BAYLOR UNIVERSITY MEDICAL CENTER
DALLAS, TEXAS

Department of Internal Medicine

Gastroenterology and Hepatology Divisions

FELLOWSHIP HANDBOOK

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MISSION STATEMENTS

Baylor Scott & White Health

Our Mission

Founded as a Christian ministry of healing, Baylor Scott & White Health promotes the well-being of all individuals, families and communities.

Our Ambition

To be the trusted leader, educator and innovator in value-based care delivery, customer experience and affordability.

Our Values

- We serve faithfully
- We act honestly
- We never settle
- We are in it together

Mission Statement of the Baylor University Medical Center Gastroenterology Fellowship Program

To provide quality training in the clinical management of patients with digestive diseases founded on scientific principles, embracing recent discoveries, and enabling trainees to assimilate future developments, thereby allowing graduates of the program to provide high quality medical care for years to come. To imbue trainees with the abilities to add to the fund of knowledge about digestive and liver diseases and to explain that knowledge to colleagues and lay persons in educational settings. To emphasize the acquisition of technical skills in clinical practice, research, and education in order to achieve these purposes in an environment promoting humanistic values and ethical behavior.

A BRIEF HISTORY OF BAYLOR UNIVERSITY MEDICAL CENTER

On May 20, 1903, Dr. George W. Truett, pastor of Dallas' First Baptist Church, issued this call to action before a gathering of Dallas business and civic leaders: "Is it not now the time to begin the construction of a great humanitarian institution, one to which men of all creeds and those of none may come with equal confidence?" Truett's words sparked immediate action; a gift from Colonel C.C. (Christopher Columbus) Slaughter—one of Baylor Health Care System's first partners in philanthropy—made possible the creation of a 25-bed hospital, the Texas Baptist Memorial Sanitarium. In 1921, its name would change to Baylor Hospital to mark its close ties with Baylor University. Although those ties have loosened, the hospital retains its name proudly in recognition of more than 100 years of service to the community. From the start, education of health professionals was an important goal of Baylor Hospital. Many nurses, medical students and physicians have received some or all of their clinical training at this institution.

Baylor Health Care System (BHCS) grew hand in hand with the Dallas area and eventually developed a network of state-of-the-art hospitals and specialty centers. Baylor Scott & White Health was born from the 2013 combination of BHCS and Scott & White Healthcare in central Texas. Today, Baylor Scott & White Health is the largest not-for-profit health care system in Texas and one of the largest in the United States with $15.1 billion in total assets and $10.5 billion in total operating revenue. It includes 52 hospitals, more than 800 patient care sites, more than 7,300 active physicians, and over 49,000 employees in a service area roughly the same size as the entire state of New Jersey with a population greater than that of Virginia.

Baylor University Medical Center is the flagship hospital of the northern division of Baylor Scott & White Health and remains the hospital of choice for more north Texans than any other. It has a national reputation as a center for medical education and research and consistently is ranked highly in US News and World Report surveys.

HISTORY OF THE GASTROENTEROLOGY FELLOWSHIP AT BAYLOR

Baylor University Medical Center has a long history of emphasis on digestive diseases. Dr. Cecil Patterson, who completed his medical school training at Baylor College of Medicine in 1931 and his internal medicine and gastroenterology training at Baylor Hospital in 1933, was a pioneer of endoscopy in the United States and was one of the first to perform sclerotherapy for esophageal varices in the 1940's. The modern era of gastroenterology at Baylor began with the arrival of Dr. Dan Polter and the establishment of the Gastroenterology Fellowship Program in 1971. Since that time, Baylor has trained over 64 gastroenterologists and has invested in the latest technology, gaining recognition as the premier clinical gastroenterology resource in the region. Dr. John Fordtran came to Baylor University Medical Center as Chief of Internal Medicine in 1979 and established a strong gastrointestinal research laboratory, publishing over 100 peer-reviewed scientific papers. One of the earliest and busiest liver transplant programs in the country was started by Dr. Goran Klintmalm in 1985, strengthening Baylor as a center for patients with liver disease. Development of the Diagnostic Center for Digestive Diseases and the Gastrointestinal Physiology Laboratory in the 1980's further

established Baylor as a center of excellence in gastroenterology and hepatology. Through these actions, the Gastroenterology division at Baylor University Medical Center has achieved a national reputation. The new millennium saw the further development of separate gastroenterology and hepatology sections under the leadership of Drs. Rick Boland and Gary Davis, national leaders in their fields, and the expansion of research efforts into the genetic basis of colon cancer and viral hepatitis. More recently, leadership of the hepatology section passed to Dr. James Trotter with enhancement of research in the sequelae of chronic liver disease and expansion of the clinical faculty. In 2017, Dr. Stuart Spechler assumed leadership of the gastroenterology division and has established a clinical center for esophageal disease and a research laboratory focusing on Barrett's esophagus and esophageal pathophysiology

The Gastroenterology and Hepatology Divisions at Baylor also have gained stature from the accomplishments of their fellows. Most have gone on to careers as successful and respected gastroenterologists in communities across the region. Others have gone on to careers in academic centers as clinicians, researchers, and educators.

RESOURCES AND ENVIRONMENT

Baylor University Medical Center, Dallas

Baylor University Medical Center is a 914-bed tertiary-care referral hospital, one of the largest private hospitals in the country. Each year Baylor handles over 39,000 inpatient admissions and more than 101,000 emergency department encounters. Baylor is the regional leader in transplant services, digestive diseases, oncology, medical imaging, and critical care. The medical staff consists of over 1,050 physicians, many of whom are experts in their fields.

In addition to its mission in patient care, Baylor University Medical Center prides itself as a center of medical education and research. The hospital is affiliated with the Texas A&M Health Science Center College of Medicine; 50 medical students from A&M spend their last three years of medical school at BUMC. Postgraduate training includes residencies in Internal Medicine, Surgery, Colon and Rectal Surgery, Vascular Surgery, Obstetrics and Gynecology, Physical Medicine, Orthopedics, Dermatology, Anesthesiology, Pathology and Radiology. Fellowship training in internal medicine is offered in gastroenterology, transplant hepatology, cardiology, nephrology, infectious diseases, pulmonary and critical care medicine, and hematology/oncology. A fully-staffed library is available on campus. Research is a priority as well. More than 800 research projects are active currently with a budget of over $50,000,000.

Gastroenterology and Hepatology at Baylor are busy and growing divisions providing a comprehensive range of diagnostic and therapeutic services, continuing education opportunities, and strong research programs. Elements of the Gastroenterology and Hepatology Divisions include:

- **The GI Endoscopy Laboratory:** This facility has eleven procedure rooms, including 3 fluoroscopy rooms, staffed by twenty-six RN's, and 12 GI techs. More than 1,500 procedures are performed monthly in the GI Endoscopy Laboratory, including upper gastrointestinal endoscopy, colonoscopy, endoscopic retrograde cholangio-pancreatography, papillotomy, biliary manometry, double-balloon and spiral overtube small bowel enteroscopy, percutaneous gastrostomy, variceal sclerotherapy, variceal banding, control of GI bleeding using thermal cautery, clips and injection techniques, argon beam coagulation techniques, tumor ablation, endoscopic mucosal resection, balloon dilatation of esophageal, pyloric, duodenal, colonic and biliary strictures, endoscopic ultrasound, and pneumatic dilatation of the esophagus.

- **The GI Physiology Laboratory:** a unique laboratory designed to provide tests for unusual disorders that might be needed in a referral center, especially tests developed by the research laboratory at Baylor. These tests include breath hydrogen testing, breath testing for *Helicobacter pylori*, complete stool analysis, gastric analysis, pancreatic function tests, and intestinal perfusion studies. In addition, the Physiology Lab performs capsule enteroscopy, high-resolution esophageal motility studies, anorectal manometry, and 24-hour esophageal pH and impedance monitoring studies.

- **The GI Research Laboratories:** Several laboratories conduct clinical and basic research in gastroenterology. One laboratory is directed by Dr. John S. Fordtran and work there has resulted in over 100 publications focusing on intestinal absorption and function in human beings. Studies done there—often in collaboration with gastroenterology fellows—have described the characteristics of calcium, magnesium and phosphorus absorption by the gut, the clinical characteristics of microscopic colitis and chronic idiopathic secretory diarrhea, and the development of colon lavage solutions, such as Golytely® and Nulytely®. Drs. Stuart Spechler and Rhonda Souza have established a research laboratory studying the mucosal biology of the esophagus, with a special interest in gastroesophageal reflux disease and Barrett's esophagus. Research fellows participate in various projects and clinical fellows have the opportunity to spend time in these research laboratories as well.

- **Hepatology Service:** Baylor's liver transplant team performs approximately 140 adult liver transplants per year and is only one of 3 programs in the world that have completed more than 4,000 adult liver transplants. The Hepatology Division evaluates all patients referred for liver transplantation. In addition, patients with a wide variety of liver diseases are seen by referral in the Hepatology Clinic and in the hospital. The liver service is headed by Dr. James Trotter. Five other hepatologists are involved actively with the training program and clinical activities of the section. Drs. Trotter, Rahimi and Asrani have established an active hepatology research effort concentrating on sequelae of chronic liver disease. In addition, research is conducted on various aspects of other liver diseases and liver transplantation.

- **Gastroenterology Academic Offices:** A 4,000-square foot area houses offices for the gastroenterology fellows and some attendings. In addition, the area houses the motility laboratory. This area features a large library/conference room and computer resources for the fellows.

- **Physician Offices:** Much of the outpatient experience gained by Gastroenterology Fellows occurs in the offices of the faculty. These facilities include offices that are parts of Digestive Health Associates of Texas, Texas Digestive Disease Consultants, and HealthTexas, large single-specialty and multi-specialty group practices. Physicians in these offices allow fellows to participate fully in the care of their patients who have a broad range of digestive disorders. In addition, by using these venues fellows gain knowledge about the organization, management and business activities of private practices. Clinic patients are seen in an area shared with the Internal Medicine Clinic which is staffed by HealthTexas physicians supported by the hospital.

Baylor is an ideal location for a gastroenterology training program because it cares for many patients with a wide variety of gastrointestinal and liver problems who are referred from an extensive area. It is well staffed with both physician and non-physician personnel, and sufficient resources have been committed to provide us with state-of-the-art facilities, both within the Gastroenterology and Hepatology Services and in the rest

of the Medical Center. Radiology and Medical Imaging in particular supply top notch support services. Interactions with experts and trainees in other subspecialties of Internal Medicine and other departments provide a fertile resource for our fellows' education. Thus, this environment combines physicians with great expertise and the most powerful tools of modern medicine. Because of this, the fellows spend the vast majority of their time at Baylor throughout the course of their fellowships.

Rotations are offered outside of Baylor to expose fellows to other settings for the delivery of care, a broader range of techniques and opinions on management, and a greater variety of patients.

Baylor Medical Center, Waxahachie

Waxahachie, Texas is a city of 35,000 and is the county seat of Ellis County, a rapidly urbanizing rural county located about 30 miles from Baylor University Medical Center. Baylor Medical Center, Waxahachie is fully accredited and has an active inpatient service and endoscopy laboratory. Fellows accompany faculty gastroenterologists who staff the facility and get to see practice in a community hospital.

Methodist Dallas Medical Center

Methodist Dallas Medical Center is the main teaching hospital of the Methodist Health System and is located in Oak Cliff in southwest Dallas. The hospital operates 585 beds and boasts a state-of the-art endoscopy lab. Fellows have the opportunity to rotate with Drs. Paul Tarnasky, Prashant Kedia and Jeffrey Linder, physicians with special expertise in advanced endoscopy and endoscopic ultrasound procedures. During a month of advanced endoscopy training, fellows perform 40—50 advanced ERCP and EUS procedures. The hospital also has an active liver transplant program. Fellows also have the option of taking a month of hepatology there with Dr. Jeffrey Weinstein, in order to see different approaches to liver diseases.

FACULTY

Overview

A prime resource of the Gastroenterology Fellowship at Baylor is the depth and devotion of the faculty. Faculty members have a variety of interests, both clinical and investigational, practice in different settings, and have distinct types of patients. This makes for an assortment of clinical experiences for each fellow that run the gamut from “routine” clinical problems, such as heartburn or abdominal pain, to esoteric complaints that have defied extensive evaluation elsewhere. This also gives the fellows exposure to a variety of practice styles and settings. The faculty members are graduates of training programs throughout the country, and this also enhances the spectrum of approaches to clinical problems to which the fellows are exposed. The faculty includes skilled educators and accomplished researchers, as well as crackerjack clinicians. Therefore, the fellows have the opportunity to see different sorts of role models as they sort out their professional personas. Each faculty member is dedicated to his or her role as a teacher and spends the bulk of each day with the fellow rotating with them. Faculty members are trained in educational techniques and are excellent judges of the fellows’ progress. They provide immediate feedback through the course of their interactions with the fellows.

GASTROENTEROLOGY / HEPATOLOGY FACULTY

Name	Year of birth	Birthplace	Undergraduate Education	Medical School	Fellowship	GI Board Certified?
ALSAHHAR, Jamil	1987	Riyadh, Saudi Arabia	UT – Dallas	Texas A&M, College Station	BUMC, Dallas	Yes, 2019
ANDERSON, Robert	1975	Ft. Worth, TX	Texas Christian Univ	UTMB, Galveston	BUMC, Dallas	Yes, 2007
ASRANI, Sumeet	1978	Bombay, India	Louisiana State Univ.	Baylor College of Medicine, Houston	Mayo Clinic, Rochester, MN	Yes, 2012
BAHIRWANI, Ranjeeta	1980	Mumbai, India	Knox College, Galesburg, IL	Northwestern Univ	Univ of Pennsylvania	Yes, 2011
BURDICK, Steve	1959	Oklahoma City, OK	Southwestern Oklahoma State Univ.	Univ. of Oklahoma	Medical College of Wisconsin	Yes, 1993
CAROLLO, Angela	1972	Port Arthur, TX	Trinity University	UT Southwestern	BUMC, Dallas	Yes, 2005
DASSOPOULOS, Themistocles	1965	Athens, Greece	Brown University	Brown University	Univ of Chicago	Yes, 1999
DEMARCO, Daniel C.	1956	Natick, MA	Univ of Notre Dame	UT Southwestern	BUMC, Dallas	Yes, 1989
ELWAZIR, Esmail M.	1966	Florence, Italy	Michigan State Univ	Columbia University	UT Southwestern	Yes, 1999
ELWIR, Saleh M. S.	1985	Jerusalem, Israel	Univ of Jordan	Univ of Jordan	Univ of Minnesota	Yes, 2016
FORDTRAN, John S.	1931	San Antonio, TX	UT – Austin	Tulane University	Massachusetts Memorial Hospital	No
GAYLE, Sarita	1981	Brazil	UT – Austin	UT San Antonio	Univ of New Mexico	Yes, 2014
HAMILTON, John Kent	1945	Pauls Valley, OK	Baylor University	Univ of Oklahoma	Cleveland Clinic	Yes, 1997
HODGES, William Gregory	1961	La Jolla, CA	Abilene Christian U	UT Southwestern	UT Southwestern	Yes, 1993
KAHN, Ben	1984	Lamesa, Texas	Rice University	UT Southwestern	UT Southwestern	Yes, 2016

KALE, Hemangi	1968	Pune, India	Fergusson College, Pune, India	BJ Medical College, Pune University	MetroHealth, Cleveland; UC Davis	Yes, 2002
KEDIA, Prashant (Methodist)	1981	New Orleans, LA	Columbia Univ.	Univ. of Chicago	Mount Sinai, Weill-Cornell	Yes, 2013
KONDA, Vani JA	1975	Chicago, IL	Brown University	Brown University	Univ of Chicago	Yes, 2008
LINDER, Jeffrey (Methodist)	1969	Ponca City, OK	Texas A&M	UT Houston	Univ of Alabama	Yes, 1995
MAHGOUB, Amar	1978	Khartoum, Sudan	Iowa State Univ.	University of Iowa	Univ of Minnesota	Yes, 2014
MARTIN, Jason	1983	Washington, DC	Carleton College	UT Southwestern	UTSouthwestern	Yes, 2016
MOPARTY, Bhavani	1974	Halifax, Nova Scotia	Louisiana College	Tulane University	UTMB Galveston, Mass. Gen.-Brigham & Women's	Yes, 2006
NGUYEN, Anh	1984	Puerto Princessa, Philippines	UT – Dallas	UT – San Antonio	UT Southwestern	Yes, 2017
ODSTRCIL, Elizabeth	1976	Bryan, TX	Duke University	UT Southwestern	BUMC, Dallas	Yes, 2006
PERILLO, Robert	1944	New York, NY	Fordham University	Georgetown Univ	Washington Univ, St. Louis	Yes, 1977
RAHIMI, Robert	1976	Cincinnati, OH	UCLA	Chicago Med. School	UT Southwestern	Yes, 2012
SCHILLER, Lawrence	1951	Philadelphia, PA	Penn State University	Jefferson, Philadelphia	UT Southwestern	Yes, 1981
SHAH, Rushikesh	1987	Ahmedabad, India		Pad. Dr D Y Patil Med. University., Pimpri, Maharashtra, India	Emory University	Yes, 2019
SOUZA, Rhonda	1965	Methuen, MA	Cornell University	Howard University	Univ of Maryland	Yes, 1997
SPECHLER, Stuart	1951	New York	Boston University	Boston University	Boston VAMC, Boston University	Yes, 1979
TARNASKY, Paul (Methodist)	1963	Grand Forks, ND	Pacific Lutheran University, WA	Univ of California	Duke University & Medical University of South Carolina	Yes, 1995
TROTTER, James	1962	Springfield, MO	Davidson College	Emory University	Duke University	Yes, 1995

VESY, Christopher J.	1966	Youngstown, OH	Miami University, OH	The Ohio State Univ	UT Southwestern	Yes, 1999
YAUSSY, Catherine Mary	1956	Bakersfield, CA	Univ of Southern California	George Washington U	BUMC, Dallas	Yes, 1995

FELLOWSHIP PROGRAM OVERVIEW

Accreditation and Certification Standards

Every effort is made to comply with the accreditation standards of the Residency Review Committee for Internal Medicine of the Accreditation Council for Graduate Medical Education. This group accredits programs based on objective standards and performance criteria.

Every effort also is made to comply with the standards set by the American Board of Internal Medicine so that fellows who complete this program can sit for the Gastroenterology Subspecialty Examination and become board certified. The American Board of Internal Medicine certifies individuals based on successful completion of a prescribed fellowship and passing the certifying examination.

Gastroenterology Core Curriculum

This program utilizes the third edition of the Gastroenterology Core Curriculum published by the four gastroenterology and hepatology organizations (*http://www.acg.gi.org/physicians/trainees/pdfs/GICoreCurriculum.pdf*) as the basic curriculum for the fellowship. In accordance with this curriculum, the training program lasts for three years with protected time for scholarly activities and a track program for the final year of fellowship. Four tracks are offered for the final year at Baylor: Comprehensive Consultant, Hepatology, Advanced Endoscopy, and Research.

The Comprehensive Consultant Track offers two additional GI rotations, and five elective blocks in addition to the three scheduled electives and one required GI rotation and one required hepatology rotation for the third year.

The Hepatology Track offers three additional Hepatology rotations, two additional electives, and one month each on Transplant Surgery and Transplant Medicine. In addition to the three scheduled electives, one required GI rotation, and one required hepatology rotation for the third year rotation. This track is designed for individuals with a special interest in hepatology and is distinct from the fourth-year program in Transplant Hepatology which also is offered separately. For selected individuals who wish to take advantage of the pilot program to allow concurrent completion of requirements to sit for the Gastroenterology Subspecialty Examination and the Transplant Hepatology Examination, the curriculum can be adjusted to meet those requirements.

The Advanced Endoscopy Track offers seven months of advanced endoscopy training (ERCP, endoscopic ultrasound) in addition to the scheduled electives and required GI and Hepatology rotations.

The Research Track offers seven months of protected research time in addition to the scheduled electives and required GI and Hepatology rotations for the third year.

SPECIFIC CURRICULAR GOALS

1. Fellows receive formal instruction, clinical experience, and must demonstrate competence in the evaluation and management of the following disorders:

    a. Diseases of the esophagus
    b. Acid peptic disorders of the gastrointestinal tract
    c. Motor disorders of the gastrointestinal tract
    d. Irritable bowel syndrome
    e. Disorders of nutrient assimilation
    f. Inflammatory bowel diseases
    g. Vascular disorders of the gastrointestinal tract
    h. Gastrointestinal infections, including retroviral, mycotic and parasitic diseases
    i. Gastrointestinal diseases with an immune basis
    j. Gallstones and cholecystitis
    k. Alcoholic liver diseases
    l. Cholestatic syndromes
    m. Drug-induced hepatic injury
    n. Hepatobiliary neoplasms
    o. Chronic liver disease
    p. Gastrointestinal manifestations of HIV infections
    q. Gastrointestinal neoplastic disease
    r. Acute and chronic hepatitis
    s. Biliary and pancreatic diseases
    t. Women's health issues in digestive diseases
    u. Geriatric gastroenterology
    v. Gastrointestinal bleeding
    w. Cirrhosis and portal hypertension
    x. Genetic/inherited disorders
    y. Medical management of patients under surgical care for gastrointestinal disorders and
    z. Management of GI emergencies in the acutely ill patient

2. Fellows have formal instruction, clinical experience and must demonstrate competence in the performance of the following procedures:

    a. Esophagogastroduodenoscopy (fellows must perform a minimum of 130 supervised studies)
    b. Esophageal dilation (fellows must perform a minimum of 20 supervised studies)
    c. Flexible sigmoidoscopy (fellows must perform a minimum of 30 supervised studies; colonoscopy experience may be substituted)
    d. Colonoscopy with polypectomy (fellows must perform a minimum of 140 supervised colonoscopies and 30 supervised polypectomies)

e. Percutaneous endoscopic gastrostomy (fellows must perform a minimum of 15 supervised studies)
f. Biopsy of the mucosa of esophagus, stomach, small bowel, and colon; gastrointestinal motility studies and 24-hour pH monitoring
g. Nonvariceal hemostasis, both upper and lower (fellows must perform 25 supervised cases, including 10 active bleeders)
h. Variceal hemostasis (fellows must perform 20 supervised cases, including five active bleeders)
i. Other diagnostic and therapeutic procedures utilizing enteral intubation
j. Moderate (conscious) sedation

3. Fellows have formal instruction and clinical experience in the interpretation of the following diagnostic and therapeutic techniques and procedures:

a. Gastric, pancreatic, and biliary secretory tests
b. Enteral and parenteral alimentation
c. Pancreatic needle biopsy
d. ERCP, and all its diagnostic and therapeutic applications
e. Imaging of the digestive system, including:
    1. ultrasound, including endoscopic ultrasound
    2. computed tomography
    3. magnetic resonance imaging
    4. vascular radiography
    5. contrast radiography
    6. nuclear medicine
    7. percutaneous cholangiography

4. Fellows spend six months in scholarly activities that may include:

a. Design and execution of a basic or clinical research project
b. Preparation of case reports, systematic reviews, and other scientific papers for publication
c. Acquisition of research skills, procedures and techniques

5. Fellows have formal instruction on the pathogenesis, manifestations, and complications of gastrointestinal disorders, including the behavioral adjustments of patients to their problems. The impact of various modes of therapy and the appropriate utilization of laboratory tests and procedures are stressed. Additional specific content areas that are included in the formal program (lectures, conferences, and seminars) include the following:

a. Anatomy, physiology, pharmacology, pathology and molecular biology related to the gastrointestinal system, including the liver, biliary tract and pancreas
b. The natural history of digestive diseases
c. Factors involved in nutrition and malnutrition

d. Surgical procedures employed in relation to digestive system disorders and their complications
e. Prudent, cost-effective, and judicious use of special instruments, tests, and therapy in the diagnosis and management of gastroenterological and liver disorders
f. Liver transplantation
g. Sedation and sedative pharmacology
h. Interpretation of abnormal liver chemistries

6. It is expected that fellows will have mastered these areas of knowledge and techniques by the time the fellowship is completed. Progress toward achieving these curricular goals is a key part of the interval assessments of each fellow and will utilize the milestones format for assessing achievement across the core competencies.

a. At a minimum by the end of the first year of the fellowship, trainees will be able to take a comprehensive and appropriate history from patients with gastrointestinal and liver problems, conduct an appropriate physical examination, formulate a basic differential diagnosis, and establish a basic diagnostic approach for each patient. In addition, trainees should be able to complete upper gastrointestinal endoscopy and colonoscopy in an average complexity patient with minimal assistance from the preceptor.

b. By the end of the second year of training, fellows should be able to formulate an advanced differential diagnosis, a comprehensive diagnostic approach, and an appropriate therapeutic plan. Trainees also will be able to complete at least 80% of complex diagnostic upper endoscopies and colonoscopies on their own and will be able to apply endoscopic therapies in cases of average complexity. In addition, fellows will understand the basic principles of study design and execution and be able to critique the literature using evidence-based criteria.

c. At the conclusion of the fellowship, graduates should be able to function as fully independent gastroenterologists: evaluating and managing simple and complex patients with digestive and liver disorders, able to competently perform endoscopic procedures, and capable of life-long learning, ethical handling of patients, and successful practice.

TYPICAL ROTATION SCHEDULE

A prototype rotation schedule for the three years of the program is illustrated in the table below. The distribution of rotations is correct, but the precise months of the rotations are subject to change.

	Fellowship Year		
Month	Year 1	Year 2	Year 3
1	GI/BUMC	Hepatology	GI/BUMC
2	GI/BUMC	GI/BUMC	Hepatology
3	Hepatology	Elective[1]	Track[2]
4	GI/BUMC	GI/BUMC	Track[2]
5	Elective[1]	Hepatology	Track[2]
6	GI/BUMC	GI/BUMC	Track[2]
7	Hepatology	Scholarly Activity	Track[2]
8	GI/BUMC	Scholarly Activity	Track[2]
9	GI/BUMC	Scholarly Activity	Track[2]
10	Hepatology	Scholarly Activity	Elective[3]
11	GI/BUMC	Scholarly Activity	Elective[3]
12	GI/BUMC	Scholarly Activity	Elective[3]

[1]Pathology or Radiology Electives
[2]Available tracks: Advanced Endoscopy, Hepatology, Comprehensive Consultant, Research
[3]Available electives: Colon/Rectal Surgery, General Surgery, Transplant Medicine, Transplant Surgery, Nutrition, Physiology/Motility, Oncology, Gynecology, Pediatric GI, or additional GI or hepatology rotations

DESCRIPTION OF INDIVIDUAL ROTATIONS AND ACTIVITIES

Gastroenterology, BUMC Dallas

Educational Goal. At the completion of the series of 12 gastroenterology rotations, the fellow should be familiar with the presentation, evaluation and therapy of diseases of the gastrointestinal tract. The fellow should also have an appreciation of the techniques, indications, complications and utility of diagnostic tests used for the evaluation of these problems and the ability to provide the techniques necessary for the treatment of these disorders.

Format. Preceptorship

Method. Each fellow rotates with one attending physician for a period of one month. During this time, the fellow is responsible for the evaluation of patients seeing the attending physician. This includes both inpatient and outpatient consultations and initial visits, inpatient and outpatient follow-up care, endoscopic and other gastrointestinal procedures provided to these patients, and the development of plans for the evaluation and management of these patients. Fellows are expected to do extensive collateral reading about these patients and their problems, not only in basic textbooks, but also by examining the medical literature. Management plans are presented to the attending physician during rounds and any procedures done on these patients are staffed by the attending physician. Throughout the rotation, fellows continue their own outpatient clinics for half a day per week, and procedures generated from the clinic are staffed by the clinic attending. Fellows are excused from clinical duties for conferences. Fellows are available for emergency procedures and consultations up to one week out of six.

Evaluation. The attending physician and fellow set goals for the rotation at the beginning of the rotation. Fellows are evaluated by their attending physician for progress toward those goals and toward developmental milestones at the conclusion of each monthly rotation. Each attending provides feedback to the fellow about his or her performance during the rotation at the time that an evaluation is filed with the program director. The program director and clinical competency committee review these evaluations at regular intervals and assure that the fellow is making satisfactory progress. In addition, fellows compile a portfolio of cases that they have investigated in detail and participate in 360^{o} evaluation of core competencies.

Hepatology, BUMC Dallas

Educational Goal. At the completion of the series of 6 liver rotations, the fellow should be familiar with the presentation, evaluation, and therapy of diseases of the liver. The fellow also should have an appreciation of the techniques, indications, complications and utility of diagnostic tests used for the evaluation of these problems and the ability to provide the techniques necessary for the treatment of liver disorders.

Format. Rotation on liver service

Method. Each fellow rotates on the liver service for a period of one month. During this time, the fellow attends general hepatology clinics staffed by the hepatology attending physicians with an emphasis on viral hepatitis, metabolic liver disease and liver tumors. Fellows participate in the liver transplant evaluation clinic, and transplant selection committee, and thereby gain experience in the management of patients with liver failure of a variety of causes. Fellows also are involved with the evaluation, and management of patients on the inpatient liver service. Fellows are expected to do extensive collateral reading about their patients and their problems, not only in basic textbooks, but also by examining the medical literature. Plans are presented to the attending physician during rounds and any procedures done on these patients are staffed by the attending physician. Throughout the rotation, the fellow continues his or her own outpatient clinic for half a day per week and procedures generated from the clinic are staffed by the clinic attending. Fellows are excused from clinical duties for conferences. Fellows are available for emergency procedures and consultations up to up to one week out of six.

Evaluation. The attending physician and fellow set goals for the rotation at the beginning of the rotation. Fellows are evaluated by the attending physicians on the liver service at the conclusion of each monthly rotation. Each attending provides feedback to the fellow about his or her performance during the rotation at the time that an evaluation is filed with the program director. The program director and clinical competency committee review these evaluations at regular intervals and assure that the fellow is making satisfactory progress. In addition, fellows compile a portfolio of cases that they have investigated in detail and participate in 360^{o} evaluation of core competencies.

Advanced Endoscopy Rotations: BUMC Dallas, & Methodist Dallas Medical Center

Educational Goal. At the completion of the series of 7 advanced endoscopy rotations, the fellow should be thoroughly familiar with the presentation, evaluation and therapy of complex biliary and pancreatic disorders. The fellow should have an expert's appreciation of the techniques, indications, complications and utility of diagnostic tests used for the evaluation of these problems. The fellow should be able to perform routine endoscopic retrograde cholangiopancreatography and be familiar with endoscopic ultrasound procedures.

Format. Preceptorship

Method. Each fellow rotates with attending physicians involved with advanced endoscopic techniques. During this time, the fellow is responsible for the evaluation of patients seeing the attending physician. This includes both inpatient and outpatient consultations and initial visits, inpatient and outpatient follow-up care, endoscopic and other gastrointestinal procedures provided to these patients, and the development of plans for the evaluation and management of these patients. Fellows are expected to do extensive collateral reading about these patients and their problems, not only in basic textbooks, but also by examining the medical literature. Management plans are presented to the attending physician during rounds and any procedures done on these patients are staffed by the attending physician. Throughout the rotation, fellows continue their own outpatient clinics for half a day per week and are available for emergency procedures and consultations up to up to one week out of six.

Evaluation. The attending physician and fellow set goals for the rotation at the beginning of the rotation. Fellows are evaluated by their attending physician for progress toward those goals and toward developmental milestones at the conclusion of each monthly rotation. Each attending provides feedback to the fellow about his or her performance during the rotation at the time that an evaluation is filed with the program director. The program director and clinical competency committee review these evaluations at regular intervals and assure that the fellow is making satisfactory progress. In addition, fellows compile a portfolio of cases that they have investigated in detail and participate in 360^{o} evaluation of core competencies.

Scholarly Activities Block

Educational Goal. To allow fellows time to conduct a research project, write case reports and systematic reviews, and learn research techniques in order to provide an appreciation for these activities.

Format. Guided research activity.

Method. During the course of the first year of fellowship, each fellow is encouraged to think about a research project for half of the second year of fellowship and to start to develop this project with the assistance of a mentor engaged in research activities. The proposal is written up and submitted to the Institutional Review Board for Human Subject Protection (as needed) ahead of the start of the block so that the fellow may begin work on the project promptly. The bulk of scholarly work (library research, research studies and writing) is done over six continuous months with the expectation that a paper reporting the research will be submitted for publication during the third year. Fellows are encouraged to submit their research work in abstract form to National and Regional Meetings for presentation.

Evaluation. Fellows are evaluated by their research mentor on forms submitted through New Innovations.

Continuity Clinic

Educational Goal. To allow fellows to develop expertise in the long term, outpatient management of a panel of patients.

Format. Supervised weekly outpatient clinic experience.

Method. Patients are referred to fellows from the Medicine Clinic and other outpatient clinics for consultation, evaluation and management of digestive diseases. The patients are seen Monday afternoons from 1pm to 4pm in the BUMC Residents' Clinic area. An attending physician is assigned to review case management with the fellows and is available to staff procedures on these patients.

Evaluation. The fellow's management of cases is subject to continuous quality review by the attending. Any problems are brought to the attention of the program director.

DESCRIPTION OF ELECTIVE ROTATIONS

Radiology/Medical Imaging

Educational Goal. To allow the fellow to understand the indications, benefits, pitfalls and interpretation of radiological and medical imaging tests that apply to the gastrointestinal tract.

Format. Preceptorship with members of the radiology and medical imaging departments.

Method. During the month that the fellow spends on this rotation, he or she spends approximately 2 weeks in the fluoroscopy section observing the performance and subsequent interpretation of dysphagiagrams, barium swallows, upper gastrointestinal series, small bowel follow-through tests, enteroclysis studies, barium enemas, and defecographies. The fellow participates in the performance of the study and sits in during the interpretation. The fellow also can review cases from the radiology teaching files. An additional week is spent in the medical imaging area where the fellow is exposed to ultrasound examinations of the abdomen and pelvis, CT scanning of the abdomen and pelvis, and magnetic resonance imaging of the liver and other abdominal structures. The fellow has the opportunity to review the case record on patients undergoing these procedures, see the performance of the study and be present for interpretation. Another week during this rotation is spent in the nuclear medicine area where the fellow has the opportunity to see gastric emptying studies, scintigraphic examination of the liver and other studies relevant to gastrointestinal practice, such as octreotide scanning. During the radiology and medical imaging rotation, the fellow is responsible for attending routine conferences, as well as continuity clinic.

Evaluation. The fellow's participation during this block will be evaluated by the radiology attending and reported to the fellowship director on standard forms.

Pathology/Cytology

Educational Goal. To learn proper analysis of pathologic specimens and to gain an appreciation of what material the pathologist needs in order to render an accurate diagnosis.

Format. Experiential rotation with gastrointestinal pathologist.

Method. Fellows spend one month in the pathology department under the direction of the gastrointestinal and hepatic pathologists. Fellows have the opportunity to review patient charts for clinical background and then to sit in as the pathologist reviews specimens. In addition fellows will have access to the library of pathologic findings of a range of gastrointestinal and liver diseases for review with the attending pathologist. During this rotation, fellows are responsible for attending routine conferences and continuity clinic.

Evaluation. The fellow's participation during this block is assessed by the pathology attending and reported to the fellowship director.

Colon/Rectal Surgery

Educational Goal. To gain experience with a variety of proctological conditions and to gain insight into the surgical approach to colon and rectal diseases.

Format. Preceptorship

Method. Fellows spend one month rotating on the colon and rectal surgery service under the direction of an attending colorectal surgeon. They have the opportunity to see a variety of outpatient and inpatient problems and to participate in the care of these patients. While it is not expected that the fellows gain proficiency in surgical procedures, fellows have the opportunity to observe surgery on these patients and thus gain insight into the type of procedures that their patients might have.

Evaluation. The fellow's performance during this rotation is assessed by the colon and rectal surgery attending and reported to the fellowship director on standard forms.

General Surgery

Educational Goal. To gain an appreciation for the surgical management of gastrointestinal diseases. This includes an appreciation of the anatomy and physiology of the digestive system, the techniques and potential complications of surgical interventions and an appreciation of the role of surgery in the management of a variety of disorders.

Format. Preceptorship

Method. Fellows spend one month on a general surgical service. During this time, they follow patients that are admitted to that service or seen in consultation by that service for digestive diseases. While it is not expected that the fellows become proficient at surgical technique, they are expected to observe operations done on patients that they are following in order to appreciate surgical finding and techniques. During this rotation, fellows continue to attend routine conferences and continuity clinic.

Evaluation. The fellow's participation on the service is evaluated the surgical attending and reported to the fellowship director on standard forms.

Transplant Medicine

Educational Goal. To understand the use and dangers of immunosuppressive therapy as used in patients with visceral transplants.

Format. Preceptorship

Method. Fellows spend one month rotating on the transplant medicine service which is involved with the management of immunosuppression in patients with transplants and a variety of immunologically-mediated diseases. During this rotation, it is expected that the fellow will gain insight into the pharmacological and infectious complications of immunosuppressive therapy and will develop an appreciation for the proper use of these medications.

Evaluation. The fellow's participation on this rotation will be assessed by the transplant medicine attending and reported to the fellowship director on standard forms.

Transplant Surgery

Educational Goal. To understand the techniques and initial therapy provided to liver transplant recipients.

Format. Preceptorship

Method. Fellows who plan a career in hepatology or who expect to be involved in the management of liver transplant patients have the opportunity to spend one month on the transplant surgery service. This enables them to see several liver transplant operations and to observe the initial medical management of these patients in the post-transplant period. During this rotation, fellows are expected to continue to attend routine conferences and continuity clinic.

Evaluation. The fellow's participation during this rotation is evaluated by the transplant surgery attending and reported to the fellowship director on standard forms.

Nutrition

Educational Goal. To gain insight into the nutritional management of digestive diseases including the proper application of enteral and parenteral nutrition.

Format. Preceptorship

Method. Fellows spend one month rotating on the gastrointestinal nutrition service with the registered dieticians assigned to this service. They have the opportunity to review patients' charts, discuss dietary consultation with the dietician and follow these patients during this rotation. This enables fellows to gain insight into dietary management of gastrointestinal diseases, such as celiac disease, as well as to learn the "nuts and bolts" of nutritional support by enteral and parenteral routes. Fellows are expected to complete assigned readings in nutrition during this rotation as well.

Evaluation. The fellow's participation during this rotation is evaluated by the dietician on standard forms and reported to the fellowship director. The fellowship director assesses the fellow's participation in completing and comprehending the assigned readings.

Physiology/Motility

Educational Goal. To understand the methodology and interpretation of clinical tests, such as esophageal and anorectal manometry, stool analysis, gastric acid measurement and other studies done in the physiology lab.

Format. Preceptorship

Method. Fellows spend one month in the GI Physiology Lab and have the opportunity to evaluate motility, stool and other studies done in the physiology lab. They gain an appreciation of the indications, interpretation, and pitfalls of these studies. They have the opportunity to review patients' records, to see how these tests assist in the management of patients and to complete assigned readings about these studies.

Evaluation. The fellow's participation during this rotation will be assessed by the attending physician on standard forms.

Oncology

Educational Goal. To gain insight into the treatment of cancers of the digestive system in order to better advise patients about options for management of their tumors.

Format. Preceptorship

Method. Fellows spend one month with medical oncologists who deal primarily with gastrointestinal or hepatic neoplasms. During this time, they will assess patients, review treatment protocols with the attending physician, and observe responses and complications to therapy.

Evaluation. Fellows are assessed for their participation during this rotation by the oncology attending using standard forms.

Gynecology

Educational Goal. To understand the overlap of gastrointestinal and gynecologic diseases particularly in regards to pelvic pain and other symptoms shared by the two disciplines.

Format. Preceptorship

Method. Fellows have the opportunity to spend one month in an office gynecology setting in order to gain expertise in the examination, evaluation and management of women with digestive problems presenting to the gynecologist office.

Evaluation. Fellows are assessed by the gynecology attending for their participation during the rotation using standard forms.

Pediatric Gastroenterology, Children's Medical Center

Educational Goal. To expose fellows to a sampling of problems and approaches to problems of the gastrointestinal tract and liver in children.

Format. Participation on the pediatric gastroenterology service at Children's Medical Center.

Method. Third year fellows may spend one month at Children's Medical Center, Dallas under the supervision of Dr. John Anderson. They participate in the evaluation and management of patients referred to the Pediatric Gastroenterology Service, gaining experience in dealing with these patients and their families and in performing procedures on children. The fellow will not be a qualified pediatric gastroenterologist at the end of the month's rotation, but will have an appreciation of the different problems and approaches to those problems in children.

Evaluation. Fellows are evaluated by their attending physician at Children's Medical Center on forms provided by the program director at Baylor.

Extramural Electives

Educational Goal. To gain unique experiences at national centers of excellence.

Format. Month-long rotations at external sites.

Method. Fellows may request the opportunity to spend a month at an external site to gain a specific educational experience, such as IBD or motility. These opportunities are arranged by the individual fellow with the approval of the program director.

Evaluation. The supervising physician evaluates the fellow's performance on forms provided by the program director.

CONFERENCE SCHEDULE AND DESCRIPTIONS

General Conditions

Fellows are expected to attend all scheduled conferences and meetings unless there is a pressing clinical need. Daily schedules need to be adjusted to allow participation, even if it means that routine matters, such as consultations and procedures, must be postponed or missed.

Fellows are asked to present at many conferences and should be prepared to ask and answer questions at other meetings. Merely attending the scheduled conferences is not considered adequate participation.

Attendance is monitored by the program director who attends most conferences.

Members of the attending staff are requested to attend as many of the teaching conferences as possible. Their participation ensures that discussions remain practical and oriented to clinical, as well as relevant basic issues.

Members of the attending staff are asked from time to time to present conferences in their areas of expertise.

The effectiveness of various conferences is reviewed annually by the curriculum committee. Both fellows and attending physicians participate in these periodic reviews.

Journal Club

Time: Mondays, 4-5 PM

Coordinator: Lawrence R. Schiller, M.D.

Aims: To review current literature for the purposes of:

a. Learning about new developments in digestive & liver diseases
b. Gaining expertise in critical evaluation of published papers
c. To discuss the application of new findings to the clinical practice of gastroenterology and hepatology

Methods: Critical review of assigned papers in a seminar setting. Each fellow presents one paper every six weeks. Attending staff, residents on service and students on service also review articles and join in the discussion.

Evaluation: The adequacy of the fellows' reviews is assessed by the attending staff and suggestions for improvement are transmitted to the fellows by the program director.

Morning Report

Time: Tuesdays, 7-8 AM

Coordinator: Lawrence R. Schiller, M.D.

Aims: To discuss topics generated by patient encounters.

Methods: Fellows briefly present cases of interest to share with the other fellows and review pertinent literature. The conference attending comments on the discussion, emphasizing both practical issues and alternative approaches. This affords the opportunity to reflect on experiences and put them in the context of evolving practice norms.

Evaluation: Each fellow's participation in the conference is evaluated by the coordinator.

Internal Medicine Grand Rounds

Time: Tuesdays, 8-9 AM

Coordinator: Michael Emmett, M.D., Chief, Internal Medicine

Aims: To provide a broad-based, ongoing review of topics in Internal Medicine including other disciplines in addition to gastroenterology and hepatology, necessary to maintain competence in General Internal Medicine.

Methods: Didactic lectures and case conferences are used to present specific teaching points.

Evaluation: Fellows' participation in this activity in assessed as part of their periodic review by the program director.

Fellows' Research Conference

Time: First Tuesdays, Noon-1 PM

Coordinator: Lawrence R. Schiller, M.D.

Aims: To review the progress of research projects and other scholarly activities undertaken by the fellows. Also, to provide input into study design, execution and publication.

Methods: Seminar with fellows and coordinator to discuss current research projects and methods.

Evaluation: Coordinator assesses the progress of each fellow.

Evidence-Based Medicine Conference

Time: Second and Fourth Tuesdays, Noon-1 PM

Coordinator: Lawrence R. Schiller, M.D.

Aims: To learn about the methods of evidence-based medicine, and to apply them in the evaluation of the medical literature.

Methods: A variety of learning methods will be used, including didactic presentations and review of texts. Fellows are assigned topics to present each session. Practical experience will be gained by each fellow by a careful search dealing with the management of a clinical problem. Fellows are encouraged to write up their findings with the help of a mentor for publication.

Evaluation: Participation by the fellows is assessed by the coordinator.

Hepatology Didactic Conference

Time: Third Tuesdays, Noon-1 PM

Coordinator: Ranjeeta Bahirwani, M.D.

Aims: To review topics in hepatology.

Methods: Attending physicians from the hepatology service will discuss important evaluation and management issues using a lecture format.

Evaluation: The coordinator will evaluate each fellow's participation in the conference.

Fellows' Case Conference

Time: Wednesdays, 7 – 8 AM

Coordinator: Lawrence R. Schiller, M.D.

Aims: To present and discuss interesting cases.

Methods: Fellows and clinicians from BUMC and Dallas Methodist Medical Center present cases of unusual interest to an audience composed of faculty, attending physicians, house staff, and students. Cases are illustrated with radiographs, endoscopic photographs, and biopsy specimens. Discussions focus on differential diagnosis, evaluation paradigms, and treatment options. On average fellows present every 6 weeks (8 times yearly).

Evaluation: Fellows' participation in this conference is evaluated as part of their global assessments.

Fellows' Board Review Conference

Time: Wednesdays, Noon-1 PM

Coordinator: Lawrence R. Schiller, M.D.

Aims: To gain proficiency with answering board-style questions and improve understanding of basic concepts and practices.

Methods: Review of questions and answers from the Digestive Disease Self-Evaluation Program of the American Gastroenterological Association (DDSEP) or the American College of Gastroenterology Postgraduate Course Test by the fellows with an attending physician.

Evaluation: The fellows' participation in this conference is assessed as part of their global evaluation.

GI/Liver Pathology Conference

Time: Fourth Wednesday, Noon-1 PM

Coordinator: Lawrence R. Schiller, M.D.

Aims: To review biopsy specimens of patients with a variety of digestive and liver diseases.

Methods: Cases of interest are presented by the fellows to a joint meeting of the gastroenterology and pathology attending staff and house staff and are discussed by the attendees.

Evaluation: Fellows' participation in this conference is evaluated by the program director as part of their global assessment.

Didactic Conference: The Scientific Basis of Gastroenterology

Time: Thursday, 11 AM - Noon

Coordinator: Lawrence R. Schiller, M.D.

Aim: To impart a comprehensive understanding of the physiology, pathophysiology, pharmacology and therapeutics, immunology, genetics, statistics and other basic knowledge that is essential for an expert gastroenterologist to know.

Methods: Didactic lectures programmed over a three year period cover the information in depth. Fellows are expected to do preparatory reading in assigned texts.

Evaluation: Participation will be evaluated by the course coordinator.

Three-Year Curriculum

Year 1:	Fall Quarter	Physiology 1	(12 lectures)
	Winter Quarter	Physiology 2	(12 lectures)
	Spring Quarter	Immunology/Microbiology	(6 lectures)
		Genetics/Molecular Biology	(6 lectures)
Year 2:	Fall Quarter	Pharmacology/Therapeutics 1	(12 lectures)
	Winter Quarter	Pharmacology/Therapeutics 2	(12 lectures)
	Spring Quarter	Statistics/Epidemiology	(12 lectures)
Year 3:	Fall Quarter	Nutrition/Nutritional Therapy	(12 lectures)
	Winter Quarter	Ethics/Professionalism	(6 lectures)
		Health Economics	(12 lectures)
	Spring Quarter	Miscellaneous Topics:	(6 lectures)
		Enterostomal Therapy	(1 lecture)
		Alternative Therapies	(2 lecture)
		Preventive Medicine	(3 lectures)

Chief's Conference

Time: Second Friday, Noon-1 PM

Aims: To learn about specific topics in gastroenterology and hepatology with an emphasis on the approaches that general internists need to be familiar with.

Methods: Didactic lecture aimed at internal medicine residents by senior faculty. Fellows participate in the discussion.

Evaluation: Fellows' participation in this conference is evaluated as part of their global assessments.

Inflammatory Bowel Disease Multidisciplinary Conference

Time: First Tuesdays, 6:30 – 7:30 AM

Coordinator: Themistocles Dassopoulos, MD

Aim: Multidisciplinary conference with representatives from the Gastroenterology, Colorectal Surgery and Medical Imaging Services. Cases are presented and management decisions are made; current literature is reviewed.

Evaluation: Fellows' participation in this conference is evaluated by the coordinator.

Esophageal Center Multidisciplinary Conference

Time: Wednesdays, 4:00 – 5:00 PM

Coordinator: Stuart Spechler, MD

Aim: Review care of patients with esophageal disorders as illuminated by current literature.

Evaluation: Fellows' participation in this conference is evaluated by the coordinator.

EVALUATIONS

ACGME Competencies

This fellowship program requires its fellows to achieve competence in the six areas listed below to the level expected of a new practitioner:

1. *Patient care* that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. This includes, but is not limited to: history-taking, including family, genetic, psychosocial, and environmental histories, and the ability to perform a comprehensive and accurate physical examination. The ability to arrive at an appropriate differential diagnosis, outline a logical plan for specific and targeted investigations pertaining to the patients' complaints, and formulate a plan for management and follow-up treatment of the patients is critical. The skills to effectively present the results of a consultation orally and in writing and to defend the clinical assessment, differential diagnosis, and diagnostic and management plans are essential. In addition, trainees must demonstrate procedural skills essential for the practice of gastroenterology and hepatology.

2. *Medical knowledge* about established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patient care. The trainee must demonstrate a core fund of knowledge in gastroenterological and hepatic physiology, pathophysiology, clinical pharmacology, radiology and surgery. The trainee must be able to demonstrate an analytic approach and use appropriate investigations, including the practice of evidence-based medicine.

3. *Practice-based learning and improvement* that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence as well as their own prior experience for the improvement of patient care. They should be able to apply knowledge of statistical methods to critically appraise clinical studies and be able to use information technology to support their own education. They must be involved in teaching and be able to facilitate the learning of other students and health care professionals.

4. *Interpersonal and communication skills* that result in the effective exchange of information and collaboration with patients, their families, and other health professionals. This would include, but not be limited to verbal and written communication as a consultant and generation of endoscopic reports that are accurate and timely. Trainees must be able to work effectively as members and leaders of the health care team.

5. *Professionalism*, as manifested by a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds. The trainee must demonstrate an understanding of and commitment to all elements of professionalism, including respect, compassion and integrity toward their patients, patient families, and other health care professionals. They must demonstrate ethical behavior, responsiveness, and sensitivity to a diverse gender, ethnic, socioeconomic and aging patient population.

6. *Systems-based practice*, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. The trainees should understand how their patient care practice impacts other health care professionals, the larger health care system, and society in general. They should be able to practice cost-effective health care without compromising quality of care for their patients. The trainee should be able to advocate for timely, quality patient care, and know how to partner with other health care providers to provide the optimal health care for their patients.

Fellow by Rotating Attending

Each month, the fellows' participation on their required and elective rotations is assessed by the rotation attending on standard forms provided by the fellowship program director. These forms cover the various aspects of performance that are mandated by the American Board of Internal Medicine. After completion of the form, the fellowship program director reviews the report with the rotation attending in order to clear up any questions and the form is then filed in the fellow's folder. The rotation attending also has a brief conference with the fellow at the conclusion of the rotation to discuss the attending's global assessment of the fellow's performance and to provide constructive criticism to enable the fellow to improve his or her performance.

Rotation Attending by Fellow

Each month, the fellow completes a form assessing the rotation attending. This is reviewed by the program director and any immediate problems are discussed with the fellow and then presented to the rotation attending.

360° Evaluation

Each quarter a 360 degree evaluation is sent out to assess the fellow's performance. Typical evaluators include nurses, technicians, coordinators, and patients that the fellows encounter. Multiple observations improve the reliability or precision of assessment and allow identification of patterns of behavior over time. Using multiple observers improves the reliability or precision of assessment and enhances the scope of assessment.

Clinical Competence Committee

Twice a year the Clinical Competence Committee meets to review the progress of each fellow. Performance is assessed against the milestones established by the ACGME and ABIM and reports are sent to the Program Director. These reports are then discussed with the trainees as part of their semiannual reviews.

Semiannual Review with Program Director

Every six months the program director and the fellow have a meeting during which the fellow's progress and performance of the training program are evaluated. The fellow has the opportunity to discuss problems with the training program or with individual attending physicians and to suggest improvements in the program. The reviews of the fellow by the attending rotations and the report of the Clinical Competence Committee are discussed with the fellow and progress over the course of the fellowship is reviewed. Plans for the next three to six months are then reviewed as well. A record of the review session is included in the fellow's folder for future reference.

GOVERNANCE

Program Director

The program director is responsible for the management of the fellowship program. This includes setting up attending and fellows' schedules, developing the weekly conference schedule, keeping track of time and attendance, and meeting and vacation time allotments. The program director is responsible for assuring that the program is conducted in accordance with the rules of the Residency Review Committee of the Accreditation Council for Graduate Medical Education and the American Board of Internal Medicine. The program director is responsible for overseeing the educational aspects of the fellowship, developing a strategic program for the development of the fellowship, soliciting external support for the fellowship program, and managing the application and selection process for new fellows. The program director is responsible for the timely filing of reports and keeping records of the educational activities of the fellowship program. The program director is also responsible for adjudicating disputes having to do with the fellowship program.

Curriculum Committee

The curriculum committee is composed of 3 faculty members, 2 fellows, and the program director who serves as chair. It is charged with reviewing the educational program of the fellowship in order to evaluate the effectiveness of the program and to suggest changes. The committee meets yearly to conduct these functions.

Clinical Competence Committee

The Clinical Competence Committee meets twice a year to review the evaluations of the fellows and to determine the progress of the fellows as determined by specific, competency-based milestones. A report is generated for each fellow and is sent to the Program Director.

Selection Committee

This committee consists of 5 faculty members and the program director. It is charged with overseeing the application and selection process for new fellows. Members of the selection committee interview candidates, set criteria for admission, and assist in the final ranking of candidates.

Graduate Medical Education Committee

The GMEC is charged with oversight of medical education programs at Baylor University Medical Center. As such, the gastroenterology fellowship comes under its review. This committee conducts regular reviews of the educational and functional aspects of the program. It assesses management, size, and programs in order to be certain that the fellowship is conducted in accordance with the policies and procedures of the institution. The GMEC sets standards for fellow contracts, compensation and working conditions.

ADMISSIONS

Application Process

The Baylor University Medical Center, Dallas, Gastroenterology Fellowship requires applicants to participate in the National Residency Matching Program (NRMP, "the match"). Applications are accepted through the Electronic Residency Application Service (ERAS). In addition to the ERAS application form, a personal statement and at least two letters of recommendation, including one from the chief of internal medicine at the applicant's internal medicine residency program should be filed. USMLE scores (Steps I and II) and medical school transcripts should be appended to the ERAS application. Applications are accepted after July 1 for the fellowship year beginning 12 months later. Applications are reviewed the following August and September. The Program Director evaluates the completed application file and invites candidates with outstanding potential based on academic credentials, recommendations, aptitude, and interest for interviews. Invitations for interviews in October and November are extended in September. The match list is submitted by the deadline in mid-November and the announcement of results occurs in December.

Eligibility

Applicants with one of the following qualifications are eligible for appointment:

Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).

Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).

Graduates of medical schools outside the United States and Canada (International Medical Graduates - IMGs) who meet the following qualifications:

Have a full and unrestricted license to practice medicine in a US licensing jurisdiction in which they are training.

Possess a Green card or procure a J-1 visa. (H1B visas are not sponsored by BUMC for residency training; Baylor sponsors only J-1 visas.)

Applicants must be graduates of or currently participating in an accredited internal medicine residency program. Fellows cannot begin their training until they have successfully completed an Internal Medicine residency program.

POLICIES AND PROCEDURES

Ethical Issues

Fellows are expected to adhere to all standards of medical ethics during their interactions with patients and staff at the hospital. This includes respecting patients' autonomy, maintaining confidences, avoiding malicious statements and innuendos, cooperating with nurses, pharmacists and other hospital personnel, minimizing risks to patients, and not taking advantage of positions of power for personal gain. In addition, as hospital employees, fellows are bound by the Business Ethics Guidelines published by Baylor Scott & White Health. These include maintaining the image and reputation of the hospital; avoiding conflict of interest; safeguarding corporate resources; maintaining accurate records; maintaining confidentiality of patient, technical, business, financial and personal information; taking care to isolate outside business and political activities; being careful not to endanger the tax-exempt status of the Institution; and following guidelines about receiving gifts, benefits, and entertainment provided by suppliers or vendors to Baylor Scott & White Health.

Academic Freedom

As an institution dedicated to education and the pursuit of knowledge for human advancement, academic freedom is extended to fellows and faculty. This freedom extends to issues of scientific and medical opinion. It is inappropriate, however, to express political or other non-scientific or non-medical opinions that might make patients or staff uncomfortable while on duty.

Research Guidelines

Any research done at any hospital or office setting as part of this fellowship program must be cleared by appropriate authorities. If it involves humans, it must be submitted and approved by the Institutional Review Board for Human Subject Protection. If it involves animals, it must be approved by the Animal Research Committee. Research must be conducted in strict accordance with the guidelines established by these committees.

Working Hours

The Gastroenterology Fellowship is a time-intensive obligation and the time involved in conferences, patient care activities, reading, research and preparation typically takes more than 40 hours per week. In addition, emergencies may arise that require the fellow to return to the hospital in order to participate in the care of patients. Nevertheless, it is the policy of this program to mandate sufficient time off to allow adequate rest for efficient performance in accordance with the rules of the Residency Review Committee. Towards this end, fellows are available for recall to the hospital for interesting cases or emergency procedures only one week out of six, and weekend call is no more frequent than every sixth weekend on average. This assures that fellows will have an average of at least one

day out of seven in which they do not have to report to the hospital, and an average work week of less than 80 hours.

Moonlighting

The time demands of the Gastroenterology Fellowship are great and moonlighting is discouraged in order to allow fellows to have adequate rest. If any outside employment is undertaken, it cannot interfere with scheduled activities or night call. Fellows need to declare any outside employment to the Program Director and have it approved in advance. Violation of this policy may lead to dismissal from the program.

Vacation Time

Each fellow is entitled to three weeks (15 working days) of vacation per year. This time does not accumulate from year to year.

Medical Conferences

Each fellow is entitled to attend one national medical conference per year. This can include the meetings of the American Association of the Study of Liver Diseases, the American College of Gastroenterology, Digestive Disease Week, or conferences of similar stature. A sum of $1,200 is available to defray expenses for attending such a meeting and can be used to offset travel or registration expenses with suitable documentation. Other conferences that do not involve substantial time away from scheduled rotations can be attended with the permission of the program director.

Family Medical Leave

This program adheres to the spirit of the Family Medical Leave Act. If a situation triggering this act should occur, the program director should be notified as soon as possible.

Sexual Harassment

It is absolutely essential that the interactions of fellows with patients and hospital staff be free of sexual harassment. Fellows must take care to avoid situations in which sexual harassment can be alleged. Accordingly, a chaperon should be present when examining patients of the opposite sex and appropriate care should be taken during interactions with hospital staff.

Substance Abuse

Abuse of alcohol and drugs that may impair judgment is a serious problem in the medical profession and may endanger patients. As with the medical staff, fellows who are suspected of being under the influence of alcohol or drugs while on duty are subject to drug testing, referral to a treatment program, or dismissal after a formal review process.

Fatigue and Impairment

Fellows are involved with making decisions about patient care that have potentially serious consequences. Anything that impairs the ability to make those decisions clearly, including fatigue, substance abuse, and mental or physical health issues is a patient safety issue and must be addressed. It is important that all members of the health care team feel at liberty to bring concerns to the attention of the Program Director so that they can be investigated and dealt with.

Complaints

Complaints that involve interactions of fellows and staff should be referred to the Program Director for investigation and adjudication. Complaints about the Program Director should be directed to the Gastroenterology Division Chief or to the Chief of the Department of Internal Medicine.

Remediation

In the event of performance problems, an informal and then formal remediation program may be put into effect. The issues, discussions, remediation program and progress through the remediation process will be documented in the fellow's educational file.

Promotion of Fellows

Fellows are promoted to the next level based on satisfactory performance and evaluations documenting appropriate professional development. Promotion is left to the discretion of the Program Director. If a resident is deemed unfit for promotion to the next level by the Program Director, a faculty meeting is called to discuss the problem. If the faculty agrees that promotion should be denied, a letter stating the reasons for denial of promotion is sent to the Graduate Medical Education Committee for its evaluation and recommendations.

Dismissal of Fellows

If the Program Director in consultation with the faculty decides that a resident should be dismissed, written documentation of the reasons for dismissal and a copy of the fellow's file are forwarded to the Director of Medical Education for review. The Director of Medical Education will review this information, obtain additional information if necessary, and will discuss the problem with the Program Director and the fellow. The fellow will be informed about his or her right to due process. The situation will be discussed at the next scheduled meeting of the Graduate Medical Education Committee. The Program Director's recommendation for dismissal must be approved by the Graduate Medical Education Committee before any action is taken.

GASTROENTEROLOGY FELLOWS 1973 – PRESENT

Name	Fellowship Dates	Board Certified
HUGHES, Lannie R.	1972-1974	Yes (IM,GI)
FOWLER, Charles R.	1975-1976	Yes (IM)
HAMILTON, J. Kent	1975-1976	Yes (IM,GI)
HUGHES, Alton Keith	1977-1978	Yes (IM,GI)
TEEGARDEN, David K	1977-1978	Yes (IM,GI)
MORRIS, Eugene I	1977-1979	Yes (IM,GI)
BO-LINN, George W.	1981-1982	Yes (IM,GI)
PACKARD, R. Andrew	1983-1984	Yes (IM,GI)
HOGAN, Reed	1983-1985	Yes (IM,GI)
DeMARCO, Daniel C.	1984-1985	Yes (IM,GI)
SHEIKH, Mudassir	1986-1987	Yes (IM,GI)
RODRIGUEZ, Jorge E.	1986-1988	Yes (IM)
METRAILER, James	1988-1989	Yes (IM,GI)
TRINKLE, Pat	1989-1990	Yes (IM,GI)
MONIER, Charles	1989-1991	Yes (IM,GI)
FINE, Kenneth	1989-1992	Yes (IM,GI)
WEBER, James	1990-1992	Yes (IM,GI)
NIGHTENGALE, Markham	1991-1993	Yes (IM,GI)
SCHMIDT, Robert D.	1991-1993	Yes (IM,GI)
MILLER, Mark	1992-1994	Yes (IM,GI)
LEWIS, Perry	1992-1994	Yes (IM,GI)
JOHNSON, Steven K	1993-1995	Yes (IM,GI)
YAUSSY, Catherine	1993-1995	Yes (IM,GI)
SANDOVAL, Ruben	1994-1996	Yes (IM,GI)
VANESKO, Grace C	1994-1996	Yes (IM,GI)
MOSSBURG, Albert J	1995-1997	Yes (IM,GI)
NELSON, Andrew	1995-1997	Yes (IM,GI)
BALASEKARAN, Ranga	1997-2000	Yes (IM,GI)
SALOUM, Yasser	1997-2000	Yes (IM,GI)

THOMPSON, Donald R	1998-2001	Yes (IM,GI)
KEFALAS, Costas	2000-2003	Yes (IM,GI)
GUIRL, Michael	2001-2004	Yes (IM,GI)
COATES JR, Stephen W	2001-2004	Yes (IM,GI)
CAROLLO, Angela	2002-2005	Yes (IM,GI)
SNOWBERGER, Noel	2003-2006	Yes (IM,GI)
ANDERSON, Robert	2004-2007	Yes (IM,GI)
SHELTON, Joseph	2004-2007	Yes (IM,GI)
PATEL, Viralkumar	2005-2008	Yes (IM,GI)
RIVERA-TORRES, Paulino	2005-2008	Yes (IM,GI)
EMMETT, Daniel	2006-2009	Yes (IM,GI)
ODSTRCIL, Elizabeth	2006-2009	Yes (IM,GI)
VAN DINTER, Thomas	2007-2010	Yes (IM,GI)
HUDSON, Alka (Mittal)	2007-2010	Yes (IM,GI)
CREEL, Bradley	2008-2011	Yes (IM,GI)
MARTINEZ, Juan	2008-2011	Yes (IM,GI)
WILLIAMS, Jane-Claire	2009-2012	Yes (IM,GI)
EVANS, Tanya	2009-2012	Yes (IM,GI)
STEFFER, Karen	2010-2013	Yes (IM,GI)
MANTAS, Alexi	2010-2013	Yes (IM,GI)
MASAND, Amit	2011-2014	Yes (IM,GI)
HOGAN, Reed III	2011-2014	Yes (IM,GI)
LAMBA, Anu Reema	2012-2015	Yes (IM,GI)
GAFFNEY, Kristin	2012-2015	Yes (IM,GI)
HAGAN, Mike	2013-2016	Yes (IM,GI)
BOYD, Stewart	2013-2016	Yes (IM,GI)
LIZARDO-SANCHEZ, Luis	2014-2017	Yes (IM,GI)
MORELAND, Amber	2014-2017	Yes (IM,GI)
EBRAHIM, Vivian	2015-2018	Yes (IM,GI)
SOAPE, Matthew	2015-2018	Yes (IM,GI)
ALSAHHAR, Jamil	2016-2019	Yes (IM,GI)
SNYDER, Patrick	2016-2019	Yes (IM,GI)
SMITH, Avery	2017-2020	Yes (IM)

SINGAPURA, Prianka	2017-2020	Yes (IM)
ROWE, Kyle	2018-2021	Yes (IM)
LINZAY, Catherine	2018-2021	Yes (IM)
ELLISON, Ashton	2019-2022	
SARMAST, Naveed	2019-2022	
GRIFFIN, Connor	2020-2023	
KAILA, Vishal	2020-2023	

BUMC GI FELLOW PUBLICATIONS

Naveed Sarmast, MD (2019-2022)

1. Sarmast N, Ogola GO, Kouznetsova M, Leise M, Bahirwani R, Maiwall R, Tapper E, Trotter J, Bajaj J, Thacker LR, Tandon P, Wong F, Reddy R, O'Leary JG, Masica A, Modrykamien AM, Kamath PS, Asrani SK. Model for End-stage Liver Disease-Lactate and Prediction of Inpatient Mortality in Patients with Chronic Liver Disease [published online ahead of print, 2020 Feb 21]. Hepatology. 2020;10.1002/hep.31199. doi:10.1002/hep.31199. PMID: 32083761

Ashton Ellison (2019-2022)

1. Vivian E, Cler L, Conwell D, Coté GA, Dickerman R, Freeman M, Gardner TB, Hawes RH, Kedia P, Krishnamoorthi R, Oduor H, Pandol SJ, Papachristou GI, Ross A, Sethi A, Varadarajulu S, Vege SS, Wassef W, Wilcox CM, Whitcomb DC, Wu BU, Yadav D, Ellison A, Habash S, Rastegari S, Reddy R, Yen T, Brooks MR, Tarnasky P.. Acute Pancreatitis Task Force on Quality: Development of Quality Indicators for Acute Pancreatitis Management. Am J Gastroenterol. 2019;114(8):1322-1342. doi:10.14309/ajg.0000000000000264. PMID: 31205135

Catherine “Abby” Linzay (2018-2021)

1. Linzay CD, Sharma B, Pandit S. Autoimmune Hepatitis. In: StatPearls. Treasure Island (FL): StatPearls Publishing; 2020. PMID: 29083819

2. Linzay CD, Pandit S. Acute Diverticulitis. In: StatPearls. Treasure Island (FL): StatPearls Publishing; 2020. PMID: 29083630

3. Johnson CM, Linzay CD, Dassopoulos T. Maneuvering Clinical Pathways for Ulcerative Colitis. Curr Gastroenterol Rep. 2019;21(10):52. Published 2019 Sep 5. doi:10.1007/s11894-019-0716-3. PMID: 31486929

Kyle Rowe, MD (2018-2021)

1. Rowe KM, Schiller LR. Ileostomy diarrhea: Pathophysiology and management. Proc (Bayl Univ Med Cent). 2020;33(2):218-226. Published 2020 Jan 30. doi:10.1080/08998280.2020.1712926 PMID: 32313465

Avery Smith, MD (2017-2020)

1. Smith AL, Santa Ana CA, Fordtran JS, Guileyardo JM. Deaths associated with insertion of nasogastric tubes for enteral nutrition in the medical intensive care unit: Clinical and autopsy findings. Proc (Bayl Univ Med Cent). 2018;31(3):310-316. Published 2018 May 21. doi:10.1080/08998280.2018.1459400. PMID: 29904295

Patrick Snyder, MD (2016-2019)

1. Snyder P, Dunbar K, Cipher DJ, Souza RF, Spechler SJ, Konda VJA. Aberrant p53 Immunostaining in Barrett's Esophagus Predicts Neoplastic Progression: Systematic Review and Meta-Analyses. Dig Dis Sci. 2019;64(5):1089-1097. doi:10.1007/s10620-019-05586-7. PMID: 30911864

Jamil Alsahhar, MD (2016-2019)

1. Alsahhar JS, Idriss R, Bahirwani R. A Rare Case of Cutaneous Metastases Secondary to Hepatocellular Carcinoma. Clin Gastroenterol Hepatol. 2018 Jan 17. pii: S1542-3565(18)30033-8. PMID: 29353009
2. Alsahhar JS, Hansen D, Page J, et al. An Atypical Biliary Fistula in a Liver Transplant Recipient. Liver Transpl. 2019;25(4):664-666. doi:10.1002/lt.25416. PMID: 30693637
3. Alsahhar JS, Rahimi RS. Updates on the pathophysiology and therapeutic targets for hepatic encephalopathy. Curr Opin Gastroenterol. 2019;35(3):145-154. doi:10.1097/MOG.0000000000000527. PMID: 30893082
4. Alsahhar JS, Mehta A, Lepe R. Con: Liver Transplantation Should Not Be Performed in Patients with Acute Alcoholic Hepatitis. Clin Liver Dis (Hoboken). 2019;13(5):144-147. Published 2019 May 31. doi:10.1002/cld.779. PMID: 31236263

Vivian Ebrahim, MD (2015-2018)

1. Ebrahim VS, Martin J, Murthy S, Odstrcil E, Huang H, Polter D. Olmesartan-associated enteropathy. Proc (Bayl Univ Med Cent). 2017 Jul;30(3):348-350. PMID: 28670083

Matthew Soape, MD (2015-2018)

1. Soape MP, Lichliter A, Cura M, Lepe-Suastegui MR, Burdick JS. Rare duodenal varix coil erosion post TIPS creation and coil embolization of mesenteric-systemic shunt. Dig Dis Sci. 2017 Sep;62(9):2601-2603. PMID: 28687942
2. Soape MP, Lichliter A, Asrani SK. Uncoiling the coil: Coil extrusion after coil assisted retrograde transvenous obliteration for gastric variceal bleeding. Clin Gastroenterol Hepatol. 2018 May;16(5):e59. PMID: 28865762
3. Soape MP, Rahimi RS, Spak CW, Trotter JF. Case report of a rare presentation of isolated cytomegalovirus hepatitis after renal transplantation. Prog Transplant. 2018 Sep;28(3):296-298. PMID: 29898621

Luis Lizardo-Sanchez, MD (2014 – 2017)

1. Trotter JF, Lizardo-Sanchez L. Everolimus in liver transplantation. Curr Opin Organ Transplant. 2014 Dec;19(6):578-82. PMID: 25254569

2. Gonzalez-Hernandez J, Lizardo-Sanchez L. An atypical presentation of blue rubber bleb nevus syndrome. Proc (Bayl Univ Med Cent). 2016 Jul;29(3):323-4. PMID: 27365887

3. Lizardo-Sanchez L, Burdick J, Trotter JF. Safety and efficacy of 2-octyl-cyanoacrylate in the management of patients with gastric and duodenal varices who are not candidates for transjugular intrahepatic portosystemic shunts. Proc (Bayl Univ Med Cent). 2016 Oct;29(4):371-373. PMID: 27695164

Amber Moreland, MD (2014 – 2017)

1. Yamada A, Cox MA, Gaffney KA, Moreland A, Boland CR, Goel A. Technical factors involved in the measurement of circulating microRNA biomarkers for the detection of colorectal neoplasia. PLoS One. 2014 Nov 18;9(11):e112481. PMID: 25405754

2. Blough B, Moreland A, Mora A Jr. Metformin-induced lactic acidosis with emphasis on the anion gap. Proc (Bayl Univ Med Cent). 2015 Jan;28(1):31-3. PMID: 25552792

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4. Moreland AM, Santa Ana CA, Asplin JR, Kuhn JA, Holmes RP, Cole JA, Odstrcil EA, Van Dinter TG Jr, Martinez JG, Fordtran JS. Steatorrhea and hyperoxaluria in severely obese patients before and after roux-en-Y gastric bypass. Gastroenterology. 2017 Jan 12. pii: S0016-5085(17)30015-X. PMID: 28089681

Michael Hagan, MD (2013 – 2016)

1. Hagan M, Asrani SK, Talwalkar J. Non-invasive assessment of liver fibrosis and prognosis. Expert Rev Gastroenterol Hepatol. 2015;9(10):1251-60. PMID: 26377444

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Kristin Gaffney, DO (2012 – 2015)

1. Yamada A, Cox MA, Gaffney KA, Moreland A, Boland CR, Goel A. Technical factors involved in the measurement of circulating microRNA biomarkers for the detection of colorectal neoplasia. PLoS One. 2014 Nov 18;9(11):e112481. PMID: 25405754

Anu Reema Lamba, MD (2012 – 2015)

1. Lamba AR, Moore AY, Moore T, Rhees J, Arnold MA, Boland CR. Defective DNA mismatch repair activity is common in sebaceous neoplasms, and may be an ineffective approach to screen for Lynch syndrome. Fam Cancer. 2015 Jun;14(2):259-64. PMID: 25637498

Reed Hogan III, MD (2011 – 2014)

1. Heithaus RE, Hogan R. Images in clinical medicine. Unblinded by the lights. N Engl J Med. 2013 Aug 15;369(7):659. PMID: 23944303

Alexi Mantas, MD (2010 – 2013)

1. Mantas AM, Carry MM. Sinus of Valsalva aneurysm. Proc (Bayl Univ Med Cent). 2009 Oct;22(4):338. PMID: 19865506

2. Mantas AM, Wells J, Trotter J. Kayser-Fleischer rings of acute Wilson's disease. Proc (Bayl Univ Med Cent). 2013 Apr;26(2):166-7. PMID: 23543978

Karen Steffer, MD (2010 – 2013)

1. Odstrcil EA, Martinez JG, Santa Ana CA, Xue B, Schneider RE, Steffer KJ, Porter JL, Asplin J, Kuhn JA, Fordtran JS. The contribution of malabsorption to the reduction in net energy absorption after long-limb Roux-en-Y gastric bypass. Am J Clin Nutr. 2010 Oct;92(4):704-13. PMID: 20739420

2. Steffer KJ, Santa Ana CA, Cole JA, Fordtran JS. The practical value of comprehensive stool analysis in detecting the cause of idiopathic chronic diarrhea. Gastroenterol Clin North Am. 2012 Sep;41(3):539-60. PMID: 22917163

Tanya Evans, MD (2009 – 2012)

1. Evans TH, Schiller LR. Chronic vestibular dysfunction as an unappreciated cause of chronic nausea and vomiting. Proc (Bayl Univ Med Cent). 2012 Jul;25(3):214-7. PMID: 22754117

Jane-Claire Williams, MD (2009 – 2012)

1. Williams JC, Hamilton JK, Shiller M, Fischer L, Deprisco G, Boland CR. Combined juvenile polyposis and hereditary hemorrhagic telangiectasia. Proc (Bayl Univ Med Cent). 2012 Oct;25(4):360-4. PMID: 23077388

Juan Martinez, MD (2008 – 2011)

1. Odstrcil EA, Martinez JG, Santa Ana CA, Xue B, Schneider RE, Steffer KJ, Porter JL, Asplin J, Kuhn JA, Fordtran JS. The contribution of malabsorption to the reduction in net energy absorption after long-limb Roux-en-Y gastric bypass. Am J Clin Nutr. 2010 Oct;92(4):704-13. PMID: 20739420

2. Moreland AM, Santa Ana CA, Asplin JR, Kuhn JA, Holmes RP, Cole JA, Odstrcil EA, Van Dinter TG Jr, Martinez JG, Fordtran JS. Steatorrhea and hyperoxaluria in severely obese patients before and after roux-en-Y gastric bypass. Gastroenterology. 2017 Jan 12. pii: S0016-5085(17)30015-X. PMID: 28089681

Bradley Creel, MD (2008 – 2011)

1. Leufkens AM, DeMarco DC, Rastogi A, Akerman PA, Azzouzi K, Rothstein RI, Vleggaar FP, Repici A, Rando G, Okolo PI, Dewit O, Ignjatovic A, Odstrcil E, East J, Deprez PH, Saunders BP, Kalloo AN, Creel B, Singh V, Lennon AM, Siersema PD; Third Eye Retroscope Randomized Clinical Evaluation [TERRACE] Study Group. Effect of a retrograde-viewing device on adenoma detection rate during colonoscopy: the TERRACE study. Gastrointest Endosc. 2011 Mar;73(3):480-9. PMID: 21067735

2. Siersema PD, Rastogi A, Leufkens AM, Akerman PA, Azzouzi K, Rothstein RI, Vleggaar FP, Repici A, Rando G, Okolo PI, Dewit O, Ignjatovic A, Odstrcil E, East J, Deprez PH, Saunders BP, Kalloo AN, Creel B, Singh V, Lennon AM, DeMarco DC. Retrograde-viewing device improves adenoma detection rate in colonoscopies for surveillance and diagnostic workup. World J Gastroenterol. 2012 Jul 14;18(26):3400-8. PMID: 22807609

Thomas Van Dinter, MD (2007 – 2010)

1. van Dinter TG Jr, Fuerst FC, Richardson CT, Ana CA, Polter DE, Fordtran JS, Binder HJ. Stimulated active potassium secretion in a patient with colonic pseudo-obstruction: a new mechanism of secretory diarrhea. Gastroenterology. 2005 Oct;129(4):1268-73. PMID: 16230079

2. Alderson JW, Van Dinter TG Jr, Opatowsky MJ, Burton EC. Disseminated aspergillosis following infliximab therapy in an immunosuppressed patient with Crohn's disease and chronic hepatitis C: a case study and review of the literature. MedGenMed. 2005 Sep 21;7(3):7. PMID: 16369233

3. Van Dinter TG. Erythema, bullae, and vesicles on the hands of a dental student. Proc (Bayl Univ Med Cent). 2007 Oct;20(4):404-5. PMID: 17948117

4. Mantas A, Van Dinter T, DeMarco D. A single center retrospective review of double balloon enteroscopy (Abstract 284). Am J Gastroenterol 2008;103(S1):S110.

5. Van Dinter TG Jr, Welch BJ. Diagnosis of Munchausen's syndrome by an electronic health record search. Am J Med. 2009 Oct;122(10):e3. PMID: 19786149

6. Van Dinter TG Jr, Schmidt JF, Tarnasky PR. Obstructive jaundice caused by intraductal hepatocellular carcinoma. Clin Gastroenterol Hepatol. 2011 Sep;9(9):e94-5. PMID: 21421078

7. Van Dinter TG Jr, John L, Guileyardo JM, Fordtran JS. Intestinal perforation caused by insertion of a nasogastric tube late after gastric bypass. Proc (Bayl Univ Med Cent). 2013 Jan;26(1):11-5. PMID: 23382601

8. Moreland AM, Santa Ana CA, Asplin JR, Kuhn JA, Holmes RP, Cole JA, Odstrcil EA, Van Dinter TG Jr, Martinez JG, Fordtran JS. Steatorrhea and hyperoxaluria in severely obese patients before and after roux-en-Y gastric bypass. Gastroenterology. 2017 Jan 12. pii: S0016-5085(17)30015-X. PMID: 28089681

Alka (Mittal) Hudson, MD (2007 – 2010)

1. Mittal A, Felter D, Shiller SM, McCollum AD, Lamont JP, Mallat D. Gastrointestinal bleeding and cutaneous nodules. Proc (Bayl Univ Med Cent). 2008 Jul;21(3):331-4. PMID: 18628933

2. Perlmutter A, Mittal A, Menter A. Tuberculosis and tumour necrosis factor-alpha inhibitor therapy: a report of three cases in patients with psoriasis. Comprehensive screening and therapeutic guidelines for clinicians. Br J Dermatol. 2009 Jan;160(1):8-15. PMID: 19016693

3. Goel A, Mittal A, Evstatiev R, Nemeth M, Kruis W, Stolte M, Boland CR, Gasche C. In vivo effects of mesalazine or E. coli Nissle 1917 on microsatellite instability in ulcerative colitis. Aliment Pharmacol Ther. 2009 Sep 15;30(6):634-42. PMID: 19558562

Elizabeth Odstrcil, MD (2006 – 2009)

1. Chen Z, Odstrcil EA, Tu BP, McKnight SL. Restriction of DNA replication to the reductive phase of the metabolic cycle protects genome integrity. Science. 2007 Jun 29;316(5833):1916-9. PMID: 17600220

2. DeMarco DC, Odstrcil E, Lara LF, Bass D, Herdman C, Kinney T, Gupta K, Wolf L, Dewar T, Deas TM, Mehta MK, Anwer MB, Pellish R, Hamilton JK, Polter D, Reddy KG, Hanan I. Impact of experience with a retrograde-viewing device on adenoma detection rates and withdrawal times during colonoscopy: the Third Eye Retroscope study group. Gastrointest Endosc. 2010 Mar;71(3):542-50. PMID: 20189513

3. Odstrcil EA, Martinez JG, Santa Ana CA, Xue B, Schneider RE, Steffer KJ, Porter JL, Asplin J, Kuhn JA, Fordtran JS. The contribution of malabsorption to the reduction in net energy absorption after long-limb Roux-en-Y gastric bypass. Am J Clin Nutr. 2010 Oct;92(4):704-13. PMID: 20739420

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Daniel Emmett, MD (2006 – 2009)

1. Emmett DS, Feranchak A, Kilic G, Puljak L, Miller B, Doctor RB, McWilliams R, and Fitz JG. Identification and characterization of a novel population of P2X4 receptors in hepatocytes. Hepatology 2005;42:255 (Abstract)

2. Emmett DS, Miller B, and Fitz JG. A subclass of purinergic receptors regulates hepatic glycogenolysis. Gastroenterology 2006;130:4 (Abstract)

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5. Emmett DS and Mallat D. Double-balloon ERCP in patients who have undergone Roux-en-Y surgery: a case series. Gastrointest Endosc. 2007 Nov;66(5):1038-41. PMID: 17963892

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Paulino Rivera-Torres, MD (2005 – 2008)

1. Fenves A, Boland CR, Lepe R, Rivera-Torres P, Spechler SJ. Fatal hyperammonemic encephalopathy after gastric bypass surgery.Am J Med. 2008 Jan;121(1):e1-2. PMID: 18187055

Viralkumar Patel, MD (2005 – 2008)

1. Fenves AZ, Kirkpatrick HM 3rd, Patel VV, Sweetman L, Emmett M. Increased anion gap metabolic acidosis as a result of 5-oxoproline (pyroglutamic acid): a role for acetaminophen. Clin J Am Soc Nephrol. 2006 May;1(3):441-7. PMID: 17699243

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Joseph Shelton, MD (2004 – 2007)

1. Sepulveda AR, Peterson LE, Shelton J, Katherine S, Graham DY, Oscar G. Distinctive histopathological features in H. pylori infected individuals with family history of gastric cancer (Abstract 4056). Gastroenterology 2000;118(4)Suppl 2:A752.

2. Shelton JH, Polter DE. Epstein-Barr virus-positive primary intestinal Hodgkin's lymphoma complicating Crohn's disease (Abstract 660). Am J Gastroenterol. 2005;100(9)Suppl:S248.

3. Shelton JH, Santa Ana CA, Thompson DR, Emmett M, Fordtran JS. Factitious diarrhea induced by stimulant laxatives: accuracy of diagnosis by a clinical reference laboratory using thin layer chromatography. Clin Chem. 2007 Jan;53(1):85-90. PMID: 17110471

4. Shelton JH, Mallat DB. Endoscopic retrograde removal of gallbladder remnant calculus. Gastrointest Endosc. 2006 Aug;64(2):272-3. PMID: 16860084

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Robert Anderson, MD (2004 – 2007)

1. Anderson RD, Patel R, Hamilton JK, Boland CR. Cronkhite-Canada syndrome presenting as eosinophilic gastroenteritis. Proc (Bayl Univ Med Cent). 2006 Jul;19(3):209-12. PMID: 17252034

2. Anderson RD, Mallat D. EUS assisted trans-papillary stent placement. Endoscopy. 2006;38 Suppl 2:E73. PMID: 17366427

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Noel Snowberger, MD (2003 – 2006)

1. Terauchi S, Snowberger N, Demarco D. Double-balloon endoscopy and Peutz-Jeghers syndrome: a new look at an old disease. Proc (Bayl Univ Med Cent). 2006 Oct;19(4):335-7. PMID: 17106494

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Angela Carollo, MD (2002 – 2005)

1. Carollo AA, Schiller LR. Chronic Diarrhea: Differential Diagnosis and Initial Management. Consultant. 2005 December;45(14):1604 – 1614.

Stephen Coates, MD (2001 – 2004)

1. Russo MA, Hogenauer C, Coates SW Jr, Santa Ana CA, Porter JL, Rosenblatt RL, Emmett M, Fordtran JS. Abnormal passive chloride absorption in cystic fibrosis jejunum functionally opposes the classic chloride secretory defect. J Clin Invest. 2003 Jul;112(1):118-25. PMID: 12840066

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Michael Guirl, MD (2001 – 2004)

1. Emmett M, Guirl MJ, Santa Ana CA, Porter JL, Neimark S, Hofmann AF, Fordtran JS. Conjugated bile acid replacement therapy reduces urinary oxalate excretion in short bowel syndrome. Am J Kidney Dis. 2003 Jan;41(1):230-7. PMID: 12500242

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Costas Kefalas, MD (2000 – 2003)

1. Kefalas CH, Schiller LR. Collagenous sprue in a patient with collagenous gastritis, collagenous colitis, and bacterial overgrowth syndrome (abstract). Am J Gastroenterol. 2002;97(9):444.

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