ACGME Requirements
Review and Comment Form

Title of Requirements	Sections I-V of the Common Program Requirements (Residency) and Common Program Requirements (Fellowship)

Commenter Information

Name	Rendell Ashton for the
Title	PD in pulmonary/critical care and president of the APCCMPD
Organization	Association of Pulmonary and Critical Care Medicine Program Directors

Select [X] only one	
Organization (consensus opinion of membership)*	☐
Organization (compilation of individual comments)*	☒
ACGME Review Committee or Council	☐
Designated Institutional Official	☐
Program Director in the Specialty	☐
Resident/Fellow	☐
Other (specify):	☐

*An organization submitting comments should indicate whether the comments represent a consensus opinion of its membership or whether they are a compilation of individual comments.

Consent

As part of the ongoing effort to encourage the participation of the graduate medical education community in the process of revising requirements, the ACGME may publish some or all of the comments it receives on the ACGME website. By submitting your comments, the ACGME will consider your consent granted. If you or your organization do not consent to the publication of any comments, please indicate such by checking the box below.

I do not give the ACGME consent to publish my comments ☐

Comments

The ACGME welcomes all comments, including support, concerns, or other feedback, regarding the proposed requirements.

Specific Comments

Comments related to (a) particular requirement(s) must be referenced by requirement number; any specific comments without an appropriate reference will not be considered. Add rows to the comment table as necessary.

Special Instructions for Common Program Requirements: The ACGME invites the community to comment on both the Residency and Fellowship versions of the Common Program Requirements. You may choose to comment on just one version, or to give feedback on both; ***please use only one form***. Note that in some areas, the exact language may not be the same between the two versions, and some requirements appear in only one version.

Please use the checkboxes in the table below to indicate for each comment whether your feedback is related to the Residency version, the Fellowship version, or both versions. (For example, you should check both boxes if you wish to comment on a difference between the two versions.) This will ensure that your feedback is attributed to the correct version.

If all of your comments relate to only one version, you may indicate here which version you have used in your review rather than checking the boxes separately in each row:

Residency version only ☐
Fellowship version only ☒

Note that Section VI of the Common Program Requirements is not open for comment. Only comments on Sections I-V will be reviewed.

Comments on Requirements		
Requirement Number(s)	**Version(s)**	**Comment/Rationale**
II.A.2	Residency ☐ Fellowship ☐	We applaud the CPR requirement that PD support be adequate for administration of the program based on size and configuration, and that this is a core requirement. In our specialty program requirements there is already a specification that this support should be 25-50% of the PD's time and salary. It has been important to many in our field to have this level specified. Otherwise, the interpretation of "adequate" is left up to the institutional administration. In our program director association's annual survey, over half of PD's felt their institutional support was inadequate.
II.A.3.b	Residency ☐ Fellowship ☐	We support the eligibility of AOA colleagues as PD's and faculty. The problem as we understand it is that the ABIM does not support this change. In cases like this where there is a lack of congruence between the CPR's and the certifying board, there should be some language in the CPR's alerting programs that although a leadership or faculty arrangement might be in compliance with the ACGME, it may leave their trainees ineligible for their board certification. It seems dangerous to assume that everyone knows there is a disconnect here, and the ones who will suffer from that disconnect are the trainees who would not be able to certify.
II.B.3.a).(1)	Residency ☐ Fellowship ☐	Another example where the board may not be in step with the CPR's. Maybe it would be reasonable to have each Review Committee have the responsibility to alert programs in their specialty-specific requirements when there is a disconnect with the certifying board. If so, should the CPR's say so in the red comments below each section where this might apply?
III.A.1.	Residency ☐	This new option allowing fellows who did residency in an accredited

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	Fellowship ☐	program in Canada to be eligible for US fellowships seems reasonable, but the issue again is whether the board will recognize these trainees as board eligible after fellowship. Since board certification will be monitored according to these new CPR's, this issue could become a barrier and an unintended consequence of allowing these Canadian residents to matriculate into ACGME accredited fellowships. Will the RC's make this clear?
IV.E. and IV.E.1.	Residency ☐ Fellowship ☐	Fellows may be assigned to practice in their core specialty up to 20% of the time of their fellowship. We understand that this is not a requirement, but only "allows" this to happen. The rationale is that some trainees need to do this to maintain their core specialty skills through the period of their subspecialty training. It seems that the more practical reason (and the reason this provision is likely to be used) is that some programs can only justify having fellowship training programs if they can offset the cost of training fellows with the clinical income those fellows would bring in to the institution while practicing in their core specialty. This could be exploited for non-educational purposes, and poses a significant risk to the fellows in such instances. The unintended consequence of this could be that program directors could be forced to "assign" their fellows to core practice blocks, simply for the financial benefit of the institution, to the detriment of the fellows' subspecialty training and scholarship. Could there be additional language here giving the PD the authority to determine whether the core specialty practice is educationally necessary, based on the anticipated practice needs of the fellows? Another unintended consequence of this change will be that J-1 visa holders will be less able to get spots in fellowship because they cannot work (unsupervised and billing) in the core specialty under the restrictions of their visa.
V.A.1.d).(2)	Residency ☐ Fellowship ☐	We understand that individual learning plans will be required for all trainees, and PD's will be responsible for developing those plans. Will those be reported in the annually reported data in the ADS system, or will this be a requirement that will be assessed some other way? If they are reported, will the actual documents be uploaded, or a simple compliance metric reported?
V.B.3.	Residency ☐ Fellowship ☐	The requirement for a faculty development plan could represent a new and significant burden for PD's if they are the ones required to implement the plans. The requirement is vague about whether all faculty will need to have such a plan or only those whose evaluations indicate significant need for improvement. All faculty should be improving and participating in faculty development—the issue for PD's is whether they must be personally responsible for creating the plans and tracking progress. Most PD's would not have this level of control over the individual faculty members, and may not have the support of a department chair to enforce that the development plans are in place.

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V.C.4.a)	Residency ☐ Fellowship ☐	It is unclear how the program's efforts to encourage all graduates to take their certifying board exam will be assessed.
V.C.4.g)	Residency ☐ Fellowship ☐	Reporting the board certification pass rate for the cohort of fellows who graduated from the program 7 years earlier will, in many cases, make the PD responsible for a metric from the program before they became the PD. Are there data to support eventual certification as the important measure? Or is this still referring to first time takers' pass rate? There are data showing that first time pass rate correlates with other important outcomes, including malpractice claims and other disciplinary action for poor medical judgment. Also, not everyone who initially certifies will necessarily be certified 7 years later. Is there a minimum pass rate for the 7 year cohort that will be considered adequate? This reporting requirement may generate a lot of PD stress because it is not clear that the PD has any control over it, and there is no standard specified to be met. PD's should also not feel they are responsible for the MOC component of certification for their past graduates.
I.D.2.b)	Residency ☐ Fellowship ☐	This new requirement that fellows have a safe, quiet, clean and private place to sleep/rest is very appropriate for programs which require fellows to stay overnight in the hospital. Is the program requirement intended to apply to programs who do not require overnight presence of fellows? For those programs, this requirement may represent a significant hardship, as it would be difficult to justify the space allocation to a hospital committee.

General Comments

Please include only general or overall comments in this box. Comments about specific requirements must be included in the requirement comment table above and referenced by requirement number in order to be considered by the ACGME.

Submission

All comments must be submitted via e-mail to cprrevision@acgme.org by 11:59 p.m. Central on March 22, 2018. Specific comments must reference the requirement(s) by number (per the applicable version of the document) as described above. All comments must be submitted using this form; comments submitted in another format will not be considered. For more information, see the ACGME Common Program Requirements In Revision page on the ACGME website.