



UAEU

جامعة الإمارات العربية المتحدة
United Arab Emirates University

NATIONAL INSTITUTE FOR HEALTH SPECIALITIES

NIHS Program Requirements for Specialty Education in Adult Rheumatology (Emirati Board in Adult Rheumatology)

The Emirati Board in Rheumatology is expected to define its specific program aims consistent with the overall mission of its Sponsoring Institution, the needs of the community it serves and that its graduates will serve, and the distinctive capabilities of physicians it intends to graduate. The Program must demonstrate substantial compliance with the Common and specialty-specific Program Requirements.

Where applicable, text in italics describes the underlying philosophy of the requirements in that section. These philosophic statements are not program requirements and are therefore not citable.

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Introduction

Int. A. Preamble

Fellowship is advanced graduate medical education beyond a core residency program for physicians who desire to enter more specialized practice. Fellowship-trained physicians serve the public by providing subspecialty care, which may also include core medical care, acting as a community resource for expertise in their field, creating and integrating new knowledge into practice, and educating future generations of physicians. Graduate medical education values the strength that a diverse group of physicians brings to medical care.

Fellows who have completed residency are able to practice independently in their core specialty. The prior medical experience and expertise of fellows distinguish them from physicians entering residency training. The fellow's care of patients within the subspecialty is undertaken with appropriate faculty supervision and conditional independence. Faculty members serve as role models of excellence, compassion, professionalism, and scholarship. The fellow develops deep medical knowledge, patient care skills, and expertise applicable to their focused area of practice. Fellowship is an intensive program of subspecialty clinical and didactic education that focuses on the multidisciplinary care of patients. Fellowship education is often physically, emotionally, and intellectually demanding, and occurs in a variety of clinical learning environments committed to graduate medical education and the well-being of patients, residents, fellows, faculty members, students, and all members of the health care team.

In addition to clinical education, many fellowship programs advance fellows' skills as physician-scientists. While the ability to create new knowledge within medicine is not exclusive to fellowship-educated physicians, the fellowship experience expands a physician's abilities to pursue hypothesis-driven scientific inquiry that results in contributions to the medical literature and patient care. Beyond the clinical subspecialty expertise achieved, fellows develop mentored relationships built on an infrastructure that promotes collaborative research.

Int. B. Definition of Specialty

Adult Rheumatology is the subspecialty of internal medicine that focuses on the diagnosis and treatment of medical diseases of the joints, muscles, and connective tissues. Rheumatology includes a wide array of autoimmune, inflammatory, and non-inflammatory conditions that affect the musculoskeletal and other organ systems. The purpose of rheumatology training programs is to 1) train fellows to be accomplished practitioners and consultants in the rheumatic diseases, and 2) encourage the professional and scholarly attitudes and approaches of a competent subspecialist that are needed to maintain an understanding of current concepts in rheumatology as advances occur.

Int. C Length of educational program

The educational program in Adult Rheumatology must be 36 months in length. ^(Core)

I. Oversight

I.A. Sponsoring Institution

The Sponsoring Institution is the entity that assumes the ultimate financial and academic responsibility for a program of graduate medical education, consistent with the NIHS Institutional Requirements.

When the Sponsoring Institution is not a rotation site for the program, the most utilized site of clinical activity for the program is the primary clinical site.

Background and Intent: *Participating sites will reflect the health care needs of the community and the educational needs of the fellows. A wide variety of organizations may provide a robust educational experience and, thus, Sponsoring Institution and participating sites may encompass inpatient and outpatient settings.*

I.A.1. The program is sponsored by a National Institute for Health Specialties (NIHS) accredited sponsoring institution. ^(Core)

I.B. Participating Sites

A participating site is an entity that provides educational experiences or educational assignments/rotations for fellows.

I.B.1. The program, with approval of its Sponsoring Institution, must designate a primary clinical site. ^(Core)

I.B.1.a) A rheumatology fellowship must function as an integral part of an NIHS-accredited residency in internal medicine. ^(Core)

I.B.1.b) The Sponsoring Institution must establish the rheumatology fellowship within a department of internal medicine or an administrative unit whose primary mission is the advancement of internal medicine subspecialty education and patient care. ^(Detail)

I.B.1.c) The Sponsoring Institution must ensure that there is a partnership and close collaboration between the program directors of the parent internal medicine residency program and fellowship program to ensure compliance with NIHS accreditation requirements. ^(Core)

I.B.2. There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship

between the program and the participating site providing a required assignment. ^(Core)

I.B.2.a) The PLA must:

I.B.2.a)(1) be renewed at least every 5 years; ^(Core)

I.B.2.a)(2) be approved by the designated institutional official (DIO); ^(Core)

I.B.2.a)(3) specify the duration and content of the educational experience; ^(Core)

I.B.2.a)(4) state the policies and procedures that will govern fellow education during the assignment; ^(Core)

I.B.2.a)(5) identify the faculty members who will assume educational and supervisory responsibility for fellows specify the responsibilities for teaching, supervision, and formal evaluation of fellows; ^(Core)

I.B.2.a)(6) specify the responsibilities for teaching, supervision, and formal evaluation of fellows. ^(Core)

I.B.3. The program has a mechanism to monitor the clinical learning and working environment at each participating site; ^(Core)

I.B.3.a) At each participating site there must be one faculty member, designated by the program director who is accountable for fellow education at that site, in collaboration with the program director. ^(Core)

Background and Intent: *While all fellowship programs must be sponsored by a single NIHS-accredited Sponsoring Institution, many programs can utilize other clinical settings from different institutions to provide required or elective training experiences. At times it is appropriate to utilize community sites that are not owned by or affiliated with the Sponsoring Institution. Some of these sites may be remote for geographic, transportation, or communication issues. When utilizing such sites, the program must ensure the quality of the educational experience.*

I.B.4. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all fellows, of one-month full time equivalent (FTE) or more through NIHS Accreditation System. ^(Core)

I.B.5. Fellow assignments away from the Sponsoring Institution should not prevent fellows' regular participation in required didactics.

I.C. Recruitment

The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of fellows, residents (if present), faculty members, senior administrative staff members, and other relevant members of its academic community. ^(Core)

I.D. Resources

I.D.1. The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for fellow education. ^(Core)

I.D.1.a) Space and Equipment

There must be space and equipment for the program, including meeting rooms, examination rooms, computers, visual and other educational aids, and work/study space. ^(Core)

I.D.1.b) Facilities

I.D.1.b)(1) Inpatient and outpatient systems must be in place to prevent fellows from performing routine clerical functions, such as scheduling tests and appointments, and retrieving records and letters ^(Detail)

I.D.1.b)(2) The Sponsoring Institution must provide the broad range of facilities and clinical support services required to provide comprehensive care of adult patients. ^(Core)

I.D.1.b)(3) Fellows must have access to a lounge facility during assigned duty hours. ^(Detail)

I.D.1.b)(4) When fellows are in the hospital, assigned night duty, or called in from home, they must be provided with a secure space for their belongings. ^(Detail)

I.D.1.c) Laboratory Services The following must be present at the primary clinical site or participating site(s):

I.D.1.c)(1) access to clinical immunology lab services; ^(Core)

I.D.1.c)(2) computerized tomography (CT), bone densitometry, magnetic resonance imaging (MRI), and angiography. ^(Core)

I.D.1.d) Other Support Services

I.D.1.d)(1) Fellows must have access to a compensated polarized light microscope. ^(Core)

I.D.1.d)(2) Fellows must have access to facilities for rehabilitation medicine. ^(Core)

I.D.1.d)(3) There should be:

I.D.1.d)(3)(a) orthopedic surgery services for obtaining synovial biopsies and consultations for joint arthroplasty; ^(Core)

I.D.1.d)(3)(b) other consultation services for obtaining indicated biopsies of muscle, nerve, skin, and arteries; ^(Core)

I.D.1.d)(3)(c) access to pathology services for evaluation of muscle, vascular, and synovial biopsy materials; ^(Core)

I.D.1.d)(3)(d) a meaningful working relationship, including availability for teaching and consultation, with a radiologist and orthopedic surgeon; ^(Core)

I.D.1.d)(3)(e) access to services such as ophthalmology, ENT, dermatology, neurology, internal medicine subspecialists (e.g. gastroenterology, nephrology, and hematology), and obstetrics/gynecology; ^(Core)

I.D.1.d)(3)(f) consultations from health care professionals such as nurses, social workers, case managers, language interpreters, dieticians, physical therapist, occupational therapist etc. to assist with patient care. ^(Core)

I.D.1.e) Medical Records Access to an electronic health record should be provided. In the absence of an existing electronic health record, institutions must demonstrate institutional commitment to its development and progress toward its implementation. ^(Core)

I.D.2. The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote fellow well-being and provide for: ^(Core)

I.D.2.a) access to food while on duty; ^(Core)

I.D.2.b) safe, quiet, clean, and private sleep/rest facilities available and accessible for fellows with proximity appropriate for safe patient care; ^(Core)

Background and Intent: *Care of patients within a hospital or health system occurs continually through the day and night. Such care requires that fellows' function at their peak abilities, which requires the work environment to provide them with the ability to meet their basic needs within proximity of their clinical responsibilities.*

Access to food and rest are examples of these basic needs, which must be met while fellows are working. Fellows should have access to refrigeration where food may be stored. Food should be available when fellows are required to be in the hospital overnight. Rest facilities are necessary, even when overnight call is not required, to accommodate the fatigued fellow.

I.D.2.c) clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; ^(Core)

Background and Intent: *Sites must provide private and clean locations where fellows may lactate and store the milk within a refrigerator. These locations should be in close proximity to clinical responsibilities. It would be helpful to have additional support within these locations that may assist the fellow with the continued care of patients, such as a computer and a phone. While space is important, the time required for lactation is also critical for the well-being of the fellow and the fellow's family.*

I.D.2.d) security and safety measures appropriate to the participating site; ^(Core)

I.D.2.e) accommodations for fellows with disabilities consistent with the Sponsoring Institution's policy. ^(Core)

I.D.3. Fellows must have ready access to Rheumatology-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. ^(Core)

I.D.4. The program's educational and clinical resources must be adequate to support the number of fellows appointed to the program. ^(Core)

I.D.4.a) Patient Population

I.D.4.a)(1) The patient population must have a variety of clinical problems and stages of diseases. ^(Core)

I.D.4.a)(2) There must be patients of each gender, with a broad age range, including geriatric patients. ^(Core)

I.D.4.a)(3) A sufficient number of patients must be available to enable each fellow to achieve the required educational outcomes. ^(Core)

I.E. Other Learners and Other Care Providers

A fellowship program usually occurs in the context of many learners and other care providers and limited clinical resources. It should be structured to optimize education for all present learners.

I.E.1. Fellows should contribute to the education of residents in core programs if present. ^(Core)

Background and Intent: *The clinical learning environment has become increasingly complex and often includes care providers, students, and post-graduate residents and fellows from multiple disciplines. The presence of these practitioners and their learners enrich the learning environment. Programs have a responsibility to monitor the learning environment to ensure that fellows' education is not compromised by the presence of other providers and learners, and that fellows' education does not compromise core residents' education.*

II. Personnel

II.A. Program Director

II.A.1. There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. ^(Core)

II.A.1.a) The Sponsoring Institution's GMEC must approve a change in program director. ^(Core)

II.A.1.b) Final approval of the program director resides with the Central Accreditation Committee. ^(Core)

Background and Intent: *While the NIHS recognizes the value of input from numerous individuals in the management of a fellowship, a single individual must be designated as program director and made responsible for the program. This individual will have dedicated time for the leadership of the fellowship, and it is this individual's responsibility to communicate with the fellows, faculty members, DIO, GMEC, and the NIHS. The program director's nomination is reviewed and approved by the GMEC. Final approval of program directors resides with the Central Accreditation Committee.*

II.A.1.c) The program must demonstrate retention of the program director for a length of time adequate to maintain continuity of leadership and program stability. ^(Core)

II.A.2. At a minimum, the program director must be provided with the salary support required to devote no less than 30 percent FTE of non-clinical time to the administration of the program. ^(Core)

Background and Intent: *Thirty percent FTE is defined as one-and-a-half (1.5) day per week. "Administrative time" is defined as non-clinical time spent meeting the responsibilities of the program director.*

II.A.3. Qualifications of the program director

II.A.3.a) must include expertise in adult Rheumatology and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Central Accreditation Committee; ^(Core)

Background and Intent: *Leading a program requires knowledge and skills that are established during fellowship and subsequently further developed. The time period from completion of fellowship until assuming the role of program director allows the individual to cultivate leadership abilities while becoming professionally established. The three-year period is intended for the individual's professional maturation.*

The broad allowance for educational and/or administrative experience recognizes that strong leaders arise through diverse pathways. These areas of expertise are important when identifying and appointing a program director. The choice of a program director should be informed by the mission of the program and the needs of the community.

In certain circumstances, the program and Sponsoring Institution may propose, and the Central Accreditation Committee may accept a candidate for program director who fulfills these goals but does not meet the three-year minimum.

II.A.3.b) must be licensed as consultant and have at least three years post structured clinical fellowship education with documented experience in adult rheumatology subspecialty, or with a specialty qualification that are acceptable to the Central Accreditation Committee; ^(Core)

II.A.3.c) must include current medical licensure and appropriate medical staff appointment; ^(Core)

II.A.3.d) must include ongoing clinical activity and involvement in scholarly activities; ^(Core)

Background and Intent: *A program director is a role model for faculty members and fellows. The program director must participate in clinical activity consistent with the specialty. This activity will allow the program director to role model the Core Competencies for the faculty members and fellows.*

II.A.4. Program Director Responsibilities

The program director must have responsibility, authority, and accountability for administration and operations; teaching and scholarly activity; fellow recruitment and selection, evaluation, and promotion of fellows, and disciplinary action; supervision of fellows; and fellow education in the context of patient care. ^(Core)

II.A.4.a) The program director must:

II.A.4.a)(1) be a role model of professionalism; ^(Core)

Background and Intent: *The program director, as the leader of the program, must serve as a role model to fellows in addition to fulfilling the technical aspects of the role. As fellows are expected to demonstrate compassion, integrity, and respect for others, they must be able to look to the program director as an exemplar. It is of utmost importance, therefore, that the program director model outstanding professionalism, high quality patient care, educational excellence, and a scholarly approach to work. The program director creates an environment where respectful discussion is welcome, with the goal of continued improvement of the educational experience.*

II.A.4.a)(2) design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program; ^(Core)

Background and Intent: *The mission of institutions participating in graduate medical education is to improve the health of the public. Each community has health needs that vary based upon location and demographics. Programs must understand the social determinants of health of the populations they serve and incorporate them in the design and implementation of the program curriculum, with the goal of addressing these needs and health disparities.*

II.A.4.a)(3) administer and maintain a learning environment conducive to educating the fellows in each of the Core Competency domains; ^(Core)

Background and Intent: *The program director may establish a leadership team to assist in the accomplishment of program goals. Fellowship programs can be highly complex. In a complex organization, the leader typically has the ability to delegate authority to others yet remains accountable. The leadership team may include physician and non-physician personnel with varying levels of education, training, and experience.*

II.A.4.a)(4) develop and oversee a process to evaluate candidates prior to approval as program faculty members

for participation in the fellowship program education and at least annually thereafter; ^(Core)

II.A.4.a)(5) have the authority to approve and/or remove program faculty members for participation in the fellowship program education at all sites; ^(Core)

II.A.4.a)(6) have the authority to remove fellows from supervising interactions and/or learning environments that do not meet the standards of the program; ^(Core)

Background and Intent: *The program director has the responsibility to ensure that all who educate fellows effectively role model the Core Competencies. Working with a fellow is a privilege that is earned through effective teaching and professional role modeling. This privilege may be removed by the program director when the standards of the clinical learning environment are not met.*

There may be faculty in a department who are not part of the educational program, and the program director controls who is teaching the fellows.

II.A.4.a)(7) submit accurate and complete information required and requested by the DIO, GMEC, and NIHS; ^(Core)

II.A.4.a)(8) provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant Rheumatology board examination(s); ^(Core)

II.A.4.a)(9) provide a learning and working environment in which fellows have the opportunity to raise concerns and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; ^(Core)

II.A.4.a)(10) ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process; ^(Core)

II.A.4.a)(11) ensure the program's compliance with the Sponsoring Institution's policies and procedures for due process when action is taken to suspend or dismiss, not to promote, or not to renew the appointment of a fellow; ^(Core)

Background and Intent: *A program does not operate independently of its Sponsoring Institution. It is expected that the program director will be aware of the Sponsoring Institution's policies and procedures and will ensure they are followed by the program's leadership, faculty members, support personnel, and fellows.*

II.A.4.a)(12) ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; ^(Core)

II.A.4.a)(13) document verification of program completion for all graduating fellows; within 30 days; ^(Core)

II.A.4.a)(14) provide verification of an individual fellow's completion upon the fellow's request, within 30 days; ^(Core)

Background and Intent: *Primary verification of graduate medical education is important to credentialing of physicians for further training and practice. Such verification must be accurate and timely. Sponsoring Institution and program policies for record retention are important to facilitate timely documentation of fellows who have previously completed the program. Fellows who leave the program prior to completion also require timely documentation of their summative evaluation.*

II.A.4.a)(15) obtain review and approval of the Sponsoring Institution's DIO before submitting information, as required in the Institutional Requirements and outlined in the NIHS guidelines to the Common Program Requirements. ^(Core)

II.A.5. Associate Program Director (APD)

II.A.5.a) For programs with an approved fellow complement of more than 15, the sponsoring institution must appoint an Associate Program director to support the PD by actively participating in administrative and educational activities. ^(Core)

II.A.5.a)(1) the associate program director must report to the program director. ^(Core)

II.A.5.b) Sponsoring institution to provide APD with 0.3 FTE (or 12 hours per week) of protected time for education and program administration. ^(Core)

II.A.5.c) APD should assume the role for a duration suitable for ensuring program continuity and stability. ^(Core)

II.B. Faculty

Faculty members are a foundational element of graduate medical education – faculty members teach fellows how to care for patients. Faculty members provide an important bridge allowing fellows to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion,

commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach. By employing a scholarly approach to patient care, faculty members improve the health of the individual and the population.

Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, fellows, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the fellows and themselves.

Background and Intent: *“Faculty” refers to the entire teaching force responsible for educating fellows. The term “faculty,” including “core faculty,” does not imply or require an academic appointment or salary support.*

II.B.1. At each participating site, there must be a sufficient number of faculty members with competence to instruct and supervise all fellows at that location. ^(Core)

II.B.1.a) The ratio of all faculty to fellows must be a minimum of 1:1. ^(Core)

II.B.2. Faculty members must:

II.B.2.a) be role models of professionalism; ^(Core)

II.B.2.b) demonstrate commitment to the delivery of safe, quality, cost-effective, patient-centered care; ^(Core)

Background and Intent: *Patients have the right to expect quality, cost-effective care with patient safety at its core. The foundation for meeting this expectation is formed during fellowship. Faculty members model these goals and continually strive for improvement in care and cost, embracing a commitment to the patient and the community they serve.*

II.B.2.c) demonstrate a strong interest in the education of fellows; ^(Core)

II.B.2.d) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; ^(Core)

II.B.2.e) administer and maintain an educational environment conducive to educating fellows; ^(Core)

II.B.2.f) regularly participate in organized clinical discussions, rounds, journal clubs, and conferences; ^(Core)

II.B.2.g) pursue faculty development designed to enhance their skills at least annually; ^(Core)

Background and Intent: *Faculty development is intended to describe structured programming developed for the purpose of enhancing transference of knowledge, skill, and behavior from the educator to the learner. Faculty development may occur in a variety of configurations using internal and/or external resources. Programming is typically needs-based and may be specific to the institution or the program.*

II.B.2.h) mentor fellows in the application of scientific principles, epidemiology, biostatistics, and evidence-based medicine to the clinical care of patients. ^(Core)

II.B.3. Faculty Qualifications

II.B.3.a) Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. ^(Core)

II.B.3.b) Physician faculty members must:

II.B.3.b)(1) have current license in Adult Rheumatology or other specialty as required, or possess qualifications judged acceptable to the Central Accreditation Committee. ^(Core)

II.B.3.c) Any non-physician faculty members who participate in fellowship program education must be approved by the program director. ^(Core)

Background and Intent: *The provision of optimal and safe patient care requires a team approach. The education of fellows by non-physician educators enables the fellows to better manage patient care and provides valuable advancement of the fellows' knowledge. Furthermore, other individuals contribute to the education of the fellow in the basic science of the specialty or in research methodology. If the program director determines that the contribution of a non-physician individual is significant to the education of the fellows, the program director may designate the individual as a program faculty member or a program core faculty member.*

II.B.4. Core Faculty

Core faculty members must have a significant role in the education and supervision of fellows and must devote a significant portion of their entire effort to fellow education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to fellows. ^(Core)

Background and Intent: Core faculty members are critical to the success of fellow education. They support the program leadership in developing, implementing, and assessing curriculum and in assessing fellows' progress toward achievement of competence in Rheumatology. Core faculty members should be selected for their broad knowledge of and involvement in the program, permitting them to effectively evaluate the program, including completion of the annual NIHS Faculty annual survey.

II.B.4.a) Core faculty members must be designated by the program director. ^(Core)

II.B.4.b) Core faculty members must complete the annual NIHS Faculty Survey. ^(Core)

II.B.4.c) In addition to the program director, there must be at least one core faculty member certified in adult rheumatology. ^(Core)

II.B.4.d) In programs approved for more than three fellows, there must be at least one core faculty member certified in adult rheumatology for every 1.5 fellows (1:1.5). ^(Core)

II.C. Program Coordinator

II.C.1. There must be a program coordinator. ^(Core)

II.C.2. At a minimum, the program coordinator must be provided with adequate time for the administration of the program. ^(Core)

Background and Intent: Each program requires a lead administrative person, frequently referred to as a program coordinator, administrator, or as titled by the institution. This person will frequently manage the day-to-day operations of the program and serve as an important liaison with learners, faculty and other staff members, and the NIHS. Individuals serving in this role are recognized as program coordinators.

The program coordinator is a member of the leadership team and is critical to the success of the program. As such, the program coordinator must possess skills in leadership and personnel management. Program coordinators are expected to develop unique knowledge of the NIHS and Program Requirements, policies, and procedures. Program coordinators assist the program director in accreditation efforts, educational programming, and support of fellows.

Programs, in partnership with their Sponsoring Institutions, should encourage the professional development of their program coordinators and avail them of opportunities

for both professional and personal growth. Programs with fewer fellows may not require a full-time coordinator; one coordinator may support more than one program.

II.D. Other Program Personnel

The program, in partnership with its Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective administration of the program. ^(Core)

II.D.1. There must be services available from other health care professionals, including dietitians, language interpreters, nurses, occupational therapists, physical therapists, and social workers. ^(Detail)

II.D.2. There must be appropriate and timely consultation from other specialties. ^(Detail)

Background and Intent: *Multiple personnel may be required to effectively administer a program. These may include staff members with clerical skills, project managers, education experts, and staff members to maintain electronic communication for the program. These personnel may support more than one program in more than one discipline.*

III. Fellows Appointments

III.A. Eligibility Requirements

III.A.1. An applicant must meet the following qualifications to be eligible for appointment to a NIHS-accredited program: ^(Core)

III.A.1.a) All required clinical education for entry into NIHS-accredited fellowship programs must be completed in an NIHS-accredited residency program, a program with ACGME International (ACGME-I) Advanced Specialty Accreditation, or another structured residency program considered acceptable by Central Accreditation Committee. ^(Core)

III.A.1.b) Prior to appointment in the fellowship, fellows should have completed an internal medicine program that satisfies the requirements in III.A.1.a) ^(Core)

III.A.1.b)(1) Refer to NIHS criteria included in the Training Bylaw. ^(Core)

III.A.1.c) Fellow Eligibility Exception

The Central Accreditation Committee for Internal Medicine will allow the following exception to the fellowship eligibility requirements:

III.A.1.c)(1) An NIHS-accredited fellowship program may accept an exceptionally qualified international graduate applicant who does not satisfy the eligibility requirements listed in III.A.1.a), but who does meet all of the following additional qualifications and conditions: ^(Core)

III.A.1.c)(1)(a) Is eligible for license of specialist in Internal Medicine by UAE Health Authority PQR. ^(Core)

III.A.1.c)(1)(b) Is evaluated by the program director and fellowship selection committee based on prior training and review of the summative evaluations of training in the core specialty; ^(Core)

III.A.1.c)(1)(c) The applicant's exceptional qualifications are reviewed and approved of by the GMEC; ^(Core)

III.A.1.c)(2) Applicants accepted through this exception must have an evaluation of their performance by the Clinical Competency Committee within 12 weeks of matriculation. ^(Core)

III.A.2. All prerequisite post-graduate clinical education required for initial entry or transfer into NIHS-accredited fellowship programs must be completed in an NIHS-accredited fellowship programs approved by the NIHS. ^(Core)

III.A.2.a) Prior to appointment in the program, fellows must fulfill the NIHS eligibility criteria. ^(Core)

III.B. Number of Fellows

III.B.1. The program director must not appoint more fellows than approved by the Central Accreditation Committee. ^(Core)

III.B.2. All changes in fellow complement must be approved by the NIHS Central Accreditation Committee. ^(Core)

III.B.3. The number of fellows appointed to the program must not exceed the program's educational and clinical resources. ^(Core)

III.B.4. The number of available fellow positions in the program must be at least one per year. ^(Core)

III.C. Fellows Transfers

The program must obtain verification of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring fellow, and Milestones evaluations upon matriculation. ^(Core)

IV. Educational Program

The NIHS accreditation system is designed to encourage excellence and innovation in medical education regardless of the organizational affiliation, size, or location of the program.

The educational program must support the development of knowledgeable, skillful physicians who provide compassionate care.

IV.A. Curriculum Components

The Educational Curriculum must contain the following educational components: ^(Core)

IV.A.1. A set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates. ^(Core)

IV.A.2. Competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice which is documented by Milestones evaluation. ^(Core)

IV.A.2.a) These goals and objectives must be distributed and available to fellows and faculty members. ^(Core)

IV.A.3. Delineation of fellow responsibilities for patient care, progressive responsibility for patient management, and graded supervision in their subspecialty. ^(Core)

IV.A.4. Structured educational activities beyond direct patient care. ^(Core)

Background and Intent: *Patient care-related educational activities, such as morbidity and mortality conferences, tumor boards, surgical planning conferences, case discussions, etc., allow fellows to gain medical knowledge directly applicable to the patients they serve. Programs should define those educational activities in which fellows are expected to participate and for which time is protected.*

IV.A.5. Advancement of fellows' knowledge of ethical principles foundational to medical professionalism. ^(Core)

IV.B. Defined Core Competencies

IV.B.1. The program must integrate the following Core Competencies into the curriculum: ^(Core)

IV.B.1.a) Professionalism

Fellows must demonstrate a commitment to professionalism and an adherence to ethical principles. ^(Core)

IV.B.1.a)(1) Primacy of patient interest

The fellow must: ^(Core)

IV.B.1.a)(1)(a) Demonstrate empathy and compassion to all patients, ^(Core)

IV.B.1.a)(1)(b) Address disparities in health care that may impact patient care. ^(Core)

IV.B.1.a)(1)(c) Take responsibility for situations where public health supersedes individual privacy (e.g. reportable infectious diseases). ^(Core)

IV.B.1.a)(2) Physician responsibility and accountability

The fellow must maintain professional and respectful interactions with patients, caregivers, and members of the interprofessional team (e.g., peers, consultants, nursing, ancillary professionals, and support personnel). ^(Core)

IV.B.1.a)(2)(a) To demonstrate commitment to providing safe patient care, the fellow must recognize, respond to, and report either the impairment in colleagues, or the provision of substandard care, via a peer review process. ^(Core)

IV.B.1.a)(2)(b) To demonstrate the professional attribute of accessibility, the fellow accepts responsibility and follows through on tasks, including but not limited to completion of clinical, administrative, curricular and research-related tasks. ^(Core)

IV.B.1.a)(2)(c) To demonstrate the professional attribute of personal accountability, the fellow

should contribute to the fiscally sound practice of medicine. ^(Core)

IV.B.1.a)(2)(d) Fellows should responsibly use technology and social media. ^(Core)

IV.B.1.a)(2)(e) To manage conflicts of interest the fellow must maintain ethical relationships with patients, colleagues, members of the interprofessional team, office staff and industry. ^(Core)

IV.B.1.a)(3) Humanistic qualities and altruism

Fellows should treat patients with dignity, civility, and respect, regardless of race, culture, gender, sexual orientation, socioeconomic status, literacy, and religious beliefs. ^(Core)

IV.B.1.a)(3)(a) To demonstrate compassion and respect to patients and their caregivers, fellows should endeavor to support patients' needs (physical, psychological, social, and spiritual). ^(Core)

IV.B.1.a)(4) Ethical behavior

The fellows must exhibit integrity and ethical behavior in professional conduct.

IV.B.1.a)(4)(a) Including, but is not limited to, accepting personal errors and honestly acknowledging them, maintaining patient confidentiality, upholding ethical expectations of clinical, scholarly and research activities, as well as maintenance of credentialing requirements. ^(Core)

IV.B.1.a)(4)(b) The fellow must address personal, psychological, and physical limitations that may affect professional performance. ^(Core)

IV.B.1.a)(4)(c) Integrity must pervade all of the components of professionalism. ^(Core)

IV.B.1.b) Patient Care and Procedural Skills

Programs must define the specific knowledge, skills, behaviors, and attitudes required, as well as provide educational experiences as needed in order for their trainees to demonstrate quality patient care. ^(Core)

IV.B.1.b)(1) The rheumatologist must provide consultation when requested, in support of the primary care relationship, for patients with rheumatic symptoms and signs and appropriately integrate recommendations from other health care providers into the evaluation and management plan. This may broadly be categorized under 4 components: ^(Core)

IV.B.1.b)(1)(a) Information Gathering:

The fellow must be able to: ^(Core)

- Obtain an accurate and comprehensive but relevant clinical history, including review of all available records.
- Perform a thorough and relevant review of systems and assess functional status of patients with rheumatic disease symptoms.
- Perform and interpret a comprehensive, accurate physical examination, using common and advanced techniques, where applicable.
- Perform and interpret the examination of all axial and peripheral joints, peri-articular structures, peripheral nerves and muscles.
- Identify extra-articular findings that are associated with specific rheumatic diseases.
- Recognize the indications for and costs of ordering laboratory tests and procedures to establish a diagnosis of rheumatic disease.
- Recognize the indications for and costs of different therapies used in the management of rheumatic diseases.
- Recognize the indications for and demonstrate competence in arthrocentesis, joint and soft tissue injections. The fellow should be able to distinguish the anatomy, precautions (including OSHA requirements) and potential sequelae of arthrocentesis and demonstrate competency in obtaining synovial fluid from diarthrodial joints, bursae and tenosynovial structures after

obtaining informed consent from the patient or caregiver.

- Perform synovial fluid analysis including the examination and interpretation of synovial fluid under conventional and polarized light microscopy from patients with a variety of rheumatic diseases.
- Obtain and interpret appropriate tests, including laboratory tests, imaging studies, and other indicated testing to evaluate patients presenting with known or possible rheumatic disease:
 - Radiographs of normal and diseased joints, bones, peri-articular structures and prosthetic joints.
 - Bone densitometry.
 - Arthrography, ultrasonography, computed tomography, magnetic resonance imaging of joints, bones, peri-articular structures and muscle. Note: Fellows shall demonstrate knowledge and skills in musculoskeletal ultrasonography.
 - Radionuclide scans of bones and joints.
 - Arteriograms (conventional, CT and MR) for patients with suspected or confirmed vasculitis.
 - Computed tomography of lungs and paranasal sinuses.
 - MRI of the CNS system (brain and spinal cord).
 - Electromyograms and nerve conduction studies.
 - Biopsy specimens including histochemistry and immunofluorescence of tissues relevant to the diagnosis of rheumatic diseases: skin, synovium, muscle, nerve, bone, minor salivary gland, artery, kidney and lung.

- Specific laboratory tests: See Medical Knowledge.
- Arthroscopy.
- Schirmer's and tests of corneal integrity; parotid scans and salivary flow studies.

IV.B.1.b)(1)(b) Synthesis of Treatment Plan: Informed medical decision-making based on current scientific information and clinical judgment that also accounts for patient preferences and circumstances.

The fellow should be able to: ^(Core)

- Construct a differential diagnosis in patients presenting with signs and symptoms related to rheumatologic diseases and to outline further testing necessary to establish the correct diagnosis.
- Construct and implement an appropriate treatment plan for the care of a patient with a rheumatologic problem integrating the prescribing of medications (oral, injectable or infused), counseling and psychosocial aspects, rehabilitative medicine, and, when necessary, surgical or other consultation. The fellow should be able to explain the rationale as well as the risks and benefits for the treatment plan.
- Formulate and implement a management plan for patients with rheumatic emergencies (including organ or life-threatening conditions), with a need for emergent, urgent or changes in level or goals of care.
- Recognize disease-related exacerbations and formulate and implement a management plan
- Refer to or consult with other health care providers for the co-management of patients with rheumatic disease.
- Identify opportunities for referral to clinical registries and trials.

IV.B.1.b)(1)(c) Implementation of Treatment

IV.B.1.b)(1)(c)(i) Prescribing medications and rehabilitation: The fellows should be able to demonstrate a working knowledge of clinical pharmacology including the dosing, pharmacokinetics, metabolism, mechanisms of action, side effects, drug interactions, compliance issues, costs, and use in specific patient populations, such as chronic kidney disease and including fertile, lactating, and pregnant women and fertile men as well as across the age spectrum. ^(Core)

IV.B.1.b)(1)(c)(ii) Pain assessment and pain management: The fellow must be able to utilize: ^(Core)

- Methods of pain assessment including visual analog scale scores, pain questionnaires.
- Non-pharmacological modalities of pain management including exercise, cognitive behavioral therapy.
- Pharmacological therapy including:
 - Immunosuppressive and anti-inflammatory management of underlying rheumatic disorder.
 - Analgesic agents including acetaminophen, nonsteroidal anti-inflammatory agents and narcotic analgesics.
 - Anti-depressants.
- Means to identify physical impairment; relate the impairment to the observed functional deficits; prescribe appropriate rehabilitation (physical therapy, occupational therapy) to achieve goals to improve the defined impairment.

IV.B.1.b)(1)(c)(iii) Surgical management: The fellow must be able to: ^(Core)

- Distinguish indications for surgical and orthopedic consultation in acute and chronic rheumatic diseases.
- Perform peri-operative management of the surgical patient:
 - Peri-operative evaluation, appropriate referral, and medication adjustments.
 - Rehabilitation of the patient with rheumatic disease after a surgical or orthopedic procedure, as well as aspects of post-operative medical management pertaining to the rheumatologic condition.

IV.B.1.b)(1)(c)(iv) Non-pharmacologic management. The fellow must be able to:
(Core)

- Describe complementary and unconventional medical practices: diet, nutritional supplements, antimicrobials, acupuncture, topical therapeutic agents, homeopathic remedies, venoms, and others.
- Perform patient education and counseling

IV.B.1.b)(1)(c)(v) Preventive medicine and proactive care. The fellow must be able to:
(Core)

- Appropriately assess and manage of bone health in a patient starting or taking glucocorticoid therapy.
- Counsel for risk factor modification for patients at risk for fracture.
- Recognize the importance of lipid panel monitoring in patients with rheumatic disease.
- Appropriately implement prophylaxis against pneumocystis pneumonia.

- Counsel for tobacco cessation.
- Appropriately screen for risk for reactivation of infectious diseases (viral hepatitis, tuberculosis) in patients beginning disease modifying, small molecules or biologic therapy.
- Counsel for appropriate dental evaluation and management.
- Counsel for appropriate vaccination administration.

IV.B.1.b)(1)(d) Reassessment and Patient Follow up:
The fellow must be able to: ^(Core)

- Reassess the patient over time, including recognition of treatment related adverse events, and alter the treatment plan accordingly.
- Utilize the validated instruments in the assessment of pain, disease activity, function, and quality of life over time to monitor and adjust therapy.
- Address comorbid illness in patients with rheumatic diseases and incorporate these considerations into the care plan.
- Enumerate disease- and treatment-related complications that may lead to long term morbidity, considering implications of comorbid diseases and effects of aging.

IV.B.1.c) Medical Knowledge

Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social behavioral sciences, as well as the application of this knowledge to patient care. ^(Core)

IV.B.1.c)(1) Fellows must demonstrate knowledge of the scientific method of problem solving and evidence-based decision making. ^(Core)

IV.B.1.c)(2) Fellows must demonstrate knowledge of indications, contraindications, limitations, complications,

techniques, and interpretation of results of those diagnostic and therapeutic procedures integral to the discipline, including the appropriate indications for and use of screening tests/procedures. ^(Core)

IV.B.1.c)(2)(a) This must include knowledge of the indications for and interpretation of:

IV.B.1.c)(2)(a)(i) arthroscopy; ^(Core)

IV.B.1.c)(2)(a)(ii) biopsy specimens, including histochemistry and immunofluorescence of tissues relevant to the diagnosis of rheumatic diseases; ^(Core)

IV.B.1.c)(2)(a)(iii) bone densitometry; ^(Core)

IV.B.1.c)(2)(a)(iv) CT of lungs and paranasal sinuses for patients with suspected or confirmed rheumatic disorders; ^(Core)

IV.B.1.c)(2)(a)(v) electromyograms and nerve conduction studies for patients with suspected or confirmed rheumatic disorders; ^(Core)

IV.B.1.c)(2)(a)(vi) MRI of the central nervous system (brain and spinal cord) for patients with suspected or confirmed rheumatic disorders; ^(Core)

IV.B.1.c)(2)(a)(vii) plain radiography, arthrography, ultrasonography, radionuclide scans, CT, and MRI of joints, bones and periarticular structures; ^(Core)

IV.B.1.c)(2)(a)(viii) arteriograms (conventional and MRI/MRA) for patients with suspected or confirmed vasculitis; ^(Core)

IV.B.1.c)(2)(a)(ix) Schirmer's and rose Bengal tests; and, ^(Core)

IV.B.1.c)(2)(a)(x) parotid scans and salivary flow studies. ^(Core)

IV.B.1.c)(3) Fellows must demonstrate knowledge of:

IV.B.1.c)(3)(a) the anatomy and biology of musculoskeletal tissues; ^(Core)

IV.B.1.c)(3)(b) basic immunology including anatomy and cellular elements of the immune system, lymphocytes, antigen presenting cells, other immune cells, immune and inflammatory mechanisms (innate and adaptive mechanisms), initiation of an immune response, types of immune responses, and immunoregulation; ^(Core)

IV.B.1.c)(3)(c) genetic basis and cell biology and metabolism pertaining to rheumatic diseases; ^(Core)

IV.B.1.c)(3)(d) rheumatic diseases such as: ^(Core)

IV.B.1.c)(3)(d)(i) Disorders of connective tissue (SLE, APLA syndrome, Sjögren syndrome, mixed connective tissue disease, undifferentiated connective tissue disease, and overlap syndromes). ^(Core)

IV.B.1.c)(3)(d)(ii) Other fibrosing skin disorders (eosinophilic fasciitis, eosinophilia-myalgia syndrome, nephrogenic systemic fibrosis, scleromyxedema, scleredema of Buschke); ^(Core)

IV.B.1.c)(3)(d)(iii) Immune-mediated inflammatory myositis. ^(Core)

IV.B.1.c)(3)(d)(iv) Spondyloarthritis (axial and peripheral spondyloarthritis, psoriatic arthritis, reactive arthritis, arthritis associated with inflammatory bowel disease); ^(Core)

IV.B.1.c)(3)(d)(v) Arthritis associated with acne and other skin diseases like hidradenitis suppurativa, synovitis, acne, pustulosis, hyperostosis, and osteitis (SAPHO) syndrome; ^(Core)

IV.B.1.c)(3)(d)(vi) Systemic vasculitis: ^(Core)

- Large vessel: giant cell arteritis/polymyalgia rheumatica, Takayasu arteritis.

- Medium vessel: polyarteritis nodosa, Kawasaki disease.
- Small vessel: ANCA-associated vasculitis such as granulomatosis with polyangiitis (GPA, formerly Wegener granulomatosis), eosinophilic granulomatosis with polyangiitis (EGPA, formerly Churg-Strauss syndrome) and microscopic polyangiitis, anti-glomerular basement membrane disease, cryoglobulinemia, IgA vasculitis (formerly Henoch-Schönlein purpura).
- Other vasculitis syndromes: hypocomplementemic urticarial vasculitis, Behçet disease, Cogan syndrome, cutaneous leukocytoclastic angiitis, primary central nervous system vasculitis.
- Miscellaneous: isolated aortitis, vasculitis from systemic disorders, infections, drugs, malignancies.

IV.B.1.c)(3)(d)(vii) Crystalline arthropathies: monosodium urate monohydrate (gout), calcium pyrophosphate dihydrate deposition disease, basic calcium phosphate (hydroxyapatite), calcium oxalate; ^(Core)

IV.B.1.c)(3)(d)(viii) Other autoimmune disease: relapsing polychondritis, panniculitis (lobular or septal [erythema nodosum]), adult-onset Still's disease, IgG4-related disease, retroperitoneal fibrosis, primary Raynaud's disease, neuromyelitis optica, interstitial pneumonia with autoimmune features (IPAF), sarcoidosis, Susac syndrome, palindromic rheumatism, autoimmune disorders associated with checkpoint inhibitors, orbital inflammatory disease, remitting seronegative symmetrical synovitis with pitting edema (RS3PE); ^(Core)

IV.B.1.c)(3)(d)(ix) Autoinflammatory syndromes; ^(Core)

IV.B.1.c)(3)(d)(x) Monogenic autoinflammatory diseases: ^(Core)

- Inflammasomopathies: Familial Mediterranean Fever (FMF), hyperimmunoglobulinemia D syndrome (HIDS), tumor necrosis factor receptor-associated periodic syndromes (TRAPS), pyogenic sterile arthritis pyoderma gangrenosum and acne syndrome (PAPA), and cryopyrin associated periodic syndrome (CAPS) including Muckle-Wells syndrome, familial cold autoinflammatory syndrome, and neonatal-onset multisystemic inflammatory disease (NOMID).
- Interferonopathies: STING-associated vasculopathy with onset in infancy (SAVI), Aicardi-Goutieres Syndrome, chronic atypical neutrophilic dermatosis with lipodystrophy and elevated temperature (CANDLE) syndrome, and coatomer protein complex subunit alpha (COPA) syndrome.
- Others: deficiency of interleukin-1 receptor agonist (DIRA), deficiency of interleukin-36 receptor antagonist (DITRA), Majeed syndrome, Blau syndrome (NOD2/CARD15), A20 haploinsufficiency (HA20), deficiency of adenosine deaminase 2 (DADA2).
- Polygenic autoinflammatory diseases:
 - Periodic fever with aphthous stomatitis, pharyngitis, and adenitis (PFAPA), chronic recurrent multifocal osteomyelitis (CRMO), and Schnitzler syndrome.

IV.B.1.c(3)(d)(xi) Inherited muscle diseases such as metabolic myopathies (glycogen storage diseases, lipid metabolism disorders, mitochondrial myopathies), muscular dystrophies, and muscle channelopathies; (Core)

IV.B.1.c(3)(d)(xii) Infectious: (Core)

- Infectious arthritides: bacterial (non-gonococcal and gonococcal), mycobacterial, spirochetal (syphilis, Lyme), viral (HIV, hepatitis B, hepatitis C, parvovirus, chikungunya, dengue), fungal, parasitic, Whipple disease.
- Post-infectious: acute rheumatic fever, arthritis associated with subacute bacterial endocarditis, intestinal bypass arthritis, post-dysenteric arthritides, post-immunization arthritis, other colitis-associated arthropathies.

IV.B.1.c(3)(d)(xiii) Metabolic, endocrine, and hematologic disease associated rheumatic disorders: e.g. endocrine-associated diseases and hematologic-associated diseases; (Core)

IV.B.1.c(3)(d)(xiv) Bone and cartilage disorders: e.g. osteoarthritis, Paget disease of bone, avascular necrosis of bone and others (transient osteoporosis, hypertrophic osteoarthropathy, diffuse idiopathic skeletal hyperostosis); (Core)

IV.B.1.c(3)(d)(xv) Hereditary, congenital, and inborn errors of metabolism associated with rheumatic syndromes: (Core)

- Disorders of connective tissue: Marfan syndrome, osteogenesis imperfecta, Ehlers-Danlos syndrome, pseudoxanthoma elasticum, hypermobility syndrome.
- Mucopolysaccharidoses.

- Osteochondrodysplasias: multiple epiphyseal dysplasia, spondyloepiphyseal dysplasia.
- Inborn errors of metabolism affecting connective tissue: homocystinuria, ochronosis.
- Storage disorders: Gaucher disease, Fabry disease.
- Immunodeficiency: IgA deficiency, complement component deficiency, SCID and ADA deficiency, PNP deficiency, others.
- Others: hemochromatosis, hyperlipidemic arthropathy, myositis ossificans progressiva, Wilson disease, others.

IV.B.1.c)(3)(d)(xvi) Non-articular and regional musculoskeletal disorders; ^(Core)

- Fibromyalgia.
- Myofascial pain syndromes.
- Axial syndromes: low back pain, spinal stenosis, intervertebral disc disease and radiculopathies, cervical pain syndromes, coccydynia, osteitis condensans ilii, osteitis pubis, spondylolisthesis/spondylolysis, discitis.
- Regional musculoskeletal disorders: in addition to bursitis, tendinitis, or enthesitis occurring around each joint, other characteristic disorders occurring at each specific joint site (e.g., shoulder: rotator cuff tear, subacromial bursitis, adhesive capsulitis, impingement syndrome; wrist: ganglion cysts, De Quervain tenosynovitis; trigger fingers/stenosing tenosynovitis, Dupuytren contractures; knee-synovial plica syndrome, internal derangements,

popliteal cyst; foot/ankle: plantar fasciitis, Achilles tendinitis, Morton neuroma; other: temporomandibular joint syndromes, femoral acetabular impingement, costochondritis).

- Biomechanical/anatomic abnormalities associated with regional pain syndromes: scoliosis and kyphosis, genu valgum, genu varum, leg length discrepancy, foot deformities.
- Overuse rheumatic syndromes: occupational, sports, recreational, performing artists.
- Sports medicine: injuries, strains, sprains, nutrition, medication issues.
- Entrapment neuropathies: thoracic outlet syndrome, upper extremity entrapments, lower extremity entrapments.
- Other: peripheral neuropathies (polyneuropathy, small fiber neuropathy), mononeuritis multiplex, complex regional pain syndrome (formerly reflex sympathetic dystrophy), erythromelalgia.

IV.B.1.c)(3)(d)(xvii) Neoplasms and tumor-like lesions; ^(Core)

- Benign:
 - Joints: loose bodies, fatty and vascular lesions, synovial osteochondromatosis, pigmented villonodular synovitis, ganglions.
 - Tendon sheaths: fibroma, giant cell tumor, nodular tenosynovitis.
 - Bone: osteoid osteoma.
- Malignant:
 - Primary: synovial sarcoma, osteosarcoma, chondrosarcoma.

- Secondary: leukemia, myeloma, metastatic malignant tumors.
- Malignancy-associated rheumatic syndromes: carcinomatous polyarthritis, palmoplantar fasciitis, Sweet syndrome, paraneoplastic presentations of rheumatic diseases.

IV.B.1.c(3)(d)(xviii) Rheumatic diseases in special populations: geriatric population, Pregnant women, dialysis patients, and transplant patients; ^(Core)

IV.B.1.c(3)(d)(xix) musculoskeletal pain syndromes; ^(Core)

IV.B.1.c(3)(d)(xx) Pathogenesis, epidemiology, clinical features and management of pediatric rheumatic diseases: Juvenile idiopathic arthritis (JIA), Juvenile dermatomyositis, Kawasaki Disease, IgA Vasculitis (formerly known as Henoch-Schönlein Purpura), acute rheumatic fever and post-streptococcal reactive arthritis, neonatal lupus syndrome, monogenic and polygenic autoinflammatory diseases; ^(Core)

IV.B.1.c(3)(d)(xxi) Non-rheumatic disorders in children that can mimic rheumatic diseases, non-articular and regional musculoskeletal disorders; ^(Core)

IV.B.1.c(3)(e) the pathogenesis, epidemiology, clinical expression, treatments, and prognosis of the full range of rheumatic and musculoskeletal diseases; ^(Core)

IV.B.1.c(3)(f) the physical and biologic basis of the range of diagnostic testing in rheumatology, and the clinical test characteristics of these procedures; ^(Core)

IV.B.1.c(3)(f)(i) Laboratory tests: rationale, methods for performing, and

utility/limitations of specific laboratory tests including but limited to: ^(Core)

- Erythrocyte sedimentation rate, C-reactive protein, and other acute phase reactants (ferritin, haptoglobin, ceruloplasmin, complement).
- Rheumatoid factors, cryoglobulins, and circulating immune complexes (C1q).
- Anti-cyclic citrullinated peptide antibodies.
- Antibodies against nuclear antigens: ANA, anti-dsDNA, anti-Smith, anti-SSA, anti-SSB, anti-U1 RNP, anti-centromere, anti-histone, anti-ribosomal P, anti-topoisomerase 1, anti-U3 RNP, anti-RNA Polymerase III.
- Lupus Erythematosus (LE) cell preparation.
- Myositis-specific autoantibodies (anti-Jo-1 and other anti-synthetases, anti-Mi-2, anti-SRP, anti-HMG CoA reductase [200/100], anti-TIF1-gamma [p155/140], anti-MJ [NXP-2], anti-CADM-140 [MDA-5], anti-SAE) and myositis-associated (anti-Ro, anti-U1RNP, anti-Ku, anti-PM-Scl) antibodies.
- Other disease-associated autoantibodies: anti-mitochondrial, anti-smooth muscle, anti-neuronal.
- Anti-neutrophil cytoplasmic antibodies (anti-proteinase 3, anti-myeloperoxidase)
- Anti-phospholipid antibodies including RPR, lupus anticoagulant, anti-cardiolipin, anti-beta-2-glycoprotein I and antiphosphatidylserine.
- Antibodies to formed blood elements including direct and indirect Coombs

testing, anti-platelet antibodies, anti-granulocyte antibodies.

- Assays for complement activity (CH50) and components of the complement cascade.
- Serum immunoglobulin levels, serum protein electrophoresis and immunofixation electrophoresis.
- HLA typing (B27, B51, B5801).
- ASO and other streptococcal antibody tests.
- Appropriate testing for Lyme disease, HIV, Hepatitis B, Hepatitis C, parvovirus, N. gonorrhoea, chikungunya and other infectious agents.
- Appropriate screening for hepatitis B, hepatitis C, tuberculosis.
- Serum and urine measurements for uric acid.
- Iron studies including total iron binding capacity, ferritin.
- Flow cytometry studies for analysis of lymphocyte subsets and function.
- Specific genetic testing.
- Diagnostic imaging techniques: basic underlying principles and technical considerations in the use of plain radiographs, computed tomography, magnetic resonance imaging, ultrasonography and radionuclide scanning of bones, joints, periarticular and vascular structures.
- Synovial fluid analysis: cell count and differential, Gram stain and bacterial culture, crystal identification, viscosity,

and other special stains/analyses (AFB, fungal culture).

IV.B.1.c)(3)(f)(ii) Laboratory test-performance characteristics: principles of sensitivity, specificity, predictive value, and likelihood ratios.

IV.B.1.c)(3)(g) the pharmacokinetics, metabolism, adverse events, interactions, and relative costs of drug therapies used in the management of rheumatic disorders; ^(Core)

- Nonsteroidal anti-inflammatory drugs
- Glucocorticoids
- Systemic anti-rheumatic drugs:
- DMARDs (anti-malarials, anti-inflammatory, anti-metabolites, alkylating agent)
- Calcineurin inhibitors
- Biologic agents and biosimilar agents: Interleukin inhibitors (1, 5, 6, 12, 17, 23), tumor necrosis factor inhibitors (soluble or monoclonal), T cell co-stimulatory inhibitors, B cell depletion therapy, and inhibitor of B-lymphocyte stimulator.
- Small molecule inhibitors of Janus kinase (JAK) enzymes
- Phosphodiesterase 4 inhibitors
- Inhibitors of complement components
- Historical agents such as gold compounds, penicillamine, and minocycline
- Urate lowering therapy: Xanthine oxidase inhibitors, Uricosuric, Uricase agents
- Bone disorder medications: Bisphosphonates, anabolic agents, RANKL inhibition, sclerostin monoclonal antibody, hormonal therapy, calcium and Vitamin D

- Vasodilators: Calcium channel blockers, topical nitrates, prostacyclin analogs, endothelin receptor antagonists, phosphodiesterase 5 inhibitors, guanylate cyclase agonist
- Antibiotic therapy for septic joints
- Opioid and non-opioid analgesics
- Colchicine
- Agents used for pain modulation: anti-depressants, anti-convulsants, gabapentinoids, muscle relaxants
- Cholinergics and non-pharmacologic agents used for the treatment of sicca symptoms
- Intravenous immunoglobulin (IVIg)
- Plasma exchange

IV.B.1.c)(3)(h) the aging influences on musculoskeletal function and responses to prescribed therapies for rheumatic diseases; ^(Core)

IV.B.1.c)(3)(i) the essential components of quality experimental design, clinical trial design, data analysis, and interpretation of results, and the importance of adherence to ethical standards of experimentation. ^(Core)

IV.B.1.c)(4) Fellows must demonstrate knowledge of the appropriate employment of principles of physical medicine and rehabilitation in the care of patients with rheumatic disorders. ^(Core)

- Rehabilitation and disability multidisciplinary approaches to rehabilitation and pain control: appropriate use of and referral/prescription to rehabilitation specialists and pain clinics.
- Methods of rehabilitation: for each method, principles, mechanism of action, indications, precautions and contraindications, potential side effects, and costs.
- Exercise.

- Rest and splinting.
- Thermal Modalities: Ultrasound, phonophoresis, Spa therapy, icing.
- Adaptive equipment and assistive devices.
- Footwear and orthotics.

IV.B.1.c)(5) Fellows must demonstrate a knowledge of surgical and perioperative management. For each procedure, the fellow should demonstrate a working knowledge of indications, pre-operative evaluation and medication adjustments, contraindications, complications, postoperative management, and expected outcome. ^(Core)

- Bone biopsy
- Arthroscopy
- Synovectomy of tendons and joints
- Entrapment neuropathy release
- Osteotomies: hip, knee
- Arthrodesis
- Spine surgery: radiculopathy, stenosis, and instability
- Reconstructive surgery of hand and foot
- Total joint replacement
- Specific surgical management problems:
- Patient with rheumatoid arthritis
- Infected joint: arthroscopy vs. arthrotomy
- Infected prosthetic joint
- Patient with ankylosing spondylitis
- Pediatric patient with rheumatic disease
- Prevention and treatment of deep venous thrombosis
- Peri-operative anti-rheumatic medication management

IV.B.1.c)(6) Complementary and alternative medical practices, including but not limited to: diet, nutritional supplements, acupuncture, chiropractic. ^(Core)

IV.B.1.c)(7) Fellows should demonstrate a basic knowledge of the principles of telehealth including: ^(Core)

- Types of Telehealth Encounters, as categorized by:
 - Timing: synchronous, asynchronous
 - Personnel Involved
- eConsult
- Direct patient-to-provider virtual visits
- If available, patient to provider via mediator where the patient is onsite with an axillary provider who may perform physical exam maneuvers and/or assist the patient with working telemedicine equipment.
- Method: Telephone visit, video visit, medical record review
- Equipment used in virtual medicine: Video-conferencing equipment (i.e. telephone, camera, etc.)
- Legal Regulations:
 - Local regulator, licensure laws for telehealth
- Components of patients' informed consent for virtual encounters
- Risks including breach of patient privacy, potential shortcomings of virtual encounters, etc.
- Benefits including improved access to care, convenience, etc.

IV.B.1.d) Practice-based Learning and Improvement

Fellows must demonstrate the ability to investigate and evaluate their care of patients, applying scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning. ^(Core)

IV.B.1.d)(1) In addition to structured learning of the basic

components of medical knowledge and patient care, the fellow must evaluate his/her knowledge base and care delivery on an ongoing basis with the goal of continually improving that care. This process includes the following components: ^(Core)

IV.B.1.d)(1)(a) Independent Learning - The fellow must be able to: ^(Core)

- Learn and improve at the point of care to enhance future clinical interactions
- Seek resources to enhance future clinical interactions.
- Recognize, and implement ways to improve his/her role in the effective management of a practice.
- Incorporate technology to manage information, support patient care decisions using evidence-based medicine and enhance both patient and physician education

IV.B.1.d)(1)(b) Self-evaluation of performance - The fellow must be able to: ^(Core)

- Monitor practice with goal for improvement
- Honestly reflect on knowledge, skills or attitude gaps to guide ongoing learning, using internal and external sources
- Actively seek, reflect on, and develop plans for practice improvement based on feedback from all members of the health care team including faculty, peers, students, health professionals, patients and patient advocates.

IV.B.1.d)(1)(c) incorporation of feedback into improvement of clinical activity - The fellow must be able to: ^(Core)

- Demonstrate that s/he learns from errors through actions taken to improve the system or processes of care.

- Display the ability to change practice based on an audit of a panel of patients using standardized, disease specific, and evidence-based criteria.
- Independently construct and pursue answers to clinical questions and perform self-reflection to incorporate learning for future clinical encounters.
- Demonstrate the ability to respond to meet situational needs, and customize management based on clinical evidence for individualized patient care.

IV.B.1.d)(1)(d) Incorporation of feedback into improvement of clinical activity - The fellow must be able to: ^(Core)

- Demonstrate that s/he learns from errors through actions taken to improve the system or processes of care.
- Display the ability to change practice based on an audit of a panel of patients using standardized, disease specific, and evidence-based criteria.
- Independently construct and pursue answers to clinical questions and perform self-reflection to incorporate learning for future clinical encounters.
- Demonstrate the ability to respond to meet situational needs, and customize management based on clinical evidence for individualized patient care.

IV.B.1.e) Interpersonal and Communication Skills

Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. This includes: ^(Core)

- Gathering information.
- Recognizing and incorporating the patient's perspective.

- Providing information.
- Trust.

IV.B.1.f) Systems-based Practice

Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. ^(Core)

IV.B.1.f)(1) Partners in health care delivery: the various providers and resources available to deliver optimal care. ^(Detail)

IV.B.1.f)(2) Systems thinking: a concept of “systems thinking” in health care delivery. ^(Detail)

IV.B.1.f)(3) Advocacy for the patient: the importance, opportunities and limits of patient advocacy. ^(Detail)

IV.B.1.f)(4) Cost-effective health care: the principles of cost allocation and resource management within the external (state, national) and local systems. ^(Detail)

IV.C. Curriculum Organization and Fellow Experiences

IV.C.1. The curriculum must be structured to optimize fellow educational experiences, the length of these experiences, and supervisory continuity. ^(Core)

IV.C.1.a) Assignment of rotations must be structured to minimize the frequency of rotational transitions, and rotations must be of sufficient length to provide a quality educational experience, defined by continuity of patient care, ongoing supervision, longitudinal relationships with faculty members, and meaningful assessment and feedback. ^(Core)

IV.C.1.b) Clinical experiences should be structured to facilitate learning in a manner that allows fellows to function as part of an effective interprofessional team that works together towards the shared goals of patient safety and quality improvement. ^(Core)

IV.C.2. The program must provide instruction and experience in pain management if applicable in Rheumatology, including recognition of the signs of addiction. ^(Core)

IV.C.3. A minimum of 30 months must be devoted to clinical experience. Fellows should attend specialized clinics in the sponsoring or other sites.

Training period must include at least 1-month pediatric rheumatology rotation, at least 1-month clinical research and at least 1-month elective. Elective rotations should be related to rheumatic diseases. Electives rotation is designed to help fulfill any objectives or rotations that are not found in the mandatory rotations. Examples of elective rotations include but not limited to Dermatology, Orthopedics, Sports Medicine, Physical Medicine and Rehabilitation, Neuromuscular Clinic, Pathology, Immunology, and Musculoskeletal Radiology.

If an elective rotation is planned to cover a disease-specific clinic (e.g., spondylitis, scleroderma, lupus), this clinic is rarely scheduled daily. In this case, more than one disease-specific clinic or general rheumatology clinic should be chosen if available and the schedule should fulfil the five sessions (a clinic session is 4 hours) of ambulatory care per week. ^(Core)

IV.C.4. Fellows must participate in training using simulation. ^(Detail)

IV.C.5. The program must include a minimum of five sessions (a clinic session is 4 hours) of ambulatory care per week, averaged over the three years of education, which includes the continuity ambulatory experience. ^(Detail)

IV.C.6. Experience with Continuity Ambulatory Patients

IV.C.5.a) Fellows must have Continuity Ambulatory Clinic experience that exposes them to the breadth and depth of the subspecialty. ^(Core)

IV.C.5.b) This experience should at least one clinic session (a clinic session is 4 hours) each week. ^(Detail)

IV.C.5.c) This experience must include an appropriate distribution of patients of each gender and a diversity of ages, ^(Core)

This should be accomplished through either:

IV.C.5.e)(1) a Continuity Clinic which provides fellows the opportunity to learn the course of disease; or, ^(Detail)

IV.C.5.e)(2) selected blocks of at least six months which address specific areas of rheumatologic diseases. For example, a fellow may train for 6 months in a weekly Spondylitis Clinic, and at the same time he/she may train in other weekly specialized clinics. ^(Detail)

IV.C.5.d) Each fellow should, on average, be responsible for four to eight patients during each session (a clinic session is 4 hours). ^(Detail)

IV.C.5.e) The continuity patient care experience should not be interrupted by more than one month, excluding a fellow's vacation. ^(Detail)

IV.C.5.f) Fellows should be informed of the status of their continuity patients when such patients are hospitalized, as clinically appropriate. ^(Detail)

IV.C.6. Procedures and Technical Skills

IV.C.6.a) Direct supervision of procedures performed by each fellow must occur until proficiency has been acquired and documented by the program director. ^(Core)

IV.C.6.b) Faculty members must teach and supervise the fellows in the performance and interpretation of procedures, which must be documented in each fellow's record, including indications, outcomes, diagnoses, and supervisor(s). ^(Core)

IV.C.7. Fellows must have experience in the role of a rheumatology consultant in both the inpatient and outpatient settings. ^(Core)

IV.C.8. The core curriculum must include a didactic program based upon the core knowledge content in the subspecialty area. ^(Core)

IV.C.8.a) The program must afford each fellow an opportunity to review topics covered in conferences that he or she was unable to attend. ^(Detail)

IV.C.8.b) Fellows must participate in clinical case conferences, journal clubs, research conference, and morbidity and mortality or quality improvement conferences. ^(Detail)

IV.C.8.c) All core conferences must have at least one faculty member present and must be scheduled as to ensure peer-peer and peer-faculty interaction. ^(Detail)

IV.C.9. Patient-based teaching must include direct interaction between fellows and faculty members, bedside teaching, discussion of pathophysiology, and the use of current evidence in diagnostic and therapeutic decisions. ^(Core)

The teaching must be:

IV.C.9.a) formally conducted on all inpatient, outpatient, and consultative services; ^(Detail)

IV.C.9.b) conducted with a frequency and duration that ensures a meaningful and continuous teaching relationship between the assigned supervising faculty member(s) and fellows. ^(Detail)

IV.C.10. Fellows must receive instruction in practice management relevant to rheumatology. ^(Detail)

IV.D. Scholarship

Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through fellow participation in scholarly activities. Scholarly activities must include discovery, integration, application, and teaching.

IV.D.1. Program Responsibilities

IV.D.1.a) The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. ^(Core)

IV.D.1.b) The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate fellow and faculty involvement in scholarly activities. ^(Core)

IV.D.2. Faculty Scholarly Activity

IV.D.2.a) Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: ^(Core)

- Research in basic science, education, translational science, patient care, or population health
- Peer-reviewed journal publications, case-presentation publications
- Quality improvement and/or patient safety initiatives
- Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports
- Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials
- Contribution to professional committees, educational organizations, or editorial boards
- Innovations in education

IV.D.2.b) The program must demonstrate scholarly activity by the following methods: ^(Core)

IV.D.2.b)(1) faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; ^(Core)

IV.D.2.b)(1)(a) At least 50% of the core faculty members who are certified in rheumatology must annually engage in a variety of scholarly activities, as listed in Program Requirement IV.D.2.b)(1). ^(Core)

IV.D.2.b)(2) peer-reviewed publication including case-discussion and letters to the editor. ^(Core)

IV.D.3. Fellow Scholarly Activity

IV.D.3.a) While in the program, fellows must engage in at least one of the following scholarly activities: participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor. ^(Core)

IV.D.3.b) Fellows must participate in scholarly project. ^(Core)

IV.D.3.b)(1) Fellows must complete a scholarly project relevant to the specialty which was conducted under direct supervision of a faculty member. ^(Core)

IV.D.3.b)(2) The project, shall be prepared in a form which can be used for publication or presentation and submitted for publication in a specialty specific journal or presented in a national or international specialty conference. ^(Core)

IV.D.3.b)(3) The proof of project submission for publication, or presentation in a medical conference, will be part of the fellow's portfolio and will be documented in the final summative evaluation prior to Board Certification, in accordance with NIHS guidelines. ^(Core)

V. Evaluation

V.A. Fellow Evaluation

V.A.1. Feedback and Evaluation

Formative and summative evaluation have distinct definitions.

Formative evaluation is monitoring fellow learning and providing ongoing feedback that can be used by fellows to improve their learning.

More specifically, formative evaluations help:

- fellows identify their strengths and weaknesses and target areas that need work
- program directors and faculty members recognize where fellows are struggling and address problems immediately.

Summative evaluation is evaluating a fellow's learning by comparing the fellows against the goals and objectives of the rotation and program, respectively and is utilized to make decisions about promotion to the next level of training, or program completion.

End-of-rotation and end-of-year evaluations have both summative and formative components. Information from a summative evaluation can be used formatively when fellows or faculty members use it to guide their efforts and activities in subsequent rotations and to successfully complete the fellowship program.

V.A.1.a) Faculty members must directly observe, evaluate, and frequently provide feedback on fellow performance during each rotation or similar educational assignment. ^(Core)

This feedback will allow for the development of the learner as they strive to achieve the Milestones. More frequent feedback is strongly encouraged for fellows who have deficiencies that may result in a poor final rotation evaluation.

V.A.1.a)(1) The faculty must discuss this evaluation with each fellow at the completion of each assignment. ^(Core)

V.A.1.a)(2) Assessment of procedural competence should include a formal evaluation process and not be based solely on a minimum number of procedures performed. ^(Detail)

V.A.1.b) Evaluation must be documented at the completion of the assignment. ^(Core)

V.A.1.b)(1) For block rotations of greater than three months in duration, evaluation must be documented at least every three months. ^(Core)

V.A.1.b)(2) For block rotations of any duration, a written evaluation must be provided at the end of the rotation. ^(Core)

V.A.1.b)(3) Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every six months and at completion. ^(Core)

V.A.1.c) The program must provide an objective performance evaluation based on the Competencies and the Rheumatology-specific Milestones, and must: ^(Core)

V.A.1.c)(1) use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members) ^(Core)

V.A.1.c)(2) provide that information to the Clinical Competency Committee (CCC) for its synthesis of progressive fellow performance and improvement toward unsupervised practice. ^(Core)

V.A.1.d) The program director or their designee, with input from the CCC, must:

V.A.1.d)(1) Meet with and review with each fellow their documented semi-annual evaluation of performance, including progress and the specialty-specific Milestones ^(Core)

V.A.1.d)(1)(a) Review of fellow Case-Logs must be a part of the semi-annual review. ^(Detail)

V.A.1.d)(2) assist fellow in developing individualized learning plans to capitalize on their strengths and identify areas for growth; ^(Core)

V.A.1.d)(3) develop plans for fellows failing to progress, following both the NIHS Emirati Board and institutional policies and procedures. ^(Core)

V.A.1.e) At least annually, there must be a summative evaluation of each fellow that includes their readiness to progress to the next year of the program. ^(Core)

V.A.1.f) The evaluations of a fellow's performance must be accessible for review by the fellow. ^(Core)

V.A.2. Final Evaluation

V.A.2.a) The program director must provide a final evaluation for each fellow upon completion of the program. ^(Core)

V.A.2.a)(1) The rheumatology-specific Milestones, and when applicable the specialty-specific Case Logs, must be used as tools to document performance and verify that the fellow has demonstrated sufficient competence to be able to engage in autonomous practice upon completion of the program, and once he/she obtain the license to practice in his/her subspecialty. ^(Core)

V.A.2.a)(2) The final evaluation must:

V.A.2.a)(2)(a) become part of the fellow's permanent record maintained by the institution, and must be accessible for review by the fellow in accordance with institutional policy; ^(Core)

V.A.2.a)(2)(b) verify that the fellow has demonstrated the knowledge, skills, and behaviours necessary to enter autonomous practice; ^(Core)

V.A.2.a)(2)(c) consider recommendations from the CCC. ^(Core)

V.A.2.a)(2)(d) be shared with the fellow upon completion of the program. ^(Core)

V.A.3. The CCC must be appointed by the program director. ^(Core)

V.A.3.a) The CCC must include at least three members of the program faculty, at least one of whom is a core faculty member. ^(Core)

V.A.3.a)(1) Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's fellows. ^(Core)

V.A.3.a)(2) The Program Director has final responsibility for fellow evaluation and promotion decisions. ^(Core)

V.A.3.b) The CCC must:

V.A.3.b)(1) Review all fellows evaluation at least semi-annually; ^(Core)

V.A.3.b)(2) determine each fellow's progress on achievement of the Rheumatology-specific Milestones; ^(Core)

V.A.3.b)(3) meet prior to the fellows' semi-annual evaluations and advise the program director regarding each fellow's progress. ^(Core)

V.B. Faculty Evaluation

V.B.1. The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. ^(Core)

V.B.1.a) This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, review of patient outcomes, professionalism, research, and scholarly activities. ^(Core)

V.B.1.b) This evaluation must include written, anonymous, and confidential evaluations by the fellows. ^(Core)

V.B.2. Faculty members must receive feedback on their evaluations at least annually. ^(Core)

V.B.3. Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. ^(Core)

V.C. Program Evaluation and Improvement

V.C.1. The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. ^(Core)

The performance of fellows and faculty members reflects program quality and will use metrics to reflect the program's goals. ^(Core)

The Program Evaluation Committee must present the Annual Program Evaluation Report in a written form to be discussed with all program faculty and fellows as a part of continuous improvement plans. ^(Core)

V.C.1.a) The PEC must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one fellow. ^(Core)

V.C.1.b) PEC responsibilities must include:

V.C.1.b)(1) acting as an advisor to the program director, through program oversight; ^(Core)

V.C.1.b)(2) review of the program's requirements, both NIHS Emirati Board required and program self-determined goals, and the progress toward meeting them; ^(Core)

V.C.1.b)(3) guiding ongoing program improvement, including developing new goals based upon outcomes. ^(Core)

V.C.1.b)(4) review of the current operating environment to identify strengths, challenges, opportunities, and threats related to the program's mission and aims. ^(Core)

V.C.1.c) The PEC should consider the following elements in its assessment of the program:

V.C.1.c)(1) program curriculum; ^(Core)

V.C.1.c)(2) outcomes from prior Annual Program Evaluation(s); ^(Core)

V.C.1.c)(3) NIHS letters of notification including citations, areas for improvement, and comments; ^(Core)

V.C.1.c)(4) the quality and safety of patient care; ^(Core)

V.C.1.c)(5) Aggregate fellows and the faculty:

V.C.1.c)(5)(a) well-being; ^(Core)

V.C.1.c)(5)(b) fellows and faculty recruitment and retention following institutional policies; ^(Core)

V.C.1.c)(5)(c) workforce diversity following institutional policies; ^(Core)

V.C.1.c)(5)(d) engagement in quality improvement and patient safety; ^(Core)

V.C.1.c)(5)(e) scholarly activity; ^(Core)

V.C.1.c)(5)(f) Fellows and Faculty Surveys; ^(Core)

V.C.1.c)(5)(g) written evaluations of the program (see above). ^(Core)

V.C.1.c)(6) Aggregate fellow:

V.C.1.c)(6)(a) achievement of the Milestones; ^(Core)

V.C.1.c)(6)(b) in-training examination results ; ^(Core)

V.C.1.c)(6)(c) board pass and certification rates ^(Core)

V.C.1.c)(6)(d) graduates' performance. ^(Core)

V.C.1.c)(7) Aggregate faculty:

V.C.1.c)(7)(a) faculty evaluation; ^(Core)

V.C.1.c)(7)(b) professional development. ^(Core)

V.C.1.d) The PEC must evaluate the program's mission and aims, strengths, areas for improvement, and threats. ^(Core)

V.C.1.e) The Annual Program Evaluation review, including the action plan, must:

V.C.1.e)(1) be distributed to and discussed with the members of the teaching faculty and the fellows ^(Core)

V.C.1.e)(2) be submitted to the DIO. ^(Core)

V.C.2. The program will be accredited and reaccredited by the NIHS in accordance with NIHS Accreditation Bylaws. ^(Core)

V.C.2.a) The program must complete a Self-Study before its reaccreditation Site Visit. ^(Core)

V.C.2.b) The Self-Study is an objective, comprehensive evaluation of the residency program with the aim to improve it. ^(Core)

V.C.3. The goal of NIHS-accredited education is to train physicians who seek and achieve a board certification. One measure of the effectiveness of the educational program is the ultimate pass rate. ^(Core)

V.C.3.a) Under the guidance of the Program Director all eligible program graduates should take the certifying examination conducted by the NIHS Emirati Board to obtain the Board Certification. ^(Core)

V.C.4. During the program, the fellows are strongly encouraged to sit for an organized Annual In-Training Examination. ^(Core)

VI. The Learning and Working Environment

Fellowship education must occur in the context of a learning and working environment that emphasizes the following principles:

- Excellence in the safety and quality of care rendered to patients by fellows today
- Excellence in the safety and quality of care rendered to patients by today's fellows in their future practice
- Excellence in professionalism through faculty modeling of:
 - the effacement of self-interest in a humanistic environment that supports the professional development of physicians
 - the joy of curiosity, problem-solving, intellectual rigor, and discovery
- Commitment to the well-being of the fellows, faculty members, and all members of the health care team

VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability

VI.A.1. Patient Safety and Quality Improvement

All physicians share responsibility for promoting patient safety and enhancing quality of patient care. Program must prepare fellows to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by fellows who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.

Fellows must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating fellows will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

It is necessary for fellows and faculty members to consistently work in a well-coordinated manner with other health care professionals to achieve organizational patient safety goals.

VI.A.1.a) Patient Safety

VI.A.1.a)(1) Culture of Safety

A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to

assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.

VI.A.1.a)(1)(a) The program, its faculty and fellows must actively participate in patient safety systems and contribute to a culture of safety. ^(Core)

VI.A.1.a)(1)(b) The program must have a structure that promotes safe, inter-professional, team-based care. ^(Core)

VI.A.1.a)(2) Education on Patient Safety

Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques. ^(Core)

Background and Intent: *Optimal patient safety occurs in the setting of a coordinated inter-professional learning and working environment.*

VI.A.1.a)(3) Patient Safety Events

Reporting, investigation, and follow-up of adverse events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.

VI.A.1.a)(3)(a) Fellows, faculty members, and other clinical staff members must:

- know their responsibilities in reporting patient safety events at the clinical site; ^(Core)
- know how to report patient safety events, including near misses, at the clinical site; ^(Core)
- be provided with summary information of their institution's patient safety reports. ^(Core)

VI.A.1.a)(3)(b) Fellows must participate as team members in real and/or simulated inter-professional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. ^(Core)

VI.A.1.a)(4) Fellow Education and Experience in Disclosure of Adverse Events

Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for fellows to develop and apply.

VI.A.1.a)(4)(a) All fellows must receive training in how to disclose adverse events to patients and families. ^(Core)

VI.A.1.a)(4)(b) Fellows should have the opportunity to participate in the disclosure of patient safety events, real or simulated. ^(Detail)

VI.A.1.b) Quality Improvement

VI.A.1.b)(1) Education in Quality Improvement

A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary for health care professionals to achieve quality improvement goals.

Fellows must receive training and experience in quality improvement processes, including an understanding of health care disparities. ^(Core)

VI.A.1.b)(2) Quality Metrics

Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.

Fellows and faculty members must receive data on quality metrics and benchmarks related to their patient populations. ^(Core)

VI.A.1.b)(3) Engagement in Quality Improvement Activities

Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.

Fellows must have the opportunity to participate in inter-professional quality improvement activities. ^(Core)

VI.A.2. Supervision and Accountability

VI.A.2.a) Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.

Supervision in the setting of fellowship medical education provides safe and effective care to patients; ensures each fellow's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

VI.A.2.a)(1) Each patient must have an identifiable and appropriately-credentialed and privileged attending physician who is responsible and accountable for the patient's care. ^(Core)

VI.A.2.a)(1)(a) This information must be available to fellows, faculty members, other members of the health care team, and patients. ^(Core)

VI.A.2.a)(1)(b) Fellows and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. ^(Core)

VI.A.2.b) Supervision may be exercised through a variety of methods. For some aspects of patient care, the supervising physician may be a more advanced fellow. Other portions of care provided by the fellow can be adequately supervised by the appropriate availability of the supervising faculty member, or senior fellow physician, either on site or by means of telecommunication technology. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of fellow-delivered care with feedback.

VI.A.2.b)(1) The program must demonstrate that the appropriate level of supervision in place for all fellows is based on each fellow's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. ^(Core)

VI.A.2.b)(2) The program must define when physical presence of a supervising physician is required. ^(Core)

VI.A.2.c) Levels of Supervision

To promote appropriate fellow supervision while providing for graded authority and responsibility, the program must use the following classification of supervision: ^(Core)

VI.A.2.c)(1) Direct Supervision: the supervising physician is physically present with the fellow during the key portions of the patient interaction. ^(Core)

VI.A.2.c)(2) Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the fellow for guidance and is available to provide appropriate direct supervision. ^(Core)

VI.A.2.c)(3) Oversight: the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. ^(Core)

VI.A.2.d) The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members. ^(Core)

VI.A.2.d)(1) The program director must evaluate each fellow' abilities based on specific criteria, guided by the Milestones. ^(Core)

VI.A.2.d)(2) Faculty members functioning as supervising physicians must delegate portions of care to fellows based on the needs of the patient and the skills of each fellow. ^(Core)

VI.A.2.d)(3) Fellows should serve in a supervisory role to junior fellows and residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. ^(Detail)

VI.A.2.e) Programs must set guidelines for circumstances and events in which fellows must communicate with the supervising faculty member(s). ^(Core)

VI.A.2.e)(1) Each fellow must know the limits of their scope of authority, and the circumstances under which the fellow is permitted to act with conditional independence. ^(Outcome)

VI.A.2.f) Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each fellow and to delegate to the fellow the appropriate level of patient care authority and responsibility. ^(Core)

VI.B. Professionalism

VI.B.1. Programs, in partnership with their Sponsoring Institutions, must educate fellows and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients. ^(Core)

VI.B.2. The learning objectives of the program must:

VI.B.2.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; ^(Core)

VI.B.2.b) be accomplished without excessive reliance on fellows to fulfill non-physician obligations; ^(Core)

VI.B.2.c) ensure manageable patient care responsibilities. ^(Core)

VI.B.3. The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. ^(Core)

VI.B.4. Fellows and faculty members must demonstrate an understanding of their personal role in the:

VI.B.4.a) provision of patient- and family-centered care; ^(Outcome)

VI.B.4.b) safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events; ^(Outcome)

Background and Intent: *This requirement emphasizes that responsibility for reporting unsafe conditions and adverse events is shared by all members of the team and is not solely the responsibility of the fellow.*

VI.B.4.c) assurance of their fitness for work, including: ^(Outcome)

VI.B.4.c)(1) management of their time before, during, and after clinical assignments; ^(Outcome)

VI.B.4.c)(2) recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team. ^(Outcome)

VI.B.4.d) commitment to lifelong learning; ^(Outcome)

VI.B.4.e) monitoring of their patient care performance improvement indicators; ^(Outcome)

VI.B.4.f) accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data. ^(Outcome)

VI.B.5. All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider. ^(Outcome)

VI.B.6. Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of fellows, faculty, and staff. ^(Core)

VI.B.7. Programs, in partnership with their Sponsoring Institutions, should have a process for education of fellows and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. ^(Core)

VI.C. Well-Being

Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of fellowship training.

Fellows and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of fellow competence. Physicians and all members of the health care team share responsibility for the well-being of each other. For example, a culture which encourages covering for colleagues after an illness without the expectation of reciprocity reflects the ideal of professionalism. A positive culture, in a clinical learning environment, models

constructive behaviors and prepares fellows with the skills and attitudes needed to thrive throughout their careers.

VI.C.1. The responsibility of the program, in partnership with the Sponsoring Institution, to address well-being must include:

VI.C.1.a) efforts to enhance the meaning that each fellow finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships; ^(Core)

VI.C.1.b) attention to scheduling, work intensity, and work compression that impacts fellow well-being; ^(Core)

VI.C.1.c) evaluating workplace safety data and addressing the safety of fellows and faculty members; ^(Core)

VI.C.1.d) policies and programs that encourage optimal fellow and faculty member well-being; ^(Core)

VI.C.1.e) attention to fellow and faculty member burnout, depression, and substance use disorders.

The program, in partnership with its Sponsoring Institution, must educate faculty members and fellows in identification of the symptoms of burnout, depression, and substance use disorders, including means to assist those who experience these conditions. Fellows and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must: ^(Core)

VI.C.1.e)(1) encourage fellows and faculty members to alert the program director or other designated personnel or programs when they are concerned that another fellow, or faculty member may be displaying signs of burnout, depression, a substance use disorder, suicidal ideation, or potential for violence; ^(Core)

VI.C.1.e)(2) provide access to appropriate tools for self-screening; ^(Core)

VI.C.1.e)(3) provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. ^(Core)

VI.C.2. There are circumstances in which fellows may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and parental leave. Each program must allow an appropriate length of absence for fellows unable to perform their patient care responsibilities. (Core)

VI.C.2.a) The program must have policies and procedures in place to ensure coverage of patient care. (Core)

VI.C.2.b) These policies must be implemented without fear of negative consequences for the fellow who is or was unable to provide the clinical work. (Core)

Background and Intent: *Fellows may need to extend their length of training depending on length of absence and specialty board eligibility requirements. Teammates should assist colleagues in need and equitably reintegrate them upon return.*

VI.D. Fatigue Mitigation

VI.D.1. Programs must:

VI.D.1.a) educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation; (Core)

VI.D.1.b) educate all faculty members and fellows in alertness management and fatigue mitigation processes; (Core)

VI.D.1.c) encourage fellows to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. (Detail)

VI.D.2. Each program must ensure continuity of patient care, consistent with the program's policies and procedures, if a fellow may be unable to perform their patient care responsibilities due to excessive fatigue. (Core)

VI.D.3. The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for fellows who may be too fatigued to safely return home. (Core)

VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care

VI.E.1. Clinical Responsibilities

The clinical responsibilities for each fellow must be based on fellow level, patient safety, fellow ability, severity and complexity of patient illness/condition, and available support services. (Core)

VI.E.2. Teamwork

Fellows must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty and larger health system. ^(Core)

VI.E.3. Transitions of Care

VI.E.3.a) Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. ^(Core)

VI.E.3.b) Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. ^(Core)

VI.E.3.c) Programs must ensure that fellows are competent in communicating with team members in the hand-over process. ^(Outcome)

VI.E.3.d) Programs and clinical sites must maintain and communicate schedules of attending physicians and fellows currently responsible for care. ^(Core)

VI.E.3.e) Each program must ensure continuity of patient care, consistent with the program's policies and procedures, in the event that a fellow may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency. ^(Core)

VI.F. Clinical Experience and Education

Programs, in partnership with their Sponsoring Institution, must design an effective program structure that is configured to provide fellows with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.

VI.F.1. Maximum Hours of Clinical and Educational Work per Week

Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities and clinical work done from home. ^(Core)

VI.F.2. Mandatory Time Free of Clinical Work and Education

VI.F.2.a) The program must design an effective program structure that is configured to provide fellows with educational

opportunities, as well as reasonable opportunities for rest and personal well-being. ^(Core)

VI.F.2.b) Fellows should have eight hours off between scheduled clinical work and education periods. ^(Detail)

VI.F.2.b)(1) There may be circumstances when fellows choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements. ^(Detail)

VI.F.2.d) Fellows must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days. ^(Core)

VI.F.3. Maximum Clinical Work and Education Period Length

VI.F.3.a) Clinical and educational work periods for fellows must not exceed 24 hours of continuous scheduled clinical assignments. ^(Core)

VI.F.3.a)(1) Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or fellow education. ^(Core)

VI.F.3.a)(1)(a) Additional patient care responsibilities must not be assigned to a fellow during this time. ^(Core)

VI.F.4. Clinical and Educational Work Hour Exceptions

VI.F.4.a) In rare circumstances, after handing off all other responsibilities, a fellow, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:

VI.F.4.a)(1) to continue to provide care to a single severely ill or unstable patient; ^(Detail)

VI.F.4.a)(2) humanistic attention to the needs of a patient or family; ^(Detail)

VI.F.4.a)(3) to attend unique educational events. ^(Detail)

VI.F.4.b) These additional hours of care or education will be counted toward the 80-hour weekly limit. ^(Detail)

VI.F.5. Moonlight

Fellows are not permitted to moonlight. ^(Core)

VI.F.8. At-Home Call

VI.F.8.a) Time spent on patient care activities by fellows on at-home call must count toward the 80-hour maximum weekly limit, averaged over a four-week period. ^(Core)

VI.F.8.b) Fellows are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit, averaged over a four-week period. ^(Detail)

*Core Requirements: Statements that define structure, resource, or process elements essential to every graduate medical educational program.

†Detail Requirements: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and sponsoring institution in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

‡Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of fellows at key stages of their graduate medical education.

Acknowledgement

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