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American Society for Gastrointestinal Endoscopy: guidance for trainees during the COVID-19 pandemic

The rapid spread of COVID-19 has forced major changes to endoscopic training around the globe. The purpose of this document is to present guidance with regard to the maintenance of a learning environment during this challenging time. It is anticipated that institutional readiness to resume normal educational programming will vary based on the status of the pandemic in a given geographic location and will evolve gradually based on local conditions and guidance from public authorities. Not all proposed measures will always be applicable to all practice settings. Gastroenterology training directors will need to exercise discretion in implementing individual suggestions, with the goal of supporting their educational efforts while ensuring the safety of patients, staff, trainees, and providers.

1. TRAINING VERSUS SERVICE

The novel coronavirus (severe acute respiratory syndrome coronavirus 2 [SARS CoV-2]) pandemic has introduced an unprecedented demand on health professionals across the nation. To urgently meet patient care needs, some institutions have offered the option of early graduation to medical students and rapid credentialing of house staff into attending roles. Residents and fellows have also reportedly been transitioned into unfamiliar consultative roles in other subspecialties as well. Although education is often used to justify deployment of trainees to the frontlines, it is also important to consider risks of exposure to a contagion and the possibility of becoming vectors for the virus. Ensuring the safety of trainees is crucial because they are the specialty's future.

The American Society for Gastrointestinal Endoscopy (ASGE) proposes that deployment of gastroenterology fellows occur only if adequate personal protective equipment (PPE) can be provided. Furthermore, fellows should not be deployed to cover other medical subspecialties in which they do not have specific fellowship training, especially if there are physicians available who are specifically trained in those subspecialties. Other specialty organizations such as the American Heart Association explicitly recommend adequately protecting trainees on the frontlines or

not deploying them into these roles at all.¹ If deployment is necessary, a discussion with the trainees is imperative, and those individuals should be given the opportunity to voice their concerns. The American Medical Association (AMA) has outlined guiding principles with regard to residents and fellows. The ASGE endorses these guiding principles, including their emphasis on involving trainees in response planning, preserving the ability for trainees to voice concerns, providing adequate PPE, and ensuring appropriate malpractice coverage and compensation for attending-level services and hazard pay. Likewise, as outlined by the AMA guiding principles, trainee vacations should be protected apart from COVID-19–related illness. Furthermore, when appropriate, special housing should be considered for those who are deployed onto the frontlines.

Faculty must keep in mind that trainees often choose not to express their concerns out of fear of reprisal, termination, or compromised training. It is important to approach these discussions empathically and acknowledge the personal, physical, and economic stresses that disproportionately affect trainees as a result of this pandemic and to listen and act on trainee concerns when possible. The AMA guiding principles for trainees can be found at this link: <https://www.ama-assn.org/delivering-care/public-health/guiding-principles-protect-resident-fellow-physicians-responding>

2. DIMINISHED VOLUME OF TRAINING PROCEDURES AND AMBULATORY VISITS

Because the volume of procedures and ambulatory visits have been markedly reduced for most trainees, many have expressed concerns over whether they will be viewed as “ready” to practice independently after completion of their fellowship. It is instructive to review what the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) have stated on this topic. As noted in their shared document, “Joint Principles: Physician Training during the COVID-19 Pandemic Statement”²:

“The ABMS and the ACGME endorse and rely upon the authority and judgement of clinical competency committees (CCCs) and training program directors (PDs) to determine readiness for

unsupervised practice, and to inform specialty board decisions regarding eligibility for initial board certification. This authority and judgement are especially important during times of crises when traditional time- and volume-based educational standards may be challenged. ABMS and ACGME understand and affirm that the judgment made by PDs and CCCs to assess trainees constitutes a vital responsibility that affects residents, fellows, and most importantly, the care of the public.”

Separate from this joint statement, the ACGME has addressed the impact on clinical volume for trainees in their “Response to the Coronavirus (COVID-19)”³ by stating the following:

“The ACGME recognizes that institutions have reduced the volume of their elective visits and procedures and have redeployed residents to support the critical services of the hospital as a result of the COVID-19 pandemic. Residents/fellows may not be able to achieve the minimum number of visits/cases as specified in the specialty-specific requirements. It is important to remember that the ACGME visit/case minima were established for program accreditation. They are used by the Review Committees to determine whether a given program provides the volume and variety of visits/cases sufficient for education of the complement of residents/fellows for which the program is accredited. The ACGME visit/case minima were not designed to be a surrogate for the competence of an individual program graduate, and are not utilized in that manner by the Review Committees. It is up to the program director, with consideration of the recommendations of the program’s Clinical Competence Committee, to assess the competence of an individual resident/fellow as one part of the determination of whether that individual is prepared to enter the unsupervised practice of medicine ... The visits/Case Logs of a program’s graduates who were on duty during this pandemic (particularly those in their ultimate or penultimate years) will be judiciously evaluated in light of the impact of the pandemic on that program. The program can delineate for the Review Committee how it was affected by the pandemic in the ‘Major Changes and Other Updates section of the Annual Update.’”

We believe this should provide fellows some degree of relief from the concern over meeting graduation requirements. Ultimately, by the time a fellow approaches his or her graduation date, the program director has accumulated information (from faculty reviews, direct observations, input from coworkers) and has significant insight about a trainee’s capabilities relative to established performance

metrics. Trainees should be encouraged to meet with their program directors individually or as a group of fellows, as the pandemic begins to slow for future expectations for graduation to be clearly delineated. Additionally, in anticipation of the possibility that they will be exposed to fewer procedures and specialty-specific clinical experiences, trainees and the program directors should take steps toward optimizing the educational value of each encounter. Trainees who graduate and move on to first jobs may wish to have an arrangement for a period of “semi-supervised” support from work colleagues, such as especially challenging cases. Although various resources to accomplish this already exist (eg, educational platforms of the various GI societies, such as the ASGE GI Leap online learning website, *Gastrointestinal Endoscopy*, and *Video-GIE*), additional training tools may need to be developed.

3. TRANSITIONING TO VIRTUAL CONFERENCES

Because clinical schedules have changed as a result of clinical reassignments or shelter-at-home risk reduction strategies, in-person conferences should continue in the form of virtual conferences. Various platforms can help facilitate these efforts. Zoom has risen in popularity, increasing from 10 million to 200 million users in 3 months. However, security concerns have been raised with the platform, which may be relevant if patient information is being discussed. Breaches in software protections have led to unidentified individuals joining calls, the ability for webcams and microphones to be accessed, and concerns about data being sent to third parties.⁴ Various alternatives have been proposed, including Doximity, Google Hangouts, GoToMeeting, and Microsoft Teams. Some of these platforms are free, whereas others require a monthly fee depending on the number of attendees who can be hosted on a call. The decision to adopt a specific virtual platform may require further discussion and clearance by institutional legal counsel or similar administrative body.

4. DECREASED RESEARCH OPPORTUNITIES, PARTICULARLY FOR PROSPECTIVE CLINICAL PURSUITS

The COVID-19 pandemic has likely had a negative impact on fellows engaged in existing research projects. Scientific experiments in the lab may have been stopped, and clinical studies may have been placed on hold because of a decline in patient visits or the inability to access records from offsite locations. On the other hand, the pandemic has brought an explosion of opportunity for future and newly initiated research studies involving the digestive system, digestive health, and the practice of endoscopy as well as opportunities to write manuscripts about completed research. As a point of reference, *Gastrointestinal Endoscopy* has experienced 122% increase in

non-COVID–related manuscript submissions in April 2020 and 155% increase in May 2020. Fellows should avail themselves of this opportunity to meet with their academic mentors and begin the process of brainstorming new ideas for research—especially while clinical demands may be lower. In addition, *Gastrointestinal Endoscopy* and *Video-GIE* have implemented a temporary “ultra-fast track” option to move Covid-19–related articles through the peer review process more quickly.

5. INABILITY TO INTERVIEW FOR JOBS AND TRAINING POSITIONS

The current pandemic is changing many facets of the way we conduct our professional lives. With the importance of social distancing, in-person meetings and interviews are being converted to phone or videoconferences. This affects applicants in their ability to present themselves in the desired light. However, there are positive aspects that come from virtual interviews. For example, travel to in-person interviews can be expensive. In addition, many fellows cannot interview at all their desired programs because they cannot always find coverage for their absences. Videoconferencing is free and timely, and most trainees have found their experience with web-based videoconferencing to meet or exceed their expectations.⁵

Below are some tips for job candidates while using web-based videoconferencing for an interview:

- Treat the interview as if it were a regular face-to-face interview
- Find a quiet, private, well-lit place that is free from distractions
- Dress professionally
- Have a pen and notepad accessible
- Make sure your computer’s audio and video capabilities are working well (ensure access to a strong wired or Wi-Fi signal or network connection, use a device with a high-resolution camera)
- Close any unnecessary web browser tabs and applications
- Use a clear and professional profile picture
- When listening, nod and smile to show you are engaged
- Use hand gestures when appropriate
- Place nearby devices that you are not using in silent mode (eg, your phone)

For more tips on a successful video interview, visit the following links:

- <https://www.indeed.com/career-advice/interviewing/video-interview-guide>.
- <https://www.themedicportal.com/blog/how-to-approach-a-skype-medicine-interview/>

Below are suggestions for employers or program directors conducting interviews:

- Simulate an onsite experience as best as possible
- Focus on the interviewee without other distractions

- Anticipate technologic issues
- Consider providing a virtual tour of your facility
- Take into account the need for breaks and the visual strain associated with video interviews
- Consider a forum for multiple applicants (such as in advanced fellowship interviews) to communicate with one another
- Anticipate an in-person visit once restrictions are lifted
- Be transparent with changes in hiring practices or benefits that may occur as a result of COVID-19
- Communicate regularly with applicants

6. FEWER EDUCATIONAL ACTIVITIES SPONSORED BY INDUSTRY

Because fewer patients are being seen and reduced numbers of procedures are being performed as a result of the pandemic, our industry partners in gastroenterology may see reductions in revenue. Some companies have noted plans for significant reductions in educational funding for 2020. This funding reduction will likely impact the development of locoregional courses and other educational events. Because these courses often provide trainees with greater insight into a breadth of endoscopic procedures, it is hoped that industry may participate in the process of organizing novel educational resources such as video demonstrations that could be used in lieu of in-person training courses. Industry can potentially collaborate with societies in efforts like the newly announced ASGE Fellows Corner, InScope, weekly webinars, and practice discussions and Endo Hangouts, where fellows can engage with experts in endoscopy in a virtual setting. Likewise, trainees are encouraged to supplement their education by using social media platforms like Twitter to engage in regularly scheduled chats such as #MondayNightIBD (@MondayNightIBD) and #ScopingSundays (@ScopingSundays).

7. IMPLICATIONS OF COVID-19 FOR FUTURE NATIONAL AND REGIONAL CONFERENCES

Digestive Disease Week 2020 and many other conferences had to be canceled or postponed. These meetings serve many functions for GI fellows: providing education in a variety of didactic formats (eg, hands-on courses, meet-the-professor luncheons, ASGE learning center, etc), opportunities to develop critical skills like public speaking and scientific presentation, ability to showcase research efforts, career workshops and opportunities to network with colleagues and potential job prospects, and interactions with established and potential mentors in unique education-oriented venues.

With creative planning and enhancements in social media platforms (increased bandwidth to accommodate simultaneous large group participation, augmentation of

audio and video functionality), many of these functions can be evolved into formats that can be delivered effectively via digital and virtual formats. For example, plenary sessions or clinical and research symposia can either be pre-recorded or developed into real-time sessions with moderators and/or panel discussions using web-based videoconferencing technologies. Networking opportunities can be conducted in a similar manner. There are even potential advantages of the virtual format—It eliminates the need to rush back and forth between meeting rooms scattered across large convention centers and various hotels. Although nothing can quite reproduce the exhilaration and anxious anticipation associated with an in-person presentation at a scientific meeting, the experience of doing so virtually with hundreds of people watching represents a similar experience that requires the same degree of practice and preparation.

Poster presentations can be converted from standard poster boards to digital format, and observers can peruse the digital posters silently on their own or choose to engage the presenter in a private virtual “room” to which the presenter is assigned. This format provides unique opportunities, such as durable written feedback for the presenter or scoring of posters by expert reviewers or by all meeting attendees to help guide selection of award recipients. Many of the networking aspects of Digestive Disease Week and other meetings, such as job interviews and academic meetups, can also be accomplished virtually using a wide range of social media and digital meeting platforms.

8. MAKING INPATIENT AND OUTPATIENT SERVICES SAFER FOR HOUSE STAFF

No intervention, other than not working, can eliminate the risk of SARS-CoV-2 exposure to healthcare providers. This is understandably a challenging and anxiety-provoking time for GI fellows, particularly those who are not involved in institutional conversations about planning and preparedness. Institutional leaders are working to ready their facilities and providers with guidance from regional and national organizations, such as the Centers for Disease Control and Prevention, centered around key infection control principles:

- Reinforcing relationships with key healthcare and public health partners, such as healthcare coalitions, state and national health entities, and infection control organizations.
- Taking steps to protect their workforce by measures such as
 - Screening of patients, visitors, and staff for symptoms of COVID-19
 - Ensuring availability of and education about appropriate use of PPE for various clinical scenarios, and strategizing with key personnel in the supply chain to avoid interruptions in provision of PPE and cleaning supplies (hand and surface disinfectants, soap, etc)

- Developing strict policies and procedures for isolation and quarantine after potential exposures
- Providing robust educational materials about hand washing and other strategies to prevent transmission of infection
- Separating patients with respiratory symptoms
- Rescheduling elective, low-priority procedures and surgeries
- Modifying workflows and processes and making infrastructure adjustments to minimize face-to-face encounters at each possible point of contact while maintaining a satisfying patient experience
- Limiting visits by people at higher risk of SARS-CoV-2 exposure (eg, group residential settings, nursing home residents, etc)
- Providing easy access to SARS-CoV-2 testing and resources with up-to-date information about the pandemic and any changes to institutional policies
- Leveraging telehealth technologies for virtual inpatient and outpatient encounters and adapting coding and billing processes.

Many of these steps are done “behind the scenes” and may not be readily apparent to house staff and trainees. Programs should actively involve trainees in conversations about restructuring of inpatient services, because these transitions may serve as an important learning opportunity in how systematic changes are made to a practice to respond to unanticipated changes in the practice environment.

9. TRANSITIONING TO VIRTUAL VISITS

As the COVID-19 pandemic evolves, healthcare providers will have to make decisions about incorporating telehealth into their clinical practice. GI fellows may be uniquely well suited for this evolution because they often have a high level of proficiency with digital platforms and the devices required to use them. In fact, at some institutions trainees are assuming vital roles in developing telehealth pathways and related training algorithms. Many recent state and federal regulatory changes have enabled the increasing use of telehealth during the pandemic. Relevant examples include the following:

- Expansion of telehealth benefits by the Centers for Medicare & Medicaid Services (CMS) under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act, significantly broadening the geographic rules governing care (patients and doctors can physically be at home or elsewhere during the encounter) and the types of encounters that are allowable (initial visits, follow-up visits, etc). Before this, telehealth Medicare encounters were only reimbursable in specific and more limited circumstances, as described in CMS Healthcare Common Procedure Coding System and the Physician Fee Schedule. More information about

coverable services and various COVID-19 waivers is available on the CMS website: www.CMS.gov (eg, <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>); (<https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page>).

- Telehealth services will be reimbursed by Medicare at the same rate as in-person visits.
- Providers may deliver “virtual” care via radio, phone, or online for patients at rural hospitals.
- More discretion on the part of the U.S. Health and Human Services Office for Civil Rights when enforcing HIPAA compliance when using various telehealth tools and platforms (frequently interpreted as greater leniency regarding penalties if providers use platforms that do not strictly comply with historic HIPAA rules, such as FaceTime or Skype).
- Reductions/waivers by U.S. Health and Human Services Office of Inspector General of cost-sharing for telehealth visits paid for by federal healthcare programs.
- Federal Communications Commission announcement of a \$200 million program to help funding of telehealth for qualifying providers using funding from the Coronavirus Aid, Relief, and Economic Security, or CARES, Act.
- Federal and state protections pertaining to medicolegal liability during the pandemic. Examples can be found on the AMA website (<https://www.ama-assn.org/practice-management/sustainability/liability-protections-health-care-professionals-during-covid-19>).

Transitioning to virtual encounters is not inherently easy or ideal. Potential hurdles and shortcomings are described in a recent *Gastrointestinal Endoscopy* Perspectives article created by gastroenterology fellows.⁶ Examples include a lack of telemedicine experience, greater difficulty establishing rapport with patients, coordinating follow-up and subsequent patient care, and the need to learn new billing and coding requirements.

10. ACGME AND AMERICAN BOARD OF INTERNAL MEDICINE GUIDANCE RELATED TO THE COVID-19 PANDEMIC

There has been a significant amount of guidance from educational boards and licensing bodies during the COVID-19 pandemic. Trainees are encouraged to visit the ACGME website to view its responses to frequently asked questions surrounding training during COVID-19 (<https://www.acgme.org/covid-19>). Important questions addressed by the ACGME include the following:

1. Can fellows be assigned to act as attending physicians on Internal Medicine or GI inpatient and/or consultative services?
2. Can residents and fellows be reassigned from their previously scheduled clinical rotations and other assignments?

3. Given the impact of the pandemic on the clinical learning environment and programs’ regular educational curricula, can residents and fellows successfully complete their education and training?
4. How should programs handle and what are the ACGME’s expectations for fulfillment by residents/fellows of minimum requirements for rotations, clinic visits, operations, or other procedures?
5. How will the review committees consider the impact of the pandemic on programs in making future accreditation decisions?

Some ACGME responses to these queries have been cited in other sections of this document. Expanded answers and additional questions can be found on the ACGME site.

Similarly, the American Board of Internal Medicine (ABIM) has attempted to address concerns expressed by trainees about board eligibility in the era of the pandemic. In their statement, “ABIM Board Eligibility and COVID-19,” they issue reassurance for residents and fellows:

“Specifically, ABIM does not anticipate interruptions of training related to COVID-19 adversely affecting Board Eligibility for the vast majority of otherwise competent residents and fellows. ABIM’s recently clarified Leave of Absence and Vacation and Deficits in Required Training Time policies are in full effect and applicable to absences that might occur due to COVID-19.”

Fellows should visit the following site for the complete compendium of ABIM links to policies on Leave of Absence and Vacation, and Deficits in Required Training Time (<http://view.mail.abim.org/?qs=9764094c8340e4b5ce42962ed5af570170bca85d91815bfbe3e5074eb81029401a994f96717fbb2e451893049561e56d52481644dc72ec73c681854acf85185c580a89572ca238f2>).

In summary, the COVID-19 pandemic has dramatically altered the landscape of GI fellowship training. The myriad of challenges associated with the pandemic have spawned unique opportunities to expand the scope of the training landscape in terms of virtual conferences and telehealth. We have also seen our professional societies augment their virtual educational platforms to meet this challenge. A major concern surrounds the hands-on aspect of endoscopic training, which still may be curtailed in many regions of the country and throughout the world. The solution to this is complex and will evolve with the availability of point-of-service testing, PPE, and hopefully the eventual attainment of herd immunity.

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