DIVISION OF GASTROENTEROLOGY

SUB-SPECIALTY TRAINING PROGRAM MANUAL

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## POLICY SECTION

Revised June 2017
INTRODUCTION

MISSION STATEMENT

"The Division of Gastroenterology is committed to achieving excellence in our clinical, educational, and research programs, thereby providing exemplary contributions to the health of current and future generations.

We will accomplish this in an atmosphere of compassion, collegiality, and scholarly inquiry, while preserving the dignity and rights of patients and their families, as well as those of our colleagues."

Welcome to the Division of Gastroenterology at the University of Alberta. As a trainee in our Subspecialty Residency Program, you will have very close contact with a group of physicians who represent the entire spectrum of the field: community gastroenterology, academic practice, hepatology and liver transplantation, therapeutic endoscopy, nutrition, motility, inflammatory bowel disease, and basic scientific investigation. The Division has a strong inpatient presence in the Edmonton Zone of the Alberta Health Services and is well represented in four hospital sites: the University of Alberta, Royal Alexandra, Grey Nuns, and Misericordia Hospitals. In addition to serving the needs of the citizens of the City of Edmonton, our group receives a large number of referrals from northern Alberta and the Northwest Territories. Furthermore, the GI Division plays a major role in the Alberta Liver Transplant Program and, under the auspices of the Home Enteral and Parenteral Nutrition Program, emphasizes clinical nutrition.

Members of the GI Division are actively engaged in a variety of research activities, which include clinical trials and basic scientific research in the areas of inflammatory bowel disease, celiac disease, Clostridium difficile infection, fecal transplant, viral hepatitis, primary biliary cirrhosis, and GI bleeding. The academic mission of the Division also encompasses education at the undergraduate, graduate and post-graduate levels, thus attracting a wide variety of MSc and PhD students to its research programs. Division members participate in undergraduate medicine teaching and offer comprehensive instruction in bedside clinical skills. Divisional members are national leaders in the field of gastroenterology and hepatology and are frequently invited speakers for Continuing Medical Education events.

Candidates for the Gastroenterology Subspecialty Residency Training Program must have completed at least three years of general internal medicine. The Program is carefully designed to hone the consultative and management skills acquired during the junior years of training in internal medicine. Our goal is to produce a consultant specialist who is an expert in the field of gastroenterology, who possesses a wide variety of endoscopic skills, and is competent in managing all the clinical problems presented in the field. With our division's strong commitment to academic medicine and leadership, our objective is to train physicians who will be leaders in the field of gastroenterology and have sound academic tools and skills. Although the Gastroenterology Subspecialty Residency Training at the University of Alberta is officially a two-year program, many of our trainees have opted for a third year of training either for research, further sub-specialized clinical training, or other academic
endeavors. Approximately, half of our graduates of our program are currently practicing in academic environments, while the remainder are in community positions. Many of our graduates, whether in academic or community positions, hold positions of leadership with positive influences in the field of gastroenterology.

**STRUCTURE**

The two clinical years of the program are structured as follows:

**Core rotations**
- Consults (20-32 weeks), this includes at least 1 block at RAH
- Endoscopy (4-6 weeks)
- Ward Rotation (12 weeks); including 1 block of Junior Attending
- Community Gastroenterology (4-8 weeks)
- In-patient Hepatology/Liver Transplant Rotation (4 weeks)
- Ambulatory Liver Rotation (4-8 weeks)
- Ambulatory Luminal Rotation (4-8 weeks)
- Nutrition (3-4 weeks)
- Motility (3 weeks)
- Senior GI Mentoring (8 weeks)
- Longitudinal Clinic (1 year)

**Electives**
- Inflammatory Bowel Disease
- Gastrointestinal Oncology
- Pathology
- Research
- Pediatric Gastroenterology

To attain the above objectives, trainees work in close collaboration with staff members in managing a variety of simple and complex problems in digestive diseases.

**EDUCATIONAL ACTIVITIES**

A number of formal teaching sessions occur, including weekly Gastroenterology Monday Rounds, weekly GI Residents’ Academic Half Day, monthly city-wide GI Journal Club, and monthly Clinical Pathology Correlation (CPC) rounds. Residents are exposed to scholarly and clinical discussions at many educational and clinical rounds: monthly Liver Tumor Rounds, weekly Liver Transplant Rounds, monthly Clinical Practice Correlation Rounds and weekly IBD rounds. In addition, residents are encouraged to attend the weekly Center of Excellence for Gastrointestinal Inflammation and Immunity Research (CEGIIR) rounds where basic and clinical research studies are presented. All of these teaching sessions encourage an appreciation of the basic science and pathophysiology of disease processes and the development of skills in critical appraisal, ethics and all the CanMEDS roles.

*See Appendix J for GI Division Academic Activities at a Glance*
ACADEMIC HALF DAY

Academic half day takes place on Tuesday afternoons (ZLC2-10). Attendance is mandatory.

The AHD schedule is available on Google Drive.

EVALUATION

Residents and staff have been provided and are aware of the general objectives of the program and rotation specific objectives. These are revised annually, and detailed in the Resident Training Manual available online. Evaluation of residents is in accordance with objectives and CanMEDS roles. ITERs record evaluation reflecting these objectives. We use one45 to allow for online completion and review of evaluation. Residents are encouraged to regularly review all completed ITERs and presentation evaluations in a timely manner.

As staff members have many occasions to assess resident’s performance outside of scheduled rotations, resident performance is discussed at divisional meetings. Evaluation and performance is reviewed with the resident by the GI Training Program Director during biannual review or more urgently if needed. Feedback is obtained from the resident with regards to his/her own thoughts on his/her performance and goals for improvement.

Daily feedback on resident’s bedside, clinical and endoscopic performance is given by the attending staff at point of care. This evaluation, while the most valuable of all, is unstructured, and for the most part undocumented.

OSCE: A mini objective structure clinical exam (OSCE) (6-8 stations) as per Royal College GI Certification Exam format has been incorporated into the Academic Half Day curriculum, and takes place twice per year (December and June). The examined topics and domains reflect the half day curriculum and CanMEDs roles. Each OSCE station is reviewed immediately after the exam. This provides formative feedback to the residents.

Written examinations: Pre- and post- written examinations (MCQ and SAQ) are incorporated into the Academic half day curriculum every 3-6 months. These are intended to be a formative test of topics covered during half day.

Western Canada GI Resident’s Practice Exam: Each year, in preparation for the Royal College subspecialty examinations, a practice exam is co-hosted by the 4 western programs (Alberta, Calgary, UBC and Manitoba). Subspecialty residents in all 4 programs participate in a full day exam consisting of written and OSCE examinations.

Final In-training Evaluation Report (FITER): is completed at the end of the two core clinical years. The resident’s performance their GI training is discussed at the Residency Program Committee (RPC) and the results collated and incorporated on the FITER form by the Program Director. The FITER is meant to represent the skill level at the time the FITER is
completed. The FITER required by the Royal College of Physicians and Surgeons of Canada is available on the Royal College website: www.royalcollege.ca → Information by Discipline → Information by Subspecialty → Gastroenterology.

STAFF EVALUATION

A rotation and staff evaluation process had been in place since 1997, and done via one since 2003. The residents are asked to rate the rotations and supervisor in terms of the educational content and teaching, and to provide constructive criticism for each rotation. Staff and rotation evaluations are accessible only to the Program Director and educational assistant. Rotation evaluations are reviewed by the RPC every 2 years to identify any pertinent issues or need for changes. Anonymous summary evaluations are forwarded to individual staff for feedback and quality assurance on a yearly basis. A copy of the evaluations is forwarded to the Gastroenterology Divisional Director. Sub-standard evaluations will be discussed at the RPC with a clear action plan for resolution. Since 2007, the Divisional Director has instituted an annual staff evaluation to be completed by all residents as a group. These results are forwarded to the Program Director, and sub-standard evaluations are discussed at the RPC.
OBJECTIVES OF THE GASTROENTEROLOGY SUBSPECIALTY TRAINING PROGRAM

GENERAL OBJECTIVE

The Gastroenterology Subspecialty Training Program at the University of Alberta is committed to providing residents with the training they require to become clinical experts in the field of gastroenterology. Our objective is to produce well-rounded gastroenterologists committed to a career in academic or community medicine, with a set of skills, which will allow functioning at the clinician-teacher level. We aspire to train physicians with strong leadership skills. Only candidates certificated by the Royal College of Physicians and Surgeons of Canada in Internal Medicine may be eligible for the Certificate of Special Competence in Gastroenterology.

Specialists in gastroenterology are expected to be competent consultants with well-founded knowledge of all aspects of gastroenterology including relevant basic sciences, research and teaching and appropriate technical capabilities who are able to establish effective professional relations with patients and their families and care givers. They must have sound knowledge of general internal medicine and an appreciation and understanding of the close relationship that commonly exists between diseases of the digestive organs and of other organ systems. They are competent self-directed learners who can adapt practice patterns according to the general principles of evidence-based medicine.

Residents must demonstrate the requisite knowledge, skills and attitudes for effective patient-centered care and service in a diverse population. The graduate must be able to address issues of gender, sexual orientation, age, culture, ethnicity, and ethics in all areas of gastroenterology in a professional manner.

Prerequisites:

Exemplary moral and ethical character.
Successful completion of 3 years of internal medicine residency approved by the Royal College; this must include at least one ICU rotation.
Completion of Advanced Cardiac Life Support (ACLS) course.
SPECIFIC OBJECTIVES

The specific objectives of training in the subspecialty of gastroenterology are defined by the Royal College of Physicians and Surgeons of Canada. The specific objectives are defined about the CanMEDS roles, with medical expert being at the center.

Specialists possess a defined body of knowledge and procedural skills, which are used to collect and interpret data, make appropriate clinical decisions, and carry out diagnostic and therapeutic procedures within the boundaries of their discipline and expertise. Their care is characterized by up-to-date, ethical, and cost-effective clinical practice and effective communication in partnership with patients, other health care providers, and the community. The role of medical expert/clinical decision-maker is central to the function of specialist physicians, and draws on the competencies included in the roles of scholar, communicator, health advocate, leader, collaborator, and professional.

The Objectives of Training as outlined by the Royal College of Physicians and Surgeons of Canada are available on the Royal College website: [www.royalcollege.ca](http://www.royalcollege.ca) → Information by Discipline → Information by Subspecialty → Gastroenterology

At the completion of training, the competent resident will have acquired the following competencies and will function effectively as a:

1. **MEDICAL EXPERT**

As *Medical Experts*, Gastroenterologists integrate all of the CanMEDS Roles, applying medical knowledge, clinical skills, and professional attitudes in their provision of patient-centered care. *Medical Expert* is the central physician Role in the CanMEDS framework.

**Key and Enabling Competencies: Gastroenterologists are able to...**

1. **Function effectively as consultants, integrating all of the CanMEDS Roles to provide optimal, ethical and patient-centered medical care**
   1.1. Perform a consultation, including the presentation of well-documented assessments and recommendations in written and/or verbal form in response to a request from another health care professional
   1.2. Demonstrate effective use of all CanMEDS competencies relevant to Gastroenterology
   1.3. Identify and appropriately respond to relevant ethical issues arising in patient care
   1.4. Demonstrate the ability to prioritize professional duties when faced with multiple patients and problems
   1.5. Demonstrate compassionate and patient-centered care
   1.6. Recognize and respond to the ethical dimensions in medical decision-making
   1.7. Demonstrate medical expertise in situations other than patient care, such as providing expert legal testimony or advising governments, as needed
2. Establish and maintain clinical knowledge, skills and attitudes appropriate to Gastroenterology

2.1. Apply knowledge of the clinical, socio-behavioural, and fundamental biomedical sciences relevant to Gastroenterology, including:

2.1.1. Anatomy, embryology, physiology and pathology of the digestive system including the pancreas and liver
2.1.2. Principles of biochemistry, molecular biology and genetics as they apply to the digestive system
2.1.3. Principles of metabolism, pharmacokinetics, pharmacodynamics and toxicity of drugs commonly used in Gastroenterology
2.1.4. Principles of endocrinology, intermediary metabolism and nutrition, oncology, microbiology and psychiatry as they apply to the digestive system
2.1.5. Principles of gastrointestinal surgery including the indications for and the complications of operations on the gastrointestinal tract
2.1.6. Diseases affecting the digestive system, pancreas and liver including the epidemiology, pathophysiology, methods of diagnosis, management and prognosis of such diseases
2.1.7. Indications, interpretations, limitations, and complications of diagnostic procedures performed on the digestive tract
2.1.8. Hazards of endoscopic procedures for the operator, assistants and patient, and the measures appropriate to minimize such hazards
2.1.9. Principles of fluoroscopy used during endoscopic procedures including the safe use of X-rays for both patient and operator
2.1.10. Advances in the management of gastrointestinal disorders, including organ transplantation, therapeutic endoscopy

2.2. Describe the CanMEDS framework of competencies relevant to Gastroenterology

2.3. Apply lifelong learning skills of the Scholar Role to implement a personal program to keep up-to-date, and enhance areas of professional competence

2.4. Contribute to the enhancement of quality care and patient safety in Gastroenterology, integrating the available best evidence and best practices

3. Perform a complete and appropriate assessment of a patient

3.1. Identify and explore issues to be addressed in a patient encounter effectively, including the patient’s context and preferences
3.2. Elicit a history that is relevant, concise and accurate to context and preferences for the purposes of prevention and health promotion, diagnosis and/or management
3.3. Perform a focused physical examination that is relevant and accurate for the purposes of prevention and health promotion, diagnosis and/or management, with particular emphasis on areas specific to the digestive system and its disorders including nutritional deficiencies
3.4. Select and interpret medically appropriate investigative methods in a resource-effective and ethical manner, including:

3.4.1. Imaging modalities (barium studies, ultrasound, computerized tomography (CT) scan, magnetic resonance imaging (MRI), radioisotope scan, endoscopic retrograde cholangiopancreatography (ERCP), endoscopic ultrasound, capsule endoscopy) for the digestive system, pancreas and liver
3.4.2. Tests commonly employed in gastrointestinal function laboratories including breath tests and motility studies
3.4.3. Tissue biopsies of the gastrointestinal tract and liver
3.4.4. Endoscopic procedures including biopsies of the upper and lower gastrointestinal tract including, but not limited to, colonoscopy, upper endoscopy and sigmoidoscopy
3.4.4.1. Appropriate use and care of equipment used in endoscopic procedures
3.4.5. Appropriate use of clinical data to formulate problems and to correctly develop investigation and management plans to deal with the patient’s problem(s)

3.5. Demonstrate effective clinical problem solving and judgment to address patient problems, including interpreting available data and integrating information to generate differential diagnoses and management plans for gastrointestinal diseases
3.5.1. Demonstrate the ability to recognize, evaluate and manage gastrointestinal emergencies, including, but not limited to:
   3.5.1.1. Acute gastrointestinal hemorrhage
   3.5.1.2. Acute abdominal pain
   3.5.1.3. Fulminant colitis
   3.5.1.4. Biliary obstruction, including ascending cholangitis
   3.5.1.5. Liver failure
   3.5.1.6. Ingested foreign bodies

4. Use preventive and therapeutic interventions effectively
   4.1. Implement an effective management plan in collaboration with a patient and their family
   4.2. Demonstrate effective, appropriate, and timely application of preventive and therapeutic interventions relevant to Gastroenterology, including, but not limited to:
      4.2.1. Screening colonoscopy
      4.2.2. Upper endoscopy for Barrett’s esophagus
      4.2.3. Upper endoscopy for portal hypertension
      4.2.4. Surveillance for hepatobiliary malignancy
   4.3. Ensure appropriate informed consent is obtained for therapies and transfusion of blood products
   4.4. Ensure patients receive appropriate end-of-life care

5. Demonstrate proficient and appropriate use of procedural skills, both diagnostic and therapeutic
   5.1. Demonstrate effective, appropriate, and timely performance of diagnostic procedures relevant to Gastroenterology including:
      5.1.1. Upper gastrointestinal (GI) endoscopy and biopsy
      5.1.2. Colonoscopy and biopsy
      5.1.3. Esophageal manometry
      5.1.4. Paracentesis (adult patients only)
   5.2. Demonstrate effective, appropriate, and timely performance of therapeutic procedures relevant to Gastroenterology including:
      5.2.1. Luminal dilation
      5.2.2. Polypectomy
5.2.3. Endoscopic hemostasis
5.2.4. Foreign body removal
5.3. Ensure appropriate informed consent is obtained for procedures
5.4. Document and disseminate information related to procedures performed and their outcomes
5.5. Ensure adequate follow-up is arranged for procedures performed

6. Seek appropriate consultation from other health professionals, recognizing the limits of their expertise
   6.1. Demonstrate insight into their own limits of expertise
   6.2. Demonstrate effective, appropriate, and timely consultation of another health professional as needed for optimal patient care
   6.3. Arrange appropriate follow-up care services for a patient and their family

Specific Requirements:

In keeping with their background in Internal Medicine, residents will emphasize the acquisition and maintenance of knowledge, clinical and technical skills and attitudes appropriate to gastroenterology. At the end of training, all residents will be able to describe the CanMEDS competencies relevant to gastroenterology. They will be able to apply lifelong learning skills to implement a personal program to keep up-to-date, and enhance professional competence. In addition, they will contribute to the enhancement of quality care and patient safety in GI, integrating the best evidence and practices. The resident will demonstrate the ability to seek appropriate consultation from other health professionals, recognizing the limits to their expertise, including:

- Demonstrate insight into his/her own limitations of expertise by self-assessment;
- Demonstrate effective, appropriate, and timely consultation as need for optimal patient care;
- Arrange appropriate follow-up care.

Residents in the adult programs should demonstrate the ability to recognize both common pediatric problems and the common disorders affecting adolescents in transition (e.g., inflammatory bowel disease, celiac sprue, cystic fibrosis, functional abdominal pain, neonatal jaundice, viral hepatitis) and knowledge of the special technical aspects of pediatric endoscopy including special needs for sedation.

The training program will offer many opportunities to perform complete histories and physical examinations in a variety of settings: inpatient, emergency room and ambulatory care. Bedside discussions, in conjunction with attending staff, will promote maturity in clinical reasoning. In addition, case discussions during Academic Half-Day sessions will emphasize the cost-effective use of ancillary investigations. This will provide an ongoing, primarily day-to-day assessment of each resident’s progress. Each rotation ITER records assessment of clinical and basic science knowledge.

2. COMMUNICATOR
Patients with gastroenterological disorders commonly benefit from collaborative care by general surgeons, social workers, dieticians and addiction specialists. To provide humane, high-quality care, specialists must establish effective relationships with patients, other physicians, and other health professionals. Communication skills are essential for the functioning of a specialist, and are necessary for obtaining information from, and conveying information to patients and their families. Furthermore, these abilities are critical in eliciting patients’ beliefs, concerns, and expectations about their illnesses, and for assessing key factors impacting on patients’ health.

**Key and Enabling Competencies: Gastroenterologists are able to...**

1. **Develop rapport, trust, and ethical therapeutic relationships with patients and families**
   1.1. Recognize that being a good communicator is a core clinical skill for Gastroenterologists, and that effective physician-patient communication can foster patient satisfaction, physician satisfaction, adherence and improved clinical outcomes
   1.2. Establish positive therapeutic relationships with patients and their families that are characterized by understanding, trust, respect, honesty and empathy
   1.3. Respect patient confidentiality, privacy and autonomy
   1.4. Listen effectively
   1.5. Communicate effectively in order to obtain a thorough and relevant patient history
   1.6. Be aware of and responsive to nonverbal cues
   1.7. Demonstrate sensitivity to patient concerns when presenting in the presence of a patient and/or family
   1.8. Facilitate a structured clinical encounter effectively

2. **Accurately elicit and synthesize relevant information and perspectives of patients and families, colleagues, and other professionals**
   2.1. Gather information about a disease and about a patient’s beliefs, concerns, expectations and illness experience
   2.2. Seek out and synthesize relevant information from other sources, such as a patient’s family, caregivers and other professionals

3. **Convey relevant information and explanations accurately to patients and families, colleagues and other professionals**
   3.1. Deliver information to a patient and family, colleagues and other professionals in a humane manner and in such a way that it is understandable, encourages discussion and participation in decision-making

4. **Develop a common understanding on issues, problems and plans with patients, families, and other professionals to develop a shared plan of care**
   4.1. Identify and explore problems to be addressed from a patient encounter effectively, including the patient’s context, responses, concerns, and preferences
4.2. Respect diversity and difference, including but not limited to the impact of gender, religion and cultural beliefs on decision-making
4.3. Encourage discussion, questions, and interaction in the encounter
4.4. Engage patients, families, and relevant health professionals in shared decision-making to develop a plan of care
4.5. Address challenging communication issues effectively such as delivering bad news, and addressing anger, confusion, misunderstanding and language barriers

5. **Convey effective oral and written information about a medical encounter**
   5.1. Maintain clear, concise, accurate and appropriate records of clinical encounters and plans
   5.2. Demonstrate effective consultation skills in presenting well documented assessments and recommendations in written and/or verbal form including:
      5.2.1. Procedural and specialty test reports
      5.2.2. Responses to requests by other health professionals and third parties
   5.3. Present medical information effectively to the public or media about a medical issue

**Specific Requirements:**

During the various ambulatory care clinics in the training program, residents will be expected to dictate consultation letters to referring physicians. These will be reviewed and critiqued by the attending staff. In addition, the resident is expected to dictate an endoscopy report for each procedure he/she performs and, during inpatient ward rotation, to interact extensively with patients and family. In addition, the ITER form completed at the end of each rotation has emphasis on the resident's proficiency in conducting histories and physical examinations, and verbal and written communication skills.

3. **COLLABORATOR**

Gastroenterologists work in partnership with others who are appropriately involved in the care of individuals or specific groups of patients. It is therefore essential for specialists to be able to collaborate effectively with patients and a multidisciplinary team of expert health professionals for provision of optimal patient care, education, and research.

**Key and Enabling Competencies: Gastroenterologists are able to...**

1. **Participate effectively and appropriately in an interprofessional health care team**
   1.1. Describe the Gastroenterologist’s roles and responsibilities to other professionals
   1.2. Describe the roles and responsibilities of other professionals within the health care team, especially general surgeons, radiologists, pathologists, nurse practitioners, dieticians, social workers and speech language pathologists
   1.3. Recognize and respect the diversity of roles, responsibilities and competences of other professionals in relation to their own
   1.4. Work with others to assess, plan, provide and integrate care for individual patients (or groups of patients)
1.5. Work with others to assess, plan, provide and review other tasks, such as research problems, educational work, program review or administrative responsibilities
1.6. Participate effectively in interprofessional team meetings
1.7. Enter into interdependent relationships with other professions for the provision of quality care
1.8. Describe the principles of team dynamics
1.9. Respect team ethics, including confidentiality, resource allocation and professionalism
1.10. Demonstrate leadership in a health care team, as appropriate

2. **Work with other health professionals effectively to prevent, negotiate, and resolve interprofessional conflict**
2.1. Demonstrate a respectful attitude towards other colleagues and members of an interprofessional team
2.2. Work with other professionals to prevent conflicts
2.3. Employ collaborative negotiation to resolve conflicts
2.4. Respect differences and address misunderstandings and limitations in other professionals
2.5. Recognize one’s own differences, misunderstanding and limitations that may contribute to interprofessional tension
2.6. Reflect on interprofessional team function

4. **LEADER**

Gastroenterologists function as managers when they make everyday practice decisions involving resources, co-workers, tasks, policies, and their personal lives. They do this in the settings of individual patient care, practice organizations, and in the broader context of the health care system. Thus, specialists require the abilities to prioritize and effectively execute tasks through teamwork with colleagues, and make systematic decisions when allocating finite health care resources. As managers, specialists take on positions of leadership within the context of professional organizations and the dynamic Canadian health care system.

**Key and Enabling Competencies: Gastroenterologists are able to...**

1. **Participate in activities that contribute to the effectiveness of their health care organizations and systems**
1.1. Work collaboratively with others in their organizations
1.1.1. Organize junior trainees to maximize clinical care and educational opportunities
1.2. Participate in systemic quality process evaluation and improvement, such as patient safety initiatives
1.2.1. Describe the principles behind the operation of a safe and effective endoscopy unit including infection control and sedation
1.3. Describe the structure and function of the health care system as it relates to Gastroenterology, including the roles of physicians
1.4. Describe principles of health care financing, including physician remuneration, budgeting and organizational funding
2. **Manage their practice and career effectively**
   2.1. Set priorities and manage time to balance patient care, practice requirements, outside activities and personal life
   2.2. Manage a practice including finances and human resources
   2.3. Implement processes to ensure personal practice improvement
   2.4. Employ information technology appropriately for patient care

3. **Allocate finite health care resources appropriately**
   3.1. Recognize the importance of just allocation of health care resources, balancing effectiveness, efficiency and access with optimal patient care
   3.2. Apply evidence and management processes for cost-appropriate care

4. **Serve in administration and leadership roles**
   4.1. Chair or participate effectively in committees and meetings including but not limited to endoscopy administration
   4.2. Lead or implement change in health care
   4.3. Plan relevant elements of health care delivery

5. **HEALTH ADVOCATE**

Gastroenterologists recognize the importance of advocacy activities in responding to the challenges represented by those social, environmental, and biological factors that determine the health of patients and society. They recognize advocacy as an essential and fundamental component of health promotion that occurs at the level of the individual patient, the practice population, and the broader community. Health advocacy is appropriately expressed both by the individual and collective responses of specialist physicians in influencing public health and policy.

**Key and Enabling Competencies: Gastroenterologists are able to...**

1. **Respond to individual patient health needs and issues as part of patient care**
   1.1. Identify the health needs of an individual patient
   1.2. Identify opportunities for advocacy, health promotion and disease prevention with individuals to whom they provide care
   1.3. Demonstrate an understanding of the role of screening tests in reducing mortality from colorectal cancer and hepatocellular carcinoma

2. **Respond to the health needs of the communities that they serve**
   2.1. Describe the practice communities that they serve
   2.2. Identify opportunities for advocacy, health promotion and disease prevention in the communities that they serve, and respond appropriately
       2.2.1. Describe, in broad terms, the key issues currently under debate regarding changes in the Canadian health care system, indicating how these changes might affect societal health outcomes and how Gastroenterologists can advocate to decrease the burden of illness at a community or societal level of conditions or problems relevant to Gastroenterology
2.2.2. Describe population-based approaches to health care services including screening and immunization programs and their implications for medical practice

2.3. Appreciate the possibility of competing interests between the communities served and other populations

3. **Identify the determinants of health for the populations that they serve**

3.1. Identify the determinants of health of the populations, including barriers to access to care and resources, and apply this understanding to common problems and conditions in Gastroenterology

3.2. Identify vulnerable or marginalized populations within those served, including but not limited to candidates for hepatitis B virus (HBV) vaccine, hepatitis C virus (HCV) screening amongst high risk populations and respond appropriately, applying the available knowledge about prevention to "at risk" groups within the practice

4. **Promote the health of individual patients, communities, and populations**

4.1. Describe an approach to implementing a change in a determinant of health of the populations they serve

4.2. Describe how public policy impacts on the health of the populations served

4.2.1. Identify current policies that affect gastrointestinal health, either positively or negatively including but not limited to immunization for viral hepatitis, anti-tobacco legislation, alcohol and substance abuse programs and health care for high risk populations

4.3. Identify points of influence in the health care system and its structure

4.4. Describe the ethical and professional issues inherent in health advocacy, including altruism, social justice, autonomy, integrity and idealism

4.5. Appreciate the possibility of conflict inherent in their role as a health advocate for a patient or community with that of manager or gatekeeper

4.6. Describe the role of the medical profession in advocating collectively for health and patient safety

6. **SCHOLAR**

Gastroenterologists engage in a lifelong pursuit of mastery of their domain of professional expertise. They recognize the need to be continually learning and model this for others. Through their scholarly activities, they contribute to the appraisal, collection, and understanding of health care knowledge, and facilitate the education of their students, patients, and others.

**Key and Enabling Competencies: Gastroenterologists are able to...**

1. **Maintain and enhance professional activities through ongoing learning**

1.1. Describe the principles of maintenance of competence

1.2. Describe the principles and strategies for implementing a personal knowledge management system

1.3. Recognize and reflect on learning issues in practice

1.4. Conduct a personal practice audit
1.5. Pose an appropriate learning question
1.6. Access and interpret the relevant evidence
1.7. Integrate new learning into practice
1.7.1. Demonstrate knowledge of new advances in the management of gastrointestinal disorders including but not limited to organ transplantation, therapeutic endoscopy, endoscopic ultrasound and capsule endoscopy
1.8. Evaluate the impact of any change in practice
1.9. Document the learning process

2. Critically evaluate medical information and its sources, and apply this appropriately to practice decisions
2.1. Describe the principles of critical appraisal
2.2. Critically appraise retrieved evidence in order to address a clinical question
2.3. Integrate critical appraisal conclusions into clinical care
   2.3.1. Describe and critically appraise recent landmark articles that impact current Gastroenterology practice

3. Facilitate the learning of patients, families, students, residents, other health professionals, the public and others
3.1. Describe principles of learning relevant to medical education
3.2. Identify collaboratively the learning needs and desired learning outcomes of others
3.3. Select effective teaching strategies and content to facilitate others’ learning
3.4. Demonstrate an effective lecture or presentation
3.5. Assess and reflect on a teaching encounter
3.6. Provide effective feedback
3.7. Describe the principles of ethics with respect to teaching

4. Contribute to the development, dissemination, and translation of new knowledge and practices
4.1. Describe the principles of research and scholarly inquiry
4.2. Describe the principles of research ethics
4.3. Pose a scholarly question
4.4. Conduct a systematic search for evidence
4.5. Select and apply appropriate methods to address the question
4.6. Disseminate the findings of a study

Specific Requirements:

Recognize the importance of self-assessment and of continuing medical education in gastroenterology and demonstrate a willingness to teach others including students, trainees from other disciplines and allied health care personnel.

Be able to appraise and evaluate scientific and clinical publications in the field of Gastroenterology, as applied to:

Clinical
• Pose a clinical question;
• Recognize and identify gaps in knowledge and expertise around the clinical question.
• Formulate a plan to fill the gap.
• Conduct an appropriate literature search based on the clinical question.
• Assimilate and appraise the literature.
• Develop a system to store and retrieve relevant literature.
• Consult others (physicians and other health professionals) in a collegial manner.
• Propose a solution to the clinical question.
• Implement the solution in practice.
• Evaluate the outcome and reassess the solution.
• Identify practice areas for research.

Research
• Pose a research question (clinical, basic or population health).
• Develop a proposal to solve the research question.
• Conduct an appropriate literature search based on the research question.
• Identify, consult and collaborate with appropriate content experts to conduct the research.
• Propose a methodological approach to solve the question.
• Carry out the research outlined in the proposal.
• Defend and disseminate the results of the research.
• Identify areas for further research stemming from the results.

Continuing Education
• Demonstrate an understanding of, and the ability to apply, the principles of adult learning, with respect to oneself and others.
• Demonstrate an understanding of preferred learning methods in dealing with students, residents, and colleagues.
• Demonstrate an understanding and appreciation of the role and significance of research in the advancement of knowledge.

Knowledge-based objectives will be achieved through attendance at and participation in the regularly scheduled teaching sessions of the GI Division (see Appendix J). However, formal teaching is no substitute for discussing relevant issues at the patient’s bedside, supplemented by individual study. The Division of Gastroenterology believes that scholarly work (research and/or quality improvement/assurance) is a vital training component for any physician: understanding scientific principles and principles of quality, testing hypotheses and acquiring analytic skills are important tools to improve the processes of clinical reasoning and critical appraisal. Consequently, residents are strongly encouraged to avail themselves of the many research activities in the Division. All residents are expected to engage in at least one scholarly project during their two core years of gastroenterology. An annual GI Research Day is in place to highlight the research activities and opportunities of the division. All GI residents are encouraged to participate in the annual Department of

At the start of the subspecialty training, each resident is assigned a career advisor. The role of the career advisor is to guide the resident in career development throughout their GI training via regular sessions.

7. PROFESSIONAL

Gastroenterologists have a unique societal role as professionals with a distinct body of knowledge, skills, and attitudes dedicated to improving the health and well-being of others. Specialists are committed to the highest standards of excellence in clinical care and ethical conduct, and to continually perfecting mastery of their discipline.

Key and Enabling Competencies: Gastroenterologists are able to...

1. Demonstrate a commitment to their patients, profession, and society through ethical practice
   1.1. Exhibit appropriate professional behaviors in practice, including honesty, integrity, disclosure, commitment, compassion, respect and altruism
   1.2. Demonstrate a commitment to delivering the highest quality care and maintenance of competence
   1.3. Recognize and appropriately respond to ethical issues encountered in practice
   1.4. Manage conflicts of interest
   1.5. Recognize the principles and limits of patient confidentiality as defined by professional practice standards and the law
   1.6. Maintain appropriate relations with patients

2. Demonstrate a commitment to their patients, profession and society through participation in profession-led regulation
   2.1. Demonstrate knowledge and an understanding of the professional, legal and ethical codes of practice, including physician-industry interaction
   2.2. Fulfill the regulatory and legal obligations required of current practice
   2.3. Demonstrate accountability to professional regulatory bodies
   2.4. Recognize and respond to others’ unprofessional behaviours in practice
   2.5. Participate in peer review

3. Demonstrate a commitment to physician health and sustainable practice
   3.1. Balance personal and professional priorities to ensure personal health and a sustainable practice
   3.2. Strive to heighten personal and professional awareness and insight
   3.3. Recognize other professionals in need and respond appropriately

Specific Requirements:

Discipline-Based Objectives:
• Display attitudes commonly accepted as essential to professionalism.
• Use appropriate strategies to maintain and advance professional competence.
• Continually evaluate one's abilities, knowledge and skills and know one's limitations of professional competence.

**Personal/Professional Boundary Objectives:**
• Adopt specific strategies to heighten personal and professional awareness and explore and resolve interpersonal difficulties in professional relationships.
• Consciously strive to balance personal and professional roles and responsibilities and to demonstrate ways of attempting to resolve conflicts and role strain.

**Objectives Related to Ethics and Professional Bodies:**
• Know and understand the professional, legal and ethical codes to which physicians are bound.
• Recognize, analyze and attempt to resolve in clinical practice ethical issues such as truth-telling, consent, advanced directives, confidentiality, end-of-life care, conflict of interest, resource allocation, research ethics, etc.
• Understand and be able to apply relevant legislation that relates to the health care system in order to guide one's clinical practice.
• Recognize, analyze and know how to deal with unprofessional behaviors in clinical practice, taking into account local and provincial regulations.

Ethical issues will commonly be discussed with attending staff during ward rounds. Formal presentations and seminars on Medical Ethics are regularly scheduled during Monday rounds and Academic Half Day.
ROTATION DESCRIPTION AND SPECIFIC OBJECTIVES

The specific rotation objectives are listed below.

CONSULTATION ROTATION (UAH, RAH, GNH, Misericordia):

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Preceptor/Coordinator</th>
<th>Contact</th>
<th>Initial Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>UAH</td>
<td>Attending Staff on Consult Service</td>
<td>Carrie-Anne Cyre Ph: 780-492-8243</td>
<td>AM Handover Rounds 2-10 ZLC M/F: 0730; Tu-Th: 0800</td>
</tr>
<tr>
<td>RAH</td>
<td>Attending Staff on Ward/Consult Service</td>
<td>Carrie-Anne Cyre Ph: 780-492-8243</td>
<td>Carrie-Anne to email schedule prior to start; page staff on Ward/Consult service per schedule</td>
</tr>
<tr>
<td>MIS*</td>
<td>Dr. Lori Stead</td>
<td>Cindi McLaughlin Ph: 780-930-1915</td>
<td>Contact Cindi by phone or at <a href="mailto:cjmlca@shaw.ca">cjmlca@shaw.ca</a></td>
</tr>
<tr>
<td>GNH*</td>
<td>Dr. Vijey Selvarajah</td>
<td>Paige Murphy Ph: 780-705-9933</td>
<td>Usually Day Medical Unit GNH Contact Paige to confirm</td>
</tr>
</tbody>
</table>

*The Misericordia and Grey Nuns rotations designated Community GI Rotations.

Rotation Description

A) UAH Site

The busy rotation at the consultation service provides excellent exposure to consultative practice in a tertiary care setting. To increase the education-to-service ratio on the consult service, the workload has been reduced with the implementation of two consult services. Consult Service 1 (Inpatient) will be responsible for consultations on patients admitted to the hospital, including ICU/CCU. Consult Service 2 (Emergency/Outpatients) will be responsible for all consultations from the Emergency (unless admitted to other services) and all emergent outpatient consultation, including those emergent patients booked directly to endoscopy. The junior residents and medical students rotating through GI will be distributed to both Consult 1 and 2 services. Widely diverse gastrointestinal problems, both acute and chronic, will be encountered. Consultations will arise from inpatient services, the intensive care units and the emergency departments, as well as from a large number of urgent referrals from northern Alberta and the Northwest Territories. Many of the patients referred to the consultation service, such as those with active upper and lower GI tract bleeding and biliary tract disease, require urgent endoscopic evaluation. The consultation rotation will expose residents to a variety of practice styles and clinical approaches by the members of the GI Division and will in turn increase the resident's competence and confidence in managing a wide variety of common GI problems.

The GI resident will take call at UAH in accordance to the schedule created by the GI Chief Resident.

B) RAH Site
During 4-week rotation, the resident will be assigned to the consult service. The resident will report directly with the gastroenterologist on consults and will be expected to triage consults, assess patients, and assist in performing any necessary endoscopic procedures. Effective communication with the attending physician and consulting service is crucial and will be assessed. Residents will be assigned to 1 block at RAH during their training and will have the option for a 2nd block (this counts towards the weeks of consults).

The GI resident will take call on the 3rd weekend in the block (if the resident is not available on this weekend – call request or vacation, the resident will take call on the 2nd weekend); duties will include daily patient care of ward patients, assessment of new consults and performance of any related endoscopic procedures.

The GI resident should attend the weekly RAH Monday GI Rounds, and will be responsible for a GI Rounds presentation at the RAH site. RAH Medical Grand Rounds on Thursday mornings are optional, but highly recommended. GI residents will attend GI Academic Half day at the University site each Tuesday afternoon.

Evaluations will be completed by each staff physician who supervises the resident.

C) GNH Site

This will be a 4-week rotation, intended to reflect an urban community gastroenterology consultant practice. The resident will be expected to take evening and weekend call at GNH, call requirements will not exceed the PARA rules. Resident will return to the UAH site for weekly Academic half day. Evaluation will be completed by the site lead.

Sample schedule:

<table>
<thead>
<tr>
<th></th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM</td>
<td>Endo/consults with Dr. Selvarajah</td>
<td>Endo &amp; consults with Dr. Siffledeen</td>
<td>Endo/consults with Dr. Bala</td>
<td>Endo/consults with Dr. Switzer</td>
<td>Endo/consults with GI on-call</td>
</tr>
<tr>
<td>PM</td>
<td>Endo/consults with Dr. Selvarajah</td>
<td>AHD</td>
<td>Endo/consults with Dr. Bala</td>
<td>Endo/consults with Dr. Switzer</td>
<td>Endo/consults with GI on-call</td>
</tr>
</tbody>
</table>

D) Misericordia Site

This will be a 4-week rotation, intended to reflect an urban community gastroenterology consultant practice. The resident will be expected to attend GI rounds and take call at the Misericordia during this rotation, call requirements will not exceed the PARA rules. Resident will return to the UAH site for weekly Academic half day. Evaluation will be completed by the site lead.
Rotation-Specific Objectives – Consultation Service at UAH Site

At the end of this rotation, the resident will be able to demonstrate the following outcomes:

**Medical Expert**
1) Complete an appropriate assessment of a gastrointestinal problem in the context of the patient with multi-system disease
2) Appropriate resuscitation of the acutely ill gastroenterology patient, including use of airway protection, blood products, and intravenous medications.
3) Assessment and treatment of GI emergencies including:
   i) Acute upper GI bleeding (non-variceal)
   ii) Acute upper GI bleeding (variceal)
   iii) Lower GI bleeding
   iv) GI foreign bodies
   v) Biliary obstruction/acute cholangitis
   vi) Acute abdominal pain
   vii) Flare of inflammatory bowel disease
   viii) Complications of chronic liver disease
4) Developing / Competent endoscopic skills for management of emergent GI conditions including:
   i) Foreign body removal
   ii) Acute upper GI bleeding (non-variceal)
   iii) Acute upper GI bleeding (variceal)
   iv) Acute lower GI bleeding
   (Expectations of endoscopic skill will depend on level of the trainee)

**Communicator**
1) Provision of accurate and concise written or dictated consult reports to requesting health care provider
2) Establishment of trust and rapport with patients and families
3) Accurate elicitation and synthesis information from patients and families
4) Empathetic delivery of information to patients and families and encourages shared decision-making
5) Appropriate management of telephone consultations, including recognition of unstable patients, and safe transfer practices (R5 residents only)

**Collaborator**
1) Recognition of own limits of expertise with appropriate consultation from other health professionals
2) Appropriate coordination of care with Emergency Room staff, in-patient Gastroenterology service, and other consulting services

Leader
1) Effective triage of acute gastroenterology patients based on clinical urgency
2) Effective time management including patient care, learning needs, and personal activities
3) Appropriate selection of diagnostic imaging and endoscopic investigations
4) Independent follow-up management of patients on the consult service, with support from attending physician (R5 residents only)
5) Effective triage/delegation/review of consultation requests to junior residents in a safe and equitable manner

Health Advocate
1) Identification of determinants of health including barriers to access to care/resources
2) Identification of vulnerable or marginalized populations

Scholar
1) Development and implementation of a personal learning plan
2) Critical evaluation of medical literature relevant to acute GI emergencies
3) Selection of appropriate teaching strategies to facilitate learning for patients and other members of the health care team

Professional
1) Delivery of patient care with honesty, integrity, compassion, respect, and altruism
2) Appropriate interpersonal relationships with patients and members of the health care team
3) Application of ethical principles to patient care
4) Punctual attendance and prompt response to pages

Rotation-Specific Objectives – Consultation at RAH, GNH, MIS Sites

At the end of this rotation, the resident will be able to demonstrate the following outcomes:

Medical Expert
1) Complete an appropriate assessment of a gastrointestinal problem in the context of the patient with multi-system disease
2) Appropriate resuscitation of the acutely ill gastroenterology patient, including use of airway protection, blood products, and intravenous medications.
3) Assessment and treatment of GI emergencies including:
   i) Acute upper GI bleeding (non-variceal)
   ii) Acute upper GI bleeding (variceal)
   iii) Lower GI bleeding
   iv) GI foreign bodies
   v) Biliary obstruction/acute cholangitis
   vi) Acute abdominal pain
   vii) Flare of inflammatory bowel disease
Complications of chronic liver disease

4) Developing / Competent endoscopic skills for management of emergent GI conditions including:
   i) Foreign body removal
   ii) Acute upper GI bleeding (non-variceal)
   iii) Acute upper GI bleeding (variceal)
   iv) Acute lower GI bleeding

(Expectations of endoscopic skill will depend on level of the trainee)

Communicator
1) Provision of accurate and concise written or dictated consult reports to requesting health care provider
2) Establishment of trust and rapport with patients and families
3) Accurate elicitation and synthesis information from patients and families
4) Empathetic delivery of information to patients and families and encourages shared decision-making

Collaborator
1) Recognition of own limits of expertise with appropriate consultation from other health professionals
2) Appropriate coordination of care with Emergency Room staff and other consulting services

Leader
1) Effective triage of acute gastroenterology patients based on clinical urgency
2) Effective time management including patient care, learning needs, and personal activities
3) Appropriate selection of diagnostic imaging and endoscopic investigations
4) Identification of the multiple roles of a community gastroenterologist

Health Advocate
1) Identification of determinants of health including barriers to access to care/resources
2) Identification of vulnerable or marginalized populations
3) Identification of distinct health care challenges of the inner-city population (RAH)

Scholar
1) Development and implementation of a personal learning plan
2) Critical evaluation of medical literature and presentation of results in a GI rounds format (RAH site only)
3) Selection of appropriate teaching strategies to facilitate learning for patients and other members of the health care team

Professional
1) Delivery of patient care with honesty, integrity, compassion, respect, and altruism
2) Appropriate interpersonal relationships with patients and members of the health care team
3) Application of ethical principles to patient care
4) Punctual attendance and prompt response to pages
The GI Division at the Walter Mackenzie Centre is responsible for a 20-30 inpatient beds on wards 5C3 and 5C4. Inpatient Ward 1 is the primary teaching service and usually is responsible for 10-15 patients. Inpatient Ward 1 is usually staffed by a staff physician, 1-2 Core IM residents, and an occasional GI resident. In general, the patients are admitted after assessment by the Consult service. Patients on this ward have serious medical illnesses such as exacerbation of inflammatory bowel disease, gastrointestinal hemorrhage, liver failure and GI infection. The patients are from the outpatient practice of the attending physicians in the GI Division and the Emergency Room, where a number of undesignated patients may present with gastrointestinal problems. In addition, many patients are transferred from outlying hospitals, which do not have the resources or expertise to manage complex GI disorders. A multidisciplinary team approach is used for effective patient care, involving all members: attending staff, GI residents and GI residents, medical students, nursing unit manager, bedside nurses, pharmacists, physiotherapists, nutritionists, social workers and discharge coordinators.

A dress code and conduct is in place. Residents and students are expected to conduct themselves professionally under the direction and at the discretion of the attending staff. The resident will make progress notes according to a patient problem list. At the end of each working day or prior to weekend, the resident will sign out critically ill patients to the resident on call to ensure continuity of care.

On discharge, the resident will review the diagnosis, prognosis, implications and medications with the patient and family. He/she will dictate a discharge summary promptly on discharge and communicate with the referring physician and/or patient’s own gastroenterologist regarding hospital course and follow-up plans.

The staff will see all patients within 24 hours of their admission and will write an admission note on the chart. The staff will review the resident’s progress notes.

Multidisciplinary rounds take place daily, Monday-Friday to discuss patient progress and discharge planning (8:30am – 5C3; 9:00am – 5C4). GI residents are expected to attend and participate in the discussion. Reductions in nursing staff mean that physicians must make an effort to reduce the workload imposed on our nursing colleagues; this is best done by ensuring that discharges are completed before noon each day.

Ward teaching rounds, lasting 2-3 hours, will be conducted at least three days per week. Residents will be encouraged to write orders on their patients during rounds. Residents are expected to write daily problem-based progress notes on each of the patients.
Procedures on patients will be performed at the first available booking. Where possible, the GI resident will do the procedure. Rotating junior residents are strongly encouraged to attend the endoscopic procedures.

The GI resident will take call at UAH in accordance to the schedule created by the GI Chief Resident.

Evaluations will be done by all attending staff interacting with the resident with input from the charge nurse and ward nursing staff.

**Rotation-Specific Objectives**

**At the end of this rotation, the resident will be able to demonstrate the following outcomes:**

**Medical Expert**
1) Complete an appropriate assessment of patients with a gastrointestinal problem requiring admission in the context of the patient with multi-system disease
2) Appropriate and timely resuscitation of the acutely ill gastroenterology patient.
3) Assessment and treatment of patients with the following problems:
   i) Acute upper GI bleeding (non-variceal)
   ii) Acute upper GI bleeding (variceal)
   iii) Lower GI bleeding
   iv) GI foreign bodies
   v) Biliary obstruction/acute cholangitis
   vi) Acute abdominal pain
   vii) Acute exacerbation of inflammatory bowel disease
   viii) Complications of chronic liver disease
   ix) Acute, severe diarrhea
4) Attaining excellence in bedside clinical diagnosis in GI patients
5) Logical sequencing of GI investigations in hospitalized patients
6) Developing / Competent endoscopic skills for management of emergent GI conditions including:
   i) Foreign body removal
   ii) Acute upper GI bleeding (non-variceal)
   iii) Acute upper GI bleeding (variceal)
   iv) Acute lower GI bleeding
   (Expectations of endoscopic skill will depend on level of the trainee)

**Communicator**
1) Obtain and integrate relevant history from patient and other sources
2) Establishment of therapeutic relationships with patients and families
3) Listens effectively to patients and families
4) Empathetic delivery of information to patients and families and encourages shared decision-making (including code status discussions)
5) Provides clear, concise discharge summaries
Collaborator
1) Recognition of own limits of expertise with appropriate consultation from other health professionals
2) Appropriate coordination of care with interdisciplinary health care team and other consulting services
3) Seeks consultation from other health care professionals appropriately
4) Contributes to patient care effectively, and collaboration with fellow ward team members

Leader
1) Effective time management including patient care, learning needs, and personal activities,
2) Rational utilization of healthcare resources, including bed management, diagnostic imaging and endoscopic investigations
3) Discuss medication coverage and affordability with patient, pharmacist, and social work
4) Effective organization of patient discharge and GI follow-up

Health Advocate
1) Understand patient care preferences, personal directives, power of attorney
2) Identify and provide counsel on risk factors for GI and liver disease
3) Identify and organize discharge supports for ongoing patient care, including those required by the inner-city population

Scholar
1) Critically appraise sources of medical information, relevant to inpatient gastroenterology
2) Facilitate learning of patients, house staff, students and other health care professionals
3) Develop, implement, and monitor a personal continuing education strategy

Professional
1) Delivery highest quality of patient care with honesty, integrity, compassion, respect, and altruism
2) Exhibit appropriate personal and interpersonal professional behaviors
3) Practice medicine ethically consistent with obligations of a physician
4) Punctual attendance and prompt response to pages
5) Communicates absences to preceptor and training office (well in advance, if possible)
UAH JUNIOR ATTENDING WARD ROTATION

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Preceptor</th>
<th>Contact</th>
<th>Initial Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Junior Attending Ward</td>
<td>Attending Staff on Ward Service</td>
<td>Carrie-Anne Cyre</td>
<td>0730 Monday AM Handover</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ph: 780-492-8243</td>
<td>Rounds 2-10 ZLC</td>
</tr>
</tbody>
</table>

This rotation is only for residents in the last 6 months of their two-year GI subspecialty residency program. It is similar in structure to the Ward Rotation, however the duties and responsibilities of the GI resident are advanced, as per the principles of graduated responsibility.

The overall goals of the Junior Attending Ward Rotation are

1) To develop the skills necessary to function independently as an attending physician on a GI in-patient service and

2) To develop the skills necessary to function as the manager and teacher in a medical team containing residents and clinical clerks.

During the rotation, the junior attending (JA) resident will provide all leadership and teaching to junior residents and medical students on the GI ward team. The JA resident will liaise with consulting services and allied health professionals (nursing unit manager, bedside nurses, pharmacists, physiotherapists, nutritionists, social workers and discharge coordinators) to optimize the care of the patients under their care.

The GI attending staff will serve as a supervisor/observer in the background to the JA resident, observing all aspects of patient care behaviour, medical expert and the other CANMEDS competencies expected of a Junior Faculty. During this time, the JA resident assumes all the day to day attending responsibilities. GI attending staff will only intervene if he/she believes that significant change in the medical plan is necessary for patient safety.

The JA GI resident will see all patients within 24 hours of their admission, review the junior resident’s progress notes and write a staff-admission note on the chart. The JA resident will review all patients and their charts every day and discuss management plans with the junior resident or medical student assigned to each patient. The JA resident will separately meet with the GI attending staff at least once daily to review ongoing patient and JA resident progress.

The JA Resident will attend the daily multidisciplinary rounds, Monday-Friday to lead the discussion of patient progress and discharge planning (8:30am – 5C3; 9:00am – 5C4). Reductions in nursing staff mean that physicians must make an effort to reduce the workload imposed on our nursing colleagues; this is best done by ensuring that discharges are completed before noon each day.

Ward rounds (usually lasting 2-3 hours) will be conducted at least three days per week led by the JA resident. The GI attending staff may attend these rounds as an observer, at a frequency at the attending staff’s discretion.
Procedures on patients will be performed at the first available booking. The JA resident will be expected to perform all procedures, with hands-off supervision by the attending staff. Rotating junior residents are strongly encouraged to attend the endoscopic procedures.

The GI resident will take weekday call at UAH in accordance to the schedule created by the GI Chief Resident. In lieu of weekend call, the GI resident will instead round on their ward for both Saturday and Sunday on 2 weekends. It is the resident’s responsibility to coordinate weekend rounding with the ward attending physicians supervising that block.

Evaluations will be completed by all supervising attending staff members with input from the charge nurse and ward nursing staff (360° evaluation).

**Rotation-Specific Objectives**

**Medical Expert**
1) Demonstrate proficiency and good judgment in the day-to-day management of complex inpatient GI problems.
2) Appropriate and timely resuscitation of the acutely ill gastroenterology patient.
3) Assessment and treatment of patients with the following problems:
   i) Acute upper GI bleeding (non-variceal)
   ii) Acute upper GI bleeding (variceal)
   iii) Lower GI bleeding
   iv) GI foreign bodies
   v) Biliary obstruction/acute cholangitis
   vi) Acute abdominal pain
   vii) Acute exacerbation of inflammatory bowel disease
   viii) Complications of chronic liver disease
   ix) Acute, severe diarrhea
4) Attaining excellence in bedside clinical diagnosis in GI patients
5) Logical sequencing of GI investigations in hospitalized patients
6) Demonstrate competence in endoscopic skills for management of emergent GI conditions including:
   i) Foreign body removal
   ii) Acute upper GI bleeding (non-variceal)
   iii) Acute upper GI bleeding (variceal)
   iv) Acute lower GI bleeding

**Communicator**
1) Establishment of therapeutic relationships with patients and families
2) Organize and lead family meetings, demonstrating the ability to handle communication challenges, such as anger, conflict or confusion
3) Show refinement in verbal and written communication, including documenting “staff notes” in the chart
4) Provides clear, concise discharge summaries

**Collaborator**
1) Serves as the leader in the coordination of care with interdisciplinary health care team and other consulting services
2) Seeks consultation from other health care professionals appropriately

**Leader**
1) Effective time management including patient care, teaching junior residents/medical students, preparing educational sessions, and personal activities
2) Rational utilization of healthcare resources, including bed management, diagnostic imaging and endoscopic investigations
3) Discuss medication coverage and affordability with patient, pharmacist, and social work
4) Effective organization of patient discharge and GI follow-up

**Health Advocate**
1) Understand patient care preferences, personal directives, power of attorney
2) Identify and provide counsel on risk factors for GI and liver disease
3) Identify and organize discharge supports for ongoing patient care, including those required by the inner-city population

**Scholar**
1) Critically appraise sources of medical information, relevant to inpatient gastroenterology
2) Facilitate learning of patients, house staff, students and other health care professionals
3) Develop, implement, and monitor a personal continuing education strategy

**Professional**
1) Delivery highest quality of patient care with honesty, integrity, compassion, respect, and altruism
2) Exhibit appropriate personal and interpersonal professional behaviors
3) Practice medicine ethically consistent with obligations of a physician
4) Punctual attendance and prompt response to pages
5) Communicates absences to preceptor and training office (well in advance, if possible)
ENDOSCOPY ORIENTATION COURSE

Coordinators: Lana Bistritz, Adriana Lazarescu

All GI residents start their GI residency with a 2-day Endoscopy Orientation Course. The course is attended by residents from the Western GI Adult and Pediatric Programs. The course provides interactive learning of various important aspects of endoscopy, using small group seminars and endoscopy training simulators.

The Endoscopy curriculum is as follows:
1. Ethics and informed consent
2. Safety and sedation
3. Diabetic management & endoscopy
4. Antibiotic prophylaxis, anticoagulation, & anti-platelet agents
5. Endoscopic therapy for GI bleeding
6. Endoscopy in the pregnant patient
7. Quality assurance and documentation
8. PEG - indications, safety, aftercare
9. Endoscopy complications
10. Bowel preparation
11. Approach to polypectomy and polyp histology
12. Foreign bodies
13. ERCP/EUS Indications
14. Small bowel imaging
The role of endoscopy in the management of patients with gastrointestinal diseases is vital and will be performed on almost all rotations. The objectives for endoscopic training are listed below and will span many rotations:

During the course of the GI Residency, the resident will be exposed to a wide variety of endoscopic procedures. The list below comprises the procedures in which the GI resident is expected to acquire competence:

- Diagnostic gastroscopy.
- Emergent gastroscopy for upper GI bleeding with skill in variceal band ligation and injection sclerotherapy, hemostasis of bleeding (esophageal, gastric and duodenal) lesions with thermal devices, sclerotherapy injection and hemoclip, etc.
- Gastroscopy with PEG insertion.
- Esophageal stricture dilatation with Savary or balloon dilators.
- Endoscopic biopsies of lesions in the upper GI tract including esophagus, stomach and duodenum.
- Diagnostic flexible sigmoidoscopy.
- Diagnostic colonoscopy.
- Colonoscopy with endoscopic removal of colonic polyps with polypectomy, snare cold forceps and hot biopsy forceps, and endoloop.
- Colonoscopy for lower GI tract bleeding, bicap and injection hemostasis of bleeding colonic lesions.
- Colonoscopy with decompression of pseudo-obstruction or volvulus.
- Endoscopic removal of foreign body/bolus impaction.

The foundation of these endoscopic skills is based in accepted quality indicators and the ASGE Principles of GI Endoscopy. They can be divided into pre-procedure, intra-procedure and post-procedure objectives.

**Pre-endoscopy Objectives:**

1. Resident should have a basic knowledge of accepted indications for endoscopy (see Endoscopy Resource Manual)
   a. Recognize the indication for each specific procedure
2. Directed history and PE, include: prior surgery, abdominal exam
   a. Antithrombotic/anticoagulant therapy - last dose, bridging, etc.
   b. ASA score
3. Procedure Preparation:
   a. Last PO intake
   b. Preparation adequacy (for colonoscopy)
4. Need for prophylactic antibiotics
5. Time-out (team pause)
6. Informed Consent
7. Equipment
   a. Availability
   b. Pre-procedure testing of equipment (suction, air/CO2, water pump)
Intra-procedure Objectives (General)
1. Safe use of sedation
   a. Use of reversal agents
2. Photodocumentation
3. Monitoring
4. Premature termination

Intra-procedure Objectives (EGD)
1. Technical skills
   a. Proper handling of the gastroscope
   b. Esophageal intubation
   c. Retroflexion in the stomach
   d. Pyloric intubation
   e. Advancing into the 2nd part of the duodenum
   f. Interventions:
      i. Biopsy
      ii. Hemostasis
      iii. Foreign body removal
      iv. Stricture dilation
      v. PEG insertion
2. Interpretative/diagnostic skills
   a. Accurate recognition of normal landmarks (and findings)
   b. Accurate recognition of abnormal findings
   c. Ability to make a treatment plan

Intra-procedure Objectives (Colonoscopy)
1. Technical skills
   a. Proper handling of the colonoscope
   b. DRE/perianal exam
   c. Intubation of splenic flexure
   d. Intubation of cecum
   e. Intubation of terminal ileum
   f. Recognition of loops
   g. Ability to reduce loops
   h. Use of abdominal pressure
   i. Use of position changes
   j. Visualization of mucosa
   k. Retroflexion in rectum
   l. Interventions
      i. Biopsy
      ii. Hemostasis
      iii. Polypectomy
      iv. Dilation of strictures
      v. Colonic decompression
2. Interpretive/diagnostic skills
   a. Accurate recognition of normal landmarks (and findings)
i. Recognition of cecal landmarks
b. Accurate recognition of abnormal findings
c. Ability to make a treatment plan

Post-procedure Objectives
1. Completion of the Endoscopy written report (eg. pathology sheet)
   a. Documentation of sedation administered
   b. Tolerance of procedure
2. Dictation of the endoscopy report - see Endoscopy Book
   a. Copy to all relevant providers (referring MD, GP, etc)
3. Diet, medications, contact info for adverse events, follow-up.
4. Maintenance of an endoscopy log (include: date, procedure, extent completed without assistance, any therapeutics, adverse events)

While some endoscopic societies such as the Canadian Association of Gastroenterology and the American Society for Gastrointestinal Endoscopy have listed minimum numbers required for assessment of competence, exposure to endoscopy in our program will be extensive. With the usual case mix seen on the various rotations and on call, sufficient numbers of the above procedures will exceed the guideline numbers, and more importantly to allow achievement of competence.

After the 2 core years of training, the GI resident is not expected to acquire competence in diagnostic or therapeutic ERCP. However, the GI resident is expected to understand the indications and contra-indications to this procedure and will have exposure to ERCP. Further training in ERCP is available in the third year, in a formal Endoscopic Fellowship.

Residents will be expected to maintain a log of procedures performed, which will be reviewed with the Program Director at the regular meetings and at the RPC. Residents are required to keep track of the type and number of procedures performed by block, including the number/type of therapeutic interventions.

Residents are encouraged to make use of available resources to enhance their endoscopic training. These include the 2 endoscopy simulators, video library of common endoscopic procedures and techniques (located in the Endoscopy Unit), the UAH GI endoscopy handbook, and endoscopy textbooks and atlas (SCHOLAR).

Recommended Reading:
ENDOSCOPY BLOCK

To assist in the acquisition of the cognitive and technical skills required for endoscopy, there are 2 separate endoscopy training blocks.

**Introduction to Endoscopy (2-week block)**
All 1st year GI residents will be assigned to a 2-week introduction to endoscopy early in the foundation phase of the GI training. The purpose of this block is to expose residents early in their career to the foundational skills of endoscopy. The objectives of this brief rotation are: recognize the indication for each procedure, be familiar with the proper handling of the gastroscope and colonoscope, and to begin acquiring the skills of diagnostic GI endoscopy.

**Endoscopy (4-week block)**
In addition, GI residents in their 1st year, will also be assigned to a formal endoscopy block. During this 4-week rotation will be exposed to common endoscopic and therapeutic problems of the ambulatory GI and liver patients. They are assigned to an endoscopy preceptor for 8-half days per week. The purpose of this block is to have focused time to work on attaining endoscopy skills in ambulatory patients.

GI residents on their endoscopy blocks are expected to attend Tuesday Academic Half Day and will be assigned 1 half day per week for reading.

The GI resident will take call at UAH in accordance to the schedule created by the GI Chief Resident.
LEADERSHIP & RESEARCH COURSE

Coordinators: Richard Fedorak, Karen Kroeker

In years past, teaching on leadership and research has been delivered in several formats, as a 2-day course or integrated throughout the 2-year Academic Half Day (AHD) curriculum. Many of these sessions will be delivered in the AHD curriculum in the summer months.

Objectives:
1. To deliver a foundation of learning and culture that will provide the GI subspecialty residents (and advanced GI fellows) with the tools necessary to succeed in leadership and research activities required during their residency and beyond (COMMUNICATOR, LEADER, ADVOCATE, SCHOLAR).
2. To provide GI subspecialty residents with tools to engage in complex, interactive communications with patients and colleagues, teach to junior trainees, learn about what it means to have a career in Medical Education (COMMUNICATOR, COLLABORATOR, PROFESSIONAL)
3. To provide guidance on career planning (PROFESSIONAL).

Key Components:
- Finding success in Residency Research
- Finding a Research Mentor
- Research Ethics
- Career Planning – What it takes to get a job in GI, how to distinguish yourself
- Developing Leadership Skills
- Collegial conversations
- Small Group Teaching
IN-PATIENT HEPATOLOGY /LIVER TRANSPLANT ROTATION

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Preceptor</th>
<th>Contact</th>
<th>Initial Reporting</th>
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</thead>
<tbody>
<tr>
<td>Inpatient Hepatology</td>
<td>Attending Staff on Hepatology Service</td>
<td>Carrie-Anne Cyre Ph: 780-492-8243</td>
<td>0730 Monday AM Handover Rounds 2-10 ZLC</td>
</tr>
</tbody>
</table>

Subspecialty GI residents on this 4-week rotation will be exposed to all aspects of liver disease through the following venues: liver transplant clinic, pre-operative assessment of liver transplant candidates, and post-operative management of liver transplant patients in ICU and on surgical ward. This will be performed under the supervision of one of the staff hepatologists. The University of Alberta Liver Unit provides consultation for complex liver patients and transplant candidates from the provinces of Alberta, Saskatchewan, Northwest Territories and Manitoba.

The GI resident will take call at UAH in accordance to the schedule created by the GI Chief Resident.

In addition to the general objectives outlined above, the following are specific to the in-patient hepatology service.

**MEDICAL EXPERT:** The GI subspecialty resident will be expected to be conversant in the common liver diseases seen by gastroenterologists including but not restricted to viral hepatitis, autoimmune liver disease, metabolic liver disease, jaundice including post-operative jaundice, management of the complications of portal hypertension including variceal bleeding and ascites, indications for liver transplantation, pharmacology and interaction profile of immunosuppressive drugs used in the transplant setting, management of common post-operative liver transplant problems including acute rejection, biliary anastomotic stricture and portal vein and hepatic artery thrombosis. The management of acute and chronic end-stage liver failure including fulminant hepatitis, indications and contra-indications to liver transplantation, and post-operative and long-term management of the liver transplant patient.

The resident will recognize the indications and contraindications for liver biopsy. The resident will also appreciate the relative merits of various liver biopsy techniques: percutaneous, ultrasound guided and trans-jugular.

**COMMUNICATOR:** The resident will establish a therapeutic relationship with patients and their families, and health care team members. He/she will be able to discuss appropriate information with patients, families and health-care team members.

**COLLABORATOR:** The Alberta Liver Transplant Program consists of multi-professional groups, spanning the entire province of Alberta. The resident will learn to consult effectively with team members and other healthcare professionals. He/she will also appreciate the mechanism of group dynamics in ensuring efficient, effective and best care for patients referred to the program. This is experienced first-hand at the weekly Liver Transplant Rounds. The resident also attends biweekly Interventional liver tumor Rounds, during which
multidisciplinary (interventional radiology, hepatobiliary surgery, and Hepatology) management of liver tumors is discussed.

**LEADER:** In the setting of limiting organ supply, the resident will appreciate and manage the balance between the physician’s role as the patient’s advocate and as manager to efficiently utilize limited societal resource. These 2 roles are routinely encountered in the weekly Liver Transplant Rounds which determine the listing/delisting and prioritization of patients for liver transplantation.

**ADVOCATE:** In the setting of limiting organ supply, the resident will appreciate and manage the balance between the physician’s role as the patient’s advocate and as manager to efficiently utilize limited societal resource. These 2 roles are routinely encountered in the weekly Liver Transplant Rounds. In the liver transplant clinics where the complex management of transplant patients is delivered, the resident will be able to identify important determinants of health affecting patients.

**SCHOLAR:** Develop, implement and monitor a personal continuing education strategy. To facilitate this objective, the following formal teaching sessions are in place, in conjunction with encouraged self-reading.

**PROFESSIONAL:** As the Alberta Liver Transplant program is based in Edmonton, the inpatients encountered during this rotation frequently have high acuity levels of illness. The resident will learn to deliver the highest quality care with integrity, honest, and compassion, but also in an efficient and timely manner.
LIVER AMBULATORY ROTATION

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<th>Rotation</th>
<th>Preceptor</th>
<th>Contact</th>
<th>Initial Reporting</th>
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<tbody>
<tr>
<td>Liver Ambulatory</td>
<td>Attending Hepatology and Hepatobiliary Staff</td>
<td>Carrie-Anne Cyre Ph: 780-492-8243</td>
<td>Per Ambulatory Clinic Schedule</td>
</tr>
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Subspecialty GI residents on this 4-week rotation will be exposed to ambulatory aspects of liver disease through the following venues: non-transplant hepatology clinic, hepatobiliary surgery clinic, transplant hepatology clinic. In addition, efforts will be made to schedule residents for occasional endoscopy half days with hepatologists assessing/treating portal hypertension. This will be performed under the supervision of staff hepatologists, hepatobiliary surgeons, and infectious disease specialists. This rotation serves to complement the in-patient hepatology rotation by providing experience in assessing and managing patients with less acute hepatobiliary problems.

The GI resident will take call at UAH in accordance to the schedule created by the GI Chief Resident.

In addition to the general objectives outlined above, the following are specific to the liver ambulatory block.

**MEDICAL EXPERT:** The GI subspecialty resident will be expected to be conversant in the common liver diseases seen by gastroenterologists including but not restricted to viral hepatitis, alcoholic liver disease, autoimmune liver disease, metabolic liver disease, non-alcoholic fatty liver disease, hepatoma, management of portal hypertension, and assessment for liver transplantation. There will be exposure to hepatobiliary issues, such as indication and contraindication for liver resection, post-op complications and pre-operative risk assessment of the patient with liver disease.

The resident will be familiar with non-invasive measures of fibrosis (fibroscan) and how to interpret these results in the management of patients with liver disease.

The resident will recognize the indications and contraindications for liver biopsy. The resident will also appreciate the relative merits of various liver biopsy techniques: percutaneous, ultrasound guided and trans-jugular.

**COMMUNICATOR:** The resident will establish therapeutic relationship with patients and their families, and referring physicians. He/she will be able to discuss appropriate information with these parties, and dictate a written consultation letter to the referring physician.

**COLLABORATOR:** The Alberta Liver Transplant Program is a multi-professional team of specialized nurses, psychologist, social worker and physicians, delivering comprehensive care for patients with end-stage liver disease (pre- and post-liver transplant). The resident
will be exposed to the workings of this team, and learn to communicate effectively with team members. He/she will also appreciate the mechanism of group dynamics in ensuring efficient, effective and best care for patients in the program. The resident also attends biweekly Interventional Liver Tumor Rounds, during which multidisciplinary (interventional radiology, hepatobiliary surgery, and hepatology) management of liver tumors is discussed. The resident may also spend time in the Cirrhosis Care Clinic (formerly Portal Hypertension Clinic) consisting of a hepatologist, nurse practitioner, and dietitian.

**LEADER:** In the setting of limiting health resources and long waiting lists, the resident will appreciate and manage the balance between the physician’s role as the patient’s advocate and as manager to optimize the use of limited health resources. This is modelled in the weekly Liver Transplant Meeting where addition or removal of patients to the liver transplant waiting list is determined.

**ADVOCATE:** Many patients with liver disease have psychosocial issues which may negatively impact compliance or ability to afford medication. The resident will be exposed to strategies and efforts needed to help these patients to focus positively on their health issues, while balancing other life challenges. Many of the staff members routinely act as patient advocates lobbying government to provide coverage of new and emerging medications. These issues will be highlighted during discussion of relevant cases.

**SCHOLAR:** Develop, implement and monitor a personal continuing education strategy. To facilitate this objective, the following formal teaching sessions are in place, in conjunction with encouraged self-reading. There is at least one half day set aside per week for self-directed learning of topics and diseases encountered in the clinics.

**PROFESSIONAL:** The patients seen in clinics frequently have diseases that may be associated with certain social stigma. The resident will learn to deliver the highest quality care with integrity, honesty, and compassion, and in an efficient and timely manner.
AMBULATORY BLOCK ROTATION

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<th>Rotation</th>
<th>Preceptor</th>
<th>Contact</th>
<th>Initial Reporting</th>
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<tbody>
<tr>
<td>Ambulatory Block</td>
<td>Attending Staff</td>
<td>Carrie-Anne Cyre</td>
<td>Per Ambulatory Clinic Schedule</td>
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<td></td>
<td></td>
<td>Ph: 780-492-8243</td>
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GI residents on this 4-week rotation will be exposed to ambulatory aspects of gastrointestinal (and liver diseases) through the following venues: gastroenterology clinic, non-transplant hepatology clinic, IBD clinic, and out-patient endoscopy. Since, there is a separate ambulatory liver block, this block will focus on GI clinics. This will be performed under the supervision of staff gastroenterologists and hepatologists. This rotation serves to complement other primarily in-patient rotations by providing experience in assessing and managing patients in the ambulatory setting. With exposure to the IBD clinics, the residents have an appreciation of the multidisciplinary team approach to management of inflammatory bowel disease.

The GI resident will take call at UAH in accordance to the schedule created by the GI Chief Resident.

In addition to the general objectives outlined above, the following are specific to the ambulatory block.

**MEDICAL EXPERT:** The GI subspecialty resident will be expected to be conversant in the common gastrointestinal and liver diseases seen by gastroenterologists including but not restricted to dyspepsia, peptic ulcer disease, esophageal disease, maldigestion and malabsorption, celiac disease, pancreatic and gallstone disease, irritable bowel disease, inflammatory bowel disease, colon polyps and colon cancer screening, iron deficiency anemia, viral hepatitis, alcoholic liver disease, autoimmune liver disease, metabolic liver disease, non-alcoholic fatty liver disease, hepatoma, management of portal hypertension, and assessment for liver transplantation.

The resident will recognize the indications and contraindications for common endoscopic procedure. The resident will perform common ambulatory endoscopic procedures such as gastroscopy and colonoscopy, screening for Barrett’s, esophageal and colonic dilatation, colon cancer screening, polypectomy, and variceal ligation.

**COMMUNICATOR:** The resident will establish medical relationship with patients and their families, and referring physicians. He/she will be able to discuss appropriate information with these parties, and dictate a written consultation letter or endoscopy note to the referring physician.

**COLLABORATOR:** Patients seen during this rotation are referred, and frequently complex. Their effective care depends on effective collaboration between us (consultants), primary care provider, and other consultant or health care providers. The Inflammatory Bowel Disease clinic is a multi-professional clinic of specialized nurses and physicians. The resident
will be exposed to the workings of this team, and learn to communicate effectively with team members. The resident may also spend time in the Portal Hypertension Clinic consisting of a hepatologist, nurse practitioner, and dietitian.

**LEADER:** In the setting of limited health resources and long waiting lists, the resident will appreciate and manage the balance between the physician’s role as the patient’s advocate and as manager to optimize the use of limited health resources. The resident will appreciate and understanding the importance of triage in delivery of limited resources.

**SCHOLAR:** To develop, implement and monitor a personal continuing education strategy. To facilitate this objective, at least one half day is set aside per week for self-directed learning of topics and diseases encountered in the clinics. Discussions between staff and resident will be centered around cases to highlight the relevant or controversial issues.

**ADVOCATE:** Many patients with gastrointestinal and liver disease have psychosocial issues which may negatively impact compliance. Many effective medications are expensive, and frequently not covered by Alberta Blue Cross. The resident will be exposed to strategies and efforts need to help these patients to focus positively on their health issues, while balancing other life challenges. Many of the staff members routinely act as patient advocates lobbying government to provide coverage of new and emerging medications. These issues will be highlighted during discussion of relevant cases.

**PROFESSIONAL:** The patients seen in clinics frequently have diseases that may be associated with certain social stigma. The resident will learn to deliver the highest quality care with integrity, honesty, and empathy.
LONGITUDINAL CLINIC

<table>
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<tr>
<th>Rotation</th>
<th>Preceptor</th>
<th>Contact</th>
<th>Initial Reporting</th>
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<tbody>
<tr>
<td>Longitudinal Clinic</td>
<td>Attending Staff</td>
<td>Carrie-Anne Cyre Ph: 780-492-8243</td>
<td>Assigned Mentor at least 1 month prior to the start of rotation</td>
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All GI residents will participate in a 12-month mandatory weekly longitudinal clinic beginning in January of their R4 year. The will afford the GI resident the opportunity to gain experience running their own practice. This rotation serves to complement other primarily in-patient rotations by providing experience in assessing and managing patients in the ambulatory setting. GI residents will be assigned two (2) preceptors for the year of longitudinal clinic. The will spend 2 half-day clinics with each preceptor per block (E.g. preceptor 1: weeks 1 & 3, preceptor 2: weeks 2 & 4). Residents will be excused from their regular clinical duties for 1 half day each week to attend their longitudinal clinic.

**Preceptor selection:** Each trainee will be assigned to 2 preceptors for the duration of the longitudinal block. Trainees will have the opportunity to review the list of physicians accepting trainees and provide their top 4-5 choices. Preceptors will be solicited by the GI Program.

**Case selection:** The GI resident and their mentor will select appropriate cases from a pool of new referrals; the expectation is that the GI resident be assigned a wide variety of new patient cases with each preceptor. All subsequent investigations, management, and longitudinal care will be the responsibility of the GI resident. Follow-up patient appointments are only for patients previously seen by the GI resident.

**Scheduling:** The GI resident will plan a weekly ½ day schedule with their preceptor’s secretary (who will reserve clinic space); taking into account the odd/even weeks. It is the resident’s responsibility to inform their mentor’s secretary of their away dates at least 8 weeks in advance. Each half day clinic will comprise of two (2) new patient slots (45 minutes) and up to 2-3 follow-ups (20-30 minutes). Follow-ups will be booked only at the direction of the GI fellow. The GI fellow may choose to book follow up appointments for patients they have seen in other settings (eg. ER room while on call). Patients requiring ongoing follow-up will be transferred back to the mentor at the end of the block. The GI resident will inform all patients of the structure of this clinic.

**Expectations:** GI fellows are responsible for the patients assigned, including dictation, subsequent investigations, and follow-up. GI residents will have the opportunity to review all patients as needed with their preceptor. The closeness of supervision will depend on the abilities of the individual resident and the complexity of the patients. In addition, the GI resident will also keep a portfolio of gaps in knowledge (as described in the scholar section below). The portfolio must be submitted to the PD quarterly.

**Evaluation:** To facilitate timely feedback and growth, an ITER will be completed quarterly by each preceptor.
In addition to the general objectives outlined above, the following are specific to the longitudinal clinic.

**MEDICAL EXPERT:** The GI subspecialty resident will be expected to function as a consultant in an outpatient clinical setting for common GI clinical presentations. They are expected to elicit a history that is relevant, concise, complete, and accurate; perform a relevant physical examination that is concise and complete; select appropriate investigations that are both cost-effective and ethical. The GI resident will collate all information and demonstrate cognitive skills in formulating a problem list and plan.

**COMMUNICATOR:** The GI resident will establish a therapeutic relationship with the patient. They will gather information from the patient in regards to the disease, but also about the patient’s beliefs, concerns, and expectations. They will be able to deliver information to the patients and families that is both clear and compassionate. They will recommend investigations and/or treatment options that include the risks, benefits, and alternatives. The GI resident will communicate a consultant level report to the referring physician in a timely manner.

**COLLABORATOR:** The GI resident will be able to identify and describe the role, expertise, and limitations of the members of the interdisciplinary team required to optimally achieve a goal related to patient care. They will develop a care plan for the patient in collaboration with members of the interdisciplinary team.

**LEADER:** In the setting of limited health resources and long waiting lists, the resident will appreciate and manage the balance between the physician’s role as the patient’s advocate and as manager to optimize the use of limited health resources. The resident will appreciate and understanding the importance of triage in delivery of limited resources.

**SCHOLAR:** To develop, implement and monitor a personal continuing education strategy. To facilitate this objective, at the end of every clinic the GI resident will identify a gap in knowledge, formulate a plan to fill this gap (e.g. Literature search, consult others), implement this plan and evaluate the outcome, including identifying areas for research. A portfolio listing the gap, plan, and outcome will be kept by the GI resident and submitted to the PD on a quarterly.

**ADVOCATE:** GI residents will identify the needs to individual patients, including the non-medical determinants of health. The resident will be exposed to strategies and efforts need to help these patients to focus positively on their health issues, while balancing other life challenges. The GI resident will also have the opportunity to implement prevention strategies (e.g. screening for upper and lower GI malignancies).

**PROFESSIONAL:** The GI resident will demonstrate professionalism in all of their interactions with patients, clinic staff, members of the interdisciplinary team, and faculty. They will use professional strategies to maintain and advance one’s professional competence. They will strive to balance personal and professional roles, and to consciously work to resolve conflicts.
In the latter ¼ of their GI training, residents will be assigned to a 4-week rotation of senior ambulatory. In this rotation, residents will have the freedom to book their own clinics and endoscopy. The intention of this rotation is to allow resident to address any gaps in their training. This rotation serves to complement other primarily in-patient rotations by providing experience in assessing and managing patients in the ambulatory (clinic and endoscopy) setting. With exposure to the IBD clinics, the residents have an appreciation of the multidisciplinary team approach to management of inflammatory bowel disease.

The GI resident will take call at UAH in accordance to the schedule created by the GI Chief Resident.

In addition to the general objectives outlined above, the following are specific to the ambulatory block.

**MEDICAL EXPERT:** The GI subspecialty resident will be expected to be conversant in the common gastrointestinal and liver diseases seen by gastroenterologists.

The resident will recognize the indications and contraindications for common endoscopic procedure. The resident will perform common ambulatory endoscopic procedures, including gastroscopy and colonoscopy.

**COMMUNICATOR:** The resident will establish medical relationship with patients and their families, and referring physicians. He/she will be able to discuss appropriate information with these parties, and dictate a written consultation letter or endoscopy note to the referring physician.

**COLLABORATOR:** Patients seen during this rotation are referred, and frequently complex. Their effective care depends on effective collaboration between us (consultants), primary care provider, and other consultant or health care providers.

**LEADER:** In the setting of limited health resources and long waiting lists, the resident will appreciate and manage the balance between the physician’s role as the patient’s advocate and as manager to optimize the use of limited health resources. The resident will appreciate and understanding the importance of triage in delivery of limited resources.

**SCHOLAR:** The resident will self-identify gaps in their clinical training and book clinic and endoscopy training accordingly. The resident will also develop, implement and monitor a personal continuing education strategy; to facilitate this objective, at least one half day is set aside per week for self-directed learning of topics and diseases encountered in the clinics.
Discussions between staff and resident will be centered around cases to highlight the relevant or controversial issues.

**ADVOCATE:** Many patients with gastrointestinal and liver disease have psychosocial issues which may negatively impact compliance. Many effective medications are expensive, and frequently not covered by Alberta Blue Cross. The resident will be exposed to strategies and efforts need to help these patients to focus positively on their health issues, while balancing other life challenges. Many of the staff members routinely act as patient advocates lobbying government to provide coverage of new and emerging medications. These issues will be highlighted during discussion of relevant cases.

**PROFESSIONAL:** The patients seen in clinics frequently have diseases that may be associated with certain social stigma. The resident will learn to deliver the highest quality care with integrity, honesty, and empathy.
On this 4-week rotation, the resident will gain experience in the management of patients, with particular emphasis on nutrition. The rotation is primarily based at RAH, with some activities at UAH (see table below). The resident will be responsible for seeing new consultations directed to the nutrition/TPN program, and following these patients during the rotation. He/she will also participate in nutrition related rounds and ambulatory clinic as outlined in the schedule below. The resident will undertake a self-directed learning project related to nutrition while on the rotation. There will also be opportunities to participate in the Malnutrition Clinic.

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<thead>
<tr>
<th>AM</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
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<tbody>
<tr>
<td>2nd</td>
<td>2nd Monday of month – Home Enteral Clinic – RAH</td>
<td>As assigned</td>
<td>Endo - RAH</td>
<td>TPN Rounds – UAH (0930-1200h)</td>
<td>TPN Rounds – RAH (0830-1000h)</td>
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<tr>
<td>PM</td>
<td>2nd Monday - Home TPN Clinic - UAH</td>
<td>AHD</td>
<td>As assigned</td>
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**Rotation-Specific Objectives**

At the end of this rotation, the resident will be able to:

**Medical Expert**

1) Perform an accurate history and physical examination focused on assessment of nutritional status, including evidence of nutritional deficiencies and SGA
2) Apply knowledge of basic science principles relevant to nutrition including:
   - **Nutrients**: micro and macronutrient requirements, digestion, absorption and deficiency
   - **Diet and Activity**: nutrition and physical activity requirements across the lifecycle including evidence for various diets
3) Accurately order and interpret investigations including laboratory evaluations, indirect calorimetry and anthropometry in assessing a patient’s nutritional status.
4) Demonstrate effective clinical problem solving skills to address specialized nutrition support issues including:
   - Short bowel syndrome
   - Enteric fistulae
   - Indications, contraindications, and complications of enteral and parenteral nutrition
   - Obesity and the bariatric patient
   - Nutrition in chronic liver disease
f) Nutrition in pancreatitis

5) Write an appropriate nutrition prescription including appropriate calculation of TPN orders, and selection of appropriate enteral and parenteral nutrition products

6) Identify and appropriately respond to ethical issues involving long term nutritional support

Communicator

1) Provide accurate and concise written or dictated consult reports to requesting health care provider

2) Establish trust and rapport with patients and families

3) Accurately elicit and synthesize information from patients and families

4) Deliver information to patients and families with empathy and encourage shared decision-making

Collaborator

1) Recognize the roles of other health care professionals in managing complex nutrition patients, including physicians, specialized nurses, dieticians, pharmacists, and enterostomal therapists

2) Work effectively with a multidisciplinary team to assess, plan, provide, and integrate care for individual patients

Leader

1) Describe the role of the healthcare system in providing long term nutritional therapy for Northern Albertans

2) Describe ways to optimize the cost-effectiveness of long term nutritional therapy

3) Select appropriate diagnostic imaging and endoscopic investigations

4) Demonstrate effective time management including patient care, learning needs, and personal activities

Health Advocate

1) Identify determinants of health including barriers to access to care/resources

2) Identify obstacles for long term nutrition patients to remain in the ambulatory setting

3) Describe the role of malnutrition screening for at-risk populations, including hospitalized patients

Scholar

1) Develop and implement of a personal learning plan

2) Critically review the medical literature for a nutrition topic

3) Comment on areas of controversy in the field of nutrition (eg, hepatic encephalopathy, peri-operative feeding, terminal cancer)

Professional

1) Deliver patient care with honesty, integrity, compassion, respect, and altruism
2) Demonstrate appropriate interpersonal relationships with patients and members of the health care team
3) Demonstrate punctual attendance and prompt response to pages
The GI motility rotation is a 3-week rotation dedicated to the study of motility disorders of the GI tract with the following opportunities for learning:

- A pre- and post-rotation written test of GI motility knowledge
- Observation of esophageal pH and impedance studies
- Observation of esophageal manometry studies
- Observation of anorectal manometry
- Hands-on experience with the diagnostic software used to interpret esophageal manometry and pH-impedance studies
- Residents will be assigned reading material based on discussions and identified knowledge gaps.
- Residents will attend clinics and endoscopy sessions as per schedule below.

Sample Schedule:

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<tr>
<td></td>
<td>Clinic UAH</td>
<td>Clinic UAH</td>
<td>Dysphagia Clinic (1st Wed of Month – UAH)</td>
<td>Esophageal Disorder Clinic RAH (Sadowski)</td>
<td>Endoscopy UAH (Lazarescu)</td>
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<tr>
<td></td>
<td>(Lazarescu)</td>
<td>(Lazarescu)</td>
<td>GI Motility Lab</td>
<td>RAH (Sadowski)</td>
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<tr>
<td>PM</td>
<td>GI Motility Lab</td>
<td>AHD</td>
<td>Endoscopy RAH (Sadowski)</td>
<td>Clinic RAH (Sadowski)</td>
<td>Reading Assignments</td>
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The GI resident will take call at UAH in accordance to the schedule created by the GI Chief Resident.

Rotation Specific Objectives

At the end of this rotation, the resident will be able to demonstrate the following outcomes:

Medical Expert
1) Application of basic science principles of neural and muscular control of motility of the upper and lower GI tract
2) Assessment and treatment of motility disorders including:
   i) Esophageal motility disorders including achalasia
   ii) GERD and refractory GERD
   iii) Non-cardiac chest pain
   iv) Gastroparesis
   v) GI dysmotility in the context of multisystem disease (scleroderma, diabetes)
vi) Constipation and laxative use
vii) Irritable bowel syndrome
viii) Fecal incontinence

4) Interpret esophageal motility studies to recognize common esophageal motility disorders
5) Interpret 24-hr pH and impedance studies in the context of clinical symptoms

**Communicator**

1) Provision of accurate and concise written or dictated consult reports to requesting health care provider
2) Establishment of trust and rapport with patients and families
3) Accurate elicitation and synthesis information from patients and families
4) Empathetic delivery of information to patients and families and encourages shared decision-making

**Collaborator**

1) Recognition of own limits of expertise with appropriate consultation from other health professionals
2) Recognition of the roles of allied health professionals in the motility lab, including nurse and technician

**Leader**

1) Appropriate selection of motility testing and 24-hr pH/impedance testing
2) Effective time management including patient care, learning needs, and personal activities

**Health Advocate**

1) Identification of determinants of health including barriers to access to care/resources which may impact patient outcomes

**Scholar**

1) Development and implementation of a personal learning plan
2) Demonstration of self-directed learning skills

**Professional**

1) Delivery of patient care with honesty, integrity, compassion, respect, and altruism
2) Appropriate interpersonal relationships with patients and members of the health care team
3) Application of ethical principles to patient care
4) Punctual attendance and prompt response to pages
The senior GI mentorship is offered to residents in the second year of training. This elective pairs the resident with Dr. R.J. Bailey, a senior gastroenterologist, in a mentoring relationship. It allows an experience in the role of a busy GI consultant. It serves as introductory training for advanced endoscopic procedures, which can be refined and consolidated during subsequent endoscopy fellowship. The recommended duration for this elective is 8 weeks.

`Rotation Specific Objectives`

**At the end of this rotation, the resident will be able to:**

**Medical Expert**

1) Complete an appropriate assessment of a gastrointestinal problem in the context of the patient with multi-system disease

2) Assess and treat ambulatory GI presentations including:
   - i) Chronic diarrhea and constipation
   - ii) Chronic abdominal pain
   - iii) Dysphagia
   - iv) Anemia
   - v) GERD
   - vi) Inflammatory bowel disease
   - vii) Celiac disease
   - viii) Complications of chronic liver disease
   - ix) Viral hepatitis
   - x) NALFD
   - xi) Hyperferritinemia
   - xii) Liver masses

3) Use preventive interventions appropriately, including:
   - i) Vaccination
   - ii) Hepatocellular carcinoma screening
   - iii) Barrett’s esophagus surveillance
   - iv) Colorectal cancer screening/surveillance

4) Demonstrate proficient endoscopic skills for management of ambulatory GI conditions including:
   - i) Gastroscopy
   - ii) Colonoscopy
   - iii) Polypectomy
   - iv) Stricture dilation
   - v) Banding of varices
Communicator
1) Provide accurate and concise written or dictated consult reports to a referring health care provider
2) Establish trust and rapport with patients and families
3) Accurately elicit and synthesize information from patients and families
4) Deliver information to patients and families with empathy, and encourage shared decision-making

Collaborator
1) Demonstrate a respectful attitude towards colleagues and other members of the health care team
2) Recognize the role of other health care providers in a multidisciplinary health care team

Leader
1) Demonstrate appropriate time management including patient care, learning needs, and personal activities
2) Select diagnostic imaging and endoscopic investigations in an appropriate and cost-effective manner
3) Identify the multiple roles of a community gastroenterologist
4) Describe basic principles of running a private practice office (finances, human resources)

Health Advocate
1) Identify determinants of health including barriers to access to care/resources
2) Identify distinct health care challenges of the inner-city population
3) Recognize the role of psychosocial factors in modifying a patient’s disease

Scholar
1) Critically appraise the medical evidence to answer a clinical question
2) Select appropriate teaching strategies to facilitate learning for patients and other members of the health care team

Professional
1) Deliver patient care with honesty, integrity, compassion, respect, and altruism
2) Demonstrate appropriate interpersonal relationships with patients and members of the health care team
3) Apply ethical principles to patient care
4) Demonstrate punctual attendance and prompt response to pages
GI ONCOLOGY ELECTIVE

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<th>Rotation</th>
<th>Preceptors</th>
<th>Contact</th>
<th>Initial Reporting</th>
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<tbody>
<tr>
<td>GI Oncology</td>
<td>Dr. Amelie Fontaine</td>
<td>Mary Burns (Med Oncology)</td>
<td>Mary will email your schedule the Friday before rotation start; meet with preceptor Monday AM as per her instructions</td>
</tr>
<tr>
<td></td>
<td>Dr. Clarence Wong</td>
<td>780-432-8513</td>
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Coordinated through Medical Oncology Residency Training Program Assistant, Mary Burns. Rotations should be confirmed at least 4 weeks prior to start of rotation. Residents need a short CCI orientation (for dictation code, which should take place on the first Monday of the rotation at noon).

Contact Info:
Dr. C. Wong's office (kelli.hucke@albertahealthservices.ca)
Medical oncology (via Dr. Amelie Fontaine)
RAH Tumor Rounds Schedule (via Dr. Bailey/Matic's office)

Rotation Description

The oncology elective is carried out at the Cross Cancer Institute and RAH. At CCI, comprehensive care is given to cancer patients from Northern Alberta. The oncology elective provides experience in the diagnosis and management of patients with common solid tumors arising from the gastrointestinal tract and in the management of GI complications arising in cancer patients. This includes pain control and the complications of radiation and chemotherapy. As well, the elective provides an opportunity to manage gastrointestinal consultations related to the care of oncology patients. This would cover specific issues in GI and non-GI cancers. The resident will gain experience in endoscopic techniques relevant to GI oncology, such endoluminal stent insertion, endoscopic ablation and argon plasma therapy for radiation induced bleeding. Through discussion, selective literature review, and experience with patients enrolled in clinical trials, the oncology elective provides an understanding of the scope and thrust of clinical research in gastrointestinal cancer.

The resident will typically divide their time between time with Dr. C. Wong and the CCI oncologists. The time with Dr. C. Wong will be divided between endoscopy, CCI clinic, and RAH clinic). The remainder of the time will be divided between the medical and radiation oncologists at CCI. If Dr. Wong is unavailable, free time will be replaced by CCI clinic, EUS observation or self-directed learning.

The resident is expected to attend GI tumor group rounds at CCI every Wednesday from 1600-1700h. The resident is expected to attend RAH HCC rounds, which occur twice monthly. Resident will check for RAH Tumor rounds schedule with Dr. Bailey/Matic's secretary at start of rotation.
The GI resident will take call at UAH in accordance to the schedule created by the GI Chief Resident.

**Rotation Specific Objectives**

**At the end of this rotation, the resident will be able to:**

**Medical Expert**
1) Complete an appropriate assessment of a gastrointestinal problem in the context of the patient with malignancy  
2) Recognize and manage gastrointestinal complications of chemotherapy and radiation  
3) Assess and develop a management plan for patients with gastrointestinal malignancies  
4) Describe appropriate indications, contraindications, and complications of endoscopy for diagnosis and management of GI malignancy including:  
   i) Endoscopic ultrasound/FNA  
   ii) Endoscopic ablation (PDT, RFA, EMR)  
   iii) Endoscopic stenting  
5) Describe the role of interventional radiology techniques for management of hepatocellular carcinoma  
6) Apply knowledge of the genetic basis of malignancy to determine the role for screening or genetic testing for family members of a patient with gastrointestinal malignancy

**Communicator**
1) Provide accurate and concise written or dictated consult reports to a referring health care provider  
2) Establish trust and rapport with patients and families  
3) Accurately elicit and synthesize information from patients and families  
4) Deliver information to patients and families with empathy, and encourage shared decision-making  
5) Discuss end of life care issues with patients and families in a compassionate, patient-centered manner

**Collaborator**
1) Demonstrate a respectful attitude towards colleagues and other members of the health care team  
2) Participate actively in multidisciplinary patient care

**Leader**
1) Demonstrate appropriate time management including patient care, learning needs, and personal activities  
2) Select diagnostic imaging and endoscopic investigations for screening, diagnosis, and surveillance, in a cost-effective manner  
3) Describe the role of prioritization of care and use of costly resources from the perspective of the patient and the health care system

**Health Advocate**
1) Identify determinants of health including barriers to access to care/resources
2) Identify methods to enhance patient compliance and improve patient outcome

**Scholar**
1) Apply current clinical trial evidence to the management of patients with gastrointestinal malignancy
2) Discuss areas of controversy in the management of patients with gastrointestinal malignancy

**Professional**
1) Deliver patient care with honesty, integrity, compassion, respect, and altruism
2) Demonstrate appropriate interpersonal relationships with patients and members of the health care team
3) Apply ethical principles to patient care
4) Demonstrate punctual attendance and prompt response to pages
IBD ELECTIVE ROTATION

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<th>Rotation</th>
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<tbody>
<tr>
<td>IBD Elective</td>
<td>Dr. Brendan Halloran</td>
<td>Leanne Bala 780-492-6941 <a href="mailto:halclin@ualberta.ca">halclin@ualberta.ca</a></td>
<td>Contact Leanne the week before rotation starts for direction on initial reporting</td>
</tr>
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Residents on this 4-week rotation will have a comprehensive experience with inflammatory bowel disease, including patient care, clinical trials, outpatient management with immunosuppressive and biologic therapy and endoscopic management. The resident will have an appreciation of the multidisciplinary care needed in caring this group of complex patients.

In order to maximize the educational benefit of this rotation, the GI resident needs to be proactive and take initiative to seek out clinical, research and educational opportunities.

**Clinic/Endoscopy** – Each week the resident will be assigned to an IBD physician and will be required to attend the clinic and endoscopy of this physician. Rotation schedule is available from Dr. Halloran’s administrative assistant (Leanne) 1 week prior to the start of the rotation. The resident is expected to update the IBD flow sheet and dictate the clinic/procedure notes for each patient.

**IBD In-patients** – When there are patients admitted under IBD physicians, the resident will round and write progress notes daily. Management plans should be reviewed with the staff regularly.

**IBD Consults** – The IBD service provides a consultation service to admitted IBD patients. All IBD consults must be seen within 24 hours and reviewed with their IBD physician or the physician assigned to IBD Consults.

**Self-directed learning** – The resident should capitalize on any free time during the rotation for self-directed study on IBD topics, especially IBD-specific radiology and pathology.

The GI resident will take call at UAH in accordance to the schedule created by the GI Chief Resident.

**Rotation-specific Objectives:**

**MEDICAL EXPERT:** The GI subspecialty resident will gain experience, understanding and knowledge in the management of complex IBD patient care, including diagnosis, advanced medical and endoscopic therapies and ongoing maintenance and support of chronic illness. The resident will recognize the indications and contraindications for complex medical therapeutic regimens and algorithms, including approved and research-related novel biologic therapy and will have direct experience in managing these therapies.
COMMUNICATOR: The resident will establish professional relationships with patients, their families and referring physicians. He/she will be able to discuss appropriate diagnostic and management information with these parties, and develop therapeutic relationships with patients and their families while providing a detailed consultation correspondence to the associated health care providers.

COLLABORATOR: Patients seen during this rotation are referred and frequently complex, and their effective care depend on effective collaboration between consultants, primary care provider, and other health care providers. The IBD clinic is a multi-professional clinic of specialized nurses and physicians. The resident will be exposed to the workings of this team and learn to communicate effectively with team members.

LEADER: In the setting of limited health resources, the resident will appreciate and manage the balance between the physician’s role as the patient’s advocate and as manager to optimize the use of limited health resources.

ADVOCATE: Many patients with IBD have psychosocial issues which may impact compliance and treatment adherence. Many effective medications are expensive, and frequently not covered by Alberta Blue Cross. The resident will be exposed to strategies and efforts needed to help these patients to focus positively on their health issues, while balancing other life challenges. Many of the staff members routinely act as patient advocates lobbying government to provide coverage of new and emerging medications. These issues will be highlighted during discussion of relevant cases.

SCHOLAR: The resident will complete a scholarly and/or research project in an aspect of IBD. To facilitate this objective, at least one ½ day is set aside per week for self-directed learning and research endeavors. Discussions between staff and resident will be centered around cases to highlight the relevant or controversial issues in current literature.

PROFESSIONAL: The resident will participate in regular discussions (case-based, journal club) with members of the IBD team in the lifelong pursuit of continuing medical education. If desired, the resident can benefit from ongoing mentorship in the development of an IBD-focused career.
Residents during their two core years of gastroenterology training are expected to participate in at least one scholarly project. This project can be either a research project or a quality improvement project. The project may be longitudinal and carried out throughout the two years of the core rotation or may be performed during a dedicated research rotation block. A variety of research projects are available to residents – a list of projects is available from Dr. Farhad Peerani. If a resident would prefer a quality improvement/assurance (QI/QA) project, they will be connected with Dr. Ali Kohansal (Quality Coordinator).

It is crucial that the resident begin to consider potential options early in the course of his training in order to ensure that the project is completed in a timely fashion. The resident is encouraged to meet with the supervisor well in advance of the actual rotation to facilitate planning and ensure that the project is ready to be started at the time of the rotation.

At the start of the GI Training program, residents will meet with Dr. Peerani, the Resident Research Director to discuss available projects in the Division, and selection of project.

Each resident will be assigned a 2-week research rotation, early in their R4 year to allow dedicated time to develop a research proposal and find a research mentor. At the end of this rotation, residents will be required to submit a brief proposal of their research and name of their research mentor to the Program Director and either the Resident Research Director or the Quality Coordinator (depending on the type of project).

Residents are also encouraged to explore research options in their meetings with their respective career advisor, who may facilitate contacts with potential research supervisors. Opportunity to present the research findings to other gastroenterology trainees nationally is provided at the GI Resident-in-Training Course (GRIT) held annually, annual Department of Medicine Research Day, and annual Division of Gastroenterology Research Day. It is expected that the resident will be the first author for any publications arising from projects on which the resident has had significant input.

The GI resident will take call at UAH in accordance to the schedule created by the GI Chief Resident.

**Rotation Specific Objectives**
**MEDICAL EXPERT:** The resident will develop an appreciation for the scientific method including hypothesis generation and testing, and statistical evaluation of results.

**COMMUNICATION:** The resident will develop skills in scientific communication by preparing the research proposal, abstract and eventual manuscript relating to the research project. The resident is expected to present the research proposal at Clinical Research Rounds, and if opportunity arises, the research findings at a scientific meeting.

**COLLABORATOR:** The resident will appreciate the importance and complexity of collaborations that are needed to conduct sound, successful clinical or scientific research.

**LEADER:** The resident will develop an appreciation in the administrative machinations needed for the conduct of scientific or clinical research. If applicable, the resident will be responsible for the ethics submission and overseeing the completion of the project.

**HEALTH ADVOCATE:** The resident will be aware of the various elements needed to ensure true informed consent by patients/subjects participating in health related research. The resident should be encouraged to develop the informed consent document to appreciate the various issues and factors that constitute a clear and concise consent form.

**SCHOLAR:** The resident will develop an appreciation for the breadth and scope of gastrointestinal research. He/she will appreciate the importance of asking relevant questions and framing them in a way that can be addressed by the scientific method. He/she will develop the skills of critical appraisal in reviewing new pieces of information published in the medical literature. He/she will develop experience in the preparation of an abstract and eventual manuscript resulting from the research findings.

**PROFESSIONAL:** The resident will develop the foundation and framework for further training if a career in research is planned.
RURAL COMMUNITY GI ELECTIVE (KELOWNA)

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<tr>
<td>Kelowna</td>
<td>Dr. Robert Penner</td>
<td>Dr. Robert Penner</td>
<td>Email Dr. Penner for instructions</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="mailto:rob@kelownagi.com">rob@kelownagi.com</a></td>
<td>for first day</td>
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The rural community gastroenterology elective is carried out in Kelowna, BC, supervised by the GI practice group, where GI consultation care is given to residents in the local and surrounding communities of BC Interior. This elective provides general gastroenterology experience in a rural community setting. It includes provision of GI consultation in ambulatory clinics and inpatient hospital settings, and the performance of endoscopic procedures in relation to these consultations.

*As this is an elective rotation, travel and accommodation are not reimbursed by the program.

Rotation Specific Objectives

MEDICAL EXPERT: The resident will encounter various gastrointestinal and liver diseases that can present in a mid-size rural community. The objectives for this role will be similar to that on the Consult Service (see above). He/she will acquire endoscopic skills in gastroscopy and colonoscopy. In selected residents, experience in ERCP may be possible.

COMMUNICATOR: Although there is a full complement of gastroenterologists in this practice, instances will arise whereby transfer to a quaternary care facility is needed. The resident will develop the verbal and written communication skills to affect such transfers.

COLLABORATOR: The resident will observe patterns of triage of referrals from primary care practitioners in a community setting. He/she will experience the type of collaboration between specialist and general practitioner in a rural community setting.

MANAGER: The resident will appreciate the differences in operation and management of an ambulatory clinic and endoscopy unit in a community setting. The resident will appreciate the differences in patient population and their management between quaternary care and community care in a smaller (but still tertiary) center. The resident will recognize when there is limitation in resources, and develop judgment for when transfer to a larger center is necessary for optimal patient care. He/she will understand how to arrange for such a transfer.

HEALTH ADVOCATE: The resident will recognize practice patterns compatible with provision of high-quality care to citizens of the community where GI consultation is provided by a single group of specialists. He/she will develop an appreciation of the health determinants that may influence patient adherence and outcome in a rural community.
SCHOLAR: The resident will understand the contribution of the consultant in the lifelong learning of the general practitioner and other health providers.

PROFESSIONAL: The resident will develop a strategy to maintain ongoing professional development in a rural (and potentially isolated) environment.
PATHOLOGY ROTATION

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<tbody>
<tr>
<td>Pathology</td>
<td>Dr. Safwat Girgis</td>
<td>Dr. Safwat Girgis</td>
<td>0800 Page Dr. Safwat Girgis</td>
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The resident should meet with the Program Director and tour the UAH Pathology Department and familiarize himself/herself with the general process and relevant personnel. The resident will participate in the daily interpretation of GI mucosal and liver biopsies including allografts, with the staff pathologist responsible. The daily work rounds are supplemented by didactic teaching sessions. The resident is also encouraged to use the available pathology resources for self-directed learning. Overall assessment is based on a pathology evaluation form.

The GI resident will take call at UAH in accordance to the schedule created by the GI Chief Resident.

**Rotation Specific Objectives:**

**MEDICAL EXPERT:** The resident will develop an understanding of the role and limitations of histologic diagnosis in the management of patients with gastrointestinal disease. He/she will be able to identify normal histologic structures in biopsies from the esophagus, stomach and proximal small bowel, colon, terminal ileum and liver. He/she will be expected to identify histologic features of common gastrointestinal conditions including (but not limited to): Candida, HSV, CMV; various types of gastritis, duodenitis and various small bowel disorders including Celiac disease, Whipple’s disease, MAI infection and inflammatory bowel disease; Helicobacter pylori, acute and chronic colitis, histologic features of inflammatory bowel disease in histologic and gross specimens, infectious colitis, various types of polypoid lesions arising from the hollow digestive organs, acute and chronic hepatitis, cirrhosis, HCC, alcoholic liver disease, hepatitis B and C, hepatic necrosis, Wilson’s disease, Hemochromatosis, alpha-1-antitrypsin deficiency and cholangitis. He/she will develop an understanding of the role of ancillary techniques such as molecular histological methods.

**COMMUNICATOR/COLLABORATOR:** The resident will gain a genuine appreciation for the role of the pathologist and the need for appropriate communication of clinical information for the benefit of the patient.

**MANAGER:** In the era of cost constraints, the resident will develop an understanding of the challenges of limited laboratory resources and potential impact on patient care. He/she will develop an appreciation of the triage of specimen processing and reporting needed to ensure optimal use of a limited resource.
HEALTH ADVOCATE: The resident will develop an understanding for the role that gastroenterologists may need to play in order to ensure timely interpretation of pathology specimen to ensure optimal patient care.

SCHOLAR: The resident is expected to take advantage of any “downtime” for self-directed learning. This is facilitated by a number of educational resources. A copy of a GI Histology textbook is also available in the GI Resident office.

Additional resources include:

- Lewin's Gastrointestinal pathology and its clinical implications, 2nd ed. (Available Online in the UofA Library)
- Teaching slide sets
PEDIATRIC GASTROENTEROLOGY ELECTIVE

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<tbody>
<tr>
<td>Pediatric GI</td>
<td>Dr. Jason Silverman</td>
<td>Paulette Gunderson (MEPA)</td>
<td>Check with Paulette 1 week prior to rotation for reporting instructions and schedule</td>
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Pediatric GI provides both an outpatient and inpatient consultation service. The Adult GI resident will be expected to participate primarily in the care of Pediatric GI ambulatory consultation with the availability of daily clinics. The consultation service is broad-based with GI, nutritional and Hepatology consults. The objectives outlined below represent topics that should be covered and discussed in the context of pathophysiology, clinical presentation and management. Many of the conditions are similar to adult gastroenterology, but the presentation, management and natural history may vary in pediatrics.

The goal of this limited rotation is **NOT** proficiency in Pediatric Gastroenterology but to understand the conditions unique to pediatrics, pediatric diseases which will impact adult life, and the similarities and differences in disorders found in both pediatrics and adult gastroenterology. The use of medications, radiological, and endoscopic investigations in children will be discussed.

The GI resident will take call at UAH in accordance to the schedule created by the GI Chief Resident.

**Rotation Specific Objectives**

**MEDICAL EXPERT:** The resident will have the opportunity to delineate pediatric issues, differential diagnosis and management when seeing consults. GI residents may have the opportunity to perform pediatric endoscopy during the regularly scheduled Monday and Friday endoscopy schedule.

**COMMUNICATOR:** The resident will be exposed to the challenges and differences in communication technique and style with the pediatric patient and parents. The resident is expected to dictate consultation letters within 48 hours and submitted to the Pediatric GI secretary for transcription.

**COLLABORATOR:** The resident will be exposed to the multidisciplinary care of the pediatric patient. If possible, the resident will attend the Transition Clinic to gain an appreciation of the various factors involved in transition of care from pediatric to adult practitioners.

**MANAGER:** The resident will be exposed to the different issues which may arise when caring for pediatric patients. He/she will be introduced to resources available to aid in the care of patients below the age of consent.
HEALTH ADVOCATE: Many of the patients encountered have chronic medical conditions developed at a very young age, which may contribute to different behavioral patterns. The resident will gain an understanding of the various determinants which may differ from those of adult patients, which contribute to patient adherence and outcome.

SCHOLAR: Consults provide the opportunity to delineate pediatric issues, differential diagnosis and management. The topics outlined below should be reviewed midway through the rotation. Twice weekly informal teaching is arranged and scheduling dependent on the staff person on service. If any of the below stated topics are not discussed in the clinical setting, they should be covered during the informal sessions.

*Luminal Diseases*

- Embryology: Congenital malformations of the gut, including:
  - Malrotation
  - Omphalocele
  - Gastrochisis
  - Tracheoesophageal fistula
  - Hirschsprung’s
  - Atresia
- Oral/Esophageal:
  - Feeding difficulties
  - GERD in infants and children
  - Dysphagia
- Stomach:
  - Peptic ulcer disease
  - Upper GI bleed
  - Dysphagia
- Small intestine:
  - Malabsorption syndromes
  - Celiac disease
  - Secretory diarrhea
  - Crohn’s disease
  - Short gut syndrome and TPN
- Colon:
  - Colitis: infectious, ulcerative, Crohn’s
  - Lower GI bleed
  - Polyposis
- Functional:
  - Recurrent abdominal pain of childhood
  - Toddler’s diarrhea
  - Constipation
  - Encopresis

*Pancreatic Diseases*

- Pancreatic insufficiency
• Cystic fibrosis
• Schwachman’s syndrome
• Pancreatitis

Liver Diseases

Recognize presentations, appropriate investigations and differential diagnosis and implications for management as adult patient.
• Unconjugated and Conjugated hyperbilirubinemia
• Viral hepatitis
• Congenital anomalies: choledochal cysts, cystic disease, congenital hepatic fibrosis
• Neoplasms
• Inborn errors of metabolism
• Liver transplantation

Nutrition

Understand normal infant and child nutrition and the changes with the growing child, therefore being able to discern abnormal nutritional habits and inappropriate growth and development.

PROFESSIONAL: The resident will develop an understanding of the professional obligations to the patient and parents when caring of patients below the age of consent compared to adult patients.
POLICY SECTION

On Call

GI residents will be expected to take night and weekend call in accordance with PARA guidelines. The call is from home, and expected not to exceed more than 1 in 4. For the month prior to the General IM Royal College written and oral exams, the resident is exempt from weekend call. The 26-hour rule is adhered to, and GI residents are not expected to return on site for more than 1 hour after midnight of the call shift. Staff is to be contacted by the GI resident if attendance at the hospital is needed (e.g. in-person assessment of a severely ill patient or need for urgent endoscopic procedure). It is crucial that the on call team maintain open lines of communication to maximize resources and most efficiently solve and manage clinical problems. Thus the correct attending staff for each patient should be notified in a timely manner for each case.

Weekend call begins at 5pm on Friday and ends on Sunday at 5pm. In addition, there are 5 evening calls (Sunday – Thursday) for evening call coverage. Residents on weekend and Sunday night call should attend Monday Hand-over.

During the weekday working hours, there are several GI services on call for the division:
**Consult Service 1:** Inpatient consultations (including Critical Care)
**Consult Service 2:** Emergency Room & Urgent Outpatient consultations
**Inpatient Service 1:** GI ward patients (Accepts admissions Mondays, Wednesdays and Fridays; weekend admissions are divided between the 2 wards)
**Inpatient Service 2:** GI ward patients (Accepts admissions Tuesdays and Thursdays; weekend admissions are divided between the 2 wards)
**Transplant Hepatology:** Hepatology is responsible for seeing all transplant-related patients. Other hepatology consults should be seen by the GI consultation service, with assistance from the Hepatologist on call as required for complex patients.
**ERCP/Advanced Therapeutics:** ERCP, EUS, and small bowel endoscopy consultations and procedures. Request and consult for ERCP, EUS, and small bowel endoscopy procedures need to be vetted first by the Consult Service, which will then contact the ERCP/Advanced Therapeutics staff
**Inflammatory Bowel Disease:** IBD-related consults should be seen by the primary GI consult/ward service. The IBD group will provide 2ndary consultations (within 2 working days) for complex IBD patients only.

The operators will be instructed to direct calls from the emergency department and inpatient services to the GI resident. Calls from outside referring doctors will be directed to the GI staff of the appropriate service. This allows efficient assessment and triage of patients in the emergency room while under supervision by GI attending staff. The attending ward physician should be called between 8:00 a.m. and 5:00 p.m. for admissions to the GI ward.

Between 5:00 p.m. and 8:00 a.m., the on-call physician should be notified by telephone of any patients being admitted and their management discussed. During the week, the on-call team (Core IM and GI resident), and the accepting services (respective Ward and Consult
services) meet for Morning Sign-over to ensure continuity of care. During the weekend, all admissions are admitted to the Staff on call, who will distribute these admissions equitably to Ward 1 and Ward 2 throughout the weekend during Monday Morning Sign-over at 7:30 am. Over the course of the subspecialty training, residents will be given graduated responsibility towards developing into a specialist consultant. GI resident with off-site clinical duties on Monday will delegate sign over duties to on-call GIM resident and/or staff, and be exempt from attendance at sign over rounds. All morning sign over takes place in the 2nd floor Zeidler Conference Room (2-10).

Guidelines for Resident Travel

Conferences allowed per Academic Year:

- Canadian Association of Gastroenterology/ GI Resident In-Training (CAG/GRIT) course (contingent on acceptance of abstract to GRIT)
- CDDW/CASL Meeting (contingent on acceptance of abstract to main meeting)
- One other international meeting, subject to Program Director's approval. Funding for second year residents is contingent on acceptance of abstract)
- Approved international conferences includes DDW, ACG Annual Meeting, The Liver Meeting
- National/Regional conferences of sound academic value, subject to Program Directors’ approval. In case of limited attendance allowance, selection will be made by Program Director based on career goals, equity and fairness. Random draw will be used in case of stalemate.

In general, residents will be responsible to provide coverage weekend call at UAH. This means that not all residents will be able to attend the same meeting. An exception to this rule, is GRIT/CDDW – ALL residents are encouraged to submit abstracts and will be excused from call requirements at UAH, provided they have an abstract accepted.

Funding per resident per academic year is currently set at $2500/year (this includes $650 from the Department of Medicine). The amount is subject to annual review by the RPC based on available funding resources. The annual allowance must be used by the end of the academic year, and unused amount cannot be carried forward. Written request for conference leave and reimbursement is mandatory. Residents are encouraged to approach the research supervisor for partial or complete funding support.

General Principles

- Approval for all meetings must be submitted prior to abstract submission. Official form must be submitted in writing at least 2 months before conference date.
- Meetings funded by industry (with no prior approval by RTC or program director) are not permitted, as per Royal College Training guidelines.
- Request for reimbursement must be accompanied by original receipts. Residents are to refer to the Department of Medicine travel reimbursement guidelines. Funding will
not be approved retroactively. Requests for reimbursement must be received within 30 days of the end of the leave.

Leave

As per the PARA agreement, residents are entitled to up to four weeks paid leave (inclusive of weekends). Residents are strongly encouraged to plan their vacation well in advance so that rotation schedules can be drawn up in a timely fashion. Requests for holidays should be made in writing to the Program Director at least three months in advance. Residents are free to elect to take holidays at any time during their two core years of training, but need to participate in call coverage for at least 5 days during Christmas/New Year period. As per the PARA agreement, residents may choose a different 5-days off in lieu of Christmas/New Years (see PARA agreement for details).

Hospital Issues

*Identification tags* – All residents are required to wear a valid hospital photo ID tag while in the hospital. This tag allows entry into the hospital after hours.

*Pager* - A pager will be provided by Alberta Health Services and must be returned at the end of training.

*Parking Pass* - A parking pass for reciprocal resident parking privileges at all other city hospitals is available for purchase. Evening/weekend access to underground parking at UAH is available to those with hospital parking – request form from the MEPC.

*Dictation Number* - Residents are expected to dictate endoscopy reports and discharge summaries. Consult notes can also be dictated at certain AHS sites, but residents should check with the consult staff regarding their preference. A dictation number must be obtained through medical records and orientation to the medical records dictating system will be provided as part of PGME orientation.

*Library and photocopy privileges* – Upon registration with PGME, each resident will be issued a university username which allows online and site access to all library resources. Photocopiers are available in GI divisional offices. A special code is set up for training program use.

Role of the Chief Resident

- To assist the Program Director in ensuring the well-being of all residents and fellows in the program.
- To assume responsibility for creating and distributing a monthly call schedule. The call schedule should be prior approved with the Program Director, and distributed at least 2 weeks before implementation.
• To assist the Program Director in other administrative responsibilities.
• To spearhead a “Chief Resident Project” which is intended to enrich the training program for future trainees. Selection of project will be made jointly by the Program Director and the chief resident(s).

Promotion, Probation, Termination, Certificate of Training and Appeals

Promotion, probation, termination and certification are provided by the Associate Dean for Post Graduate Medical Education upon written recommendation by the GI Program Director. Certificate of satisfactory performance is issued at the end of the training period on the written recommendation of the GI Training Program Director and the Residency Program Committee.

It is anticipated that the vast majority of residents in the GI Training Program will satisfactorily meet the objectives set out by the Program. However, in the case of a failure to meet Program objectives, the deficiency requiring remediation will be communicated to the resident both verbally by the Program Director and in writing. All trainees have the right of appeal against written evaluations of performance. The first line of appeal is to the GI Program Director and to the Residency Program Committee. Beyond this, the Division or Department Chair is the next level. A formal appeal may also be launched through the Associate Dean Post Graduate Medical Education through an Appeals Committee.

In circumstances where there are multiple deficiencies in the resident’s performance, a remedial program may be initiated. The length of the remedial process shall be approximately equal to the time on the rotation that was deemed to be unsatisfactory. The remedial process will be designed and implemented by the Residency Program Committee. A written contract outlining the details of remediation plan will be co-signed by the resident and program director. A mentor will be appointed to directly supervise the process and ensure that the training objectives are met, and remediation is successful.

Examinations of the Royal College of Physicians and Surgeons

Residents who enter the GI program after three years of internal medicine are currently required to sit the written and oral portion of the Fellowship exam in Internal Medicine during the first core year of gastroenterology (this is expected to change in 2019). Assistance in preparing for the written portion of the Royal College exam is available through the Department of Internal Medicine and includes practice questions, study groups and exam counseling. Preparation for the oral exam in internal medicine is available through bedside clinical examinations provided by members of the Department of Medicine. Residents are expected to participate in the approved 4:30pm exam prep sessions and are excuses from clinical duties. Residents should clearly communicate their plans to attend to their attending physician.
The Subspecialty examination in Gastroenterology is a written and oral examination, that usually takes place in the fall after completion of the 2-year program. The written exam consists of two papers of short answer questions relevant to gastrointestinal disease. The oral exam consists of a pre-determined number of OSCE stations. Please refer to the Royal College website for the most current information.

Career Advisor Program

Objective
To foster successful career development of the Gastroenterology resident, a one-on-one mentor will be assigned to each resident in the program. It is imperative that the resident be pro-active in meeting with their mentor, throughout their GI training.

Role of the Mentor

- To provide advice and guidance to the resident with respect to career development and planning (including planning for PGY6 – Appendix F)
- To apprise the resident of available Divisional and national resources which will help in the resident’s career development
- To meet on a regular basis with the resident to ensure satisfactory progress in the resident’s career development (see Career Development Progress Grid in Appendix E)
- To apprise (in writing) the Program Director of the resident progress on a regular basis (by filling out Career Development Progress Report)
- To apprise the Program Director of any issues in the resident’s career development or well-being

Career Development Progress Grid

- To serve as a reminder for key time-sensitive landmarks to be covered during meeting
- Serves only as a guide. Mentor and resident should be encouraged to cover other relevant issues as they arise
- For quality assurance, and to ensure that career development of residents is on track, progress reports need to be signed and returned to Program Director after each meeting.

PGME POLICIES

The Postgraduate Medical Education Office has a number of policies relating to postgraduate medical education at the University of Alberta. This includes policies about Academic Appeals, Assessment Guideline, Leave of Absence (including vacation, sick leaves, etc.), Remediation, Safety and Supervision. The policies can be found online at: https://www.ualberta.ca/medicine/programs/residency/policies
Residents should be familiar with these policies and should refer to this website for up to date information.
APPENDICES

APPENDIX A: CanMEDS FRAMEWORK

The CanMEDS Framework is available on the Royal College of Physicians and Surgeons of Canada website: http://www.royalcollege.ca/rcsite/canmeds/canmeds-framework-e
APPENDIX B: GUIDELINES FOR GI RESIDENTS: NIGHTTIME/WEEKEND CALL

The objective of Resident involvement in the call process is to develop skill in the efficient assessment and triage of patients in the Emergency Room and consultations on patients admitted to hospital, include the intensive care units, while under supervision by GI attending staff. GI call for subspecialty residents is home call and thus assessment will often occur over the phone by communicating with a junior in-house resident. In situations of diagnostic or therapeutic uncertainty, patients may require direct assessment by the resident in person. (MEDICAL EXPERT, COMMUNICATOR, COLLABORATOR, MANAGER, SCHOLAR, PROFESSIONAL)

Attending staff on-call remains available for advice either by phone or in person. Attending staff needs to be informed of every patient who has been seen or assessed by the subspecialty resident. The timing of this notification depends on the resident’s stage of training, and subject to the judgment of the resident. Graduated responsibility applies as the resident’s knowledge and skills mature. Routine and uncomplicated consultations can usually be discussed with staff early on the next working day.

Attending staff should be informed in a timely fashion in the following circumstances:

1. Patients who require urgent after-hours endoscopy. This will usually follow a direct assessment by the GI resident or staff (if after midnight).
2. Patients who have been assessed directly by the GI subspecialty resident who have complex management and triage issues, which the resident does not feel capable of handling without further advice.
3. Seriously ill patients.

Several things to note:

1. Patients seen in consult by the in-house resident, who are being discharged from the Emergency Room after discussion with the GI subspecialty resident, need to have a satisfactory follow-up plan in place. This must be discussed with attending staff prior to discharge. Residents are encouraged to book these patients into their longitudinal clinic (whenever possible).
2. The GI subspecialty resident should not be functioning simply as a conduit of information between the in-house junior resident and the GI staff. If the GI Resident is not certain about appropriate course of management, the patient will need to be assessed by the GI Resident in person before contacting the staff person. GI residents are encouraged to review the cases in Alberta NetCare to assist in their assessment and management.
3. Sign-over of GI admissions and consults will occur at morning rounds the following morning (or Monday after weekend call).
4. Between 5 p.m. Friday and 8 a.m. Monday, patients will be admitted under the attending staff on weekend call. The weekend on-call GI Resident will be expected to follow these admitted patients to ensure continuity of care until transfer of care to the Ward Attending Physician occurs (either during the weekend or at Monday Sign-over rounds).
5. After-hours consultations from in-patient services: the junior residents should discuss these referrals with the GI Resident on call, prior to assessment to determine the urgency of the consult and to determine if this patient should be seen after-hours.
APPENDIX C: DIVISION OF GI LEAVE REQUEST FORM

I, ___________________________________ HEREBY APPLY FOR LEAVE FROM MY DUTIES IN THE DIVISION OF GASTROENTEROLOGY.

I WILL BE ON __________________ SERVICE WITH __________________

(ROTATION) (STAFF MEMBER)

☐ STAFF MEMBER NOTIFIED

REASON FOR LEAVE:

____________________________________________________________________________________________________________________________________________________

☐ CONFERENCE LEAVE ☐ HOLIDAY / VACATION LEAVE ☐ LEAVE OF ABSENCE

TRAVEL REIMBURSEMENT REQUESTED YES ☐ NO ☐

ESTIMATED TRAVEL EXPENSES ________________________________________________

______________________________________________ TO: ___________________________________________________

FIRST DAY OF LEAVE ___________________ FINAL DAY OF LEAVE ___________________

_________________________________________ APPLICANT'S SIGNATURE

APPROVED BY: ________________________________ GI RESIDENCY PROGRAM DIRECTOR or DIVISIONAL DIRECTOR

RETURN TO: MEPC - GI RESIDENCY TRAINING PROGRAM
Zeidler Ledcor Centre
PH: 492-8243 / FAX: 492-1455
**APPENDIX D: MISCELLANEOUS INFORMATION**

1. **PROVINCIAL ASSOCIATION OF RESIDENTS OF ALBERTA (PARA)**

The Provincial Association of Residents of Alberta (PARA) and its parent body, the Canadian Association of Residents (CAR), are the provincial and national organizations, respectively, of residents. All residents are members. These organizations have an interest in all matters of concern to interns and residents.

Non-academic matters such as remuneration, vacations, on call schedules, on call facilities, work environment, health care, dental care, disability insurance, and many other issues are directly the concern of these organizations. Agreements are negotiated (annually) between PARA and the Council (Council of Academic Health Centres of Alberta). Only non-academic issues can be negotiated. PARA does not directly involve itself in academic issues.

2. **LIBRARY AND PHOTOCOPY PRIVILEGES**

The UofA medical school library (John Scott Library) is located adjacent to the University of Alberta Hospital. A good representation of subspecialty journals and textbooks is available. Photocopiers in the Library accept either coins or the University “One Card”. In addition, the Library offers Internet access to the Medline databases. This database can also be accessed online from any computer using the University CCID. Hard copies and CD’s of major textbooks are available for communal use in the GI Resident library.

3. **GI RESIDENT WORKSPACE**

The GI Resident Workspace is located on 3rd Floor Zeidler Ledcor Centre (3-12). This workspace can be accessed with a numerical code. This code will be provided to you by the MEPC, and changed at regular intervals to increase security. This code should be kept confidential for security reasons. Each resident is assigned an individual workspace and computer with internet connection. A locked drawer is supplied for storage of resident’s own laptop and other personal supplies. A printer is available for communal use in the GI Resident office. A fax machine is available for use in the MEPC Office upon request.

4. **RESIDENT WELL-BEING COMMITTEE**

The Faculty of Medicine has created a Resident Well-Being Committee to recognize the existence of personal stress amongst house staff. It has a general role of monitoring levels of impairment and stress amongst house staff throughout the Faculty. It intends to develop means of prevention and it offers informal counselling and trouble-shooting for individuals or programs that are requesting help. It ensures that impaired or potentially impaired individuals are offered access to treatment in absolute confidentiality. The Committee is composed of various staff physicians and representatives of PARA. Residents are encouraged to make contact with the committee for help and can do so through their
resident representatives, the program director or directly.

5. **LEARNER ADVOCACY AND WELLNESS (LAW) OFFICE**

Support for residents with any type of concern is available through the LAW Office. For more information on services offered and how to access this resource, please refer to their website: [https://www.med.ualberta.ca/programs/support-wellness/postgraduate](https://www.med.ualberta.ca/programs/support-wellness/postgraduate).

6. **THE PULSE GENERATOR (FITNESS CENTRE-UH)**

The Pulse Generator is the UAH Recreation and Fitness Centre. Located in the basement of the hospital, the Centre has two training rooms, one of which has an assortment of free weights as well as computerized bicycles, rowing machines, and stair climbers, while the other training room houses universal machines, exercise bikes, and steps. The Pulse Generator also has squash and racquetball courts, and a gymnasium where staff may drop in to play volleyball, basketball, or badminton.

The Pulse Generator offers a variety of programs that are available to both members and non-members of the Centre. Programs include various aerobics and stretch 'n' tone classes, weight training and squash lessons. The Centre also conducts fitness appraisals and assists members in establishing personalized training programs.

All UAH employees, including residents, are eligible to purchase memberships to the Pulse Generator. Memberships are available on a payroll deduction plan per month, which includes complete use of the facilities, equipment, and towel service. More information on the Pulse Generator or any of its programs or services is available at the Centre, located at PJ2.00 ([http://www.pulsegenerator.ca/university-of-alberta-hospital.html](http://www.pulsegenerator.ca/university-of-alberta-hospital.html)).

7. **CANADIAN MEDICAL PROTECTIVE ASSOCIATION (CMPA)**

The possibility of litigation over patient management lingers over all physicians throughout their medical careers. Although each hospital provides legal coverage for its resident staff, the Professional Association of Interns and Residents of Alberta asks all its members to obtain liability insurance from the Canadian Medical Protective Association. CMPA, founded by the Canadian Medical Association, is a non-profit organization whose sole aim is to provide its members with legal counsel, at no additional cost, in case of litigation involving medical management of a patient. It is the only such organization operated by physicians for physicians. As such, it is free of any conflict of interest in a legal case. The University of Alberta requires all residents to have a CMPA membership before they can partake in their residency. CMPA dues are the responsibility of the residents; the University will not reimburse this cost. The address is: Canadian Medical Protective Association, P.O. Box 8225, Station T, Ottawa, CANADA K1G 3H7 (phone: 1-800-267-6522, fax: 613-725-1300).

8. **ADVANCED CARDIAC LIFE SUPPORT (ACLS) AND ADVANCED TRAUMA LIFE SUPPORT (ATLS)**
The majority residents commence their training having already achieved their qualification in ACLS. Those who have not are expected to do so.
APPENDIX E: CAREER ADVISOR PROGRAM

RESIDENT CAREER DEVELOPMENT PROGRAM

Background

To foster successful career development of the Gastroenterology Resident, a one-on-one advisor will be assigned to each resident in the program. We are optimistic that this relationship will develop over time into a mentorship-type relationship, but you may also identify other attending physicians that will also mentor/guide you. We have developed this Career Advisor program to assist you in your career development that extends beyond your GI residency.

Role of the Advisor

- To provide advice, guidance, and support to the resident with respect to career development and planning
- To apprise the resident of available Divisional and national resources which will help in the resident’s career development
- To meet on a regular basis with the resident to ensure satisfactory progress in the resident’s career development (see Career Development Progress Grid below)
- To apprise (in writing) the Program Director of the resident progress on a regular basis (by filling out Career Development Progress Report)
- To apprise the Program Director of any issues in the resident’s career development or well-being

Career Development Progress Grid

- To serves as a reminder for key time-sensitive landmarks to be covered during meeting
- Serves only as a guide. Advisor and resident should be encouraged to cover other relevant issues as they arise
- For quality assurance, and to ensure that career development of residents are on track, progress reports need to be signed and returned to Program Director after each meeting

We recommend that at the end of each meeting, the resident and advisor chose the date/time of their next meeting. This is helpful to keep on track with the Advisor Program.
CAREER DEVELOPMENT PROGRESS GRID

### June, Year 1

- Program director, in consultation with Divisional Director and resident, selects a mentor for each resident.

### July, Year 1

- **Advisor arranges for first meeting with resident:**
  - Meet & greet – share stories
  - Discusses possible career paths and training goals
  - Set date for 2nd meeting in August

**Discussions:**

**Plans:**

<table>
<thead>
<tr>
<th>Meeting Date</th>
<th>Mentor</th>
<th>Resident</th>
</tr>
</thead>
</table>

Date of next meeting: ________________
August, Year 1

- Advisor checks in with resident:
  - Wellness
    - Assess resident support system (family, friends, etc.)
  - Skill development/progress of training
  - Career plan
- Review post-GI residency options – R6 and beyond – See Appendix F
  - If planning international fellowship for R6 – time to explore options/application deadlines
  - If planning for CIP year (between R4 & R5) – application is due in September
- Ensures resident is linked with a project supervisor for CDDW submission
- Set date for 3rd meeting – September/October

Discussions:

Plans:

<table>
<thead>
<tr>
<th>Meeting Date</th>
<th>Mentor</th>
<th>Resident</th>
</tr>
</thead>
</table>

Date of next meeting: ________________
September/October, Year 1

- Advisor checks in with resident:
  - Wellness
  - Skill development/progress of training
  - Career plan
- Ensures that a draft proposal of the planned scientific abstract submission to the CAG/CDDW meeting is reviewed by preceptor/RPC/PD for October deadline
- Discusses potential plans for third year +/- selection of a research supervisor for year 2/3
  - Be cognizant of deadlines for applications/funding
- Set date for next meeting in January

Discussions:

Plans:

__________________________

Meeting Date  Mentor  Resident

Date of next meeting: ________________
### January, Year 1

- Advisor checks in with resident:
  - Wellness
  - Skill development/progress of training
  - Career plan
- Preparation for Internal Medicine Royal College Exam (if applicable)
- Checks progress on decision re: Year 2/3 research mentor(s) and project proposal
- Set date for next meeting in May/June

#### Discussions:

#### Plans:

<table>
<thead>
<tr>
<th>Meeting Date</th>
<th>Mentor</th>
<th>Resident</th>
</tr>
</thead>
</table>

Date of next meeting: ________________
May/June, Year 1

- Advisor checks in with resident:
  - Wellness
  - Skill development/progress of training
    - Does the schedule for R5 meet their training goals?
  - Career plan
    - Ensure residents have a plan for next year
    - Ensure applications for R6 year are in progress
      - Fellowships, funding, jobs
      - Residents should link with a research mentor if planning a research year
- Checks progress re: completion of background literature review of the year 2/3 research proposal, goals towards submission for publication in a peer-reviewed journal
- Advises resident on follow-up with research mentor
- Set date for next meeting in July/August

Discussions:

Plans:

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Meeting Date ____________________________ Mentor ____________________________ Resident ____________________________

Date of next meeting: ____________________________

Revised June 2017
July/August, Year 2

- Advisor checks in with resident:
  - Wellness
  - Skill development/progress of training
  - Career plan
- Research Progress
  - Ensures that a draft proposal of the planned scientific abstract submission to the CAG/CDDW meeting is reviewed by preceptor/RPC/PD for October deadline
  - Is this project appropriate for submission to an International meeting?
- Set date for next meeting in September

Discussions:

Plans:

Meeting Date ____________________________________________
Mentor ____________________________________________
Resident ____________________________________________

Date of next meeting: ________________________________
September, Year 2

- Advisor checks in with resident:
  - Wellness
  - Skill development/progress of training
  - Career plan
    - Ensure residents have a plan for next year
    - Ensure applications for R6 year are in progress
      - Fellowships, funding, jobs
      - CIP, CAG, CASL deadlines are imminent
- Advises resident on follow-up with research mentor
- Set date for next meeting in January

Discussions:

Plans:

Meeting Date ____________________________ Mentor ____________________________ Resident ____________________________

Date of next meeting: _________________
January, Year 2

- Advisor checks in with resident:
  - Wellness
  - Skill development/progress of training
  - Career plan
    - Resident planning 3rd year in research:
      - Ensures progress in planning for proposed training
    - Resident planning 3rd year in clinical training:
      - Ensures progress in planning for proposed training
    - Resident planning to enter clinical practice directly
      - Ensures progress of clinical training and well being
      - Ensures progress of job-hunt
- Advise on process of getting locum work
  - Approach leaders about potential opportunities
  - Allow adequate time for license, privileges, etc.
- Set date for next meeting for Spring

Discussions:

Plans:

Meeting Date ____________________________ Mentor ____________________________ Resident ____________________________

Date of next meeting: ____________________________
Spring, Year 2

- Advisor checks in with resident:
  - Wellness
  - Skill development/progress of training
  - Career plan
    - Resident planning 3rd year in research:
      - Ensures progress in planning for proposed training
    - Resident planning 3rd year in clinical training:
      - Ensures progress in planning for proposed training
    - Resident planning to enter clinical practice directly
      - Ensures progress of clinical training and well being
      - Ensures progress of job-hunt; discuss alternatives if unsuccessful
- Set date of further meetings, as required

Discussions:

Plans:

Meeting Date ____________________________
Mentor ____________________________
Resident ____________________________
APENDIX F. PLANNING FOR PGY6 & Beyond

Options:

- Resident planning 3rd year in clinical or research/education fellowship:
  - International deadlines for application – usually 1.5-2 years prior to start date
    - If there is a break between the end of GI residency and fellowship, you should consider keeping/developing your clinical skills with locum work (week/weekends/endoscopy)*
  - Canadian deadlines for application – usually 1 year prior to start date
  - For research/education – carefully consider if you want to get a Master's degree or CIP certificate – this will add to your CV
  - Funding options (depends on type of fellowship):
    - CAG/CASL/AIHS – check websites for deadlines
    - Sponsored by Institution of Study (may be industry-funded)
    - Clinical Investigator Program (CIP)
    - Self-funded – FFS work*
    - Other

Note: if you are planning a research-only fellowship – it is important to maintain your clinical skills – you should continue to work part-time

*If you are planning to do FFS work, you will need to get a license and hospital privileges – start this process early.

- Resident planning to enter clinical practice directly
  - Advises on modification of training based on intended job
    - Consider delaying start date until after GI Royal College Exam
  - Advises on job availability and networking contacts
  - Advises on pearls on “landing a job”
Critical Path to Successful Research Funding of the Gastroenterology Fellowship [PGY6/7]

WHILE IN YOUR GASTROENTEROLOGY RESIDENCY YEAR 1 [PGY 4]

July – Begin your Gastroenterology Residency

August/September - Find a supervisor and research project that will allow you to submit an abstract for CDDW. An accepted abstract is mandatory for you to attend the CDDW and the GRIT Course.

October - Complete and submit your CDDW abstract; ensure reviewed by research preceptor, RPC, PD prior. You need a letter from the PD to accompany your application to GRIT.

November – If your project is robust enough, talk to your supervisor about submission as an abstract to DDW. Complete the manuscript relative to your CDDW project.

December – Complete and submit your DDW abstract

January – Ensure deadlines for International Fellowships are met.

February-April - Study for and write your Internal Medicine Royal College Exam

May/June – Recover from writing your IM exam – take some time for yourself. Now is the time to decide what you want to do after your R5 year (see options in Appendix F). It is important that you have identified a supervisor for a research fellowship, if you are planning on this. Work with your supervisor to determine the exact structure, boundaries and objectives for your Gastroenterology Fellowship (R6) year. This will define the project proposal you write and any plans for advanced education outside of Edmonton. Discuss what happens if you’re not funded through any of the standard grants you are applying for.

WHILE IN YOUR GASTROENTEROLOGY RESIDENCY YEAR 2 [PGY 5]

July – Secure most up to date funding application and begin writing the project proposal with your supervisor.

August – Funding application completed and project proposal being edited and fine-tuned.

September - Application for appropriate grant for either a postdoctoral or Master’s program through one of the above funding agencies should be completed and ready for submission. Decide if you are going to enter the: (1) Clinician Investigator Program, (2) Master’s Program in the Department of Medicine, (3) Master’s Program in Public Health Sciences, (4) Fellowship Program without a thesis.

October – Submit your grant application and proposal for funding. Beware of the deadlines
September/October - Clinician Investigators Program – see website for details

- DEADLINES FOR APPLICATION (dates subject to change):
  o September 30th – Intent to Conduct Research (signed by Residency Program Director)
  o October 30th – Formal Application

Details on applying to the CIP are available at:
https://www.med.ualberta.ca/programs/residency/postgraduateprograms/listing/clinician-investigator-program/apply

December/January – Grad Studies - Master’s Program

- Students must complete an online application to apply. UofA Residents must submit a letter of support from their program director.
- Deadlines for Canadian students are April 1st for spring semester, August 1st for fall semester; International student deadlines are earlier.

Details on applying to graduate studies are available at:
https://www.ualberta.ca/department-of-medicine/education/graduate-studies

January/February – Look into locum opportunities to: 1) bridge to fellowship training, 2) bridge to permanent staff position, 3) fund/supplement funding for fellowship. Apply for license, CPSA coverage, hospital privileges, etc.

March – Apply for Alberta Innovates Health Solutions (AIHS) Funding. Use the same proposal as you did for the other grants. Note that the application form is different. Apply even if you are successful at the other grants as it will provide you additional salary support.

April/May - Discuss with supervisor their role and what is covered and not covered by the granting/funding agency and the above programs (ie benefits, recommended clinical duties, etc.). Make sure that the project grants are in place with RSO and that the supervisor has been sent the speed codes. These project grants are sent in trust of the supervisor.
APPENDIX G: CONFLICT OF INTEREST

Physicians and Industry - Conflicts of Interest

Conflict of interest exists in medicine when the physician's primary responsibility to the patient is influenced by secondary competing considerations such as, for example, personal gain or the obligation to control health care costs. As professionals we all ascribe to the primacy of the welfare of our patients and this is reflected in advancing the patient's interest above our own self-interest and the interest of others. The application of these fundamental professional obligations has become all the more difficult in the current context of health care restructuring and abundance of competing loyalties. Among these challenges to professionalism, are the many interactions that occur between members of the health care industry (pharmaceuticals, manufacturers of devices and equipment, etc.) and physicians whether involved in care, education, research, administration or other roles.

Suggested Reading

- Code of Ethics, Canadian Medical Association. (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf)
APPENDIX H: STANDARDS IN MEDICAL DOCUMENTATION

1. WHO ARE PROGRESS NOTES FOR?

a) Ourselves: Principally, we write progress notes for ourselves, summarizing our thoughts and placing them on paper helps to crystallize our thinking and formulate our overall plan. Writing notes helps us to identify the individual problems and assess the progress of investigations / therapy of those problems day-by-day.

b) Others: They direct the on-call resident to what the underlying and most current / urgent clinical problems may be. They inform consultant residents / staff what the other ongoing medical problems are, and assist the nursing staff and other paramedical staff's understanding of the patient's difficulties and long term plans.

c) Discharge Summaries: A good set of progress notes will aid the discharge dictation summary and provide a complete medical-legal document.

2. WHAT DOES A GOOD PROGRESS NOTE LOOK LIKE?

A legible, organized note, however brief, is more valuable than a lengthy but disorganized and illegible one. Patient-centered, problem-orientated notes describing symptoms / clinical changes are more effective than regurgitation of laboratory data and vital signs / monitoring data. Notes should be dated and timed. They should focus on formulating impressions and plans.

3. HOW OFTEN SHOULD PROGRESS NOTES BE WRITTEN?

Timing of notes should correlate with the estimate of the patient's stability, or rather, instability. A complete update should precede every weekend and q 2-3 days otherwise, and in patients who have ongoing problems a smaller, more directed note should appear daily. Those who are unstable, and whose medical problems fluctuate significantly, may require more than one note daily. Conversely, stable patients awaiting placement may only need a detailed note weekly.

4. WHO SHOULD WRITE PROGRESS NOTES?

Whoever has the most contact with the patient, be it a resident or medical student, should write the most notes. The senior supervising resident (+/- staff) should write at least one summary note soon after the patient's admission, and as seems indicated by patient progress afterwards. Additionally, whoever writes an order on the chart should consider writing an accompanying explanatory progress note.

5. DISCHARGE SUMMARIES

Residents are responsible for the dictation of the discharge summaries of those patients who came under their care. They should be completed within 24 hours of the patient's discharge or demise and should be comprehensive but brief - remember that they are...
summaries and not a complete and detailed review of the patient's course in hospital. They should not be an exhaustive retelling of all minor facts in the record. Ordinarily, they should be one to two pages in length. Pertinent history, physical findings, laboratory data, investigations and subsequent therapy should be outlined. Ideally, the discharge summary should follow the format of the Problem Oriented Medical Record in which individual problems are defined, analysed, and their final disposition described. Remember that these records go as copies to referring physicians outside the University of Alberta Hospital and other affiliated teaching hospitals and must, therefore, contain sufficient information to be useful to follow up physicians - particularly in regard to discharge management recommendations.
APPENDIX I: WEEKDAY AND WEEKEND SIGN-OVER PROTOCOL

WEEKDAY SIGN-OVER PROTOCOL FOR GI SERVICES

During the weekdays (Monday to Friday), adequate sign-over to the on-call team (GIM resident, GI resident, and staff) is expected, usually around 5 pm. Information can be transferred via telephone by the respective staff or GI resident. Sign-over is mandatory for sick GI or consult inpatients, patients still in process of assessment (consult or assessment for admission), and expected transfers from other sites. Sign-over should include patient demographics (name, PHN, location), interim assessment, pending investigations, and management plans.

Weekday morning sign-over occurs daily (times and locations as below). It should be attended by the on call CIM and GI resident (unless onto off-service rotations) and relevant consult and ward services.

Monday-Friday: 0730h, 2nd Floor Zeidler Conference Room (2-10)

To ensure patient continuity, an "Inpatient Consult Service" list is kept by the GI Resident on the Google Drive. This list should be updated after consultation with staff.

Active: All consults requiring ongoing follow-up by the consult team.
Inactive: All consults that are discharged from active follow-up. It should be documented in the patient chart that the consult service is no longer actively following.
Weekend check: Consults with sufficient acuity to warrant follow-up on weekends.
APPENDIX J: GI DIVISION ACADEMIC ACTIVITIES AT-A-GLANCE

<table>
<thead>
<tr>
<th>Time</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
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<tbody>
<tr>
<td>7:30</td>
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<td>Liver Tumor Rounds ( )*</td>
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<td>8:00</td>
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<td>UAH Medicine Grand Rounds (Classroom D)</td>
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<tr>
<td>12:00</td>
<td>RAH GI Rounds ( )*</td>
<td>CEGIIIR Research Rounds</td>
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<td>12:30#</td>
<td>UAH GI Rounds (Classroom D)</td>
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<td>UAH Liver Transplant Rounds ( )*</td>
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<td>1:30</td>
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<td>Academic Half Day (ZLC 2-10)</td>
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<td>3:30</td>
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<td></td>
<td>UAH IBD Rounds (ZLC 2-10) ( )*</td>
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<td>5:00</td>
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<td>CPC Rounds (3rd Wed of Month) (ZLC 2-10)</td>
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<tr>
<td>6:30-9:00</td>
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<td>City-wide Grand Rounds (2nd Tues of Month)</td>
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Bolded – mandatory sessions
*Mandatory when on the related rotations
#UAH Monday Rounds will start at 12NOON in January 2018
## APPENDIX K: ATTENDANCE POLICY FOR OFF-SITE ROTATIONS

<table>
<thead>
<tr>
<th>ROTATION</th>
<th>MONDAY GI ROUNDS</th>
<th>ACADEMIC ½ DAY</th>
<th>NIGHT/WEEEKEND CALL</th>
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<tbody>
<tr>
<td>RAH Senior GI</td>
<td>√ (RAH)</td>
<td>√</td>
<td>RAH*</td>
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<tr>
<td>RAH Consult</td>
<td>√ (RAH)</td>
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<td>RAH#</td>
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<td>GNH Consult</td>
<td>GNH Medicine</td>
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<td>GNH</td>
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<td>Grand Rounds</td>
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<td>Misericordia Consult</td>
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<td>MIS</td>
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<tr>
<td>Nutrition</td>
<td>√ (UAH/RAH)</td>
<td>√</td>
<td>No call</td>
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<td>GI Oncology</td>
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<td>√</td>
<td>UAH</td>
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<tr>
<td>Motility</td>
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<td>IBD</td>
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<td>Research</td>
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<td>UAH</td>
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<tr>
<td>Pathology</td>
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<td>√</td>
<td>UAH</td>
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<tr>
<td>Pediatrics</td>
<td>√</td>
<td>√</td>
<td>UAH</td>
</tr>
</tbody>
</table>

√ Mandatory  
*Call with Dr. Bailey (or as otherwise assigned)  
#Call is on the 3rd weekend of the block (unless away, then 2nd weekend)  

**Please Note:** 1 week prior to start of elective, please inform site coordinator of your time commitment for UAH academic activities
APPENDIX L: GUIDELINES FOR CLINICAL SERVICE (UAH SITE)

CONSULT SERVICE 1 – INPATIENTS (C1)
1. On call for all patients admitted to non-GI wards, including ICU, CCU.
2. Attendance to the ICU/CCU consultations within 4h
3. Attendance to inpatient consultations within 24h
4. Manpower
   • Gastroenterology staff
   • GI resident
   • PGY2/3 CIM Resident

INPATIENT WARD SERVICE 1 (WARD 1)
1. On take (0800-0800) Monday, Wednesday, Friday
2. Admitting history and physical within 4h
3. Rounding daily Monday to Friday
4. Manpower
   • Gastroenterology staff
   • GI resident (~30-50% of time)
   • PGY1 CIM resident

CONSULT SERVICE 2 – EMERGENCY/OUTPATIENT (C2)
1. On call for all non-admitted patients in emergency; non-admitted consults held in ED after-hours will be seen by the consult service designated for the next day. On call for all outside GI call, including Rapid North (excluding hepatology calls)
2. Attendance to the Emergency Department consults within 4h
3. Attendance to inpatient consultations within 24h
4. Manpower
   • Gastroenterology staff
   • GI resident
   • CIM resident (R2/3), as assigned

INPATIENT WARD SERVICE (WARD 2)
1. On take (0800-0800) Tuesday, Thursday
2. Admitting history and physical within 4h
3. Rounding daily Monday to Friday and Saturday morning
4. Manpower
   • Gastroenterology staff or approved GI fellow without or with GI certification*
   • GI physician extender (Monday to Friday)
   • GI Pharmacist (Monday to Friday)
   • PGY1 GIM resident (if > 1 PGY1 per ward rotation)

HEPATOLOGY CONSULT SERVICE
1. On take 7-days per week
2. Attendance to the Emergency Department consultations within 4h
3. Attendance to inpatient consultations within 24h
4. Attendance to inpatient liver transplants
5. Manpower
   - Hepatology staff
   - GI resident (when available)
   - CIM Elective Resident
   - Hepatology fellow
APPENDIX M: FELLOW PRESENTATION OF GI NOON ROUNDS

UAH Noon Rounds

Objectives:

1. Develop awareness of controversies and recent developments in various GI topics.
2. Develop experience in posing, and researching a clinical question.
3. Develop experience in critical appraisal of medical literature.
4. Develop experience in the “art” of preparation and effective delivery of audiovisual presentation.
5. Develop experience in multidisciplinary collaborations.
6. Foster the development of collegiality and mentorship with GI Division staff.

To achieve the above objectives, the following guidelines should be followed in the preparation of GI noon rounds.

1. You will be assigned a broad topic in the field of gastroenterology. You should identify an area of controversy, recent development, or sub-topic within that area that you are unfamiliar with. You should not present a review on this broad topic. This can be achieved with the help of a staff mentor or through recent clinical exposure. This should be done early, at least 1 month prior to the scheduled date of presentation.

2. Conduct a literature search, and evaluate the available literature critically, based on established critical appraisal principles.

3. Identify possible co-presenters from other disciplines. A multi-disciplinary approach is highly desirable for noon rounds. Possible collaborating disciplines include Pathology, General surgery, Hepatobiliary surgery, Radiology, Nutrition, Basic Sciences, Epidemiology, Infectious disease, etc. This needs to be done early, at least 1 month prior to the scheduled date of presentation.

4. Prepare the audiovisual presentation. This should be done at least 2 weeks prior to the scheduled date, and reviewed with mentor for modifications.

5. The rounds should preferably be introduced with a case. This serves to help focus subsequent discussion.

6. Always remember to leave enough time (10-15 minutes) for discussion. With the help of the mentor, the presenter can become adept at leading and focusing the discussion to facilitate active audience learning.
**UAH GI Resident Cases**

In addition to the formal 1-hour rounds with assigned topics, you will also be asked to present 1-2 interesting cases at GI Resident Case Rounds. In comparison to the 1 hour rounds, these should be a presentation of a case, seen by the GI resident, along with pertinent history, physical exam, and investigations. Cases with interesting radiology or histology should include a brief presentation by the involved radiologist/pathologist.

**Objectives:**

1. To gain experience in developing the “art” of presenting patient cases.
2. Develop experience in multidisciplinary collaborations.
3. Foster the development of collegiality and mentorship with GI Division staff.

To achieve the above objectives, the following guidelines should be followed in the preparation of resident cases.

1. Always be on the look-out for interesting cases to present. The best case presentations are ones that you have been involved with personally.
2. Identify possible co-presenters from other disciplines. Remember to ask early to be respectful of their time.

**RAH Noon Rounds**

You will also be assigned a date to present a topic at RAH Monday Rounds, when on a consult rotation at RAH. Please talk to the
APPENDIX N: ENDOSCOPY LOG DOCUMENTS

ENDOSCOPY TRAINING LOG DOCUMENTATION

Residents are responsible for keeping a log of procedures done, by each rotation. GI residents are encouraged to keep up to date records of the procedures completed. However, GI residents will be required to provide their numbers for the regularly scheduled meetings with the GI Program Director throughout the training. In addition, these numbers will be reviewed by the Residency Program Committee at regular intervals.

An online resource (Google Drive) is available for use in tracking their procedures. Residents are responsible for having their summative numbers available for the regularly scheduled meetings with the program director.
## ENDOscopy TRAINING LOG DOCUMENTATION

Endoscopy Log is available on Google Drive. It is formatted as below.

<table>
<thead>
<tr>
<th>R4 BLOCKS</th>
<th>Gastroscopy</th>
<th>Colonoscopy</th>
<th>Hemostasis</th>
<th>Banding</th>
<th>Polypectomy</th>
<th>EMR - Polyp</th>
<th>Dilations</th>
<th>Foreign Body</th>
<th>PEG</th>
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<th>Banding</th>
<th>Polypectomy</th>
<th>EMR - Polyp</th>
<th>Dilations</th>
<th>Foreign Body</th>
<th>PEG</th>
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**APPENDIX O: TELEPHONE LIST**

The GI Master Contact List is located on the Common drive → common → Administrative Documents & Forms → GI Master Contact List.

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone Number</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>GI Residents/Fellows Office</td>
<td>P: 780-492-8245</td>
<td>F: 780-492-1455</td>
</tr>
<tr>
<td>GI MEPC</td>
<td>P: 780-492-8243</td>
<td>F: 780-492-1455</td>
</tr>
<tr>
<td>Zeidler Clinic – 3rd Floor</td>
<td>P: 780-407-6801</td>
<td>F: 780-407-4359</td>
</tr>
<tr>
<td>UAH Switchboard</td>
<td>P: 780-407-8220</td>
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</tr>
<tr>
<td>UAH Internal Paging</td>
<td>P: 76191</td>
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<tr>
<td>RAH Switchboard</td>
<td>P: 780-735-4111</td>
<td></td>
</tr>
<tr>
<td>RAH Endoscopy</td>
<td>P: 780-735-4431</td>
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</table>
APPENDIX P: RESOURCES

CAG Website – http://www.cag-acg.org/
CASL Website – Http://Hepatology.Ca
Alberta Innovates Website – http://albertainnovates.ca/
AASLD Website – Http://www.AASLD.org
AASL Website – http://www.acg.gi.org/
AGA Website – http://www.gastro.org/
ASGE Website – http://www.asge.org/
Alberta NetCare – https://portal.albertanetcare.ca/cha/NetcareLogin.htm
GI Subspecialty Program Website – http://www.medicine.med.ualberta.ca/Residency/GAST/
GI Division Website – http://www.medicine.med.ualberta.ca/Divisions/GAST/
Dept Of Medicine Website – http://www.medicine.med.ualberta.ca/Home/index.cfm
CEGIIR Website – http://www.medicine.med.ualberta.ca/CEGIIR/
NACTRC Website – http://www.clinicaltrials.ualberta.ca/
PGME Website - http://www.med.ualberta.ca/education/pgme/index.cfm

PARA collective agreement - http://www.para-ab.ca/agreement/know-your-contract
University of Alberta - http://www.med.ualberta.ca/education/pgme/index.cfm
AHS (access via AHS intranet - http://insite.albertahealthservices.ca/Files/cpd-pol-swe03-approved-workplace-health-safety.pdf)

Contact information:
PARA – 780-432-1749
Occupational Health and Safety Office - 780-342-8400
AMA Physician and Family Support Program (PFSP) hotline 1-877-767-4637
University of Alberta Office of Safe Disclosure - 780-492-7325
University of Alberta counselling services – 780-492-4268
Faculty of Medicine and Dentistry Office Learner Advocacy & Wellness
CPSA – 780-423-4764
CMPA – 1-800-867-6522

APPENDIX Q: PATIENT SAFETY/QUALITY IMPROVEMENT

In 2016, PS/QI training was introduced into the GI Residency Training Program to help address this key competency as outlined in the CanMEDS 2015 Physician Competency Framework. Several formats have been added:

- AHD Lecture on PS/QI from a local expert
- Self-study – residents are strongly encouraged to take advantage of the Institute for Health Care Improvement (IHI.org) Open School – while there are 33 modules, residents are expected to complete the IHI Open School Basic Certificate (13 modules)
- Attendance/Participation in the Monthly Clinical Practice Correlation Rounds
In addition, a QI/QA Coordinator has been added to the RPC. We will also participate in the PS/QI initiatives organized by the PGME.

**APPENDIX R: RESIDENT PROGRAM COMMITTEE**

Terms of Reference

The Residency Program Committee (RPC) is chaired by the program director. The role of the RPC is to assist the program director in the planning, organization, and supervision of the residency program. The committee meets at least quarterly, or more frequently as deemed necessary. The minutes are taken by the medical education program coordinator (MEPC) and previous minutes are reviewed at each meeting.

Membership

This committee should include a representative from each participating site, and each major component of the program. This committee must include representation from the residents in the program, at least one of whom must be elected by his or her peers.

Voting Rights

**Program Director:** Can only vote in the instance of a tie  
**Divisional Director:** No voting rights  
**GI Resident Representatives:** Voting rights  
**Chief Resident:** No voting rights (conflict of interest, appointed by the program director)  
**Medical Education Program Coordinator:** No voting rights  
**All other members:** Voting rights

**Quorum** is six voting members

**Mandate**

1. To provide and plan educational resources which allow residents to achieve the goals of the program, according to both the program mission statement as well as the program specific objectives of training.

2. To be responsible for the interview and selection of candidates for the program.

3. To assess and evaluate the performance and promotion of residents, in accordance with the University of Alberta Department of Medicine/Division of Gastroenterology policies, including formative and summative assessments on a regular basis.

4. To develop, organize, and provide additional educational resources, remediation, or probation programs for those residents who are experiencing difficulties meeting objectives/competence.

5. To work in conjunction of the University PGME Evaluation subcommittee as well as the Faculty of Medicine Appeals Committee to receive and review resident appeals in accordance with the University of Alberta policy.
6. To evaluate with resident body, opinion invited and welcomed for all aspects of the University of Alberta Gastroenterology program including: curriculum, objectives, rotations, teachers, resources, and the learning environment on a regular basis.

7. To provide all residents within the program with knowledge, resources, and the learning environment on a regular basis.

8. To provide career guidance to residents in keeping with the goals of the program.

9. To ensure that residents within the program can effectively access wellness and stress management resources.

10. To ensure the personal safety for all residents within the University of Alberta’s gastroenterology program.

11. To ensure active and effective liaison with all sites participating in the program.

Program Director Responsibilities

1. The responsibilities of the program director, assisted by the residency program committee include:
   a. development and operation of the program such that it meets the general standards of accreditation as set forth in this document, and the specific standards of accreditation of programs in the specialty or subspecialty as set forth in the specialty or subspecialty document;
   b. providing opportunities for residents to attain all competencies as outlined in the specialty-specific Objectives of Training;
   c. selection of candidates for admission to the program;
   d. evaluation and promotion of residents in the program in accordance with policies determined by the faculty postgraduate medical education committee;
   e. maintenance of an appeal mechanism. The residency program committee should receive and review appeals from residents and, where appropriate, refer the matter to the faculty postgraduate medical education committee or faculty appeal committee;
   f. establishment of mechanisms to provide career planning and counselling for residents;
   g. establishment of mechanisms to deal with problems such as those related to stress;
   h. an ongoing review of the program to assess the quality of the educational experience and to review the resources available in order to ensure that maximal benefit is being derived from the integration of the components of the program. The opinions of the residents must be among the factors considered in this review. Appropriate faculty/resident interaction and communication must take place in an open and collegial atmosphere so that a free discussion of the strengths and weaknesses of the program can occur without hindrance. This review must be conducted in a manner that protects confidentiality and include:
      i. an assessment of each component of the program to ensure that the educational objectives are being met;
      ii. an assessment of resource allocation to ensure that resources and facilities are being utilized with optimal effectiveness;
iii. an assessment of the teachers in the program;
   i. establishment of a written policy governing resident safety related to travel, patient
      encounters, including house calls, after-hours consultations in isolated departments
      and patient transfers (i.e. Medevac). The policy should allow resident discretion and
      judgment regarding their personal safety and ensure residents are appropriately
      supervised during all such clinical encounters. The policy **must** specifically include
      educational activities (e.g. identifying risk indicators).

2. There **must** be a program coordinator or supervisor, responsible to the program director, at
   each site participating in the program, including electives. There **must** be active liaison
   between the program director and the program coordinators.

3. There **must** be an identified faculty member with the responsibility to facilitate and supervise
   the involvement of residents in research and other scholarly work.

4. An environment of inquiry and scholarship **must** be maintained in the program.
   A satisfactory level of research and scholarly activity **must** be maintained among the faculty
   identified with the program, as evidenced by:
      a. peer-reviewed research funding;
      b. publication of original research in peer-reviewed journals and/or publication of review
         articles or textbook chapters;
      c. involvement by faculty and residents in current research projects;
      d. recognized innovation in medical education, clinical care or medical administration.