



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.

PROGRAM DIRECTOR:

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DATE LAST MODIFIED:

August 2022

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. It is intended as a source of general information, rather than as a legal or technical statement of any contractual relationship. If program-specific policies and/or procedures are in conflict with the policies and/or procedures contained in the current version of the Upstate Medical University Resident & Fellow Handbook, the policies and procedures contained within the Upstate Medical University Resident & Fellow Handbook control and will supersede any inconsistent or contradictory policies and/or procedures.

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. Fifty-two fellows have successfully completed our GI Fellowship during this time. To date, all of our GI fellows who have taken the test 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. 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:

BOARD CERTIFIED

	<u>IM</u>	<u>GI</u>	<u>Hep</u>
Ronald D. Szyjkowski, MD	C	C	
Savio John, MD	C	C	C
Ganesh Aswath, MD	C	C	
Hafiz Khan, MD	C	C	
Kelita Singh, MD	C	C	
Uma Murthy, MD	C	C	
Anand Gupta, MD	C	C	
Bishnu Sapkota, MD	C	C	
Ajoy Roy, MD	C	C	C

IM = Internal Medicine, GI = Gastroenterology, Hep = Hepatology, C = Board Certified, E= Board Eligible

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:

HSC

VAMC

Upper endoscopy	Y	Y
Colonoscopy	Y	Y
Flexible sigmoidoscopy	Y	Y
Percutaneous liver biopsy	Y	Y
Percutaneous endoscopic gastrostomy	Y	Y
ERCP:		
Diagnostic	Y	Y
Sphincterotomy	Y	Y
Balloon cholangioplasty & papercatoplasty	Y	Y
Insertion of biliary and pancreatic stents	Y	Y
Endoscopic lithotripsy	Y	Y
Biliary manometry	Y	N
Choledochoscopy	Y	Y
Endoscopic laser therapy	Y	N
Endoscopic therapeutic Hemostasis:		
Laser	Y	N
Bicap	Y	Y
Heater probe	Y	Y
Injection sclerotherapy	Y	Y
Variceal band ligation	Y	Y
Argon plasma coagulator	Y	Y
Endoscopic ultrasound - diagnostic	Y	Y
Endoscopic ultrasound - therapeutic	Y	Y
Esophageal manometry	Y	Y
Esophageal pH studies	Y	Y
Anal rectal manometry	Y	N
Photodynamic Therapy	Y	N
Capsule Endoscopy	Y	Y
Radio Frequency Ablation	Y	Y

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 nutrition, and pediatric gastroenterology will also be encouraged. The fellows will also be exposed to approximately 3-6 months of inpatient consultative rotations during the third year of fellowship. The specific details of the rotations follow.

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 placed 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 assigned to this rotation will have these same expectations and evaluations with an emphasis on complex patients and procedures.

C. INPATIENT CONSULTATIONS (ALL FELLOWS – 12-17 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 their 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 their 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 in 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 their 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)

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, either Upstate or the Syracuse VA. 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. At the end of each Research rotation, the fellows will be required to submit a Research form to the fellowship coordinator, signed by their mentor, outlining what they've worked on.

Mentor/Fellow Meeting Schedule:

2 months BEFORE Scheduled Rotation: Fellows are REQUIRED to meet with their mentor at least 2 months before their Research block is scheduled to begin to come up with a proposal. Failure to do so will result in that block will be changed to Outpatient.

1st Day of Scheduled Research Block: Fellow must meet with their mentor on the first day of their Research block to go over their plan for the block, how they will spend their time, what they plan to accomplish, etc.

By End of Research Block: Fellows must submit a report to their mentor and the fellowship coordinator no later than the final day of their scheduled research block. Failure to do so will result in their next Research block being changed to Outpatient.

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 and approved 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 their 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.

For the most up to date documents for both UH and VA Research requirements, you can contact the program coordinator, or access them via our Google Drive:

<https://drive.google.com/drive/folders/1BIZsK0DtQGq15lkOgQsECkBHp8uUQHvs?usp=sharing>

Upstate IRB Approval Process:

For Upstate Research, you'll need to complete the following CITI Training at www.citiprogram.org

- Choose State University of New York (SUNY) for the institution, here:
<https://www.citiprogram.org/index.cfm?pageID=154&icat=0&ac=0®ion=1&message=0>
- Create your user name and password.
- Complete Steps 1-7 as it directs you to fill out all necessary information (contact, etc.).
- This should be no cost to you if you register under Upstate.
- Complete the following modules:
 - Human Subjects Research – Group 1
 - Responsible Conduct of Research
 - Conflict of Interest
 - Good Clinical Practice, if not previously completed
- Register with IRBNet at <https://www.irbnet.org/release/index.html>
- Click: New User Registration (upper right-hand corner)
- Enter your legal first and last names in the appropriate fields. (Please use appropriate capitalization as you register into the system; the system does not alphabetize names that begin with lower-case letters.)
- Create your User Name and Password (at least 8 characters); confirm your password, and enter a password hint.
- Click on Continue
- Accept the Terms of Use
- On the next screen, type "Upstate" in the "Search for an organization" field and click "Search" OR scroll to and select "SUNY Upstate Medical University" from the list on the screen.
- Review info for accuracy, edit if needed, then Click on Continue
- On the next screen, enter your telephone number and email address; click on Continue
- Click Register; Click Continue
- You will receive an email from IRBNet with a link that you need to click on in your e-mail in order to activate your account.

June 8, 2022

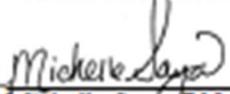
SUNY Upstate requires department chair review and sign off for all new projects submitted to the IRB for review, as well as when there is a change in Principal Investigator. Each division director should review and sign off in IRBNet to ensure that the following requirements are met:

- To determine that the PI is qualified to conduct the proposed research and has the necessary credentials and resources to safely conduct the study.
- To determine that the research uses procedures consistent with sound research design; and the research design is sound enough to reasonably expect the research to yield the expected knowledge.

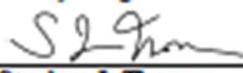
Once division director sign off is complete, the project may be shared with Dr. Knohl for co-signature. This process is consistent with Upstate IRB policies and will ensure that division directors are included in the process of protecting human subjects participating in research.

**Institute for Global Health & the Division of Infectious Disease:* Studies conducted under the Institute for Global Health will be signed by Institute Director, Dr. Thomas. Studies conducted under the Division of Infectious Disease will be signed by Dr. Elizabeth Asiago Reddy.

**Please reference Section 1.10.6 of HRPP SOP's: Department Chairs and/or Deans*


Michelle Sayo, RN, BSN MSM
Chief Compliance Officer of Research


Dr. Stephen J. Knohl
Professor and Interim Chair, Department of Medicine
Residency Program Director and Vice Chair for Education


Dr. Stephen J. Thomas
Professor of Microbiology and Immunology
Director of Institute for Global Health and Translational Science

10 JUN 2022

VA IRB Approval Process:

Anyone doing research with a VA faculty will need to work on this **before** and while they are on their VA research months.

- Contact VA HR to obtain a Research WOC Appointment, which will allow you to do Research at the Syracuse VA. This is handled solely by HR and can take a couple of months to complete. You will need this appointment before you are able to submit anything.
- For anyone doing Research, the VA requires CITI training. You may be able to knock this out for UH and the VA at the same time, since UH requires the same training for UH IRB approval (reminder/details of that attached).
- Heather Hall from the VA (HR/IRB Administrator) provided us with the attached research determination guide for you to look at. Once you get to this point, you'll need to email Heather your proposed protocol for the study and/or quick overview (heather.hall3@va.gov).

Approval of these studies would be limited to the Syracuse VA exclusively. There are ways of including other VAMC's in a study but that is another process in itself, she says.

Once a study is submitted to the VA IRB, it general takes about one month for review before going to the R & D Committee for their approval. If the IRB has questions or concerns, this can go back and forth several times lengthening the process. If it is a simple study that the IRB has no issues with, it can be approximately 2 months for approval. If there is a lot involved and the IRB has requests for changes, it can take several months.

PROCESS FOR PAYMENT FOR RESIDENT & FELLOW RESEARCH & QUALITY IMPROVEMENT PROJECTS

VHA DIRECTIVE 1400.05, DISBURSEMENT AGREEMENTS



Requirements:

- Rotation specified in advance in the Trainee's MedHub schedule and the resident must also have a clinical rotation at VA during year
- Project applicable to VA patient care
- Accreditation requirement of all Trainees in the program
- Research approved by VA IRB and/or R&DC – send a copy of the Approval Letter to the VA GME Office
- Research supervised by an Attending with a VA Appointment (as PI)
- Resident VA time & attendance tracked on OAA EARs Tracker [VA proportionate share]

Includes Categories of Educational Activities:

- Research-VA
- Scholarly Activity Preparatory to research – VA
 - Includes, but not limited to, researching existing literature, writing protocol, completing IRB/R&DC proposal and all associated submissions, and completing mandatory VA research education
- Quality Improvement projects – VA
- Other Scholarly Activity

7/1/20XX

Pitch deck title

Tips on Human Research for Residents & Fellows
Catherine M. Vessio, MD, PhD
Chief Research & Compliance Officer
Assistant Chief of Staff Education
Office of the Director, Research VAMC
Assistant Clinical Professor, Internal Medicine
SUNY Upstate Medical University

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VA Research Determination Aid Sheet:

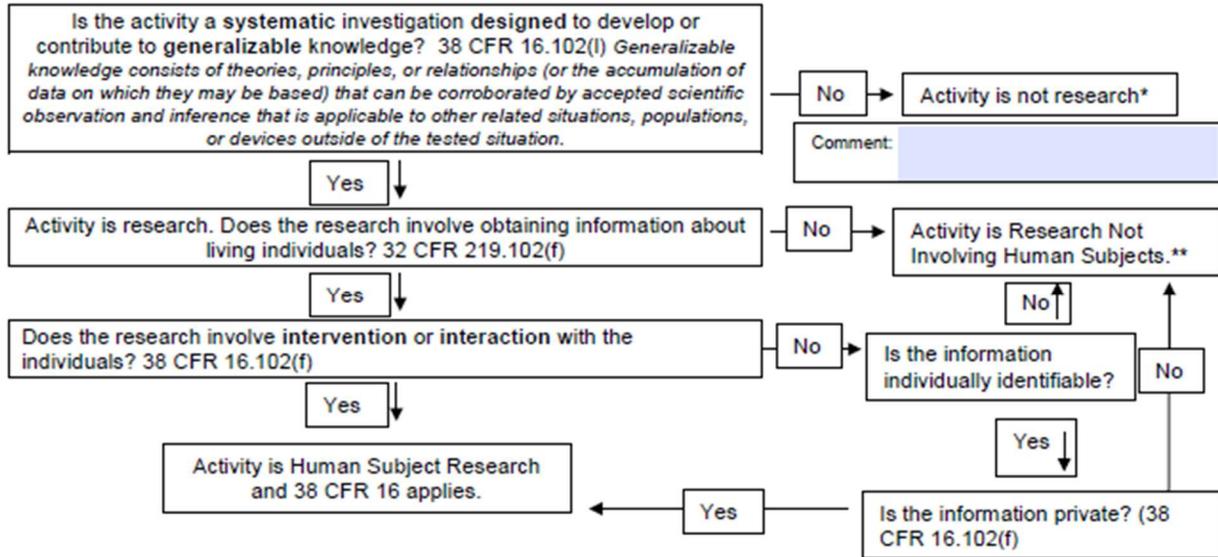
Determination Checklist for Research and Research Involving Human Subjects

Protocol Title: [Redacted]

Principal Investigator: [Redacted]

Human Subjects Research Determination. To be completed by qualified staff member.

Review the following questions to determine if the activity constitutes human subjects research.



This activity has been determined to be (check one):

*Not Research – submit to Department Chief or Quality management

Comment:

**Research Not Involving Human Subjects - Report to R&DC

Comment:

Human Subject Research – Seek Further Determination

Reviewer Name (Print): [Redacted]

Reviewer Name (Sign): [Redacted]

Date: [Redacted]

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 program administrator masullon@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.

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

H. Module on Nutrition

<https://sites.google.com/site/nutritioneducationmodule/home>

Each fellow will sign an attestation form documenting this once during their fellowship.

I. To report patient safety events, click on link – occurrence reporting

<http://sievent.upstate.edu/live/index.php>

J. Sexual violence

Copy of “Workplace Sexual Violence” flyer below.

Each fellow will sign an attestation form documenting this once during their fellowship. Each attending, NP, PA will sign an attestation form documenting the review of this flyer at beginning of their employment.

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.ⁱ

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).ⁱⁱ 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.ⁱⁱⁱ

Almost 50% of rape victims lose their jobs or are forced to quit in the aftermath of the crime.^{iv}

**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.^v

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 (VAWnet)
www.vawnet.org

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

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

References

- i Duhart, D.T. (2001) *National Crime Victimization Survey: Violence in the workplace, 1993-1999* (NCJ No. 190076) U.S. Department of Justice
- ii U.S. Equal Opportunity Commission. (2008) *Sexual Harassment* Retrieved August 15, 2008 from www.eeoc.gov/types/sexual_harassment.html
- iii Resick, P.A., Calhoun, K.S., Atkeson, B.M., & Ellis, E.M. (1981) Social adjustment in victims of sexual assault. *Journal of Consulting and Clinical Psychology*, 49, 705-712.
- iv S. Rep No. 103-108, at 54, n 69 (1993) citing E. Ellis, B. Atkeson & K. Calhoun, An Assessment of the Long Term Reaction to Rape, *Journal of Psychology*, 90, 264
- v U.S. Merit Systems Protection Board (1995) *Sexual Harassment in the Federal Workforce: Trends, Progress, and Continuing Challenges*. Washington, DC: Government Printing Office

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
- a. Biopsy of the mucosa of the esophagus, stomach, small bowel and colon - Minimum 5 supervised studies any site
- b. Moderate sedation – Completion to competence
- c. 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 5 supervised studies
- a. Biopsy of the mucosa of the esophagus, stomach, small bowel and colon - Minimum 5 supervised studies each site
- b. Other diagnostic and therapeutic procedures utilizing enteral intubation and bouginage - Minimum 5 supervised studies
- c. Non-variceal hemostasis - Minimum 5 supervised studies
- d. Variceal hemostasis - Minimum 5 supervised studies
- e. 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 10 supervised studies and demonstrate competence
- a. Biopsy of the mucosa of the esophagus, stomach, small bowel and colon - demonstrate competence

- b. Other diagnostic and therapeutic procedures utilizing enteral intubation and bouginage - demonstrate competence
- c. Gastrointestinal motility studies - minimum of 20 each of pH and esophageal motility studies and demonstrate competence
- d. Non-variceal hemostasis - Fellows will perform 25 supervised cases including 10 active bleeders studies and demonstrate competence
- e. Variceal hemostasis - 10 supervised cases, including 5 active bleeders studies and demonstrate competence
- f. Moderate sedation studies and demonstrate competence
- g. Small bowel capsule endoscopy studies and demonstrate competence
- h. Complete original research report in publishable form
- i. 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 chose therapy and testing for typical routine internal medicine symptoms and conditions related to the gastrointestinal tract including but not limited to loose stools, nausea, vomiting, pain and abnormal labs / x-rays etc. in an academic, VA or community setting. After assessing and integrating all available data and understanding the likelihood of response to standard medical therapy the R3 will be able to determine when subspecialty consultation is appropriate based upon available skill sets at any level, thereby being able to fully practice independently.

OUTPATIENT

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

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

By the end of the third year the R3 will be able to independently choose therapy and testing for typical routine and more esoteric condition more complicated than conditions such as reflux, abnormal liver functions while understanding the standard preventative measures such as colorectal cancer screening and vaccinations. The learner will be able to integrate and coordinate the care of these conditions themselves as well as in interaction with other medical problems and therapeutics. After assessing and integrating all available data and understanding the likelihood of response to standard medical therapy using multiple sources (including when appropriate outside information) the graduating R3 will be able to follow through on and coordinate subspecialty consultation recommendations, thereby being able to fully practice independently, guiding and orchestrating their care so as to avoid polypharmacy, drug / drug interactions etc.

VI. CONFERENCE SCHEDULE

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

B. CONFERENCES FOR FELLOWSHIP TRAINING:

1. Pathology Conference (Bi-Weekly) - Recognizing that changes in department of pathology faculty availability and service constraints, as well as changes in technology, teaching material / methods we are presented with an opportunity to improve how our didactic pathology teaching. These organ systems and patho-physiologically-based bi-weekly didactics which are integrated with our board review schedule are staffed by Upstate Department of Pathology faculty. On alternate weeks recent cases of teaching interest are reviewed with the staff pathologist. This allows correlation of endoscopic findings with histopathology. In addition, specific areas of interest are targeted for discussion with appropriate histologic material for review. At the midway point of academic year, 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>

VII. CORE CURRICULUM

A. CLINICAL EXPERIENCE, CONCEPTS AND FACTS - This will include an opportunity to observe and manage a sufficient number of new and follow-up inpatients and outpatients of appropriate age, including adolescent and geriatric age groups, with a wide variety of common and uncommon digestive disorders. Fellows will be given opportunities to assume continuing responsibility for both acute and chronically ill patients, to learn the natural history of gastroenterological disorders, as well as

effectiveness of therapeutic programs.

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

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

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

1. Dysphagia
2. Abdominal pain
3. Acute abdomen
4. Nausea and vomiting
5. Diarrhea
6. Constipation
7. Gastrointestinal bleeding
8. Jaundice
9. Abnormal liver chemistries
10. Cirrhosis and portal hypertension
11. Malnutrition
12. Genetic/inherited disorders

13. Depression, neurosis and somatization syndromes pertaining to the gastrointestinal tract
14. Surgical care of gastrointestinal disorders

B. ENDOSCOPIC PROCEDURES, TECHNICAL AND OTHER SKILLS - The program will provide for instruction in the indications, contraindications, complications, limitations, and where applicable, interpretation of the following diagnostic and therapeutic techniques and procedures.

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

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

1. 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, GMCC 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. John
- Associate Program Director – Dr. Aswath
- Full-Time Program Faculty – Drs. Szykowski, Khan, Singh; VA – Drs. Gupta, Murthy, Sapkota
- Program Administrator – Nikkole Masullo (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 considered 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 required to extend their fellowship training, graduating later than scheduled. No more than one week off may be taken per block, unless it is within the research block. Please note, contiguous week and weekend days off count toward DAT.

28 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.

When time off is charged for payroll, the coordinator will enter holiday accruals off first (using holiday comp time before actual vacation time), since holiday accruals cannot be rolled over year to year. Any leftover “vacation” time remaining at the end of the 3-year fellowship will be paid out in the fellows’ final check. Time will not be paid out for fellows in their first or second year of the program, only once they are fully leaving the institution. Your 28 DAT must be taken and are not paid out. These extra “vacation” payout days are actually holiday compensation earned accruals from years past. Questions about this should be directed to the fellowship coordinator and/or HR.

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 program administrator 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 program administrator. 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 the program administrator to ensure there are no scheduling conflicts. The administrator will then forward the time off request to the program director 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.

Fellows who request time off less than 9 weeks away, as required, will need to individually obtain permission from all of the providers that they are scheduled to work with during that time, starting with the VA. This will need to be done by the fellow themselves, before submitting the official request to the program administrator for approval. If permission is given by all faculty, the formal request can be sent for approval.

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 program administrator, 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 2022-2023 are as follows:

Independence Day: Monday, July 4, 2022 (one-day holiday, office closed)

Labor Day: Monday, September 5, 2022 (three-day weekend, office closed)

Columbus Day: Monday, October 10, 2022 (three-day weekend, office closed)

Election Day: Tuesday, November 8, 2022 (one-day holiday, office remains open)

Veteran's Day: Friday, November 11, 2022 (one-day holiday, office remains open)
Thanksgiving: Thursday, November 24, 2022 (one-day holiday, office closed)
Christmas Day: Sunday, December 25, 2022 (one-day holiday, office closed)
New Year's Day: Sunday, January 1, 2023 (one-day holiday, office closed)
Martin Luther King: Monday, January 16, 2023 (three-day weekend, office closed)
Memorial Day: Monday, May 29, 2023 (three-day weekend, office closed)
Juneteenth: Monday, June 19, 2023 (one-day holiday, office remains open)

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 program administrator).

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 Fellowship Program Administrator will assist you in securing this funding.

Educational allotment

\$300 annually (must be approved by DOM Administrative office before purchasing).

1st Author Conference Presentation "Scholarship Fund"

\$600 annually (Educational allotment can be used as well) – Requires Fellowship Administrator approval

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 gastroenterological 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 \$600 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, and at least 24 full hours off (1 day) at least once per week. They cannot moonlight on their one day off, nor can they exceed 80 hours total in a work week (program and moonlighting time combined). Our workweek begins on Sunday. Disregarding 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, in addition to the GME Moonlighting permission slip, having been completed and signed by the Program Director. Contact the Program Administrator with questions or to obtain this form.

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.

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

AAMC Policy Guidance on Graduate Medical Education, October 2001.

ASGE Guidelines for Training and Practice, January 2000.

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

ACGME Common Program Requirements (Fellowship), July 2019.

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

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**ACGME Program Requirements for
Graduate Medical Education
in Gastroenterology**

ACGME-approved Focused Revision: February 7, 2022; effective July 1, 2022

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ACGME Program Requirements for Graduate Medical Education in Gastroenterology

Common Program Requirements (Fellowship) are in BOLD

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

Background and Intent: These fellowship requirements reflect the fact that these learners have already completed the first phase of graduate medical education. Thus, the Common Program Requirements (Fellowship) are intended to explain the differences.

Introduction

Int.A. *Fellowship is advanced graduate medical education beyond a core residency program for physicians who desire to enter more specialized practice. Fellowship-trained physicians serve the public by providing subspecialty care, which may also include core medical care, acting as a community resource for expertise in their field, creating and integrating new knowledge into practice, and educating future generations of physicians. Graduate medical education values the strength that a diverse group of physicians brings to medical care.*

Fellows who have completed residency are able to practice independently in their core specialty. The prior medical experience and expertise of fellows distinguish them from physicians entering into residency training. The fellow's care of patients within the subspecialty is undertaken with appropriate faculty supervision and conditional independence. Faculty members serve as role models of excellence, compassion, professionalism, and scholarship. The fellow develops deep medical knowledge, patient care skills, and expertise applicable to their focused area of practice. Fellowship is an intensive program of subspecialty clinical and didactic education that focuses on the multidisciplinary care of patients. Fellowship education is often physically, emotionally, and intellectually demanding, and occurs in a variety of clinical learning environments committed to graduate medical education and the well-being of patients, residents, fellows, faculty members, students, and all members of the health care team.

In addition to clinical education, many fellowship programs advance fellows' skills as physician-scientists. While the ability to create new knowledge within medicine is not exclusive to fellowship-educated physicians, the fellowship experience expands a physician's abilities to pursue hypothesis-driven scientific inquiry that results in contributions to the medical literature and patient care. Beyond the clinical subspecialty expertise achieved, fellows develop mentored relationships built on an infrastructure that promotes collaborative research.

Int.B. **Definition of Subspecialty**

Gastroenterology is the subspecialty of internal medicine that focuses on the evaluation and treatment of disorders of the gastrointestinal tract. Gastroenterology requires an extensive understanding of the entire gastrointestinal tract, including the esophagus, stomach, small intestine, liver, gall bladder, pancreas, colon, and rectum.

Some gastroenterology programs may choose to offer fellows intensive clinical experiences in transplant hepatology. Transplant hepatology is the study of the diseases leading to transplantation, the evaluation of patients pre-transplant, the evaluation and treatment of the post-transplant patient, and the management of the complications of transplantation.

Int.C. Length of Educational Program

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

I. Oversight

I.A. Sponsoring Institution

The Sponsoring Institution is the organization or entity that assumes the ultimate financial and academic responsibility for a program of graduate medical education consistent with the ACGME Institutional Requirements.

When the Sponsoring Institution is not a rotation site for the program, the most commonly utilized site of clinical activity for the program is the primary clinical site.

Background and Intent: Participating sites will reflect the health care needs of the community and the educational needs of the fellows. A wide variety of organizations may provide a robust educational experience and, thus, Sponsoring Institutions and participating sites may encompass inpatient and outpatient settings including, but not limited to a university, a medical school, a teaching hospital, a nursing home, a school of public health, a health department, a public health agency, an organized health care delivery system, a medical examiner's office, an educational consortium, a teaching health center, a physician group practice, federally qualified health center, or an educational foundation.

I.A.1. The program must be sponsored by one ACGME-accredited Sponsoring Institution. (Core)*

I.B. Participating Sites

A participating site is an organization providing educational experiences or educational assignments/rotations for fellows.

I.B.1. The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)

- I.B.1.a) To be eligible for the optional dual gastroenterology/transplant hepatology (GI/TH) pathway, the Sponsoring Institution should also sponsor an ACGME-accredited fellowship in transplant hepatology. ^(Core)

Subspecialty-Specific Background and Intent: While the same Sponsoring Institution typically sponsors both the gastroenterology and transplant hepatology programs, there may be exceptions to this rule. Programs interested in participating in the GI/TH pathway that are not sponsored by the same Sponsoring Institution will need to establish program letters of agreement. See Program Requirement I.B.2. for more information on such agreements. The Committee will consider any exceptions on a case by case basis.

Refer to the “Subspecialty-Specific Background and Intent” box that follows Program Requirement III.A.1.b).(2).b) for a summary of the dual GI/TH pathway.

- I.B.1.b) The Sponsoring Institution must establish the gastroenterology fellowship within a department of internal medicine or an administrative unit whose primary mission is the advancement of internal medicine subspecialty education and patient care; and, ^(Detail)

- I.B.1.c) The Sponsoring Institution must ensure that there is a reporting relationship with the program director of the internal medicine residency program to ensure compliance with ACGME accreditation requirements. ^(Core)

- I.B.2. There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. ^(Core)**

- I.B.2.a) The PLA must:**

- I.B.2.a).(1) be renewed at least every 10 years; and, ^(Core)**

- I.B.2.a).(2) be approved by the designated institutional official (DIO). ^(Core)**

- I.B.3. The program must monitor the clinical learning and working environment at all participating sites. ^(Core)**

- I.B.3.a) At each participating site there must be one faculty member, designated by the program director, who is accountable for fellow education for that site, in collaboration with the program director. ^(Core)**

Background and Intent: While all fellowship programs must be sponsored by a single ACGME-accredited Sponsoring Institution, many programs will utilize other clinical settings to provide required or elective training experiences. At times it is appropriate to utilize community sites that are not owned by or affiliated with the Sponsoring Institution. Some of these sites may be remote for geographic, transportation, or

communication issues. When utilizing such sites, the program must designate a faculty member responsible for ensuring the quality of the educational experience. In some circumstances, the person charged with this responsibility may not be physically present at the site, but remains responsible for fellow education occurring at the site. The requirements under I.B.3. are intended to ensure that this will be the case.

Suggested elements to be considered in PLAs will be found in the ACGME Program Director's Guide to the Common Program Requirements. These include:

- Identifying the faculty members who will assume educational and supervisory responsibility for fellows
- Specifying the responsibilities for teaching, supervision, and formal evaluation of fellows
- Specifying the duration and content of the educational experience
- Stating the policies and procedures that will govern fellow education during the assignment

I.B.4. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all fellows, of one month full time equivalent (FTE) or more through the ACGME's Accreditation Data System (ADS). ^(Core)

I.C. The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents (if present), fellows, faculty members, senior administrative staff members, and other relevant members of its academic community. ^(Core)

Background and Intent: It is expected that the Sponsoring Institution has, and programs implement, policies and procedures related to recruitment and retention of minorities underrepresented in medicine and medical leadership in accordance with the Sponsoring Institution's mission and aims. The program's annual evaluation must include an assessment of the program's efforts to recruit and retain a diverse workforce, as noted in V.C.1.c).(5).(c).

I.D. Resources

I.D.1. The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for fellow education. ^(Core)

I.D.1.a) Space and Equipment

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

I.D.1.b) Facilities

I.D.1.b).(1) Inpatient and outpatient systems must be in place to prevent fellows from performing routine clerical functions,

such as scheduling tests and appointments, and retrieving records and letters. ^(Detail)

I.D.1.b).(2) The sponsoring institution must provide the broad range of facilities and clinical support services required to provide comprehensive care of adult patients. ^(Core)

I.D.1.b).(3) Facilities for the intensive care of critically ill patients with gastrointestinal disorders must be provided. These facilities should have a working relationship with diagnostic radiology, general surgery, oncology, pathology services, and pediatrics. ^(Core)

I.D.1.b).(4) Fellows must have access to a lounge facility during assigned duty hours. ^(Detail)

I.D.1.b).(5) When fellows are in the hospital, assigned night duty, or called in from home, they must be provided with a secure space for their belongings. ^(Detail)

I.D.1.c) Laboratory Services

I.D.1.c).(1) There must be a procedure laboratory completely equipped to provide modern capability in gastrointestinal procedures. This equipment must include an up-to-date array of complete diagnostic and therapeutic endoscopic instruments and accessories, with esophageal motility instrumentation. ^(Core)

I.D.1.c).(2) There should be a laboratory for parasitology testing. ^(Core)

I.D.1.d) Other Support Services

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

I.D.1.e) Medical Records

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

I.D.2. The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote fellow well-being and provide for: ^(Core)

I.D.2.a) access to food while on duty; ^(Core)

- I.D.2.b) **safe, quiet, clean, and private sleep/rest facilities available and accessible for fellows with proximity appropriate for safe patient care;** ^(Core)

Background and Intent: Care of patients within a hospital or health system occurs continually through the day and night. Such care requires that fellows function at their peak abilities, which requires the work environment to provide them with the ability to meet their basic needs within proximity of their clinical responsibilities. Access to food and rest are examples of these basic needs, which must be met while fellows are working. Fellows should have access to refrigeration where food may be stored. Food should be available when fellows are required to be in the hospital overnight. Rest facilities are necessary, even when overnight call is not required, to accommodate the fatigued fellow.

- I.D.2.c) **clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care;** ^(Core)

Background and Intent: Sites must provide private and clean locations where fellows may lactate and store the milk within a refrigerator. These locations should be in close proximity to clinical responsibilities. It would be helpful to have additional support within these locations that may assist the fellow with the continued care of patients, such as a computer and a phone. While space is important, the time required for lactation is also critical for the well-being of the fellow and the fellow's family, as outlined in VI.C.1.d).(1).

- I.D.2.d) **security and safety measures appropriate to the participating site; and,** ^(Core)

- I.D.2.e) **accommodations for fellows with disabilities consistent with the Sponsoring Institution's policy.** ^(Core)

- I.D.3. **Fellows must have ready access to subspecialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities.** ^(Core)

- I.D.4. **The program's educational and clinical resources must be adequate to support the number of fellows appointed to the program.** ^(Core)

- I.D.4.a) Patient Population

- I.D.4.a).(1) The patient population must have a variety of clinical problems and stages of diseases. ^(Core)

- I.D.4.a).(2) There must be patients of each gender, with a broad age range, including geriatric patients. ^(Core)

- I.D.4.a).(3) A sufficient number of patients must be available to enable each fellow to achieve the required educational outcomes. ^(Core)

I.D.4.a).(4) Programs participating in the dual GI/TH pathway must perform 20 liver transplantations per year for each dual GI/TH fellow in addition to the number of liver transplantations required for the separate ACGME-accredited transplant hepatology fellowship program complement. ^(Detail)

I.E. *A fellowship program usually occurs in the context of many learners and other care providers and limited clinical resources. It should be structured to optimize education for all learners present.*

I.E.1. Fellows should contribute to the education of residents in core programs, if present. ^(Core)

Background and Intent: The clinical learning environment has become increasingly complex and often includes care providers, students, and post-graduate residents and fellows from multiple disciplines. The presence of these practitioners and their learners enriches the learning environment. Programs have a responsibility to monitor the learning environment to ensure that fellows' education is not compromised by the presence of other providers and learners, and that fellows' education does not compromise core residents' education.

II. Personnel

II.A. Program Director

II.A.1. There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. ^(Core)

II.A.1.a) The Sponsoring Institution's Graduate Medical Education Committee (GMEC) must approve a change in program director. ^(Core)

II.A.1.b) Final approval of the program director resides with the Review Committee. ^(Core)

Background and Intent: While the ACGME recognizes the value of input from numerous individuals in the management of a fellowship, a single individual must be designated as program director and have overall responsibility for the program. The program director's nomination is reviewed and approved by the GMEC. Final approval of the program director resides with the applicable ACGME Review Committee.

II.A.2. The program director and, as applicable, the program's leadership team, must be provided with support adequate for administration of the program based upon its size and configuration. ^(Core)

II.A.2.a) At a minimum, the program director must be provided with the dedicated time and support specified below for administration of the program: ^(Core)

Number of Approved Fellow Positions	Minimum Support Required (FTE)
<7	.2
7-9	.25
10-12	.3
13-15	.35
16-18	.4
19-21	.45
>21	.5

II.A.2.b)

Programs must appoint at least one of the subspecialty-certified core faculty members to be associate program director(s). The associate program directors(s) must be provided with support equal to a dedicated minimum time for administration of the program as follows: ^(Core)

Number of Approved Fellow Positions	Minimum Support Required (FTE)
<7	0
7-9	.13
10-12	.14
13-15	.15
16-18	.16
19-21	.17
22-24	.18
25-27	.24
28-30	.30
31-33	.36
34-36	.42

Background and Intent: To achieve successful graduate medical education, individuals serving as education and administrative leaders of fellowship programs, as well as those significantly engaged in the education, supervision, evaluation, and mentoring of fellows, must have sufficient dedicated professional time to perform the vital activities required to sustain an accredited program.

The ultimate outcome of graduate medical education is excellence in fellow education and patient care.

The program director and, as applicable, the program leadership team, devote a portion of their professional effort to the oversight and management of the fellowship program, as defined in II.A.4.-II.A.4.a).(16). Both provision of support for the time required for the leadership effort and flexibility regarding how this support is provided are important. Programs, in partnership with their Sponsoring Institutions, may provide support for this time in a variety of ways. Examples of support may include, but are not limited to, salary support, supplemental compensation, educational value units, or relief of time from other professional duties.

Program directors and, as applicable, members of the program leadership team, who are new to the role may need to devote additional time to program oversight and management initially as they learn and become proficient in administering the program. It is suggested that during this initial period the support described above be increased as needed.

Subspecialty-Specific Background and Intent: For instance, a program with an approved complement of 12 fellows is required to have at least 30 percent FTE support for the Program Director and at least 14 percent FTE support for the associate program director(s). Because an associate program director is also a core faculty member, the minimum dedicated time requirements for associate program directors are inclusive of core faculty activities. An additional 10 percent FTE for the core faculty position is not required. For example, if one core faculty member is named the associate program director for a 12-fellow program, the required minimum support for that position is 14 percent FTE. Further, the Review Committee allows the minimum required FTE support to be shared among multiple associate program directors, as delegated by and at the discretion of the program director.

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

II.A.3.a) must include subspecialty expertise and qualifications acceptable to the Review Committee; and, (Core)

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

II.A.3.b) must include current certification in the subspecialty for which they are the program director by the American Board of Internal Medicine (ABIM) or by the American Osteopathic Board of Internal Medicine (AOBIM), or subspecialty qualifications that are acceptable to the Review Committee. (Core)

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

II.A.4. Program Director Responsibilities

The program director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; fellow recruitment and selection, evaluation, and promotion of fellows, and disciplinary action; supervision of fellows; and fellow education in the context of patient care. (Core)

II.A.4.a) The program director must:

II.A.4.a).(1) be a role model of professionalism; (Core)

Background and Intent: The program director, as the leader of the program, must serve as a role model to fellows in addition to fulfilling the technical aspects of the role. As fellows are expected to demonstrate compassion, integrity, and respect for others, they must be able to look to the program director as an exemplar. It is of utmost importance, therefore, that the program director model outstanding professionalism, high quality patient care, educational excellence, and a scholarly approach to work. The program director creates an environment where respectful discussion is welcome, with the goal of continued improvement of the educational experience.

- II.A.4.a).(2) design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program; ^(Core)

Background and Intent: The mission of institutions participating in graduate medical education is to improve the health of the public. Each community has health needs that vary based upon location and demographics. Programs must understand the social determinants of health of the populations they serve and incorporate them in the design and implementation of the program curriculum, with the ultimate goal of addressing these needs and health disparities.

- II.A.4.a).(3) administer and maintain a learning environment conducive to educating the fellows in each of the ACGME Competency domains; ^(Core)

Background and Intent: The program director may establish a leadership team to assist in the accomplishment of program goals. Fellowship programs can be highly complex. In a complex organization the leader typically has the ability to delegate authority to others, yet remains accountable. The leadership team may include physician and non-physician personnel with varying levels of education, training, and experience.

- II.A.4.a).(4) develop and oversee a process to evaluate candidates prior to approval as program faculty members for participation in the fellowship program education and at least annually thereafter, as outlined in V.B.; ^(Core)

- II.A.4.a).(5) have the authority to approve program faculty members for participation in the fellowship program education at all sites; ^(Core)

- II.A.4.a).(6) have the authority to remove program faculty members from participation in the fellowship program education at all sites; ^(Core)

- II.A.4.a).(7) have the authority to remove fellows from supervising interactions and/or learning environments that do not meet the standards of the program; ^(Core)

Background and Intent: The program director has the responsibility to ensure that all who educate fellows effectively role model the Core Competencies. Working with a

fellow is a privilege that is earned through effective teaching and professional role modeling. This privilege may be removed by the program director when the standards of the clinical learning environment are not met.

There may be faculty in a department who are not part of the educational program, and the program director controls who is teaching the residents.

- II.A.4.a).(8)** submit accurate and complete information required and requested by the DIO, GMEC, and ACGME; ^(Core)
- II.A.4.a).(9)** provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant subspecialty board examination(s); ^(Core)
- II.A.4.a).(10)** provide a learning and working environment in which fellows have the opportunity to raise concerns and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; ^(Core)
- II.A.4.a).(11)** ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process; ^(Core)
- II.A.4.a).(12)** ensure the program's compliance with the Sponsoring Institution's policies and procedures for due process when action is taken to suspend or dismiss, not to promote, or not to renew the appointment of a fellow; ^(Core)

Background and Intent: A program does not operate independently of its Sponsoring Institution. It is expected that the program director will be aware of the Sponsoring Institution's policies and procedures, and will ensure they are followed by the program's leadership, faculty members, support personnel, and fellows.

- II.A.4.a).(13)** ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; ^(Core)
- II.A.4.a).(13).(a)** Fellows must not be required to sign a non-competition guarantee or restrictive covenant. ^(Core)
- II.A.4.a).(14)** document verification of program completion for all graduating fellows within 30 days; ^(Core)
- II.A.4.a).(15)** provide verification of an individual fellow's completion upon the fellow's request, within 30 days; and, ^(Core)

Background and Intent: Primary verification of graduate medical education is important to credentialing of physicians for further training and practice. Such verification must be accurate and timely. Sponsoring Institution and program policies for record retention are important to facilitate timely documentation of fellows who have previously completed the program. Fellows who leave the program prior to completion also require timely documentation of their summative evaluation.

- II.A.4.a).(16)** obtain review and approval of the Sponsoring Institution’s DIO before submitting information or requests to the ACGME, as required in the Institutional Requirements and outlined in the ACGME Program Director’s Guide to the Common Program Requirements. ^(Core)

II.B. Faculty

Faculty members are a foundational element of graduate medical education – faculty members teach fellows how to care for patients. Faculty members provide an important bridge allowing fellows to grow and become practice ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.

Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, fellows, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the fellows and themselves.

Background and Intent: “Faculty” refers to the entire teaching force responsible for educating fellows. The term “faculty,” including “core faculty,” does not imply or require an academic appointment.

- II.B.1.** For each participating site, there must be a sufficient number of faculty members with competence to instruct and supervise all fellows at that location. ^(Core)
- II.B.2.** Faculty members must:
- II.B.2.a)** be role models of professionalism; ^(Core)
- II.B.2.b)** demonstrate commitment to the delivery of safe, quality, cost-effective, patient-centered care; ^(Core)

Background and Intent: Patients have the right to expect quality, cost-effective care with patient safety at its core. The foundation for meeting this expectation is formed during residency and fellowship. Faculty members model these goals and continually strive for improvement in care and cost, embracing a commitment to the patient and the community they serve.

- II.B.2.c) demonstrate a strong interest in the education of fellows; ^(Core)
- II.B.2.d) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; ^(Core)
- II.B.2.e) administer and maintain an educational environment conducive to educating fellows; ^(Core)
- II.B.2.f) regularly participate in organized clinical discussions, rounds, journal clubs, and conferences; and, ^(Core)
- II.B.2.g) pursue faculty development designed to enhance their skills at least annually. ^(Core)

Background and Intent: Faculty development is intended to describe structured programming developed for the purpose of enhancing transference of knowledge, skill, and behavior from the educator to the learner. Faculty development may occur in a variety of configurations (lecture, workshop, etc.) using internal and/or external resources. Programming is typically needs-based (individual or group) and may be specific to the institution or the program. Faculty development programming is to be reported for the fellowship program faculty in the aggregate.

II.B.3. Faculty Qualifications

- II.B.3.a) Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. ^(Core)
- II.B.3.b) Subspecialty physician faculty members must:
 - II.B.3.b).(1) have current certification in the subspecialty by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine, or possess qualifications judged acceptable to the Review Committee. ^(Core)
- II.B.3.c) Any non-physician faculty members who participate in fellowship program education must be approved by the program director. ^(Core)

Background and Intent: The provision of optimal and safe patient care requires a team approach. The education of fellows by non-physician educators enables the fellows to better manage patient care and provides valuable advancement of the fellows'

knowledge. Furthermore, other individuals contribute to the education of the fellow in the basic science of the subspecialty or in research methodology. If the program director determines that the contribution of a non-physician individual is significant to the education of the fellow, the program director may designate the individual as a program faculty member or a program core faculty member.

II.B.3.d) Any other specialty physician faculty members must have current certification in their specialty by the appropriate American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board, or possess qualifications judged acceptable to the Review Committee. ^(Core)

II.B.4. Core Faculty

Core faculty members must have a significant role in the education and supervision of fellows and must devote a significant portion of their entire effort to fellow education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to fellows. ^(Core)

Background and Intent: Core faculty members are critical to the success of fellow education. They support the program leadership in developing, implementing, and assessing curriculum, mentoring fellows, and assessing fellows' progress toward achievement of competence in and the independent practice of the specialty. Core faculty members should be selected for their broad knowledge of and involvement in the program, permitting them to effectively evaluate the program. Core faculty members may also be selected for their specific expertise and unique contribution to the program. Core faculty members are engaged in a broad range of activities, which may vary across programs and specialties. Core faculty members provide clinical teaching and supervision of fellows, and also participate in non-clinical activities related to fellow education and program administration. Examples of these non-clinical activities include, but are not limited to, interviewing and selecting fellow applicants, providing didactic instruction, mentoring fellows, simulation exercises, completing the annual ACGME Faculty Survey, and participating on the program's Clinical Competency Committee, Program Evaluation Committee, and other GME committees.

II.B.4.a) Core faculty members must be designated by the program director. ^(Core)

II.B.4.b) Core faculty members must complete the annual ACGME Faculty Survey. ^(Core)

II.B.4.c) In addition to the program director, there must be at least three core faculty members certified in gastroenterology by the ABIM or the AOBIM. ^(Core)

II.B.4.d) For programs approved for seven or more fellows, there must be at least one core faculty member certified in gastroenterology by the ABIM or the AOBIM for every 1.5 fellows. ^(Core)

- II.B.4.e) At least one core faculty member certified in gastroenterology by the ABIM or the AOBIM must have demonstrated expertise and a primary focus in hepatology. ^(Core)
- II.B.4.f) At least one core faculty member certified in gastroenterology by the ABIM or the AOBIM must have demonstrated expertise in all aspects of endoscopy, including advanced procedures. ^(Core)
- II.B.4.g) At a minimum, the required core faculty members, in aggregate and excluding members of the program leadership, must be provided with support equal to an average dedicated minimum of .1 FTE for educational and administrative responsibilities that do not involve direct patient care. ^(Core)

Subspecialty-Specific Background and Intent: For instance, a program with an approved complement of 12 fellows is required to have a minimum of eight ABIM- or AOBIM-subspecialty-certified faculty members and an FTE of 10 percent each. Because an associate program director is also a core faculty member, the minimum dedicated time requirements for associate program directors are inclusive of core faculty activities. An additional 10 percent FTE for the core faculty position is not required. For example, if one core faculty member is named the associate program director for a 12-fellow program, the required minimum support for that position is 14 percent FTE.

II.C. Program Coordinator

II.C.1. There must be a program coordinator. ^(Core)

II.C.2. The program coordinator must be provided with support adequate for administration of the program based upon its size and configuration. ^(Core)

II.C.2.a) At a minimum, the program coordinator must be provided with the dedicated time and support specified below for administration of the program. Additional administrative support must be provided based on the program size as follows: ^(Core)

Number of Approved Fellow Positions	Minimum FTE Required for Coordinator Support	Additional Aggregate FTE Required for Administration of the Program
1-3	.3	0
4-6	.3	.2
7-9	.3	.38
10-12	.3	.44
13-15	.3	.50
16-18	.3	.56
19-21	.3	.62
22-24	.3	.68
25-27	.3	.74
28-30	.3	.80

31-33	.3	.86
34-36	.3	.92

Background and Intent: The requirement does not address the source of funding required to provide the specified salary support.

Each program requires a lead administrative person, frequently referred to as a program coordinator, administrator, or as otherwise titled by the institution. This person will frequently manage the day-to-day operations of the program and serve as an important liaison and facilitator between the learners, faculty and other staff members, and the ACGME. Individuals serving in this role are recognized as program coordinators by the ACGME.

The program coordinator is a key member of the leadership team and is critical to the success of the program. As such, the program coordinator must possess skills in leadership and personnel management appropriate to the complexity of the program. Program coordinators are expected to develop in-depth knowledge of the ACGME and Program Requirements, including policies and procedures. Program coordinators assist the program director in meeting accreditation requirements, educational programming, and support of fellows.

Programs, in partnership with their Sponsoring Institutions, should encourage the professional development of their program coordinators and avail them of opportunities for both professional and personal growth. Programs with fewer fellows may not require a full-time coordinator; one coordinator may support more than one program.

Subspecialty-Specific Background and Intent: For instance, a program with an approved complement of 12 fellows is required to have at least 74 percent FTE administrative support: 30 percent FTE for the program coordinator; and an additional 44 percent FTE aggregate support. This additional support may be for the program coordinator only or divided among the program coordinator and one or more other administrative personnel. The Review Committee has not specified how the FTE should be distributed to allow programs, in partnership with their Sponsoring Institution, to allocate the FTE as they see fit.

II.D. Other Program Personnel

The program, in partnership with its Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective administration of the program. ^(Core)

Background and Intent: Multiple personnel may be required to effectively administer a program. These may include staff members with clerical skills, project managers, education experts, and staff members to maintain electronic communication for the program. These personnel may support more than one program in more than one discipline.

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

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

III. Fellow Appointments

III.A. Eligibility Criteria

III.A.1. Eligibility Requirements – Fellowship Programs

All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, an AOA-approved residency program, a program with ACGME International (ACGME-I) Advanced Specialty Accreditation, or a Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency program located in Canada.
(Core)

<p>Background and Intent: Eligibility for ABMS or AOA Board certification may not be satisfied by fellowship training. Applicants must be notified of this at the time of application, as required in II.A.4.a).(9).</p>

III.A.1.a) **Fellowship programs must receive verification of each entering fellow’s level of competence in the required field, upon matriculation, using ACGME, ACGME-I, or CanMEDS Milestones evaluations from the core residency program.** (Core)

III.A.1.b) Prior to appointment in the fellowship, fellows should have completed an internal medicine program that satisfies the requirements in III.A.1. (Core)

III.A.1.b).(1) Fellows who did not complete an internal medicine program that satisfies the requirements in III.A.1. must have completed at least three years of internal medicine education prior to starting the fellowship as well as met all of the criteria in the “Fellow Eligibility Exception” section below. (Core)

III.A.1.b).(2) To be eligible for appointment to the dual GI/TH pathway in the second or third year of education, fellows must be:

III.A.1.b).(2).(a) on a trajectory to achieving competence in gastroenterology by the end of the 36-month educational program based on progress along the subspecialty-specific Milestones; and, (Core)

III.A.1.b).(2).(b) approved by the gastroenterology Clinical Competency Committee, the gastroenterology program director, and the transplant hepatology program director. (Core)

Subspecialty-Specific Background and Intent: The dual GI/TH pathway is an intensive clinical education pathway that requires accelerated progression along gastroenterology subspecialty-specific Milestones in order to successfully achieve competence in both gastroenterology and transplant hepatology within the 36-month educational program. A fellow's trajectory and suitability for this pathway will need to be assessed during the first year; therefore, it may not be appropriate to designate a fellow for this pathway before starting fellowship education and training. Education and training in transplant hepatology in the dual GI/TH pathway cannot begin until the second year. In some cases, a fellow may not be ready to enter the dual GI/TH pathway until the third year.

III.A.1.c) Fellow Eligibility Exception

The Review Committee for Internal Medicine will allow the following exception to the fellowship eligibility requirements:

III.A.1.c).(1) An ACGME-accredited fellowship program may accept an exceptionally qualified international graduate applicant who does not satisfy the eligibility requirements listed in III.A.1., but who does meet all of the following additional qualifications and conditions:
(Core)

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

III.A.1.c).(1).(b) review and approval of the applicant's exceptional qualifications by the GMEC; and, (Core)

III.A.1.c).(1).(c) verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification. (Core)

III.A.1.c).(2) Applicants accepted through this exception must have an evaluation of their performance by the Clinical Competency Committee within 12 weeks of matriculation. (Core)

Background and Intent: An exceptionally qualified international graduate applicant has (1) completed a residency program in the core specialty outside the continental United States that was not accredited by the ACGME, AOA, ACGME-I, RCPSC or CFPC, and (2) demonstrated clinical excellence, in comparison to peers, throughout training. Additional evidence of exceptional qualifications is required, which may include one of the following: (a) participation in additional clinical or research training in the specialty or subspecialty; (b) demonstrated scholarship in the specialty or subspecialty; and/or (c) demonstrated leadership during or after residency. Applicants being considered for

these positions must be informed of the fact that their training may not lead to certification by ABMS member boards or AOA certifying boards.

In recognition of the diversity of medical education and training around the world, this early evaluation of clinical competence required for these applicants ensures they can provide quality and safe patient care. Any gaps in competence should be addressed as per policies for fellows already established by the program in partnership with the Sponsoring Institution.

III.B. The program director must not appoint more fellows than approved by the Review Committee. (Core)

III.B.1. All complement increases must be approved by the Review Committee. (Core)

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

III.C. Fellow Transfers

The program must obtain verification of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring fellow, and Milestones evaluations upon matriculation. (Core)

IV. Educational Program

The ACGME accreditation system is designed to encourage excellence and innovation in graduate medical education regardless of the organizational affiliation, size, or location of the program.

The educational program must support the development of knowledgeable, skillful physicians who provide compassionate care.

In addition, the program is expected to define its specific program aims consistent with the overall mission of its Sponsoring Institution, the needs of the community it serves and that its graduates will serve, and the distinctive capabilities of physicians it intends to graduate. While programs must demonstrate substantial compliance with the Common and subspecialty-specific Program Requirements, it is recognized that within this framework, programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will reflect the nuanced program-specific goals for it and its graduates; for example, it is expected that a program aiming to prepare physician-scientists will have a different curriculum from one focusing on community health.

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

IV.A.1. a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates; (Core)

IV.A.1.a) The program's aims must be made available to program applicants, fellows, and faculty members. (Core)

IV.A.2. competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice in their subspecialty. These must be distributed, reviewed, and available to fellows and faculty members; (Core)

IV.A.3. delineation of fellow responsibilities for patient care, progressive responsibility for patient management, and graded supervision in their subspecialty; (Core)

Background and Intent: These responsibilities may generally be described by PGY level and specifically by Milestones progress as determined by the Clinical Competency Committee. This approach encourages the transition to competency-based education. An advanced learner may be granted more responsibility independent of PGY level and a learner needing more time to accomplish a certain task may do so in a focused rather than global manner.

IV.A.4. structured educational activities beyond direct patient care; and, (Core)

Background and Intent: Patient care-related educational activities, such as morbidity and mortality conferences, tumor boards, surgical planning conferences, case discussions, etc., allow fellows to gain medical knowledge directly applicable to the patients they serve. Programs should define those educational activities in which fellows are expected to participate and for which time is protected. Further specification can be found in IV.C.

IV.A.5. advancement of fellows' knowledge of ethical principles foundational to medical professionalism. (Core)

IV.B. ACGME Competencies

Background and Intent: The Competencies provide a conceptual framework describing the required domains for a trusted physician to enter autonomous practice. These Competencies are core to the practice of all physicians, although the specifics are further defined by each subspecialty. The developmental trajectories in each of the Competencies are articulated through the Milestones for each subspecialty. The focus in fellowship is on subspecialty-specific patient care and medical knowledge, as well as refining the other competencies acquired in residency.

IV.B.1. The program must integrate the following ACGME Competencies into the curriculum: (Core)

IV.B.1.a) Professionalism

Fellows must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)

IV.B.1.b)

Patient Care and Procedural Skills

Background and Intent: Quality patient care is safe, effective, timely, efficient, patient-centered, equitable, and designed to improve population health, while reducing per capita costs. (See the Institute of Medicine [IOM]'s *Crossing the Quality Chasm: A New Health System for the 21st Century*, 2001 and Berwick D, Nolan T, Whittington J. *The Triple Aim: care, cost, and quality. Health Affairs.* 2008; 27(3):759-769.). In addition, there should be a focus on improving the clinician's well-being as a means to improve patient care and reduce burnout among residents, fellows, and practicing physicians.

These organizing principles inform the Common Program Requirements across all Competency domains. Specific content is determined by the Review Committees with input from the appropriate professional societies, certifying boards, and the community.

IV.B.1.b).(1)

Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. (Core)

IV.B.1.b).(1).(a)

Fellows must demonstrate competence in the practice of health promotion, disease prevention, diagnosis, care, and treatment of patients of each gender, from adolescence to old age, during health and all stages of illness; and, (Core)

IV.B.1.b).(1).(b)

Fellows must demonstrate competence in prevention, evaluation, and management of the following:

IV.B.1.b).(1).(b).(i)

acid peptic disorders of the gastrointestinal tract; (Core)

IV.B.1.b).(1).(b).(ii)

acute and chronic gallbladder and biliary tract diseases; (Core)

IV.B.1.b).(1).(b).(iii)

acute and chronic liver diseases; (Core)

IV.B.1.b).(1).(b).(iv)

acute and chronic pancreatic diseases; (Core)

IV.B.1.b).(1).(b).(v)

diseases of the esophagus; (Core)

IV.B.1.b).(1).(b).(vi)

disorders of nutrient assimilation; (Core)

IV.B.1.b).(1).(b).(vii)

gastrointestinal and hepatic neoplastic disease; (Core)

IV.B.1.b).(1).(b).(viii)

gastrointestinal bleeding; (Core)

IV.B.1.b).(1).(b).(ix)

gastrointestinal diseases with an immune basis; (Core)

IV.B.1.b).(1).(b).(x)	gastrointestinal emergencies in the acutely ill patient; ^(Core)
IV.B.1.b).(1).(b).(xi)	gastrointestinal infections, including retroviral, mycotic, and parasitic diseases; ^(Core)
IV.B.1.b).(1).(b).(xii)	genetic/inherited disorders; ^(Core)
IV.B.1.b).(1).(b).(xiii)	geriatric gastroenterology; ^(Core)
IV.B.1.b).(1).(b).(xiv)	inflammatory bowel diseases; ^(Core)
IV.B.1.b).(1).(b).(xv)	irritable bowel syndrome; ^(Core)
IV.B.1.b).(1).(b).(xvi)	motor disorders of the gastrointestinal tract; ^(Core)
IV.B.1.b).(1).(b).(xvii)	patients under surgical care for gastrointestinal disorders; ^(Core)
IV.B.1.b).(1).(b).(xviii)	vascular disorders of the gastrointestinal tract; and, ^(Core)
IV.B.1.b).(1).(b).(xix)	women's health issues in digestive diseases; ^(Core)
IV.B.1.b).(1).(c)	Fellows in the dual GI/TH pathway must also demonstrate competence in:
IV.B.1.b).(1).(c).(i)	the comprehensive management of patients high on the transplant list and in the intensive care setting with complications of end-stage liver disease, including refractory ascites, hepatic hydrothorax, hepatorenal syndrome, hepatopulmonary and portal pulmonary syndromes, and refractory portal hypertensive bleeding; ^(Core)
IV.B.1.b).(1).(c).(ii)	the diagnosis and management of hepatocellular carcinoma and cholangiocarcinoma, including transplantation and non-transplantation, and surgical and non-surgical approaches; ^(Core)
IV.B.1.b).(1).(c).(iii)	the ethical considerations relating to liver transplant donors, including questions related to living donors, non-heart beating donors, criteria for brain death, and appropriate selection of recipients; ^(Core)

IV.B.1.b).(1).(c).(iv)	the evaluation and management of both inpatients and outpatients with acute and chronic end-stage liver disease; (Core)
IV.B.1.b).(1).(c).(v)	the management of chronic viral hepatitis in the pre-transplantation, peri-transplantation, and post-transplantation settings; (Core)
IV.B.1.b).(1).(c).(vi)	the management of fulminant liver failure; (Core)
IV.B.1.b).(1).(c).(vii)	nutritional support of patients with chronic liver disease; (Core)
IV.B.1.b).(1).(c).(viii)	the prevention of acute and chronic end-stage liver disease; and, (Core)
IV.B.1.b).(1).(c).(ix)	the psychosocial evaluation of all transplant candidates, particularly those with a history of substance abuse. (Core)
IV.B.1.b).(2)	Fellows must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)
IV.B.1.b).(2).(a)	Fellows must demonstrate competence in the performance of the following procedures:
IV.B.1.b).(2).(a).(i)	biopsy of the mucosa of esophagus, stomach, small bowel, and colon; (Core)
IV.B.1.b).(2).(a).(ii)	capsule endoscopy; (Core)
IV.B.1.b).(2).(a).(iii)	colonoscopy with polypectomy; (Core)
IV.B.1.b).(2).(a).(iv)	conscious sedation; (Core)
IV.B.1.b).(2).(a).(v)	esophageal dilation; (Core)
IV.B.1.b).(2).(a).(vi)	esophagogastroduodenoscopy; (Core)
IV.B.1.b).(2).(a).(vii)	nonvariceal hemostasis, both upper and lower including actively bleeding patients; (Core)
IV.B.1.b).(2).(a).(viii)	other diagnostic and therapeutic procedures utilizing enteral intubation; (Core)
IV.B.1.b).(2).(a).(ix)	paracentesis; (Core)

- IV.B.1.b).(2).(a).(x) percutaneous endoscopic gastrostomy; ^(Core)
- IV.B.1.b).(2).(a).(xi) retrieval of foreign bodies from the esophagus; and, ^(Core)
- IV.B.1.b).(2).(a).(xii) variceal hemostasis including actively bleeding patients. ^(Core)
- IV.B.1.b).(2).(b) Fellows in the dual GI/TH pathway must also demonstrate competence in:
- IV.B.1.b).(2).(b).(i) the performance of native and allograft liver biopsies and interpretation of results; and, ^(Core)
- IV.B.1.b).(2).(b).(i).(a) Each fellow must perform a minimum of 20 liver biopsies. ^(Detail)
- IV.B.1.b).(2).(b).(ii) the use of interventional radiology in the diagnosis and management of portal hypertension, as well as biliary and vascular complications. ^(Core)

IV.B.1.c) Medical Knowledge

Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. ^(Core)

- IV.B.1.c).(1) Fellows must demonstrate knowledge of the scientific method of problem solving and evidence-based decision making; ^(Core)
- IV.B.1.c).(2) Fellows must demonstrate knowledge of indications, contraindications, limitations, complications, techniques, and interpretation of results of those diagnostic and therapeutic procedures integral to the discipline, including the appropriate indication for and use of screening tests/procedures; and, ^(Core)
- IV.B.1.c).(3) Fellows must demonstrate knowledge of:
- IV.B.1.c).(3).(a) anatomy, physiology, pharmacology, pathology and molecular biology related to the gastrointestinal system, including the liver, biliary tract and pancreas; ^(Core)
- IV.B.1.c).(3).(b) interpretation of abnormal liver chemistries; ^(Core)
- IV.B.1.c).(3).(c) liver transplantation; ^(Core)

- IV.B.1.c).(3).(d) nutrition; (Core)
- IV.B.1.c).(3).(e) prudent, cost-effective, and judicious use of special instruments, tests, and therapy in the diagnosis and management of gastroenterologic disorders; (Core)
- IV.B.1.c).(3).(f) sedative pharmacology; and, (Core)
- IV.B.1.c).(3).(g) surgical procedures employed in relation to digestive system disorders and their complications. (Core)
- IV.B.1.c).(4) Fellows in the dual GI/TH pathway must also demonstrate knowledge of:
- IV.B.1.c).(4).(a) drug hepatotoxicity and the interaction of drugs with the liver; (Core)
- IV.B.1.c).(4).(b) the impact of various modes of therapy and the appropriate use of laboratory tests and procedures; (Core)
- IV.B.1.c).(4).(c) the natural history of chronic liver disease; (Core)
- IV.B.1.c).(4).(d) factors involved in nutrition and malnutrition and their management; (Core)
- IV.B.1.c).(4).(e) the organizational and logistic aspects of liver transplantation, including the role of nurse coordinators and other support staff members (including social work), organ procurement, and United Network for Organ Sharing policies, to include those regarding organ allocation; (Core)
- IV.B.1.c).(4).(f) principles and application of artificial liver support; (Core)
- IV.B.1.c).(4).(g) principles of donor selection and rejection (e.g., hemodynamic management, donor organ steatosis, and indication for liver biopsy); (Core)
- IV.B.1.c).(4).(h) principles of living donor selection, including appropriate surgical, psychosocial and ethical considerations; (Core)
- IV.B.1.c).(4).(i) principles and practice of pediatric liver transplantation; (Core)
- IV.B.1.c).(4).(j) transplant immunology, including blood group matching, histocompatibility, tissue typing, and

infectious and malignant complications of immunosuppression; and, (Core)

IV.B.1.c).(4).(k)

indications, contraindications, limitations, complications, alternatives, and techniques of native and allograft biopsies and non-invasive methods of fibrosis assessment. (Core)

IV.B.1.d)

Practice-based Learning and Improvement

Fellows must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning. (Core)

Background and Intent: Practice-based learning and improvement is one of the defining characteristics of being a physician. It is the ability to investigate and evaluate the care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning.

The intention of this Competency is to help a fellow refine the habits of mind required to continuously pursue quality improvement, well past the completion of fellowship.

IV.B.1.e)

Interpersonal and Communication Skills

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

IV.B.1.f)

Systems-based Practice

Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)

IV.C. Curriculum Organization and Fellow Experiences

IV.C.1.

The curriculum must be structured to optimize fellow educational experiences, the length of these experiences, and supervisory continuity. (Core)

IV.C.1.a)

Assignment of rotations must be structured to minimize the frequency of rotational transitions, and rotations must be of sufficient length to provide a quality educational experience, defined by continuity of patient care, ongoing supervision, longitudinal relationships with faculty members, and meaningful assessment and feedback. (Core)

IV.C.1.b) Clinical experiences should be structured to facilitate learning in a manner that allows fellows to function as part of an effective interprofessional team that works together towards the shared goals of patient safety and quality improvement. ^(Core)

IV.C.2. The program must provide instruction and experience in pain management if applicable for the subspecialty, including recognition of the signs of addiction. ^(Core)

IV.C.3. A minimum of 18 months must be devoted to clinical experience, of which the equivalent of five months should be composed of hepatology. ^(Core)

IV.C.3.a) Dual GI/TH pathway:

IV.C.3.a).(1) In addition to the minimum of 18 months devoted to clinical experience in gastroenterology, a minimum of 12 months must be devoted to clinical experience in transplant hepatology. ^(Core)

IV.C.3.a).(2) All 12 months of transplant hepatology must include clinical experiences and appropriate protected (block or concurrent) time for research. ^(Core)

IV.C.3.a).(3) Fellows must not begin education and training in transplant hepatology in the dual GI/TH pathway until the second year of the educational program. ^(Core)

Subspecialty-Specific Background and Intent: The dual GI/TH pathway is an intensive clinical education pathway that is appropriate for fellows seeking a career in clinical advanced and transplant hepatology. This intensive clinical fellowship may not be appropriate for fellows who prefer to focus on other career interests prior to transplant hepatology education and training, including research or an additional advanced degree. Programs are expected to identify fellows in the first year who may be interested in the dual GI/TH pathway. Faculty and clinical resources will need to be available to support the education of dual GI/TH pathway fellows in addition to fellows in the transplant hepatology fellowship. The curriculum, experiences, and evaluation of fellows in the dual GI/TH pathway should occur in collaboration with the transplant hepatology program director, faculty members, and Clinical Competency Committee. As such, the education of fellows in the dual GI/TH pathway requires close cooperation between the gastroenterology and transplant hepatology program directors. The 12 months of transplant hepatology clinical experience do not need to be consecutive. Programs are expected to notify the ACGME, via ADS, of a fellow's participation in the dual GI/TH pathway at the beginning of the second and/or third year of the educational program.

IV.C.4. Fellows must participate in training using simulation. ^(Detail)

IV.C.5. Experience with Continuity Ambulatory Patients

IV.C.5.a) Fellows must have continuity ambulatory clinic experience that exposes them to the breadth and depth of the subspecialty. ^(Core)

- IV.C.5.b) This experience should average one half-day each week. ^(Detail)
- IV.C.5.c) This experience must include an appropriate distribution of patients of each gender and a diversity of ages. ^(Core)
- This should be accomplished through either:
- IV.C.5.c).(1) a continuity clinic which provides fellows the opportunity to observe and learn the course of disease; or, ^(Detail)
- IV.C.5.c).(2) selected blocks of at least six months which address specific areas of gastrointestinal disease. ^(Detail)
- IV.C.5.d) Each fellow should, on average, be responsible for four to eight patients during each half-day session. ^(Detail)
- IV.C.5.e) The continuity patient care experience should not be interrupted by more than one month, excluding a fellow's vacation. ^(Detail)
- IV.C.5.f) Fellows should be informed of the status of their continuity patients when such patients are hospitalized, as clinically appropriate. ^(Detail)
- IV.C.6. Dual GI/TH pathway:
- IV.C.6.a) Fellows must have continuity ambulatory clinic experience that exposes them to the breadth and depth of gastroenterology and transplant hepatology. ^(Core)
- IV.C.6.b) Each fellow must participate in primary evaluation, presentation, and discussion at selection conferences of potential transplant candidates. ^(Core)
- IV.C.6.b).(1) Each fellow must participate at selection conferences of at least 10 potential transplant candidates. ^(Detail)
- IV.C.6.c) Each fellow must provide follow-up for new liver transplant recipients for a minimum of three months from the time of their transplantation. ^(Core)
- IV.C.6.c).(1) Each fellow must provide follow-up for at least 20 new liver transplant recipients for a minimum of three months from the time of their transplantation. ^(Detail)
- IV.C.6.d) Fellows must gain familiarity and expertise with the management of common long-term problems such as cardiovascular disease, acute and chronic kidney injury, screening for malignancies, and diagnosis and treatment of recurrent disease. ^(Core)
- IV.C.6.e) Each fellow must participate in the follow-up of liver transplant

recipients who have survived more than one year after transplantation. ^(Core)

- IV.C.6.e).(1) This must include at least 20 such patients. ^(Detail)
- IV.C.6.e).(2) There must be a minimum six-month follow-up period for each patient to ensure longitudinal care of transplant recipients. ^(Detail)
- IV.C.6.f) Each fellow must actively participate in transplant recipients' medical care, including management of acute cellular rejection, recurrent disease, infectious diseases, and biliary tract complications, and must serve as a primary member of the transplantation team and participate in making decisions about immunosuppression. ^(Core)
- IV.C.6.f).(1) The fellows and faculty members in the program must share patient co-management responsibilities with transplant surgeons from the pre-operative phase to the outpatient period. ^(Detail)
- IV.C.6.f).(2) The program must ensure close interactions and education with an experienced liver transplant pathologist. ^(Detail)
- IV.C.6.g) Fellows must observe in one cadaveric liver procurement and three liver transplant surgeries. ^(Core)
- IV.C.6.h) Fellows must have formal instruction and clinical experience in interpretation of the following diagnostic and therapeutic techniques and procedures:
 - IV.C.6.h).(1) review of native and allograft liver biopsies; and, ^(Core)
 - IV.C.6.h).(1).(a) A minimum of 200 reviews of such biopsies must be done ^(Detail)
 - IV.C.6.h).(2) the appropriate use of ultrasound localized, laparoscopy-guided and transjugular liver biopsies. ^(Core)
- IV.C.6.i) Fellows must have formal didactic instruction in the pathogenesis, manifestations, and complications of end-stage liver disease and hepatic transplantation, including the behavioral adjustments of patients to their problems. ^(Core)
- IV.C.7. Procedures and Technical Skills
 - IV.C.7.a) Direct supervision of procedures performed by each fellow must occur until proficiency has been acquired and documented by the program director. ^(Core)
 - IV.C.7.b) Faculty members must teach and supervise the fellows in the

performance and interpretation of procedures, which must be documented in each fellow's record, including indications, outcomes, diagnoses, and supervisor(s). (Core)

- IV.C.7.c) Fellows must have formal instruction and clinical experience in the interpretation of the following diagnostic and therapeutic techniques and procedures:
- IV.C.7.c).(1) Endoscopic Retrograde Cholangiopancreatography, in all its diagnostic and therapeutic applications; (Core)
 - IV.C.7.c).(2) enteral and parenteral alimentation; (Core)
 - IV.C.7.c).(3) imaging of the digestive system, including:
 - IV.C.7.c).(3).(a) computed tomography (CT); including CT entero/colography; (Core)
 - IV.C.7.c).(3).(b) contrast radiography; (Core)
 - IV.C.7.c).(3).(c) magnetic resonance imaging; (Core)
 - IV.C.7.c).(3).(d) nuclear medicine; (Core)
 - IV.C.7.c).(3).(e) percutaneous cholangiography; (Core)
 - IV.C.7.c).(3).(f) ultrasound, including endoscopic ultrasound; (Core)
 - IV.C.7.c).(3).(g) vascular radiography; and (Core)
 - IV.C.7.c).(3).(h) wireless capsule endoscopy. (Core)
 - IV.C.7.c).(4) interpretation of gastrointestinal and hepatic biopsies; and, (Core)
 - IV.C.7.c).(5) motility studies, including esophageal motility/pH studies. (Core)
- IV.C.7.d) Fellows must have exposure to and clinical experience in the performance of gastrointestinal motility studies and 24-hour pH monitoring. (Core)
- IV.C.8. The core curriculum must include a didactic program based upon the core knowledge content in the subspecialty area. (Core)
- IV.C.8.a) The core curriculum for fellows in the dual GI/TH pathway must include a didactic program based upon the core knowledge content of transplant hepatology in addition to the didactic program based upon the core knowledge content in gastroenterology. (Core)

- IV.C.8.b) Fellows must have the opportunity to review topics covered in conferences that they were unable to attend. ^(Detail)
- IV.C.8.c) Fellows must participate in clinical case conferences, journal clubs, research conferences, and morbidity and mortality or quality improvement conferences. ^(Detail)
- IV.C.8.d) All core conferences must have at least one faculty member present, and must be scheduled as to ensure peer-peer and peer-faculty interaction. ^(Detail)
- IV.C.9. Patient-based teaching must include direct interaction between fellows and faculty members, bedside teaching, discussion of pathophysiology, and the use of current evidence in diagnostic and therapeutic decisions. ^(Core)
- The teaching must be:
- IV.C.9.a) formally conducted on all inpatient, outpatient, and consultative services; and, ^(Detail)
- IV.C.9.b) conducted with a frequency and duration that ensures a meaningful and continuous teaching relationship between the assigned supervising faculty member(s) and fellows. ^(Detail)
- IV.C.10. Fellows must receive instruction in practice management relevant to gastroenterology. ^(Detail)
- IV.C.10.a) Fellows in the dual GI/TH pathway must be instructed in practice management relevant to transplant hepatology in addition to gastroenterology. ^(Detail)

IV.D. Scholarship

Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through fellow participation in scholarly activities as defined in the subspecialty-specific Program Requirements. Scholarly activities may include discovery, integration, application, and teaching.

The ACGME recognizes the diversity of fellowships and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other programs might choose to utilize more classic forms of biomedical research as the focus for scholarship.

IV.D.1. Program Responsibilities

IV.D.1.a) The program must demonstrate evidence of scholarly activities, consistent with its mission(s) and aims. ^(Core)

IV.D.1.b) The program in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate fellow and faculty involvement in scholarly activities. ^(Core)

IV.D.2. Faculty Scholarly Activity

IV.D.2.a) Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: ^(Core)

- **Research in basic science, education, translational science, patient care, or population health**
- **Peer-reviewed grants**
- **Quality improvement and/or patient safety initiatives**
- **Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports**
- **Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials**
- **Contribution to professional committees, educational organizations, or editorial boards**
- **Innovations in education**

IV.D.2.b) The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:

Background and Intent: For the purposes of education, metrics of scholarly activity represent one of the surrogates for the program's effectiveness in the creation of an environment of inquiry that advances the fellows' scholarly approach to patient care. The Review Committee will evaluate the dissemination of scholarship for the program as a whole, not for individual faculty members, for a five-year interval, for both core and non-core faculty members, with the goal of assessing the effectiveness of the creation of such an environment. The ACGME recognizes that there may be differences in scholarship requirements between different specialties and between residencies and fellowships in the same specialty.

IV.D.2.b).(1) faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a

journal reviewer, journal editorial board member, or editor. (Outcome)‡

IV.D.2.b).(1).(a)

At least 50 percent of the core faculty members who are certified in the subspecialty by the ABIM or AOBIM (see II.B.4.c)-d)) must annually engage in a variety of scholarly activities, as listed in Program Requirement IV.D.2.b).(1). (Core)

IV.D.3. Fellow Scholarly Activity

IV.D.3.a)

While in the program, at least 50 percent of the program's fellows must have engaged in more than one of the following scholarly activities: participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor. (Outcome)

V. Evaluation

V.A. Fellow Evaluation

V.A.1. Feedback and Evaluation

Background and Intent: Feedback is ongoing information provided regarding aspects of one's performance, knowledge, or understanding. The faculty empower fellows to provide much of that feedback themselves in a spirit of continuous learning and self-reflection. Feedback from faculty members in the context of routine clinical care should be frequent, and need not always be formally documented.

Formative and summative evaluation have distinct definitions. Formative evaluation is *monitoring fellow learning* and providing ongoing feedback that can be used by fellows to improve their learning in the context of provision of patient care or other educational opportunities. More specifically, formative evaluations help:

- **fellows identify their strengths and weaknesses and target areas that need work**
- **program directors and faculty members recognize where fellows are struggling and address problems immediately**

Summative evaluation is *evaluating a fellow's learning* by comparing the fellows against the goals and objectives of the rotation and program, respectively. Summative evaluation is utilized to make decisions about promotion to the next level of training, or program completion.

End-of-rotation and end-of-year evaluations have both summative and formative components. Information from a summative evaluation can be used formatively when fellows or faculty members use it to guide their efforts and activities in subsequent rotations and to successfully complete the fellowship program.

Feedback, formative evaluation, and summative evaluation compare intentions with accomplishments, enabling the transformation of a new specialist to one with growing subspecialty expertise.

- V.A.1.a) Faculty members must directly observe, evaluate, and frequently provide feedback on fellow performance during each rotation or similar educational assignment. ^(Core)**
- V.A.1.a).(1) The faculty must discuss this evaluation with each fellow at the completion of each assignment. ^(Core)
- V.A.1.a).(2) Assessment of procedural competence should include a formal evaluation process and not be based solely on a minimum number of procedures performed. ^(Detail)
- V.A.1.a).(3) Dual GI/TH pathway:
- V.A.1.a).(3).(a) Evaluation of performance must include evaluation of competence in transplant hepatology in addition to gastroenterology, including progress along the subspecialty-specific Milestones for each specialty independently. ^(Core)
- V.A.1.a).(3).(b) The gastroenterology program director must obtain input from the transplant hepatology program director and transplant hepatology Clinical Competency Committee to assist with evaluation of fellows. ^(Core)
- V.A.1.a).(3).(c) The summative evaluation must include each fellow's readiness to participate or continue in the dual GI/TH pathway, if applicable. ^(Core)
- V.A.1.a).(3).(d) The gastroenterology program director must obtain input from the transplant hepatology program director to provide a final evaluation for each fellow upon completion of the program. ^(Core)
- V.A.1.a).(3).(e) The final evaluation of fellows must:
- V.A.1.a).(3).(e).(i) verify that the fellow has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice in transplant hepatology and gastroenterology; and, ^(Core)
- V.A.1.a).(3).(e).(ii) consider recommendations from both transplant hepatology and gastroenterology Clinical Competency Committees. ^(Core)
- V.A.1.a).(3).(f) The Clinical Competency Committee must obtain input from the transplant hepatology program

director and transplant hepatology Clinical Competency Committee to determine each fellow's progress on achievement of the subspecialty-specific Milestones in transplant hepatology and to advise the program director regarding each fellow's progress. ^(Core)

V.A.1.a).(3).(g)

The fellows should evaluate transplant hepatology faculty members as relates to the transplant hepatology educational program. ^(Detail)

Subspecialty-Specific Background and Intent: Due to the unique nature of education and training in two specialties, the evaluation of fellows in the dual GI/TH pathway should occur in collaboration with the transplant hepatology fellowship program director, faculty members, and Clinical Competency Committee. The gastroenterology program director and Clinical Competency Committee will obtain input from the transplant hepatology program director and Clinical Competency Committee to determine the progress of each dual GI/TH fellow in transplant hepatology based on achievement of the subspecialty-specific Milestones. This should include broad input from multiple evaluators, including transplant nurses, transplant social workers, and transplant surgeons. This assessment should be in addition to the assessment of progress toward the unsupervised practice of gastroenterology. The annual summative evaluation should determine if a fellow is ready to participate or continue in the dual GI/TH pathway. The dual GI/TH fellow also should have the opportunity to evaluate transplant hepatology faculty members in addition to gastroenterology faculty members.

Background and Intent: Faculty members should provide feedback frequently throughout the course of each rotation. Fellows require feedback from faculty members to reinforce well-performed duties and tasks, as well as to correct deficiencies. This feedback will allow for the development of the learner as they strive to achieve the Milestones. More frequent feedback is strongly encouraged for fellows who have deficiencies that may result in a poor final rotation evaluation.

V.A.1.b)

Evaluation must be documented at the completion of the assignment. ^(Core)

V.A.1.b).(1)

For block rotations of greater than three months in duration, evaluation must be documented at least every three months. ^(Core)

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

Longitudinal experiences such as continuity clinic in the context of other clinical responsibilities must be evaluated at least every three months and at completion. ^(Core)

V.A.1.c)

The program must provide an objective performance evaluation based on the Competencies and the subspecialty-specific Milestones, and must: ^(Core)

V.A.1.c).(1)

use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and, ^(Core)

V.A.1.c).(2) provide that information to the Clinical Competency Committee for its synthesis of progressive fellow performance and improvement toward unsupervised practice. ^(Core)

Background and Intent: The trajectory to autonomous practice in a subspecialty is documented by the subspecialty-specific Milestones evaluation during fellowship. These Milestones detail the progress of a fellow in attaining skill in each competency domain. It is expected that the most growth in fellowship education occurs in patient care and medical knowledge, while the other four domains of competency must be ensured in the context of the subspecialty. They are developed by a subspecialty group and allow evaluation based on observable behaviors. The Milestones are considered formative and should be used to identify learning needs. This may lead to focused or general curricular revision in any given program or to individualized learning plans for any specific fellow.

V.A.1.d) The program director or their designee, with input from the Clinical Competency Committee, must:

V.A.1.d).(1) meet with and review with each fellow their documented semi-annual evaluation of performance, including progress along the subspecialty-specific Milestones. ^(Core)

V.A.1.d).(2) assist fellows in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and, ^(Core)

V.A.1.d).(3) develop plans for fellows failing to progress, following institutional policies and procedures. ^(Core)

Background and Intent: Learning is an active process that requires effort from the teacher and the learner. Faculty members evaluate a fellow's performance at least at the end of each rotation. The program director or their designee will review those evaluations, including their progress on the Milestones, at a minimum of every six months. Fellows should be encouraged to reflect upon the evaluation, using the information to reinforce well-performed tasks or knowledge or to modify deficiencies in knowledge or practice. Working together with the faculty members, fellows should develop an individualized learning plan.

Fellows who are experiencing difficulties with achieving progress along the Milestones may require intervention to address specific deficiencies. Such intervention, documented in an individual remediation plan developed by the program director or a faculty mentor and the fellow, will take a variety of forms based on the specific learning needs of the fellow. However, the ACGME recognizes that there are situations which require more significant intervention that may alter the time course of fellow progression. To ensure due process, it is essential that the program director follow institutional policies and procedures.

- V.A.1.e)** At least annually, there must be a summative evaluation of each fellow that includes their readiness to progress to the next year of the program, if applicable. ^(Core)
- V.A.1.f)** The evaluations of a fellow's performance must be accessible for review by the fellow. ^(Core)
- V.A.2.** Final Evaluation
- V.A.2.a)** The program director must provide a final evaluation for each fellow upon completion of the program. ^(Core)
- V.A.2.a).(1)** The subspecialty-specific Milestones, and when applicable the subspecialty-specific Case Logs, must be used as tools to ensure fellows are able to engage in autonomous practice upon completion of the program. ^(Core)
- V.A.2.a).(2)** The final evaluation must:
- V.A.2.a).(2).(a)** become part of the fellow's permanent record maintained by the institution, and must be accessible for review by the fellow in accordance with institutional policy; ^(Core)
- V.A.2.a).(2).(b)** verify that the fellow has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice; ^(Core)
- V.A.2.a).(2).(c)** consider recommendations from the Clinical Competency Committee; and, ^(Core)
- V.A.2.a).(2).(d)** be shared with the fellow upon completion of the program. ^(Core)
- V.A.3.** A Clinical Competency Committee must be appointed by the program director. ^(Core)
- V.A.3.a)** At a minimum the Clinical Competency Committee must include three members, at least one of whom is a core faculty member. Members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's fellows. ^(Core)
- V.A.3.b)** The Clinical Competency Committee must:
- V.A.3.b).(1)** review all fellow evaluations at least semi-annually; ^(Core)

V.A.3.b).(2) determine each fellow's progress on achievement of the subspecialty-specific Milestones; and, (Core)

V.A.3.b).(3) meet prior to the fellows' semi-annual evaluations and advise the program director regarding each fellow's progress. (Core)

V.B. Faculty Evaluation

V.B.1. The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)

Background and Intent: The program director is responsible for the education program and for whom delivers it. While the term faculty may be applied to physicians within a given institution for other reasons, it is applied to fellowship program faculty members only through approval by a program director. The development of the faculty improves the education, clinical, and research aspects of a program. Faculty members have a strong commitment to the fellow and desire to provide optimal education and work opportunities. Faculty members must be provided feedback on their contribution to the mission of the program. All faculty members who interact with fellows desire feedback on their education, clinical care, and research. If a faculty member does not interact with fellows, feedback is not required. With regard to the diverse operating environments and configurations, the fellowship program director may need to work with others to determine the effectiveness of the program's faculty performance with regard to their role in the educational program. All teaching faculty members should have their educational efforts evaluated by the fellows in a confidential and anonymous manner. Other aspects for the feedback may include research or clinical productivity, review of patient outcomes, or peer review of scholarly activity. The process should reflect the local environment and identify the necessary information. The feedback from the various sources should be summarized and provided to the faculty on an annual basis by a member of the leadership team of the program.

V.B.1.a) This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities. (Core)

V.B.1.b) This evaluation must include written, confidential evaluations by the fellows. (Core)

V.B.2. Faculty members must receive feedback on their evaluations at least annually. (Core)

V.B.3. Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core)

Background and Intent: The quality of the faculty's teaching and clinical care is a determinant of the quality of the program and the quality of the fellows' future clinical care. Therefore, the program has the responsibility to evaluate and improve the

program faculty members' teaching, scholarship, professionalism, and quality care. This section mandates annual review of the program's faculty members for this purpose, and can be used as input into the Annual Program Evaluation.

V.C. Program Evaluation and Improvement

V.C.1. The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. ^(Core)

V.C.1.a) The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one fellow. ^(Core)

V.C.1.b) Program Evaluation Committee responsibilities must include:

V.C.1.b).(1) acting as an advisor to the program director, through program oversight; ^(Core)

V.C.1.b).(2) review of the program's self-determined goals and progress toward meeting them; ^(Core)

V.C.1.b).(3) guiding ongoing program improvement, including development of new goals, based upon outcomes; and, ^(Core)

V.C.1.b).(4) review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. ^(Core)

Background and Intent: In order to achieve its mission and train quality physicians, a program must evaluate its performance and plan for improvement in the Annual Program Evaluation. Performance of fellows and faculty members is a reflection of program quality, and can use metrics that reflect the goals that a program has set for itself. The Program Evaluation Committee utilizes outcome parameters and other data to assess the program's progress toward achievement of its goals and aims.

V.C.1.c) The Program Evaluation Committee should consider the following elements in its assessment of the program:

V.C.1.c).(1) curriculum; ^(Core)

V.C.1.c).(2) outcomes from prior Annual Program Evaluation(s); ^(Core)

V.C.1.c).(3) ACGME letters of notification, including citations, Areas for Improvement, and comments; ^(Core)

V.C.1.c).(4) quality and safety of patient care; ^(Core)

- V.C.1.c).(5)** **aggregate fellow and faculty:**
- V.C.1.c).(5).(a)** **well-being;** ^(Core)
- V.C.1.c).(5).(b)** **recruitment and retention;** ^(Core)
- V.C.1.c).(5).(c)** **workforce diversity;** ^(Core)
- V.C.1.c).(5).(d)** **engagement in quality improvement and patient safety;** ^(Core)
- V.C.1.c).(5).(e)** **scholarly activity;** ^(Core)
- V.C.1.c).(5).(f)** **ACGME Resident/Fellow and Faculty Surveys (where applicable); and,** ^(Core)
- V.C.1.c).(5).(g)** **written evaluations of the program.** ^(Core)
- V.C.1.c).(6)** **aggregate fellow:**
- V.C.1.c).(6).(a)** **achievement of the Milestones;** ^(Core)
- V.C.1.c).(6).(b)** **in-training examinations (where applicable);** ^(Core)
- V.C.1.c).(6).(c)** **board pass and certification rates; and,** ^(Core)
- V.C.1.c).(6).(d)** **graduate performance.** ^(Core)
- V.C.1.c).(7)** **aggregate faculty:**
- V.C.1.c).(7).(a)** **evaluation; and,** ^(Core)
- V.C.1.c).(7).(b)** **professional development** ^(Core)
- V.C.1.d)** **The Program Evaluation Committee must evaluate the program’s mission and aims, strengths, areas for improvement, and threats.** ^(Core)
- V.C.1.e)** **The annual review, including the action plan, must:**
- V.C.1.e).(1)** **be distributed to and discussed with the members of the teaching faculty and the fellows; and,** ^(Core)
- V.C.1.e).(2)** **be submitted to the DIO.** ^(Core)
- V.C.2.** **The program must participate in a Self-Study prior to its 10-Year Accreditation Site Visit.** ^(Core)
- V.C.2.a)** **A summary of the Self-Study must be submitted to the DIO.** ^(Core)

Background and Intent: Outcomes of the documented Annual Program Evaluation can be integrated into the 10-year Self-Study process. The Self-Study is an objective, comprehensive evaluation of the fellowship program, with the aim of improving it. Underlying the Self-Study is this longitudinal evaluation of the program and its learning environment, facilitated through sequential Annual Program Evaluations that focus on the required components, with an emphasis on program strengths and self-identified areas for improvement. Details regarding the timing and expectations for the Self-Study and the 10-Year Accreditation Site Visit are provided in the *ACGME Manual of Policies and Procedures*. Additionally, a description of the [Self-Study process](#), as well as information on how to prepare for the [10-Year Accreditation Site Visit](#), is available on the ACGME website.

- V.C.3.** *One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.*
- The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.*
- V.C.3.a)** For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty. (Outcome)
- V.C.3.b)** For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty. (Outcome)
- V.C.3.c)** For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty. (Outcome)
- V.C.3.d)** For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty. (Outcome)

V.C.3.e) For each of the exams referenced in V.C.3.a)-d), any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that subspecialty. ^(Outcome)

Background and Intent: Setting a single standard for pass rate that works across subspecialties is not supportable based on the heterogeneity of the psychometrics of different examinations. By using a percentile rank, the performance of the lower five percent (fifth percentile) of programs can be identified and set on a path to curricular and test preparation reform.

There are subspecialties where there is a very high board pass rate that could leave successful programs in the bottom five percent (fifth percentile) despite admirable performance. These high-performing programs should not be cited, and V.C.3.e) is designed to address this.

V.C.3.f) Programs must report, in ADS, board certification status annually for the cohort of board-eligible fellows that graduated seven years earlier. ^(Core)

Background and Intent: It is essential that fellowship programs demonstrate knowledge and skill transfer to their fellows. One measure of that is the qualifying or initial certification exam pass rate. Another important parameter of the success of the program is the ultimate board certification rate of its graduates. Graduates are eligible for up to seven years from fellowship graduation for initial certification. The ACGME will calculate a rolling three-year average of the ultimate board certification rate at seven years post-graduation, and the Review Committees will monitor it.

The Review Committees will track the rolling seven-year certification rate as an indicator of program quality. Programs are encouraged to monitor their graduates' performance on board certification examinations.

In the future, the ACGME may establish parameters related to ultimate board certification rates.

VI. The Learning and Working Environment

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

- *Excellence in the safety and quality of care rendered to patients by fellows today*
- *Excellence in the safety and quality of care rendered to patients by today's fellows in their future practice*
- *Excellence in professionalism through faculty modeling of:*

- *the effacement of self-interest in a humanistic environment that supports the professional development of physicians*
- *the joy of curiosity, problem-solving, intellectual rigor, and discovery*
- *Commitment to the well-being of the students, residents, fellows, faculty members, and all members of the health care team*

Background and Intent: The revised requirements are intended to provide greater flexibility within an established framework, allowing programs and fellows more discretion to structure clinical education in a way that best supports the above principles of professional development. With this increased flexibility comes the responsibility for programs and fellows to adhere to the 80-hour maximum weekly limit (unless a rotation-specific exception is granted by a Review Committee), and to utilize flexibility in a manner that optimizes patient safety, fellow education, and fellow well-being. The requirements are intended to support the development of a sense of professionalism by encouraging fellows to make decisions based on patient needs and their own well-being, without fear of jeopardizing their program's accreditation status. In addition, the proposed requirements eliminate the burdensome documentation requirement for fellows to justify clinical and educational work hour variations.

Clinical and educational work hours represent only one part of the larger issue of conditions of the learning and working environment, and Section VI has now been expanded to include greater attention to patient safety and fellow and faculty member well-being. The requirements are intended to support programs and fellows as they strive for excellence, while also ensuring ethical, humanistic training. Ensuring that flexibility is used in an appropriate manner is a shared responsibility of the program and fellows. With this flexibility comes a responsibility for fellows and faculty members to recognize the need to hand off care of a patient to another provider when a fellow is too fatigued to provide safe, high quality care and for programs to ensure that fellows remain within the 80-hour maximum weekly limit.

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

VI.A.1. Patient Safety and Quality Improvement

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

Fellows must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating fellows

will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

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

VI.A.1.a) Patient Safety

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

A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.

VI.A.1.a).(1).(a) The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)

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

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

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

Background and Intent: Optimal patient safety occurs in the setting of a coordinated interprofessional learning and working environment.

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

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

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

- VI.A.1.a).(3).(a).(i) know their responsibilities in reporting patient safety events at the clinical site; (Core)
- VI.A.1.a).(3).(a).(ii) know how to report patient safety events, including near misses, at the clinical site; and, (Core)
- VI.A.1.a).(3).(a).(iii) be provided with summary information of their institution's patient safety reports. (Core)
- VI.A.1.a).(3).(b) Fellows must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)
- VI.A.1.a).(4) Fellow Education and Experience in Disclosure of Adverse Events
- Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for fellows to develop and apply.*
- VI.A.1.a).(4).(a) All fellows must receive training in how to disclose adverse events to patients and families. (Core)
- VI.A.1.a).(4).(b) Fellows should have the opportunity to participate in the disclosure of patient safety events, real or simulated. (Detail)†
- VI.A.1.b) Quality Improvement
- VI.A.1.b).(1) Education in Quality Improvement
- A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.*
- VI.A.1.b).(1).(a) Fellows must receive training and experience in quality improvement processes, including an understanding of health care disparities. (Core)
- VI.A.1.b).(2) Quality Metrics

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

VI.A.2.b) *Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced fellow. Other portions of care provided by the fellow can be adequately supervised by the appropriate availability of the supervising faculty member or fellow, either on site or by means of telecommunication technology. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of fellow-delivered care with feedback.*

Background and Intent: Appropriate supervision is essential for patient safety and high-quality teaching. Supervision is also contextual. There is tremendous diversity of fellow patient interactions, education and training locations, and fellow skills and abilities even at the same level of the educational program. The degree of supervision is expected to evolve progressively as a fellow gains more experience, even with the same patient condition or procedure. All fellows have a level of supervision commensurate with their level of autonomy in practice; this level of supervision may be enhanced based on factors such as patient safety, complexity, acuity, urgency, risk of serious adverse events, or other pertinent variables.

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

VI.A.2.b).(2) The program must define when physical presence of a supervising physician is required. ^(Core)

VI.A.2.c) Levels of Supervision

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

VI.A.2.c).(1) Direct Supervision:

VI.A.2.c).(1).(a) the supervising physician is physically present with the fellow during the key portions of the patient interaction; or, ^(Core)

VI.A.2.c).(1).(b) the supervising physician and/or patient is not physically present with the fellow and the supervising physician is concurrently

monitoring the patient care through appropriate telecommunication technology. ^(Core)

VI.A.2.c).(2) Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the fellow for guidance and is available to provide appropriate direct supervision. ^(Core)

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

VI.A.2.d) The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members. ^(Core)

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

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

VI.A.2.d).(3) Fellows should serve in a supervisory role to junior fellows and residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. ^(Detail)

VI.A.2.e) Programs must set guidelines for circumstances and events in which fellows must communicate with the supervising faculty member(s). ^(Core)

VI.A.2.e).(1) Each fellow must know the limits of their scope of authority, and the circumstances under which the fellow is permitted to act with conditional independence. ^(Outcome)

Background and Intent: The ACGME Glossary of Terms defines conditional independence as: Graded, progressive responsibility for patient care with defined oversight.

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

VI.B. Professionalism

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

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

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

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

Background and Intent: Routine reliance on fellows to fulfill non-physician obligations increases work compression for fellows and does not provide an optimal educational experience. Non-physician obligations are those duties which in most institutions are performed by nursing and allied health professionals, transport services, or clerical staff. Examples of such obligations include transport of patients from the wards or units for procedures elsewhere in the hospital; routine blood drawing for laboratory tests; routine monitoring of patients when off the ward; and clerical duties, such as scheduling. While it is understood that fellows may be expected to do any of these things on occasion when the need arises, these activities should not be performed by fellows routinely and must be kept to a minimum to optimize fellow education.

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

Background and Intent: The Common Program Requirements do not define “manageable patient care responsibilities” as this is variable by specialty and PGY level. Review Committees will provide further detail regarding patient care responsibilities in the applicable specialty-specific Program Requirements and accompanying FAQs. However, all programs, regardless of specialty, should carefully assess how the assignment of patient care responsibilities can affect work compression.

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

VI.B.4. 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; ^(Outcome)

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

Background and Intent: This requirement emphasizes that responsibility for reporting unsafe conditions and adverse events is shared by all members of the team and is not solely the responsibility of the fellow.

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

Background and Intent: This requirement emphasizes the professional responsibility of faculty members and fellows to arrive for work adequately rested and ready to care for patients. It is also the responsibility of faculty members, fellows, and other members of the care team to be observant, to intervene, and/or to escalate their concern about fellow and faculty member fitness for work, depending on the situation, and in accordance with institutional policies.

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

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

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

VI.B.4.e) monitoring of their patient care performance improvement indicators; and, (Outcome)

VI.B.4.f) accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data. (Outcome)

VI.B.5. All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider. (Outcome)

VI.B.6. Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, fellows, faculty, and staff. (Core)

VI.B.7. Programs, in partnership with their Sponsoring Institutions, should have a process for education of fellows and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)

VI.C. Well-Being

Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require

proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of fellowship training.

Fellows and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. For example, a culture which encourages covering for colleagues after an illness without the expectation of reciprocity reflects the ideal of professionalism. A positive culture in a clinical learning environment models constructive behaviors, and prepares fellows with the skills and attitudes needed to thrive throughout their careers.

Background and Intent: The ACGME is committed to addressing physician well-being for individuals and as it relates to the learning and working environment. The creation of a learning and working environment with a culture of respect and accountability for physician well-being is crucial to physicians' ability to deliver the safest, best possible care to patients. The ACGME is leveraging its resources in four key areas to support the ongoing focus on physician well-being: education, influence, research, and collaboration. Information regarding the ACGME's ongoing efforts in this area is available on the ACGME website: www.acgme.org/physicianwellbeing.

The ACGME also created a repository for well-being materials, assessments, presentations, and more on the [Well-Being Tools and Resources page](#) in Learn at ACGME for programs seeking to develop or strengthen their own well-being initiatives. There are many activities that programs can implement now to assess and support physician well-being. These include the distribution and analysis of culture of safety surveys, ensuring the availability of counseling services, and paying attention to the safety of the entire health care team.

- VI.C.1. The responsibility of the program, in partnership with the Sponsoring Institution, to address well-being must include:**
- VI.C.1.a) efforts to enhance the meaning that each fellow finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships; ^(Core)**
 - VI.C.1.b) attention to scheduling, work intensity, and work compression that impacts fellow well-being; ^(Core)**
 - VI.C.1.c) evaluating workplace safety data and addressing the safety of fellows and faculty members; ^(Core)**

Background and Intent: This requirement emphasizes the responsibility shared by the Sponsoring Institution and its programs to gather information and utilize systems that monitor and enhance fellow and faculty member safety, including physical safety. Issues to be addressed include, but are not limited to, monitoring of workplace injuries, physical or emotional violence, vehicle collisions, and emotional well-being after adverse events.

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

Background and Intent: Well-being includes having time away from work to engage with family and friends, as well as to attend to personal needs and to one's own health, including adequate rest, healthy diet, and regular exercise.

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

Background and Intent: The intent of this requirement is to ensure that fellows have the opportunity to access medical and dental care, including mental health care, at times that are appropriate to their individual circumstances. Fellows must be provided with time away from the program as needed to access care, including appointments scheduled during their working hours.

VI.C.1.e) attention to fellow and faculty member burnout, depression, and substance use disorder. The program, in partnership with its Sponsoring Institution, must educate faculty members and fellows in identification of the symptoms of burnout, depression, and substance use disorder, including means to assist those who experience these conditions. Fellows and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must: ^(Core)

Background and Intent: Programs and Sponsoring Institutions are encouraged to review materials in order to create systems for identification of burnout, depression, and substance use disorder. Materials and more information are available in Learn at ACGME (<https://dl.acgme.org/pages/well-being-tools-resources>).

VI.C.1.e).(1) encourage fellows and faculty members to alert the program director or other designated personnel or programs when they are concerned that another fellow, resident, or faculty member may be displaying signs of burnout, depression, a substance use disorder, suicidal ideation, or potential for violence; ^(Core)

Background and Intent: Individuals experiencing burnout, depression, substance use disorder, and/or suicidal ideation are often reluctant to reach out for help due to the stigma associated with these conditions, and are concerned that seeking help may have a negative impact on their career. Recognizing that physicians are at increased risk in these areas, it is essential that fellows and faculty members are able to report their concerns when another fellow or faculty member displays signs of any of these conditions, so that the program director or other designated personnel, such as the department chair, may assess the situation and intervene as necessary to facilitate access to appropriate care. Fellows and faculty members must know which personnel, in addition to the program director, have been designated with this responsibility; those personnel and the program director should be familiar with the institution's impaired physician policy and any employee health, employee assistance, and/or wellness programs within the institution. In cases of physician impairment, the program director or designated personnel should follow the policies of their institution for reporting.

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

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

Background and Intent: The intent of this requirement is to ensure that fellows have immediate access at all times to a mental health professional (psychiatrist, psychologist, Licensed Clinical Social Worker, Primary Mental Health Nurse Practitioner, or Licensed Professional Counselor) for urgent or emergent mental health issues. In-person, telemedicine, or telephonic means may be utilized to satisfy this requirement. Care in the Emergency Department may be necessary in some cases, but not as the primary or sole means to meet the requirement.

The reference to affordable counseling is intended to require that financial cost not be a barrier to obtaining care.

VI.C.2. There are circumstances in which fellows may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and parental leave. Each program must allow an appropriate length of absence for fellows unable to perform their patient care responsibilities. ^(Core)

VI.C.2.a) The program must have policies and procedures in place to ensure coverage of patient care. ^(Core)

VI.C.2.b) These policies must be implemented without fear of negative consequences for the fellow who is or was unable to provide the clinical work. ^(Core)

Background and Intent: Fellows may need to extend their length of training depending on length of absence and specialty board eligibility requirements. Teammates should assist colleagues in need and equitably reintegrate them upon return.

VI.D. Fatigue Mitigation

VI.D.1. Programs must:

- VI.D.1.a) educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation; ^(Core)**
- VI.D.1.b) educate all faculty members and fellows in alertness management and fatigue mitigation processes; and, ^(Core)**
- VI.D.1.c) encourage fellows to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. ^(Detail)**

Background and Intent: Providing medical care to patients is physically and mentally demanding. Night shifts, even for those who have had enough rest, cause fatigue. Experiencing fatigue in a supervised environment during training prepares fellows for managing fatigue in practice. It is expected that programs adopt fatigue mitigation processes and ensure that there are no negative consequences and/or stigma for using fatigue mitigation strategies.

This requirement emphasizes the importance of adequate rest before and after clinical responsibilities. Strategies that may be used include, but are not limited to, strategic napping; the judicious use of caffeine; availability of other caregivers; time management to maximize sleep off-duty; learning to recognize the signs of fatigue, and self-monitoring performance and/or asking others to monitor performance; remaining active to promote alertness; maintaining a healthy diet; using relaxation techniques to fall asleep; maintaining a consistent sleep routine; exercising regularly; increasing sleep time before and after call; and ensuring sufficient sleep recovery periods.

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

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

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

VI.E.1. Clinical Responsibilities

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

Background and Intent: The changing clinical care environment of medicine has meant that work compression due to high complexity has increased stress on fellows. Faculty

members and program directors need to make sure fellows function in an environment that has safe patient care and a sense of fellow well-being. Some Review Committees have addressed this by setting limits on patient admissions, and it is an essential responsibility of the program director to monitor fellow workload. Workload should be distributed among the fellow team and interdisciplinary teams to minimize work compression.

VI.E.2. Teamwork

Fellows must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the subspecialty and larger health system.
(Core)

VI.E.3. Transitions of Care

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

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

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

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

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

VI.F. Clinical Experience and Education

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

Background and Intent: In the new requirements, the terms “clinical experience and education,” “clinical and educational work,” and “clinical and educational work hours” replace the terms “duty hours,” “duty periods,” and “duty.” These changes have been

made in response to concerns that the previous use of the term “duty” in reference to number of hours worked may have led some to conclude that fellows’ duty to “clock out” on time superseded their duty to their patients.

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

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

Background and Intent: Programs and fellows have a shared responsibility to ensure that the 80-hour maximum weekly limit is not exceeded. While the requirement has been written with the intent of allowing fellows to remain beyond their scheduled work periods to care for a patient or participate in an educational activity, these additional hours must be accounted for in the allocated 80 hours when averaged over four weeks.

Scheduling

While the ACGME acknowledges that, on rare occasions, a fellow may work in excess of 80 hours in a given week, all programs and fellows utilizing this flexibility will be required to adhere to the 80-hour maximum weekly limit when averaged over a four-week period. Programs that regularly schedule fellows to work 80 hours per week and still permit fellows to remain beyond their scheduled work period are likely to exceed the 80-hour maximum, which would not be in substantial compliance with the requirement. These programs should adjust schedules so that fellows are scheduled to work fewer than 80 hours per week, which would allow fellows to remain beyond their scheduled work period when needed without violating the 80-hour requirement. Programs may wish to consider using night float and/or making adjustments to the frequency of in-house call to ensure compliance with the 80-hour maximum weekly limit.

Oversight

With increased flexibility introduced into the Requirements, programs permitting this flexibility will need to account for the potential for fellows to remain beyond their assigned work periods when developing schedules, to avoid exceeding the 80-hour maximum weekly limit, averaged over four weeks. The ACGME Review Committees will strictly monitor and enforce compliance with the 80-hour requirement. Where violations of the 80-hour requirement are identified, programs will be subject to citation and at risk for an adverse accreditation action.

Work from Home

While the requirement specifies that clinical work done from home must be counted toward the 80-hour maximum weekly limit, the expectation remains that scheduling be structured so that fellows are able to complete most work on site during scheduled clinical work hours without requiring them to take work home. The new requirements acknowledge the changing landscape of medicine, including electronic health records, and the resulting increase in the amount of work fellows choose to do from home. The requirement provides flexibility for fellows to do this while ensuring that the time spent by fellows completing clinical work from home is accomplished within the 80-hour weekly maximum. Types of work from home that must be counted include using an electronic health record and taking calls from home. Reading done in preparation for the

following day's cases, studying, and research done from home do not count toward the 80 hours. Fellow decisions to leave the hospital before their clinical work has been completed and to finish that work later from home should be made in consultation with the fellow's supervisor. In such circumstances, fellows should be mindful of their professional responsibility to complete work in a timely manner and to maintain patient confidentiality.

During the public comment period many individuals raised questions and concerns related to this change. Some questioned whether minute by minute tracking would be required; in other words, if a fellow spends three minutes on a phone call and then a few hours later spends two minutes on another call, will the fellow need to report that time. Others raised concerns related to the ability of programs and institutions to verify the accuracy of the information reported by fellows. The new requirements are not an attempt to micromanage this process. Fellows are to track the time they spend on clinical work from home and to report that time to the program. Decisions regarding whether to report infrequent phone calls of very short duration will be left to the individual fellow. Programs will need to factor in time fellows are spending on clinical work at home when schedules are developed to ensure that fellows are not working in excess of 80 hours per week, averaged over four weeks. There is no requirement that programs assume responsibility for documenting this time. Rather, the program's responsibility is ensuring that fellows report their time from home and that schedules are structured to ensure that fellows are not working in excess of 80 hours per week, averaged over four weeks.

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

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

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

VI.F.2.b).(1) There may be circumstances when fellows choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements. ^(Detail)

Background and Intent: While it is expected that fellow schedules will be structured to ensure that fellows are provided with a minimum of eight hours off between scheduled work periods, it is recognized that fellows may choose to remain beyond their scheduled time, or return to the clinical site during this time-off period, to care for a patient. The requirement preserves the flexibility for fellows to make those choices. It is also noted that the 80-hour weekly limit (averaged over four weeks) is a deterrent for scheduling fewer than eight hours off between clinical and education work periods, as it would be difficult for a program to design a schedule that provides fewer than eight hours off without violating the 80-hour rule.

VI.F.2.c) Fellows must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)

Background and Intent: Fellows have a responsibility to return to work rested, and thus are expected to use this time away from work to get adequate rest. In support of this goal, fellows are encouraged to prioritize sleep over other discretionary activities.

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

Background and Intent: The requirement provides flexibility for programs to distribute days off in a manner that meets program and fellow needs. It is strongly recommended that fellows' preference regarding how their days off are distributed be considered as schedules are developed. It is desirable that days off be distributed throughout the month, but some fellows may prefer to group their days off to have a "golden weekend," meaning a consecutive Saturday and Sunday free from work. The requirement for one free day in seven should not be interpreted as precluding a golden weekend. Where feasible, schedules may be designed to provide fellows with a weekend, or two consecutive days, free of work. The applicable Review Committee will evaluate the number of consecutive days of work and determine whether they meet educational objectives. Programs are encouraged to distribute days off in a fashion that optimizes fellow well-being, and educational and personal goals. It is noted that a day off is defined in the ACGME Glossary of Terms as "one (1) continuous 24-hour period free from all administrative, clinical, and educational activities."

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

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

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

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

Background and Intent: The additional time referenced in VI.F.3.a).(1) should not be used for the care of new patients. It is essential that the fellow continue to function as a member of the team in an environment where other members of the team can assess fellow fatigue, and that supervision for post-call fellows is provided. This 24 hours and up to an additional four hours must occur within the context of 80-hour weekly limit, averaged over four weeks.

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

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

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

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

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

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

Background and Intent: This requirement is intended to provide fellows with some control over their schedules by providing the flexibility to voluntarily remain beyond the scheduled responsibilities under the circumstances described above. It is important to note that a fellow may remain to attend a conference, or return for a conference later in the day, only if the decision is made voluntarily. Fellows must not be required to stay. Programs allowing fellows to remain or return beyond the scheduled work and clinical education period must ensure that the decision to remain is initiated by the fellow and that fellows are not coerced. This additional time must be counted toward the 80-hour maximum weekly limit.

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

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

VI.F.5. Moonlighting

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

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

Background and Intent: For additional clarification of the expectations related to moonlighting, please refer to the Common Program Requirement FAQs (available at <http://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements>).

VI.F.6. In-House Night Float

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

Background and Intent: The requirement for no more than six consecutive nights of night float was removed to provide programs with increased flexibility in scheduling.

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

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

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

VI.F.8. At-Home Call

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

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

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

Background and Intent: This requirement has been modified to specify that clinical work done from home when a fellow is taking at-home call must count toward the 80-hour maximum weekly limit. This change acknowledges the often significant amount of time fellows devote to clinical activities when taking at-home call, and ensures that taking at-home call does not result in fellows routinely working more than 80 hours per week. At-home call activities that must be counted include responding to phone calls and other forms of communication, as well as documentation, such as entering notes in an electronic health record. Activities such as reading about the next day's case, studying, or research activities do not count toward the 80-hour weekly limit.

In their evaluation of fellowship programs, Review Committees will look at the overall impact of at-home call on fellow rest and personal time.

***Core Requirements:** Statements that define structure, resource, or process elements essential to every graduate medical educational program.

†Detail Requirements: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

‡Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.

Osteopathic Recognition

For programs with or applying for Osteopathic Recognition, the Osteopathic Recognition Requirements also apply (www.acgme.org/OsteopathicRecognition).