GASTROENTEROLOGY TRAINING PROGRAM
CURRICULUM AND OBJECTIVES

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

SPONSOR: State University of New York

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

SUNY Upstate Medical University Mission Statement: The mission of SUNY Upstate Medical University is to improve the health of the communities we serve through education, biomedical research and patient care.

SUNY Upstate Medical University Gastroenterology Fellowship Program Mission Statement: SUNY Upstate Medical University's Gastroenterology Fellowship Program has the primary aim to produce graduates that are exceptional clinicians, excellent teachers, and life-long learners.

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DATE LAST MODIFIED: March 2020

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-seven 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:
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, Upstate Community Hospital, and the Veteran’s Administration Medical Center at Syracuse. All facilities are tertiary care referral centers which provide staff support and material consistent with tertiary care referral hospitals. The general medical patient population is diverse and is derived from the population base living in and around the immediate Syracuse area. 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 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. All 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 all hospitals enjoy state-of-the-art equipment, which permits safe and skillful performance of the latest diagnostic and
therapeutic endoscopic procedures. The faculty at all 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>
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</thead>
<tbody>
<tr>
<td>Upper endoscopy</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>Colonoscopy</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>Flexible sigmoidoscopy</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>Percutaneous liver biopsy</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>Percutaneous endoscopic gastrostomy</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>ERCP:</td>
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<tr>
<td>Diagnostic</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>Sphincterotomy</td>
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<tr>
<td>Balloon cholangioplasty &amp; pancreaticoplasty</td>
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<td>Y</td>
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<tr>
<td>Insertion of biliary and pancreatic stents</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>Endoscopic lithotripsy</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>Biliary manometry</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>Choledochoscopy</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>Endoscopic laser therapy</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>Endoscopic therapeutic Hemostasis:</td>
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<tr>
<td>Laser</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>Bicap</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>Heater probe</td>
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<td>Y</td>
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<tr>
<td>Injection sclerotherapy</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>Variceal band ligation</td>
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<td>Y</td>
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<tr>
<td>Argon plasma coagulator</td>
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<td>Y</td>
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<tr>
<td>Endoscopic ultrasound - diagnostic</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>Endoscopic ultrasound - therapeutic</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>Esophageal manometry</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>Esophageal pH studies</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>Anal rectal manometry</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Photodynamic Therapy</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Capsule Endoscopy</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Radio Frequency Ablation</td>
<td>Y</td>
<td>Y</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 the gastroenterology program will all receive training at all 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
B. GENERAL OUTPATIENT CLINIC ROTATION (ALL FELLOWS – 8-13 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 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. When occasionally assigned to this rotation, third year fellows will focus on assessment of patients requiring more advanced procedures and emphasis will be paced on following those patients into the procedure area.

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. As the fellows progress, emphasis will allow involvement in complicated cases requiring advanced diagnostic and therapeutic modalities. 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 and third year fellows 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. The third year fellow occasionally assigned to this rotation will have these same expectations and evaluations with an emphasis on complex patients and procedures.

C. INPATIENT CONSULTATIONS (ALL FELLOWS – 11-14 BLOCKS TOTAL) - During those rotations the fellows consult on patients with gastrointestinal problems at all sites, depending upon assignment, hospitalized on various inpatient wards including general medicine, surgical, pediatric wards, and various intensive care units throughout all 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 at both the Upstate sites and VA Medical Center. 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. The fellow will be assessed for their ability to appropriately triage consults and will be expected to be significantly more proficient than during the first year. The fellow’s knowledge of indications and contraindications to medicines, therapeutic plans and endoscopy will be assessed for competency and to ensure adequate progression and maturation. The fellow should be beginning to master integration of data to form a coherent assessment and plan and will be expected to be beginning to transition toward independent inpatient consultation.

The third year fellow will be expected to not only have mastered the basic ability to develop a pertinent and coherent differential diagnosis based on a history and physical but also to be able to appropriately focus that evaluation on the gastrointestinal tract. The fellow should be able to consistently make appropriate triage decisions. The fellow should be virtually competent in his / her knowledge of indications and contraindications to medicines, therapeutic plans and endoscopy will be expected to continue to progress toward being able to practice independently and therefore they will be afforded the opportunity to have the bulk of activity at the Upstate sites. 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 – 3-6 BLOCKS TOTAL)** – As with the general outpatient clinic rotation (above) the fellow examines and treats scheduled and unscheduled patients with a wide variety of unusual gastrointestinal conditions. The fellow is exposed to a truly outpatient experience with emphasis on the outpatient experience in a more
private practice like arena. The fellows are also supervised while seeing more acute emergency patients with their attending and triaging and determining acuity and level of care needs. They will see patients with attendings caring for more complex problems, requiring therapeutic intervention, such as with ERCP, in order to experience the unique outpatient aspects of those types of patients. 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 and the fellow in this role will be the on-site provider for the group of patients managed in fellows’ 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 all facilities, having their procedures at the outpatient center. The fellows will be supervised in triage and management of outpatient issues, assess immediate and remote care issues and learn methods of interacting with clinical and administrative staff ion the outpatient arena.

GOALS: To allow an on-site, focused, and truly didactic outpatient 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 as well as to learn how to function in this manner in a true outpatient setting, which is most likely to reflect their ultimate practice. It is not the goal of this rotation to ensure sufficient skill is developed to recommend independent practice in these advanced procedures after graduation, but it is the goal of this rotation to arm the fellows with the knowledge, skills and attributes to successfully function independently in various outpatient clinical settings.

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 (2 BLOCKS PER YEAR)
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 bladhln@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 bladhln@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](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**


**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:

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 rape 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.⁵

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

(continued 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 (VWnet)
www.vwnet.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 bleeders studies and demonstrate competence
i. Variceal hemostasis - 20 supervised cases, including 5 active bleeders studies and demonstrate competence
j. Moderate sedation studies and demonstrate competence
k. Small bowel capsule endoscopy studies and demonstrate competence
l. Complete original research report in publishable form
m. Summary of evaluations showing adequate performance in each of the six core competencies

The major advancement milestones in the area of gastroenterology for the general internist in training are divided into three general areas: Inpatient Urgent, Routine Inpatient and Outpatient. It is important that all members of the team (including our fellows) be aware of these and that they also recognize they are a major part of the process. These are listed here.

**INPATIENT URGENT**

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

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

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

**INPATIENT ROUTINE**

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

By the end of the second year the R2 will be able to synthesize and work through the differential diagnosis selecting appropriate testing and initial therapy for typical routine internal medicine symptoms and conditions related to the gastrointestinal tract including but not limited to loose stools, nausea, vomiting, pain and abnormal labs / x-rays etc. The learner will demonstrate the ability to integrate patient information from multiple internal and external sources. The learner will be able to work with the available systems to initiated disposition plans and will begin to apply these skills at all sites.
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 pathophysiologically-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 2020-2021 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 (Weekly)** - 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

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 Curriculum(reference): [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 orders. 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. Esophagogastroduodenoscopy - 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 & VI.B.4):

The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. Fellows 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:
VI.B.4.c).(1) management of their time before, during, and after clinical assignments; and,
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.
VI.B.4.d) commitment to lifelong learning;
VI.B.4.e) monitoring of their patient care performance improvement indicators; and,
VI.B.4.f) accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data.

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 work 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 on 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 each institution therefore, all members of the teaching team will comply with the following across all 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 each institution 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 – Primary consulting services on call covers all 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 all 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 any of the facilities. If the primary on call fellow is already called in to any of the facilities, there will be another fellow available to cover the second call.

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.
   - Division Chief – Dr. John
   - Program Director – Dr. Szyjkowski
   - Associate Director(s) – Dr. Manocha
   - Full-Time Program Faculty – Drs. Arif, Ozden; VA – Drs. Gupta, Murthy, Sapkota; 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, aims 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. Core faculty are responsible for fellow education. 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, 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, aims 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, aims 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 all institutions, as well as the Program Director. The guidelines for endoscopic progression as noted on the checklist will also be considered. Trainees will be allowed to progress to the second and third years, after having mastered the main requirements of the Core Curriculum described above, as well as achieved the required endoscopic technical and cognitive skills. Appropriate documentation of the trainees’ progress will be accomplished and maintained in the Graduate Medical Education Office of the sponsoring consortium.

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 2020-2021 are as follows:

Independence Day: Saturday, July 4, 2020 (one-day holiday, office closed)
Labor Day: Monday, September 7, 2020 (three-day weekend, office closed)
Columbus Day: Monday, October 12, 2020 (three-day weekend, office closed)
Election Day: Tuesday, November 3, 2020 (one-day holiday, office remains open)
Veteran's Day: Wednesday, November 11, 2020 (one-day holiday, office remains open)
Thanksgiving: Thursday, November 26, 2020 (one-day holiday, office closed)
Christmas Day: Friday, December 25, 2020 (three-day weekend, office closed)
New Year's Day: Friday, January 1, 2021 (three-day weekend, office closed)
Martin Luther King: Monday, January 18, 2021 (three-day weekend, office closed)

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.

WORK 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 work 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 work 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 Work Hour Definitions (4/29/2011)**
Below are the specialty-specific work 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 Common Program Requirements (Fellowship), July 2019.

ACGME Program Requirements for Graduate Medical Education in Gastroenterology, July 2019.

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