



GASTROENTEROLOGY TRAINING PROGRAM

CURRICULUM AND OBJECTIVES

TITLE OF PROGRAM: State University of New York Upstate Medical University, Gastroenterology Fellowship Training Program

SPONSOR: State University of New York

PARTICIPATING INSTITUTIONS: State University of New York Upstate Medical University, Veteran's Administration Medical Center at Syracuse

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INTRODUCTION: The purpose of this document is to outline the subspecialty education program in gastroenterology fellowship training, sponsored by the State University of New York Upstate Medical University. Fellowship training in gastroenterology is a three-year program, and successful completion of this fellowship training will allow candidates to be eligible for certification examination in the subspecialty of gastroenterology by the American Board of Internal Medicine. The curriculum and objectives in this document are outlined in accordance with program requirements for residency education in gastroenterology, published by the Accreditation Council for Graduate Medical Education (ACGME) in their "Essentials and Information Items", 1996-1997.

A candidate is selected for GI fellowship based on a number of factors. These include, but are not limited to: performance on standardized test; grades and transcripts, letters of recommendation (3); degree of research experience; personal statements; academic interests;

ability to speak and understand English; completion of Internal Medicine Residency training and at least “Board Eligible” status; and interview performance.

Our program has been accredited since 1987. Twenty-two+ fellows have successfully completed our GI Fellowship during this time. To date, all of our GI fellows have been Board Certified.

I. PROGRAM OUTLINE - GENERAL

A. Training in the gastroenterology fellowship program will provide opportunities for fellows to develop clinical competence in the field of gastroenterology, including exposure to hepatology, clinical nutrition, gastrointestinal oncology, radiology, and pathology. While this is a subspecialty program, training will emphasize the trainee functioning as a total physician, internist and consultant, with interest in the entire person and his/her environment.

B. The training program will be three years in duration and will provide the opportunity for the trainee to observe and manage patients with a wide variety of digestive disorders in both the outpatient and inpatient setting.

C. The training program will provide access to the basic and clinical sciences necessary to develop the skills necessary to practice sound gastroenterology.

D. The training program will be designed to teach critical analysis and reasoning relative to clinical and investigative problems in gastroenterology, and to consider choices in light of current cost/benefit analysis.

E. The training program will be designed to teach both cognitive and technical aspects of gastrointestinal endoscopy.

F. The training program will offer in-depth interaction with other disciplines such as radiology, pathology, surgery, pediatrics and nutrition. Principles of psychosomatic medicine will also be taught.

G. While this is primarily a clinical training program, it is recognized that research training is mandatory for all fellows in training and will receive appropriate emphasis.

II. TEACHING STAFF

All Faculty receive training in work hour rules, moonlighting and general policy regarding Fellows' service annually. In conjunction with this training a refresher/review of fatigue recognition and management will be conducted during the annual Fellowship orientation meeting. Strategies for assessing learners for - and helping learners with - fatigue, triage, and stress management will be reviewed at training session. Effective July 1, 2010 a Faculty Attestation form will be completed regarding training documentation. Teaching Attendings are to attend greater than 50% of all required teaching conferences and all appropriate 360 degree evaluations.

A. The following are the full-time key academic staff of the State University of New York Upstate Medical University Gastroenterology Fellowship Training Program:

	<u>BOARD CERTIFIED</u>	
	<u>IM</u>	<u>GI</u>
Philip G. Holtzapple, M.D.	C	C
Uma Murthy, M.D.	C	C
Ronald D. Szykowski, M.D.	C	C
Renee Williams, MD	C	C
Ajoy Roy, MD	C	C
Praveen Sampath, MD	C	E

IM = Internal Medicine GI = Gastroenterology C = Board Certified
E =Board Eligible

B. The following are non-full-time staff (Academic – Emeritus) of the State University of New York Upstate Medical University Gastroenterology Fellowship Training Program:

Robert A. Levine, MD

C. The following are Clinical Adjunct staff of the State University of New York Upstate Medical University Gastroenterology Fellowship Training Program:

	<u>BOARD CERTIFIED</u>	
	<u>IM</u>	<u>GI</u>

D. The following are Research mentor staff of the State University of New York Upstate Medical University Gastroenterology Fellowship Training Program:

III. CONSULTANTS

Scholarly input from outside consultants – Several times a year professorial experts from outside of the program are invited to provide didactic lectures and case discussions of interesting and challenging GI disease. The advent of recorded talks, societal programs such as the ACG universe and didactic material from major scholarly meetings have allowed this function to now include prepared teaching programs. These consultants are of the highest caliber and enjoy a national and often international reputation. The period of each visit varies and may at time be virtual. When possible, interaction with the visiting professors is structured to provide a close, intense, small group experience in which clinical problems are discussed in detail and questions are encouraged to maximize the learning experience. In addition, the consultant (also when applicable) also gives didactic lectures at the State University of New York Upstate Medical University Department of Medicine Departmental Grand Rounds.

IV. RESOURCES

A. General and Patient Population - The participating institutions and facilities for the State University of New York Upstate Medical University are the Upstate Medical University and Veteran's Administration Medical Center at Syracuse. Both facilities are tertiary care referral centers which provide staff support and material consistent with tertiary care referral hospitals. The general medical patient population is diverse and is derived from the population base living in and around the immediate Syracuse area. The Upstate Medical University is the major referral center for central New York servicing outlying facilities from the Canadian border to Pennsylvania. The Veteran's Administration Medical Center at Syracuse serves as the primary referral hospital for a variety of outlying hospitals and clinics and is the major source for veteran's inpatient care in central New York. Additionally, patients are also referred from local military bases.

B. Physical Plant - The Gastroenterology Services at both hospitals have very modern physical facilities that provide adequate office space, as well as individual areas for each type of diagnostic and therapeutic procedures and modalities. Both hospitals share the medical school's library facility which provides an excellent selection of current gastroenterology and internal medicine textbooks and journals.

C. **Inpatient Facilities** - The Gastroenterology Service provides consultative services to patients who are admitted to both facilities as well as occasional patients at Crouse Hospital.

D. **Endoscopic Facilities and Equipment** - The Gastroenterology Services of both hospitals enjoy state-of-the art equipment, which permits safe and skillful performance of the latest diagnostic and therapeutic endoscopic procedures. The faculty at both institutions possesses the technical expertise and access to the equipment to perform the following procedures:

	<u>HSC</u>	<u>VAMC</u>
Upper endoscopy	Y	Y
Colonoscopy	Y	Y
Flexible sigmoidoscopy	Y	Y
Percutaneous liver biopsy	Y	Y
Percutaneous endoscopic gastrostomy	Y	Y
ERCP:		
Diagnostic	Y	Y
Sphincterotomy	Y	Y
Balloon cholangioplasty & paecreatoplasty	Y	Y
Insertion of biliary and pancreatic stents	Y	Y
Endoscopic lithotripsy	Y	Y
Biliary manometry	Y	N
Choledochoscopy	Y	N
Endoscopic laser therapy	Y	N
Endoscopic therapeutic Hemostasis:		
Laser	Y	N
Bicap	Y	Y
Heater probe	Y	Y
Injection sclerotherapy	Y	Y
Variceal band ligation	Y	Y
Argon plasma coagulator	Y	Y
Endoscopic ultrasound - diagnostic	Y	N
Endoscopic ultrasound - therapeutic	Y	N
Esophageal manometry	Y	N

Esophageal pH studies	Y	N
Anal rectal manometry	Y	N
Photodynamic Therapy	Y	N
Capsule Endoscopy	Y	N
Radio Frequency Ablation	Y	Y

Both institutions have state-of-the art fluoroscopy and x-ray equipment available for performing endoscopic procedures requiring the assistance of fluoroscopy. Endoscopic equipment is also available for performing endoscopic procedures outside the endoscopy suites, to include those performed in various intensive care units throughout the hospitals. Both facilities have endoscopic equipment which is completely computerized and utilizing video endoscopy.

V. ROTATIONS

- A. **GENERAL** - The fellows in gastroenterology program will all receive training at both facilities. Rotations at other facilities, which offer specialty training or expertise not available from either institution, will be allowed and encouraged based on the fellows interest. The three year fellowship is divided into 39 four-week blocks or 13 blocks per year. At least 18 months will be devoted entirely to clinical gastroenterology, of which approximately 35% of which will be related to diseases of the liver. The third year of gastroenterology fellowship training will stress research, advance therapeutics to include ERCP and endoscopic ultrasound, and motility training. Training in hepatic transplantation, clinical nutrition, and pediatric gastroenterology will also be encouraged. Off campus electives will preferentially be scheduled during this third year. The fellows will also be exposed to approximately 1-2 months of inpatient consultative rotations during the third year of fellowship. The specific details of the rotations follow.

B. **GENERAL OUTPATIENT CLINIC ROTATION (1st and 2nd YEAR FELLOWS – 9-11 BLOCKS TOTAL)** - Examines and treats scheduled and unscheduled patients with a wide variety of common gastrointestinal conditions. Fellows will also see more acute emergency patients with more complex problems, requiring interaction with surgical and radiology departments at both facilities. Patients are followed for their active problems or referred back to the primary physician. When appropriate, long-term follow up will be continued through the fellow's continuity clinic. Fellows will perform GI endoscopic procedures on such patients after a determination is made that such procedures are required. The second year fellow

will begin to be exposed to motility as well as some advanced diagnostic and therapeutic procedures during this rotation.

GOALS: The outpatient rotation is designed to allow the trainee to gain expertise in handling a multitude of common gastrointestinal problems, not only from a scientific standpoint, but also to include psychosocial considerations. Experience at determining appropriate follow-up intervals and scheduling is also gained, thus develop clinical competence in the field of gastroenterology. All fellows will be assessed for the six competencies as outlined on the Internal medicine Resident evaluation Form, including patient care, medical knowledge base, practice based learning, interpersonal and communication skills, professionalism and systems based learning. Overall all clinical acumen and competence will also be assessed. On going assessment of progress will be included in the evaluation process at all levels.

The first year fellow will be evaluated based on ability to develop a pertinent and coherent differential diagnosis based on a history and physical. The fellow's knowledge of indications and contraindications to medicines, therapeutic plans and endoscopy will be assessed for competency and to ensure adequate progression and maturation.

The second year fellow will be expected to have mastered the basic ability to develop a pertinent and coherent differential diagnosis based on a history and physical and will be evaluated on being able to appropriately focus that evaluation on the gastrointestinal tract. The fellow's knowledge of indications and contraindications to medicines, therapeutic plans and endoscopy will be assessed for competency and to ensure adequate progression and maturation. The fellow should be beginning to master integration of data to form a coherent assessment and plan.

C. INPATIENT CONSULTATIONS (ALL FELLOWS – 11-14 BLOCKS

TOTAL) - During those rotations the fellows consult on patients with gastrointestinal problems, hospitalized on various inpatient wards including general medicine, surgical, pediatric wards, and various intensive care units throughout both institutions. The fellow evaluates patients and advises primary care and specialty services physicians of his diagnostic impressions, recommended diagnostic tests and appropriate therapy. The trainee also performs endoscopic procedures or other GI procedures generated by such patient contacts, under the direct supervision of the attending staff.

GOALS: To evaluate patients who are generally sicker than those seen in the outpatient setting. Complex co-morbid inpatient problems are seen, which aid in the development of factual knowledge, reasoning ability and problem solving. In addition, the trainee learns the art of

consultative medicine, which requires interaction with the primary and specialty physicians to influence the final diagnostic and therapeutic decisions. This activity develops experience with differing levels of “like it” assertiveness and diplomacy. All fellows will be assessed for the six competencies as outlined on the Internal medicine Resident evaluation Form, including patient care, medical knowledge base, practice based learning, interpersonal and communication skills, professionalism and systems based learning. Overall all clinical acumen and competence will also be assessed. On going assessment of progress will be included in the evaluation process at all levels.

The first year fellow will be evaluated based on ability to develop a pertinent and coherent differential diagnosis based on a history and physical. The fellow will also be evaluated on their ability to adequately triaging of consults. Instruction and assessment will be geared toward allowing the fellow to develop his / her knowledge base and clinical experience to that end. The fellow’s knowledge of indications and contraindications to medicines, therapeutic plans and endoscopy will be assessed for competency and to ensure adequate progression and maturation.

The second year fellow will be expected to have mastered the basic ability to develop a pertinent and coherent differential diagnosis based on a history and physical and will be evaluated on being able to appropriately focus that evaluation on the gastrointestinal tract. The fellow will be assessed for their ability to appropriately triage consults and will be expected to be significantly more proficient than during the first year. The fellow’s knowledge of indications and contraindications to medicines, therapeutic plans and endoscopy will be assessed for competency and to ensure adequate progression and maturation. The fellow should be beginning to master integration of data to form a coherent assessment and plan and will be expected to be beginning to transition toward independent inpatient consultation.

The third year fellow will be expected to not only have mastered the basic ability to develop a pertinent and coherent differential diagnosis based on a history and physical but also to be able to appropriately focus that evaluation on the gastrointestinal tract. The fellow should be able to consistently make appropriate triage decisions. The fellow should be virtually competent in his / her knowledge of indications and contraindications to medicines, therapeutic plans and endoscopy will be expected to continue to progress toward being able to practice independently. The inpatient staff will specifically assess the fellow’s ability to integrate of data to form a coherent assessment and plan. This plan should include appropriate use of ancillary services and assessment of the most medically appropriate venue (i.e. outpatient versus inpatient.) The fellow will be specifically assessed for the ability to transition to independent inpatient consultation.

D. ADVANCED OUTPATIENT CLINIC ROTATION (3rd YEAR FELLOW – 6-8 BLOCKS TOTAL) – As with the general outpatient clinic rotation (B. above) the fellow examines and treats scheduled and unscheduled patients with a wide variety of unusual gastrointestinal conditions. The fellows see more acute emergency patients with more complex problems, requiring therapeutic intervention such as with ERCP. The fellow will be allowed to assess patients sent for and to perform the majority of motility and pH studies in conjunction with the attending staff. Patients are followed for their active problems or referred back to the primary physician or gastroenterologist. When appropriate, long term follow up will be continued through the fellow's continuity clinic. The fellow's clinic schedule will be structured so that they can participate in didactic discussions about these cases and so that they can perform or assist in performing all therapeutic and advanced diagnostic at both facilities.

GOALS: To allow a truly didactic setting in which the fellow can be exposed to and learn from complicated cases requiring advanced diagnostic and therapeutic modalities. To give the fellow greater responsibility in determining the best overall care plan for the patients they are consulted on. It is not the goal of this rotation to ensure sufficient skill is developed to recommend independent practice in these procedures after graduation.

The third year fellow will be expected to not only have mastered the basic ability to develop a pertinent and coherent differential diagnosis based on a history and physical but also to be able to appropriately focus that evaluation on the gastrointestinal tract. The fellow should be virtually competent in his / her knowledge of indications and contraindications to medicines, therapeutic plans and endoscopy will be expected to continue to progress toward being able to practice independently. The fellow should be able to integrate of data to form a coherent assessment and plan. The fellow will be specifically assessed for the ability to transition to independent practice. At the same time the fellow will be assessed for the six competencies as outlined on the Internal medicine Resident evaluation Form, including patient care, medical knowledge base, practice based learning, interpersonal and communication skills, professionalism and systems based learning.

E. RESEARCH AND SCHOLARLY ACTIVITIES (FIRST YEAR FELLOW 2 MONTHS, SECOND YEAR FELLOW 2 MONTHS, THIRD YEAR FELLOW 3 MONTHS) - The research rotation will be conducted under through the Graduate Medical Education Office under the auspices of Clinical Investigation Divisions at the Upstate Medical University and Veterans Administration Medical Center. Fellows will be exposed to research

activities by designing a clinical or basic science research protocol, which would then be submitted for approval by the Institutional Review Board and Human Use Committee of the respective institutions. Once the protocols have been approved, fellows will then conduct the study under the supervision of a staff gastroenterologist, in cooperation with other members of facilities where appropriate. Fellows will be taught how to analyze data and apply statistical techniques to interpret such data. A manuscript will then be prepared which will be submitted to satisfy fellowship program graduation requirements. Preparation of a publishable piece of investigation, either clinical or basic science, is required for graduation.

GOALS: To acquaint the trainee with the scientific method by asking and attempting to answer a question of biomedical importance. It is expected that the research performed will eventually lead to a scientific presentation at a national meeting and a published manuscript.

First year fellows will be expected to develop a hypothesis and complete a research proposal and have it evaluated by the appropriate reviewing board. This will be in conjunction with a staff of the fellow's choice who agrees to support the project.

The second year will be expected to complete virtually all of his / her data collection in conjunction with their staff and in preparation for manuscript preparation, presentation, etc.

The third year fellow will be expected to prepare a manuscript in publishable format in conjunction with their staff. This will be reviewed by the collective teaching faculty for adequacy and will be reviewed during a monthly research meeting or journal club.

F. Pregnancy in Gastrointestinal disorders

This monograph is available in our curriculum library both in print form (which will be stored in the fellow's library at the CWB) and virtually. (To view virtually, please request from Division Secretary krauseb@upstate.edu)

The structure of our educational system is such that fellows have less than average exposure to pregnant patients, therefore reading of this document will be required. Each fellow will sign an attestation form documenting this once during their fellowship.

As a part of their duties regarding conference scheduling, the third year fellow will insure that at least one Tuesday lecture each quarter will be devoted to topics in this document.

G. Monograph on IBS, Constipation and Acid-Related Disorders

This monograph is available in our curriculum library virtually. (To view virtually, please request from Division Secretary krauseb@upstate.edu)

Reading of this document will be required. Each fellow will sign an attestation form

documenting this once during their fellowship.

Milestones

First Year:

- a. Esophagogastroduodenoscopy - Minimum of 25 supervised studies
- b. Esophageal dilations - Minimum 5 supervised studies
- c. Colonoscopy with polypectomy - Minimum of 25 supervised colonoscopies and 5 supervised polypectomies
- d. Percutaneous endoscopic gastrostomy - Minimum of 3 supervised studies and completion of didactic training in complications and anatomy and physiology of replacement relative to time of placement
- e. Biopsy of the mucosa of the esophagus, stomach, small bowel and colon - Minimum 5 supervised studies any site
- f. Moderate sedation – Completion to competence
- g. Summary of evaluations showing adequate performance in each of the six core competencies

Second Year:

- a. Esophagogastroduodenoscopy - Minimum of 50 supervised studies
- b. Esophageal dilations - Minimum 10 supervised studies
- c. Colonoscopy with polypectomy - Minimum of 50 supervised colonoscopies and 10 supervised polypectomies
- d. Percutaneous endoscopic gastrostomy - Minimum of 6 supervised studies
- e. Biopsy of the mucosa of the esophagus, stomach, small bowel and colon - Minimum 5 supervised studies each site
- f. Other diagnostic and therapeutic procedures utilizing enteral intubation and bouginage - Minimum 5 supervised studies

- g. Non-variceal hemostasis - Minimum 5 supervised studies
- h. Variceal hemostasis - Minimum 5 supervised studies
- i. Summary of evaluations showing adequate performance in each of the six core competencies

Third Year:

- a. Esophagogastroduodenoscopy - Minimum number to be performed - 130 supervised studies and demonstrate competence
- b. Esophageal dilations - Minimum 50 supervised studies and demonstrate competence
- c. Colonoscopy with polypectomy - Minimum of 140 supervised colonoscopies and 30 supervised polypectomies studies and demonstrate competence
- d. Percutaneous endoscopic gastrostomy - Minimum of 15 supervised studies and demonstrate competence
- e. Biopsy of the mucosa of the esophagus, stomach, small bowel and colon - demonstrate competence
- f. Other diagnostic and therapeutic procedures utilizing enteral intubation and bouginage - demonstrate competence
- g. Gastrointestinal motility studies - minimum of 20 each of pH and esophageal motility studies and demonstrate competence
- h. Non-variceal hemostasis - Fellows will perform 25 supervised cases including 10 active bleeders studies and demonstrate competence
- i. Variceal hemostasis - 20 supervised cases, including 5 active bleeders studies and demonstrate competence
- j. Moderate sedation studies and demonstrate competence
- k. Small bowel capsule endoscopy studies and demonstrate competence
- l. Complete original research report in publishable form
- m. Summary of evaluations showing adequate performance in each of the six core competencies

The major advancement milestones in the area of gastroenterology for the general internist in training are divided into three general areas: Inpatient Urgent, Routine Inpatient and Outpatient.

It is important that all members of the team (including our fellows) be aware of these and that they also recognize they are a major part of the process. These are listed here.

INPATIENT URGENT

By the end of the first year the R1 will be able to rapidly assess and triage the inpatient presenting with symptom and sign complexes typical of common urgent diagnoses including but not limited to GI bleeding, cholangitis, appendicitis, perforation, bowel obstruction, SBP, etc. The learner will have the ability to perform a full abdominal exam to facilitate the evaluation of their patient. The needs for routine stabilization will be easily identified.

By the end of the second year the R2 will be able to identify and prioritize the appropriate testing to guide initial therapy decisions for common urgent diagnoses including but not limited to GI bleeding, cholangitis, appendicitis, perforation, bowel obstruction, SBP, etc. The learner will be able to initiation measures for routine stabilization and resuscitation.

By the end of the third year the R3 will be able to initiate therapy for common and more unusual urgent diagnoses including but not limited to GI bleeding, cholangitis, appendicitis, perforation, bowel obstruction, SBP, IBD, ischemia, etc. After assessing and understanding the likelihood of response to standard medical therapy the R3 will be able to determine when subspecialty consultation is appropriate, thereby being able to fully practice independently.

INPATIENT ROUTINE

By the end of the first year the R1 will be able to assess and triage the inpatient presenting with typical routine internal medicine symptoms and conditions related to the gastrointestinal tract including but not limited to loose stools, nausea, vomiting, pain and abnormal labs / x-rays etc. The learner will have the ability to perform a full abdominal exam to facilitate the evaluation of their patient. The learner will be facile in routine initiation of assessment and directed therapy will be easily identified.

By the end of the second year the R2 will be able to synthesize and work through the differential diagnosis selecting appropriate testing and initial therapy for typical routine internal medicine symptoms and conditions related to the gastrointestinal tract including but not limited to loose stools, nausea, vomiting, pain and abnormal labs / x-rays etc. The learner will demonstrate the ability to integrate patient information from multiple internal and external sources. The learner

will also be able to work with the available systems to initiated disposition plans.

By the end of the third year the R3 will be able to independently chose therapy and testing for typical routine internal medicine symptoms and conditions related to the gastrointestinal tract including but not limited to loose stools, nausea, vomiting, pain and abnormal labs / x-rays etc. After assessing and integrating all available data and understanding the likelihood of response to standard medical therapy the R3 will be able to determine when subspecialty consultation is appropriate, thereby being able to fully practice independently.

OUTPATIENT

By the end of the first year the R1 will be able to assess and triage the clinic patient presenting with typical routine internal medicine symptoms and conditions including such conditions as reflux, abnormal liver functions while understanding the standard preventative measures such as colorectal cancer screening and vaccinations. The learner will have the ability to perform a full abdominal exam to facilitate the evaluation of their patient. The learner will be facile in routine initiation of symptom directed assessment and understand the pharmacology of typical gastrointestinal medications.

By the end of the second year the R2 will be able to synthesize and work through the differential diagnosis selecting appropriate testing and initial therapy for the clinic patient presenting with typical routine internal medicine symptoms and conditions including such conditions as reflux, abnormal liver functions while understanding the standard preventative measures such as colorectal cancer screening and vaccinations, enacting and making future follow up plans including subspecialty consultation. The learner will demonstrate the ability to integrate patient information from multiple internal and external sources and determining the pharmacologic interactions of existing medications with planned gastroenterological therapeutics. The learner will also be able to work with the available systems to initiated disposition plans.

By the end of the third year the R3 will be able to independently choose therapy and testing for typical routine and more esoteric condition more complicated than conditions such as reflux, abnormal liver functions while understanding the standard preventative measures such as colorectal cancer screening and vaccinations. The learner will be able to integrate and coordinate the care of these conditions themselves as well as in interaction with other medical problems and therapeutics. After assessing and integrating all available data and understanding the likelihood of response to standard medical therapy using multiple sources (including when

appropriate outside information) the graduating R3 will be able to follow through on and coordinate subspecialty consultation recommendations, thereby being able to fully practice independently, guiding and orchestrating their care so as to avoid polypharmacy, drug / drug interactions etc.

VI. CONFERENCE SCHEDULE

A. GENERAL: Fellows will attend at least ninety percent of gastroenterology conferences. An attendance record will be maintained. Some conferences will be combined with other functions at either institution and/or the medical school. Other services, students, residents and the gastroenterology community are encouraged to attend all fellowship conferences.

B. CONFERENCES FOR FELLOWSHIP TRAINING:

1. Pathology Conference (Weekly) - Recent cases of teaching interest are reviewed with the staff pathologist. This allows correlation of endoscopic findings with histopathology. In addition, specific areas of interest are targeted for discussion with appropriate histologic material for review.

2. GI Radiology Conference (Monthly) - Cases are selected either by the Gastroenterology Service or by the Radiology staff presenting the conference. Common and uncommon radiologic features are reviewed. This may be on a selected interesting case or targeted topic basis. Normal anatomy as well as imaging techniques and general principles of radiology will also be covered (and will also be addressed in Clinical and Basic Science Conferences – 4 and 5 below).

3. Case Conference (Weekly) - The entire staff including house staff and fellow physicians meet to discuss either perplexing diagnostic cases or management problems so that all may be allowed to participate and contribute their knowledge and experience. The fellow presenting the case also reviews and formally presents the most recent and/or pertinent literature concerning the case. Specific attention to the nutritional aspects of ongoing patient care will be explored when appropriate. At least once a month on average a case specifically focusing on nutrition will be discussed.

4. Clinical Conference Series (Biweekly) - A series of lectures, usually of

didactic nature, on common clinical problems, diagnostic techniques or therapeutic modalities, are presented by both staff and trainees on a rotating basis. The topics are spread out over a three year period, so that during the entire fellowship training the fellows are exposed to each lecture only once during their training. The only exception is those topics that the staff feels the fellows (especially the incoming first year fellow) must be exposed to on a yearly basis. For this conference, slides are prepared utilizing a variety of slide making software such as Harvard Graphics or Power Point, both of which are readily available within the department. Handouts or lecture outlines are also highly encouraged. Feedback via form will be given to both staff and fellows. The fellow's performance and progression will be included as a part of their training recorded.

Given Doctor Holtzapple expertise and training in nutrition, he will serve as co-coordinator for the nutrition and alimentation portion of these lectures.

5. Basic Science Conference (Biweekly) - A series of lectures by both staff and fellow physicians, covering basic science and physiology topics. These topics are spread over the entire three year fellowship training, so that fellows are exposed to each topic once during their fellowship. For this conference, slides are prepared utilizing a variety of slide making software such as Harvard Graphics or Power Point, both of which are readily available within the department. Handouts or lecture outlines are also highly encouraged. Feedback via form will be given to both staff and fellows. The fellow's performance and progression will be included as a part of their training recorded.

6. Journal Club (Monthly) - Articles from the general medical literature, as well as gastroenterology journals, are reviewed by the entire Service. Critical review of scientific articles is emphasized. Important articles and reviews are xeroxed for lateral review and permanent files.

7. Research Conference (Monthly) – The status of on-going fellow research projects will be tracked and reviewed on a monthly basis. This will include independent projects for graduation requirements as well as other projects on which fellows are assistant investigators. This forum, often in conjunction with Journal Club, will also be used to develop research ideas. Staff will be serving as a sounding board for these ideas, shepherding and mentoring the fellows in the development of these hypotheses. Research design principles, ethics of research, informed consent standards, human subject use, etc. will be an a priori part of these sessions.

8. Internal Medicine Grand Rounds (Weekly) - Topics of general medicine

interest are presented by UMU and VAMC staff or by distinguished visiting professors. Participation is hospital wide.

9. GI / Surgery Conference (weekly) - Cases are selected by both the Gastroenterology Service and the Surgery staff for presentation at the conference. Common and uncommon cases are reviewed with emphasis on interaction between the specialties, thereby promoting system integration, professional relations and teamwork. This may be on a selected interesting case or targeted topic basis. Surgical technique and approach will be discussed for the benefit of the medical trainees, and medical approaches will be discussed for the benefit of the surgical trainees. Radiological and pathologic input will be solicited when appropriate.

10. Pregnancy in Gastrointestinal disorders (Quarterly)
As a part of their duties regarding conference scheduling, the third year fellow will insure that at least one Tuesday lecture each quarter will be devoted to topics in this document.

11. VA GI Tumor Multi-Disciplinary Conference (Monthly)
All UH GI Fellows will attend/participate in this GI conference.
Cases may be assigned to an individual Fellow – discussion will follow presentation.

12. Nutrition (Quarterly)
As a part of their duties regarding conference scheduling, the third year fellow will insure that at least one Tuesday lecture each quarter will be devoted to this topic.

The inpatient fellow will prepare weekly case conference in conjunction with the consult attending. First year fellows will be assigned a minimum of one clinical and one basic science lecture per year. During subsequent years fellows will be expected to select a minimum of two topics based on the core curriculum cycle and trainee interest. Fellows are expected to select cases for pathology, radiology and gastrointestinal / Surgery conference, as well as articles for review during journal club. The third year fellow will be the point of contact for coordination of these cases. The attending staff will evaluate the lecture and feedback will be provided to the trainee informally and formally at the bi-annual assessment.

VII. CORE CURRICULUM

A. CLINICAL EXPERIENCE, CONCEPTS AND FACTS - This will include an opportunity to observe and manage a sufficient number of new and follow-up inpatients and outpatients of appropriate age, including adolescent and geriatric age groups, with a wide variety

of common and uncommon digestive disorders. Fellows will be given opportunities to assume continuing responsibility for both acute and chronically ill patients, to learn the natural history of gastroenterologic disorders, as well as effectiveness of therapeutic programs.

Specifically, the fellows will receive formal instruction, clinical experience, and opportunities to acquire expertise in the evaluation and management of the following disorders:

1. Diseases of the esophagus
2. Acid peptic disorders of the gastrointestinal tract
3. Motor disorders of the gastrointestinal tract
4. Irritable bowel syndrome
5. Disorders of nutrient assimilation
6. Inflammatory bowel diseases
7. Vascular disorders of the gastrointestinal tract
8. Gastrointestinal infections including viral, bacterial, mycotic and parasitic diseases
9. Gastrointestinal pancreatic neoplasms
10. Gastrointestinal diseases with an immune basis
11. Pancreatitis
12. Gallstones and cholecystitis
13. Alcoholic liver diseases
14. Viral and immune hepatitis
15. Cholestatic syndromes
16. Drug-induced liver injury
17. Hepatobiliary neoplasms
18. Chronic liver disease
19. Gastrointestinal manifestations of HIV infections
20. Gastrointestinal neoplastic disease
21. Acute and chronic hepatitis
22. Biliary and pancreatic diseases
23. Women's health issues in digestive diseases
24. Geriatric gastroenterology
25. Gastrointestinal bleeding
26. Cirrhosis and portal hypertension
27. Genetic/inherited disorders
28. Medical management of patients under surgical care for gastrointestinal disorders

29. Management of GI emergencies in the acutely ill patient

2. Fellows will also receive formal instruction, clinical experience, and opportunities to acquire expertise in the evaluation and management of the patients with the following clinical problems:

- a. Dysphagia
- b. Abdominal pain
- c. Acute abdomen
- d. Nausea and vomiting
- e. Diarrhea
- f. Constipation
- g. Gastrointestinal bleeding
- h. Jaundice
- i. Abnormal liver chemistries
- j. Cirrhosis and portal hypertension
- k. Malnutrition
- l. Genetic/inherited disorders
- m. Depression, neurosis and somatization syndromes pertaining to the gastrointestinal tract
- n. Surgical care of gastrointestinal disorders

B. ENDOSCOPIC PROCEDURES, TECHNICAL AND OTHER SKILLS -

1. The program will provide for instruction in the indications, contraindications, complications, limitations, and where applicable, interpretation of the following diagnostic and therapeutic techniques and procedures.

- a. Imaging of the digestive system including:
 - (1) Ultrasound procedures, including endoscopic ultrasound
 - (2) Computed tomography
 - (3) Magnetic resonance imaging
 - (4) Vascular radiology procedures
 - (5) Contrast radiography
 - (6) Nuclear medicine procedures
 - (7) Percutaneous cholangiography

- b. Endoscopic procedures.
- c. Specialized dilation procedures
- d. Percutaneous cholangiography
- e. Percutaneous endoscopic gastrostomy
 - (1) placement
 - (2) appropriate replacement
- f. Liver and mucosal biopsies
- g. Gastric, pancreatic and biliary secretory tests
- h. Other diagnostic and therapeutic procedures utilizing enteral intubation and bouginage
- i. Gastrointestinal motility studies
- j. Sclerotherapy
- k. Enteral and parenteral alimentation
- l. Liver transplantation
- m. Pancreatic needle biopsy
- n. ERCP including papillotomy and biliary stent placement

2. Opportunities will be provided for fellows to gain competence in the following procedures and a skill endoscopic preceptor will be available to teach and supervise the procedures. The performance of these procedures will be documented in the fellow's record, providing indications, outcomes, diagnosis, and supervisor(s).

- a. Esophagogastroduodenoscopy - Minimum number to be performed - 130 supervised studies
- b. Esophageal dilations - Minimum 50 supervised studies
- c. Flexible sigmoidoscopy - Minimum 30 supervised studies
- d. Colonoscopy with polypectomy - Minimum of 140 supervised colonoscopies and 30 supervised polypectomies
- e. Percutaneous liver biopsy - Minimum of 20 supervised studies
- f. Percutaneous endoscopic gastrostomy - Minimum of 15 supervised studies and completion of didactic training in complications and anatomy and physiology of replacement relative to time of placement
- g. Biopsy of the mucosa of the esophagus, stomach, small bowel and colon
- h. Other diagnostic and therapeutic procedures utilizing enteral intubation and bouginage
- i. Gastrointestinal motility studies

- j. Non-variceal hemostasis - Fellows will perform 25 supervised cases including 10 active bleeders
 - k. Variceal hemostasis - 20 supervised cases, including 5 active bleeders
 - l. Enteral and parenteral alimentation
 - m. Moderate sedation
 - n. Small bowel capsule endoscopy
 - o. Esophageal capsule endoscopy
3. While fellows may not directly perform them, exposure to the following diagnostic and therapeutic procedures will be provided:
- a. Laser treatment of gastrointestinal tract
 - b. Endoscopic ultrasound
 - c. Biliary manometry
 - d. ERCP
 - e. Endoluminal Reflux Therapy
 - f. Radio frequency Ablation
4. As a part of the fellow's orientation and prior to initially performing any endoscopic procedure, the trainee will review available introductory literature through books, videotapes, and slide films. Subsequently, throughout training, the supervising staff member will review the indications for each procedure, as well as complications and treatment, along with the clinical utility and limitations of each procedure on a case by case basis, as well as in a didactic fashion during our conference/lecture series. Knowledge of the operational and maintenance aspects of endoscopic instruments is also considered essential, and is therefore included in the fellow's initial orientation.
5. A qualified staff physician will provide daily, close and immediate supervision of scheduled and emergent cases. After the trainee has reached a competent level of endoscopic technique and interpretation, the fellows may be allowed to perform some elective procedures such as flexible sigmoidoscopy independently. All endoscopic procedures requiring conscious sedation with intravenous medications will be supervised at all institutions through which the fellows rotate. Additionally, competence with endoscopic biopsy, cytology and photographic documentation is also essential.

C. Pregnancy in Gastrointestinal disorders

The structure of our educational system is such that fellows have less than average exposure to pregnant patients, therefore reading of this document will be required. Each fellow will sign an attestation form documenting this once during their fellowship.

The monograph is available in our curriculum library both in print form (which will be stored in the fellow's library at the CWB) and virtually.

As a part of their duties regarding conference scheduling, the third year fellow will insure that at least one Tuesday lecture each quarter will be devoted to topics in this document.

VIII. SUPERVISION: The ultimate responsibility for the care of the patient and instruction and supervision of the fellow lies with the attending staff physician. As such it is the fellow's responsibility to always obtain staff review of all their patient care activity as outlined below. The master rotation schedule, which is distributed in July and with each change lists fellow and staff assignments by clinic in all ambulatory settings. This schedule also lists inpatient fellow assignments. The inpatient attending schedule, distributed in July and with each change settings, lists staff inpatient attending for the entire year. If the fellow feels the number of patients or complexity of the patient load exceeds his or her ability to manage / triage they are instructed to seek the assistance of the appropriate staff.

Circumstance or Events Requiring Attending Physician Approval

- Accepting for transfer patients from another institution.
- Accepting a patient transferred from another service.
- Scheduling an endoscopic procedure.
- Initial antibiotic treatment of a wound infection.
- Undertaking any invasive diagnostic study.

Circumstance or Events Requiring Attending Physician Notification

- Resident/fellow believes decisions can best be accomplished after communication with an attending.
- Concern of anyone, including nurses, that a situation is more complicated than a resident or fellow can manage effectively.

- Patient, a family member, nurse, allied professional, or a physician suggests that an attending be notified.
- Decision to admit patient to the hospital.
- Transfer to locus for a higher level of care or to ICU.
- Significant arrhythmia, cardiac arrest, unplanned intubation or need for ventilatory support, critical results of lab, radiology, or cardiac diagnostic tests, medication or treatment errors requiring intervention related to GI prognosis and procedure.
- Any issue prompting a significant change in a previously agreed upon treatment plan.
- Patient leaving hospital against medical advice.
- Changes in code status.
- Patient death.

IX. FITNESS FOR DUTY/Fellow Back-Up Plan Policy

The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Residents and faculty members must demonstrate (Common Program Requirements VI A 5)

- V1 A 5 a.) Assurance of the safety and welfare of patients entrusted to their care,
- V1A 5 b.) provision of patient and family centered care,
- V1A 5 c.) assurance of their fitness for duty,
- V1A 5 d.) management of their time before, during and after clinical assignments,
- V1A 5 e.) recognition of impairment, including illness and fatigue, in themselves and in their peers.

Residents and Fellows must be educated about their self reflection on “Fitness for Duty”. It is clear that current alcohol or illicit substance use is incompatible with fitness to provide medical care to others. Excess fatigue, medical or psychiatric illness may also preclude participation in the workplace. Examples of additional situations in which a resident or fellow may not be fit for duty include but are not limited to – the use of medications that impair dexterity significantly, grief that precludes concentration or acute illness that would make the physician a risk to others (ex. infectious illness)

This policy is designed to:

- a. Provide guidance to both residents/fellows and supervisors when a fellow is unfit for duty
- b. Provide coverage for clinical duties if another fellow is ill or has a family emergency.
- c. Ensure the availability of coverage for fellow who calls in ill.
- d. Delineate the fellow’s responsibility for coverage.

FITNESS FOR DUTY:

A resident or fellow who does not feel fit for duty should consult with their current program director or Employee health. Additionally, a supervisor who has concerns regarding a resident or fellow's fitness for duty should also consult with the Associate Dean for Graduate medical Education.

BACK-UP SUPPORT:

Appropriate use of sick call includes unexpected illness, death in the family or other personal emergency. Sick call is not to be used for scheduled absences, e.g., doctor's visits, family responsibilities, interviews, etc. for such scheduled absences, the resident/fellow will complete the appropriate leave form in their department or discuss with program director per departmental policy.

PROCEDURE:

1. The fellow requesting coverage will contact the program director to inform him/her of the illness and obtain approval. If the program director is unavailable, the attending on-call should be contacted.
2. Once approval from the program director is obtained, the senior fellow or the person designated to handle the fellows' schedule should be contacted to ensure coverage of the appropriate service.
3. The fellow requesting/receiving coverage will be expected to return the coverage at a later date as determined by the program director/senior fellow. It should be understood that receiving return coverage is a courtesy, but is not an absolute requirement and may not be possible in all circumstances. SUNY Upstate Medical University's institutional policy allows employees to be out for a number of sick days without consequences. It is in this context that professionalism and courtesy should exist. Repayment of coverage may never result in an ACGME/New York State duty hours' regulation violation, no matter what the circumstances.
4. If a fellow is out sick greater than three days, documentation must be brought to the program director's attention upon his/her request within 24 hours of returning to work. Documentation needs to show the name, date, time and place where the fellow was seen. Diagnosis does not need to be disclosed as this information is confidential. Failure to comply with the documentation requirement could lead to comments regarding professionalism in the final evaluation of the fellow or disciplinary action.

5. For extended absences/illness, please refer to the institutional policy on Leaves of Absence on SUNY upstate's website. Fellows should be mindful of individual Board requirements that may set limits on the amount of leave one may take at any level. In most cases, vacation time cannot be forfeited for leave and hence the duration of the training period may/will be extended by the program director to account for the missed days of training.
6. While every attempt will be made to cover a fellow with another fellow, the final responsibility for patient care and supervision lies with the attending. In all cases when another fellow cannot cover or cannot be reached, the attending on service will provide this coverage.

A. First, Second and Third Year Fellows on Outpatient Consultant Services - It will be the responsibility of the fellow to receive and triage all unscheduled requests for consultation and to obtain staff review of same at the VAMC and HSC. No ambulatory patients will be scheduled at Crouse hospital. The fellow's consultations are confirmed, reviewed and signed by a staff physician in all cases. For outpatient follow up cases, the fellow is encouraged to seek staff opinion at the time he/she is seeing the patient, but direct staff review is not necessary for the more ordinary problems. In all cases where immediate staff input is deemed necessary, the fellow will seek the consultation of the outpatient staff per the master rotation schedule. Whether or not the case requires immediate staff discussion, Outpatient staff will always be available on site for discussion of cases by fellows at the VAMC and HSC institutions while fellows are seeing patients on the outpatient clinics. Fellow's are encouraged to interact with more junior rotating house staff to develop their teaching skills, but all other learners assigned to the service will be supervised by the attending staff.

B. Inpatient Consultant Services - There is one consulting service for all three institutions therefore, all members of the teaching team will comply with the following across all three clinical sites. It will be the responsibility of the fellow to receive and triage all requests for inpatient consultation and to obtain staff review of same. The fellow's consultations are confirmed, reviewed and signed by a staff physician in all cases. The assigned staff physician will make formal rounds on all patients at all three institutions daily and in conjunction with the fellow, will interview and examine patients, documenting appropriate advice as necessary in the inpatient chart. . Bedside teaching rounds will be stressed and will occur at least thrice weekly. The assigned staff physician will review the fellow's suggestions as reflected in the fellow's chart note during ward rounds. Formal consultation will be placed in patient's records after

discussion has taken place between the fellow and staff. In general, most endoscopic procedures will be staffed by the Inpatient Consultant staff, except in situations where the Inpatient Consultant staff may be needed elsewhere, in which case the endoscopic procedures will be staffed by an alternative staff gastroenterologist. This policy will be adhered to at all participating institutions (VAMC, HSC, Crouse). Fellow's are encouraged to interact with more junior rotating house staff to develop their teaching skills, but all other learners assigned to the service will be supervised by the attending staff.

C. Procedures - All endoscopic procedures requiring the use of intravenous sedative medications are supervised on a 1:1 basis at all 3 institutions. The fellow's impression and plan regarding endoscopy are confirmed, reviewed and signed by a staff physician in all cases. The staff physician is responsible for supervising the patient and the fellow's performance of the procedure at all times. All emergent endoscopic procedures are also supervised. A staff gastroenterologist supervises all percutaneous liver biopsies. Other procedures such as simple maloney esophageal dilation, flexible sigmoidoscopy, and some manometry may be supervised on a case by case basis. Under all circumstances, trainees are highly encouraged to solicit assistance whenever necessary when performing these procedures.

D. On Call - Consulting services on call covers all three institutions therefore the following applies across all clinical sites. Each trainee will be on call at home an average of no more than four days in sequence. The number of calls per year will average approximately 123 days. A staff member will be on call at all times as per published roster. This policy will be adhered to at both institutions. If emergency endoscopic procedures are required in the evenings or weekends, the fellow on call will have a staff person present during such procedures at both facilities.

E. All fellows must check for and sign electronic records (as well as make sure all elements of the encounter form are completed) at least twice a week. The VA policy is such that charts must be signed and completed in less than 7 days. In order for your attendings to meet this rule you must complete your portion of the record within 3 days. Records are to be completed before you leave clinic on Monday and again by COB Wednesday, allowing your attendings time to review and sign your notes.

It is the Fellows' responsibility to check and empty his/her mail boxes at both Hill and the VA at least weekly before or after his/her Monday clinic. It is expected that there will be no items requiring Fellows' action left in his/her boxes by Monday morning at Hill and by Tuesday

morning at the VA. Fellow will be called or paged for more urgent items, to which he/she will reply in a timely fashion.

IX. EVALUATION

A. Concepts and Facts - Progression in knowledge base will be achieved on a day to day basis by review of consultations performed and general questioning as to proposed diagnostic and therapeutic measures. This method is by definition nonstandard. Informal written examinations and quizzes on core subjects will be given two to three times per year, as required by the American Board of Internal Medicine (ABIM). Questions will be devised by staff or other modalities such as GESAP, MKSAP, or other standard or pretest type examinations which are available in gastroenterology will be used as needed and results maintained in the fellow's training file. This may include videotapes prepared by the American Society for Gastrointestinal Endoscopy or American College of Gastroenterology postgraduate course self-assessment questionnaires. Some questions may also be drawn from the Medical Knowledge Self-Assessment Program of the ABIM. No specific grades will be assigned. The major reasoning for such information examinations will be to provide fellows input regarding areas where he/she may demonstrate some weakness. Periodic staff meetings will be held at which time the general knowledge base of each trainee will be reviewed. Formal evaluation will be in accordance with ABIM recommendations outlined in "AA System for Evaluation of Clinical Competence in Gastroenterology - 1996" and appropriate guidelines will be followed. A formal, written, comprehensive, evaluation, including constructive criticism and appropriate feedback will be provided to all fellows at least biannually and will be maintained in the fellows training record.

Specific expectations based on rotation and level of training are listed in section V.
ROTATIONS

B. Endoscopic Procedures

1. All fellows are required to perform minimum number of procedures required by the ABIM (see previous). Minimum number of endoscopic procedures will be required for certification of competence. This judgment will be made by the Program Director and staff members at the respective institutions. Factors to be evaluated will include: a) Knowledge of pertinent diseases; b) Knowledge of indications, contraindications, and complications; c) Technical ability; d) Interpretation of endoscopic findings; and 3) Ability to

evaluate results and use them to influence patient management. Suggested minimal standard for cognitive and technical skills required will be adhered to as recommended by ABIM, and as per guidelines published by the ASGE.

2. Each typed procedure report is reviewed and signed by the responsible staff physician to ensure appropriate format and content.

3. The trainee will maintain copies of reports from all endoscopies and other procedures performed during fellowship. The trainee will also generate a tabular record and a bi-annual summary of these procedures using the standard Gastrointestinal Fellow Procedure Log Sheet provided by the ABIM. A duplicate of these tabular records will be maintained in the individual fellow's training record maintained by the Program Director.

4. A letter of competence will be signed by the Program Director when competency has been achieved. Competence in endoscopic procedures has been outlined as above, and will be required to graduate. Competence does not relieve the fellow of their obligation to obtain staffing for procedures during training.

5. As a general rule, the trainee should be able to achieve competency in routine endoscopic procedures as required by the ABIM at the end of their fellowship, and usually within the first 24 months of the fellowship.

X. PROGRESSION AND PROMOTION OF TRAINEES

Periodic staff conferences will be held at least once every 3-6 months, wherein the trainee's progress in both academic and technical areas will be reviewed. Input will be obtained from all staff members at both institutions, as well as the Program Director. The guidelines for endoscopic progression as noted on the checklist will also be considered. Trainees will be allowed to progress to the second and third years, after having mastered the main requirements of the Core Curriculum described above, as well as achieved the required endoscopic technical and cognitive skills. Appropriate documentation of the trainees' progress will be accomplished and maintained in the Graduate Medical Education Office of the sponsoring consortium.

XI. FEEDBACK TO TRAINEES

A conference between the staff member and trainee will be held at the middle and end of

each rotation. As described above a formal, written, comprehensive, evaluation, including constructive criticism and appropriate feedback will be provided to all fellows at least biannually and will be maintained in the fellows training record. Similar evaluation may be provided sooner if necessary. Both positive and negative aspects of performance will be discussed. Areas in need of improvement will be indicated and emphasized to the trainee as soon as they are documented, with presentation of a grace period of approximately 30 days in which the fellow will work on the deficiencies. Should improvement not be forthcoming, a formal memorandum for record dated and signed by the staff and trainee in question will be initiated. Continued problems or more severe problems, will be dealt with through the Medical Education Committee. If performance is not found to be satisfactory, or if the fellow has failed to improve in the area of deficiency noted, request for probation will be made.

XII. MONITORING AFTER GRADUATION

Approximately four to six months after reaching a new assignment, the Program Director will contact the immediate supervisor of the newly graduate trainee and inquire as to any deficiencies or strong points and file a summary in the fellow's training file. Overall performance will be noted and this information will be taken into account when adjusting the new training program.

XIII. ABSENCE FROM THE TRAINING PROGRAM

- A. Ordinary Leave - Any absence must be coordinated and approved by the Program Director.
- B. Days for Interviews: In the 3rd year, the fellow's interview days are counted as part of his/her DAT time.
- C. Excessive Leave - 12 weeks of leave will be allowed during the entire three year training program (not to be taken in one 12-week block). Exceptions will be considered on an individual basis and may result in extension of training. Normally leave will be limited to 28 days per year. Only under exceptional circumstances will leave be granted during major clinical rotations which include the inpatient rotations. GI fellows should not take more than 2 weeks of leave at any one time. Individual cases for leave longer than 2 weeks will require approval of the Program Director.

ANNUAL LEAVE ACCRUALS: In accordance with ABIM policy Days Absent from Training

(DAT) including vacation, illness, Family-Medical Leave act absences, and **pregnancy-related** disabilities: It is our policy that use of DATs is essential and should not be forfeited or postponed in any year of training.

Each fellow is allowed 4 weeks of absences. These 28 DATs (20 weekdays, 8 weekend days) must be used each academic year. Any one who exceeds the 28 day limit will be extended. No more than one week off may be taken per block. Please note that contiguous week and weekend days off count toward DAT.

DATs MUST BE USED IN FULL DURING EACH ACADEMIC YEAR OR THE TIME WILL BE LOST. LEAVE TIME CANNOT BE CARRIED OVER TO THE NEXT ACADEMIC YEAR NOR WILL ANYONE, AT ANY TIME, BE COMPENSATED IN PAY FOR ANY TIME LEFT UNUSED.

TIME ACCRUAL REPORT: A monthly report listing time used and earned must be submitted each month to the Payroll Office. Each fellow is required to sign this form electronically confirming the times listed. The academic secretary will contact you for this.

REQUEST FOR TIME OFF:

Whenever it is necessary to take time off from fellowship duties; i.e., vacation, extramural electives, conferences, meetings, etc, the fellow must request the time off in advance by filling out a “time off request” form which is supplied by the GI secretary. This should be done at least 8 weeks prior to the dates requested (see below for call schedule deadline information also). The form should be submitted to division secretary to ensure there are no scheduling conflicts. The secretary will then forward the time off request to Dr. Szykowski for final approval. As this information is used as an indicator for scheduling purposes, requests for attendance to *all* extracurricular conferences, even the ones assigned to you during your fellowship, should be included.

It is expected that before requesting time off, the fellow check with the other GI fellows to be sure there will be no duplication of requests.

In addition, the fellow is expected to check each clinic and notify the secretary, ASAP, that you are considering taking time off, so that he/she can put scheduling on hold for you.

Upon approval of the time off, it is the fellow's responsibility to confirm with all clinics and

relevant areas, (including Endoscopy) that you will be unavailable on the days approved for leave, so that clinic and procedure schedules can be readjusted.

HOLIDAYS: In place of compensatory time for holidays worked, there is a new policy concerning holiday coverage. The fellows will work together at the beginning of the academic year (July 1st) to create a schedule for coverage that will be fair to all. The holidays for the GI fellows for the academic year 2010-2011 are as follows:

Independence Day, Monday, July 4, 2011

Labor Day, Monday, September 5, 2011 (three-day weekend)

Columbus Day, Monday, October 10, 2011 (three-day weekend)

Election Day, Tuesday, November 8, 2011 (one-day holiday-office remains open)

Veteran's Day, Friday, November 11, 2011 (one-day holiday-office remains open)

Thanksgiving, Thursday, November 24, 2011 (one-day holiday)

Thanksgiving Friday, November 25, 2011 (could count as three-day holiday weekend)

Christmas Day, Sunday, December 25, 2011 (one-day holiday observed on Monday, December 26, 2011)

New Year's Day, Sunday, January 1, 2012 (one-day holiday observed on Monday, January 2, 2012)

Martin Luther King, Monday, January 16, 2012 (three-day weekend)

Memorial Day, Monday, May 28, 2012 (three-day weekend)

MEETINGS AND CONFERENCES:

Fellows' Conferences are scheduled as follows:

First Year GI Fellow will attend the American College of Gastroenterology Annual Meeting which is held in the fall of each year.

Second Year GI Fellow will attend the annual meeting of the American Association for the Study of Liver Diseases which is held in November.

Third Year GI Fellow will attend the annual meeting of the American Gastroenterology Association Meeting held in May.

The fellow should complete registration forms and travel arrangements (With written permission from the program director, fellows may use company travel agency to book flights for direct billing to company. Contact number via division secretary).

When traveling to meetings, courses, etc., which are sponsored by the division, submission of all receipts for meals (you are required to request a receipt for each meal), travel and lodging is mandatory.

Per policy, travelers should use any shuttle service available when appropriate. Flight changes/itinerary changes are allowed provided attendance is not affected, but will not be reimbursed. Meal submissions in excess of the state guidelines for per diem will be reimbursed at the per diem rate.

Upon return from the conference, fellows must produce original receipts for anything to be reimbursed. They must obtain original receipts for the meeting registration fees, courses taken, special luncheon or dinner meetings, taxis (if complimentary shuttle service is not offered), parking, (mileage, if personal car is used) airline ticket, hotel, etc. Even E-tickets have an original receipt. Original receipts are needed for immediate reimbursement. Failure to produce original receipts will result in considerable delay.

DEPARTMENT OF MEDICINE \$300 ALLOTMENT:

The Department allocates \$300 to each fellow each year for use for educational endeavors. It is the policy of the Division of Gastroenterology to use this allowance to help to cover the expenses of travel to meetings and conferences. The GI Department secretary will assist you in securing this funding.

GASTROENTEROLOGY ORGANIZATION MEMBERSHIP

It is recommended that the GI fellow join the American Gastroenterological Association, as a trainee member, as soon as entering the GI fellowship. In addition to the AGA, membership in the American College of Gastroenterology, American Society for Gastrointestinal Endoscopy and the American Association for the Study of Liver Diseases are also encouraged.

GI FELLOW CLINICS:

Mon-Friday AM/PM Fellows Clinics at Hill & VA (Fellows times/days per Fellowship Block Rotation Schedule and generic schedule)

MOONLIGHTING: The Department of Medicine has initiated a very strict policy towards moonlighting. A GI fellow is allowed a certain amount of moonlighting, as long as it conforms to the guidelines of Code 405, which requires 10 hours off after any clinical work. Our workweek begins on Sunday. Because the disregard of these rules could result in the fellowship losing its accreditation, as well as thousands of dollars penalty for each infraction, there will be very serious consequences for fellows who do not abide by these rules.

Fellows are required to obtain their own malpractice coverage and obtain a New York State License.

DUTY HOURS

Section 405 rules and the RRC (Resident Review Committee) state that a resident shall work a maximum of 80 hours per week with 10 hours between shifts and one full 24 hour period off per week. It also states that if patient care will be compromised by adhering strictly to these rules, these time frames can be altered, (but only in the case of emergent patient care). The Department of Medicine feels that the 80 hour work week is quite adequate to perform the necessary tasks assigned. However, the practice of medicine is not an hourly job, but a profession that transcends general working hours. The GME (Graduate Medical Education) office at SUNY UMU (State University of New York at Upstate Medical University) use time studies to monitor compliance with these work-hour regulations. Residents must adhere to these policies at all times.

Trainees are instructed as to Gastroenterology and the overriding departmental GME office requirements including the guidelines of Code 405, which requires 10 hours off after any clinical work. Time sheets are maintained by GME and Gastro Division. Our work week begins on Sunday. A mandatory duty hour survey form for Gastro is to be completed monthly by fellows and submitted to division secretary.

Trainees are instructed that any questions (including those about moonlighting) or concerns should be directed to the attending, the fellowship office, and the training director or to the Internal Medicine GME office/Program Director. Time sheet submission and attestation is monitored quarterly. Departmental and divisional duty hour rules are reviewed at Annual Program Review meeting typically occurring in June.

1. Each fellow must have 24 hours of unscheduled time each week (24 hrs. off)
2. There must be ten (10) hours off between in-house shifts (10 hrs. shift)
3. There must be no more than 24 hours of assigned in-house duty per shift (24+hrs.)

Scheduled on duty assignments must be separated by a minimum of 10 non-working hours. If called back to the hospital while on home call, you do not necessarily need an additional 10 hours off. This is determined on the duration of your stay in the hospital and based on individual need. If you are feeling fatigued after being called in and are not rested by the normal start time of the day it is required that you contact your program director to arrange for the necessary coverage until you feel you can return to work.

If at any time fellow has exceeded work hour rules, a written explanation as to why must be submitted to the Program Director.

Specialty-specific Duty Hour Definitions (4/29/2011)

Below are the specialty-specific duty hour definitions that will be incorporated into each respective set of program requirements on July 1, 2011 and specialty-specific FAQs. Additional definitions and FAQs will be developed over time.

VI.D.1. - In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.

VI.D.5.a).(1) - Supervision of Residents: In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available. [Each Review Committee will describe the achieved competencies under which PGY-1 residents progress to be supervised indirectly, with direct supervision available.]

VI.E. - Clinical Responsibilities: The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services. [Optimal clinical workload will be further specified by each Review Committee.]

VI.F. - Teamwork: Residents must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty. [Each Review Committee will define the elements that must be present in each specialty.]

VI.G.5.b) - Minimum Time Off between Scheduled Duty Periods: Intermediate-level residents [as defined by the Review Committee] should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.

VI.G.5.c) - Minimum Time Off between Scheduled Duty Periods: Residents in the final years of their residency education [as defined by the Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

VI.G.5.c).(1) - Minimum Time Off between Scheduled Duty Periods: This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of their residency education have eight hours free of duty between scheduled duty periods, there may be circumstances [as defined by the Review Committee and as may occur during fellowship – see VI.G.5.c] when these residents must stay on duty to care for their patients or return to the hospital with fewer than

eight hours free of duty.

VI.G.6.- In-House Night Float: There is no in-house nightfloat system for our fellowship.

Internal Medicine Subspecialties

VI.D.1.

VI.D.5.a).(1)

VI.E.

VI.F.

VI.G.5.b) Internal medicine subspecialty fellows are considered to be in the final years of education.

VI.G.5.c) Internal medicine subspecialty fellows are considered to be in the final years of education.

VI.G.5.c).(1) In unusual circumstances, residents may remain beyond their scheduled period of duty or return after their scheduled period of duty to provide care to a single patient.

Justifications for such extensions of duty are limited to reasons of required continuity of care for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of the patient or family. Such episodes should be rare, must be of the residents' own initiative, and need not initiate a new 'off-duty period' nor require a change in the scheduled 'off-duty period.' Under such circumstances, the resident must appropriately hand over care of all other patients to the team responsible for their continuing care, and document the reasons for remaining or returning to care for the patient in question and submit that documentation to the program director. The program director must review each submission of additional service and track both individual residents' and program-wide episodes of additional duty.

REFERENCES

Graduate Medical Education Director 1996-97, specific sections to include AProgram Requirements for Residency in Gastroenterology; AEssentials of Accredited Residents in Graduate Medical Education: Institutional and Program Requirements, page 23-28, pages 91-93.

Revised institutional requirements published March 21, 1996, to be effective July 11, 1997, and entitled AEssential of Accredited Residencies in Graduate Medical Education, pages 1-8, Section 1, A Institutions Requirements, pages 1-9.

AAMC Policy Guidance on Graduate Medical Education, October 2001.

ASGE Guidelines for Training and Practice, Revised January 2000.

ABIM Guidelines on Evaluation of Clinical Competence and Other Information: A Resource Document for Subspecialty Program Directors, Clinical Competence and Communications Programs 1999-2000.

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Common Program Requirements

Effective: July 1, 2011

Note: The term “resident” in this document may refer to both specialty residents and subspecialty fellows. Once the Common Program Requirements are inserted into each set of specialty and subspecialty requirements, the terms “resident” and “fellow” will be used respectively.

Introduction Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident.

The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident physician to assume personal responsibility for the care of individual patients. For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As residents gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept—graded and progressive responsibility—is one of the core tenets of American graduate medical education. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident’s development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.

I. Institutions

I.A. Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating sites. The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program.

I.B. Participating Sites

I.B.1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years.

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The PLA should:

I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for residents;

I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;

I.B.1.c) specify the duration and content of the educational experience; and,

I.B.1.d) state the policies and procedures that will govern resident education during the assignment.

I.B.2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).

[As further specified by the Review Committee]

II. Program Personnel and Resources

II.A. Program Director

II.A.1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS. [As further specified by the Review Committee]

II.A.2. The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.

II.A.3. Qualifications of the program director must include:

II.A.3.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;

II.A.3.b) current certification in the specialty by the American Board of _____, or specialty qualifications that are acceptable to the Review Committee; and,

II.A.3.c) current medical licensure and appropriate medical staff appointment.

[As further specified by the Review Committee]

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II.A.4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:

II.A.4.a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;

II.A.4.b) approve a local director at each participating site who is accountable for resident education;

II.A.4.c) approve the selection of program faculty as appropriate;

II.A.4.d) evaluate program faculty and approve the continued participation of program faculty based on evaluation;

II.A.4.e) monitor resident supervision at all participating sites;

II.A.4.f) prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;

II.A.4.g) provide each resident with documented semiannual evaluation of performance with feedback;

II.A.4.h) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;

II.A.4.i) provide verification of residency education for all residents, including those who leave the program prior to completion;

II.A.4.j) implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:

II.A.4.j).(1) distribute these policies and procedures to the residents and faculty;

II.A.4.j).(2) monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;

II.A.4.j).(3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,

II.A.4.j).(4) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive

service demands and/or fatigue.

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II.A.4.k) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;

II.A.4.l) comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;

II.A.4.m) be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;

II.A.4.n) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:

II.A.4.n).(1) all applications for ACGME accreditation of new programs;

II.A.4.n).(2) changes in resident complement;

II.A.4.n).(3) major changes in program structure or length of training;

II.A.4.n).(4) progress reports requested by the Review Committee;

II.A.4.n).(5) responses to all proposed adverse actions;

II.A.4.n).(6) requests for increases or any change to resident duty hours;

II.A.4.n).(7) voluntary withdrawals of ACGME-accredited programs;

II.A.4.n).(8) requests for appeal of an adverse action;

II.A.4.n).(9) appeal presentations to a Board of Appeal or the ACGME; and,

II.A.4.n).(10) proposals to ACGME for approval of innovative educational approaches.

II.A.4.o) obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:

II.A.4.o).(1) program citations, and/or

II.A.4.o).(2) request for changes in the program that would have significant impact, including financial, on the program or institution. [As further specified by the Review Committee].

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II.B. Faculty

II.B.1. At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location.

The faculty must:

II.B.1.a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents, and

II.B.1.b) administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.

II.B.2. The physician faculty must have current certification in the specialty by the American Board of _____, or possess qualifications acceptable to the Review Committee.

[As further specified by the Review Committee]

II.B.3. The physician faculty must possess current medical licensure and appropriate medical staff appointment.

II.B.4. The non physician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.

II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.

II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.

II.B.5.b) Some members of the faculty should also demonstrate scholarship by one or more of the following:

II.B.5.b).(1) peer-reviewed funding;

II.B.5.b).(2) publication of original research or review articles in peer reviewed journals, or chapters in textbooks;

II.B.5.b).(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,

II.B.5.b).(4) participation in national committees or educational organizations.

II.B.5.c) Faculty should encourage and support residents in scholarly activities.

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[As further specified by the Review Committee]

II.C. Other Program Personnel

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program.

[As further specified by the Review Committee]

II.D. Resources

The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in the specialty program requirements.

[As further specified by the Review Committee]

II.E. Medical Information Access

Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available.

III. Resident Appointments

III.A. Eligibility Criteria

The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements.

[As further specified by the Review Committee]

III.B. Number of Residents

The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. The program's educational resources must be adequate to support the number of residents appointed to the program.

[As further specified by the Review Committee]

III.C. Resident Transfers

III.C.1. Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident.

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III.C.2. A program director must provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion.

III.D. Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents' education. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.

[As further specified by the Review Committee]

IV. Educational Program

IV.A. The curriculum must contain the following educational components:

IV.A.1. Overall educational goals for the program, which the program must distribute to residents and faculty annually;

IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation;

IV.A.3. Regularly scheduled didactic sessions;

IV.A.4. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and,

IV.A.5. ACGME Competencies

IV.A.5.a) The program must integrate the following ACGME competencies into the curriculum:

IV.A.5.b) Patient Care

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents:

[As further specified by the Review Committee]

IV.A.5.c) Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social behavioral sciences, as well as the application of this knowledge

to patient care. Residents:

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[As further specified by the Review Committee]

IV.A.5.d) Practice-based Learning and Improvement Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning.

Residents are expected to develop skills and habits to be able to meet the following goals:

IV.A.5.d).(1) identify strengths, deficiencies, and limits in one's knowledge and expertise;

IV.A.5.d).(2) set learning and improvement goals;

IV.A.5.d).(3) identify and perform appropriate learning activities;

IV.A.5.d).(4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;

IV.A.5.d).(5) incorporate formative evaluation feedback into daily practice;

IV.A.5.d).(6) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;

IV.A.5.d).(7) use information technology to optimize learning; and,

IV.A.5.d).(8) participate in the education of patients, families, students, residents and other health professionals.

[As further specified by the Review Committee]

IV.A.5.e) Interpersonal and Communication Skills Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.

Residents are expected to:

IV.A.5.e).(1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;

IV.A.5.e).(2) communicate effectively with physicians, other health professionals, and health related agencies;

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IV.A.5.e).(3) work effectively as a member or leader of a health care team or other professional group;

IV.A.5.e).(4) act in a consultative role to other physicians and health professionals; and,

IV.A.5.e).(5) maintain comprehensive, timely, and legible medical records, if applicable.

[As further specified by the Review Committee]

IV.A.5.f) Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:

IV.A.5.f).(1) compassion, integrity, and respect for others;
IV.A.5.f).(2) responsiveness to patient needs that supersedes self interest;
IV.A.5.f).(3) respect for patient privacy and autonomy;
IV.A.5.f).(4) accountability to patients, society and the profession; and,
IV.A.5.f).(5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.
[As further specified by the Review Committee]

IV.A.5.g) Systems-based Practice

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:

IV.A.5.g).(1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;

IV.A.5.g).(2) coordinate patient care within the health care system relevant to their clinical specialty;

IV.A.5.g).(3) incorporate considerations of cost awareness and risk benefit analysis in patient and/or population-based care as appropriate;

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IV.A.5.g).(4) advocate for quality patient care and optimal patient care systems;

IV.A.5.g).(5) work in interprofessional teams to enhance patient safety and improve patient care quality; and,

IV.A.5.g).(6) participate in identifying system errors and implementing potential systems solutions.

[As further specified by the Review Committee]

IV.B. Residents' Scholarly Activities

IV.B.1. The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.

IV.B.2. Residents should participate in scholarly activity.

[As further specified by the Review Committee]

IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.

[As further specified by the Review Committee]

V. Evaluation

V.A. Resident Evaluation

V.A.1. Formative Evaluation

V.A.1.a) The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.

V.A.1.b) The program must:

V.A.1.b).(1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;

V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);

V.A.1.b).(3) document progressive resident performance improvement appropriate to educational level; and,

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V.A.1.b).(4) provide each resident with documented semiannual evaluation of performance with feedback.

V.A.1.c) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.

V.A.2. Summative Evaluation

The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. This evaluation must:

V.A.2.a) document the resident's performance during the final period of education, and

V.A.2.b) verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.

V.B. Faculty Evaluation

V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program.

V.B.2. These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.

V.B.3. This evaluation must include at least annual written confidential evaluations by the residents.

V.C. Program Evaluation and Improvement

V.C.1. The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:

V.C.1.a) resident performance;

V.C.1.b) faculty development;

V.C.1.c) graduate performance, including performance of program graduates on the certification examination; and,

V.C.1.d) program quality. Specifically:

V.C.1.d).(1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and

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V.C.1.d).(2) The program must use the results of residents' assessments of the program together with other program evaluation results to improve the program.

V.C.2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.

VI. Resident Duty Hours in the Learning and Working Environment

VI.A. Professionalism, Personal Responsibility, and Patient Safety

VI.A.1. Programs and sponsoring institutions must educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.

VI.A.2. The program must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment.

VI.A.3. The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.

VI.A.4. The learning objectives of the program must:

VI.A.4.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,

VI.A.4.b) not be compromised by excessive reliance on residents to fulfill non-physician service obligations.

VI.A.5. The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the following:

VI.A.5.a) assurance of the safety and welfare of patients entrusted to their care;

VI.A.5.b) provision of patient- and family-centered care;

VI.A.5.c) assurance of their fitness for duty;

VI.A.5.d) management of their time before, during, and after clinical assignments;

VI.A.5.e) recognition of impairment, including illness and fatigue, in themselves and in their peers;

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VI.A.5.f) attention to lifelong learning;

VI.A.5.g) the monitoring of their patient care performance improvement

indicators; and,

VI.A.5.h) honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.

VI.A.6. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.

VI.B. Transitions of Care

VI.B.1. Programs must design clinical assignments to minimize the number of transitions in patient care.

VI.B.2. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.

VI.B.3. Programs must ensure that residents are competent in communicating with team members in the hand-over process.

VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care.

VI.C. Alertness Management/Fatigue Mitigation

VI.C.1. The program must:

VI.C.1.a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;

VI.C.1.b) educate all faculty members and residents in alertness management and fatigue mitigation processes; and,

VI.C.1.c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.

VI.C.2. Each program must have a process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties.

VI.C.3. The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to

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safely return home.

VI.D. Supervision of Residents

VI.D.1. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.

VI.D.1.a) This information should be available to residents, faculty members, and patients.

VI.D.1.b) Residents and faculty members should inform patients of their respective roles in each patient's care.

VI.D.2. The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients. Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident delivered care with feedback as to the appropriateness of that care.

VI.D.3. Levels of Supervision

To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:

VI.D.3.a) Direct Supervision – the supervising physician is physically present with the resident and patient.

VI.D.3.b) Indirect Supervision:

VI.D.3.b).(1) with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.

VI.D.3.b).(2) with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

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VI.D.3.c) Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

VI.D.4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.

VI.D.4.a) The program director must evaluate each resident's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.

VI.D.4.b) Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.

VI.D.4.c) Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.

VI.D.5. Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.

VI.D.5.a) Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.

VI.D.5.a).(1) In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available. [Each Review Committee will describe the achieved competencies under which PGY-1 residents progress to be supervised indirectly, with direct supervision available.]

VI.D.6. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.

VI.E. Clinical Responsibilities

The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services.

[Optimal clinical workload will be further specified by each Review Committee.]

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VI.F. Teamwork

Residents must care for patients in an environment that maximizes effective communication.

This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty.

[Each Review Committee will define the elements that must be present in each specialty.]

VI.G. Resident Duty Hours

VI.G.1. Maximum Hours of Work per Week

Duty hours must be limited to 80 hours per week, averaged over a four week period, inclusive of all in-house call activities and all moonlighting.

VI.G.1.a) Duty Hour Exceptions

A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.

VI.G.1.a).(1) In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.

VI.G.1.a).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.

VI.G.2. Moonlighting

VI.G.2.a) Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

VI.G.2.b) Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.

VI.G.2.c) PGY-1 residents are not permitted to moonlight.

VI.G.3. Mandatory Time Free of Duty

Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

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VI.G.4. Maximum Duty Period Length

VI.G.4.a) Duty periods of PGY-1 residents must not exceed 16 hours in duration.

VI.G.4.b) Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.

VI.G.4.b).(1) It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.

VI.G.4.b).(2) Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

VI.G.4.b).(3) In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

VI.G.4.b).(3).(a) Under those circumstances, the resident must:

VI.G.4.b).(3).(a).(i) appropriately hand over the care of all other patients to the team responsible for their continuing care; and,

VI.G.4.b).(3).(a).(ii) document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.

VI.G.4.b).(3).(b) The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

VI.G.5. Minimum Time Off between Scheduled Duty Periods

VI.G.5.a) PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.

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VI.G.5.b) Intermediate-level residents [as defined by the Review Committee] should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.

VI.G.5.c) Residents in the final years of education [as defined by the Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

VI.G.5.c).(1) This preparation must occur within the context of the 80- hour, maximum duty period length, and one-day-off-in seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [as defined by the Review Committee] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

VI.G.5.c).(1).(a) Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.

VI.G.6. Maximum Frequency of In-House Night Float

Residents must not be scheduled for more than six consecutive nights of night float.

[The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.]

VI.G.7. Maximum In-House On-Call Frequency

PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

VI.G.8. At-Home Call

VI.G.8.a) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.

VI.G.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.