DIVISION OF GASTROENTEROLOGY

SUB-SPECIALTY TRAINING PROGRAM MANUAL

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Revised June 2019
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INTRODUCTION

GI DIVISION 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 gastroenterology, hepatology and liver transplantation, therapeutic endoscopy, nutrition, motility, inflammatory bowel disease, and basic scientific investigation. The Division has a strong inpatient consultation presence in the Edmonton Zone of the Alberta Health Services at the 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. Quality improvement is also a part of our divisional activities. The academic mission of the Division also encompasses education at the undergraduate, graduate and post-graduate levels, thus attracting a wide variety of graduate (MSc and PhD) and postgraduate students to its research programs. Division members participate in undergraduate and postgraduate 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 in Canada. 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 gastroenterologist 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 opt 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.
PROGRAM STRUCTURE

In July 2019, Gastroenterology Residency Training in Canada moved to the Royal College of Physicians and Surgeons ‘Competency by Design’ Framework. The two clinical years of the program consists of 26 (4-week) blocks, including 8 weeks of vacation. The training experiences are divided into 4 phases of ‘Competence by Design’ with the following structure:

Transition to Discipline (2 blocks)
- Consults (UAH) – 1 block
- Ward (UAH) – ½ block
- Research – ½ block

Foundations of Discipline (5 blocks)
- Ward (UAH) – 1 block
- Consults (RAH) – 1 block
- Endoscopy 1 – 1 block
- Clinic – 1 block
- Elective/Buffer – 1 block

Core of Discipline (14-16 blocks)
- Consults (UAH) – 1-2 blocks
- Consults (RAH) – 1 block
- Ward – Jr Attending (UAH) - 1 block
- Hepatology (Inpatient/Transplant) - 1 block
- Community GI (GNH/MIS) – 1 block
- Endoscopy 2 – 1 block
- Nutrition (RAH) – 1 block
- Motility (UAH) – 1 block
- Clinic – 1 block
- Longitudinal Clinic – 1 year
- Research – 1 block
- Elective/Buffer – 3-5 blocks

Transition to Practice (3 blocks)
- Consults (UAH) – 1 block
- Endoscopy (UAH/RAH/MIS/GNH) – 1 block
- Elective/Buffer – 1 block

Buffer/elective time has been built into the framework to allow residents extra time in a phase of training to help them attain the competencies of each phase of training.

Available Elective Rotations:
Inflammatory Bowel Disease
Gastrointestinal Oncology
Pathology
Research
Pediatric Gastroenterology

Elective time outside of Edmonton needs to be planned well in advance and in keeping with the policies of the Postgraduate Education Office. [https://www.ualberta.ca/medicine/programs/residency/resident-resources/electives](https://www.ualberta.ca/medicine/programs/residency/resident-resources/electives)

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, city-wide GI Journal Club, and Clinical Pathology Correlation (CPC) rounds. Residents will have the opportunity to participate in scholarly and clinical discussions at many educational and clinical rounds including: Liver Tumor Rounds (UAH/RAH), Liver Transplant Rounds (UAH), IBD rounds (UAH). In addition, residents are encouraged to attend the 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 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 & ASSESSMENT**

Residents and staff are aware of the general objectives of the program and rotation specific objectives. These are available in the Resident Training Manual available online.

**RESIDENT ASSESSMENT:**

*Entrustable Professional Activities*

The primary form of resident assessment is with Entrustable Professional Activities (EPAs). Each phase of training has a number of assigned EPAs which must be successfully completed and signed off by the Competency Committee (CC) and the Residency Program Committee (RPC). Each resident will be assigned an academic advisor to meet with regularly and present their progress to the CC. Resident are required to be knowledgeable about which EPAs are assigned to each phase of training. Residents are encouraged regularly review all completed EPAs to provide them with timely feedback.
Links:
cbme.med.ualberta.ca – to start/enter EPAs
dash.med.ualberta.ca – to review progress (Portfolio)

As staff members have many occasions to assess resident’s performance outside of scheduled rotations, resident performance may be discussed with the Program Director and at divisional meetings.

Rotations that do not have assigned EPAs (e.g. Pathology) will still have ITER-style evaluations – these are found in One45 (https://www.webeval.med.ualberta.ca/webeval/).

Endoscopy Log
Residents will also be expected to keep track of their endoscopy skills using the endoscopy log. In the endoscopy log, residents will keep track of the type and number of procedures performed by block, including the number/type of therapeutic interventions.

Resident Portfolio
Each resident will also have an individual GI portfolio (available in sites.google.com) for tracking their scholarly activity (presentations, publications, research/QI projects, and professional development), assessments, and career planning. The endoscopy log will also link to this site for easy viewing by the RPC and competency committee. We encourage you to share this with your career advisor.

Additional Formative Assessments:
Throughout the 2-year training program, there are a number of formative assessments that will be used to help develop skills and are used to by the Program Director and RPC to ensure residents are on track.

Evaluation of Rounds Presentations: For each Monday Rounds Presentation, residents will be provided with summative scores and comments.

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 Canadian GI 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.
**ROTATION & FACULTY EVALUATION**

*Rotation Evaluation*
At the end of each rotation, residents will be asked to complete an evaluation of educational content and teaching, and to provide constructive criticism for each rotation in One45. Rotation evaluations are reviewed by the RPC every 2 years to identify any pertinent issues or need for changes.

*Faculty Evaluation*
In addition to the rotation evaluations, residents are expected to provide feedback to faculty preceptors. Summary evaluations (to help preserve anonymity) are provided to individual staff for feedback and quality assurance on an annual basis. A copy of the faculty evaluations is forwarded to the Gastroenterology Divisional Director. Since 2007, the Divisional Director has instituted an annual staff evaluation to be completed by all residents as a group. These results are reviewed by the Program Director who will review the results with the Division Director. Sub-standard evaluations will be discussed at the RPC with a clear action plan for resolution.

*Academic Half Day*
At the end of each AHD, we ask that the residents provide feedback regarding the session and presenter quality. These evaluations are used to help improve the AHD.
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 ‘Competencies’ and ‘Training Experiences’ for the subspecialty of gastroenterology are defined by the Royal College of Physicians and Surgeons of Canada. The key and enabling competencies for Gastroenterology are described by each CanMEDS role. Training experiences are required (or recommended) by each phase of training. These documents can be found at: http://www.royalcollege.ca/rcsite/ibd-search-e

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.

Specific Requirements:

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 Medicine Research Day, Gastroenterology Residents in Training (GRIT) Program and Canadian Digestive Diseases Week (CDDW).

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.
ROTATION DESCRIPTION AND SPECIFIC OBJECTIVES

The specific rotation objectives are listed below.

UAH CONSULTS

<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</td>
<td>Carrie-Anne to email schedule</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ph: 780-492-8243</td>
<td>prior to start; handover – 7:30AM</td>
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<td></td>
<td></td>
<td></td>
<td>– ZLC 2-10</td>
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</tbody>
</table>

FOCUS OF THIS ROTATION

- Provide consultation for emergent and urgent GI presentations, at a teaching hospital
- Lead the team

The busy rotation at the consultation service provides excellent exposure to consultative practice in a quaternary care setting. To increase the education-to-service ratio, consultation services is currently divided into 2 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 GI resident will supervise the junior residents and medical students assigned to their team. 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 and uncommon GI problems.

Call for this rotation:
- UAH - The GI resident will take call at UAH in accordance to the schedule created by the GI Chief Resident.

CBD stage(s) for this rotation:
- TTD
- Core
- TTP

Length of this rotation:
- 1 block

PGY Level(s) for this rotation:
- PGY4/5

Locations for rotation:
- UAH
Required training experiences included in this rotation
- Found/Core 1.1 GI Consultative and/or inpatient service
- Core 1.4 After-hours coverage of the GI service

Other training experiences that may be included in this rotation
- Scholar 2.4 Plan and deliver learning activities
- Core 2.4 Teaching other learners

<table>
<thead>
<tr>
<th>EPAs* Mapped to this rotation:</th>
<th>Total # of Entrustments</th>
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<tr>
<td>TRANSITION TO DISCIPLINE:</td>
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<tr>
<td>TTD1A – Assessing, triaging, and initiating management for patients with GI emergencies</td>
<td>2/4</td>
</tr>
<tr>
<td>TTD2A – Performing the preprocedural assessment and risk optimization for patients undergoing endoscopy PART A: Consent Part B: Patient Preparation</td>
<td>2/2 3/4</td>
</tr>
<tr>
<td>CORE:</td>
<td></td>
</tr>
<tr>
<td>C3AP – Managing patients with exacerbations, disease progression, and/or complications of chronic GI conditions  - Chronic liver disease, IBD, other</td>
<td>1/10</td>
</tr>
<tr>
<td>C7A – Identifying clinically significant findings during endoscopy of the upper or lower GIT</td>
<td>1/12</td>
</tr>
<tr>
<td>Core 8A. Performing therapeutic interventions of the upper and lower GI tract PART A – Procedural Skills  - Variceal hemostasis  - Non-variceal hemostasis</td>
<td>1/25 2/25</td>
</tr>
<tr>
<td>Core 10A. Leading the provision of GI care for patients on an inpatient service</td>
<td>4/10</td>
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<tr>
<td>TRANSITION TO PRACTICE:</td>
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<tr>
<td>TTP1A – Managing the day’s list of endoscopy procedures</td>
<td>2/5</td>
</tr>
</tbody>
</table>

*Depends on if in TTD or Core or TTP

Other assessments during this rotation:

<table>
<thead>
<tr>
<th>Other assessments during this rotation:</th>
<th>Tool Location / Platform (e.g. POWER, Entrada):</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Endoscopy log</td>
<td>Google Drive</td>
</tr>
</tbody>
</table>

Key Goals for this Rotation:
## TRANSITION TO DISCIPLINE:

1. **P 1.1** Work within personal limitations, asking for assistance as needed  
   - **P**

2. **ME 2.1** Determine the acuity of the issues and establish priorities for patient care  
   - **ME**

3. **ME 2.2** Perform a history and physical exam relevant to the patient’s presentation, in a time-effective manner; Develop a differential diagnosis relevant to the patient’s presentation  
   - **ME**

4. **ME 2.4** Develop and implement initial management plans for gastrointestinal emergencies  
   - **ME**

## CORE:

5. **ME 2.2** Interpret the clinical significance of findings of endoscopic procedures  
   - **ME**

6. **ME 3.4** Identify clinical significant findings during endoscopic procedures  
   - **ME**

7. **ME 3.4** Demonstrate appropriate and safe use of ancillary equipment, identify and react to immediate complications of the procedure, if applicable  
   - **ME**

8. **P 1.1** Work within personal limitations, asking for assistance as needed  
   - **P**

9. **ME 1.4** Perform relevant and time-effective clinical assessments  
   - **ME**

10. **ME 3.1** Determine the most appropriate procedures or therapies for the purpose of assessment and/or management  
    - **ME**

11. **L 2.1** Allocate health care resources for optimal patient care  
    - **L**

12. **L 4.2** Run the service efficiently, safely, and effectively  
    - **L**

## TRANSITION TO PRACTICE:

13. **ME 3.4** Perform endoscopic procedures in a skillful and safe manner, adapting to unanticipated findings or changing clinical circumstances  
    - **ME**

14. **L 4.2** Demonstrate leadership skills in the endoscopy suite  
    - **L**

15. **L 4.1** Manage time effectively to maintain patient and endoscopy flow  
    - **L**

### Other:

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RAH CONSULTS

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<tr>
<th>Rotation</th>
<th>Preceptor/Coordinator</th>
<th>Contact</th>
<th>Initial Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>RAH</td>
<td>P: Attending Staff on Consult Service C: Dr. L. Bistritz</td>
<td>Carrie-Anne Cyre Ph: 780-492-8243</td>
<td>Carrie-Anne to email schedule prior to start; page staff on Consult service per schedule by 0800</td>
</tr>
</tbody>
</table>

FOCUS OF THIS ROTATION

- Provide consultation for emergent and urgent GI presentations
- Focus on providing GI care to an inner city population of patients

The Royal Alexandra Hospital is located in the inner city of Edmonton; as such patients often have additional needs related to socioeconomic status. In addition, RAH is a high risk obstetrical hospital which may provide access to assessment and management of pregnant patients with GI/liver conditions. During this rotation, 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. 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.

Call for this rotation:

- 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.

CBD stage(s) for this rotation:

- Foundation
- Core

Length of this rotation:

- 1 block

PGY Level(s) for this rotation:

- PGY4/5

Locations for rotation:

- RAH

Required training experiences included in this rotation

- Found/Core 1.1 GI Consultative and/or inpatient service
- Core 1.4 After-hours coverage of the GI service
Other training experiences that may be included in this rotation

- Scholar 2.4 Plan and deliver learning activities

<table>
<thead>
<tr>
<th>EPAs* Mapped to this rotation:</th>
<th>Total # of Entrustments</th>
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<tbody>
<tr>
<td><strong>FOUNDATIONS:</strong></td>
<td></td>
</tr>
<tr>
<td>1. F1AP – Assessing and initiating management for uncomplicated patients</td>
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</tr>
<tr>
<td>PART A: Hx &amp; PE (direct observation)</td>
<td>1/2</td>
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<tr>
<td>PART B: Clinical Assessment &amp; Management</td>
<td>2/12</td>
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<tr>
<td>2. F3A – Performing EGD</td>
<td></td>
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<tr>
<td>PART A: Procedure</td>
<td>2/6</td>
</tr>
<tr>
<td>PART B: Procedure note</td>
<td>1/3</td>
</tr>
<tr>
<td>3. F4A – Performing endoscopic examination to the sigmoid colon</td>
<td>2/6</td>
</tr>
<tr>
<td><strong>CORE:</strong></td>
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<tr>
<td>4. C1A – Assessing and initiating management for complex patients</td>
<td>1/5</td>
</tr>
<tr>
<td>- Pregnancy</td>
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<td>- Significant social barriers to health care</td>
<td></td>
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<tr>
<td>- Cultural/language/religious barriers to communication care</td>
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</tr>
<tr>
<td>5. C3AP – Managing patients with exacerbations, disease progression, and/or complications of chronic GI conditions</td>
<td>1/10</td>
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<tr>
<td>- Chronic liver disease, IBD, other</td>
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<tr>
<td>6. C7A – Identifying clinically significant findings during endoscopy of the upper or lower GIT</td>
<td>2/12</td>
</tr>
<tr>
<td>7. Core 8A. Performing therapeutic interventions of the upper and lower GI tract</td>
<td></td>
</tr>
<tr>
<td>PART A – Procedural Skills</td>
<td></td>
</tr>
<tr>
<td>- Variceal hemostasis</td>
<td>1/25</td>
</tr>
<tr>
<td>- Non-variceal hemostasis</td>
<td>2/25</td>
</tr>
</tbody>
</table>

*Depends on if in Foundation or Core

<table>
<thead>
<tr>
<th>Other assessments during this rotation:</th>
<th>Tool Location / Platform (e.g. POWER, Entrada):</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Endoscopy log</td>
<td>Google Drive</td>
</tr>
</tbody>
</table>

Key Goals for this Rotation:

<table>
<thead>
<tr>
<th>FOUNDATIONS:</th>
<th>CanMEDS Role(s):</th>
</tr>
</thead>
</table>

Revised June 2019
1. ME 2.2 Elicit an accurate, relevant history, Perform a physical examination that informs the diagnosis, Synthesize information from the clinical assessment, Select and interpret appropriate investigations  

2. ME 2.4 Develop and implement management plans  

3. COL 1.3 Communicate effectively with other health care professionals  

4. ME 3.4 Apply knowledge of anatomy, key landmarks and the endoscopic procedure, manipulate the endoscope appropriately, achieving stabilization, orientation, and direction, use appropriate strategies for endoscopic advancement, achieve clear visualization, perform tissue biopsies (as appropriate), demonstrate fine tip control  

5. COL 1.1 Respond appropriately to input from other health care professionals  

6. COL 1.3 Communicate effectively with other health care professionals  

7. P 1.1 Work within personal limitations, asking for assistance as needed.  

**CORE:**  

8. HA 1.1 Identify barriers to access and care for individual patients  

9. COL 1.3 Integrate the patient’s perspective and context into the collaborative care plan  

10. ME 2.2 Prioritize which issues need to be addressed, Select and interpret the results of investigations performed to monitor treatment and clinical status  

11. ME 2.2 Interpret the clinical significance of findings of endoscopic procedures  

12. ME 3.4 Identify clinical significant findings during endoscopic procedures  

13. ME 3.4 Demonstrate appropriate and safe use of ancillary equipment, identify and react to immediate complications of the procedure, if applicable  

14. P 1.1 Work within personal limitations, asking for assistance as needed  

**Other:**
COMMUNITY CONSULTATION (MIS, GNH)

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Preceptor/Coordinator</th>
<th>Contact</th>
<th>Initial Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIS*</td>
<td>Dr. Lori Stead</td>
<td>Sarah Bond Ph: 780-930-1915</td>
<td>Contact Sarah by phone or at <a href="mailto:sbond@westedgi.ca">sbond@westedgi.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>

FOCUS OF THIS ROTATION

- Gain experience in a community GI setting
- Work on improving endoscopy skills, with a focus on polypectomy

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 the assigned site, call requirements will not exceed the PARA rules. Resident will return to the UAH site for weekly Academic half day.

Call for this rotation:

- Site based – not to exceed PARA rules

CBD stage(s) for this rotation:

- Core

Length of this rotation:

- 1-2 blocks

PGY Level(s) for this rotation:

- PGY4 or 5

Locations for rotation:

- MIS
- GNH

Required training experiences included in this rotation

- Core 1.1 GI consultative and/or inpatient service
- Core 1.3. Endoscopy
- Core 1.5 – Gastroenterology in community setting

Other training experiences that may be included in this rotation

- Core 1.2. GI outpatient clinics
- Core 2.3 - Career counselling/planning
<table>
<thead>
<tr>
<th>EPAs Mapped to this rotation:</th>
<th>Total # of Entrustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Core 6A. Performing Colonoscopy</td>
<td>2/12</td>
</tr>
<tr>
<td>2. Core 7A. Identifying clinically significant findings during endoscopic procedures</td>
<td>2/12</td>
</tr>
<tr>
<td>3. Core 8A. Performing therapeutic interventions of the upper and lower GI tract</td>
<td></td>
</tr>
<tr>
<td>PART A – Procedural Skills</td>
<td></td>
</tr>
<tr>
<td>- Polypectomies</td>
<td>6/10</td>
</tr>
<tr>
<td>- Polypectomies &gt;1cm</td>
<td>2/5</td>
</tr>
<tr>
<td>4. Core 8A. Performing therapeutic interventions of the upper and lower GI tract</td>
<td></td>
</tr>
<tr>
<td>PART B – Procedure Note</td>
<td>1/4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<tr>
<th>Key Goals for this Rotation:</th>
<th>CanMEDS Role(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ME 3.4 Select and gather appropriate ancillary equipment</td>
<td>ME</td>
</tr>
<tr>
<td>2. ME 3.4 Manipulate endoscope appropriately...</td>
<td>ME</td>
</tr>
<tr>
<td>3. COM 5.1 Document all relevant findings</td>
<td>COM</td>
</tr>
</tbody>
</table>

**Other:**
UAH WARD ROTATION

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

FOCUS OF THIS ROTATION

- Nutritional assessment of uncomplicated patients
- Managing uncomplicated GI patients

Call for this rotation:
- UAH - The GI resident will take call at UAH in accordance to the schedule created by the GI Chief Resident.

CBD stage(s) for this rotation:
- TTD – ½ block
- Foundation – 1 block

Length of this rotation:
- TTD – ½ block
- Foundation – 1 block

PGY Level(s) for this rotation:
- PGY4

Locations for rotation:
- UAH

Required training experiences included in this rotation
- Found/Core 1.1 Inpatient service

Other training experiences that may be included in this rotation
- N/A
<table>
<thead>
<tr>
<th>EPAs Mapped to this rotation:</th>
<th>Total # of Entrustments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TRANSITION TO DISCIPLINE:</strong></td>
<td></td>
</tr>
<tr>
<td>1. TTD 1A: Assessing, triaging, and initiating management for patients with GI emergencies</td>
<td>2/4</td>
</tr>
<tr>
<td><strong>FOUNDATIONS:</strong></td>
<td></td>
</tr>
<tr>
<td>2. Found 1AP – Assessing and initiating management of uncomplicated patients</td>
<td>1/2</td>
</tr>
<tr>
<td>PART A: Hx &amp; PE</td>
<td>3/12</td>
</tr>
<tr>
<td>Part B: Clinical Assessment &amp; Management</td>
<td></td>
</tr>
<tr>
<td>3. Found 2A – Assessing the nutritional status and initiating nutritional support plan for uncomplicated patients</td>
<td>2/2</td>
</tr>
<tr>
<td>4. Core 10A. Leading the provision of GI care for patients on an inpatient service</td>
<td>2/10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other assessments during this rotation:</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>TRANSITION TO DISCIPLINE:</strong></td>
<td></td>
</tr>
<tr>
<td>1. P 1.1 Work within personal limitations, asking for assistance as needed</td>
<td>P</td>
</tr>
<tr>
<td>2. ME 2.4 Develop and implement initial management plans for gastrointestinal emergencies</td>
<td>ME</td>
</tr>
<tr>
<td><strong>FOUNDATIONS:</strong></td>
<td></td>
</tr>
<tr>
<td>3. ME 2.2 Elicit an accurate, relevant history, Perform a physical examination that informs the diagnosis, Synthesize information from the clinical assessment, Select and interpret appropriate investigations</td>
<td>ME</td>
</tr>
<tr>
<td>4. ME 2.4 Develop and implement management plans</td>
<td>ME</td>
</tr>
<tr>
<td>5. COL 1.3 Communicate effectively with other health care professionals</td>
<td>COL</td>
</tr>
<tr>
<td>6. P1.1 Work within personal limitations, asking for assistance as needed.</td>
<td>P</td>
</tr>
<tr>
<td>7. ME 2.2. Elicit a diet and nutritional history, synthesize patient information to determine a patient’s nutritional status, including macronutrient and micronutrient sufficiency,</td>
<td>ME</td>
</tr>
</tbody>
</table>
estimate nutritional requirements in an uncomplicated patient, develop and implement a plan for nutritional support, by any route; oral, enteral, parenteral

Other:

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 12-18 patients. The inpatient Ward 1 team consists of a staff physician, 1-2 Core IM residents, occasionally medical students and an occasional GI resident. In general, the patients are admitted after assessment by the Consult service or weekend team. A multidisciplinary team approach is used for effective patient care.

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.

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 all endoscopic procedures.
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 Ph: 780-492-8243</td>
<td>0730 Monday AM Handover Rounds 2-10 ZLC</td>
</tr>
</tbody>
</table>

FOCUS OF THIS ROTATION

- Management of complicated GI patients
- Leading/managing the GI ward, and team members

Call for this rotation:

- UAH - The GI resident will take weeknight 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.

CBD stage(s) for this rotation:

- Core

Length of this rotation:

- 1 block

PGY Level(s) for this rotation:

- PGY4/5

Locations for rotation:

- UAH

Required training experiences included in this rotation

- Core 1.1 Inpatient service

Other training experiences that may be included in this rotation

- Core 2.4 Teaching other learners
<table>
<thead>
<tr>
<th>EPAs Mapped to this rotation:</th>
<th>Total # of Entrustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Core 10A. Leading the provision of GI care for patients on an inpatient service</td>
<td>3/10</td>
</tr>
<tr>
<td>2. C3AP – Managing patients with exacerbations, disease progression, and/or complications of chronic GI conditions Chronic liver disease, IBD, other</td>
<td>4/10</td>
</tr>
<tr>
<td>3. Core 4AP – Identifying and referring patients who need additional specialized care PART A: Assessment and decision for referral PART B: Communication with consultant</td>
<td>1/3, 1/2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other assessments during this rotation:</th>
<th>Tool Location / Platform (e.g. POWER, Entrada):</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Core 10A – PART B. Interprofessional Assessment</td>
<td>360 Evaluation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Goals for this Rotation:</th>
<th>CanMEDS Role(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. L 2.1 Allocate health care resources for optimal patient care</td>
<td>L</td>
</tr>
<tr>
<td>2. L 4.2 Run the service efficiently, safely, and effectively</td>
<td>L</td>
</tr>
<tr>
<td>3. ME 2.1 Prioritize which issues need to be addressed</td>
<td>ME</td>
</tr>
<tr>
<td>4. ME 2.2 Select and interpret the results of investigations performed to monitor treatment and clinical status, differentiate signs and symptoms of disease and/or disease progression from adverse effects of treatment</td>
<td>ME</td>
</tr>
<tr>
<td>5. COM 3.1 Provide information related to the patient’s health status, care and needs clearly and compassionately</td>
<td>COM</td>
</tr>
<tr>
<td>6. HA 1.1 Facilitate timely patient access to services and resources</td>
<td>HA</td>
</tr>
<tr>
<td>7. ME 4.1 Formulate clear and appropriate requests for consultation</td>
<td>ME</td>
</tr>
<tr>
<td>8. COL 3.2 Summarize the patient’s issues for the consultant</td>
<td>COL</td>
</tr>
<tr>
<td>9. COL 2.1 Communicate with other health professionals clearly and respectfully</td>
<td>COL</td>
</tr>
<tr>
<td>10. COL 1.3 Work effectively with other physicians and health care professionals to provide integrated care</td>
<td>COL</td>
</tr>
</tbody>
</table>

Other:
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 junior trainees.

During the rotation, the junior attending (JA) resident will provide leadership and teaching to junior residents and medical students on the GI ward team. In addition, the JA resident will deliver two (2) formal AM teaching sessions to the junior trainees rotating on GI. The attending physician will be present at these sessions and will provide feedback to the JA resident on their presentation skills – both what they did well and how they can improve.

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). The GI attending staff will serve as a supervisor/observer in the background to the JA resident. 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.

Procedures on patients are performed at the first available booking. The JA resident is expected to perform all procedures, with hands-off supervision by the attending staff.
ENDOSCOPY ORIENTATION COURSE

Coordinators: Adriana Lazarescu, Richard Sultanian

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 includes:
1. Consent, quality, and documentation
2. Bowel preparation
3. Medication management
4. Polyps and polypectomy
5. ERCP/EUS
6. Endoscopy in pregnant patients
7. Sedation
8. Foreign bodies
9. Diabetes
10. Complications
11. Hands-on training with simulators
ENDOSCOPY ROTATION - I, II, III

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. In addition, we have 3 dedicated endoscopy blocks during foundations, core, and TTP.

FOCUS OF THIS ROTATION – FOUNDATIONS (ENDOSCOPY I)
- Performing and documenting EGD
- Performing lower GI endoscopy to the level of the sigmoid colon

During this 1-block, rotation will be exposed to common endoscopic problems of the ambulatory GI and liver patients. The purpose of this block is to have focused time to work on attaining endoscopy skills in ambulatory patients.

FOCUS OF THIS ROTATION - CORE (ENDOSCOPY II)
- Performing colonoscopy (difficult cases)
- Identifying clinically significant endoscopic findings
- Performing therapeutic interventions

This will be a 1-block rotation, intended to focus on developing endoscopic skills in the Core portion of GI training – focused on colonoscopy, identifying findings and therapeutic intervention of ambulatory patients.

FOCUS OF THIS ROTATION – TRANSITION TO PRACTICE (ENDOSCOPY III)
- Develop the skills to manage a caseload of clinical work – including endoscopy while balancing other responsibilities

This will be a 4-week rotation, with a resident made schedule of outpatient endoscopy lists, allowing for assessment by multiple assessors and needs to include lists of medium-high complexity.

Call for this rotation:
- UAH - The GI resident will take call at UAH in accordance to the schedule created by the GI Chief Resident.

CBD stage(s) for this rotation:
- Foundation
- Core
- TTP

Length of this rotation:
- Foundation – 1 block
- Core – 1 block
- TTP – 1 block
PGY Level(s) for this rotation:
- Foundations - PGY4
- Core - PGY 4/5
- TTP - RGY 5

Locations for rotation:
- UAH
- RAH

Required training experiences included in this rotation
- Foundation/Core/TTP 1.3. Endoscopy

Other training experiences that may be included in this rotation
- None

<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>FOUNDATIONS:</strong></td>
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</tr>
<tr>
<td>1. F3A – Performing EGD</td>
<td></td>
</tr>
<tr>
<td>PART A: Procedure</td>
<td>4/6</td>
</tr>
<tr>
<td>PART B: Procedure note</td>
<td>2/3</td>
</tr>
<tr>
<td>2. F4A – Performing endoscopic examination to the sigmoid colon</td>
<td>4/6</td>
</tr>
<tr>
<td><strong>CORE:</strong></td>
<td></td>
</tr>
<tr>
<td>3. C6A – Performing colonoscopy</td>
<td>2/12</td>
</tr>
<tr>
<td>- Above average difficulty (4)</td>
<td>(2/4)</td>
</tr>
<tr>
<td>4. C7A – Identifying clinically significant findings during endoscopic procedures of the upper and lower GIT</td>
<td>2/12</td>
</tr>
<tr>
<td>5. C8A – Performing therapeutic endoscopic interventions</td>
<td>5/25</td>
</tr>
<tr>
<td>PART A: Procedural Skills</td>
<td></td>
</tr>
<tr>
<td>- Polypectomy</td>
<td>(3/10)</td>
</tr>
<tr>
<td>- Polypectomy &gt;1cm</td>
<td>(3/5)</td>
</tr>
<tr>
<td>- Dilations</td>
<td>(1/2)</td>
</tr>
<tr>
<td>- Variceal banding</td>
<td>(1/3)</td>
</tr>
<tr>
<td>Part B: Procedure Note</td>
<td>2/4</td>
</tr>
<tr>
<td><strong>TRANSITION TO PRACTICE:</strong></td>
<td></td>
</tr>
<tr>
<td>6. TP1A – Managing the day’s list of endoscopy procedures</td>
<td>3/5</td>
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<tr>
<td>At least 2 assessors</td>
<td></td>
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<tr>
<td>Other assessments during this rotation:</td>
<td>Tool Location / Platform (e.g. POWER, Entrada):</td>
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<td>----------------------------------------</td>
<td>-----------------------------------------------</td>
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<tr>
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<tr>
<td><strong>FOUNDATIONS:</strong></td>
<td></td>
</tr>
<tr>
<td>1. ME 3.4 Apply knowledge of anatomy, key landmarks and the endoscopic procedure, manipulate the endoscope appropriately, achieving stabilization, orientation, and direction, use appropriate strategies for endoscopic advancement, achieve clear visualization, perform tissue biopsies (as appropriate), demonstrate fine tip control</td>
<td>ME</td>
</tr>
<tr>
<td>2. COL 1.1 Respond appropriately to input from other health care professionals</td>
<td>COL</td>
</tr>
<tr>
<td>3. COL 1.3 Communicate effectively with other health care professionals</td>
<td>COL</td>
</tr>
<tr>
<td>4. P1.1 Work within personal limitations, asking for assistance as needed.</td>
<td>P</td>
</tr>
<tr>
<td>5. COM 5.1 Document the encounter to accurately convey the procedure and outcome, document the quality and findings of the endoscopic procedure, using instruments with strong validity evidence as appropriate, record high quality images of significant findings, complete clinical documentation in a timely manner</td>
<td>COM</td>
</tr>
<tr>
<td><strong>CORE:</strong></td>
<td></td>
</tr>
<tr>
<td>6. ME 3.4 Recognize loop formation and use loop reduction techniques appropriately, use position changes and other techniques, as appropriate, to advance the endoscope safely, demonstrate pace and progress during insertion and withdrawal</td>
<td>ME</td>
</tr>
<tr>
<td>7. COL 1.2 Communicate effectively with nurses and assistants during the procedure</td>
<td>COL</td>
</tr>
<tr>
<td>8. ME 2.2 Interpret the clinical significance of findings of endoscopic procedures</td>
<td>ME</td>
</tr>
<tr>
<td>9. ME 2.4 Integrate endoscopic findings to develop a provisional diagnosis and management plan</td>
<td>ME</td>
</tr>
<tr>
<td>10. ME 4.1 Propose and implement plans for ongoing care and/or follow-up on investigations</td>
<td>ME</td>
</tr>
<tr>
<td>11. ME 3.4 Demonstrate appropriate and safe use of ancillary equipment</td>
<td>ME</td>
</tr>
<tr>
<td>12. COM 5.1 Complete clinical documentation in a timely manner, document the encounter to accurately convey the procedure and outcome</td>
<td>COM</td>
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</table>
TRANSITION TO PRACTICE:

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<tr>
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</thead>
<tbody>
<tr>
<td><strong>13.</strong></td>
<td>ME 3.4 Perform endoscopic procedures in a skillful and safe manner, adapting to unanticipated findings or changing clinical circumstances</td>
<td>ME</td>
</tr>
<tr>
<td><strong>14.</strong></td>
<td>L 4.2 Adhere to occupational safety procedures to ensure patient, personal and team safety</td>
<td>L</td>
</tr>
<tr>
<td><strong>15.</strong></td>
<td>ME 3.4 Identify clinically significant findings of endoscopic procedures</td>
<td>ME</td>
</tr>
<tr>
<td><strong>16.</strong></td>
<td>ME 4.1 Propose and implement plans for ongoing care, follow-up on investigations, and further treatment or referral</td>
<td>ME</td>
</tr>
<tr>
<td><strong>17.</strong></td>
<td>L 4.2 Demonstrate leadership skills in the endoscopy suite</td>
<td>L</td>
</tr>
<tr>
<td><strong>18.</strong></td>
<td>L 4.1 Manage time effectively to maintain patient and endoscopy flow</td>
<td>L</td>
</tr>
</tbody>
</table>

Other:

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. Photo-documentation
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 (e.g. 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)

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 contraindications to this procedure and will have exposure to ERCP. Further training in ERCP is available in the third year, in a formal Advanced Therapeutic 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:**
IN-PATIENT HEPATOLOGY /LIVER TRANSPLANT ROTATION

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Preceptor</th>
<th>Contact</th>
<th>Initial Reporting</th>
</tr>
</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>

FOCUS OF THIS ROTATION
- Assessment and management of patients with complex liver disease, in an in patient setting
- Assessment and management of liver transplant patients (pre- and post-transplant)

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. They will also be expected to attend the weekly multidisciplinary liver transplant rounds and the monthly liver tumor rounds.

Call for this rotation:
- UAH - The GI resident will take call at UAH in accordance to the schedule created by the GI Chief Resident.

CBD stage(s) for this rotation:
- Core

Length of this rotation:
- 1 block

PGY Level(s) for this rotation:
- PGY 4/5

Locations for rotation:
- UAH

Required training experiences included in this rotation
- 1.1 GI consultative and/or inpatient service
- 1.2 GI Outpatient clinics

Other training experiences that may be included in this rotation
- None

Optional training experiences that may be included in this rotation
- Core 5.8. GI transplantation
### EPAs Mapped to this rotation:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Total # of Entrustments</th>
</tr>
</thead>
</table>
| 1. | C1A – Assessing and initiating management for complex patients  
    - Extrahepatic manifestations of liver disease  
    - Significant social barriers to health care  
    - Cultural/language/religious barriers to communication care | 1/5 |
| 2. | C2AP – providing ongoing management for patients with stable, chronic, and/or complex conditions  
    - Liver transplant  
    - Chronic liver disease | 3/14 |
| 3. | C3AP – Managing patients with exacerbations, disease progression, and/or complications of chronic GI conditions  
    - In patient  
    - Chronic liver disease | 2/10 |
| 4. |   |   |

### Other assessments during this rotation:  

<table>
<thead>
<tr>
<th></th>
<th>Tool Location / Platform (e.g. POWER, Entrada):</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>None</td>
</tr>
</tbody>
</table>

### Key Goals for this Rotation:

<table>
<thead>
<tr>
<th></th>
<th>CanMEDS Role(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>ME 2.2 Prioritize which issues need to be addressed, Select and interpret the results of investigations performed to monitor treatment and clinical status</td>
</tr>
<tr>
<td>2.</td>
<td>ME 2.2 Assess treatment adherence, efficacy, and/or toxicity</td>
</tr>
<tr>
<td>3.</td>
<td>ME 2.2 Select and interpret the results of investigations performed to monitor treatment and clinical status, differentiate signs and symptoms of disease and/or disease progression from adverse effects of treatment, synthesize patient information to determine clinical course, response to treatment and/or toxicity, and short and long-term prognosis</td>
</tr>
<tr>
<td>4.</td>
<td>COM 3.1 Provide information related to the patient’s health status, care and needs clearly and compassionately</td>
</tr>
<tr>
<td>5.</td>
<td>ME 4.1 Coordinate treatment and follow-up plans</td>
</tr>
</tbody>
</table>

### Other:
AMBULATORY BLOCK ROTATION

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Preceptor</th>
<th>Contact</th>
<th>Initial Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Block</td>
<td>Attending Staff</td>
<td>Carrie-Anne Cyre</td>
<td>Per Ambulatory Clinic Schedule</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ph: 780-492-8243</td>
<td></td>
</tr>
</tbody>
</table>

FOCUS OF THIS ROTATION - FOUNDATIONS

- Assessment and management of ambulatory patients with uncomplicated GI and liver problems

During this 4-week rotation, residents will be assigned to a mix of gastrointestinal and hepatology clinics. They will be assigned to 8 half-day clinics per week. This rotation serves to complement other primarily in-patient rotations by providing experience in assessing and managing (uncomplicated) patients in the ambulatory setting.

FOCUS OF THIS ROTATION - CORE

- Assessment and management of ambulatory patients with chronic or complex GI and liver problems

During this 4-week rotation, residents will be assigned to a mix of gastrointestinal and hepatology clinics. They will be assigned to 8 half-day clinics per week. This rotation serves to complement other primarily in-patient rotations by providing experience in assessing and managing (uncomplicated) patients in the ambulatory setting.

Call for this rotation:

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

CBD stage(s) for this rotation:

- Foundations
- Core

Length of this rotation:

- 1 block

PGY Level(s) for this rotation:

- PGY-4

Locations for rotation:

- UAH
- RAH

Required training experiences included in this rotation

- 1.2 GI Outpatient clinics

Other training experiences that may be included in this rotation

- Core 3.2. Specialized clinics in Gastroenterology
### EPAs Mapped to this rotation:

<table>
<thead>
<tr>
<th>FOUNDATIONS:</th>
<th>Total # of Entrustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. F1AP – Assessing and initiating management of uncomplicated patients</td>
<td>1/2</td>
</tr>
<tr>
<td>PART A: Hx &amp; PE</td>
<td></td>
</tr>
<tr>
<td>Part B: Clinical Assessment &amp; Management</td>
<td>6/12</td>
</tr>
<tr>
<td>2. C1A – Assessing and initiating management for complex patients</td>
<td>(2/5)</td>
</tr>
<tr>
<td>- Outpatient</td>
<td>(2/2)</td>
</tr>
<tr>
<td>- Anticoagulation issues</td>
<td></td>
</tr>
<tr>
<td>- EIM of GI disease, or EHM of liver disease</td>
<td></td>
</tr>
<tr>
<td>- Pregnancy</td>
<td></td>
</tr>
<tr>
<td>Significant family history of malignancy</td>
<td></td>
</tr>
<tr>
<td>3. C2AP – Providing ongoing management for patients with stable</td>
<td>5/14</td>
</tr>
<tr>
<td>chronic and/or complex conditions</td>
<td></td>
</tr>
<tr>
<td>4. C3AP – Managing patients with exacerbations, disease progression, and/or complications of chronic GI conditions</td>
<td>2/10</td>
</tr>
<tr>
<td>Chronic liver disease, IBD, other</td>
<td></td>
</tr>
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</table>

### Other assessments during this rotation:

<table>
<thead>
<tr>
<th>Tool Location / Platform (e.g. POWER, Entrada):</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. None</td>
</tr>
</tbody>
</table>

### Key Goals for this Rotation:

<table>
<thead>
<tr>
<th>CanMEDS Role(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOUNDATIONS:</td>
</tr>
<tr>
<td>1. ME 2.2 Elicit an accurate, relevant history, Perform a physical examination that informs the diagnosis, Synthesize information from the clinical assessment, Select and interpret appropriate investigations</td>
</tr>
<tr>
<td>2. ME 2.4 Develop and implement management plans</td>
</tr>
<tr>
<td>3. COL 1.3 Communicate effectively with other health care professionals</td>
</tr>
<tr>
<td>4. COM 5.1 Document the clinical encounter to adequately convey clinical reasoning, rationale for decisions and/or recommendations</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>CORE:</th>
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<td>7.</td>
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<td>8.</td>
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<tr>
<td>9.</td>
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<tr>
<td>10.</td>
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<tr>
<td>11.</td>
</tr>
</tbody>
</table>

Other:
LONGITUDINAL CLINIC

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Preceptor</th>
<th>Contact</th>
<th>Initial Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Longitudinal Clinic</td>
<td>Attending Staff</td>
<td>Carrie-Anne Cyre</td>
<td>Assigned Preceptors at least 1 month prior to the start of rotation</td>
</tr>
</tbody>
</table>

FOCUS OF THIS ROTATION

- Assessment and management of ambulatory patients with chronic or complex GI and liver problems

This is a 12-month longitudinal clinic half day during the CORE phase of GI training. This is to 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 on average 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. The GI resident will work with the 2 clinic’s administrative support to create a schedule with on average of 3-4 half day clinics per block.

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 primarily for patients previously seen by the GI resident. Residents should communicate clearly with their preceptor’s administrative assistant when they want these patients booked back to see them.

Patients requiring ongoing follow-up will be transferred back to the mentor at the end of the year. 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.

Call for this rotation:
- As per block schedule

CBD stage(s) for this rotation:
- Core
Length of this rotation:
- 1 year

PGY Level(s) for this rotation:
- PGY-4/5

Locations for rotation:
- UAH
- RAH
- MIS
- GNH

Required training experiences included in this rotation
- Core 3.1 Longitudinal clinic

Other training experiences that may be included in this rotation
- Core 3.2. Specialized clinics in Gastroenterology

<table>
<thead>
<tr>
<th>EPAs Mapped to this rotation:</th>
<th>Total # of Entrustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. C1A – Assessing and initiating management for complex patients</td>
<td>(1/5)</td>
</tr>
<tr>
<td>- Outpatient</td>
<td>(1/2)</td>
</tr>
<tr>
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<tr>
<td>- Pregnancy</td>
<td></td>
</tr>
<tr>
<td>- Significant family history of malignancy</td>
<td></td>
</tr>
<tr>
<td>2. C2AP – Providing ongoing management for patients with stable, chronic and/or complex conditions</td>
<td>3/14</td>
</tr>
<tr>
<td>3. C3AP – Managing patients with exacerbations, disease progression, and/or complications of chronic GI conditions</td>
<td>2/10</td>
</tr>
<tr>
<td>Chronic liver disease, IBD, other</td>
<td></td>
</tr>
</tbody>
</table>

Other assessments during this rotation:
- None

Key Goals for this Rotation:
- ME 1.4 Perform clinical assessments that address all relevant issues

CanMEDS Role(s):
- ME
<table>
<thead>
<tr>
<th></th>
<th>HA 1.1 Identify barriers to access and care for individual patients</th>
<th>HA</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.</td>
<td>COL 1.3 Integrate the patient’s perspective and context into the collaborative care plan</td>
<td>COL</td>
</tr>
<tr>
<td>4.</td>
<td>ME 2.4 Develop and implement management plans that consider all the patient’s health problems and needs, adjust management plans based on clinical status and/or response to treatment</td>
<td>ME</td>
</tr>
<tr>
<td>5.</td>
<td>COM 3.1 Provide information related to the patient’s health status, care and needs clearly and compassionately</td>
<td>COM</td>
</tr>
<tr>
<td>6.</td>
<td>COL 3.2 Communicate with the patient’s primary health care professional about the patient’s care</td>
<td>COL</td>
</tr>
<tr>
<td>7.</td>
<td>HA 1.1 Facilitate timely patient access to services and resources</td>
<td>HA</td>
</tr>
</tbody>
</table>

**Other:**
NUTRITION ROTATION

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Preceptor/Coordinator</th>
<th>Contact</th>
<th>Initial Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition</td>
<td>Dr. Jennifer Jin RAH</td>
<td>Dr. Jennifer Jin</td>
<td>Contact Dr. Jin the week prior to starting, via switchboard or email</td>
</tr>
</tbody>
</table>

FOCUS OF THIS ROTATION

- Management of patients with complex nutritional needs, including the development of complete nutritional assessment and plan (including parenteral nutrition).

On this 4-week rotation, the resident will gain experience in the management of patients, with particular emphasis on nutrition. The rotation is based primarily at RAH, with some activities at UAH. The resident will be responsible for seeing new consults 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.

Call for this rotation:

- There is no call requirements for this rotation.

CBD stage(s) for this rotation:

- Core

Length of this rotation:

- 1 block

PGY Level(s) for this rotation:

- PGY 4/5

Locations for rotation:

- RAH
- (UAH)

Required training experiences included in this rotation

- 1.1 GI consultative and/or inpatient service
- 1.2. GI outpatient clinics
- 5.1 Nutrition

Other training experiences that may be included in this rotation

- None
### EPAs Mapped to this rotation:

<table>
<thead>
<tr>
<th>EPA</th>
<th>Description</th>
<th>Total # of Entrustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>C5AP – Providing complete nutritional assessment and plans for patients with complex nutritional needs</td>
<td>2/2</td>
</tr>
</tbody>
</table>
| 2.  | C2AP – providing ongoing management for patients with stable, chronic, and/or complex conditions  
   - Post-bariatric surgery  
   - Cystic fibrosis  
   - Chronic pancreatobiliary disease | 2/14                    |
| 3.  | C3AP – Managing patients with exacerbations, disease progression, and/or complications of chronic GI conditions  
   - Complication of therapy | 2/10                    |

### Other assessments during this rotation:

- None

### Key Goals for this Rotation:

<table>
<thead>
<tr>
<th>Goal</th>
<th>CanMEDS Role(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ME 2.2 Estimate nutritional requirements in a complex patient</td>
<td>ME</td>
</tr>
<tr>
<td>2. ME 2.4 Develop and implement a plan for nutritional support by any route; oral, enteral, parenteral, identify and manage complications of nutritional support (medical, and device and access related)</td>
<td>ME</td>
</tr>
<tr>
<td>3. L 2.1 Consider costs when choosing care options</td>
<td>L</td>
</tr>
<tr>
<td>4. ME 2.3 Work with the patient and family to understand relevant options for care</td>
<td>ME</td>
</tr>
<tr>
<td>5. ME 4.1 Develop and implement a plan for monitoring and follow-up</td>
<td>ME</td>
</tr>
<tr>
<td>6. COL 1.2 Work effectively within an interprofessional team</td>
<td>COL</td>
</tr>
<tr>
<td>7. ME 2.2 Differentiate signs and symptoms of disease and/or disease progression from adverse effects of treatment, synthesize patient information to determine clinical course, response to treatment and/or toxicity, and short and long-term prognosis</td>
<td>ME</td>
</tr>
</tbody>
</table>

### Other:

- None
MOTILITY ROTATION

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Preceptor/Coordinator</th>
<th>Contact</th>
<th>Initial Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motility</td>
<td>Dr. Adriana Lazarescu</td>
<td>Kirstine Paisley Ph: 492-8170</td>
<td>0830 Dr. Lazarescu's clinic in ZLC Contact Dr. Lazarescu to confirm</td>
</tr>
</tbody>
</table>

FOCUS OF THIS ROTATION

- Assessment and management of patients with motility disorders
- Interpretation of esophageal manometry, pH/impedence studies
- Therapeutic endoscopy - dilation of strictures

The GI motility rotation is a 1-block rotation dedicated to the study of motility disorders of the GI tract. It includes the following opportunities for learning: pre- and post-rotation written test of GI motility knowledge, observation of esophageal pH and impedance studies, observation of esophageal and ano-rectal manometry studies, 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:

<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>Clinic UAH</td>
<td>Clinic UAH</td>
<td>Dysphagia</td>
<td>Esophageal</td>
<td>Endoscopy UAH</td>
</tr>
<tr>
<td></td>
<td>(Lazarescu)</td>
<td>(Lazarescu)</td>
<td>Clinic (1st of month)</td>
<td>Disorder Clinic RAH (Sadowski)</td>
<td>(Lazarescu)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>GI Motility Lab</td>
<td></td>
<td></td>
</tr>
<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>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Call for this rotation:
- UAH - The GI resident will take call at UAH in accordance to the schedule created by the GI Chief Resident.

CBD stage(s) for this rotation:
- Core

Length of this rotation:
- 1 block

PGY Level(s) for this rotation:
- PGY 4/5

Locations for rotation:
- UAH
• Motility Lab

**Required training experiences included in this rotation**
• Core 1.2 GI Outpatient clinics
• Core 1.3 Endoscopy
• Core 5.2 Gastrointestinal motility

**Other training experiences that may be included in this rotation**
• Core 3.2. Specialized clinics in Gastroenterology

<table>
<thead>
<tr>
<th>EPAs Mapped to this rotation:</th>
<th>Total # of Entrustments</th>
</tr>
</thead>
</table>
| 1. C1A – Assessing and initiating management for complex patients  
  - Atypical presentation  
  - Ambiguity in presentation | 1/5 |
| 2. C2AP – providing ongoing management for patients with stable, chronic, and/or complex conditions  
  - Refractory GERD, functional abdominal pain/IBS | 1/14 |
| 3. C3AP – Managing patients with exacerbations, disease progression, and/or complications of chronic GI conditions  
  - Motility disorders  
  - Esophageal disease | 2/10 |
| 4. C7A - Identifying clinically significant findings during endoscopic procedures of the upper and lower gastrointestinal tract | 1/12 |
| 5. C8A – Performing therapeutic endoscopic interventions of the upper/lower GIT  
  - Dilations | 1/2 dilations |

<table>
<thead>
<tr>
<th>Other assessments during this rotation:</th>
<th>Tool Location / Platform (e.g. POWER, Entrada):</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Interpret esophageal manometry</td>
<td></td>
</tr>
<tr>
<td>2. Pre- and post-rotation test</td>
<td>Formative Exam(s)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Goals for this Rotation:</th>
<th>CanMEDS Role(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ME 2.2 Select and interpret the results of investigations performed to monitor treatment and clinical status, differentiate signs and symptoms of disease and/or disease progression from adverse effects of treatment, synthesize</td>
<td>ME</td>
</tr>
</tbody>
</table>
patient information to determine clinical course, response to treatment and/or toxicity, and short and long-term prognosis

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>2.</strong></td>
<td>COM 3.1 Provide information related to the patient’s health status, care and needs clearly and compassionately</td>
</tr>
<tr>
<td><strong>3.</strong></td>
<td>ME 3.4 Demonstrate appropriate and safe use of ancillary equipment, monitor patient comfort and safety, and adjust the procedure as needed, identify and react to immediate complications of the procedure, if applicable</td>
</tr>
<tr>
<td><strong>4.</strong></td>
<td>P 1.1 Work within personal limitations, asking for assistance as needed</td>
</tr>
</tbody>
</table>

**Other:**
SENIOR GI MENTORSHIP ELECTIVE

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Preceptor</th>
<th>Contact</th>
<th>Initial Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior RAH</td>
<td>Dr. Robert Bailey</td>
<td>Dr. Robert Bailey via Switchboard</td>
<td>Usually Dr. Bailey’s clinic; contact him the week before to confirm</td>
</tr>
</tbody>
</table>

FOCUS OF THIS ROTATION

- This is a preceptor-based rotation, with a focus on the skills necessary to transition to practice.

The senior GI mentorship is available 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 1-2 blocks (may/may not be consecutive).

Call for this rotation:
- RAH – call will Dr. Bailey

CBD stage(s) for this rotation:
- Core
- TTP

Length of this rotation:
- 1-2 blocks

PGY Level(s) for this rotation:
- PGY5

Locations for rotation:
- RAH

Required training experiences included in this rotation
- 1.2 GI Outpatient clinics
- 1.3 Endoscopy

Other training experiences that may be included in this rotation
- 1.1 GI consultative and/or inpatient service
<table>
<thead>
<tr>
<th>EPAs Mapped to this rotation:</th>
<th>Total # of Entrustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. C1A - Assessing &amp; initiating management for complex patients</td>
<td>*</td>
</tr>
<tr>
<td>2. C2AP - Providing ongoing management for patients with stable, chronic and/or complex conditions</td>
<td>*</td>
</tr>
<tr>
<td>3. C6A - Performing colonoscopy (includes sampling - difficult colons)</td>
<td>*</td>
</tr>
</tbody>
</table>
| 4. C8A - Performing therapeutic endoscopic interventions of the upper and lower gastrointestinal tract (need to include 5 of med-high complexity)  
  - Hemostasis – variceal  
  - Polypectomy  
  - Polypectomy >1cm |  |

<table>
<thead>
<tr>
<th>Other assessments during this rotation:</th>
<th>Tool Location / Platform (e.g. POWER, Entrada):</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Endoscopy log</td>
<td>Google Drive</td>
</tr>
</tbody>
</table>
GI ONCOLOGY ELECTIVE

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Preceptors</th>
<th>Contact</th>
<th>Initial Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>GI Oncology</td>
<td>Dr. Sanraj Basi</td>
<td>Coordinator <a href="mailto:medonc@ualberta.ca">medonc@ualberta.ca</a></td>
<td>The coordinator 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>
<td></td>
</tr>
</tbody>
</table>

Coordinated through Medical Oncology Residency Training Program Coordinator. 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](mailto:kelli.hucke@albertahealthservices.ca))
Medical oncology (via Dr. Sanraj Basi)
RAH Tumor Rounds Schedule (via Dr. Bailey/Matic’s office)

**FOCUS OF THIS ROTATION**
- Experience in the diagnosis and management of patients with common solid tumors arising from the gastrointestinal tract.
- Management of GI complications arising in cancer patients.

The oncology elective is carried out at the Cross Cancer Institute (CCI) 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. 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.

**Call for this rotation:**
- UAH - The GI resident will take call at UAH in accordance to the schedule created by the GI Chief Resident.

**CBD stage(s) for this rotation:**
- Foundations
- Core

**Length of this rotation:**
- 1 block

**PGY Level(s) for this rotation:**
• PGY 4/5

Locations for rotation:
• Cross Cancer Institute
• RAH

Required training experiences included in this rotation
• 1.2 GI Outpatient clinics
• 1.3 Endoscopy

Other training experiences that may be included in this rotation
• 5.5. GI oncology

<table>
<thead>
<tr>
<th>EPAs Mapped to this rotation:</th>
<th>Total # of Entrustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. C2AP - Providing ongoing management for patients with stable, chronic and/or complex conditions</td>
<td></td>
</tr>
<tr>
<td>2. C3AP - Managing patients with exacerbations, disease progression, and/or complications of chronic GI conditions</td>
<td></td>
</tr>
<tr>
<td>3. C4AP - Identifying and referring patients who need additional specialized care Part A - Assessment &amp; decision</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other assessments during this rotation:</th>
<th>Tool Location / Platform (e.g. POWER, Entrada):</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Endoscopy log</td>
<td>Google Drive</td>
</tr>
</tbody>
</table>
**IBD ELECTIVE**

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Preceptor</th>
<th>Contact</th>
<th>Initial Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>IBD Elective</td>
<td>Dr. Brendan Halloran</td>
<td>Leanne Bala 780-492-8691x4 <a href="mailto:halclin@ualberta.ca">halclin@ualberta.ca</a></td>
<td>Contact Leanne the week before rotation starts to set a meeting with Dr. Halloran</td>
</tr>
</tbody>
</table>

**FOCUS OF THIS ROTATION**
- Assessment and management of patients with inflammatory bowel disease.

Residents on this 1-block rotation will have a comprehensive experience with inflammatory bowel disease (IBD), 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. A schedule of clinical activities will be made at the start of this block assigning the GI resident to clinic and endoscopy with the IBD physicians.

**Call for this rotation:**
- UAH - The GI resident will take call at UAH in accordance to the schedule created by the GI Chief Resident.

**CBD stage(s) for this rotation:**
- Core

**Length of this rotation:**
- 1 block

**PGY Level(s) for this rotation:**
- PGY 4/5

**Locations for rotation:**
- UAH

**Required training experiences included in this rotation**
- Core 1.2 GI Outpatient clinics
- Core 1.3 Endoscopy
- Core 3.2. Specialized clinics in Gastroenterology

**Other training experiences that may be included in this rotation**
- 1.1 GI consultative and/or inpatient service
<table>
<thead>
<tr>
<th>EPAs Mapped to this rotation:</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1. C1A - Assessing &amp; initiating management for complex patients</td>
<td>*</td>
</tr>
<tr>
<td>2. C3AP - Managing patients with exacerbations, disease progression, and/or complications of chronic GI conditions</td>
<td>*</td>
</tr>
<tr>
<td>3. C6A - Performing colonoscopy (includes sampling - difficult colons)</td>
<td>*</td>
</tr>
<tr>
<td>4. C7A - Identifying clinically significant findings during endoscopic procedures of the upper and lower gastrointestinal tract</td>
<td>*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other assessments during this rotation:</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1. Endoscopy log</td>
<td>Google Drive</td>
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</tbody>
</table>
RESEARCH ELECTIVE

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Preceptor</th>
<th>Contact</th>
<th>Initial Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research</td>
<td>Research Supervisor</td>
<td>Research Supervisor</td>
<td>Resident should meet with supervisor pre-rotation to ensure readiness for project start</td>
</tr>
</tbody>
</table>

Coordinator: Dr. Farhad Peerani

FOCUS OF THIS ROTATION
- Participation in a scholarly project

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. Residents will be assigned a 2-week research block early in their training to help them connect with a preceptor and set up a project for GRIT/CDDW. Residents will also have the option of additional Research blocks.

Call for this rotation:
- UAH - The GI resident will take call at UAH in accordance to the schedule created by the GI Chief Resident. Note: during the 1 month block, call will only be on weekends.

CBD stage(s) for this rotation:
- TTD
- Foundations
- Core
- TTP

Length of this rotation:
- TTD – ½ block
- F/C/TTP – 1 block

PGY Level(s) for this rotation:
- PGY4/5

Locations for rotation:
- N/A

Required training experiences included in this rotation
- N/A

Other training experiences that may be included in this rotation
- 4.1. Participation in scholarly activity
TABLE

<table>
<thead>
<tr>
<th>EPAs Mapped to this rotation:</th>
<th>Total # of Entrustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. None</td>
<td></td>
</tr>
</tbody>
</table>

Other:

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. Mahmod Mohamed (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.
PATHOLOGY ELECTIVE

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Preceptor</th>
<th>Contact</th>
<th>Initial Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathology</td>
<td>Dr. Aducio Thiessen</td>
<td>Dr. Aducio Thiessen</td>
<td>0800 Page Dr. Aducio Thiessen</td>
</tr>
</tbody>
</table>

The resident should meet with the Rotation Coordinator 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.

**FOCUS OF THIS ROTATION**
- Interpretation of GI mucosal and liver biopsies

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.

**Call for this rotation:**
- UAH - The GI resident will take call at UAH in accordance to the schedule created by the GI Chief Resident.

**CBD stage(s) for this rotation:**
- Foundations
- Core

**Length of this rotation:**
- 1 block

**PGY Level(s) for this rotation:**
- PGY 4/5

**Locations for rotation:**
- UAH

**Required training experiences included in this rotation**
- None

**Other training experiences that may be included in this rotation**
- None

**Other training experiences that may be included in this rotation**
- 5.4. Pathology of the digestive system
### EPAs Mapped to this rotation:

<table>
<thead>
<tr>
<th>EPAs Mapped to this rotation:</th>
<th>Total # of Entrustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. None</td>
<td></td>
</tr>
</tbody>
</table>

### Other assessments during this rotation:

<table>
<thead>
<tr>
<th>Other assessments during this rotation:</th>
<th>Tool Location / Platform (e.g. POWER, Entrada):</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ITER Evaluation</td>
<td>One45</td>
</tr>
</tbody>
</table>

### Key Goals for this Rotation:

<table>
<thead>
<tr>
<th>Key Goals for this Rotation:</th>
<th>CanMEDS Role(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 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.</td>
<td>ME</td>
</tr>
<tr>
<td>2. He/she will be expected to identify histologic features of common gastrointestinal conditions.</td>
<td>ME</td>
</tr>
<tr>
<td>3. He/she will develop an understanding of the role of ancillary techniques such as molecular histological methods</td>
<td>ME</td>
</tr>
</tbody>
</table>

### Other:

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

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Preceptor</th>
<th>Contact</th>
<th>Initial Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric GI</td>
<td>Dr. Jason Silverman</td>
<td>Jessica Tucker (MEPA)</td>
<td>Check with Jessica 1 week prior to rotation for reporting instructions and schedule</td>
</tr>
</tbody>
</table>

FOCUS OF THIS ROTATION
- Understand the conditions unique to pediatrics, pediatric diseases which will impact adult life.
- Appreciate the similarities and differences in disorders found in both pediatrics and adult gastroenterology

Call for this rotation:
- UAH - The GI resident will take call at UAH in accordance to the schedule created by the GI Chief Resident.

CBD stage(s) for this rotation:
- CORE

Length of this rotation:
- 1 Block

PGY Level(s) for this rotation:
- PGY 4/5

Locations for rotation:
- Stollery Children’s Hospital

Required training experiences included in this rotation
- N/A

Other training experiences that may be included in this rotation
- N/A

Optional training experiences that may be included in this rotation
- Core 5.7. Pediatric Gastroenterology for clinic and endoscopy experience
<table>
<thead>
<tr>
<th>EPAs Mapped to this rotation:</th>
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</thead>
<tbody>
<tr>
<td>1. C1AP - Assessing &amp; initiating management for complex patients</td>
<td></td>
</tr>
<tr>
<td>2. C2AP - Providing ongoing management for patients with stable, chronic and/or complex conditions</td>
<td></td>
</tr>
<tr>
<td>3. C3AP - Managing patients with exacerbations, disease progression, and/or complications of chronic GI conditions</td>
<td></td>
</tr>
<tr>
<td>4. C5AP - Providing complete nutritional assessment and plans for patients with complex nutritional needs</td>
<td></td>
</tr>
<tr>
<td>5. C6A - Performing colonoscopy (includes sampling - difficult colons)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other assessments during this rotation:</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1. Endoscopy log</td>
<td>Google Drive</td>
</tr>
</tbody>
</table>

**Other:**

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. 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.
LEADERSHIP & RESEARCH

In years past, teaching on leadership and research has been 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:
- Introduction to research
- Research Ethics
- Research – setting up a scholarly project
- Introduction to Quality Improvement
- Career Planning – What it takes to get a job in GI, how to distinguish yourself
- Collegial conversations
- Presentation skills
POLICY SECTION

On Call

UAH Site

GI residents will be expected to take night and weekend call in accordance with PARA guidelines. The call is from home; rather than the 1 in 3 call for home calls as outlined by PARA, GI call will not exceed 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:

*(NOTE: this structure is being re-visited by the UAH site, and therefore is subject to change)*

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 may be asked to provide consultation advice 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).

**RAH Site**

Residents assigned to RAH will provide call at RAH. See rotation descriptions for details.

**GNH/MIS Sites**

Residents assigned to GNH/MIS sites will provide call at the site that they are assigned.

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Call Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>UAH Consults</td>
<td>UAH</td>
</tr>
<tr>
<td>RAH Consults</td>
<td>RAH (3rd or 2nd weekend)</td>
</tr>
<tr>
<td>MIS Consults</td>
<td>MIS</td>
</tr>
<tr>
<td>GNH Consults</td>
<td>GNH</td>
</tr>
<tr>
<td>UAH Ward</td>
<td>UAH</td>
</tr>
<tr>
<td>UAH Ward Jr Attending</td>
<td>UAH weeknights &amp; 2 weekends ward rounding</td>
</tr>
<tr>
<td>Ambulatory – all</td>
<td>UAH</td>
</tr>
<tr>
<td>Nutrition</td>
<td>None</td>
</tr>
<tr>
<td>Motility</td>
<td>UAH</td>
</tr>
<tr>
<td>Sr. GI</td>
<td>RAH – call with RJB or as assigned</td>
</tr>
<tr>
<td>GI Oncology</td>
<td>UAH</td>
</tr>
<tr>
<td>IBD</td>
<td>UAH</td>
</tr>
<tr>
<td>Research</td>
<td>UAH – see rotation description</td>
</tr>
<tr>
<td>Pathology</td>
<td>UAH</td>
</tr>
<tr>
<td>Pediatric GI</td>
<td>UAH</td>
</tr>
<tr>
<td>Electives – in Edmonton</td>
<td>UAH</td>
</tr>
<tr>
<td>Electives – out of town</td>
<td>N/A</td>
</tr>
</tbody>
</table>
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 provided by the PGME at $650/year. Additional funds from the GI Division may be available – this amount is subject to annual review by the RPC based on available funding resources. 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 last day 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 during Winter Break (Christmas/New Year). Resident
are entitled to 6 consecutive days off during the Winter Break (December 20-January 5). As per the PARA agreement, residents may choose a different 6-days off in lieu the Winter Break to accommodate the observance of an alternate religious holiday (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 will generally have completed their IM exam at the start of their GI residency. For those that have not successfully completed this exam, 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.

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. Residents starting their GI training in July 2019 will be required to pass the written portion before being invited to the oral examination. 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 Advisor**
- 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, Electives, 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.

**GI SAFETY POLICY**
1. Introduction
The Faculty of Medicine and Dentistry (FoMD), and more specifically, the Division of Gastroenterology, at the University of Alberta has a legal requirement to maintain a safe and healthy workplace for all postgraduate medical (PME) students. Medical education and clinical training must occur in a physically safe environment (Royal College of Physicians and Surgeons of Canada and College of Family Physicians of Canada – accreditation standards)).

The Division of Gastroenterology also recognizes that a safe working environment for PME students is beneficial to medical education and patient care, and that there are ethical and moral reasons for maintaining such a working environment. The University of Alberta will ensure compliance with required legal standards for occupational health and safety for PME students at all times. In addition, the University through the PGME office will look to achieve standards of best practice in occupational health and safety, subject to the broader demands of working within a healthcare environment.

Residents are postgraduate medical students registered with the University of Alberta and are employees of Alberta Health Services (AHS). In addition, during the course of their employment they may work under the supervision of non-university employees, and on non-university premises. It is therefore important that issues of health and safety are effectively coordinated between these agencies. Safety requirements are identified through the residents’ collective agreement of the Provincial Association of Residents of Alberta (PARA) and through the Health and Safety policy of the University of Alberta.

Other relevant policies include those of the Post-Graduate Medical Office, Alberta Health Services and the College of Physicians and Surgeons of Alberta.

2. Scope
The University and affiliated teaching sites are accountable for the environmental, occupational and personal health and safety of their employees and have the right to make implementation decisions within their respective policies and resource allocations. PME students must adhere to the relevant health and safety policies and procedures of their rotation’s training sites. In addition, all teaching sites for residents must meet the requirements of the PARA collective agreement.

3. Purpose
- To demonstrate the commitment of FoMD to the health, safety and protection of its PME students
- To minimize the risk of injury and promote a safe and healthy environment at the university and teaching sites
- To provide a procedure to report hazardous or unsafe training conditions and a mechanism to take corrective action
4. Procedure and responsibility

A. Environmental health
Accidents, incidents and environmental illnesses occurring during training will be reported by the trainee to the site Office of Occupational Health, Safety and Wellness and will be dealt with according to their reporting policies and procedures.

B. Occupational health
The FoMD through the office of PGME and the residency programs are responsible for providing an introductory program to residents on body substance precautions, infection control and occupational health procedures in the teaching sites. PME students are responsible for attending the program and to abide by the safety codes relevant to the area where he/she is training.
AHS Workplace Health and Safety collects the immunization data of the PME students. PME students not meeting the immunization requirements are not permitted to work within AHS teaching sites.
Communicable disease concerns are reviewed by AHS Workplace Health and Safety and dealt with on a case-by-case basis.

C. Personal health and safety
The Division of Gastroenterology strives for a safe environment for PME students in all teaching sites. All sites are responsible for ensuring the safety and security of residents in their facilities in compliance with their existing employee safety and security policies as well as requirements laid out in the PARA collective agreement. PME students may be required to attend patients in the community but will not be required to see patients without adequate supervision or in an unsafe environment.

- Physical safety: travel, patient encounters, including house calls, after-hours consultations in isolated departments and patient transfers, dealing with violent patients, body substance exposure, immunizations, call rooms, radiation or toxin exposure.
- Psychological safety – intimidation and harassment, psychological illness, personal wellness and well-being, substance abuse, inequity in the workplace.
- Professional safety – conflict in ethical/religious beliefs, adverse event/critical incident support, confidentiality of personal information, medical liability coverage, and threat of medico-legal action.

Personal Safety at work
Postgraduate trainees should not work alone after hours in health care or academic facilities without adequate support from the applicable health authority’s security services or University of Alberta’s security services, respectively.

- Residents are not expected to work alone at after-hours clinics or endoscopy. If they are required to work late, residents should be aware of the University’s lone worker program.
- Residents are entitled to a safe and secure environment when using health care facilities or University of Alberta’s premises, including parking lots and parkades. Residents are encouraged to notify and utilize available the student’s union safewalk or security services when walking outdoors or to the parkade at night.
- Residents should only telephone patients from an institutional phone line or while using caller blocking if calling from a personal phone line.
- Residents should not provide patients with their personal or private information, including home or cell phone numbers, personal email addresses, social media contact information, and home addresses.
- Residents should not assess violent or agitated and potentially violent patients without having received appropriate training on how to deal with such patients. Site orientations from the PME office include a review of local hospital safety procedures and policies.

**Safety while travelling**
Postgraduate trainees will be provided with appropriate time to travel for clinical or other academic assignments by car. When long distance travel is required by a Postgraduate trainee as part of their training program, the call restrictions specified in the PARA will be followed.

For long distance travel for conference, workshop, exams, external electives or other academic assignments, Residents should ensure that a colleague or the home residency office is aware of their itinerary, flights, and return date.

In situations where postgraduate trainees are concerned about personal safety related to travel during inclement weather, they should communicate promptly with the program office. Assignment of an alternate activity is at the discretion of the Program Director.

**Fatigue Management**
Residents are encouraged to monitor their levels of fatigue and be supported to take a post-call day if needed. Staff members should be made aware of this policy and not penalize residents for taking post-call time to rest. Residents should avoid driving home after call if they have not had adequate rest and should make alternate arrangements.

**Conflict Management**
Learning environments must be free from intimidation, harassment, and discrimination. Residents identifying a psychologically or emotionally unsafe learning environment should
report to their immediately supervisor or preceptor or program director (if they feel comfortable) or the Office of Advocacy and Wellbeing for resolution. Feedback and complaints made by postgraduate trainees must be handled in a manner in accordance with the PARA Intimidation and Harassment policy. Residents should be familiar with the DoM Working with respect guidance document.

5. Reporting and resolution
PME students identifying a personal safety or security breach in either institutional settings or non-institutional settings must report it to their immediate supervisor and their program director as soon as reasonably possible to allow resolution of the issue and to comply with site reporting requirements. PME students can also bring their safety concerns to the attention of the PGME office, the Resident Wellbeing Committee, the Office of Safe Disclosure and Human Rights, the Office of Learner Advocacy and Wellness and PARA.

The residency or fellowship program director has the authority to remove the trainee from the clinical placement if the issue is urgent and the risk is unacceptable. Should this occur, the training site coordinator and the Associate Dean, PGME must be notified.

APPENDIX 1

Online links
1. PARA collective agreement - https://para-ab.ca/para-agreement/
2. University of Alberta - https://www.med.ualberta.ca/programs/residency/policies
3. AHS (access via AHS intranet - http://insite.albertahealthservices.ca/2933.asp )
5. CPSA - http://www.cpsa.ca/
6. Faculty of Medicine and Dentistry: https://www.ualberta.ca/medicine
6. GI Residency website: https://sites.google.com/ualberta.ca/gi-residency/home
7. Office of Advocacy and Wellbeing: https://www.ualberta.ca/medicine/programs/support-wellness/contact

Contact information
PARA: 780 432-1749
Workplace Health and Safety Office: 780 342-8448 (Staff Injury Reporting Line 1-888-482-8550)
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: 780-492-5205
Office of Advocacy & Wellbeing: 1-134 Katz Group Centre for Pharmacy & Health Research
Edmonton, AB T6G 2E1 780 492-3092
CPSA: 780-423-4764
CMPA: 1-800-267-6522
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 expected 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

UNIVERSITY OF ALBERTA - DIVISION OF GASTROENTEROLOGY
RESIDENT LEAVE REQUEST FORM
(1-month notice required)

Residents requesting a day(s) off from their assigned rotation for any reason (exam, special, lieu of stat, flex, conference, etc.) MUST ensure that this form is completed, signed by appropriate individuals and returned to the PROGRAM OFFICE at least ONE MONTH prior to the first day of the leave.

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

________________________________ TO: __________________________________
FIRST DAY OF LEAVE ___________________________ FINAL DAY OF LEAVE ___________________________

I WILL BE ON __________________ SERVICE WITH __________________
(Rotation) (Staff Member[s])

☐ STAFF MEMBER SIGNATURE ___________________________

☐ STAFF MEMBER SIGNATURE ___________________________

REASON FOR LEAVE: __________________________________________________________

☐ CONFERENCE LEAVE   ☐ HOLIDAY / VACATION LEAVE   ☐ LEAVE OF ABSENCE
☐ LIEU OF STAT ______________   ☐ FLEX DAY   ☐ EXAM LEAVE

TRAVEL REIMBURSEMENT REQUESTED: YES ☐ NO ☐

ESTIMATED TRAVEL EXPENSES ________________________________

_________________________ ____________________________ APPLICANT’S SIGNATURE
DATE/TIME

APPROVED BY: _________________________________ ________________________________
GI RESIDENCY PROGRAM DIRECTOR DATE

RETURN TO: MEPC - GI RESIDENCY TRAINING PROGRAM
Zeidler Ledcor Centre
PH: 492-8243 / FAX: 492-1455

Revised June 2019
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 University of Alberta 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.

6. THE PULSE GENERATOR (FITNESS CENTRE-UAH)

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).

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 CMPA membership before they can partake in their residency. CMPA dues are the responsibility of the residents; the UofA 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:

Meeting Date  Mentor  Resident

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:**

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<th>Meeting Date</th>
<th>Mentor</th>
<th>Resident</th>
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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:

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<th>Mentor</th>
<th>Resident</th>
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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:

Meeting Date ____________________________
Mentor ____________________________
Resident ____________________________

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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<th>Mentor</th>
<th>Resident</th>
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Date of next meeting: ____________________

Revised June 2019
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:

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<th>Mentor</th>
<th>Resident</th>
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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:

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<th>Resident</th>
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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:

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<th>Meeting Date</th>
<th>Mentor</th>
<th>Resident</th>
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APPENDIX 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):
  - September 30th – Intent to Conduct Research (signed by Residency Program Director)
  - 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)
- CPSA - Conflict of Interest involving Financial or Personal Gain by Physicians (http://www.cpsa.ca/standardspractice/conflict-of-interest/)
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-centred, 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

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<th>Time</th>
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<td>UAH GI Rounds (Classroom D)</td>
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<td>(ZLC 2-10)*</td>
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<td>6:30-9:00</td>
<td>City-wide Grand Rounds (2nd Tues of Month)</td>
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Bolded – mandatory sessions

*Mandatory when on the related rotations
APPENDIX K: ATTENDANCE POLICY FOR OFF-SITE ROTATIONS

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<th>ROTATION</th>
<th>MONDAY GI ROUNDS</th>
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<td>RAH Senior GI</td>
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<tr>
<td>RAH Consult</td>
<td>√ (RAH)</td>
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<td>GNH Consult</td>
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<td>√ (GNH Medicine Grand Rounds)</td>
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<td>MIS Consult</td>
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<td>Nutrition</td>
<td>√ (UAH/RAH)</td>
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<tr>
<td>Elective – Edm</td>
<td>Depends</td>
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✓ Mandatory

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 Case Rounds
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. It is recommended that you use this tool to calculate your cecal- and TI-intubation rates.
# 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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</tr>
</tbody>
</table>
# 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 1</th>
<th>Phone 2</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>
<td></td>
</tr>
<tr>
<td>UAH Internal Paging</td>
<td>P: 76191</td>
<td></td>
</tr>
<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>
<td></td>
</tr>
</tbody>
</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
AASLD Website – http://www.acg.gi.org/
AGA Website – http://www.gastro.org/
ASGE Website – http://www.asge.org/
Alberta Innovates Website – 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
- Resident M&M Presentations in AHD – twice per year, with faculty present for discussion

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 must 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.