Pursuing Fellowship Training in Colorectal Surgery: A Candidate's Perspective

Vincent J. Obias, M.S., M.D.¹

ABSTRACT

Colorectal surgery is a fulfilling profession that has become more difficult to match into. There are many factors that go into choosing a career in colorectal surgery. Having a mentor as a colorectal surgeon, performing research in colorectal surgery, and being involved with the American Society of Colon and Rectal Surgeons are all important aspects in providing exposure to young surgeons in training and guiding them toward the field of colorectal surgery. Once the decision has been made, the application and interview process can be daunting. This article reviews salient points about the process I took in choosing colorectal surgery and the steps I took in applying and interviewing for my fellowship.

KEYWORDS: Fellowship, application, interview, colorectal surgery

Objectives: Upon completion of this article, the reader should be able to summarize the issues associated with choosing a career in colorectal surgery and the application and interview process for fellowship in colorectal surgery.

When I recall making the decision many years ago to enter the field of general surgery, I know I made the right choice. Throughout my years as a general surgery resident, my teachers and mentors have given me a solid foundation in care of patients and surgical technique that has carried me through all of my most challenging moments. Yet, as fulfilling as it was to solve problems in those diverse settings, it was not long before my interest in general surgery evolved into a particular *pursuance* in colorectal surgery.

ENTERING THE FIELD

As a young surgeon in training, I developed an early interest in the specialty field of colon and rectal surgery. Anorectal cases such as hemorrhoidectomy often fell to junior residents. In addition, we were fortunate at our institution to have colon and rectal surgeons on our

teaching faculty. This provided an early exposure to the role this specialty plays in the management of patients with diseases of the colon and rectum. As a result of this clinical experience, I saw a field that was much more than an extension of general surgery.

THE VALUE OF MENTORSHIP

One particular colorectal surgeon shaped my view of the field through his verve and intellectual curiosity. At the time, he was a surgeon in a private general surgery group practice, and his partners found his expertise in colorectal surgery invaluable. He pursued research opportunities and encouraged my enthusiasm for the field by involving me in projects. He fostered my personal and professional growth while painstakingly guiding me through my first presentations and also by introducing me to his colleagues at local colorectal society meetings.

¹Department of Colorectal Surgery, Cleveland Clinic Foundation, Cleveland, Ohio.

Address for correspondence and reprint requests: Vincent J. Obias, M.S., M.D., University Hospitals Health System, Colorectal Surgery, 11100 Euclid Ave., Cleveland, OH 44106-5047. E-mail: vobias@ccf.org.

Career Development; Guest Editors, Harry T. Papaconstantinou, M.D., H. David Vargas, M.D.

Clin Colon Rectal Surg 2006;19:109-113. Copyright © 2006 by Thieme Medical Publishers, Inc., 333 Seventh Avenue, New York, NY 10001, USA. Tel: +1(212) 584-4662. DOI 10.1055/s-2006-948020. ISSN 1531-0043.

His mentorship and contagious, inquisitive energy fueled my own enthusiasm for a career as a colon and rectal surgeon.

INCREASING PROFESSIONAL GROWTH

Involvement in local colorectal societies is an important way to become introduced to the field, gain experience in research presentations, and network with local colorectal surgeons. A listing of local colorectal societies as well as conferences is on the American Society of Colon and Rectal Surgeons (ASCRS) website.¹ Active involvement in research is a vital aspect of any resident training and an excellent way to be exposed to a field. Being intimately involved in gathering and analyzing data, forming an abstract, presenting the data at conferences, and writing a paper solidified my interest in colorectal surgery. Beyond the process, research also allowed me to explore the boundaries of the field where many questions were left unanswered. I was fortunate to be able to interact with experts in the field at local and national conferences where my abstracts were being presented. Most important, attending conferences also gave me a good glimpse of many fellowship opportunities. The annual ASCRS meeting, for example, provides a great venue for residents to present research and meet various fellowship directors. At the ASCRS resident's breakfast, you have time to introduce yourself to various fellowship directors, and by participating in evening activities a resident can meet his or her peers in a relaxed atmosphere.

Another good way to expand your knowledge of colorectal surgery is to do an elective away rotation. Going to an institution that exclusively focuses on colorectal surgery was an eye-opener and provided me the opportunity to observe the styles, teachings, and techniques of other colorectal surgeons in a high-volume referral center practice.

THE APPLICATION PROCESS

Once the decision to pursue formally colorectal surgery has been made, the application process begins. Residents must be fully aware of all deadlines. Do not just rely on information from one website or program. Rather, contact all programs you are interested in and find out their specific schedules. Using the Electronic Residency Application Service (ERAS) has simplified the application process, but getting into colorectal surgery has become increasingly competitive, and it is important that your application is both complete and on time.

The ASCRS website is an invaluable source in the application process. It should be used extensively, as it has information on all the fellowship programs including contact information. Applying as early as possible is important. This may seem obvious, but interview slots fill up early. By applying early, one can best schedule

interviews with programs by geographic location. One of the challenging aspects of applying for a fellowship is that the process occurs during surgical residency. This is especially true regarding colorectal fellowship application and interviews, which take place during the chief residency year. This tends to be the busiest time for a resident as well as the time when you have the most responsibility. Applying early can help coordinate interviews away from important dates and gives a resident time to coordinate coverage for his or her service. If there were one aspect I could change about the application process, it would be applying during the fourth year of residency and not during the chief year.

The next process in applying is obtaining recommendations. Recommendations from your mentor and your chairman are important. Strong recommendations from prominent colorectal surgeons are excellent, and a good recommendation from someone who knows you well and what your strengths are is better received than a generic recommendation from a prominent surgeon you barely have contact with. Ideally, you have met and interacted with a colorectal surgeon. The colorectal world is small and any little edge helps. When you have your recommendations, you can actually choose which recommendations to send to the various programs via ERAS. Use this to your advantage and send recommendations from individuals with association with those programs.

CHOOSING YOUR PROGRAM

One of the most exciting yet frustrating aspects of applying is determining the programs to which you would like to apply. This is where a mentor in colorectal surgery can be invaluable. Attending local and national colorectal meetings and conferences and interacting with surgeons helped highlight various programs. Other good resources include the FASCRS.org website and individual program websites. Once you begin to read about the fellowships, it is soon apparent that many programs have only one or two fellowship positions. Even if you feel you are a strong applicant, are you in the top one or two in a program's rank list? With a match rate of only 61% in 2005,² it is important to apply and interview at several programs.

I assessed many aspects of each program during my evaluation. Important aspects were operative and patient volume, experience of the staff, laparoscopic and anorectal physiology experience, reputation of the staff and department, research opportunities, and how the current fellows felt about training at their institution. I had no absolute minimum for the number of operative cases performed by fellows. However, there are certain core competences that all fellows must fulfill in a year, and I would ask whether there were any areas of deficiencies. The American Board of Colon and Rectal Surgery defines standards, which are outlined in their Operative Procedure Standards Policy (Table 1).

**Table 1 American Board of Colon and Rectal Surgery
Operative Procedure Standards Policy**

Procedure for hemorrhoids	34	Colonoscopy	138
Abscess/fistula	32	Segmental colectomy	37
Procedures for fissures	9	Low anterior resection	11
Pilonidal etc.	12	Abdominoperineal resection	14
Anoplasty	5	Resection for Crohn's	4
Transanal excision/tumor	7	Resection for CUC/FAP	3
Prolapse procedure	4	IPAA/coloanal	7
Rigid sigmoidoscopy	20	Stoma procedures	19
Flexible sigmoidoscopy	25		

Trainees with insufficient numbers in five or more categories are not allowed to enter the certification process until they are able to fulfill categorical numbers. September 2000.

CUC/FAP, chronic ulcerative colitis/familial adenomatous polyposis; IPAA, ileal pouch anal anastomosis.

An area that many interviewees really wanted in their fellowship was extensive experience in laparoscopy. A colorectal surgeon coming out of a fellowship does not need to be an expert but should be competent in the basics of laparoscopic surgery. More and more studies are coming out demonstrating the safety and benefits of laparoscopic surgery, and programs should provide a fellow with at least 25 laparoscopic colectomy cases over the year.

Another objective source in assessing a program is the Residency Review Committee (RRC). Each program is assessed by the RRC. It is important to ask how the program did in its last evaluation and whether there were any issues or recommendations. This can be discussed with the current fellows or program director. In brief, the RRC mandates that a program must teach six core competences: patient care that is appropriate, medical knowledge in the field, practice-based learning and improvement, interpersonal and communications skills, professionalism, and system-based practice. A program should also have a didactic program that includes anesthesiology, radiology, and pathology of the colon and rectum as well as care of intestinal stomas. In the clinical requirements, a program should have sufficient volume, training in colonoscopy, and training in an outpatient facility or clinic. The full Accreditation Council for Graduate Medical Education (ACGME) common program requirements can be found on their website.³

Many times a program director would show the applicants a case load report from the previous year to provide an overview of the types and volume of surgery available. In assessing the anorectal physiology experience, it was important to ascertain whether there was a laboratory, how the fellow was integrated into it, and the current fellows' experience.

Talking with the current fellows is very important as they provide an all-important insider's perspective. If I did not have a chance to talk with the fellows during my initial interview, I would make it a point to contact them shortly thereafter. Generally, fellows offer honest and

forthcoming information about the strengths and weaknesses of a program that may not be gleaned from other objective assessments. However, these are subjective opinions, and a fellow who is unhappy may not be providing unbiased information. On the other hand, if current and former fellows express dissatisfaction or disappointment in their fellowship experience, this may be a legitimate red flag.

Speaking with the current fellows also provides insight into potential career options and job opportunities. Fellowship training leads to our ultimate goal of a career in colon and rectal surgery. If one desires a career in academic surgery, are the current fellows pursuing similar career paths? What are their experiences in terms of job interviews and recruitment?

One important aspect of a program that is hard to quantify is reputation. A program that is well known locally and nationally would help me procure a job after completion of the fellowship program. There are many excellent programs, but some are smaller than others. I was concerned about programs that were young, had problems, or had only one fellow. There are many excellent programs with only one fellow, but if there was only one, it was important to talk about how structured his or her experience was and how many responsibilities the fellow had. It was easy to see that one fellow in a group of three or more attendings could be pulled in many different directions if the program lacked structure. The best way I found to determine reputation was to discuss the programs with my mentor and chairman while also talking with other applicants. This helped me determine which programs were well known and how some programs were doing.

Unfortunately, some programs that were discussed on the interview trail were unjustly labeled. This did not affect my decision to interview at these places, and many of the rumors were wrong, but there were many people on the interview trail who stated that they were avoiding certain programs because of a negative reputation or supposed turmoil in that program.

A mixture of both new and more mature attendings within a program was important. A program with surgeons who have trained in different programs or during different eras could teach varied techniques and different points of view in the management of colorectal diseases. I also wished to participate in a program where I would be trained only by colorectal surgeons. Some programs had their fellows rotate through general surgery. A fellowship is only 1 year, and I felt it was important to do only colorectal surgery during that time.

A program with a good research department was also important to me. I was not sure whether I wanted to do academic or private surgery, but a program that had active research allowed me to pursue projects during my fellowship and help me venture toward an academic track. Now, traditional academics usually involve a

university hospital setting where becoming a junior attending means that research will be a major part of one's career. Interestingly, most colorectal fellowships are not in this setting. Many fellowships are actually in private groups with some association with a university. Some do have resident involvement, but most do not involve basic science. Thus, an "academic" surgeon can mean different things: one can go the traditional university setting route or one can join a group that trains colorectal surgeons, which is mostly in a private group setting. I felt research would help give me access to either group depending on my interests.

LARGE VERSUS SMALL PROGRAMS

One of the first steps applicants can take in choosing which program to apply to is determining the style of program they are interested in. There is a good variety of fellowships out there. Some programs are large, with four or five ACGME fellows and one or two international fellows, and some programs are smaller, with only one fellow. There are obvious advantages to both scenarios. Some are major referral centers, affording the fellows opportunities in managing rare diseases or complicated cases. In a program with many fellows, work and call coverage can be spread out. One can also have a good one-on-one experience with an attending with many fellows. For instance, at the Cleveland Clinic in Ohio the fellows are assigned to one attending per month and do everything they do (clinic, endoscopy, operating room). This one-on-one mentorship allows us to focus on one attending's technique and management style. An obvious disadvantage is obtaining adequate volume and exposure with so many other fellows around. Thus, when reviewing a program with many fellows, really look at the volume of cases. Still, large programs have strong positives such as research opportunities with databases and dedicated research faculty.

The positive aspect of a program with fewer fellows is that volume tends to be good and all of a program's resources are now pooled toward fewer fellows. Smaller programs can offer a more personalized educational experience and can be less hectic than a larger program. Programs that are not in a large tertiary care center, or ones that are not major referral centers, can also give a broad exposure to many colorectal diseases. Sometimes in a large center, you see many rare conditions or a large volume of difficult cases but bread-and-butter cases are disproportionately fewer. Of course, being in a program with few fellows puts more of a work burden onto fewer individuals. These are just generalizations, of course; there are programs that are major referral centers with only two fellows and there are some programs with many fellows that provide a very personalized experience. An important opportunity to determine the positives and negatives of a program is during the interview.

INTERVIEWING

The interview is important as it not only allows you to share your background and skills but also helps you determine the program's pros and cons. Ideally, the interview will consist of an organized day with access to current fellows. A disorganized day with limited access to fellows and negative interviews tended to leave me with a negative impression. During my interview, I tried to get an idea how happy the fellows were in a program, was it what they expected, what they would change, and how much operating they were doing. Interviewing for a colorectal fellowship spot tended to be a great deal less stressful than interviewing for general surgery. There was very little pressure during the interviews as they mostly allowed the program coordinators to get to know me. I tended to ask about operative experience, anorectal physiology exposure, and laparoscopy. I also asked about what rotations the fellows did, what the education curriculum was, and where previous fellows went after their fellowship.

I felt the best interviews were the ones where we arrived the night before and had dinner at one of the attending's houses. This provided a social venue in which to interact with other interviewees as well as talk with the current fellows and attendings outside a hospital setting. During our busy chief year, it was difficult to get the time off, but it was worth it.

After the interview, I sent thank-you notes as soon as possible. It is important to do so after every interview. At some programs, I was told specifically that if I did not send a thank-you note to certain attendings, I probably would not be ranked.

Upon completion of the interview process, the difficult part starts: ranking the programs. Feedback during the interviews and my experience at each institution played a large role for me. Just as in the general surgery match, the colorectal match favors the applicant, and if you like a place, you should rank it higher. For the programs that I had ranked number one or two, I asked both my chairman and my mentor to contact them and put in a good word for me. I also sent that program a second letter stating my interest. Once you have decided which program you want to go to, contact them quickly and tell them your interest because programs tend to meet early and make their rank list quickly after interviews. I do feel that programs rank applicants who express interest in them higher, and sending thank-you notes and having contacts call them is essential.

In trying to determine which program I was interested in, it came down to a variety of issues for me. Is the program in an area with opportunities for my spouse, which programs did I feel comfortable in during the interview, which programs seemed interested in me, and which programs contained the attributes I most looked for in a program? Fortunately, you can revise your

list as often as you wish as long as you did not finalize it or place it after the deadline.

CONCLUSION

Now that I am in my fellowship, I can look back at all the work I put into the application process and know it was worth it. As I watch the competitiveness of the match for colorectal surgery increase from year to year, I feel justified in my decision to interview at many programs. Only in retrospect can I safely say that I went to more interviews than was necessary. Although exhausting, the process did afford me a good look at a variety of programs and challenged me to think very carefully about the type of surgeon that I was to become as I pictured myself in each setting. It also allowed me to meet several prominent surgeons from our specialty as well as meet and interact with other applicants who will become my future colorectal colleagues.

The many terrific people I met during the application and interview process have done exciting work in colorectal surgery and continue to inspire my interest in the field. My fellowship has been everything I would

want it to be. It is demanding, but the amount of surgery I am doing is incredible and the exposure to world-class care for colorectal diseases is invaluable. When I finish my fellowship, I know I will be well trained to handle all colorectal diseases. I attribute my current happiness to all the careful steps I took during my general surgery years and the application process to prepare for my fellowship.

DISCLOSURE

The author is a colon and rectal surgery trainee at the Cleveland Clinic Foundation and the opinions expressed are his own. He has no other conflicts to disclose relative to this article.

REFERENCES

1. www.fascrs.org under regional societies
2. National Resident Match Program (NRMP) website. Colon and rectal surgery fellowship match results statistics for November 30, 2005
3. www.acgme.org under residency review committees and colon and rectal surgery