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). 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. Forty-three 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 academic 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:

<table>
<thead>
<tr>
<th></th>
<th>IM</th>
<th>GI</th>
<th>Hep</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ronald D. Szyjkowski, MD</td>
<td>C</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>Savio John, MD</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Sekou Rawlins, MD</td>
<td>C</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>David Heisig, MD</td>
<td>C</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>Nuri Ozden, MD</td>
<td>C</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>Muhammad Osman Arif, MD</td>
<td>C</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>Divey Manocha, MD</td>
<td>C</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>Uma Murthy, MD</td>
<td>C</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>Anand Gupta, MD</td>
<td>C</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>Bishnu Sapkota, MD</td>
<td>C</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>Ajoy Roy, MD</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
</tbody>
</table>

IM = Internal Medicine, GI = Gastroenterology, Hep = Hepatology, C = Board Certified, E= Board Eligible
B. The following are Research mentor staff of the State University of New York Upstate Medical University Gastroenterology Fellowship Training Program: currently none.

III. CONSULTANTS

   Scholarly input from outside consultants – 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 and may at time be virtual. When possible, interaction will be 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.

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, including the Veteran’s Administration Medical Center at Syracuse and the Oswego Health System, Oswego N.Y. Both Syracuse facilities are tertiary care referral centers which provide staff support and material consistent with tertiary care referral hospitals. The OHS, including affiliated out-patient clinics, is a local, regional leader in community level health care. The general medical patient population is diverse and is derived from the population base living in and around the immediate Syracuse area. Additionally, Upstate Medical University is the major referral center for central New York servicing outlying facilities from the Canadian border to Pennsylvania and Veteran’s Administration Medical Center at Syracuse serves as the primary referral hospital for a variety of outlying hospitals and clinics. It 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 all three 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 each facility.

   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:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>HSC</th>
<th>VAMC</th>
<th>OHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper endoscopy</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Flexible sigmoidoscopy</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Percutaneous liver biopsy</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Percutaneous endoscopic gastrostomy</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>ERCP:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Sphincterotomy</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Procedure</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Balloon cholangioplasty &amp; pancreatoplasty</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insertion of biliary and pancreatic stents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endoscopic lithotripsy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biliary manometry</td>
<td></td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Choledochoscopy</td>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Endoscopic laser therapy</td>
<td></td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Endoscopic therapeutic Hemostasis:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laser</td>
<td></td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Bicap</td>
<td></td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Heater probe</td>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Injection sclerotherapy</td>
<td></td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Variceal band ligation</td>
<td></td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Argon plasma coagulator</td>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Endoscopic ultrasound - diagnostic</td>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Endoscopic ultrasound - therapeutic</td>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Esophageal manometry</td>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Esophageal pH studies</td>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Anal rectal manometry</td>
<td></td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Photodynamic Therapy</td>
<td></td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Capsule Endoscopy</td>
<td></td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Radio Frequency Ablation</td>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

All 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. All 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 all three 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. 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 all three facilities. By their nature each facility will have different patient populations and consultative experiences, allowing the fellow to learn how to manage inpatients in various settings/practice patterns, which is our goal. 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. Ongoing 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 at all three sites, depending upon assignment, 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 at an academic center, a mixed academic and closed population center and a community practice depending upon assignment. Complex co-morbid inpatient problems are seen more commonly at the university and the VA Medical Center while generally lower acuity patients are seen at the Oswego site. This mix aids in the development of factual knowledge, reasoning ability and problem solving. In addition, the trainee learns the art of consultative medicine in different clinical settings, 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. Ongoing assessment of progress will be included in the evaluation process at all levels and at each site.

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, and therefore the greater percentage of this experience will be at University Hospital and the VA Medical Center. 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 and therefore will have a greater presence at the Oswego center in the latter part of the year. 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 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 and therefore they will be afforded the opportunity to have the bulk of activity at the Oswego Center. 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 important. 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 bladholn@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 bladholn@upstate.edu)

Reading of this document will be required. Each fellow will sign an attestation form, documenting this, once during their fellowship.

H. Module on Nutrition
https://sites.google.com/site/nutritioneducationmodule/home
Each fellow will sign an attestation form documenting this once during their fellowship.

I. To report patient safety events, click on link – occurrence reporting
http://sievent.upstate.edu/live/index.php

J. Sexual violence
Copy of “Workplace Sexual Violence” flyer below.
Each fellow will sign an attestation form documenting this once during their fellowship. Each attending, NP, PA will sign an attestation form documenting the review of this flyer at beginning of their employment.
**FACT SHEET: Respect Works**

**What is Workplace Sexual Violence?**

**Defining Sexual Violence**
Sexual violence includes all types of sexual behavior, ranging from sexual harassment to rape and incest, that happens without the freely given consent of the victim. All forms of sexual violence can and do happen in the workplace. While working or on duty, U.S. employees experienced 36,500 rapes and sexual assaults from 1993 to 1999.¹

**Sexual Violence at Work**
Most often, we hear about sexual harassment in the workplace. In 2006, the Equal Employment Opportunity Council received 12,025 charges of sexual harassment (15.4% filed by males).² In the pyramid at right, the range of sexually violent behaviors can be seen. Most of these are considered sexual harassment. Behaviors that involve physical contact are usually called abuse, rape, or sexual assault. All forms of sexual violence can and do happen in the workplace. The abuser or offender can be of the same or opposite sex, a supervisor, an agent of the employer, a supervisor in another area, a co-worker, or a non-employee.

**Consequences for Victims**
Due to the often devastating emotional and physical consequences of sexual violence, victims may have difficulty meeting ongoing work demands in the aftermath of an assault. Women who have been raped or sexually assaulted report decreased work functioning, sometimes for up to 8 months after the attack.³ Almost 50% of rape victims lose their jobs or are forced to quit in the aftermath of the crime.⁴

- **Physical abuse** • Rape • Sexual assault
  (hitting; touching someone sexually; manipulating or forcing someone to have sex)
- **Verbal abuse**
  (yelling at someone; making derogatory comments to someone)
- **Pay inequity**
  (paying men more than women doing the same job)
- **Images**
  (pornographic or offensive images in the workplace)
- **Language**
  (name-calling; using sexual slurs; comments about someone’s body)
- **Jokes**
  (about race or about women as sex objects)

**Cost of Workplace Sexual Violence**
All forms of sexual violence result in high costs for businesses and the economy. Sexual violence on the job is related to lower productivity, higher rates of absenteeism, and lower employee morale. In 1994, sexual harassment cost the federal government an estimated $327 million due to job turnover, sick leave, and individual and work group productivity losses among federal employees.⁷

Interrupted work as a result of sexual violence can also jeopardize the economic stability of individuals, families, and communities. It also increases healthcare costs for both individuals and employers. If employees bring lawsuits (continned on back)
against a company for sexual harassment or violence, businesses may incur large legal fees.

Preventing Workplace Sexual Violence
Prevention means stopping sexual violence before it happens. This requires us to change how we treat one another, and how we look at sexual violence in our society. Employees and employers have a role to play in prevention. Here are some examples:

- Employees treat one another with respect and dignity, regardless of gender, race, or religion.
- Employers have well-publicized company policies for reporting and responding to acts of sexual harassment and violence.
- Businesses support their local rape crisis center through donation of time and/or money. By showing they care, others in the community are inspired to learn more about how to help.

Resources
National Sexual Violence Resource Center
www.nsvrc.org

National Online Resource Center on Violence Against Women (VAWnet)
www.vawnet.org

U.S. Department of Labor
Occupational Health and Safety Administration (OSHA)
www.osha.gov

AFL-CIO Violence Against Women in the Workplace
http://www.aflcio.org/issues/jobseconomy/women/violence.cfm

References

For more information on workplace sexual violence, visit www.nsvrc.org/saam.
K. IHI Quality/Safety Modules-Basic Certificate Requirement – to be completed by All Fellows in their First Year.
Please reference the attached instruction page for accessing education module.

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 bleeder studies and demonstrate competence
i. Variceal hemostasis - 20 supervised cases, including 5 active bleeder 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 and will begin to apply these skills at the Oswego Center.
By the end of the third year the R3 will be able to independently choose 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. in an academic, VA or community setting. 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 based upon available skill sets at any level, 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 (Bi-Weekly)** - Recognizing that changes in department of pathology faculty availability and service constraints, as well as changes in technology, teaching material / methods we are presented with an opportunity to improve how our didactic pathology teaching. These organ systems and patho-physiologically-based bi-weekly didactics which are integrated with our board review schedule are staffed by Upstate Department of Pathology faculty. On alternate weeks 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. At the midway point of academic year 2018/2019 we will reassess if our goal of increasing pathologic information into the day to day practice and education is working.

2. **GI Radiology Conference (Monthly October - June)** - 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.

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 AKA Chairman’s Rounds (Monthly)** - 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. In addition to lecture, the below link will be reviewed.

   [https://sites.google.com/site/nutritioneducationmodule/home](https://sites.google.com/site/nutritioneducationmodule/home)

   An outpatient fellow will prepare weekly case conference based on the published and equally distributed schedule in conjunction with their supervising attending mentor. 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.

ACP High Value Curriculumreference: [https://www.acponline.org/clinical-information/high-value-care/medical-educators-resources/curriculum-for-subspecialty-fellows](https://www.acponline.org/clinical-information/high-value-care/medical-educators-resources/curriculum-for-subspecialty-fellows)

**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 gastroenterological 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

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:

1. Dysphagia
2. Abdominal pain
3. Acute abdomen
4. Nausea and vomiting
5. Diarrhea
6. Constipation
7. Gastrointestinal bleeding
8. Jaundice
9. Abnormal liver chemistries
10. Cirrhosis and portal hypertension
11. Malnutrition
12. Genetic/inherited disorders
13. Depression, neurosis and somatization syndromes pertaining to the gastrointestinal tract
14. Surgical care of gastrointestinal disorders

B. ENDOSCOPIC PROCEDURES, TECHNICAL AND OTHER SKILLS - 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.

1. Imaging of the digestive system including:
   a. Ultrasound procedures, including endoscopic ultrasound
   b. Computed tomography
   c. Magnetic resonance imaging
   d. Vascular radiology procedures
   e. Contrast radiography
   f. Nuclear medicine procedures
   g. Percutaneous cholangiography
2. Endoscopic procedures
3. Specialized dilation procedures
4. Percutaneous cholangiography
5. Percutaneous endoscopic gastrostomy
   a. Placement
   b. Appropriate replacement
6. Liver and mucosal biopsies
7. Gastric, pancreatic and biliary secretory tests
8. Other diagnostic and therapeutic procedures utilizing enteral intubation and bouginage
9. Gastrointestinal motility studies
10. Sclerotherapy
11. Enteral and parenteral alimentation
12. Liver transplantation
13. Pancreatic needle biopsy
14. ERCP including papillotomy and biliary stent placement

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).

1. Esophagastroduodenoscopy - Minimum number to be performed – 130 supervised studies
2. Esophageal dilations - Minimum 50 supervised studies
3. Flexible sigmoidoscopy - Minimum 30 supervised studies
4. Colonoscopy with polypectomy - Minimum of 140 supervised colonoscopies and 30 supervised polypectomies
5. 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
6. Biopsy of the mucosa of the esophagus, stomach, small bowel and colon
7. Other diagnostic and therapeutic procedures utilizing enteral intubation and bouginage
8. Non-variceal hemostasis - Fellows will perform 25 supervised cases including 10 active bleeders
9. Variceal hemostasis - 20 supervised cases, including 5 active bleeders
10. Enteral and parenteral alimentation
11. Moderate sedation
12. Small bowel capsule endoscopy
13. Esophageal capsule endoscopy

While fellows may not directly perform them, exposure to the following diagnostic and therapeutic procedures will be provided:
1. Laser treatment of gastrointestinal tract
2. Endoscopic ultrasound
3. Biliary manometry
4. ERCP
5. Endoluminal Reflux Therapy
6. Radio frequency Ablation
7. Percutaneous liver biopsy - Minimum of 20 supervised studies
8. Gastrointestinal motility studies

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.

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, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility (Common Program Requirements VI.B.3):

Residents and faculty members must demonstrate an understanding of their personal role in the:

VI.B.4.a) provision of patient- and family-centered care;
VI.B.4.b) safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events;
VI.B.4.c) assurance of their fitness for work, including:
   (1) Management of their time before, during, and after clinical assignments; and,
   (2) Recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team.
VI.B.4.d) commitment to lifelong learning;
VI.B.4.e) monitoring of their patient care performance improvement

20
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 resident/fellow is unfit for duty
   b. Provide coverage for clinical duties if another resident/fellow is ill or has a family emergency.
   c. Ensure the availability of coverage for residents/fellow who call-in ill.
   d. Delineate the resident’s responsibility for coverage.
   e. It is not designed to change definitions of time off for human resources/payroll purposes. These remain unchanged.

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 Program Director and/or 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 follow their department procedures in compliance with human resources/payroll policy.

PROCEDURE:
1. The resident will call the Chief Resident to inform them of his/her illness or situation. The resident/fellow will talk directly to the Chief. No voicemail messages should be left. When paging the Chief, a resident must leave a phone number where they can be reached (cell phone and/or home number, not a pager).

2. The resident/fellow will discuss the work type and duration for which coverage is needed. The Chief will ascertain what responsibilities need to be covered to ensure safe, comprehensive transfer of duties to the covering colleague. This will occur prior to each shift for which the resident is ill unless otherwise determined by Chief.

3. As a general rule, each resident/fellow will be expected to complete an equal share of weekend and holiday calls. If the resident/fellow is unable to meet this responsibility due to illness or another situation as listed above, the resident/fellow will complete the requisite number of calls at a later date as determined by the Program Director or Chief. It should be understood that receiving return coverage is a courtesy but is not an absolute requirement and may not be possible in all situations. SUNY Upstate Medical University’s institutional policy allows employees to be out for a number of sick days without consequences. It is in this regard that professionalism and courtesy should exist.

NOTE: Repayment of coverage may never result in an ACGME or New York State duty hours regulation violation, no matter what the circumstances.
4. If a resident/fellow is out sick greater than four days, documentation must be brought to the Program Director’s attention within 24 hours of returning to work. Documentation needs to show the name, date, time, and place where the resident/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 resident/fellow or disciplinary action.

5. For extended absences/illness, please refer to the institutional policy on Leaves of Absence available on SUNY Upstate’s website. Residents and 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.

6. While every attempt will be made to cover a resident or fellow with another resident or fellow, the final authority for patient care and supervision lies with the attending. In all cases when another resident or fellow cannot cover or cannot be reached, the attending on service will provide this coverage.

All trainees are subject to the Office of Graduate Medical Education's drug testing policy.

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 in the outpatient clinics. Fellows 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, and Community). Fellows 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 61 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.

**X. 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 “A 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 fellows 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.

C. Clinical Competency Committee (CCC)

1. Purpose

The Clinical Competency Committee (CCC) is charged with monitoring and evaluating resident/fellow academic and clinical performance, and providing feedback to the Program Director pursuant to this charter, GMEC policies, and the ACGME requirements.

2. Functions:

   a. Serves as an Advisory Committee to the program director with regard to:
      b. Advancement / Promotion
      c. Semi-annual evaluations
      d. Semi-annual Milestones
      e. Promotion, including passage of USMLE Step 3 before the penultimate year
      f. Board Certification
      g. Remediation, including academic probation, academic discipline
      h. Termination of appointment
      i. Professional Discipline

3. The Committee (or subgroup) assures that all processes related to the interface of departmental and institutional grievance processes are addressed should a resident wish to appeal a Program
Director judgment including those on: academic deficiency, academic probation, misconduct, advancement, or Board certification.

4. Committee regularly discusses issues which may affect resident performance (in conjunction with the Associate Dean for GME as needed) including but not limited to:
   a. Substance abuse
   b. Inadequate rest
   c. Stress
   d. Anxiety
   e. Depression

5. Offer feedback to the program on issues related to resident education including but not limited to:
   f. Feedback
   g. Evaluation
   h. Education

6. Membership
   The Clinical Competency Committee is appointed by the Program Director. The Committee shall include a quorum of the fellowship faculty. A quorum is defined as the entire faculty or 12 faculty if the number of teaching faculty exceed 15 members. Members will be appointed for three (3) year terms which may be renewable.
   • Chair: Program Director – Dr. Szyjkowski
   • Associate Director(s) – n/a
   • Full-Time Program Faculty – Drs. Heisig, Arif, Manocha, Rawlins, Ozden, John; VA – Drs. Gupta, Murthy, Sapkota; Oswego – Dr. Roy
   • Program Coordinator – Nikkole Bladholm (non-voting member)

7. Format/Agendas
   The regular meetings of the Committee are held semi-annually in January and June.
   The agenda includes the following activities:
   • Review all Fellow evaluations by all evaluators semi-annually
   • Preparation and assurance of proper reporting of the Milestone evaluations of each fellow semi-annually to the ACGME
   • Making recommendations to the program director for fellow progress, including promotion, remediation and dismissal
   • An attendance of 2/3 of the voting membership of the Committee shall be required.
   • Work within the Committee is confidential. Others who may be brought into Committee deliberations will be advised of the confidential nature of the Committee work.

D. Program Evaluation Committee: The duties of the Program Evaluation Committee (PEC) are to participate in the development of the program’s curriculum and related learning activities, to annually evaluate the program to assess the effectiveness of that curriculum, and to identify actions needed to
foster continued program improvement and correction of areas of non-compliance with ACGME standards.

1. **RESPONSIBILITIES** - per ACGME Common Program Requirements, V.C.1 and V.C.2.:
   The Program Evaluation Committee (PEC) serves as a committee to:

   1. Plan, develop, implement, and evaluate educational activities of the program, including:
      a. Fellow performance
      b. Faculty development
      c. Graduate performance, including performance of program graduates on the certifying examination
      d. Program quality
      e. Review and make recommendations for revision of competency-based curriculum goals and objectives
      f. Address areas of non-compliance with ACGME standards

   2. Review the program annually using evaluations of faculty, fellows, and others.
      a. Fellows and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually.
      b. The program must use the results of fellows’ and faculty members’ assessments of the program together with other program evaluation results to improve the program.

   3. Assess and document progress on the previous year’s action plan(s)

   4. Develop and submit a written Annual Program Evaluation (APE) (ARPE) documenting the formal, systematic evaluation of the curriculum, including 2-5 areas targeted for improvement with action plans.

With the goal of continually improving the educational program, the fellowship must document a formal, systematic evaluation of the curriculum at least annually. Both core faculty responsible for fellow education and fellows must have the opportunity to evaluate the program confidentially and in writing. To assure confidentiality of such evaluations, the responses should be collected over a sufficient period of time so that the collated information contains responses from several fellows and cannot be linked to specific respondents. The evaluation could include planning/organization, support/delivery, and quality. Programs may have fellows complete an evaluation of rotations or specific assignments or learning experiences as part of a targeted improvement plan. The fellows’ confidential evaluation of the teaching faculty may also be used as part of this evaluation. The PEC is responsible for reviewing these confidential evaluations along with the other information collected to improve the program in a systematic and structured fashion with a written plan of action.

2. **PROCEDURE:** Program Evaluation Committee

   1. The program director will invite all GI faculty at University Hospital, Veteran’s Administration Hospital GI faculty, Oswego GI faculty and current fellows to the PEC meeting.
   2. The PEC will be attended by at least 2 members of the fellowship program’s faculty, and include at least one fellow. The PEC will function in accordance with the written description of its responsibilities, as specified in item 3, below.
3. The PEC will participate actively in
   a. Planning, developing, implementing, and evaluating all significant activities of the fellowship program;
   b. Reviewing and making recommendations for revision of competency-based curriculum goals and objectives
   c. Addressing areas of non-compliance with ACGME standards, and
   d. Reviewing the program annually, using evaluations of faculty, resident and others, as specified below.

3. Annual Program Evaluation
   The program, through the PEC, will document formal, systematic evaluation of the curriculum at least annually, and will render a full, written, annual program evaluation (APE)(ARPE).

1. The annual program evaluation will be conducted in the spring of each year, unless scheduled for other programmatic reasons.

2. Approximately two months prior to the review date, the Program Director will:
   a. Facilitate the Program Evaluation Committees’ process to establish and announce the date of the review meeting
   b. Identify an administrative coordinator to assist with organizing the data collection, review process, and report development
   c. Solicit written confidential evaluations from the entire faculty and resident body for consideration in the review (if not done previously for the academic year under review)

3. At the time of the initial meeting, the Committee will consider:
   a. Achievement of action plan improvement initiatives identified during the last annual program evaluation
   b. Achievement of correction of citations and concerns from last ACGME program survey
   c. Fellowship program goals and objectives
   d. Faculty members’ confidential written evaluation of the program
   e. The fellows’ annual confidential written evaluation of the program and faculty
   f. Fellow performance and outcome assessment, as evidenced by:
      i. Aggregate data from general competency assessments
      ii. In-training examination performance
      iii. Case/procedure logs
      iv. Productivity in scholarly activity projects
   g. Graduate performance, including performance on certification examination and scholarly activity successes
   h. Faculty development/education needs and effectiveness of faculty development activities during the past year

4. Additional meetings may be scheduled, as needed, to continue to review data, discuss concerns and potential improvement opportunities and to make recommendations.

   Written minutes will be taken of all meetings.

5. As a result of the information considered and subsequent discussion, the Committee will prepare a written plan of action to document initiatives to improve performance in one or more of these areas:
   a. Resident performance
b. Faculty development  
c. Graduate performance  
d. Program quality  
e. Continued progress on the previous year’s action plan

The plan will delineate how those performance improvement initiatives will be measured and monitored.

6. The final report and action plan will be reviewed and approved by the program’s teaching faculty, and documented in faculty meeting minutes. A report will be provided to the GMEC, and discussed at a full meeting of the GMEC.

XI. 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 trainee’s progress will be accomplished and maintained in the Graduate Medical Education Office of the sponsoring consortium.

XII. 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.

XIII. 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.

XIV. 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. Anyone 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 9 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. Szyjkowski 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 2018-2019 are as follows:

Independence Day, Wednesday, July 4, 2018
Labor Day, Monday, September 3, 2018 (three-day weekend)
Columbus Day, Monday, October 8, 2018 (three-day weekend)
*Election Day, Tuesday, November 6, 2018 (one-day holiday-office remains open)*
*Veteran's Day, Sunday, November 11, 2018 (one-day holiday-office remains open)*
Thanksgiving, Thursday, November 22, 2018 (one-day holiday)
Thanksgiving Friday, November 23, 2018 (could count as three-day holiday weekend)
Christmas Eve, Monday, December 24, 2018 (could count as three-day holiday weekend)
Christmas Day, Tuesday, December 25, 2018 (one-day holiday)
New Year's Day, Tuesday, January 1, 2019 (one-day holiday)
Martin Luther King, Monday, January 21, 2019 (three-day weekend)
Memorial Day, Monday, May 27, 2019 (three-day weekend)

**MEETINGS AND CONFERENCES:**
Fellows' Conferences are scheduled as follows: All Fellows having an approved abstract/poster may request written permission from Mentor/Attending, Gastro Program Director and EPO director for attendance at meetings and reimbursement.

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 approved through DOM Administrative office. The GI Department secretary will assist you in securing this funding.

**Educational allotment**
$300 annually (must be approved by DOM Administrative office before purchasing).

**1st Author Conference Presentation**
$1200 annually (Educational allotment can be used as well)

**Manuscript Acceptance**
If 1st author conference presentation leads to manuscript acceptance in a peer-reviewed journal in the F-1 or F-2 year, the Presentation allotment increases by $300 (to $1500 annually) in the F-2 or F-3 year.

The training program will pay for trainee membership to the American College of Gastroenterology for first year fellows. Fellows will be allowed to decide which single organization they wish the training
program to subsidize trainee membership for during the second and third year of training. Trainees may pay for their own membership to all 3 other societies from their stipend.

1. Fellows receive an annual stipend ($300) for education related use. Educational use is as defined by the Department of Medicine, Upstate Medical and New York State reimbursement policies.

2. One in-training exam per year per fellow is paid for by the program. Which in-training exam is used will be determined by the program director and will apply to all fellows.

3. Membership in one major gastroenterologic subspecialty society trainee membership per fellow per year will be subsidized by the program.

4. Additional expenditures beyond this are borne by individual division external funds (sale of service, educational grants, foundation accounts, etc.)

5. For 1st-author fellow presentation/s at reputable specialty society meetings, the department will provide a maximum of $1200 annually to support travel/accommodations for the presenting 1st-author fellow...and only the 1st-author fellow with no substitution allowed. The $300 education fund can be used to support this as well, but not vice versa.

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 14 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 MedHub.

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 night float 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 Program Requirements for Residency in Gastroenterology; Essentials of Accredited Residents in Graduate Medical Education: Institutional and Program Requirements, page 23-28, pages 91-93.


AAMC Policy Guidance on Graduate Medical Education, October 2001.


ACGME Program Requirements for Graduate Medical Education in Gastroenterology (Internal Medicine)

ACGME-approved: February 5, 2011; effective: July 1, 2012
ACGME approved categorization: September 30, 2012; effective: July 1, 2013
Revised Common Program Requirements effective: July 1, 2015
Revised Common Program Requirements effective: July 1, 2016
Revised Common Program Requirements effective: July 1, 2017

ACGME Program Requirements for Graduate Medical Education in Gastroenterology (Internal Medicine)

Common Program Requirements are in BOLD

Where applicable, text in italics describes the underlying philosophy of the requirements in that section. These philosophic statements are not program requirements and are therefore not citable.

Introduction

Int.A. 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.

Int.B. Gastroenterology fellowships provide advanced education to allow a fellow to acquire competency in the subspecialty with sufficient expertise to act as an independent consultant.

Int.C. The educational program in gastroenterology must be 36 months in length. (Core)*

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 fellow assignments at all participating sites. (Core)

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. (Core)

I.A.1. A gastroenterology fellowship must function as an integral part of an ACGME-accredited residency in internal medicine. (Core)

I.A.2. The sponsoring institution must:

I.A.2.a) establish the gastroenterology fellowship within a department of internal medicine or an administrative unit whose primary mission is the advancement of internal medicine subspecialty education and patient care; and, (Detail)

I.A.2.b) provide the program director with adequate support for the administrative activities of the fellowship. (Core)

I.A.2.b).(1) The program director must not be required to generate clinical or other income to provide this administrative support. (Core)

I.A.2.b).(2) This support should be 25-50% of the program director's salary, or protected time, depending on the size of the program. (Detail)

I.A.3. The sponsoring institution and participating sites must share appropriate inpatient and outpatient faculty performance data with the program director. (Core)

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. (Core)
The PLA should:

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

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

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

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

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

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. (Core)

II.A.1.a) The program director must submit this change to the ACGME via the ADS. (Core)

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. (Detail)

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; (Core)

II.A.3.a).(1) The program director must have at least five years of participation as an active faculty member in an ACGME-accredited internal medicine residency or gastroenterology fellowship. (Detail)

II.A.3.b) current certification in the subspecialty by the American Board of Internal Medicine (ABIM), or subspecialty qualifications that are acceptable to the Review Committee; and, (Core)

II.A.3.b).(1) The Review Committee only accepts current ABIM certification in gastroenterology. (Core)

II.A.3.c) current medical licensure and appropriate medical staff appointment. (Core)
II.A.4. The program director must administer and maintain an educational environment conducive to educating the fellows in each of the ACGME competency areas. (Core)

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; (Core)

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

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

II.A.4.d) evaluate program faculty; (Core)

II.A.4.e) approve the continued participation of program faculty based on evaluation; (Core)

II.A.4.f) monitor fellow supervision at all participating sites; (Core)

II.A.4.g) prepare and submit all information required and requested by the ACGME; (Core)

II.A.4.g).(1) This includes but is not limited to the program application forms and annual program updates to the ADS, and ensure that the information submitted is accurate and complete. (Core)

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; (Detail)

II.A.4.i) provide verification of fellowship education for all fellows, including those who leave the program prior to completion; (Detail)

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

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

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

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

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. (Detail)

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; (Detail)
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 fellows, disciplinary action, and supervision of fellows; (Detail)

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; (Detail)

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

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

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

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

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

II.A.4.n).(5) requests for increases or any change to fellow duty hours; (Detail)

II.A.4.n).(6) voluntary withdrawals of ACGME-accredited programs; (Detail)

II.A.4.n).(7) requests for appeal of an adverse action; and, (Detail)

II.A.4.n).(8) appeal presentations to a Board of Appeal or the ACGME. (Detail)

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

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

II.A.4.o).(2) request for changes in the program that would have significant impact, including financial, on the program or institution. (Detail)

II.A.4.p) be responsible for monitoring fellow stress, including mental or emotional conditions inhibiting performance or learning, and drug- or alcohol-related dysfunction; (Core)

II.A.4.p).(1) The program director should provide access to timely confidential counseling and psychological support services to fellows. (Detail)

II.A.4.p).(2) Situations that demand excessive service or that consistently produce undesirable stress on fellows must be evaluated and modified. (Detail)

II.A.4.q) ensure that fellows' service responsibilities are limited to patients for whom the teaching service has diagnostic and therapeutic responsibility. (Core)

II.A.4.r) dedicate an average of 20 hours per week of his or her professional effort to the fellowship, including time for administration of the program; (Detail)
II.A.4.s) participate in academic societies and in educational programs designed to enhance his or her educational and administrative skills; (Detail)

II.A.4.t) have a reporting relationship with the program director of the internal medicine residency program to ensure compliance with ACGME accreditation standards; (Core)

II.A.4.u) be available at the primary clinical site; and, (Detail)

II.A.4.v) establish a reporting relationship between him or herself and the dependent accredited subspecialty program. (Core)

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 fellows at that location. (Core)

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 fellows, and (Core)

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

II.B.2. The physician faculty must have current certification in the subspecialty by the American Board of Internal Medicine, or possess qualifications judged acceptable to the Review Committee. (Core)

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

II.B.4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)

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

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

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; (Detail)

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

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

II.B.5.c) Faculty should encourage and support fellows in scholarly activities. (Core)

II.B.6. The physician faculty must meet professional standards of ethical behavior. (Core)

II.B.7. Key Clinical Faculty

II.B.7.a) In addition to the program director, each program must have at least three Key Clinical Faculty (KCF). (Core)

II.B.7.b) KCF are attending physicians who dedicate, on average, 10 hours per week throughout the year to the program. (Core)

II.B.7.c) For programs with more than six fellows, there must be at least one KCF for every 1.5 fellows. (Core)

II.B.7.d) Key Clinical Faculty Qualifications

II.B.7.d).(1) KCF must be active clinicians with knowledge of, experience with, and commitment to gastroenterology as a discipline. (Core)

II.B.7.d).(2) KCF must have current ABIM certification in gastroenterology. (Core)

II.B.7.d).(3) At least one KCF should have demonstrated expertise and primary focus in hepatology. (Core)

II.B.7.d).(4) At least one KCF should have demonstrated expertise in all aspects of endoscopy, including advanced procedures. (Core)

II.B.7.e) Key Clinical Faculty Responsibilities

II.B.7.e).(1) In addition to the responsibilities of all individual faculty members, the KCF and the program director are responsible for the planning, implementation, monitoring and evaluation of the fellows' clinical and research education.. (Core)

II.B.7.e).(2) At least 50% of the KCF must demonstrate evidence of productivity in scholarship, specifically, peer-reviewed funding; publication of original research, review articles, editorials, or case reports in peer-reviewed journals; or chapters in textbooks. (Detail)

II.B.7.e).(3) At least one of the KCF must:

II.B.7.e).(3).(a) be knowledgeable in the evaluation and assessment of the ACGME competencies; and, (Detail)

II.B.7.e).(3).(b) spend significant time in the evaluation of fellows including the direct observation of fellows with patients. (Detail)

40
II.B.7.e).(4) Appointment of one KCF to be an associate program director is suggested. (Detail)

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. (Core)

II.C.1. There must be services available from other health care professionals, including dietitians, language interpreters, nurses, occupational therapists, physical therapists, and social workers. (Detail)

II.C.2. There must be appropriate and timely consultation from other specialties. (Detail)

II.D. Resources

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

II.D.1. Space and Equipment

There must be space and equipment for the program, including meeting rooms, examination rooms, computers, visual and other educational aids, and work/study space. (Core)

II.D.2. Facilities

II.D.2.a) Inpatient and outpatient systems must be in place to prevent fellows from performing routine clerical functions, such as scheduling tests and appointments, and retrieving records and letters. (Detail)

II.D.2.b) The sponsoring institution must provide the broad range of facilities and clinical support services required to provide comprehensive care of adult patients. (Core)

II.D.2.c) Facilities for the intensive care of critically ill patients with gastrointestinal disorders must be provided. These facilities should have a working relationship with diagnostic radiology, general surgery, oncology, pathology services, and pediatrics. (Core)

II.D.2.d) Fellows must have access to a lounge facility during assigned duty hours. (Detail)

II.D.2.e) When fellows are in the hospital, assigned night duty, or called in from home, they must be provided with a secure space for their belongings. (Detail)

II.D.3. Laboratory Services

II.D.3.a) There must be a procedure laboratory completely equipped to provide modern capability in gastrointestinal procedures. This equipment must include an up-to-date array of complete diagnostic and therapeutic endoscopic instruments and accessories, with esophageal motility instrumentation. (Core)

II.D.3.b) There should be a laboratory for parasitology testing. (Core)
II.D.4. Other Support Services

Support services, including anesthesiology, diagnostic radiology, general surgery, interventional radiology, medical imaging and nuclear medicine, oncology, and pathology must be available. (Core)

II.D.5. Medical Records

Access to an electronic health record should be provided. In the absence of an existing electronic health record, institutions must demonstrate institutional commitment to its development, and progress towards its implementation. (Core)

II.D.6. Patient Population

II.D.6.a) The patient population must have a variety of clinical problems and stages of diseases. (Core)

II.D.6.b) There must be patients of each gender, with a broad age range, including geriatric patients. (Core)

II.D.6.c) A sufficient number of patients must be available to enable each fellow to achieve the required educational outcomes. (Core)

II.E. Medical Information Access

Fellows 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. (Detail)

III. Fellow Appointments

III.A. Eligibility Criteria

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

III.A.1. Eligibility Requirements – Residency Programs

III.A.1.a) All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, or in Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada. Residency programs must receive verification of each applicant’s level of competency in the required clinical field using ACGME or CanMEDS Milestones assessments from the prior training program. (Core)

III.A.1.b) A physician who has completed a residency program that was not accredited by ACGME, RCPSC, or CFPC may enter an ACGME-accredited residency program in the same specialty at the PGY-1 level and, at the discretion of the program director at the ACGME-accredited program may be advanced to the PGY-2 level based on ACGME Milestones assessments
at the ACGME-accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry. (Core)

III.A.1.c) A Review Committee may grant the exception to the eligibility requirements specified in Section III.A.2.b) for residency programs that require completion of a prerequisite residency program prior to admission. (Core)

III.A.1.d) Review Committees will grant no other exceptions to these eligibility requirements for residency education. (Core)

III.A.2. Eligibility Requirements – Fellowship Programs

All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, or in an RCPSC-accredited or CFPC-accredited residency program located in Canada. (Core)

Prior to appointment in the fellowship, fellows should have completed an ACGME- or RCPSC-accredited internal medicine program. (Core)

III.A.2.a) Fellowship programs must receive verification of each entering fellow’s level of competency in the required field using ACGME or CanMEDS Milestones assessments from the core residency program. (Core)

III.A.2.b) Fellow Eligibility Exception

A Review Committee may grant the following exception to the fellowship eligibility requirements:

An ACGME-accredited fellowship program may accept an exceptionally qualified applicant**, who does not satisfy the eligibility requirements listed in Sections III.A.2. and III.A.2.a), but who does meet all of the following additional qualifications and conditions: (Core)

III.A.2.b).(1) Assessment by the program director and fellowship selection committee of the applicant’s suitability to enter the program, based on prior training and review of the summative evaluations of training in the core specialty; and, (Core)

III.A.2.b).(2) Review and approval of the applicant’s exceptional qualifications by the GMEC or a subcommittee of the GMEC; and, (Core)

III.A.2.b).(3) Satisfactory completion of the United States Medical Licensing Examination (USMLE) Steps 1, 2, and, if the applicant is eligible, 3; and, (Core)

III.A.2.b).(4) For an international graduate, verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification; and, (Core)

III.A.2.b).(5) Applicants accepted by this exception must complete fellowship Milestones evaluation (for the purposes of establishment of baseline performance by the Clinical Competency Committee), conducted by the receiving fellowship program within six weeks of matriculation. This evaluation may be waived for an applicant who has completed an ACGME International-
accredited residency based on the applicant’s Milestones evaluation conducted at the conclusion of the residency program; and, (Core)

III.A.2.b).(5).(a) If the trainee does not meet the expected level of Milestones competency following entry into the fellowship program, the trainee must undergo a period of remediation, overseen by the Clinical Competency Committee and monitored by the GMEC or a subcommittee of the GMEC. This period of remediation must not count toward time in fellowship training. (Core)

** An exceptionally qualified applicant has (1) completed a non-ACGME-accredited residency program in the core specialty, and (2) demonstrated clinical excellence, in comparison to peers, throughout training. Additional evidence of exceptional qualifications is required, which may include one of the following: (a) participation in additional clinical or research training in the specialty or subspecialty; (b) demonstrated scholarship in the specialty or subspecialty; (c) demonstrated leadership during or after residency training; (d) completion of an ACGME-International accredited residency program.

III.A.2.b).(6) Fellows from non-ACGME- or RCPSC-accredited internal medicine programs must have completed at least three years of internal medicine education prior to starting the fellowship. (Core)

III.A.2.b).(6).(a) The program director must inform applicants from non-ACGME-accredited programs, prior to appointment and in writing, of the ABIM policies and procedures that will affect their eligibility for ABIM certification. (Detail)

III.A.2.c) The Review Committee for Internal Medicine does allow exceptions to the Eligibility Requirements for Fellowship Programs in Section III.A.2. (Core)

III.B. Number of Fellows

The program’s educational resources must be adequate to support the number of fellows appointed to the program. (Core)

III.B.1. The program director may not appoint more fellows than approved by the Review Committee, unless otherwise stated in the specialty specific requirements. (Core)

III.B.2. The number of available fellow positions in the program must be at least one per year. (Detail)

III.C. Fellow Transfers

III.C.1. Before accepting a fellow 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 fellow. (Detail)

III.C.2. A program director must provide timely verification of fellowship education and summative performance evaluations for fellows who may leave the program prior to completion. (Detail)

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 fellows' education. (Core)

III.D.1. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines. (Detail)

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, make available to fellows and faculty; (Core)

IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to fellows and faculty at least annually, in either written or electronic form; (Core)

IV.A.3. Regularly scheduled didactic sessions; (Core)

IV.A.3.a) The core curriculum must include a didactic program based upon the core knowledge content in the subspecialty area. (Core)

IV.A.3.a).(1) The program must afford each fellow an opportunity to review topics covered in conferences that he or she was unable to attend. (Detail)

IV.A.3.a).(2) Fellows must participate in clinical case conferences, journal clubs, research conferences, and morbidity and mortality or quality improvement conferences. (Detail)

IV.A.3.a).(3) All core conferences must have at least one faculty member present, and must be scheduled as to ensure peer-peer and peer-faculty interaction. (Detail)

IV.A.3.b) Patient-based teaching must include direct interaction between fellows and faculty members, bedside teaching, discussion of pathophysiology, and the use of current evidence in diagnostic and therapeutic decisions. (Core)

The teaching must be:

IV.A.3.b).(1) formally conducted on all inpatient, outpatient, and consultative services; and, (Detail)

IV.A.3.b).(2) conducted with a frequency and duration that ensures a meaningful and continuous teaching relationship between the assigned supervising faculty member(s) and fellows. (Detail)

IV.A.3.c) Fellows must receive instruction in practice management relevant to gastroenterology. (Detail)

IV.A.4. Delineation of fellow responsibilities for patient care, progressive responsibility for patient management, and supervision of fellows over the continuum of the program; and, (Core)
IV.A.5. ACGME Competencies

The program must integrate the following ACGME competencies into the curriculum: (Core)

IV.A.5.a) Patient Care and Procedural Skills

IV.A.5.a).(1) Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Fellows: (Outcome)

IV.A.5.a).(1).(a) must demonstrate competence in the practice of health promotion, disease prevention, diagnosis, care, and treatment of patients of each gender, from adolescence to old age, during health and all stages of illness; and, (Outcome)

IV.A.5.a).(1).(b) must demonstrate competence in prevention, evaluation, and management of the following:

IV.A.5.a).(1).(b).(i) acid peptic disorders of the gastrointestinal tract; (Outcome)
IV.A.5.a).(1).(b).(ii) acute and chronic gallbladder and biliary tract diseases; (Outcome)
IV.A.5.a).(1).(b).(iii) acute and chronic liver diseases; (Outcome)
IV.A.5.a).(1).(b).(iv) acute and chronic pancreatic diseases; (Outcome)
IV.A.5.a).(1).(b).(v) diseases of the esophagus; (Outcome)
IV.A.5.a).(1).(b).(vi) disorders of nutrient assimilation; (Outcome)
IV.A.5.a).(1).(b).(vii) gastrointestinal and hepatic neoplastic disease; (Outcome)
IV.A.5.a).(1).(b).(viii) gastrointestinal bleeding; (Outcome)
IV.A.5.a).(1).(b).(ix) gastrointestinal diseases with an immune basis; (Outcome)
IV.A.5.a).(1).(b).(x) gastrointestinal emergencies in the acutely ill patient; (Outcome)
IV.A.5.a).(1).(b).(xi) gastrointestinal infections, including retroviral, mycotic, and parasitic diseases; (Outcome)
IV.A.5.a).(1).(b).(xii) genetic/inherited disorders; (Outcome)
IV.A.5.a).(1).(b).(xiii) geriatric gastroenterology; (Outcome)
IV.A.5.a).(1).(b).(xiv) inflammatory bowel diseases; (Outcome)
IV.A.5.a).(1).(b).(xv) irritable bowel syndrome; (Outcome)
IV.A.5.a).(1).(b).(xvi) motor disorders of the gastrointestinal tract; (Outcome)
IV.A.5.a).(1).(b).(xvii) motor disorders of the gastrointestinal tract; (Outcome)
IV.A.5.a).(1).(b).(xviii) vascular disorders of the gastrointestinal tract; (Outcome) and,
IV.A.5.a).(1).(b).(xix) women’s health issues in digestive diseases; (Outcome)

IV.A.5.a).(2) Fellows must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. Fellows: (Outcome) must demonstrate competence in the performance of the following procedures:

IV.A.5.a).(2).(a) biopsy of the mucosa of esophagus, stomach, small bowel, and colon; (Outcome)
IV.A.5.a).(2).(b) capsule endoscopy; (Outcome)
IV.A.5.a).(2).(c) colonoscopy with polypectomy; (Outcome)
IV.A.5.a).(2).(d) conscious sedation; (Outcome)
IV.A.5.a).(2).(e) esophageal dilation; (Outcome)
IV.A.5.a).(2).(f) esophagogastroduodenoscopy; (Outcome)
IV.A.5.a).(2).(g) nonvariceal hemostasis, both upper and lower including actively bleeding patients; (Outcome)
IV.A.5.a).(2).(h) other diagnostic and therapeutic procedures utilizing enteral intubation; (Outcome)
IV.A.5.a).(2).(i) paracentesis; (Outcome)
IV.A.5.a).(2).(j) percutaneous endoscopic gastrostomy; (Outcome)
IV.A.5.a).(2).(k) retrieval of foreign bodies from the esophagus; and, (Outcome)
IV.A.5.a).(2).(l) variceal hemostasis including actively bleeding patients. (Outcome)

IV.A.5.b) Medical Knowledge
Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and socialbehavioral sciences, as well as the application of this knowledge to patient care. Fellows: (Outcome)

IV.A.5.b).(1) must demonstrate knowledge of the scientific method of problem solving and evidence-based decision making; (Outcome)
IV.A.5.b).(2) must demonstrate knowledge of indications, contraindications, limitations, complications, techniques, and interpretation of results of those diagnostic and therapeutic procedures integral to the discipline, including the appropriate indication for and use of screening tests/procedures; and, (Outcome)
IV.A.5.b).(3) must demonstrate knowledge of:

IV.A.5.b).(3).(a) anatomy, physiology, pharmacology, pathology and molecular biology related to the gastrointestinal system, including the liver, biliary tract and pancreas; (Outcome)
IV.A.5.b).(3).(b) interpretation of abnormal liver chemistries; (Outcome)
IV.A.5.b).(3).(c) liver transplantation; (Outcome)
IV.A.5.b).(3).(d) nutrition; (Outcome)
IV.A.5.b).(3).(e) prudent, cost-effective, and judicious use of special instruments, tests, and therapy in the diagnosis and management of gastroenterologic disorders; (Outcome)
IV.A.5.b).(3).(f) sedative pharmacology; and, (Outcome)
IV.A.5.b).(3).(g) surgical procedures employed in relation to digestive system disorders and their complications. (Outcome)

IV.A.5.c) Practice-based Learning and Improvement

Fellows 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. (Outcome)

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

IV.A.5.c).(1) identify strengths, deficiencies, and limits in one's knowledge and expertise; (Outcome)
IV.A.5.c)(2) set learning and improvement goals; (Outcome)

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

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

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

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

IV.A.5.c)(7) use information technology to optimize learning; (Outcome)

IV.A.5.c)(8) participate in the education of patients, families, students, fellows and other health professionals; and, (Outcome)

IV.A.5.c)(9) obtain procedure-specific informed consent by competently educating patients about rationale, technique, and complications of procedures. (Outcome)

IV.A.5.d) Interpersonal and Communication Skills

Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Outcome)

Fellows are expected to:

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

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

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

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

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

IV.A.5.e) Professionalism

Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. (Outcome)

Fellows are expected to demonstrate:

IV.A.5.e)(1) compassion, integrity, and respect for others; (Outcome)

IV.A.5.e)(2) responsiveness to patient needs that supersedes self-interest; (Outcome)

IV.A.5.e)(3) respect for patient privacy and autonomy; (Outcome)
IV.A.5.e).(4) accountability to patients, society and the profession; (Outcome)

IV.A.5.e).(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; and, (Outcome)

IV.A.5.e).(6) high standards of ethical behavior, including maintaining appropriate professional boundaries and relationships with other physicians and other health care team members, and avoiding conflicts of interest. (Outcome)

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

Fellows 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. (Outcome)

Fellows are expected to:

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

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

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

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

IV.A.5.f).(5) work in inter-professional teams to enhance patient safety and improve patient care quality; and, (Outcome)

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

IV.A.6. Curriculum Organization and Fellow Experiences

IV.A.6.a) A minimum of 18 months must be devoted to clinical experience, of which the equivalent of five months should be comprised of hepatology. (Core)

IV.A.6.b) Fellows must participate in training using simulation. (Detail)

IV.A.6.c) Experience with Continuity Ambulatory Patients

IV.A.6.c).(1) Fellows must have continuity ambulatory clinic experience that exposes them to the breadth and depth of the subspecialty. (Core)

IV.A.6.c).(2) This experience should average one half-day each week. (Detail)

IV.A.6.c).(3) This experience must include an appropriate distribution of patients of each gender and a diversity of ages. (Core)
This should be accomplished through either:

IV.A.6.c).(3).(a) a continuity clinic which provides fellows the opportunity to observe and learn the course of disease; or, (Detail)

IV.A.6.c).(3).(b) selected blocks of at least six months which address specific areas of gastrointestinal disease. (Detail)

IV.A.6.c).(4) Each fellow should, on average, be responsible for four to eight patients during each half-day session. (Detail)

IV.A.6.c).(5) The continuity patient care experience should not be interrupted by more than one month, excluding a fellow's vacation. (Detail)

IV.A.6.c).(6) Fellows should be informed of the status of their continuity patients when such patients are hospitalized, as clinically appropriate. (Detail)

IV.A.6.d) Procedures and Technical Skills

IV.A.6.d).(1) Direct supervision of procedures performed by each fellow must occur until proficiency has been acquired and documented by the program director. (Core)

IV.A.6.d).(2) Faculty members must teach and supervise the fellows in the performance and interpretation of procedures, which must be documented in each fellow's record, including indications, outcomes, diagnoses, and supervisor(s). (Core)

IV.A.6.d).(3) Fellows must have formal instruction and clinical experience in the interpretation of the following diagnostic and therapeutic techniques and procedures:

IV.A.6.d).(3).(a) Endoscopic Retrograde Cholangiopancreatography, in all its diagnostic and therapeutic applications; (Core)

IV.A.6.d).(3).(b) enteral and parenteral alimentation; (Core)

IV.A.6.d).(3).(c) imaging of the digestive system, including:

IV.A.6.d).(3).(c).(i) computed tomography (CT); including CT enterocolography; (Core)

IV.A.6.d).(3).(c).(ii) contrast radiography; (Core)

IV.A.6.d).(3).(c).(iii) magnetic resonance imaging; (Core)

IV.A.6.d).(3).(c).(iv) nuclear medicine; (Core)

IV.A.6.d).(3).(c).(v) percutaneous cholangiography; (Core)

IV.A.6.d).(3).(c).(vi) ultrasound, including endoscopic ultrasound; (Core)

IV.A.6.d).(3).(c).(vii) vascular radiography; and (Core)

IV.A.6.d).(3).(c).(viii) wireless capsule endoscopy. (Core)

IV.A.6.d).(3).(d) interpretation of gastrointestinal and hepatic biopsies; and, (Core)

IV.A.6.d).(3).(e) motility studies, including esophageal motility/pH studies. (Core)

IV.A.6.d).(4) Fellows must have exposure to and clinical experience in the performance of gastrointestinal motility studies and 24-hour pH monitoring. (Core)

IV.B. Fellows' Scholarly Activities

IV.B.1. The curriculum must advance fellows' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care. (Core)
IV.B.2. Fellows should participate in scholarly activity. (Core)

IV.B.2.a) The majority of fellows must demonstrate evidence of scholarship conducted during the fellowship. (Outcome)

This should be achieved through one or more of the following:

IV.B.2.a).(1) publication of articles, book chapters, abstracts or case reports in peer-reviewed journals; (Detail)

IV.B.2.a).(2) publication of peer-reviewed performance improvement or education research; (Detail)

IV.B.2.a).(3) peer-reviewed funding; or, (Detail)

IV.B.2.a).(4) peer-reviewed abstracts presented at regional, state or national specialty meetings. (Detail)

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

V. Evaluation

V.A. Fellow Evaluation

V.A.1. The program director must appoint the Clinical Competency Committee. (Core)

V.A.1.a) At a minimum the Clinical Competency Committee must be composed of three members of the program faculty. (Core)

V.A.1.a).(1) The program director may appoint additional members of the Clinical Competency Committee.

V.A.1.a).(1).(a) These additional members must be physician faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program’s fellows in patient care and other health care settings. (Core)

V.A.1.a).(1).(b) Chief residents who have completed core residency programs in their specialty and are eligible for specialty board certification may be members of the Clinical Competency Committee. (Core)

V.A.1.b) There must be a written description of the responsibilities of the Clinical Competency Committee. (Core)

V.A.1.b).(1) The Clinical Competency Committee should:

V.A.1.b).(1).(a) review all fellow evaluations semi-annually; (Core)

V.A.1.b).(1).(b) prepare and ensure the reporting of Milestones evaluations of each fellow semi-annually to ACGME; and, (Core)
V.A.1.b).(1).(c) advise the program director regarding fellow progress, including promotion, remediation, and dismissal. (Detail)

V.A.2. Formative Evaluation

V.A.2.a) The faculty must evaluate fellow performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment. (Core)

V.A.2.a).(1) The faculty must discuss this evaluation with each fellow at the completion of each assignment. (Core)

V.A.2.a).(2) Assessment of procedural competence should include a formal evaluation process and not be based solely on a minimum number of procedures performed. (Detail)

V.A.2.b) The program must:

V.A.2.b).(1) provide objective assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the specialty-specific Milestones; (Core)

V.A.2.b).(1).(a) Patient Care

The program must assess the fellow in data gathering, clinical reasoning, patient management and procedures in both the inpatient and outpatient setting. (Core)

V.A.2.b).(1).(a).(i) This assessment must involve direct observation of fellow patient encounters. (Detail)

V.A.2.b).(1).(a).(ii) Each program must define criteria for competence for all required and elective procedures. (Detail)

V.A.2.b).(1).(a).(iii) The record of evaluation must include the fellow’s logbook or an equivalent method to demonstrate that each fellow has achieved competence in the performance of required procedures. (Detail)

V.A.2.b).(1).(b) Medical Knowledge

The program must use an objective formative assessment method. The same formative assessment method must be administered at least twice during the program. (Detail)

V.A.2.b).(1).(c) Practice-based Learning and Improvement

The program must use performance data to assess the fellow in:

V.A.2.b).(1).(c).(i) application of evidence to patient care; (Detail)

V.A.2.b).(1).(c).(ii) practice improvement; (Detail)

V.A.2.b).(1).(c).(iii) teaching skills involving peers and patients; and, (Detail)

V.A.2.b).(1).(c).(iv) scholarship. (Detail)

52
V.A.2.b).(1).(d) Interpersonal and Communication Skills

The program must use both direct observation and multi-source evaluation, including patients, peers and non-physician team members, to assess fellow performance in:
V.A.2.b).(1).(d).(i) communication with patient and family; (Detail)
V.A.2.b).(1).(d).(ii) teamwork; (Detail)
V.A.2.b).(1).(d).(iii) communication with peers, including transitions in care; and, (Detail)
V.A.2.b).(1).(d).(iv) record keeping. (Detail)

V.A.2.b).(1).(e) Professionalism

The program must use multi-source evaluation, including patients, peers, and non-physician team members, to assess each fellow’s:
V.A.2.b).(1).(e).(i) honesty and integrity; (Detail)
V.A.2.b).(1).(e).(ii) ability to meet professional responsibilities; (Detail)
V.A.2.b).(1).(e).(iii) ability to maintain appropriate professional relationships with patients and colleagues; and, (Detail)
V.A.2.b).(1).(e).(iv) commitment to self-improvement. (Detail)

V.A.2.b).(1).(f) Systems-based Practice

The program must use multi-source evaluation, including peers, and non-physician team members, to assess each fellow’s:
V.A.2.b).(1).(f).(i) ability to provide care coordination, including transition of care; (Detail)
V.A.2.b).(1).(f).(ii) ability to work in interdisciplinary teams; (Detail)
V.A.2.b).(1).(f).(iii) advocacy for quality of care; and, (Detail)
V.A.2.b).(1).(f).(iv) ability to identify system problems and participate in improvement activities. (Detail)

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

V.A.2.b).(3) document progressive fellow performance improvement appropriate to educational level; and, (Core)

V.A.2.b).(4) provide each fellow with documented semiannual evaluation of performance with feedback. (Core)

V.A.2.b).(4).(a) Fellows’ performance in continuity clinic must be reviewed with them verbally and in writing at least semiannually. (Detail)

V.A.2.c) The evaluations of fellow performance must be accessible for review by the fellow, in accordance with institutional policy. (Detail)

V.A.3. Summative Evaluation

V.A.3.a) The specialty-specific Milestones must be used as one of the tools to ensure fellows are able to practice core professional activities without supervision upon completion of the program. (Core)
V.A.3.b) The program director must provide a summative evaluation for each fellow upon completion of the program. (Core)

This evaluation must:

V.A.3.b).(1) become part of the fellow's permanent record maintained by the institution, and must be accessible for review by the fellow in accordance with institutional policy; (Detail)

V.A.3.b).(2) document the fellow's performance during the final period of education; and, (Detail)

V.A.3.b).(3) verify that the fellow has demonstrated sufficient competence to enter practice without direct supervision. (Detail)

V.B. Faculty Evaluation

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

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. (Detail)

V.B.3. This evaluation must include at least annual written confidential evaluations by the fellows. (Detail)

V.B.3.a) Fellows must have the opportunity to provide confidential written evaluations of each supervising faculty member at the end of each rotation. (Detail)

V.B.3.b) These evaluations must be reviewed with each faculty member annually. (Detail)

V.C. Program Evaluation and Improvement

V.C.1. The program director must appoint the Program Evaluation Committee (PEC). (Core)

V.C.1.a) The Program Evaluation Committee:

V.C.1.a).(1) must be composed of at least two program faculty members and should include at least one fellow; (Core)

V.C.1.a).(2) must have a written description of its responsibilities; and, (Core)

V.C.1.a).(3) should participate actively in:

V.C.1.a).(3).(a) planning, developing, implementing, and evaluating educational activities of the program; (Detail)

V.C.1.a).(3).(b) reviewing and making recommendations for revision of competency-based curriculum goals and objectives; (Detail)
V.C.1.a).(3).(c) addressing areas of non-compliance with ACGME standards; and, (Detail)

V.C.1.a).(3).(d) reviewing the program annually using evaluations of faculty, fellows, and others, as specified below. (Detail)

V.C.2. The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written, annual program evaluation. (Core)

The program must monitor and track each of the following areas:

V.C.2.a) fellow performance; (Core)

V.C.2.b) faculty development; (Core)

V.C.2.c) graduate performance, including performance of program graduates on the certification examination; (Core)

V.C.2.c).(1) At least 80% of the program’s graduating fellows from the most recently defined five year period who are eligible should take the ABIM certifying examination. (Outcome)

V.C.2.c).(2) At least 80% of a program’s graduates taking the ABIM certifying examination for the first time during the most recently defined five year period should pass. (Outcome)

V.C.2.d) program quality; and, (Core)

V.C.2.d).(1) Fellows and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually. (Detail)

V.C.2.d).(2) The program must use the results of fellows’ and faculty members’ assessments of the program together with other program evaluation results to improve the program. (Detail)

V.C.2.d).(3) At least 80% of the entering fellows should have completed the program when averaged over a five-year period. (Outcome)

V.C.2.e) progress on the previous year’s action plan(s). (Core)

V.C.3. The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section V.C.2., as well as delineate how they will be measured and monitored. (Core)

V.C.3.a) The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes. (Detail)

V.C.4. Representative program personnel, at a minimum to include the program director, representative faculty, and one fellow, must review program goals and objectives, and the effectiveness with which they are achieved. (Detail)
VI. The Learning and Working Environment

Residency education must occur in the context of a learning and working environment that emphasizes the following principles:

• Excellence in the safety and quality of care rendered to patients by residents today

• Excellence in the safety and quality of care rendered to patients by today’s residents in their future practice

• Excellence in professionalism through faculty modeling of:
  o the effacement of self-interest in a humanistic environment that supports the professional development of physicians
  o the joy of curiosity, problem-solving, intellectual rigor, and discovery

• Commitment to the well-being of the students, residents, faculty members, and all members of the health care team

VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability

VI.A.1. Patient Safety and Quality Improvement

All physicians share responsibility for promoting patient safety and enhancing quality of patient care. Graduate medical education must prepare residents to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by residents who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.

Residents must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating residents will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

It is necessary for residents and faculty members to consistently work in a well-coordinated manner with other health care professionals to achieve organizational patient safety goals.

VI.A.1.a) Patient Safety

VI.A.1.a).(1) Culture of Safety

A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.
VI.A.1.a).(1).(a) The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)

VI.A.1.a).(1).(b) The program must have a structure that promotes safe, interprofessional, team-based care. (Core)

VI.A.1.a).(2) Education on Patient Safety

Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)

VI.A.1.a).(3) Patient Safety Events

Reporting, investigation, and follow-up of adverse events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.

VI.A.1.a).(3).(a) Residents, fellows, faculty members, and other clinical staff members must:

VI.A.1.a).(3).(a).(i) know their responsibilities in reporting patient safety events at the clinical site; (Core)

VI.A.1.a).(3).(a).(ii) know how to report patient safety events, including near misses, at the clinical site; and, (Core)

VI.A.1.a).(3).(a).(iii) be provided with summary information of their institution’s patient safety reports. (Core)

VI.A.1.a).(3).(b) Residents must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)

VI.A.1.a).(4) Resident Education and Experience in Disclosure of Adverse Events

Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for residents to develop and apply.

VI.A.1.a).(4).(a) All residents must receive training in how to disclose adverse events to patients and families. (Core)

VI.A.1.a).(4).(b) Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated. (Detail)

VI.A.1.b) Quality Improvement
VI.A.1.b).(1) Education in Quality Improvement

A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.

VI.A.1.b).(1).(a) Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities. (Core)

VI.A.1.b).(2) Quality Metrics

Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.

VI.A.1.b).(2).(a) Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)

VI.A.1.b).(3) Engagement in Quality Improvement Activities Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.

VI.A.1.b).(3).(a) Residents must have the opportunity to participate in interprofessional quality improvement activities. (Core)

VI.A.1.b).(3).(a).(i) This should include activities aimed at reducing health care disparities. (Detail)

VI.A.2. Supervision and Accountability

VI.A.2.a) Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.

Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident’s development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

VI.A.2.a).(1) Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient’s care. (Core)

VI.A.2.a).(1).(a) This information must be available to residents, faculty members, other members of the health care team, and patients. (Core)

VI.A.2.a).(1).(b) Residents and faculty members must inform each patient of their respective roles in that patient’s care when providing direct patient care. (Core)

VI.A.2.b) Supervision may be exercised through a variety of methods.
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, fellow, or senior resident physician, either on site or by means of telephonic and/or electronic modalities. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.

VI.A.2.b).(1) The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident’s level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core)

VI.A.2.c) Levels of Supervision

To promote oversight of resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision: (Core)

VI.A.2.c).(1) Direct Supervision – the supervising physician is physically present with the resident and patient. (Core)

VI.A.2.c).(2) Indirect Supervision:

VI.A.2.c).(2).(a) 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. (Core)

VI.A.2.c).(2).(b) 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. (Core)

VI.A.2.c).(3) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. (Core)

VI.A.2.d) 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. (Core)

VI.A.2.d).(1) The program director must evaluate each resident’s abilities based on specific criteria, guided by the Milestones. (Core)

VI.A.2.d).(2) Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. (Core)

VI.A.2.d).(3) Senior residents or fellows should serve in a supervisory role to 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. (Detail)

VI.A.2.e) Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). (Core)
VI.A.2.e).(1) Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. (Outcome)

VI.A.2.e).(1).(a) Initially, PGY-1 residents must be supervised either directly, or indirectly with direct supervision immediately available. (Core)

VI.A.2.f) Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility. (Core)

VI.B. Professionalism

VI.B.1. Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients. (Core)

VI.B.2. The learning objectives of the program must:

VI.B.2.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; (Core)

VI.B.2.b) be accomplished without excessive reliance on residents to fulfill non-physician obligations; and, (Core)

VI.B.2.c) ensure manageable patient care responsibilities. (Core)

VI.B.3. The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)

VI.B.4. Residents and faculty members must demonstrate an understanding of their personal role in the:

VI.B.4.a) provision of patient- and family-centered care; (Outcome)

VI.B.4.b) safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events; (Outcome)

VI.B.4.c) assurance of their fitness for work, including: (Outcome)

VI.B.4.c).(1) management of their time before, during, and after clinical assignments; and, (Outcome)

VI.B.4.c).(2) recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team. (Outcome)

VI.B.4.d) commitment to lifelong learning; (Outcome)

VI.B.4.e) monitoring of their patient care performance improvement indicators; and, (Outcome)
VI.B.4.f) accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data. (Outcome)

VI.B.5. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition 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. (Outcome)

VI.B.6. Programs must provide a professional, respectful, and civil environment that is free from mistreatment, abuse, or coercion of students, residents, faculty, and staff. Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)

VI.C. Well-Being

In the current health care environment, residents and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician. Self-care is an important component of professionalism; it is also a skill that must be learned and nurtured in the context of other aspects of residency training. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as they do to evaluate other aspects of resident competence.

VI.C.1. This responsibility must include:

VI.C.1.a) efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships; (Core)

VI.C.1.b) attention to scheduling, work intensity, and work compression that impacts resident well-being; (Core)

VI.C.1.c) evaluating workplace safety data and addressing the safety of residents and faculty members; (Core)

VI.C.1.d) policies and programs that encourage optimal resident and faculty member well-being; and, (Core)

VI.C.1.d).(1) Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core)

VI.C.1.e) attention to resident and faculty member burnout, depression, and substance abuse. The program, in partnership with its Sponsoring Institution, must educate faculty members and residents in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must; (Core)
VI.C.1.e).(1) encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence; (Core)

VI.C.1.e).(2) provide access to appropriate tools for self-screening; and, (Core)

VI.C.1.e).(3) provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)

VI.C.2. There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. Each program must have policies and procedures in place that ensure coverage of patient care in the event that a resident may be unable to perform their patient care responsibilities. These policies must be implemented without fear of negative consequences for the resident who is unable to provide the clinical work. (Core)

VI.D. Fatigue Mitigation

VI.D.1. Programs must:

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

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

VI.D.1.c) encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. (Detail)

VI.D.2. Each program must ensure continuity of patient care, consistent with the program’s policies and procedures referenced in VI.C.2, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue. (Core)

VI.D.3. The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home. (Core)

VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care

VI.E.1. Clinical Responsibilities

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

VI.E.2. Teamwork
Residents must care for patients in an environment that maximizes 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 and larger health system. (Core)

VI.E.3. Transitions of Care

VI.E.3.a) Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)

VI.E.3.b) Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. (Core)

VI.E.3.c) Programs must ensure that residents are competent in communicating with team members in the hand-over process. (Outcome)

VI.E.3.d) Programs and clinical sites must maintain and communicate schedules of attending physicians and residents currently responsible for care. (Core)

VI.E.3.e) Each program must ensure continuity of patient care, consistent with the program’s policies and procedures referenced in VI.C.2, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency. (Core)

VI.F. Clinical Experience and Education

Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.

VI.F.1. Maximum Hours of Clinical and Educational Work per Week

Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. (Core)

VI.F.2. Mandatory Time Free of Clinical Work and Education

VI.F.2.a) The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being. (Core)

VI.F.2.b) Residents should have eight hours off between scheduled clinical work and education periods. (Detail)

VI.F.2.b).(1) There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements. (Detail)
VI.F.2.c) Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)

VI.F.2.d) Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days. (Core)

VI.F.3. Maximum Clinical Work and Education Period Length

VI.F.3.a) Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. (Core)

VI.F.3.a).(1) Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. (Core)

VI.F.3.a).(1).(a) Additional patient care responsibilities must not be assigned to a resident during this time. (Core)

VI.F.4. Clinical and Educational Work Hour Exceptions

VI.F.4.a) In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:

VI.F.4.a).(1) to continue to provide care to a single severely ill or unstable patient; (Detail)

VI.F.4.a).(2) humanistic attention to the needs of a patient or family; or, (Detail)

VI.F.4.a).(3) to attend unique educational events. (Detail)

VI.F.4.b) These additional hours of care or education will be counted toward the 80-hour weekly limit. (Detail)

VI.F.4.c) A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.

The Review Committee for Internal Medicine will not consider requests for exceptions to the 80-hour limit to the fellows’ work week.

VI.F.4.c).(1) In preparing a request for an exception, the program director must follow the clinical and educational work hour exception policy from the ACGME Manual of Policies and Procedures. (Core)

VI.F.4.c).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval from the Sponsoring Institution’s GMEC and DIO. (Core)

VI.F.5. Moonlighting
VI.F.5.a) Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident’s fitness for work nor compromise patient safety. (Core)

VI.F.5.b) Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (Core)

VI.F.5.c) PGY-1 residents are not permitted to moonlight. (Core)

VI.F.6. In-House Night Float

Night float must occur within the context of the 80-hour and one day-off-in-seven requirements. (Core)

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

Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). (Core)

VI.F.7.a) Internal Medicine fellowships must not average in-house call over a four-week period. (Core)

VI.F.8. At-Home Call

VI.F.8.a) Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the everythird-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. (Core)

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

VI.F.8.b) Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit. (Detail)

*Core Requirements: Statements that define structure, resource, or process elements essential to every graduate medical educational program. Detail Requirements: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements. Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.

Osteopathic Recognition
For programs seeking Osteopathic Recognition for the entire program, or for a track within the program, the Osteopathic Recognition Requirements are also applicable.

(http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/Osteopathic_Recognition_Requirements.pdf)