Association
of Pulmonary and
Critical Care Medicine
Program Directors

April 30, 2026

American Board of Internal Medicine
Pulmonary Disease and Critical Care Medicine Boards
510 Walnut Street, Suite 1700
Philadelphia, PA 19106

Re: Comments on Proposed Procedural Competency Requirements for Board Eligibility in Pulmonary Disease and Critical Care Medicine

Dear Members of the ABIM Pulmonary Disease and Critical Care Medicine Boards:

The Association of Pulmonary and Critical Care Medicine Program Directors (APCCMPD) respectfully submits the following comments in response to the ABIM's proposed procedural competency requirements for Board Eligibility in Pulmonary Disease (PD) and Critical Care Medicine (CCM). APCCMPD represents the program directors of 98% of all ACGME-accredited Pulmonary Disease, Pulmonary and Critical Care Medicine (PCCM), and Critical Care Medicine fellowship programs in the United States. As the organization whose members are directly responsible for designing, delivering, and evaluating the procedural training described in these proposed requirements, APCCMPD is uniquely positioned to provide substantive feedback on the clinical relevance, educational soundness, and programmatic feasibility of the training.

After careful review, APCCMPD has identified two primary concerns with the proposed requirements: (1) a fundamental structural concern regarding the alignment between ABIM's proposed competency framework and the existing requirements of the Accreditation Council for Graduate Medical Education (ACGME) and (2) the operational definition of "Opportunity to Train" (OTT).

Alignment with ACGME Program Requirements

The concept of OTT sounds like a program requirement that falls within the ACGME's purview rather than certification board eligibility criteria. The fundamental structural concern that goes beyond framework terminology that ACGME and ABIM are fundamentally regulating different aspects of fellowship training, and ABIM's proposed framework does not adequately reflect that distinction. Our understanding is that ACGME's purview is to regulate fellowship program requirements. The purview of ABIM is to determine individual board eligibility. Conflating these two regulatory purposes creates interpretive confusion that will fall entirely on program directors to resolve

The ACGME sets minimum training requirements that programs apply uniformly to all fellows. ACGME's accreditation standards function as a floor—a set of competencies that every program must provide to every fellow. When ACGME requires that fellows "demonstrate competence" in a procedural skill, that requirement is universal and non-negotiable. It does not allow for variation based on institutional resources, program size, or fellow career trajectory. All programs must meet the standard for all fellows, or program accreditation is at risk.

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ABIM's proposed use of the OTT mixes programmatic requirements with individual board eligibility. It is difficult to understand how an individual trainee could certify that they have had the opportunity to train when the decision remains in the control of the fellowship program, which is governed by ACGME program requirements.
Additionally, the current framing of OTT implies a conditional competency structure. For example, fellows who choose to train must achieve competency. But fellows who choose not to train or are part of a program who cannot support the procedure are held to a different standard.

> *APCCMPD Position: APCCMPD strongly recommends that ABIM initiate a formal coordination process with ACGME to ensure that the two organizations' frameworks are explicitly reconciled and that jointly issued guidance is applied consistently by program directors. Finalizing ABIM's requirements without this clarification would leave a structural gap that programs are ill-equipped to navigate on their own.*

Defining OTT

If ABIM proceeds with OTT, it needs to clarify the definition of OTT at a minimum. This was a recurring concern noted among our members, warranting dedicated attention. Multiple program directors across several procedures—including EBUS, PA catheter placement, percutaneous tracheostomy, and CRRT—expressed uncertainty about what the OTT standard obligates programs to do when a fellow requests training that the program cannot provide internally. Specifically, it is unclear whether programs would be required to arrange external rotations or inter-institutional agreements to fulfill an OTT requirement.

This ambiguity carries significant implications for program planning, resource allocation, and accreditation. If OTT is interpreted as a binding obligation to provide training on request—regardless of local capacity—many programs, particularly those at community hospitals or smaller academic centers, may find themselves unable to comply. If, instead, OTT is interpreted as a best-effort expectation contingent on institutional resources, that should be stated explicitly.

> *APCCMPD Position: APCCMPD strongly urges the ABIM to publish a clear, operationally precise definition of the "Opportunity to Train" standard. We recommend incorporating the following language: "If procedural expertise exists within the program, the program must provide a training opportunity to any fellow who requests it, with the goal of enabling independent performance. If such expertise does not exist within the program, the program must ensure that all fellows achieve a knowledge-level understanding of the procedure, and may facilitate access to external training opportunities as institutional resources allow."*

APCCMPD Survey Methodology

To ensure that this letter reflects the collective judgment of our membership, APCCMPD surveyed program directors across all three disciplines prior to submitting these comments. The survey was distributed to 308 program directors in Pulmonary, PCCM, and CCM programs. A total of 38 program directors responded (response rate: 12.3%), all of whom completed the survey in its entirety (100% completion rate). Respondents evaluated each of the 32 proposed procedures and provided individual written comments. The quantitative vote tallies and thematic findings emerging from those comments form the basis of the positions presented in this letter.

Specific Program Requirements

A. Bronchoscopy

1. Diagnostic Bronchoscopy with Bronchoalveolar Lavage (BAL)
PD Board Recommendation: Perform Competently (no change) | Support: 100%
CCM Board Recommendation: Perform Competently (no change) | Support: 100%

Our membership is in unanimous agreement with the proposed standard for both boards. Diagnostic bronchoscopy with BAL is a foundational procedural skill for both pulmonary and critical care physicians, and the "Perform Competently" designation appropriately reflects its central role in clinical practice.

> *APCCMPD Position: APCCMPD fully supports the proposed standard for both boards.*

2. Bronchoscopy with Endobronchial Ultrasound (EBUS)
PD Board Recommendation: Knowledge Standard + Opportunity to Train | Support: 92%
CCM Board Recommendation: Do Not Require | Support: 89%

APCCMPD supports the proposed designation of EBUS as an "opportunity to train" procedure for Pulmonary Disease fellows. This approach is consistent with our longstanding position—affirmed through a joint position paper with ATS, CHEST, AIPPD, AABIP[1]—that EBUS training should be accessible to fellows in general pulmonary and critical care medicine programs, independent of interventional pulmonology fellowship affiliation. We are encouraged that the proposed framework seeks to extend that access without imposing a universal competency mandate that many programs would be unable to fulfill.
EBUS is also the procedure that most clearly illustrates the "some/not all" principle we describe in Section II. The appropriate goal for EBUS is not that every PD fellow graduates independently competent—that is neither feasible nor necessary across the full range of programs. Rather, the appropriate goal is that:

> **Programs with EBUS-qualified faculty** have the authority and obligation to train interested fellows to independent competency and to certify those graduates accordingly. These programs can and should produce independently competent EBUS practitioners. This is a scope-of-practice question: PCCM-trained physicians should retain the ability to achieve EBUS certification through fellowship, without being required to complete a separate interventional pulmonology fellowship.
>
> **Programs without EBUS-qualified faculty** fulfill their OTT obligation by ensuring all fellows achieve a knowledge-level understanding of EBUS—its indications, yield, limitations, and complications—and by facilitating access to external training opportunities where institutional resources allow. These programs are not obligated to produce independent graduates, and should not be penalized for failing to do so.

This distinction matters precisely because the current framing of OTT risks collapsing independence into the standard by implication. If OTT is understood to mean "train toward independence on request," it becomes a conditional competency mandate that smaller programs cannot meet. If instead it is understood as "train toward knowledge, with independence possible where resources permit," it correctly reflects a "some fellows, some programs" model rather than an ACGME-style universal floor. Both outcomes at graduation—independent EBUS competency and a sound knowledge foundation—should be explicitly recognized as consistent with program compliance under this standard.

The CCM Board's recommendation that EBUS be designated "Do Not Require" is also supported by our membership, consistent with the recognition that EBUS is fundamentally a pulmonary procedural skill and that critical care trainees focus their procedural development elsewhere.

> *APCCMPD Position: APCCMPD supports both board recommendations as proposed. ABIM should explicitly clarify that the OTT standard for EBUS permits—but does not require—programs to certify graduates as independently competent, depending on available institutional resources. Programs are encouraged to actively offer EBUS training to PD fellows who identify procedural bronchoscopy as a career goal.*

3. Bronchoscopy with Transbronchial Biopsies
PD Board Recommendation: Perform Competently (no change) | Support: 89%
CCM Board Recommendation: Do Not Require | Support: 92%

Our membership broadly supports both recommendations. The continued "Perform Competently" designation for PD is appropriate given the ongoing clinical utility of transbronchial biopsy. However, a notable minority of program directors raised concern that rapid adoption of robotic-assisted bronchoscopy is shifting procedural volume away from conventional transbronchial biopsy techniques, resulting in reduced training exposure in some programs. As this technology continues to evolve, the competency standard for transbronchial biopsy may require revisiting.

> *APCCMPD Position: APCCMPD supports both board recommendations and strongly encourages the ABIM to monitor trends in advanced bronchoscopic technology adoption—including robotic-assisted bronchoscopy—and to revisit this standard in a timely manner.*

4. Advanced Airway Procedures (e.g., Stent Placement, Endobronchial Therapeutic Procedures)

PD Board Recommendation: Knowledge Standard | Support: 97%
CCM Board Recommendation: Do Not Require | Support: 89%

The "Knowledge Standard" designation for PD reflects the reality that advanced airway procedures are the domain of interventional pulmonology and require training beyond the scope of standard fellowship. Our membership supports this recommendation. For CCM, a minority of respondents believed that a Knowledge Standard—rather than "Do Not Require"—would better ensure that critical care physicians are aware of the indications, limitations, and complications of these procedures, particularly when managing patients who have undergone them.

> *APCCMPD Position: APCCMPD supports the PD Board recommendation. For the CCM Board, we recommend consideration of a Knowledge Standard rather than "Do Not Require," given the clinical frequency with which critical care physicians manage patients with endobronchial stents or who have undergone therapeutic airway procedures.*

B. Pulmonary Function and Cardiopulmonary Exercise Testing

5. Supervision of Technical Aspects of Pulmonary Function Testing (PFT)
PD Board Recommendation: Perform Competently (no change) | Support: 94%
CCM Board Recommendation: Do Not Require (no change) | Support: 97%

There is strong support for both board recommendations. A small number of PD program directors expressed a preference for "Opportunity to Train" rather than "Perform Competently" for PFT supervision, citing variability in how directly pulmonologists interact with technical execution across different practice settings. Nevertheless, the majority view supports maintaining the existing standard.

> *APCCMPD Position: APCCMPD supports both board recommendations as proposed.*

6. Interpretation of Pulmonary Function Testing Results
PD Board Recommendation: Perform Competently (no change) | Support: 97%
CCM Board Recommendation: Knowledge Standard | Support: 92%

Our membership strongly supports both recommendations. Interpretation of PFTs is a core cognitive skill for pulmonary physicians, and the "Perform Competently" standard is well justified. The "Knowledge Standard" for CCM fellows appropriately acknowledges that critical care physicians should be conversant with PFT results in managing patients with chronic lung disease, without requiring independent interpretive competency.

> *APCCMPD Position: APCCMPD fully supports both board recommendations.*

7. Supervision of Technical Aspects of Cardiopulmonary Exercise Testing (CPET)
PD Board Recommendation: Perform Competently (no change) | Support: 89%
CCM Board Recommendation: Do Not Require (no change) | Support: 92%

This procedure generated among the lower support rates for PD in our survey. A meaningful number of program directors questioned whether supervision of CPET should continue to be required for all PD fellows, noting that CPET is a highly specialized test performed in a subset of programs, that many pulmonologists in general practice never supervise CPET independently, and that the infrastructure required to train fellows to competency in CPET supervision is not uniformly available across training programs. Multiple respondents advocated for downgrading this requirement to "Knowledge Standard" or "Opportunity to Train."

> *APCCMPD Position: APCCMPD recommends that the PD Board reconsider the "Perform Competently" standard for CPET supervision, and instead adopt a "Knowledge Standard + Opportunity to Train" designation to reflect the specialized nature of this skill and the significant variability in program resources.*

8. Interpretation of Cardiopulmonary Exercise Testing Results
PD Board Recommendation: Perform Competently (no change) | Support: 89%
CCM Board Recommendation: Do Not Require (no change) | Support: 92%

Similar concerns were raised about CPET interpretation for PD fellows. While some respondents acknowledged the value of CPET interpretation in managing complex pulmonary and cardiopulmonary conditions, others argued that this represents a niche skill that most general pulmonologists will rarely use independently. Multiple program directors recommended a Knowledge Standard as more appropriate and uniformly attainable. The CCM "Do Not Require" designation received broad support.

> *APCCMPD Position: APCCMPD recommends that the PD Board consider downgrading CPET interpretation to "Knowledge Standard," thereby ensuring all fellows understand the test's role and limitations without imposing a competency requirement that many programs cannot reliably fulfill.*

C. Cardiac Procedures

9. Pericardiocentesis
PD Board Recommendation: Knowledge Standard | Support: 92%
CCM Board Recommendation: Knowledge Standard | Support: 95%

Our membership broadly supports the "Knowledge Standard" designation for both boards. A minority of program directors advocated for an "Opportunity to Train" designation, noting that critical care physicians increasingly manage patients with malignant pericardial effusions and that fellowship exposure to pericardiocentesis can be clinically valuable.

> *APCCMPD Position: APCCMPD supports the proposed Knowledge Standard for both boards. We encourage the ABIM to consider whether "Knowledge Standard + Opportunity to Train" would be appropriate for CCM fellows at programs with sufficient patient volume and multidisciplinary support.*

10. Temporary Transvenous Pacemaker Insertion
PD Board Recommendation: Knowledge Standard | Support: 89%
CCM Board Recommendation: Knowledge Standard | Support: 92%

Support for the Knowledge Standard is solid across both boards. However, a subset of our members—particularly those at mixed medical-surgical or cardiac ICUs—felt that this procedure warrants at least an "Opportunity to Train" designation for CCM fellows, given the frequency with which critical care physicians encounter patients requiring temporary pacing and the practical value of being able to perform or supervise this procedure independently.

> *APCCMPD Position: APCCMPD supports the proposed Knowledge Standard for both boards. We encourage the ABIM to consider an "Opportunity to Train" designation for CCM fellows at programs where procedural volume and institutional partnerships with cardiology support meaningful training opportunities.*

D. Pleural Procedures

11. Thoracentesis
PD Board Recommendation: Perform Competently (no change) | Support: 97%
CCM Board Recommendation: Perform Competently (no change) | Support: 100%

There is near-unanimous agreement with the proposed standard for both boards. Thoracentesis is a core procedural skill in both pulmonary and critical care medicine, and the "Perform Competently" designation is fully appropriate.

> *APCCMPD Position: APCCMPD fully supports both board recommendations.*

12 & 13. Chest Tube Placement and Management
PD Board Recommendation: Perform Competently (no change) | Support: 97%

CCM Board Recommendation: Perform Competently (no change) | Support: 100%
Chest tube placement and management received near-unanimous support across both boards. These procedures are fundamental to the scope of practice of pulmonary and critical care physicians, and the "Perform Competently" standard is strongly endorsed by our membership.

> *APCCMPD Position: APCCMPD fully supports both board recommendations.*

14. Advanced Pleural Procedures: Tunneled Pleural Catheter
PD Board Recommendation: Knowledge Standard + Opportunity to Train | Support: 97%
CCM Board Recommendation: Knowledge Standard | Support: 97%

Our membership strongly endorses both recommendations. The "Knowledge Standard + Opportunity to Train" designation for PD appropriately recognizes the growing role of tunneled pleural catheters in the management of recurrent pleural effusions, while acknowledging that not all programs have sufficient volume to require competency for all fellows. The expectation that programs must train fellows to competency upon request is a reasonable and important commitment. The Knowledge Standard for CCM is also appropriate.

> *APCCMPD Position: APCCMPD fully supports both board recommendations.*

15. Advanced Pleural Procedures: Pleurodesis
PD Board Recommendation: Knowledge Standard + Opportunity to Train | Support: 92%
CCM Board Recommendation: Knowledge Standard | Support: 95%

Our membership supports both recommendations. Pleurodesis, like tunneled pleural catheter placement, is an important skill for pulmonologists managing malignant and recurrent pleural disease. The OTT framework appropriately balances clinical relevance with programmatic feasibility.

> *APCCMPD Position: APCCMPD fully supports both board recommendations.*

16. Advanced Pleural Procedures: Pleuroscopy
PD Board Recommendation: Knowledge Standard | Support: 95%
CCM Board Recommendation: Knowledge Standard | Support: 89%

Strong support exists for the Knowledge Standard for PD. Support for CCM was somewhat lower, with a minority of program directors questioning the clinical relevance of pleuroscopy knowledge for critical care physicians, who rarely encounter or manage this procedure independently. Nonetheless, a basic understanding of pleuroscopy—its indications, yield, and complications—is a reasonable expectation for both specialties.

> *APCCMPD Position: APCCMPD supports both board recommendations.*

E. Vascular Access

17. Arterial Blood Gas Sampling
PD Board Recommendation: Perform Competently (no change) | Support: 97%
CCM Board Recommendation: Perform Competently (no change) | Support: 100%

Arterial blood gas sampling is a fundamental procedural skill with near-unanimous support across both boards. No concerns were raised by our membership.

> *APCCMPD Position: APCCMPD fully supports both board recommendations.*

18. Arterial Catheter Placement
PD Board Recommendation: Perform Competently (no change) | Support: 92%
CCM Board Recommendation: Perform Competently (no change) | Support: 100%

Strong support exists for the "Perform Competently" designation across both boards. Arterial catheter placement is a core procedural skill required in the management of critically ill patients and in the monitoring of patients undergoing complex pulmonary procedures.

> *APCCMPD Position: APCCMPD fully supports both board recommendations.*

19. Central Venous Catheter (CVC) Placement
PD Board Recommendation: Knowledge Standard + Opportunity to Train | Support: 79%
CCM Board Recommendation: Perform Competently (no change) | Support: 100%

The proposed downgrade of CVC placement for Pulmonary Disease fellows to "Knowledge Standard + Opportunity to Train" received the lowest level of support of any PD recommendation in our survey, with 79% agreement and seven respondents actively opposing the change. Our membership expressed significant concern that this proposal creates an internal inconsistency in the PD Board's own framework: arterial catheter placement—a procedure generally considered less complex than CVC placement—would remain at "Perform Competently," while CVC placement would be downgraded. This

is difficult to justify educationally or clinically. PCCM fellows in particular are expected to function in ICU environments upon completion of training, and CVC placement is a foundational skill in that setting.

> *APCCMPD Position: APCCMPD strongly recommends that the PD Board retain "Perform Competently" as the standard for CVC placement. This is consistent with the CCM Board's recommendation and reflects the clinical realities of pulmonary and critical care practice.*

20. Bedside Pulmonary Artery (PA) Catheter Placement
PD Board Recommendation: Knowledge Standard + Opportunity to Train | Support: 87%
CCM Board Recommendation: Knowledge Standard + Opportunity to Train | Support: 89%

The OTT designation for both boards received majority support, though a meaningful minority of respondents felt that PA catheter placement should remain "Perform Competently." These respondents noted that outside of large academic medical centers, critical care physicians frequently work in mixed ICUs that include cardiac and heart failure patients in whom PA catheter placement remains a relevant clinical tool. Others raised practical concerns about whether the OTT standard can be reliably fulfilled given declining procedural volume and the need for cooperation from other services—particularly interventional cardiology—to facilitate training.

> *APCCMPD Position: APCCMPD supports the "Knowledge Standard + Opportunity to Train" designation for both boards, and encourages the ABIM to provide clear guidance on how programs should document fulfillment of the OTT standard in settings where PA catheter volume is low.*

21. Non-tunneled Vascular Access for Temporary Dialysis
PD Board Recommendation: Knowledge Standard | Support: 84%
CCM Board Recommendation: Perform Competently (no change) | Support: 100%

While the CCM recommendation received unanimous support, the PD recommendation generated the second-lowest level of support for any PD procedure. Multiple program directors advocated for a higher standard—either "Perform Competently" or at minimum "Knowledge Standard + Opportunity to Train"—for Pulmonary Disease fellows, particularly those in combined PCCM programs where fellows are expected to manage critically ill patients requiring renal replacement therapy. The argument that PCCM fellows who place CVCs should also be capable of placing dialysis access lines was raised repeatedly.

> *APCCMPD Position: APCCMPD supports the CCM recommendation and recommends that the PD Board consider elevating its standard to at minimum "Knowledge Standard + Opportunity to Train" for non-tunneled dialysis access, particularly for PCCM program fellows.*

F. Point-of-Care Ultrasound (POCUS)
22. POCUS for Diagnosis
PD Board Recommendation: Perform Competently (pleural/parenchymal lung disease) | Support: 95%
CCM Board Recommendation: Perform Competently (shock, respiratory failure, DVT, cardiac) | Support: 100%

Our membership strongly endorses both POCUS recommendations, which reflect the substantial and ongoing expansion of POCUS into both pulmonary and critical care clinical practice. Prior APCCMPD survey data confirms that the vast majority of fellowship programs have already developed POCUS curricula and possess the faculty expertise and equipment to train fellows to competency. A minority of PD respondents advocated for a broader scope of diagnostic POCUS for pulmonary fellows—extending beyond pleural and parenchymal disease to include cardiac and vascular applications—on the basis that these competencies increasingly inform pulmonary clinical decision-making.

> *APCCMPD Position: APCCMPD fully supports both board recommendations. We encourage the ABIM to consider whether the scope of PD diagnostic POCUS should be expanded to include focused cardiac and vascular assessment, consistent with the broader competencies now standard in CCM training.*

23. POCUS for Procedural Guidance
PD Board Recommendation: Perform Competently (pleural procedures) | Support: 97%
CCM Board Recommendation: Perform Competently (vascular access, pleural drainage, paracentesis) | Support: 100%

There is near-unanimous agreement with both recommendations. Real-time ultrasound guidance has become the standard of care for thoracentesis, chest tube placement, and central venous catheter insertion, and the requirement that fellows train to competency in its use is strongly endorsed by our membership.

> *APCCMPD Position: APCCMPD fully supports both board recommendations.*

G. Airway and Ventilator Management

24. Non-invasive Ventilator Management
PD Board Recommendation: Perform Competently (no change) | Support: 97%
CCM Board Recommendation: Perform Competently (no change) | Support: 100%

Near-unanimous support exists for both recommendations. Non-invasive ventilation is a foundational skill in both disciplines, and the "Perform Competently" standard is fully appropriate.

> *APCCMPD Position: APCCMPD fully supports both board recommendations.*

25. Invasive Ventilator Management
PD Board Recommendation: Perform Competently (no change) | Support: 95%
CCM Board Recommendation: Perform Competently (no change) | Support: 100%

Invasive mechanical ventilation management received near-unanimous support across both boards and is among the most essential competencies for pulmonary and critical care physicians.

> *APCCMPD Position: APCCMPD fully supports both board recommendations.*

26. Moderate Sedation
PD Board Recommendation: Perform Competently (no change) | Support: 95%
CCM Board Recommendation: Perform Competently (no change) | Support: 97%

Support for both board recommendations is strong. A small number of respondents noted that institutional variability in how sedation is managed during procedures—including significant differences in the involvement of anesthesia versus proceduralists—can create challenges for programs trying to ensure consistent training experiences, and suggested that an "Opportunity to Train" standard might be more equitable across programs.

> *APCCMPD Position: APCCMPD supports both board recommendations. We encourage the ABIM to consider how programs in settings with limited fellow-driven sedation practice can demonstrate fulfillment of this standard.*

27. Endotracheal Intubation
PD Board Recommendation: Perform Competently (no change) | Support: 92%
CCM Board Recommendation: Perform Competently (no change) | Support: 100%

Endotracheal intubation received strong support for both boards. A small minority of PD respondents raised the point that general pulmonologists who practice exclusively in outpatient or non-ICU environments may not routinely perform intubation independently following fellowship, and suggested that a Knowledge Standard might suffice for that subset of trainees. The majority view, however, supports maintaining the existing competency standard.

> *APCCMPD Position: APCCMPD supports both board recommendations.*

28. Percutaneous Tracheostomy
PD Board Recommendation: Knowledge Standard | Support: 95%
CCM Board Recommendation: Knowledge Standard + Opportunity to Train | Support: 92%

Both board recommendations received majority support. For CCM, a subset of respondents expressed concern about whether the "Opportunity to Train" standard is operationally feasible across all training programs, particularly smaller community-based programs where percutaneous tracheostomy may be performed primarily by surgery or ENT rather than by critical care physicians. The feasibility of this standard depends significantly on how ABIM defines the program's obligation when a fellow requests training—specifically, whether programs would be required to arrange external rotations or partnerships if internal volume is insufficient.

> *APCCMPD Position: APCCMPD supports both board recommendations and strongly urges the ABIM to clarify the operational definition of "Opportunity to Train"—specifically, whether programs bear an affirmative obligation to arrange training at external sites if internal resources are inadequate. This clarification is essential for programs to understand and plan for their accreditation obligations.*

H. Renal Replacement Therapy and Extracorporeal Support

29. Continuous Renal Replacement Therapy (CRRT)
PD Board Recommendation: Do Not Require (no change) | Support: 84%
CCM Board Recommendation: Knowledge Standard + Opportunity to Train | Support: 79%

The proposed elevation of CRRT to "Knowledge Standard + Opportunity to Train" for CCM received the lowest level of support of any CCM recommendation in our survey, with 79% agreement and seven respondents actively opposing the change. Concerns centered on two principal themes. First, the appropriate clinical domain: multiple program directors argued that CRRT initiation and management falls within the scope of nephrology rather than critical care medicine, and that a Knowledge Standard—consistent with the existing designation for hemodialysis—would be more appropriate. Second, the feasibility of the OTT standard: not all fellowship programs have access to CRRT, and programs based at community centers or smaller academic institutions may be structurally unable to offer this training. Given that hemodialysis is designated "Knowledge Standard" for CCM, the proposed elevation of CRRT to OTT is viewed by a significant minority of our members as inconsistent and potentially unworkable.

> *APCCMPD Position: APCCMPD recommends that the CCM Board designate CRRT as "Knowledge Standard" rather than "Knowledge Standard + Opportunity to Train," consistent with the approach taken for hemodialysis and in recognition of the significant institutional variability in CRRT availability and the primary role of nephrology in managing this therapy.*

30. Management of Extracorporeal Membrane Oxygenation (ECMO)
PD Board Recommendation: Knowledge Standard | Support: 97%
CCM Board Recommendation: Knowledge Standard | Support: 100%

Our membership overwhelmingly supports the Knowledge Standard for both boards. ECMO management is a highly specialized skill typically delivered by dedicated ECMO teams, and requiring competency in its management—particularly cannulation—would not be feasible across most training programs. A small number of respondents noted that at high-volume ECMO centers, an "Opportunity to Train" designation for CCM fellows could be considered where institutional support exists.

> *APCCMPD Position: APCCMPD fully supports both board recommendations.*

I. Resuscitation, Dialysis, and Hemodynamic Monitoring

31. Advanced Cardiac Life Support (ACLS)
PD Board Recommendation: Perform Competently (no change) | Support: 97%
CCM Board Recommendation: Perform Competently (no change) | Support: 100%
Near-unanimous support for both recommendations. ACLS competency is a foundational expectation for all pulmonary and critical care physicians and requires no further commentary.

> *APCCMPD Position: APCCMPD fully supports both board recommendations.*

32. Hemodialysis
PD Board Recommendation: Do Not Require (no change) | Support: 89%
CCM Board Recommendation: Knowledge Standard (no change) | Support: 97%

Our membership supports both recommendations. Hemodialysis management is principally within the domain of nephrology, and the existing designations—"Do Not Require" for PD and "Knowledge Standard" for CCM—appropriately reflect the differential relevance of this therapy across the two disciplines. A minority of respondents felt that PCCM fellows should also carry a Knowledge Standard given their exposure to critically ill patients requiring renal support.

> *APCCMPD Position: APCCMPD supports both board recommendations.*

33. Calibration and Operation of Hemodynamic Recording Systems
PD Board Recommendation: Knowledge Standard | Support: 92%
CCM Board Recommendation: Knowledge Standard | Support: 95%

Our membership broadly supports the Knowledge Standard for both boards. The ability to recognize and troubleshoot common errors in hemodynamic recording systems is a practical clinical skill relevant to both disciplines. Given the wide variability in systems encountered across clinical environments, a Knowledge Standard is a pragmatic and appropriate expectation.

> *APCCMPD Position: APCCMPD fully supports both board recommendations.*

Closing

APCCMPD appreciates the ABIM's collaborative and transparent approach to developing these procedural competency requirements, including the solicitation of public comment. The proposed framework reflects careful deliberation and, in many respects, represents a meaningful and well-reasoned update to existing standards. Our membership's feedback—summarized in this letter—is offered in a spirit of partnership and shared commitment to training the next generation of exceptional pulmonary and critical care physicians.

We respectfully urge the ABIM to give particular consideration to the following recommendations before finalizing the proposed requirements:

- Explicitly define "Opportunity to Train" as a training access standard, not a conditional competency mandate, and adopt a "some/not all" model that permits—but does not require—programs with sufficient resources to certify graduates as independently competent in OTT-designated procedures
- Initiate a formal coordination process with ACGME to reconcile the two organizations' frameworks and issue joint guidance clarifying that ACGME sets universal graduation floors while ABIM's OTT tier governs training access with variable competency outcomes
- Retain "Perform Competently" for CVC placement in PD (Procedure 19)
- Downgrade CPET supervision and interpretation for PD to "Knowledge Standard + Opportunity to Train" (Procedures 7–8)
- Retain "Knowledge Standard" for CRRT in CCM, consistent with the hemodialysis standard (Procedure 29)
- Consider elevating dialysis access for PD to at minimum "Knowledge Standard + Opportunity to Train" (Procedure 21)
- Consider a Knowledge Standard for advanced airway procedures in CCM (Procedure 4)
- Monitor trends in advanced bronchoscopic technology, including robotic-assisted bronchoscopy, and revisit the transbronchial biopsy standard accordingly

APCCMPD would welcome the opportunity to discuss any of these recommendations in further detail and stands ready to assist the ABIM as this process moves toward finalization. Thank you for considering our comments.

Sincerely,

Neal Chaisson, MD
President
Association of Pulmonary and Critical Care Medicine Program Directors (APCCMPD)
On behalf of the APCCMPD Board of Directors and Membership

1. Interventional Pulmonology Fellowship Accreditation Standards Executive Summary of the Multisociety Interventional Pulmonology Fellowship Accreditation Committee John J. Mullon, MD; Kristin M. Burkart, MD; Gerard Silvestri, MD; D. Kyle Hogarth, MD; Francisco Almeida, MD; David Berkowitz, MD; George A. Eapen, MBBS; David Feller-Kopman, MD; Henry E. Fessler, MD; Erik Folch, MD; Colin Gillespie, MD; Andrew Haas, MD; Shaheen U. Islam, MBBS, MPH; Carla Lamb, MD; Stephanie M. Levine, MD; Adnan Majid, MD; Fabien Maldonado, MD; Ali I. Musani, MD; Craig Piquette, MD; Cynthia Ray, MD; Chakravarthy B. Reddy, MBBS; Otis Rickman, DO; Michael Simoff, MD; Momen M. Wahidi, MD; and Hans Lee, MD
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