February 26, 2023

Jerry Vasilias, PhD
Executive Director
Review Committee for Internal Medicine
Accreditation Council for Graduate Medical Education
Suite 2000
401 North Michigan Avenue
Chicago, IL 60611

Dear Dr. Vasilias,

On behalf of the Association of Pulmonary and Critical Care Medicine Program Directors (APCCMPD); Association of Program Directors in Endocrinology, Diabetes, and Metabolism (APDEM); American Gastroenterological Association (AGA); American College of Rheumatology (ACR); Infectious Diseases Society of America (IDSA); and the American Society of Clinical Oncology (ASCO) we are writing in response to the recently proposed major revisions to the Program Requirements in Graduate Medical Education for the Internal Medicine Subspecialties.

We represent Program Directors in Pulmonary Disease; Critical Care Medicine; Pulmonary and Critical Care Medicine; Endocrinology; Infectious Disease; Rheumatology; Gastroenterology; Hematology and Medical Oncology; and Medical Oncology representing 1,135 Accreditation Council on Graduate Medical Education (ACGME) Accredited Programs and 8,500+ trainees.

The administration of postgraduate medical education programs has become more and more time-consuming as accreditation standards have (rightly) standardized expectations and medical education knowledge has improved.

Our subspecialty fellowship programs are responsible for providing necessary faculty expertise to address the needs of trainees within our program, including meeting the subspecialty program requirements and milestones. Fundamentally, many core faculty within subspecialty fellowship programs are not from the core IM program or are not shared across the institution. Fellowship training continues to have increasing complexity as we move toward personalized education plans for each learner, which requires additional coaching and mentoring in addition to new areas of expertise such as data management, population health, quality improvement, patient safety, etc., that are hard to for each subspecialty training program to provide efficiently. It is particularly burdensome for smaller programs, which have the exact requirements to train their fellows as larger programs, without the ability to leverage the infrastructure and resources that larger institutions provide.

As the representatives of program directors in our subspecialties, we collectively provide comments on the proposed major revisions to the Program Requirements in Graduate Medical Education for the Internal Medicine Subspecialties intended for all of our subspecialties. Individually, as subspecialties, we will provide feedback relevant to our specific subspecialties.

To that end, we respectfully provide feedback for the following requirements:

**PCCM Requirement #: I.B.5.**
**CCM Requirement #: I.B.5**.
**Pulmonary Requirement #: I.B.5**.
**Endocrinology Requirement #: I.B.5**
**Gastroenterology Requirement #: I.B.5**
**Rheumatology Requirement #: I.B.5**
**Infectious Disease Requirement #: I.B.5**
**Hematology and Medical Oncology Requirement #: I.B.5**
**Medical Oncology Requirement #: I.B.5**

**The program should ensure that fellows are not unduly burdened by required rotations at geographically distant sites.** (Core)

We recommend clarifying the intent of this requirement. We appreciate the intention of reducing the burden on fellows by limiting extended travel. The background and intent discuss using two measurements to determine extended travel 1) time over 60 minutes each way or 2) greater than 60 miles. The use of time is an inconsistent measurement across programs and locations. For example, travel time depends on many variables, including traffic patterns, time of day, seasonal conditions, etc.

It also needs to be clarified if providing travel and housing reimbursement is required and would allow for rotations at distant sites. As such, we recommend strengthening the requirement to reimburse fellows for travel and housing if a fellow has to travel and reside at a remote location from their program for a required (not elective) experience.

**PCCM Requirement #: II.B.1.a)**
**CCM Requirement #: II.B.1.a)**
**Pulmonary Requirement #: II.B.1.a)**
**Endocrinology Requirement #: II. B.1.a)**
**Gastroenterology Requirement #: II. B.1.a)**
**Rheumatology Requirement #: II. B.1.a)**
**Infectious Disease Requirement #: II. B.1.a)**
**Hematology and Medical Oncology Requirement #: II. B.1.a)**
**Medical Oncology Requirement #: II. B.1.a)**

**There must be faculty members with expertise in the analysis and interpretation of practice data, data management science, clinical decision support systems, and managing emerging health issues.** (Core)

In many smaller programs, and non-academic settings, it is not feasible to have faculty members with expertise in the analysis and interpretation of practice data, data management science, clinical decision support systems, and managing emerging health issues. Many of our subspecialties will only be able to meet this requirement, with the core IM residency program being required to provide this type of faculty expertise to the subspecialty training programs.

We request flexibility be afforded to the subspeciality fellowship programs to provide training in these areas by allowing the subspecialty fellowship program discretion of how the training is implemented.

As such, we recommend revising this requirement to state that… "*the program must implement a curriculum that teaches trainees how to analyze and interpret practice data, data management science, clinical decision support systems, and management of emerging health issues.* (Core)"

**PCCM Program Requirement #: II A.2.b) and II.B.4.b) and II.B.4.e)**
**CCM Requirement #: II A.2.b) and II.B.4.b) and II.B.4.d)**
**Pulmonary Requirement #: II A.2.b) and II.B.4.b) and II.B.4.d)**
**Endocrinology Program Requirement #: II A.2.b) and II.B.4.b) and II.b.4.d)**
**Gastroenterology Requirement #: II A.2.b) and II.B.4.b) and II.B.4.f)**
**Rheumatology Requirement #: II A.2.b) and II.B.4.b) and II.B.4.d)**
**Infectious Disease Requirement #: II A.2.b) and II.B.4.b) and II.B.4.d)**
**Hematology and Medical Oncology Requirement #: II A.2.b) and II.B.4.b) and II.B.4.e)**
**Medical Oncology Requirement #: II A.2.b) and II.B.4.b) and II.B.4.d)**

We applaud the ACGME and the Review Committee for Internal Medicine for recognizing the value of allowing Fellowship Programs the flexibility and discretion to allocate the minimum aggregated support among their core faculty members.

With this said, the unintended consequence of the revised requirement for core faculty support is its impact on the smaller subspecialty fellowship program's ability to support an associate program director.

Per the July 2022 ACGME Program Requirements for Graduate Medical Education in the IM Subspecialties, *"Programs must appoint at least one of the subspecialty-certified core faculty members to be associate program director(s) (APD)…".* We support this requirement, as it is essential for the stability of the subspecialty fellowship program to have an APD in place. Although, without adequate support, it is difficult for programs to recruit core faculty for the APD role. This is a particular burden to smaller programs with no dedicated support for an APD and now minimal aggregated core faculty support.

Furthermore, many of the revised requirements that require fellowship programs to provide individualized educational experiences for fellows and to ensure fellows can demonstrate the management of patients in various healthcare settings, using telemedicine and with population-based data will require faculty to plan, teach, supervise, and coach fellows in this training. Many of these new requirements will likely not generate faculty RVUs. As such, additional protected time, rather than less protected time, will be necessary for faculty to meet these requirements.

We propose using a clear and concise formula for all programs to implement. APD support for programs with less than 24 fellows is 50% of the program director's (PD) support, and the aggregated core faculty support is equal to that of the PD. As such, we request that APD support be required for subspeciality fellowship programs of all sizes and that the core faculty support be marginally increased. We have illustrated this proposed formula in the table below.

The FTEs outlined in the table should be considered as minimum requirements, and institutions are strongly encouraged to provide additional FTE in consideration of training program complexity, the need for a program to develop new curricular and training elements, as well as specialty-specific issues (such as the burden of recruitment). IDSA supports a higher minimum FTE as outlined in feedback submitted directly by IDSA.

| Number of Approved Fellow Positions | Minimum Support Required (FTE) for the **Program Director** | Minimum Aggregate Support Required (FTE) for the **Associate Program Director(s)** | Minimum Aggregate Support Required (FTE) for **Core Faculty** |
|---|---|---|---|
| <7 | .2 | ~~0~~ .1 | ~~.10~~ .2 |
| 7-9 | .25 | .13 | ~~.15~~ .25 |
| 10-12 | .3 | ~~.14~~ .15 | ~~.15~~ .3 |
| 13-15 | .35 | ~~.15~~ .18 | ~~.20~~ .35 |
| 16-18 | .4 | ~~.16~~ .2 | ~~.20~~ .4 |
| 19-21 | .45 | ~~.17~~ .23 | ~~.25~~ .45 |
| 22-24 | .5 | ~~.18~~ .25 | ~~.25~~ .5 |
| 25-27 | .5 | .25 | ~~.30~~ .5 |
| 28-30 | .5 | .30 | .5 |
| 31-33 | .5 | .36 | .5 |
| 34-36 | .5 | .42 | .5 |
| 37-39 | .5 | .48 | .5 |

**PCCM Requirement #: IV.B.1.b).(1).(b).(i)**
**CCM Requirement #: IV.B.1.b).(1).(b).(i)**
**Pulmonary Requirement #: IV.B.1.b).(1).(b).(i)**
**Endocrinology Requirement: IV.B.1.b).(1)(b)(i)**
**Gastroenterology Requirement #: IV.B.1.b).(1).(b).(i)**
**Rheumatology Requirement #: IV.B.1.b).(1).(b).(i)**
**Infectious Disease Requirement #: IV.B.1.b).(1).(b).(i)**
**Hematology and Medical Oncology Requirement #: IV.B.1.b).(1).(b).(i)**
**Medical Oncology Requirement #: IV.B.1.b).(1).(b).(i)**

**[Fellows must demonstrate the ability to manage the care of patients:] in a variety of health care settings, including inpatient and various ambulatory settings; (Core)**

We appreciate the intention of this requirement to ensure our trainees are adequately trained to provide care in settings that serve under-resourced populations; however, this requirement is difficult to implement across all the IM subspecialties. While it is feasible and necessary for infectious disease programs to teach fellows to manage patients in various healthcare settings, providing Critical Care in a pop-up health clinic or on a mobile bus would not be feasible. Furthermore, as written, this requirement requires additional faculty to train and supervise fellows in non-traditional settings.

We recommend rephrasing this requirement to state that the program must implement a curriculum that teaches trainees to manage the care for under-resourced populations, in healthcare settings appropriate for the delivery of care within the subspecialty, without prescribing the setting.

**PCCM Requirement #: IV.B.1.c).(3)**
**CCM Requirement #: IV.B.1.c).(3).(a)**
**Pulmonary Requirement #: IV.B.1.c).(3)**
**Endocrinology Requirement #: IV.B.1.c).(3).(a)**
**Gastroenterology Requirement #: IV.B.1.c).(3).(a)**
**Rheumatology Requirement #: IV.B.1.c).(3).(a)**
**Infectious Disease Requirement #: IV.B.1.c).(3).(a)**
**Hematology and Medical Oncology Requirement #: IV.B.1.c).(3).(a)**
**Medical Oncology Requirement #: IV.B.1.c).(3)**

**Fellows must demonstrate sufficient knowledge in the clinical context, including evolving techniques. (Core)**

We applaud the ACGME and the Review Committee for Internal Medicine for developing requirements that ensure our trainees have access to emerging technologies. However, without clarity around what specific evolving technologies our subspecialty trainees should demonstrate knowledge of is challenging to understand how subspecialty

programs would be accountable for evaluating fellow knowledge. Furthermore, emerging technologies only sometimes become the standard of care or withstand the test of time. Those technologies may not be appropriate for use outside tertiary care referral centers in the community.

We recommend, at this time, modifying this requirement to be labeled as a (Detail) requirement rather than a (Core) requirement.

Our intention with this letter, as the representatives of Program Directors in our subspecialties, is to collectively recognize the ACGME's effort toward greater fellowship program support and to clarify the impact of the revised requirements on our subspecialty fellowship programs. As individual subspecialties, we will provide comments on our respective subspecialty program requirements that represent the nuances of our unique subspecialty needs. These comments will be made using the ACGME online subspecialty program requirements comment form.

Thank you to the ACGME for recognizing what it takes to do what we do and what it will take to reach the goals of Internal Medicine 2035 (and beyond). This lays a framework for all our programs to move our specialties forward together.

Sincerely,

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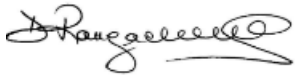

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