

Gastroenterology Fellowship Program FAQ	
General Subspecialty Requirements	
Question	Answer
Do the General Subspecialty Program Requirements apply to gastroenterology? [see ACGME Program Requirements for Fellowship Education in the Subspecialties of Internal Medicine] [see RRC-IM General Subspecialty FAQ]	<ul style="list-style-type: none"> Absolutely. Gastroenterology program directors should study carefully the General Subspecialty Program Requirements, and the FAQs related to these program requirements. The requirements cover required structural elements in the program such as required institutional support, facilities and resources, key faculty and program director qualifications and responsibilities, conferences, continuity clinic, scholarship and research, evaluation, etc. Subspecialty fellowship programs are expected to be in full compliance with <u>both</u> the General Subspecialty Program Requirements, and the Subspecialty Specific Program Requirements.
Educational Program	
Question	Answer
Our gastroenterology fellowship is 4 years in length. Can we spread out the clinical training over 48 months? Can we use the time fellows spend in continuity clinic to reduce the block time of 18 months clinical? [Program Requirement VIII.A.]	<ul style="list-style-type: none"> All required training must be completed within the accredited 36-months of training. An additional year of training (i.e., for research) may be required (or offered) by the program, but the required training (at least 18 months clinical, continuity clinic, conferences, and research) must be completed during the accredited three years (36 months) of training: Time spent in continuity clinic (one-half day weekly x 36 months) may not be used to reduce the minimum block time required for clinical training.
Can continuity clinic time during research be used to reduce the 18 months of (block) clinical time? [Program Requirement VIII.C.]	Continuity clinic time during research may not be used to reduce the 18 months of (block) clinical time.
Are block rotations mandatory to meet the 5 months clinical experience required in hepatology? [Program Requirement VIII.C.]	No. Experience in hepatology can be integrated within other clinical rotations provided that in aggregate the experience is at least 5 months. However, if all of the hepatology experience is not provided as block rotations, then the program director must indicate in the PIF how this experience is obtained (e.g., indicate the % of time spent interacting with hepatology patients on non-hepatology rotations).
Faculty	
Question	Answer
What would demonstrate that a key clinical faculty member has "expertise and primary focus in hepatology?" [Program Requirement IX.C]	The Review Committee expects that at least one key clinical faculty member in the program maintains clinical activity in hepatology and has at least one of the following characteristics: is a liver society member (e.g., American Association for the Study of Liver Diseases, European Association for the Study of the Liver, etc); has a record of scholarship in liver disease; is ABIM certified in transplant hepatology; is a United Network for Organ Sharing recognized transplant hepatologist; or has completed a transplant hepatology fellowship. The program will need to provide evidence of this expertise in the PIF - in the CV portion of the faculty roster. (July 2011 RC Meeting)
What would demonstrate that a key clinical faculty member has expertise in all aspects of endoscopy, including advanced procedures? [Program Requirement IX.C]	The Review Committee expects that at least one key clinical faculty member has achieved competence in endoscopy as defined by the American Society of Gastrointestinal Endoscopy. Specifically, the individual should have performed: (a) between 180-200 Endoscopic Retrograde Cholangiopancreatographys with an 80-90% technical success rate, of which greater than 50% is therapeutic; and (b) at least 240 Endoscopic Ultrasounds, which includes 75 mucosal tumors, 40 submucosal tumors, 75 pancreaticobiliary assessments, 25 non-pancreas Fine Needle Aspirations (FNA), and 25 pancreas FNA. The program will need to provide evidence of this expertise in the PIF - in

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	the CV portion of the faculty roster. (July 2011 RC Meeting)
Facilities and Resources	
Question	Answer
We are considering starting a GI fellowship, but do not have an esophageal motility laboratory at the primary site. The VA hospital does have an esophageal motility laboratory. [Program Requirement X.A.1.]	If programs have two or three participating institutions to provide fellowship training (i.e., university, VA, community), then the RRC-IM will accept certain facilities (i.e., motility lab) at one site if: <ul style="list-style-type: none"> • Fellows have required rotations that include experience in that facility • Fellows are able to easily obtain the necessary studies at the other site(s) lacking the facility.
Specific Program Content	
Question	Answer
How does the RRC-IM define competence? [Program Requirement XI.A.1.] [Program Requirement XI.A.2-26.] [Program Requirement XI.B1-2.]	<ul style="list-style-type: none"> • Note the common stem for these program requirements: Fellows must have formal instruction, clinical experience, and must <u>demonstrate competence</u> ... The RRC-IM expects programs to develop metrics and instruments to evaluate and measure competency in each of these content areas. • For certain procedural skills, the RRC-IM requires that the program demonstrate a minimum number of procedures have been performed by the fellow as the primary operator. The RRC-IM expects that programs will provide each fellow with this minimum experience. However, completion of the minimum number of procedures does not insure procedural competency. Programs must also evaluate and measure competency in each of these procedural skills.
How is competence in the evaluation and management of diseases of the esophagus determined? [Program Requirement XI.A.1.]	The program requirements require competence (+ instruction and experience) in 26 content areas. The program defines the measures of competency.
The program requirements require competency in Flexible Sigmoidoscopy. This procedure is performed infrequently by gastroenterologists in our program. [Program Requirement XI.B.1.c)]	The RRC-IM will allow programs to substitute colonoscopy with special emphasis on the recto-sigmoid region to substitute for flexible sigmoidoscopy.
How is competency in the performance of colonoscopy with polypectomy demonstrated? [Program Requirement XI.B.1.d.]	Fellows must perform a minimum of 140 completed colonoscopies and 30 polypectomies in which the fellow undertakes all of the procedure from time of insertion, to complete withdrawal, including cannulation and inspection of the cecum, and polypectomy. The program defines the measures of competency.
Most of our liver biopsies are done in radiology. The ABIM no longer requires liver biopsy performance by GI fellows. Will the RRC still require programs to train GI fellows in liver biopsy? [Program Requirement XI.B.1.e)]	<ul style="list-style-type: none"> • Effective July 2007, liver biopsy is no longer required by the ABIM for candidates to be eligible for the certification examination. • Therefore, the RRC-IM will no longer require programs to track liver biopsy or train fellows to competence in this procedure. • Note that Transplant Hepatology fellows still must train to competency in liver biopsy, but that this training can occur under the supervision of interventional radiology.
How is competency in the performance of biopsy of the mucosa of esophagus, stomach, small bowel, and colon demonstrated? [Program Requirement XI.B.1.g.)]	There is not a minimum standard for the number of procedures. The program defines the measures of competency.
How is competency in the performance of gastrointestinal	There is not a minimum standard for the number of procedures. The program defines the measures of competency.

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motility studies and 24-hour pH monitoring determined? [Program Requirement XI.B.1.g.)]	
What is the minimum Endoscopic Retrograde Cholangiopancreatography (ERCP) experience required for each fellow? [Program Requirement XI.B.2.d)]	<ul style="list-style-type: none"> • Note that ERCP is a didactics and experience program requirement, and training to competency is not required. • Therefore, there is no requirement for a specific number of ERCP procedures. • The program needs to provide formal instruction and sufficient experience in the interpretation of ERCP for graduates to be able to order this study appropriately and interpret the results. The amount and nature of both is up to the program to decide what fellows need when they enter practice.
What procedures does the program need to track for gastroenterology fellows? [Program Requirement XI.B.1.a)-k)]	<p><u>Gastroenterology procedures that must be documented In fellow's procedure log:</u></p> <ul style="list-style-type: none"> • Flexible sigmoidoscopy (colonoscopy with special emphasis on recto-sigmoid may be substituted) • Diagnostic upper gastrointestinal endoscopy (EGD) • Colonoscopy, including biopsy and polypectomy • Esophageal dilation • Percutaneous gastrostomy • Therapeutic upper and lower gastrointestinal endoscopy, including variceal and non-variceal hemorrhage • Liver biopsy. <p>Note that liver biopsy is no longer required by the ABIM (July 2007) for candidates to be eligible for the certification examination. Effective July 2007, the RRC-IM will no longer require programs to track liver biopsy or train fellows to competence in this procedure.</p>

APPENDIX I

RRC-IM Calculation of Minimum KCF and Key Clinical Faculty (KCF) Scholarship Participation/Productivity Gastroenterology

Minimum 4 Key Clinical Faculty (KCF)* or 1:1.5 faculty-fellow ratio for programs with 7 or more fellows

Approved Fellow Complement	Minimum Certified KCF (incl PD)	Minimum <u>Hepatology</u> KCF (incl PD)	Minimum <u>Advanced Endoscopy</u> KCF (incl PD)	Majority of Minimum KCF (50%)	<u>PARTICIPATION</u> KCF with at Least 1 Pub Past 3 Years [259]	<u>PRODUCTIVITY</u> Pubs All KCF Past 3 Years (1/yr x 3 yrs) [259]
2	4	1	1	2	2	6
3	4	1	1	2	2	6
4	4	1	1	2	2	6
5	4	1	1	2	2	6
6	4	1	1	2	2	6
7	5	1	1	3	3	9
8	6	1	1	3	3	9
9	6	1	1	3	3	9
10	7	1	1	4	4	12
11	8	1	1	4	4	12
12	8	1	1	4	4	12
13	9	1	1	5	5	15
14	10	1	1	5	5	15
15	10	1	1	5	5	15
16	11	1	1	6	6	18
17	12	1	1	6	6	18
18	12	1	1	6	6	18
19	13	1	1	7	7	21
20	14	1	1	7	7	21
21	14	1	1	7	7	21
22	15	1	1	8	8	24
23	16	1	1	8	8	24
24	16	1	1	8	8	24
25	17	1	1	9	9	27

- Publication = Research publication, review article, or editorial in a peer review journal (PRJ), funded peer-review grant, or book chapter.
- Scholarly case reports acceptable (Sept 2007) if indexed in Pub Med, and copy submitted with PIF
- Peer review publication = indexed in Pub Med (or Medline). If not in Pub Med, PD must supply evidence of peer review
- In press or accepted for publication counts. Submitted or in preparation does not count.
- Abstract, illustration, letter to the editor, presentation, or publication in non-PRJ does not count.
- Peer-reviewed funding (NIH, NCI, or other government-funded or national-foundation funded) counts
- Industry, pharmaceutical, or other non-peer-review grant does not count.
 - Exception: Pharmaceutical studies in which the KCF is the overall PI (lead investigator) for all sites will be accepted as counting as one product of scholarship

- 1 paper = 1 paper; Do not count multi-author papers more than once.
- Count the last three calendar years prior to PIF submission. If site visit is in Sep. 2008, count publications from 2005, 2006, and 2007 as well as 2008.
- Contribute to participation: Only ABIM certified KCF
- Contribute to productivity:
 - Certified KCF
 - Additional sub-specialty KCF (above minimum required, certified or non-certified)
 - Non-physician faculty and faculty in other specialties IF:
 - Contribute to fellow education
 - Devote at least 10 hours/ week to the program