May 1, 2015

Jerry Vasilias, PhD
Executive Director
Residency Review Committee (RRC) for Internal Medicine
Accreditation Council for Graduate Medical Education (ACGME)
525 N. State Street, Suite 200
Chicago, IL 60654

Dear RRC Members:

The Association of Pulmonary and Critical Care Medicine Program Directors (APCCMPD) and members of the Critical Care Societies Collaborative (CCSC) task force on Critical Care Educational Pathways in Internal Medicine (IM), has been asked by the ACGME to provide a rationale and justification for modifying the current program requirements for pulmonary/critical care (PCCM) and critical care medicine (CCM) fellowship programs, as well as to propose the specific language to be used for this purpose.

The current ACGME requirement in question reads as follows: "*Located at the primary clinical site, there should be at least three ACGME-accredited subspecialty programs from the following disciplines: in cardiovascular disease, gastroenterology, infectious diseases, nephrology, or pulmonary disease.*" For PCCM programs, this requires two additional programs as the combined pulmonary training serves as one of the three subspecialty programs. We endorse the proposal to modify this requirement and to remove the specific language indicating the requirement for having three additional ACGME accredited fellowship programs at the primary clinical site.

RATIONALE AND JUSTIFICATION

In response to the significant workforce requirements in the area of Critical Care, it is the recommendation of the APCCMPD and the American College of Chest Physicians, the American Thoracic Society, and the Society of Critical Care Medicine that, ***as long as strict educational rigor is maintained***, potential barriers to creating new training programs should be minimized (*Crit Care Med*. 2014 May;42(5):1272-9). We view the requirement to have three additional ACGME-accredited Fellowship Programs at the primary clinical site as one such potential barrier that may discourage establishment of new PCCM and CCM training programs. No similar requirement exists for other IM-based subspecialty fellowship programs.

We are committed to assuring the rigor of the education of our trainees in critical care medicine. We recognize that CCM training is uniquely multidisciplinary. However, we do not believe that training programs in these other subspecialties, as opposed to clinical expertise within these subspecialties in a learning environment, are needed to ensure that educational rigor is maintained. The learning environment is established by the institutional presence of core residency programs in Internal Medicine and Surgery. These programs require institutional infrastructure and resources that are specified in the common and specialty-specific program requirements, reviewed by the CLER process. Faculty in the subspecialty fields needed to educate fellows in CCM will therefore, by design, already be practicing in an 'academic" environment that demands a commitment to education.

We also fully recognize that CCM training and practice require that clinical expertise in a wide variety of fields be immediately available at the primary clinical site. This is essential for both education and patient care. In other subspecialties of Internal Medicine in which expertise in other fields is needed for education and patient care, training program requirements specify the availability of ABIM-certified faculty in these fields to participate in fellow education. Likewise, current program requirements for CCM and PCCM already specify the need for qualified faculty in several other disciplines and relevant medical fields, which will assure availability of broad clinical expertise for teaching and clinical care.

We appreciate that this particular requirement has already been softened from a "must" requirement to language indicating that they "should" be located at the primary site. In a recent communication with Jerry Vasilias, PhD, ACGME Executive Director, RC for Internal Medicine, we were informed that "*… the RC-IM would like the stakeholder groups to know that, in general, noncompliance with only this particular requirement has not led to an adverse action. In fact, the RC has accredited four CCM programs that did not meet the aforementioned requirement. A citation was given because the requirement had not been met and because an acceptable alternative to the requirement (which is allowable with a "should" requirement such as this one) had not been provided or demonstrated. It is also worth noting that this particular requirement was categorized as a "detail" in NAS. This designation allows established programs in good standing the flexibility to innovate and [not] demonstrate compliance with the requirement.*"

We applaud this evolution. However, the current wording is potentially confusing, and individuals considering the creation of a new PCCM or CCM fellowship program may not grasp the intended distinction between "should" and "must" or between "sponsor" and "located at." While these issues could probably be addressed through a FAQ, in our view a less ambiguous approach is to simply create new language which clearly indicates what the actual intended requirement(s) is (are). This will avoid inadvertently discouraging institutions that may be considering establishing these fellowships.

Finally, in the summer of 2014, the APCCMPD conducted a poll of all PCCM and CCM program directors, and the majority response (58% and 71%, respectively) was in favor of removing this requirement. However, the response rate was only 48% from CCM fellowships and 47% from PCCM programs. To improve the response rate, the poll was repeated in December 2014, and the response rate this time was 65% for PCCM Program Directors and 70% for CCM Program Directors. Among PCCM training programs, 57% were in favor of removing this requirement, 9% responded "I don't know", and 35% were NOT in favor. Among CCM programs, 61% were in favor of removing this requirement, 17% responded, "I don't know", 22% were NOT in favor. Thus, overall, 33% of PCCM program directors and 22% of CCM program directors expressed disagreement with the proposed change.

PROPOSED LANGUAGE

It is our recommendation that the language pertaining to the requirements for the sponsoring institution of PCCM and CCM fellowship programs be similar to the one used for other fellowship programs in Internal Medicine, such as Gastroenterology, Hematology, Infectious Diseases, and Endocrinology.

IA Sponsoring Institution

The establishment of a PCCM or CCM fellowship program must occur within a department or an administrative unit whose primary mission is the advancement of internal medicine subspecialty education and patient care. The primary clinical site of a PCCM or CCM fellowship must have or participate in ACGME-accredited residency training programs in Internal Medicine and General Surgery.

In our view, the need for broad clinical expertise to ensure academic rigor in the teaching of Critical Care, as well as to maintain the highest standards of patient care, is already adequately addressed in the requirements for PCCM and CCM Fellowships as currently written. Specifically, the needed Program Personnel and Resources are defined clearly and in detail in section II, mainly (but not exclusively) in sections IIB8, IIB9, IIC, IIC1, and IIC2. We do not believe that substantial changes in the language of these sections are necessary.

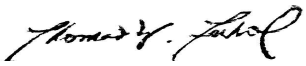
We thank the ACGME for their consideration of these changes, and for seeking our input.

Sincerely,

Rolando Berger, MD
President, Association of Pulmonary and Critical Care Medicine Program Directors

Kristin M. Burkart, MD, MSc
President-Elect, Association of Pulmonary and Critical Care Medicine Program Directors

Curtis N. Sessler, MD, FCCP
President, American College of Chest Physicians

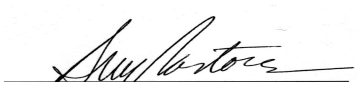


Thomas W. Ferkol, MD
President, American Thoracic Society

Craig M. Coopersmith, MD, FCCM
President, Society of Critical Care Medicine

Henry E. Fessler, MD
Taskforce Member, Association of Pulmonary and Critical Care Medicine

Program Directors



Stephen M. Pastores, MD
Taskforce Member, Association of Pulmonary and Critical Care Medicine Program Directors