TRAINING ARCHITECTURE · RAPID RESEARCH PRESENTATION

A three-tier training architecture for restorative reproductive medicine: office diagnostics and tubal cannulation, S-MAP diagnostics, and surgical fellowship

Why restorative reproductive medicine needs its own specialty, and how a credentialing ladder would train and measure it.

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RRM Academy
22nd International Clinical & Scientific Congress for Restorative Reproductive Medicine
Orlando, Florida · October 9 to 10, 2026

How each credential defines completion

Real credentials define completion the same way. They name case categories, set a number in each, and have the program director sign. The ASRM Practice Committee reported that 43% of REI fellows had not performed a tubal anastomosis as primary surgeon. The proposed RRM spine borrows the mechanism and points it at the procedures nobody else certifies. No credential today asks the surgeon to repair the pelvis or to prevent adhesions; this one would.

PATHWAY	BODY · LENGTH	COMPLETION IS DEFINED BY	PELVIOPLASTY AND ADHESION PREVENTION
OB-GYN residency	ACGME and ABOG · 4 years	Case-log minimums: 85 hysterectomy, 60 laparoscopy, 40 hysteroscopy, 10 cystoscopy. Myomectomy is done but has no minimum. Adhesion prevention, tubal repair, and excision are not core minimums, and exposure is often nil	Case-log minimums cover hysterectomy, laparoscopy, hysteroscopy, cystoscopy. No pelvioplasty or adhesion-prevention category.
REI fellowship	ACGME subspecialty · 3 years	ACGME procedural volume guidelines, 2020: 100 oocyte retrievals and 80 embryo transfers, both IVF procedures (mock transfers count), 40 IUI, 30 laparoscopies, 40 hysteroscopies, 10 myomectomies. Tubal anastomosis: no guideline set. Endometriosis: no guideline set. Cystectomy and selective HSG: not listed. 43% of fellows never performed a tubal anastomosis	100 IVF retrievals and 80 IVF transfers required; tubal anastomosis and endometriosis: no guideline set. No cystectomy, no selective HSG, no pelvioplasty, no adhesion-prevention requirement.
MIGS, FMIGS	AAGL · 2 years	Case minimums: 110 minimally invasive hysterectomies, 35 adnexal, 35 retroperitoneal dissections, 35 stage III to IV endometriosis, 30 adhesiolysis, 15 laparoscopic myomectomies, 25 hysteroscopies. Not listed: tubal surgery, selective HSG, wedge resection. Observed median 510 cases and 210 hysterectomies	110 hysterectomies required; tubal surgery, selective HSG, and wedge resection not listed. No pelvioplasty or adhesion-prevention category; adhesiolysis is counted, prevention is not.
RRM surgical fellowship, proposed	**In development · 12 to 24 months, proposed**	**Both required: minimums met in every named category, and director-attested milestones. About 130 proposed key-indicator cases across 13 procedures**	**Required: pelvioplasty. Complex tubal surgery, uterine repair, documented advanced adhesion-prevention technique. All proposed.**
One RRM fellowship, logged (the author, 2018)	*NaPro medical and surgical fellowship · 1 year*	*Case log: 114 laparoscopies (58 robotic), 54 endometriosis excisions, 25 ovarian wedge resections, 28 or more selective HSG with cannulation, about 15 myomectomies, 6 cystectomies, 3 tubal anastomoses, 3 isthmocele repairs, 3 laser diaphragm cases, 8 appendectomies, 40 or more hysteroscopies*	***Logged: tubal, ovarian, and uterine repair, and 8 Gore-Tex adhesion-prevention placements***

The problem

Restorative surgery stays rare for two reasons. Each needs its own fix.

Endometriosis takes 6.7 years to reach surgical diagnosis. Most of that wait sits in primary care. Among couples labeled unexplained, 44% of the women have endometriosis at laparoscopy. 74% of those lesions are minimal or mild. Cycles run on disease nobody looked for.

No board sets a case count for repair that preserves fertility. ACGME residency does set counts. They cover hysterectomy, laparoscopy, and hysteroscopy. There is none for myomectomy, tubal repair, or excision.

REI is the IVF subspecialty. Its volume guideline asks for 100 oocyte retrievals and 80 embryo transfers, both IVF procedures, and sets no number for tubal anastomosis or endometriosis surgery. MIGS teaches advanced laparoscopy, aimed at removing disease and organs. Hysterectomy is the core of its training, a median of 210 in a two-year fellowship. Salpingectomy is routine. Tubal repair has no published category.

Why RRM needs its own specialty

MIGS
Pain
Remove disease and organ. Hysterectomy and salpingectomy, not tubal repair.
End product: The organ removed, the patient back to work

GYNECOLOGIC ONCOLOGY
Cancer
Remove the organ. Survival is the endpoint.
End product: The tumor out, survival

REI
IVF
Bypass the tube. Salpingectomy for hydrosalpinx before IVF.
End product: An IVF cycle, an embryo transferred

RRM
The couple's own fertility
Repair the organ. Preserve it. Prevent adhesions.
End product: A repaired pelvis and the couple's own conception

Three surgical specialties operate in the pelvis. Each is trained toward a different endpoint. MIGS toward pain, with hysterectomy as its core case. Gynecologic oncology toward cancer. REI, the IVF subspecialty, toward IVF. None is trained for natural fertility itself: the expertise to restore function, reconstruct the organ, and support the couple's own conception. The young woman with pain, and the couple who want a fertility-supportive operation, have no specialty yet.

Hydrosalpinx shows the pattern. For communicating hydrosalpinges, the ASRM opinion recommends salpingectomy or tubal occlusion before IVF. The Cochrane review found no trial reporting live birth for salpingectomy versus no surgery. Most evidence is very low to low quality. The operation serves the IVF cycle. Both tubes gone, she cannot conceive on her own. *Yet 7 to 9 years after IVF began, 24% of couples left childless had a baby conceived on their own. That chance exists only while a tube remains. Salpingectomy removes it.*

A specialty is how a field sets a standard, trains to it, and measures whether it held.

The ladder

Laparoscopy draws the line between tiers 1 and 2. Complexity of disease and repair draws the line to tier 3.

TIER 3 · REPAIR
RRM surgical fellowship

WHO	OB-GYN graduates, MIGS-trained surgeons, general surgeons with pelvic skill
DURATION	12 to 24 months, proposed
DOES	Complex repair, certified by case counts and milestones
PROCEDURES	S-MAP mapping on every case, deep excision, complex tubal surgery, wedge resection, ovarian reconstruction, myomectomy, adenomyomectomy, isthmocele repair

TIER 2 · LAPAROSCOPY
S-MAP surgical diagnostics

WHO	General OB-GYNs
DURATION	A short fellowship block, or supervised practice plus log and exam
DOES	Maps the whole pelvis and stages the disease
PROCEDURES	S-MAP diagnostic laparoscopy, stage I to II, plus operative hysteroscopy, cultures, selective HSG
LADDERS TO	Tier 3, as disease and repair grow complex
NEXT	Complex tubal surgery · Excision, including deep disease · Uterine repair · Male factor, with urology

TIER 1 · NO LAPAROSCOPY
Office diagnostics and tubal cannulation

WHO	Family doctors, interventional radiologists, OB-GYNs who do not do S-MAP
DURATION	About three months, proctored, case log
DOES	Answers the early questions, no laparoscope
PROCEDURES	Office hysteroscopy with biopsy and cultures, cervical stenosis treatment, selective HSG with cannulation
LADDERS TO	Tier 2, when laparoscopy is added

What a fellow completes

The proposed credential is a whole program, and the case log is only one part.

CLINICAL CORE	At least 80% case attendance. Primary surgeon on more than half the logged cases. Video review of every robotic case not attended.
DIDACTICS	The RRM medical courses plus a surgical lecture series. Each module ties to a procedure category in the case log.
MENTORSHIP	Three to four hours a month of structured director review against the milestone rubric.
SCHOLARSHIP	Surgical videos: one for the IIRRM or AAGL congress, and more for an online surgical training platform such as SurgeryU. One research project with an innovation. One or two case reports or a series. One public-education piece.
COMPLETION	Minimums met in every category, plus director attestation of milestones. Then a capstone defense of the case list.
MILESTONES	Seen at least once and done at least once: Allen-Masters windows around the rectum, disease on the ureter, disease on the rectum, bowel endometriosis with bowel-resection planning, diaphragmatic endometriosis, appendectomy, Gore-Tex planning and placement.

Which tier owns which competency

COMPETENCY	TIER	WHAT THAT TIER DOES WITH IT
Office hysteroscopy with biopsy and cultures	Tier 1	Vaginoscopic, in office, see and treat minor disease
Chronic endometritis diagnosis and treatment	Tier 1 Tier 3	Tier 1 runs the workup. Tier 3 folds it into repair
Cervical stenosis treatment	Tier 1	Restores access to the cavity, in the office
Selective HSG with tubal cannulation	Tier 1	Sorts true occlusion from spasm. Opens tubes outside the OR
S-MAP diagnostic laparoscopy with pelvic mapping, stage I to II	Tier 2 Tier 3	Every laparoscopy starts with the full survey. Tier 3 repairs what it finds
Operative hysteroscopy: septum, adhesiolysis, polyp	Tier 2 Tier 3	Tier 2 does standard cases. Tier 3 takes the complex ones
Wide excision of endometriosis, stage I to II	Tier 3	Excision, then repair. Tier 2 refers here
Deep infiltrating disease on bowel, ureter, or diaphragm	Tier 3	Specialist repair only. Tier 2 refers it up
Complex tubal surgery, including fimbrioplasty and salpingostomy	Tier 3	Tier 3 only, from distal repair to anastomosis
Wedge resection, myomectomy, adenomyomectomy, isthmocele repair	Tier 3	The full uterine and ovarian repair set

Scope discipline is the safety mechanism. Tier 1 refers what the office cannot reach. Tier 2 maps deep disease and refers it up. The ladder doubles as the referral network.

We want your expert feedback

IIRRM is building a formal postgraduate RRM training program. The surgical track is still in design, and we want to make it the best program it can be before it launches. Everything on this poster is a proposal: the tiers, the procedures, the minimums. Tell us what you would change, what is missing, and what you have learned training surgeons. Find the authors at this poster or at the RRM Academy booth.

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Email your feedback directly, subject line "IIRRM Surgical Fellowship feedback". Or scan the code for the five-question survey.

The 13 procedures, with proposed minimums

These 13 procedures have proposed starting minimums, about 130 major cases in a 12 to 24 month fellowship.

PROCEDURE	PRIMARY	ASSIST OR SIM
S-MAP diagnostic laparoscopy with complete pelvic mapping	40	·
Excision of endometriosis, stage I to II, confirmed on pathology	20	·
Excision of deep infiltrating endometriosis, stage III to IV	10	15
Tissue-sparing ovarian cystectomy with ovarian reconstruction, for endometrioma	10	·
Ovarian wedge resection for PCOS (PMOS)	5	10
Complex tubal surgery: anastomosis, tuboplasty, fimbrioplasty, salpingostomy	10	10
Selective HSG with proximal tubal cannulation	10	·
Fertility-preserving myomectomy	10	·
Isthmocele repair with niche-prevention cesarean technique	5	·
Focal adenomyomectomy	1	5
Operative hysteroscopy: uterine septum resection, adhesiolysis including Asherman syndrome, polypectomy	10	·
Chronic endometritis workup and treatment *diagnostic competency, not a major case*	15	·
Documented adhesion-prevention technique *logged concurrently with other cases*	30	·

Six of the 13 have no published learning-curve data. There the milestone attestation carries the weight and the number marks exposure. Every number awaits ratification.

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Disclosure. The authors declare no competing financial interest. Speaker honorarium and travel support for this congress were provided by IIRRM. A generative AI language model assisted with structural drafting and prose editing; all conceptual claims, citations, and quantitative data were generated and verified by the authors. Icons: Tabler, Health Icons, IBM Carbon.

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