surgical education.

The quality of the general surgery training has been of deep concern to the American Board of Surgery for some time now. Recent legislation such as the 80-hours work limit and the increased mandated resident supervision with consequent decreased resident autonomy have created changes in our general surgery training programs that some fear have impaired our ability to produce a competent general surgeon by the end of five years of training. This seems to be supported by the worsening performance in recent years by graduated residents on the
ABS certifying exam and the increasing percentage of graduating residents embracing additional post-residency training. At recent count, more than 80% of graduating residents seek additional training in one of the many available fellowships.

However, the abundance of post-residency fellowship opportunities means that requirements for uniformity are needed so residents can be assured of getting comparable quality experience no matter what specialty or what program they choose. The present system doesn’t assure this level of uniformity.

Our Society is one of several surgical societies with a representative to the ABS Board of Directors. Dr. Ronald Tompkins was our first representative, followed by Drs. Keith Kelly, David Fromm, and Ted Pappas. Our current representative is Dr. David Mahvi, who also is the current Chair of the Board of Directors. His term expires in June when he will be replaced by Dr. Joe Hines.

In recognition of several surgical disciplines becoming mature and somewhat different in the landscape of surgical training, the ABS established several advisory councils in 2005.

The GI Surgery Advisory Council (GISAC) was charged to report to the board and to the GI surgery community on matters of interest such as training, certification, and maintenance of certification. The initial chair was Dr. Keith Lillimoe; he was followed by Drs. Ted Pappas, Chris Ellison, and Ken Sharp. The current chair is Dr. John Hunter, Past President of the SSAT: he will become Vice Chair of the ABS Board of Directors in June and Chair of the Board of Directors in 2016. In addition, Dr. Nat Soper is the current SSAT representative to the GISAC.

With Dr. David Mahvi assuming the Chairmanship of the Board of Directors of the ABS last June, a discussion was initiated regarding options to more closely align fellowship training with core residency training. At a Board retreat earlier this year, a motion was carried that the
ABS consider the possibility of changing the timing and the requirements for the written Qualifying and oral Certifying Examinations.

Although the specifics still need to be worked out and the proposal has substantial levels of complexity, it is envisioned that residents would be allowed to sit for the Qualifying Examination after their fourth year of general surgery training. They would then be eligible to take the Certifying Examination after completion of additional training, for sure another year, probably two. The training between the two examinations would be designed to facilitate transition to practice and could be focused on specialty training.

In a 4+2 design, fellowships training programs could become a structured continuation of a core general residency training program. Fundamental to such a design would be assurance, at the level of the ABS, of a quality competency-based curriculum, definition of appropriate milestones to measure fellows’ progression, and a meaningful oversight process with strict evaluation of faculty, facilities, and experience of the trainees. Although relevant to many surgical specialties, this decision is very relevant to the SSAT as far as GI surgery training is concerned.

As I mentioned at the beginning of my talk, there is another issue of potential importance on the horizon: it appears that, for the first time, the American Board of Medical Specialties might be willing to allow the ABS to confer certificates of additional qualification to individuals who successfully complete an accredited non-ACGME fellowship after passing one or more examinations.

The American Board of Medical Specialties Task Force on Recognition of Added Training, co-chaired by Dr. Jo Buyske, Associate Executive Director of the ABS and a member of our Society, has recently approved the concept of awarding these certificates. A proposal with
specific requirements was sent to COCERT – the Committee on Certification, Subcertification and Recertification - where it was received favorably. COCERT will now put the proposal up for a vote by ABMS board of directors at one of their future meetings.

And here lies the opportunity for specialty societies and specifically for the SSAT. If we combine the recent decision by the ABS to develop a method to more closely align fellowships with core surgical training with a possible favorable vote by the American Board of Medical Specialties on awarding certificates of additional qualification to graduates of approved non-ACGME fellowships, we could envision specialty societies, such as the SSAT, defining fellowship curricula, conceiving competency-based training, providing program accreditation, and supplying content for a final examination. The ABS would then issue a certificate of added qualification after successful fellowship and examination completion.

For GI Surgery, this curriculum could be composed of two years of advanced alimentary tract rotations...or one year of advanced alimentary tract rotations, followed by one year of rotations focused on a component of the GI tract: foregut, hepato-pancreatico-biliary, bariatric, or even colorectal.

So, what opportunities have we had so far to engage in this process, to offer our collective expertise, and to shape the parameters of change rather than waiting passively for changes to be dictated to us?

Under the auspices of the Fellowship Council, the SSAT and SAGES have formed a Joint Task Force on Upper GI Fellowships and Training with the purpose to define the boundaries of an upper GI fellowship, consider what a curriculum would include, and what a certificate process for an accredited upper GI fellowship would look like.
The Task Force is co-chaired by Dr. Matt Hutter, who is our SSAT Representative to the Fellowship Council and Dr. Aurora Pryor, the SAGES Representative, and it sees Drs. Moriyama, Zenilman, and Soper as SSAT members and Drs. Swanstrom, Mellinger, and Scott as SAGES members. Dr. Rebecca Minter, President of the Fellowship Council, is a member as well.

The task force has already started to define the appropriate curricula components. Although technical skills such as diagnostic and therapeutic flexible endoscopy and advanced laparoscopy will be included in the curriculum for sure, the curricular modules will be more disease based rather than technique based, a recognition of the concept of “Discipline” fostered by Dr. Pellegrini 15 years ago.

This task force was initiated in anticipation of the potential opportunity for societies to partner with the ABS in the near future around the development of standards for the assessment of competence in surgical subspecialty domains not overseen by the ACGME. Obviously this is an opportunity for us, the SSAT, to share our knowledge and expertise, but in my opinion it is not the only opportunity. In fact, although one could think that the task of providing well-defined fellowship curricula could be conveniently allocated to specialty societies for their expertise and focus, this allocation does not serve the need to define the curriculum for broader training in GI surgery.

This broader training, an Advanced Alimentary Tract Surgery Fellowship if you will, speaks to the breadth and depth of experience necessary to provide effective and safe care to patients outside of the tertiary and quaternary medical centers. The product of this training would be surgeons at ease with both elective and emergent operations, with upper and lower GI conditions, with laparotomy and laparoscopy, and with basic diagnostic and therapeutic endoscopy.
And, here again, this offers another opportunity for the SSAT to exercise leadership. This is where we are in a unique position, having at our core the interest of all GI organ-based disciplines. Working with sister specialty societies in a cooperative and mature way, we can serve as a leader to meld specialized curricula and create outstanding training programs that would unify GI surgery – not fragment it. These programs would attract the best and brightest of our graduating chief residents to produce well-trained surgeons that the public will trust.

Through both these projects and additional initiatives, we can position ourselves to play an important role in the overall re-design of GI surgery training, rather than sit on the sidelines and wait to be handed a final product. Our involvement is important not just for the training of the next generation of GI surgeons, but also for the future relevance and growth of our Society.

I think it is clear that an emphasis on training will eventually pay major dividends for our Society. Without a structured and integrated training program, the “best and brightest” will gravitate to other sister surgical disciplines, which already have a more formalized training program and possibly a Board recognition. For example, disciplines such as Complex General Surgical Oncology or Colorectal Surgery or Thoracic Surgery or Acute Care Surgery each deal in whole or in part with disorders of the gastrointestinal tract. If we abdicate training on the treatment of malignant GI disorders to surgical oncologists and colorectal disorders to colorectal surgeons and esophageal disorders to thoracic surgeons and acute conditions to acute care surgeons, not much will be left for us to take care of and our relevance will be greatly lessened.

As such, we, the SSAT, need to assume a leadership position in defining advanced GI surgery training for the development of the next generation of GI surgeons and for the continued relevance and preeminence of our Society.
To this end, I have decided to establish a Presidential Task Force on Advanced GI Surgery Training.

It will be composed of thoughtful SSAT members who have been active in discussions on advanced GI surgery training in the SSAT, the American Board of Surgery, the Fellowship Council, and the RRC for Surgery, as well as other specialty societies.

The Task Force will have a three-year charter. At the end, it could morph into a committee, be sunsetted, or be approved for a second three-year term by the SSAT Board.

It will be the purview of the Task Force to decide which aims to undertake. Yet, without having the presumption to be comprehensive or the desire to be prescriptive, I would offer a preliminary agenda of topics to discuss:

1. As I have mentioned earlier, the SSAT/SAGES Joint Task Force on Upper GI Fellowships and Training has been charged to provide a competency-based curriculum in Upper GI surgery. The Task Force could very well decide to offer support and expertise to our representatives in this critical process.

2. As I alluded to earlier, the need for a broader Advanced Alimentary Tract Surgery Fellowship is greater now than ever in the past. The products of these fellowships would be trainees seeking broad knowledge of gastrointestinal disorders and less specialized knowledge in each GI subcomponent to respond to the need of the public away from tertiary and quaternary medical centers. The Task Force could very well define the optimal curriculum for this fellowship training.

3. The Task Force should work within the Fellowship Council to develop a stringent accreditation process and provide expert content for the development of a high-stakes
terminal examination. This can be done and should be done irrespective of whether the General Surgery training is restructured or not.

4. Funding of training positions through The Foundation for Surgical Fellowships is rapidly dwindling due to the multitude of fellowship training programs requiring support and the diminishing support from Industry. We need to look at alternative funding sources and the Task Force may want to indicate new and innovative ways to support advanced GI surgical fellowships.

5. Finally, should the SSAT develop enduring educational products or consider the establishment of an Educational Institute for GI Surgery Fellows?

I see many opportunities which the Task Force should consider. But to assure a tangible and actionable product at the end of the deliberations, I will ask the Chair of the Task Force to update the SSAT Board of Trustees at each Board meeting over the next 12 months and to produce a white paper by no later than one year from now.

During the second and the third year, the Task Force will help with the implementation of the actionable and approved recommendations.

Our Society has had an influential role in shaping GI training over the last three decades. In order to be true to the educational mission of the Society, to ensure the training of the next generation of GI surgeons, and secure quality GI surgery for the American public, we must continue our relevant role in the landscape of advanced GI surgery training.

Nobody knows exactly what advanced GI surgery training will look like in a few years, but I know we’re at a critical junction that will define it for many years to come.
The task is large and complex...but we certainly have the right people...right here...in this room....the SSAT...the leaders in GI surgery...to accomplish it.

Let’s rise to the challenge and create a modern path for the training of the gastrointestinal surgeon of tomorrow.

Let’s follow in the footsteps of the past masters so that future leaders of our Society will point with great pride to our landmark accomplishments that benefited our specialty...surgery in broader terms...and the public as a whole.

Thank you for your attention.
GASTROINTESTINAL SURGERY ADVISORY COUNCIL
(GISAC)

DEFINITION OF GENERAL SURGERY

Preamble:

The below definition of General Surgery was developed by the General Surgery Advisory Council (GENSAC) of the American Board of Surgery. With this, the GENSAC hopes to define the General Surgeon in practice (often in a rural or resource-limited environment with few specialists accessible) and hopes to aid in the General Surgery residency redesign process by defining a potential end point for General Surgery residency training. We offer this definition for review and comment by the Component Boards and Advisory Councils of the ABS.

Definition of General Surgery:

General Surgery is a discipline that requires knowledge of and familiarity with a broad spectrum of diseases that may require surgical treatment across a wide age span, including the very young and very old. By necessity, the breadth and depth of this knowledge will vary by disease category. In most areas, the general surgeon will be expected to be competent or proficient in diagnosing, treating and providing perioperative care for the full spectrum of disease from the commonest to the most complex situations. This may include treatment of uncommon diseases and/or specific populations (e.g., extremes of age, the morbidly obese) for which a surgeon acquires expertise resulting from additional training or experience.

By virtue of an individual’s specific training, general surgeons are able to perform complex emergency procedures and can work in environments where resources and specialty support may be limited.

Comprehensive knowledge should be gained by training in the following areas:

- Abdomen and its contents
- Alimentary tract (to include endoscopy skills)
- Breast, skin and soft tissues
- Endocrine system
- Hernia
- Surgical critical care
- Surgical oncology
- Trauma and emergency surgery
- Vascular surgery
- Thoracic surgery
Among the many challenges currently facing postgraduate medical education, one ongoing tension is how to best support the growth and advancement of specialty education with national standards of excellence, while trying to ensure an appropriate blend of generalist and specialist physicians to meet the health human resource needs of Canadian society, and without causing harm to the existing system.

A draft proposal for the creation of new category of Royal College discipline recognition, driven by feedback from Fellows from the Core Competency Report was first presented to the Royal College Committee on Specialties (COS) in April 2009.

After embarking on a broad national consultation with Fellows and key stakeholders, the Royal College Council approved the Areas of Focused Competence (Diploma) Program on February 25, 2011.

Areas of Focused Competence (Diploma) Programs

The format for diploma programs:

- Typically 1-2 years of additional training, but competency-based
- Built upon training in a broader discipline
- Supported within the existing Specialty Committee of the primary discipline (unless one does not currently exist)
- Assessed through summative portfolio
- Training programs accredited by the Royal College (C Standards)
- A separate annual dues fee and Maintenance of Certificate (MOC) requirements
Candidates successfully completing all requirements of an approved program and who annually maintained their status as a Diplomate or Diplomate Affiliate of the Royal College would receive an added qualification known as a Diploma of the Royal College of Physicians and Surgeons of Canada, or DRCPSC. Members with a DRCPSC will be known nationally, and internationally, as individuals who have sought to advance their knowledge and expertise with additional complementary skills and competencies.

Implications for Royal College Fellows and Other Stakeholders

By introducing a mechanism to recognize established disciplines of medicine that enhance scope of practice, the diploma programs will:

- Establish national standards for training and specialist competence, thereby improving quality of care and patient safety;
- Avoid unnecessary fragmentation of specialty training, care and practice by mitigating the recognition of subspecialties;
- Provide Fellows with another opportunity to acquire nationally and internationally portable credentials, DRCPSC;
- Offer universities opportunities to enhance the academic environment, with new nationally accredited programs; and
- Provide a mechanism for the Royal College to formally recognize disciplines that meet a legitimate societal health need, but that do not meet the current criteria for a primary specialty or subspecialty.

Current Status

The Committee on Specialties will consider diploma applications two times per year, at their fall and spring meetings.

As of April 2014, the following AFC (diploma) disciplines have been formally approved by the Education Committee of the Royal College:

Adolescent and Young Adult (AYA) Oncology
Adult Cardiac Electrophysiology
Adult Echocardiography
Adult Thrombosis Medicine
Aerospace Medicine
Brachytherapy
Child Maltreatment Pediatrics
Clinician Educator
Cytopathology
Hepatology
Hyperbaric Medicine
Interventional Cardiology
Solid Organ Transplantation
Sport and Exercise Medicine
Transfusion Medicine
Trauma General Surgery
Core Curriculum for American Society for Metabolic and Bariatric Surgery
Fellowship Training Requirements

COGNITIVE EXPERIENCE:

In addition to the clinical and technical experience, it is expected that the fellow will also participate in non-clinical educational endeavors. These activities must be documented and validated by the Program Director.

A. Didactic Educational Sessions Required:

It is mandatory that all fellows and at least one mentor attend these sessions. The fellow must document that they participated in at least 80% of meetings. Our ASMBS Fellowship Sign Off Sheet can be used for this required documentation. The didactic sessions may include specially designated bariatric textbook review sessions, journal clubs, peer-review conferences, and resident teaching rounds. The following topics must be covered during the fellowship:

1. Epidemiology of Obesity
2. History of Bariatric Surgery
3. Physiology and Interactive Mechanisms in Morbid Obesity
4. Preoperative Evaluation of the Bariatric Patient
5. Psychology of the Morbidly Obese Patient
6. Essentials of a Bariatric Program
7. Postoperative Management of the Bariatric Patient
8. Laparoscopic versus Open
9. Laparoscopic Adjustable Banding
10. Other Restrictive Operations
11. Gastric Bypass
12. Biliopancreatic Diversion/Duodenal Switch
13. Revisional Weight Loss Surgery
14. Managing Postoperative Complications
15. Nutritional Deficiencies
16. Obesity in Childhood and Adolescence
17. Outcomes of Bariatric Surgery
18. Role of Endoscopy in Bariatric Surgery

B. Management Conference Requirements:

Fellows are expected to participate in at least quarterly morbidity and mortality (M&M), including quality improvement and peri-operative management conferences. Participation must be documented.

C. Research Requirements:

Fellows are expected to conduct research and are expected to complete at least one clinical and/or research project during the fellowship and submitted to a National or Regional Society. The research project need not be accepted for presentation by the conference or for publication in the journal to which it was submitted.
D. Multidisciplinary Conference Requirements:

Fellows are expected to participate in regular bariatric multidisciplinary conferences. They also must attend at least one patient support group and one patient educational seminar.

CLINICAL AND TECHNICAL EXPERIENCE:

A. Surgical Operation Requirements: In order to meet the designation of comprehensive training, fellows must be exposed to more than one type of weight loss operation and participate in at least 100 weight loss operations. The fellow should have assumed the role of primary surgeon in at least 51% of cases, defined as having performed the key components of the operation. There should be a minimum of: 50 intestinal bypass operations (Roux – en Y Gastric bypass or Biliopancreatic Diversion +/- Duodenal Switch); a combined total of 10 Restrictive operations (Sleeve Gastrectomy operations and/or Adjustable Gastric Banding procedures); 5 Revisional procedures; and exposure to and/or extensive teaching of bariatric-specific emergency procedures (leaks, bowel obstructions, internal hernias, intussusceptions, gastrointestinal hemorrhage and ulcers), as deemed adequate by the program director to establish competence in managing these complications. Fellows should also have an exposure to endoscopy (as attested by the Program Director eventually to be evaluated by a competency tool effective 2014.)

New in 2015: Should a fellow be unable to complete the minimum number of surgeries during their fellowship program, fellows can complete any additional needed surgeries with in the first year after the completion of their fellowship program. If minimum surgeries are completed within one year of the end of their fellowship, fellows are still eligible and can then apply for a Certificate of Acknowledgement for Satisfactory Training in Bariatric Surgery from the ASMBS.

B. Evaluation Requirements:

The fellow will participate in 50 patient preoperative evaluations, 100 postoperative in-patient management encounters, and 100 postoperative outpatient evaluations. Documentation required.

C. Performance Assessment Synopsis:

The Program Director will be responsible for conducting at least 2 fellow performance assessment interviews and providing the ASMBS with a brief synopsis of the meeting.
GASTROINTESTINAL SURGERY ADVISORY COUNCIL
(GISAC)

REVIEW OF SCORE GENERAL SURGERY CURRICULUM IN
GASTROINTESTINAL SURGERY

SCORE seeks input from the GISAC on the SCORE content outline for General Surgery residency training. Every other year, SCORE will ask for your input as a content expert group. We would like the GISAC to review the following content to determine whether (a) important content is currently omitted; or (b) content is included that is beyond the scope of training for a General Surgery resident. Additionally, if you believe content that is currently listed as “core” should be moved to “advanced” (or vice versa), we would appreciate that input as well. As content experts, we believe you are uniquely suited to advise SCORE, as technology and disease management issues can change over time, impacting the content of the curriculum outline.

We ask that you discuss this at the June ABS meeting and send any recommendations for change to Mary Klingensmith and Mark Malangoni after the meeting. Mary and Mark will collate the suggested changes and submit them to the General Surgery Residency Committee (GSRC) of the ABS at the January meeting for consideration and action by the GSRC. (It is the GSRC that ultimately decides on the content outline for the SCORE General Surgery curriculum, and it considers the advice of many different stakeholder groups to determine the content for General Surgery residency.) After the GSRC meeting in January, Mary and/or Mark will report back to the GISAC regarding the actions of the GRSC on your recommendations.
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