

May 24, 2023

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

Dear Dr. Vasiliadis:

On behalf of the Association of Pulmonary and Critical Care Medicine Program Directors (APCCMPD), American College of Chest Physicians (CHEST), and American Thoracic Society (ATS), we collectively represent the breadth of pulmonary critical care medicine (PCCM), pulmonary disease, and interventional pulmonology. We are responding to the recent call for comments on the new *ACGME Program Requirements for Graduate Medical Education in Interventional Pulmonology*.

This letter will explain how the proposed requirements will impact our pulmonary disease and combined PCCM fellowship programs. We would like to note two points as we provide recommendations for these requirements. Firstly, while the Subspecialty-Specific Background and Intent boxes can help clarify a requirement, some institutions do not view them as enforceable, which may lead to inconsistent enforcement of the intended requirement and language used in the boxes. Secondly, we understand the desire of the Internal Medicine Resident Review Committee to standardize the requirements across all the ACGME Program Requirements for Graduate Medical Education in the Internal Medicine Subspecialties. However, we believe that the unique relationship of pulmonary and combined PCCM programs with IP programs and the shared pathways to competency for some training elements should be considered. Therefore, we respectfully provide feedback on the following requirements.

Comments on Requirements Specific to the *ACGME Program Requirements for Graduate Medical Education in Interventional Pulmonology*

I.B.1.a)

An interventional pulmonology fellowship program must function as an integral part of an ACGME-accredited pulmonary disease or combined pulmonary disease and critical care medicine fellowship program. (Core)

I.B.1.b) The Sponsoring Institution must ensure that the program has a collaborative relationship with the program director of the pulmonary disease or the combined pulmonary disease and critical care medicine program to ensure compliance with ACGME accreditation requirements. (Core)

We recognize the use of the language "*The Sponsoring Institution must ensure that the program has a collaborative relationship...*" rather than "*The Sponsoring Institution must ensure that there is a reporting relationship with the program director of the pulmonary disease or the combined pulmonary disease and critical care medicine program...*" is in alignment with other IM Subspecialty and Sub-Subspecialty Program Requirements. However, pulmonary and combined PCCM program directors will be accountable for ensuring that Interventional Pulmonary (IP) Programs comply with ACGME accreditation requirements.

We recommend strengthening the language to clearly define the roles and relationships between the core pulmonary or combined PCCM program directors and IP program directors. The following language can be considered: The IP program must collaborate with the core pulmonary or combined PCCM program to ensure that all ACGME training requirements related to bronchoscopic and pleural procedures are met for both the IP program and the core pulmonary or combined PCCM program.

I.D.1.e) A sufficient number of patients and procedural cases must be available annually at the primary clinical site to enable each fellow to achieve the required educational outcomes defined in section IV. This must include a minimum of:

I.D.1.e).(1) 50 rigid bronchoscopies; (Core)

I.D.1.e).(2) 20 endobronchial/endotracheal stent placements; (Core)

I.D.1.e).(3) 20 diagnostic medical thoracoscopies/pleuroscopies; (Core)

I.D.1.e).(4) 20 navigation bronchoscopies; (Core)

I.D.1.e).(5) 100 convex linear endobronchial ultrasound cases; (Core)

I.D.1.e).(6) 50 endobronchial ablative procedures; (Core)

I.D.1.e).(7) 20 image-guided thoracostomy tube placement procedures; (Core)

I.D.1.e).(8) 20 tunneled pleural catheter placement procedures; and, (Core)

I.D.1.e).(9) 100 convex linear endobronchial ultrasound cases. (Core)

As an integral part of a core pulmonary or combined PCCM program, both IP and general pulmonary training needs must be met. We acknowledge there is little data to support procedural numbers as a surrogate for clinical competency and agree that the total volume of the training site is more important than specific numbers for individual trainees. As such, we suggest clarifying whether the above numbers pertain to the minimum number of procedures and/or cases for the site or for each fellow.

Program directors in pulmonary and combined PCCM programs are concerned that the new standards may give the impression that IP is the only way to achieve competency in certain procedures. While some procedures are exclusive to IP, others are currently being taught in many Pulmonary and combined PCCM programs, and the graduates are competently performing them in practice.

However, if there is insufficient patient and case volume at a clinical site, an IP fellowship could negatively impact the training of pulmonary or combined PCCM fellows. To address this concern, we recommend revising the requirement to clearly state that there must be a sufficient number of patients and procedural cases available annually at the primary clinical site to enable each pulmonary, combined PCCM, and IP fellow to achieve the required educational outcomes specific to their subspecialty, as defined by the program and their ACGME Program Requirements for Graduate Medical Education. This emphasizes the multiple pathways to competency in many overlapping training areas, ensuring that all fellows have the opportunity to receive the required training.

We noted that both I.D.1.e) (5) and I.D.1.e) (9) specify convex linear EBUS. Is the intent for one requirement to specify radial endobronchial ultrasound cases and one requirement to specify convex linear endobronchial ultrasound cases?

I.E. Other Learners and Health Care Personnel

The presence of other learners and health care personnel, including but not limited to residents from other programs, subspecialty fellows, and advanced practice providers, must not negatively impact the appointed fellows' education. (Core)

The pulmonary and combined PCCM program directors oversee their program's learning environment to ensure that the education of pulmonary and combined PCCM fellows is not affected by the presence of other learners. Pulmonary and combined PCCM Programs program directors are worried that the educational requirements of the IP fellows might negatively impact the educational needs of Pulmonary and PCCM fellows.

To ensure that the educational needs of the pulmonary or combined PCCM fellows are not negatively impacted by the presence of sub-subspecialty IP fellows, we recommend acknowledging the inherent overlap in training, education outcomes, and competency pathways among the subspecialties. This can be achieved through a new core requirement (I.E.1) ensuring that the pulmonary disease or combined PCCM fellows are not adversely affected.

Comments on Requirements Common to All ACGME Program Requirements for Graduate Medical Education in Internal Medicine Subspecialties

I.B.5. The program should ensure that fellows are not unduly burdened by required rotations at geographically distant sites. (Core)

We recommend clarifying 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. For example, travel time depends on many variables, including traffic patterns, time of day, seasonal conditions, etc. We recommend eliminating the time measurement and only using the more objective mileage measurement.

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

II.B.1.b) 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 that flexibility be afforded to the subspecialty fellowship programs to provide training in these areas by allowing the subspecialty fellowship program discretion in how the training is implemented.

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

IV.B.1.b).(1).(a).(iv) [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. For example, providing interventional pulmonology care in a pop-up health clinic or on a mobile bus would be difficult or impractical. This requirement, as written, creates a need for 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 without prescribing the setting.

IV.B.1.b).(1).(a).(v) [Fellows must demonstrate the ability to manage the care of patients:] with whom they have limited or no physical contact through the use of telemedicine; ^(Core)

We appreciate the rationale ACGME and the Review Committee for Internal Medicine provided. Based on feedback from the APCCMPD membership, many institutions have deemphasized telemedicine or do not have the resources to provide care through its use. Additionally, with reimbursement for telemedicine by Medicare and insurers being in flux, telemedicine may be financially non-viable. If these clinics close, training opportunities and the need for such training will vanish.

Specification of what is considered telemedicine is needed. Our membership questioned if managing a patient locally over the telephone is considered telemedicine. Given this lack of clarity on what defines telemedicine, fellowship programs from institutions that have deemphasized telemedicine would need help meeting this requirement.

Until institutions are required to provide care using telemedicine, we recommend restating the requirement to require that fellowship programs provide training in communicating with patients who are not in the same physical space or making this a ^(Detail) rather than a ^(Core) requirement.

IV.B.1.c).(1).(f) 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, it's difficult to understand how subspecialty programs would be accountable for evaluating fellow knowledge.

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

IV.C.5. The educational program must provide fellows with individualized educational experiences to allow them to participate in opportunities relevant to

their future practice or to further skill/competence development in the foundational educational experiences of the subspecialty. ^(Core)

We support the intent of this revision. We recommend including within the "background and intent" that individualized educational experiences should be within the ability of the individual subspecialty fellowship and institution. Some individualized educational experiences may require high cost, distant sites, etc., and are not feasible.

As pulmonary, PCCM, and interventional pulmonology representatives, we commend the ACGME's effort toward greater fellowship program support. As individual organizations, we will provide comments using the ACGME online subspecialty program requirements comment form.

Sincerely,



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