January 27, 2010

Karen L. Lambert
Associate Executive Director
Accreditation Council for Graduate Medical Education
515 North State Street, Suite 2000
Chicago, IL 60610-4322

Dear Ms. Lambert:

On behalf of the Association of Pulmonary and Critical Care Medicine Program Directors (APCCMPD), we appreciate the opportunity to review and comment on the 2011 pulmonary, critical care, and pulmonary critical care program requirement revisions.

The APCCMPD Board of Directors solicited comments from the APCCMPD membership. The individual member comments are enclosed with this letter. Overall, the APCCMPD feels that many of the revisions are well intended, however, there is a lack of clear specificity as to why the requirement was revised and how to implement the requirement within a program. This will lead to poorly informed decisions and controversy because of misunderstandings of the intent. Whether these changes prove useful, onerous, or both, will depend more on how they are interpreted. Therefore, the APCCMPD recommends that the ACGME utilize clear and concise language and carefully examines the unintended consequences of the requirements.

The APCCMPD offers the following specific comments on the major revisions.

Pulmonary Critical Care Line Numbers 46-50
Pulmonary Line Numbers 41-47
Critical Care Line Numbers 45-50
Requirement Revision (major revisions only): ensure that the program director is provided with adequate salary support for the administrative activities of the fellowship. The program director must not be required to generate clinical or other income to provide this administrative support. This support should be 25-50% of the program director's salary, depending on the size of the program

The APCCMPD supports this requirement without comment.

Joyce Bruno-Reitzner, MBA, MIPH
Executive Director

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Pulmonary Critical Care Line Numbers 55-57
Pulmonary Line Numbers 51-53
Critical Care Line Numbers 45-50
Requirement Revision (major revisions only): The sponsoring institution and participating sites must: demonstrate that there is a culture of continuous quality improvement in the areas of patient care, patient safety, and education;

While the APCCMPD appreciates the intent of this revision, we question its feasibility. More specificity needs to be given as to how sponsoring institutions and participating sites must demonstrate its culture of quality. It is unclear if the program would be in compliance of this requirement by virtue of the institution implementing a quality improvement process. Furthermore, the APCCMPD questions whether the program should be held accountable for a process that is largely controlled by the institution. In addition, programs would benefit from understanding the criteria used by the RRC to meet compliance with this new requirement.

Pulmonary Critical Care Line Numbers 59-61
Pulmonary Line Numbers 55-57
Critical Care Line Numbers 58-60
Requirement Revision (major revisions only): demonstrate a commitment to quality patient-centered care and safety, education research and scholarship sufficient to support the fellowship program;

As in the revision outlined in Pulmonary Critical Care Line Numbers 55-57; Pulmonary Line Numbers 51-53; and Critical Care Line Numbers 45-50 the APCCMPD appreciates the intent of this revision, although, questions its feasibility and how the ACGME defines "sufficient to support the fellowship program". Furthermore, the APCCMPD questioned whether leaving out "pulmonary and critical care" before the word fellowships was a typo.

Pulmonary Critical Care Line Numbers 63-64
Pulmonary Line Numbers 59-60
Critical Care Line Numbers 62-63
Requirement Revision (major revisions only): share appropriate inpatient and outpatient faculty performance data with the program director;

The APCCMPD raised a number of questions regarding this requirement: 1) what is the intent of this requirement; 2) what constitutes appropriate inpatient and outpatient faculty performance data; 3) which indicators will be used to collect this data; and 4) how will the program director collect or ascertain this data? This requirement is burdensome and costly.

Pulmonary Critical Care Line Numbers 71-74
Pulmonary Line Numbers 67-70
Critical Care Line Numbers 70-73
Requirement Revision (major revisions only): notify the Review Committee within 30 days of changes in institutional governance, affiliation, or resources that affect the educational program as outlined in the Institutional Requirements;

No comment.

Pulmonary Critical Care Line Numbers 130-133
Pulmonary Line Numbers 127-130
Critical Care Line Numbers 129-132
Requirement Revision (major revisions only): The program director must have at least five years of participation as an active faculty member in an ACGME-accredited core internal medicine residency or pulmonary disease or critical care medicine fellowship program.

No comment.

Pulmonary Critical Care Line Numbers 145-146
Pulmonary Line Numbers 136-137
Critical Care Line Numbers 138-139
Requirement Revision (major revisions only): The Review Committee only accepts current ABIM-certification in pulmonary disease or critical care medicine.

No comment.

Pulmonary Critical Care Line Numbers 370-375
Pulmonary Line Numbers 362-366
Critical Care Line Numbers 362-366
Requirement Revision (major revisions only): ~~The majority of~~ 50% of the KCF must demonstrate evidence of productivity in the scholarship, specifically peer-reviewed funding or publication of original research or review articles in peer- reviewed journals, or chapters in textbooks. ~~as defined in II.B.5.b.(1), or (2) above.~~

The APCCMPD appreciates the clarification of 50% given to this requirement, but feels that 50% may be unrealistic to achieve.

Pulmonary Critical Care Line Numbers 377-384
Pulmonary Line Numbers 368-375
Critical Care Line Numbers 368-375
Requirement Revision (major revisions only): At least one of the KCF must be specifically trained in the evaluation and assessment of the ACGME competencies; and, spend significant time in the evaluation of fellows including the direct observation of fellows with patients.

The APCCMPD feels that this requirement is burdensome and costly to training programs. In many programs all key clinical faculty (KCF) have clear purposes and

roles that contribute to the fellow's training. This requirement would create an additional job function without additional funding to support it.

The APCCMPD also questions the evidence demonstrating the need for a KCF to be specifically trained to evaluate and document compliance with ACGME competencies.

Pulmonary Critical Care Line Numbers 386-387
Pulmonary Line Numbers 377-378
Critical Care Line Numbers 377-378
Requirement Revision (major revisions only): Appointment of one KCF to be an associate program director is suggested.

The APCCMPD recommends that the ACGME recommend to sponsoring institutions that this position be compensated; otherwise institutions will not support it.

Pulmonary Critical Care Line Numbers 409-411
Pulmonary Line Numbers 386-388
Critical Care Line Numbers 399-401
Requirement Revision (major revisions only): There must be services available from other health care professionals, including nurses, social workers, language interpreters, dietitians, physical therapists, and occupational therapists.

No comment.

Pulmonary Critical Care Line Numbers 431-434
Pulmonary Line Numbers 410-413
Critical Care Line Numbers 422-425
Requirement Revision (major revisions only): 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.

The APCCMPD feels that many physicians in all areas of practice are burdened with clerical functions. Without additional specification of what constitutes clerical functions, unintended consequences may arise. For example, ascertaining records to understand test results and patient histories is fundamental to quality patient care. However, it is not clear under this definition if this would constitute a clerical function. Furthermore, without clarification there may be difficulty distinguishing this requirement with the requirement outlined in Pulmonary Critical Care Line Numbers 1073-1077; Pulmonary Line Numbers 907-911; and Critical Care Line Numbers 968-972.

Pulmonary Critical Care Line Numbers 439-443
Pulmonary Line Numbers 418-422
Critical Care Line Numbers 430-434
Requirement Revision (major revisions only): When fellows are ~~assigned night duty~~ in the hospital, assigned night duty, or called in from home, they must be provided with ~~on-call facilities that are convenient and that afford privacy, safety, and a restful environment with~~ a secure space for their belongings.

No comment.

Pulmonary Critical Care Line Numbers 419-422
Pulmonary Line Numbers 458-461
Critical Care Line Numbers 495-498
Requirement Revision (major revisions only): 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 towards its implementation;

The APCCMPD appreciates the benefit of utilizing an electronic health record (EHR). However, the APCCMPD feels that a program should not be held accountable for a requirement, which is out of the purview of the program. Implementation and utilization of EHRs are enforced and resourced by the sponsoring institution not the program.

Pulmonary Critical Care Line Numbers 426-427
Pulmonary Line Numbers 465-466
Critical Care Line Numbers 502-503
Requirement Revision (major revisions only): The patient population must have a variety of clinical problems and stages of diseases.

No comment.

Pulmonary Critical Care Line Numbers 564-568
Pulmonary Line Numbers 498-502
Critical Care Line Numbers 547-551
Requirement Revision (major revisions only): When averaged over any five-year period, a minimum of 75% of fellows in each ~~subspecialty training~~ program must be graduates of an ACGME accredited internal medicine ~~training~~ program. ~~Non-ACGME internal medicine trained fellows must have at least three years of internal medicine education training prior to starting fellowship.~~

No comment.

Pulmonary Critical Care Line Numbers 619-622
Pulmonary Line Numbers 553-555
Critical Care Line Numbers 602-604
Requirement Revision (major revisions only): The core curriculum must include a didactic program that is based on the core knowledge content and areas defined as a fellow's outcomes in the subspecialty

The APCCMPD appreciates the intent of this requirement, however feels that it could be worded more clearly. The APCCMPD recommends the following wording " The curriculum must include opportunities to learn the content of the field of pulmonary and critical care medicine. The curriculum may include lectures, demonstrations, hands on practice, problem solving, journal clubs, simulations and other aids to acquiring the knowledge necessary for full competency." The APCCMPD believes that mandating didactic educational methodology for core knowledge for all fellows is inflexible and interferes with development of self-directed learning skills.
We recommend that programs be held accountable for measuring competence in medical knowledge, but that the ACGME should leave the educational methodology to the purview of the training program.

Additionally, the APCCMPD requests the term "fellow's outcome" be more clearly defined.

Pulmonary Critical Care Line Numbers 627-629
Pulmonary Line Numbers 560-563
Critical Care Line Numbers 609-611
Requirement Revision (major revisions only): Fellows must participate in clinical case conferences, journal clubs, research conferences, and morbidity and mortality or quality improvement conferences.

No comment.

Pulmonary Critical Care Line Numbers 631-633
Pulmonary Line Numbers 564-566
Critical Care Line Numbers 613-615
Requirement Revision (major revisions only): All required core conferences must have at least one faculty member present and be scheduled as to ensure peer-peer and peer-faculty interaction.

No comment.

Pulmonary Critical Care Line Numbers 668-671
Pulmonary Line Numbers 601-605
Critical Care Line Numbers 650-654
Requirement Revision (major revisions only): Patient Care must demonstrate competence in the practice of health promotion, disease prevention, diagnosis, care and treatment of men and women from adolescence to old age, during health and all stages of illness.

The APCCMPD recommends that more specification be given as to how competence should be demonstrated and questions if evidence exists suggesting that a gap in competence.

Pulmonary Critical Care Line Numbers 791-792
Pulmonary Line Numbers 671-672
Critical Care Line Numbers 732-733
Requirement Revision (major revisions only): Patient Care flexible fiber-optic bronchoscopy procedures (a minimum of ~~50~~ 100 such procedures);

The APCCMPD posed a number of concerns with this requirement. 1) The APCCMPD questions the evidence base to support a 100% increase in required number of flexible fiber-optic bronchoscopy (FOB) procedures. 2) While most programs exceed this average, some programs may achieve competence with fewer than 100 bronchoscopies. 3) The number of procedures performed does not necessarily imply competence with the procedure. 4) The utilization of FOB for airway hygiene (as much as 75% of bronchoscopies in the ICU) is very much debatable, with little randomized controlled data to support its use in the ICU. 5) This requirement contradicts the revisions outlined in Pulmonary Critical Care Line Numbers 1235-1238; Pulmonary Line Numbers 1055-1058; and Critical Care Line Numbers 1064-1067.

Instead, we recommend that the ACGME require programs to establish assessment mechanisms that account for the varying abilities and pace of learning for individual trainees. We are aware of published expert opinion regarding the "100" threshold for bronchoscopies, but believe this threshold is arbitrary and this "one size fits all" approach detracts from the true goal of developing valid assessment tools for procedural competence.

Pulmonary Critical Care Line Numbers 825-827
Pulmonary Line Numbers 700-702
Critical Care Line Numbers 753-755
Requirement Revision (major revisions only): Patient Care use of ultrasound techniques to perform thoracentesis and place intravascular and intracavitary tubes and catheters; and

No comment.

Pulmonary Critical Care Line Numbers 838-839
Pulmonary Line Numbers 718-722
Critical Care Line Numbers 766-770
Requirement Revision (major revisions only): Medical Knowledge must demonstrate knowledge of the scientific method of problem solving and evidence-based decision-making. ~~commitment to lifelong learning, and an attitude of caring that is derived from humanistic and professional values.~~

The APCCMPD questions how the scientific method of problem solving is defined and how it would be demonstrated. Assessing the use of the scientific method of problem solving and evidence-based decision-making is qualitative and based on

direct observation as fellows present their patients to their faculty members. We request greater clarification on how the ACGME would determine compliance with this requirement.

Pulmonary Critical Care Line Numbers 841-846
Pulmonary Line Numbers 724-729
Critical Care Line Numbers 772-778
Requirement Revision (major revisions only): Medical Knowledge must ~~develop~~ demonstrate a comprehensive understanding of indications, contraindications, limitations, complications, techniques, and interpretation of results of those diagnostic and therapeutic procedures integral to the discipline, including the appropriate indication for and use of screening tests/procedures.

The APCCMPD recommends that this requirement be simplified and more clearly specified, as outlined above in Pulmonary Critical Care Line Numbers 838-839; Pulmonary Line Numbers 718-722; and Critical Care Line Numbers 766-770.

Pulmonary Critical Care Line Numbers 898-900
Critical Care Line Numbers 817-819
Requirement Revision (major revisions only): Medical Knowledge must demonstrate knowledge of the indications, contraindications and complications of placement of percutaneous tracheostomies.

The APCCMPD recommends the ACGME assess the unintended consequences of this requirement. This procedure is largely performed by surgeons, requiring pulmonary critical care fellows to demonstrate knowledge will lead to maintaining competence for a procedure that is typically not performed by this specialty.

Pulmonary Critical Care Line Numbers 942-944
Requirement Revision (major revisions only): obtain procedure-specific informed consent by competently educating patients about rationale, technique, and complications of procedures; and

No comment.

Pulmonary Critical Care Line Numbers 946-947
Pulmonary Line Numbers 804-805
Critical Care Line Numbers 853-854
Requirement Revision (major revisions only): Practice-based Learning & Improvement apply new contributions to the management and care of their patients.

The APCCMPD questions the intent of the requirement and recommends the language be simplified. Does the ACGME mean that the program must ensure that fellows are exposed to advances in the practice of medicine?

Pulmonary Critical Care Line Numbers 972-975
Pulmonary Line Numbers 830-833
Critical Care Line Numbers 879-882
Requirement Revision (major revisions only): Interpersonal and Communication Skills
demonstrate the ability to relate to patients and their families, as well as, other members of the health care team with compassion, respect, and professional integrity; and

No comment.

Pulmonary Critical Care Line Numbers 977
Pulmonary Line Numbers 835
Critical Care Line Numbers 884
Requirement Revision (major revisions only): Interpersonal and Communication Skills
be effective teachers.

No comment.

Pulmonary Critical Care Line Numbers 999-1001
Pulmonary Line Numbers 857-859
Critical Care Line Numbers 906-908
Requirement Revision (major revisions only): Professionalism high standards of ethical behavior including maintaining appropriate professional boundaries and relationships with other physicians and avoiding conflicts of interest; and,

No comment.

Pulmonary Critical Care Line Numbers 1003-1004
Pulmonary Line Numbers 861-862
Critical Care Line Numbers 910-911
Requirement Revision (major revisions only): Professionalism a commitment to lifelong learning, and an attitude of caring that is derived from humanistic and professional values.

The APCCMPD agrees with the intent of this requirement; however, the APCCMPD recommends this statement be part of a preamble, listing the goals of a fellowship program that includes moral and ethical behaviors, professionalism and commitment to lifelong learning. These things can and should be at the center of our professional lives, but cannot be measured except by their absence.

Pulmonary Critical Care Line Numbers 1071
Pulmonary Line Numbers 905
Critical Care Line Numbers 966
Requirement Revision (major revisions only): Fellows must have access to training using simulation;

The APCCMPD questions why the ACGME justifies this requirement by stating that it will not require additional resources on behalf of the program. If a program does not have access to a simulation facility within their institution additional resources

would be required to access an external simulation facility. We also believe this requirement should be part of the requirements for sponsoring institutions.

Pulmonary Critical Care Line Numbers 1073-1077
Pulmonary Line Numbers 907-911
Critical Care Line Numbers 968-972
Requirement Revision (major revisions only): Fellows must be instructed in the organization and financing of clinical practice, including personnel and business management, scheduling, billing and coding procedures, telephone and telemedicine management, and maintenance of an appropriate confidential patient record system.

The APCCMPD appreciates the intent; however, recommends that more specificity be given to this requirement. Without additional specification of what constitutes such management functions unintended consequences may arise. Furthermore, without clarification there may be difficulty distinguishing this requirement with the requirement outlined in Pulmonary Critical Care Line Numbers 431-434; Pulmonary Line Numbers 410-413; and Critical Care Line Numbers 422-425.

Pulmonary Critical Care Line Numbers 1135-1138
Pulmonary Line Numbers
Critical Care Line Numbers
Requirement Revision (major revisions only): For programs with at least 24 months of clinical rotations, fellows must complete a minimum of 24 months of one half-day weekly ambulatory care clinic during the 36-month fellowship program.

No comment.

Pulmonary Critical Care Line Numbers 1140-1143
Pulmonary Line Numbers
Critical Care Line Numbers
Requirement Revision (major revisions only): For programs with 18-23 months of required clinical rotations, fellows must complete a minimum of 30 months of one half-day weekly ambulatory care clinic during the 36-month fellowship program.
1144

No comment.

Pulmonary Critical Care Line Numbers 1159-1162
Pulmonary Line Numbers
Critical Care Line Numbers
Requirement Revision (major revisions only): If the above clinic blocks are interrupted by other clinical rotations, they must be extended so that their total duration is at least six months.

No comment.

Pulmonary Critical Care Line Numbers 1178-1180
Pulmonary Line Numbers 994-996
Critical Care Line Numbers 1004-1006
Requirement Revision (major revisions only): Direct faculty supervision of procedures performed by each fellow must occur until proficiency has been acquired and documented by the program director.

The APCCMPD questions the purpose of requiring fellowship programs to re-assess competence that may have been achieved during core training in internal medicine. We support the requirement of programs assessing procedural competence for new procedural skills prior to allowing trainees to perform procedures unsupervised. However, we believe that programs have the option of relying on documented previous competence during residency training, much as hospital credentialing does for faculty members.

Pulmonary Critical Care Line Numbers 1188-1189
Pulmonary Line Numbers
Critical Care Line Numbers
Requirement Revision (major revisions only):
It is suggested that fellows have clinical experience in the placement of percutaneous tracheostomies.

As with Pulmonary Critical Care Line Numbers 898-900 and Critical Care Line Numbers 817-819, the APCCMPD recommends the ACGME assess the unintended consequences of this requirement. This procedure is largely performed by surgeons, requiring pulmonary/critical care fellows to demonstrate knowledge will lead to maintaining competence for a procedure that is typically not performed by this specialty. Many programs do not see a need for this type of training. While this might be a useful skill for a Pulmonary Critical Care Physician practicing in a small hospital, other bedside procedures in the ICU would also meet this criteria including; placement of intracranial pressure monitors and continuous EEG. Until there is more unanimous agreement that there is a need for acquiring skill in percutaneous tracheostomies, we recommend training of this procedure remain optional.

Pulmonary Critical Care Line Numbers 1199-1212
Pulmonary Line Numbers 1018-1031
Critical Care Line Numbers 1031-1044
Requirement Revision (major revisions only): The majority of fellows must demonstrate evidence of recent research productivity conducted during the fellowship through one or more of the following:
-publication of journal articles, book chapters, abstracts or case reports (manuscripts or abstracts) in peer-reviewed journals;
-publication of peer-reviewed performance improvement or education research;
-peer-reviewed funding; or,
-peer-reviewed abstracts presented at regional, state or national specialty meetings.

No comment.

Pulmonary Critical Care Line Numbers 1235-1238
Pulmonary Line Numbers 1055-1058
Critical Care Line Numbers 1064-1067
Requirement Revision (major revisions only): Assessment of procedural competence should not be based solely on a minimum number of procedures performed, but should include a formal evaluation process. These evaluations should include objective performance criteria.

The APCCMPD agrees with the intent of this requirement to base competence on more than just a minimum number of procedures preformed. However, the APCCMPD recommends the time and resources required for a unspecified and formative evaluation process be carefully weighted. Without a clear mandate that this be recognized and compensated by the sponsoring institution or practice plan it may result in additional burden on the program director. Furthermore, the APCCMPD questions if evidence exists indicated that a formative evaluation process lead to better care.

Pulmonary Critical Care Line Numbers 1248-1333
Pulmonary Line Numbers 1068-1154
Critical Care Line Numbers 1077-1162
Requirement Revision (major revisions only):

The APCCMPD recommend that the ACGME carefully assess unintended consequences of the requirements regarding the competencies. Without a clear mandate that this be recognized and compensated by the sponsoring institution or practice plan these revisions may result in excess burden on the program director.

Patient Care
The program must assess the fellow in data gathering, clinical reasoning, patient management and procedures in both the inpatient and outpatient setting. This assessment must involve direct observation of fellow-patient encounters.

The record of evaluation must include the fellow's logbook or an equivalent method to demonstrate that each fellow has achieved competence in the performance of required procedures.

Medical Knowledge
The program must use an objective validated formative assessment method, e.g., in-service training examination or chart stimulated recall. The same formative assessment method must be administered at least twice during the program.

Practice-based Learning and Improvement
The program must use performance data to assess the fellow in: application of evidence to patient care, practice improvement, teaching skills involving peers and patients and, scholarship.

Interpersonal and Communication Skills
The program must use both direct observation and multi-source evaluation including patients, peers and non-physician team members, to assess fellow performance in: communication with patient and family, teamwork, communication with peers, including transitions in care, and record keeping.

Professionalism
The program must use multi-source evaluation including patients, peers, and non-physician team members, to assess each fellow's: honesty and integrity, ability to meet professional responsibilities, ability to maintain appropriate professional relationships with patients and colleagues, and commitment to self-improvement.

Systems-based Practice
The program must use multi-source evaluation including peers, and non-physician team members, to assess each fellow's: ability to provide care coordination, including transition of care, ability to work in interdisciplinary teams, advocacy for quality of care, and ability to identify system problems and participate in improvement activities.

Pulmonary Critical Care Line Numbers 1404-1406
Pulmonary Line Numbers 1225-1227
Critical Care Line Numbers 1237-1239
Requirement Revision (major revisions only): *A program's graduates should achieve a pass rate on the certifying examination of the ABIM of at least 80% for first-time takers in the past five years.*

No comment.

Pulmonary Critical Care Line Numbers 1418-1419
Pulmonary Line Numbers 1239-1240
Critical Care Line Numbers 1252-1253
Requirement Revision (major revisions only): At least 80% of the entering fellows should have completed the program.

No comment.

Pulmonary Critical Care Line Numbers 1427-1430
Pulmonary Line Numbers 1248-1251
Critical Care Line Numbers 1261-1264
Requirement Revision (major revisions only): The program must organize representative program personnel, at a minimum to include the program director, representative faculty, and one fellow, to review program goals and objectives, and the effectiveness with which they are achieved.

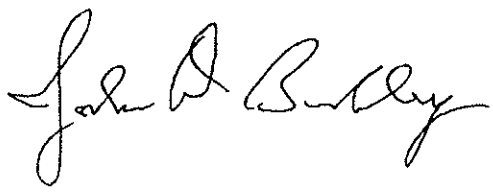
No comment.

Pulmonary Critical Care Line Numbers 390-394
Critical Care Line Numbers 381-384

The APCCMPD questions the evidence behind the required presence of at least three Internal Medicine-based accredited sub-specialities. This requirement is burdensome to many sponsoring institutions and is often the sole obstacle preventing the creation of additional training programs. The APCCMPD recognizes the intense shortage of Critical Care Medicine physicians in the United States, and believes this restriction lacks supporting evidence. The APCCMPD agrees with the goal of providing opportunities for peer interaction in the care of critically ill patients, but recommends the educational methodology be left to the discretion and control of the training program.

Again the APCCMPD appreciates the opportunity to comment on the revisions and welcomes the opportunity to work closer with the ACGME to ensure that our pulmonary, critical care, and pulmonary/critical care medicine programs provide the highest quality education and experience to our fellows.

Sincerely,



John D. Buckley, MD, MPH
President
Association of Pulmonary and Critical Care Medicine Program Directors

Comments on:	Program Director	Institution
Overall Document		
Some of the proposed requirements are useful and can be implemented. Some are unrealistic, confusing or unnecessary. One of the obvious problems is the attempt to quantify behaviors that are cultural, ethical, vary with the context and the moment and are therefore basically unquantifiable. The document also suffers from bureaucratic language that is hard to decipher. What follows is a point-by-point response to the requirements that are problematic for this program director. 1. The use of the word "outcomes" to describe fellows training is borrowed from evidence based medicine. But, evidence based medicine arises from studies that have hard data, such as survival, death rates, costs. The application of the word to "fellow outcomes" implies that there is a hard science of training that leads to accurate measurement of functionality. This is unfortunately not true. ACGME is way ahead of the science of education and is asking Programs to make measurements that don't have a scientific basis. This is very frustrating and leads to wasted time. 2. ACGME tries to generalize about processes by using bureaucratic, pseudo-scientific language. ACGME needs to borrow a New England Journal editor to clean up the language. Simple is always better. Some of the sentences in this document are incomprehensible. 3. ACGME seems to believe that increased measurement and documentation will lead to better physicians. It completely ignores the continuous, daily, case-by-case, intensive, public process of communication, supervision, instant feedback that occurs when trainees see patients and present them to faculty, and then move to supervised procedures. All of this process is outcomes based as the doctors follow their patients. ACGME should put a moratorium on further documentation until it has the science to prove it works. ACGME requirements should have the same evidence based requirements that we have in our practices.	John H. Newman, MD	Vanderbilt Medical Center
My major comment is that some of the new requirements as related to the competencies will result in an increased work on the part of the program director and key clinical faculty but without a clear mandate that this work should be recognized and compensated by the sponsoring institution or practice plan	Confidential	Confidential
The biggest concern expressed by our faculty at Iowa concerns the requirement for training all pulmonary/critical care fellows to perform percutaneous tracheostomy. We do not feel this is a procedure that all pulmonary/critical fellows in our specialty should be trained in. For selected individuals this could be part of an additional year of training in Interventional Pulmonology (IP) – during this year a fellow might be able to perform the minimum 20 procedures to establish competency - the number recently recommended by an IP working group and published in *CHEST*.	Confidential	Confidential

Comments on:	Program Director	Institution
Pulmonary Critical Care Line Numbers 55-57 **Pulmonary Line Numbers 51-53** **Critical Care Line Numbers 45-50** Requirement Revision (major revisions only): *The sponsoring institution and participating sites must: demonstrate that there is a culture of continuous quality improvement in the areas of patient care, patient safety, and education;*		
The CQI process is broadly institutional. For instance, the implementation of central line insertion protocols is shared by all ICU's at Vanderbilt. Asking each subspecialty to describe these initiatives seems redundant and unnecessary. **ACGME should get this information as a large institutional package, because the initiatives are voluminous in scope and in documentation.** Vanderbilt has hundreds of pages of CQI initiatives, documentation, quantification and reporting to various programs.	John H. Newman, MD	Vanderbilt Medical Center
Comments on:	**Program Director**	**Institution**
Pulmonary Critical Care Line Numbers 59-61 **Pulmonary Line Numbers 55-57** **Critical Care Line Numbers 58-60** Requirement Revision (major revisions only): *demonstrate a commitment to quality patient-centered care and safety, education research and scholarship sufficient to support the fellowship program;*		
The CQI process is broadly institutional. For instance, the implementation of central line insertion protocols is shared by all ICU's at Vanderbilt. Asking each subspecialty to describe these initiatives seems redundant and unnecessary. **ACGME should get this information as a large institutional package, because the initiatives are voluminous in scope and in documentation.** Vanderbilt has hundreds of pages of CQI initiatives, documentation, quantification and reporting to various programs.	John H. Newman, MD	Vanderbilt Medical Center
It should say 'pulmonary and critical care medicine' fellowship	Confidential	Confidential
Comments on:	**Program Director**	**Institution**
Pulmonary Critical Care Line Numbers 63-64 **Pulmonary Line Numbers 59-60** **Critical Care Line Numbers 62-63** Requirement Revision (major revisions only): *share appropriate inpatient and outpatient faculty performance data with the program director;*		
Most of the data that is created has to do with patient evaluations and complaints. This is institutional data. There is no systematic data on "faculty performance" because no quantification scheme is feasible. This is an example of bureaucratic language that is hard to interpret. The requirements that appear to arise from the language don't make practical sense. We know about lawsuits, patient evaluations, M&M issues. These things are very rare and rise up easily without a broad performance evaluation system. What does ACGME envision from this requirement?	John H. Newman, MD	Vanderbilt Medical Center
I find this troublesome—this is more in the province of division chiefs, not program directors	Confidential	Confidential
I suspect that my faculty members would view this as a privacy invasion. There will be some faculty (who do research and do not attend private clinics) for whom such data will be hard to obtain. There is likely to be substantial cost in collecting this data.	Paul V. Carlile, MD	The University of Oklahoma Health Sciences Center

I believe meeting this requirement will consume enormous resources (human and fiscal) with little benefits to the educational aspects of the program. There currently are no reliable, validated metrics to assess physician performance. This is a major thrust of ongoing research, is enormously complicated and controversial. It is premature for the ACGME to mandate this as an educational program requirement when there is as yet no robust relationship between performance measures and the quality of clinical care, much less teaching skill.	Henry E. Fessler, MD	Johns Hopkins
Comments on:	**Program Director**	**Institution**
Pulmonary Critical Care Line Numbers 370-375 **Pulmonary Line Numbers 362-366** **Critical Care Line Numbers 362-366** Requirement Revision (major revisions only): ~~*The majority of*~~ *50% of the KCF must demonstrate evidence of productivity in the scholarship, specifically peer-reviewed funding or publication of original research or review articles in peer- reviewed journals, or chapters in textbooks.* ~~*as defined in II.B.5.b.(1), or (2) above.*~~		
50% of KCF is better than a majority but is still high and perhaps an unrealistic requirement	Confidential	Confidential
Comments on:	**Program Director**	**Institution**
Pulmonary Critical Care Line Numbers 377-384 **Pulmonary Line Numbers 368-375** **Critical Care Line Numbers 368-375** Requirement Revision (major revisions only): *At least one of the KCF must be specifically trained in the evaluation and assessment of the ACGME competencies; and, spend significant time in the evaluation of fellows including the direct observation of fellows with patients.*		
I thought that the competencies we were helping our fellows achieve were those of pulmonary and critical care medicine. **What scientific evidence does ACGME have that its scheme is superior to the mentoring interaction that occurs when a faculty member supervises, assists and evaluates a fellow?** Without evidence, ACGME should not propose that its scheme is "outcome based". This is just unsupportable. Also, this feels like an unfunded mandate. Many program directors are chosen for the job because they are highly functional clinicians, scientists and educators. I think you risk dumbing down the job by asking for this additional effort, driving off the best program directors. At Vanderbilt, in the PCCM program, we already have me as program director, an associate director who also runs the MICU, an education director, a recruiting director, and three assistant education doctors who maintain and improve the curriculum. We have a research director and Research Advisory Committees for all of our fellows. All of our faculty participate in training and teaching. We also have a full time administrative assistant. We run a large, well constructed, disciplined training program and take it very seriously. Asking us to train a faculty to evaluate our fellows for progress in ACGME competencies is diverting us from the important job of training to the less productive job of documentation.	John H. Newman, MD	Vanderbilt Medical Center
My major comment is that some of the new requirements as related to the competencies will result in an increased work on the part of the program director and key clinical faculty but without a clear mandate that this work should be recognized and compensated by the sponsoring institution or practice plan. For	Confidential	Confidential

example, a KCF must spend time directly observing patients on a regular basis		
Another cost issue. In addition I do not think that direct observation of fellow-patient interactions is useful. Our trainees have all had three years of training in Internal Medicine where they learn how to interact with patients.	Paul V. Carlile, MD	The University of Oklahoma Health Sciences Center
Comments on:	**Program Director**	**Institution**
Pulmonary Critical Care Line Numbers 386-387 **Pulmonary Line Numbers 377-378** **Critical Care Line Numbers 377-378** Requirement Revision (major revisions only): *Appointment of one KCF to be an associate program director is suggested.*		
This should also include that this position be compensated in some way, otherwise institutions will not support it.	Confidential	Confidential
Comments on:	**Program Director**	**Institution**
Pulmonary Critical Care Line Numbers 419-422 **Pulmonary Line Numbers 458-461** **Critical Care Line Numbers 495-498** Requirement Revision (major revisions only): *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 towards its implementation;*		
The mandate for an electronic health record while obviously desirable is beyond our control and requires considerable institutional resources - another unfunded mandate	Confidential	Confidential
Comments on:	**Program Director**	**Institution**
Pulmonary Critical Care Line Numbers 431-434 **Pulmonary Line Numbers 410-413** **Critical Care Line Numbers 422-425** Requirement Revision (major revisions only): *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.*		
I agree with this, but, all physicians, in academia, in straight clinical practice and in training, perform some clerical functions, depending on the definition. This is a slippery slope if you don't define it carefully. You will have some fellows complain about any clerical effort they have, and then you will have to develop a measurement scheme, again burdening the programs with busy work.	John H. Newman, MD	Vanderbilt Medical Center
Comments on:	**Program Director**	**Institution**
Pulmonary Critical Care Line Numbers 619-622 **Pulmonary Line Numbers 553-555** **Critical Care Line Numbers 602-604** Requirement Revision (major revisions only): *The core curriculum must include a didactic program that is based on the core knowledge content and areas defined as a fellow's outcomes in the subspecialty*		
This is a great example of terrible English usage. It took me several readings to figure it out. Why not say, " The curriculum must include opportunities to learn the content of the field of pulmonary and critical care medicine. The curriculum may include lectures, demonstrations, hands on practice, problem solving, journal clubs, simulations and other aids to acquiring the	John H. Newman, MD	Vanderbilt Medical Center

knowledge necessary for full competency." Just what is a **fellow's outcome**? That is an ambiguous couplet that should be abandoned.		
Comments on:	**Program Director**	**Institution**
Pulmonary Critical Care Line Numbers 668-671 **Pulmonary Line Numbers 601-605** **Critical Care Line Numbers 650-654** Requirement Revision (major revisions only): Patient Care *must demonstrate competence in the practice of health promotion, disease prevention, diagnosis, care and treatment of men and women from adolescence to old age, during health and all stages of illness.*		
What actually is "*outcomes based training?*" ACGME has made up new language. Also, isn't this redundant with the overall curriculum goals? You end up saying the same things in different ways over and over.	John H. Newman, MD	Vanderbilt Medical Center
Comments on:	**Program Director**	**Institution**
Pulmonary Critical Care Line Numbers 791-792 **Pulmonary Line Numbers 671-672** **Critical Care Line Numbers 732-733** Requirement Revision (major revisions only): Patient Care flexible fiber-optic bronchoscopy procedures (a minimum of ~~50~~ 100 such procedures);		
The major objection we have is the 100 bronchoscopy requirements. Our fellows are typically well-skilled after 50 and perform approximately 70 over their fellowship. While we expect this to rise with interventional bronchoscopies, the requirement of 100 is onerous, unjustified, and simply adds service requirements to the detriment of education. The Requirements even note that competency is not based on number but on performance.	Jonathan M. Fine, MD	Norwalk Hospital
I suggest 80 bronchoscopies are reasonable for competency.	Confidential	Confidential
There is a new requirement for Critical Care Fellows (not Pulmonary fellows) to have experience with 50 fiberoptic broncoscopies. This is not possible and not what is needed at all for state of the Art Training. Critical care fellows should have let's say 3-5 opportunities in their clinical training to pass an endotracheal tube into the trachea with a fiberoptic bronchoscope as they made need to do this for emergency airway management.	Michael A. Matthay MD	University of California, San Francisco
I thought we were moving in the direction of assessing competence rather than counting the number of procedures performed. The RRC seems to want to have it both ways.	Paul V. Carlile, MD	The University of Oklahoma Health Sciences Center
No other procedures have a minimum number for achieving competency, why bronchoscopy? The number is extreme considering that virtually all of critical care bronchoscopy is for diagnosis and treatment of atelectasis with passage of the scope via an endotracheal tube or tracheostomy tube for directional suctioning. The number of procedures needed to obtain competency for diagnosis of atelectasis and suctioning is vastly less than even 50, let alone 100. Most fellows naive in bronchoscopy learn to perform it after about 5-10 procedures. This is in distinction from pulmonary	Confidential	Confidential

medicine training where bronchoscopy is done via the upper airway, not only via a previously inserted tracheal tube, encompasses the diagnosis of many airway diseases and tumors, and techniques including endobronchial biopsy, transbronchial biopsy, Wang needle aspiration, endobronchial ultrasound, etc. It is puzzling that a set number of procedures would be the component of competency when the current outcomes evaluation process set forth by the ACGME stresses the achievement of competency as judged by the training supervisors as the gold standard, not the number of procedures performed. The number of procedures required would result in inappropriate bronchoscopy procedures just to meet a predetermined quota and besides being completely unethical, would increase the cost of medical care.		
Thank you for the opportunity to review the new program requirements for the Critical Care Medicine (Internal Medicine) Fellowship Program. I appreciate the clarity that has been introduced with the new documentation. Compliance with these changes will be easier given the specific nature of the documentation. I do, however, have a significant reservation about one section of the requirements, specifically IV.A.5.a).(4).(d) that states that fellows must demonstrate competence in "therapeutic flexible fiber-optic bronchoscopy procedures (each fellow must perform a minimum of 100 such procedures)". First, there are no numerical requirements for any other procedures, including procedures that have much more evidence based indication than therapeutic bronchoscopy. Second, for fellows who have 12 clinical ICU months, this would be 2 bronchoscopies in the ICU each week, which is more than are done in our ICUs currently, and if this is multiplied by 4 CCM fellows, there is no physical way to account for that many procedures. Third, there is considerable evidence that deep tracheal aspirations with quantitative cultures and blind bronchial lavage are equivalent to fiberoptic bronchoscopy (FOB) for the diagnosis of nosocomial pneumonia, so our practice has been to discourage routine FOB for this purpose. Finally, the utilization of FOB for airway hygiene (as much as 75% of bronchoscopies in the ICU) is very much debatable, with little randomized controlled data to support its use in the ICU. Requiring a specific number of bronchoscopies seems reasonable. However, for therapeutic bronchoscopy, 100 is unreasonable, and 50 is too many: both from the standpoint of acquiring competency (which can probably be accomplished with 20 - 25), and from a feasibility perspective, as many busy tertiary care ICUs perform far fewer than this number in an entire year	Confidential	Confidential
Comments on:	**Program Director**	**Institution**
Pulmonary Critical Care Line Numbers 838-839 **Pulmonary Line Numbers 718-722** **Critical Care Line Numbers 766-770** Requirement Revision (major revisions only): Medical Knowledge *must demonstrate knowledge of the scientific method of problem solving and evidence-based decision making.* ~~commitment to lifelong~~		

Pulmonary Critical Care Line Numbers 838-839 **Pulmonary Line Numbers 718-722** **Critical Care Line Numbers 766-770** Requirement Revision (major revisions only): Medical Knowledge *must demonstrate knowledge of the scientific method of problem solving and evidence-based decision making.* ~~commitment to lifelong learning, and an attitude of caring that is derived from humanistic and professional values.~~		
Another example of bad language making a good intent look silly. Please show me a good reference to the scientific method of problem solving and how one would demonstrate it. In practice we discover these things because we staff every case with the fellows, they present the case, tell their synthesis and then discuss it with the faculty. Is that what you mean, that we should round with the fellows, have them present cases, discuss and then evaluate the fellows competence? If so, please say it. That is what we do.	John H. Newman, MD	Vanderbilt Medical Center
Vague requirement. Would be hard to measure or demonstrate in an objective way.	Paul V. Carlile, MD	The University of Oklahoma Health Sciences Center
Comments on:	**Program Director**	**Institution**
Pulmonary Critical Care Line Numbers 841-846 **Pulmonary Line Numbers 724-729** **Critical Care Line Numbers 772-778** Requirement Revision (major revisions only): Medical Knowledge *must* ~~*develop*~~ *demonstrate a comprehensive understanding of indications, contraindications, limitations, complications, techniques, and interpretation of results of those diagnostic and therapeutic procedures integral to the discipline, including the appropriate indication for and use of screening tests/procedures.*		
Very jumbled sentence full of big words. Please simplify.	John H. Newman, MD	Vanderbilt Medical Center
Comments on:	**Program Director**	**Institution**
Pulmonary Critical Care Line Numbers 898-900 **Pulmonary Line Numbers** **Critical Care Line Numbers 817-819** Requirement Revision (major revisions only): Medical Knowledge must demonstrate knowledge of the indications, contraindications and complications of placement of percutaneous tracheostomies.		
I note the suggestion for education in percutaneous tracheostomy - I don't necessarily think this is a good thing as it will ultimately require competence and proving and maintaining competence will be difficult because of turf battles with surgeons. The people doing the most are likely to be better at it and I think should probably be surgeons.	Confidential	Confidential
Comments on:	**Program Director**	**Institution**
Pulmonary Critical Care Line Numbers 946-947 **Pulmonary Line Numbers 804-805** **Critical Care Line Numbers 853-854** Requirement Revision (major revisions only): Practice-based Learning & Improvement *apply new contributions to the management and care of their patients.*		
These sentences do not easily betray their intent. Also, the use of the word "outcomes" is best left to patient outcomes. My	John H. Newman, MD	Vanderbilt Medical

Enclosure: APCCMPD Member Comments to the 2011 Pulmonary, Critical Care, and Pulmonary/Critical Care RRC Requirement Revisions

Comments on:	Program Director	Institution
Pulmonary Critical Care Line Numbers 1003-1004 **Pulmonary Line Numbers 861-862** **Critical Care Line Numbers 910-911** Requirement Revision (major revisions only): Professionalism *a commitment to lifelong learning, and an attitude of caring that is derived from humanistic and professional values.*		
I agree with the intent. I am an educator, I learn and publish. How do you instill it and measure it except by example and cultural exposure? By writing it down as a goal, it appears you think it may be enforceable, when it isn't. This should be part of a preamble, listing the goals of a fellowship program, that includes moral and ethical behaviors, professionalism and commitment to lifelong learning. These things can and should be at the center of our professional lives, but cannot be measured except by their absence.	John H. Newman, MD	Vanderbilt Medical Center

Comments on:	Program Director	Institution
Pulmonary Critical Care Line Numbers 1071 **Pulmonary Line Numbers 905** **Critical Care Line Numbers 966** Requirement Revision (major revisions only): *Fellows must have access to training using simulation;*		
I don't see how this wouldn't have an impact on resources. I don't have to have a simulation facility, but I have to have access to one, and that is not going to be free. My example would be that I could offer access to the ACCP's training and simulation facility, but that costs money. I could try and find another institution with a simulation facility, but no one is going me access for free. So, they can mandate access to simulation, but they should not lie to themselves or us and claim that it won't have monetary implications.	Sean Forsythe, MD	Loyola
We have a wonderful simulation center at our institution, but simulation is a poor substitute for the real thing. For instance, the fellows discuss life and death issues in the ICU daily, involve palliative care when helpful, talk to patients and families about decision making. The fellow is observed doing this. How can simulation of the real thing be required when you already do the real thing? Also, simulation centers are VERY expensive and are thus and unfunded mandate. I think this obligation is overstepping.	John H. Newman, MD	Vanderbilt Medical Center
The impact statement says that institutions would not be required to have a simulation facility. If not, then how do fellows get simulation experience? There will be a cost incurred somewhere. Also, this is unproven as a teaching modality. I think that it is a poor use of time and resources.	Paul V. Carlile, MD	The University of Oklahoma Health Sciences Center

Comments on:	Program Director	Institution
Pulmonary Critical Care Line Numbers 1073-1077 **Pulmonary Line Numbers 907-911** **Critical Care Line Numbers 968-972** Requirement Revision (major revisions only): *Fellows must be instructed in the organization and financing of clinical practice, including personnel and business management, scheduling, billing and coding procedures, telephone and telemedicine management, and maintenance of an appropriate confidential patient record system.*		

Please justify this proposed requirement. There are innumerable practice styles and practice organizations. There are small practices, hospital based, hospital affiliated, HMO affiliated, hospitalist, academic, teaching, multi-specialty. When a fellow is recruited into a practice, they learn about the details of that practice by interviews and visiting the practice, and they usually get a lawyer to review the contract. All contracts are different. **The idea that a fellowship program should or even can instruct graduating fellows in this process is naïve and is not appropriate.**	John H. Newman, MD	Vanderbilt Medical Center
Education regarding setting up a practice should be made available to trainees but not required as part of the core curriculum.	Confidential	Confidential
I would restrict this requirement to only those items where the physician is directly involved – billing and coding, and the medical record. The other tasks (personnel and business mgmt, telephone mgmt, scheduling etc) are not done by physicians in private practice	Paul V. Carlile, MD	The University of Oklahoma Health Sciences Center
Comments on:	**Program Director**	**Institution**
Pulmonary Critical Care Line Numbers 1178-1180 **Pulmonary Line Numbers 994-996** **Critical Care Line Numbers 1004-1006** Requirement Revision (major revisions only): *Direct faculty supervision of procedures performed by each fellow must occur until proficiency has been acquired and documented by the program director.*		
Direct faculty supervision of procedures—many procedures are performed at night during call. There is no practical way for them to be supervised.	Confidential	Confidential
Comments on:	**Program Director**	**Institution**
Pulmonary Critical Care Line Numbers 1235-1238 **Pulmonary Line Numbers 1055-1058** **Critical Care Line Numbers 1064-1067** Requirement Revision (major revisions only): *Assessment of procedural competence should not be based solely on a minimum number of procedures performed, but should include a formal evaluation process. These evaluations should include objective performance criteria.*		
All of our major procedures are staffed by faculty on site. If a fellow has problems with a procedure, they get the point- of - service training that they need. What is the point of a formal evaluation process? It just means more paperwork that goes into a file that no one ever sees or uses. Faculty time is too valuable and they are already doing the intended purpose of this requirement. **The tendency to add more and more evaluative process has never been scientifically validated and should be avoided.** Show us the outcome data that proves these evaluations make better doctors.	John H. Newman, MD	Vanderbilt Medical Center
Trying to have it both ways. Is it demonstration of competence or the number of procedures? Some trainees will be competent after 50 procedures whereas others may not be competent after 100. Demonstration of competence seems to me to be the way to go.	Paul V. Carlile, MD	The University of Oklahoma Health Sciences Center
My major comment is that some of the new requirements as	Confidential	Confidential

related to the competencies will result in an increased work on the part of the program director and key clinical faculty but without a clear mandate that this work should be recognized and compensated by the sponsoring institution or practice plan. For example, a formal evaluative process will be needed for procedures		
Comments on:	**Program Director**	**Institution**
Pulmonary Critical Care Line Numbers 1248-1333 **Pulmonary Line Numbers 1068-1154** **Critical Care Line Numbers 1077-1162** Requirement Revision (major revisions only): *Patient Care* *The program must assess the fellow in data gathering, clinical reasoning, patient management and procedures in both the inpatient and outpatient setting. This assessment must involve direct observation of fellow-patient encounters.* *The record of evaluation must include the fellow's logbook or an equivalent method to demonstrate that each fellow has achieved competence in the performance of required procedures.* *Medical Knowledge* *The program must use an objective validated formative assessment method, e.g., in-service training examination or chart stimulated recall. The same formative assessment method must be administered at least twice during the program.* *Practice-based Learning and Improvement* *The program must use performance data to assess the fellow in: application of evidence to patient care, practice improvement, teaching skills involving peers and patients and, scholarship.* *Interpersonal and Communication Skills* *The program must use both direct observation and multi-source evaluation including patients, peers and non-physician team members, to assess fellow performance in: communication with patient and family, teamwork, communication with peers, including transitions in care, and record keeping.* *Professionalism* *The program must use multi-source evaluation including patients, peers, and non-physician team members, to assess each fellow's: honesty and integrity, ability to meet professional responsibilities, ability to maintain appropriate professional relationships with patients and colleagues, and commitment to self-improvement.* *Systems-based Practice* *The program must use multi-source evaluation including peers, and non-physician team members, to assess each fellow's: ability to provide care coordination, including transition of care, ability to work in interdisciplinary teams, advocacy for quality of care, and ability to identify system problems and participate in improvement activities.*		
Medical Knowledge: During a three-year fellowship, our fellows take three tests, the internal medicine boards, the pulmonary boards and the critical care medicine boards. Isn't that enough? Practice-based learning: Does the ACGME have an idea about what data, and how to find it? This is an example of the perceived need to quantify things that are fundamentally qualitative. We evaluate our fellows daily, scrutinize their functionality, discuss their qualities. The requirement to use some quantitative or semi-	John H. Newman, MD	Vanderbilt Medical Center

Medical Knowledge: During a three-year fellowship, our fellows take three tests, the internal medicine boards, the pulmonary boards and the critical care medicine boards. Isn't that enough? Practice-based learning: Does the ACGME have an idea about what data, and how to find it? This is an example of the perceived need to quantify things that are fundamentally qualitative. We evaluate our fellows daily, scrutinize their functionality, discuss their qualities. The requirement to use some quantitative or semi-quantitative scheme will lead to useless, sanitized information. We already use the ABIM evaluations which are highly imperfect but at least cover the spectrum of functions.	John H. Newman, MD	Vanderbilt Medical Center
My major comment is that some of the new requirements as related to the competencies will result in an increased work on the part of the program director and key clinical faculty but without a clear mandate that this work should be recognized and compensated by the sponsoring institution or practice plan. For example, increased parameters to be followed regarding the competencies. As my schedule is presently structured, I would not have time, nor be compensated, for sessions in which I directly observe fellow-patient interactions.	Confidential	Confidential
As mentioned above, our trainees have all had three years of training in Internal Medicine where they learn how to interact with patients. I do not view observation of fellow-patient encounters as a good use of faculty time.	Paul V. Carlile, MD	The University of Oklahoma Health Sciences Center
Comments on:	**Program Director**	**Institution**
Pulmonary Critical Care Line Numbers 390-394 **Critical Care Line Numbers 381-384**		
There is a shortage of Critical Care Intensivists in the USA. The single requirement of 3/5 other fellowships (Pulm, ID, Cards, Nephro, GI) limits many excellent programs such as ours from offering CCM with Pulmonary. This requirement is archaic and reflects a bias to large academic centers as opposed to the much more common community based teaching programs such as where I work. The interaction of fellows across disciplines is negligible and this is a requirement that should be removed with this revision.	James A. Barker, MD FACP, FCCP, FAASM	Palmetto Richland Hospital