Association of Pulmonary and Critical Care Medicine Program Directors

Fellowship Program Benchmarking Survey Results

2021 Survey
Survey Open December 18, 2021 -February 15, 2023
Distributed to 234 Pulmonary, Critical Care, and PCCM Program Directors
Response rate: n = 137 (59%)
Completion rate: n = 107 (78%)

2020 Survey
Survey Open December 21, 2020 - February 1, 2021
Distributed to 245 Pulmonary, Critical Care, and PCCM Program Directors
Response rate: n = 129 (53%)
Completion rate: n = 107 (44%)

2019 Survey
Survey Open February 3 - February 21, 2020
Distributed to 237 Pulmonary, Critical Care, and PCCM Program Directors
Response rate: n = 116 (49%)
Completion rate: n = 104 (44%)

SECTION 1: PROGRAM CHARACTERISTICS & LEADERSHIP

1. Please indicate which type of fellowship program(s) you direct, as designated by the ACGME. If you direct a PCCM program with a pulmonary or CCM track available within that program, select combined PCCM only. If the ACGME officially recognizes multiple programs (NOT tracks), select all that apply (choose all that apply)

	2019	2020	2021
	120 (100%)	129 (100%)	137 (100%)
a. Pulmonary and Critical Care Medicine (PCCM)	95 (79.2%)	103 (79.8%)	105 (76.5%)
b. Critical Care Medicine ONLY	18 (15%)	18 (14%)	27 (19.7%)
c. Pulmonary Medicine ONLY	7 (7%)	8 (6.2%)	5 (3.6%)

Display if PCCM is selected as "Yes" in Q 1.

2. If your program is a combined PCCM fellowship, how often have you offered occasional positions for:

Fellowship		a. Never	b. Rarely	c. Sometimes	d. Frequently	e. Always (Established track)
2.1. Pulmonary Medicine	**2019**	68 (76.4%)	9 (10.1%)	6 (6.7%)	1 (1.1%)	5 (5.6%)
	2020	68 (71.6%)	16 (16.8%)	3 (3.2%)	1 (1.1%)	7 (7.4%)
	2021	70 (72.2%)	16 (16.5%)	2 (2.1%)	3 (3.1%)	6 (6.2%)
2.2. Critical Care Medicine	**2019**	44 (49.4%)	23 (25.8%)	10 (11.2%)	3 (3.4%)	9 (10.1%)
	2020	48 (50.5%)	18 (18.9%)	7 (7.4%)	4 (4.2%)	18 (18.9%)
	2021	40 (41.2%)	23 (23.7%)	8 (8.2%)	3 (3.1%)	23 (23.7%)

3. How many graduates did you have in 2021?
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	2019	2020	2021
Number of Graduates			
0	8 (7.4%)	11 (9.7%)	8 (6.7%)
1	5 (4.6%)	4 (3.5%)	4 (3.3%)
2	19 (17.5%)	18 (15.9%)	17 (14.2%)
3	16 (14.8%)	12 (10.6%)	24 (20.0%_
4	18 (16.7%)	19 (16.8%)	22 (18.3%)

5	10 (9.3%)	14 (12.4%)	14 (11.7%)
6	12 (11.1%)	12 (10.6%)	7 (5.8%)
7	9 (8.3%)	10 (8.8%)	6 (5.0%)
8	6 (5.6%)	6 (5.3%)	9 (7.5%)
9	4 (3.7%)	1 (.9%)	4 (3.3%)
10	0	1 (.9%)	2 (1.7%)
11	1 (0.9%)	0	3 (2.5%)
12	0	5 (4.4%)	0
13	0	0	0
14	0	0	0
15	0	0	0
16	0	0	0
17	0	0	0
18	0	0	0
19	0	0	0
20	0	0	0
>20	0	0	0
Total	106 (100%)	112 (100%)	120 (100%)

4. As of July 1, 2021, what is the total number of Fellows in each of the following groups, excluding sub-sub-specialty fellows (e.g. IP and transplant fellows). :

Year 1: [*drop down menu 0-20 and >20]*
Year 2: [*drop down menu 0-20 and >20]*
Year 3(if applicable): [*drop down menu 0-20 and >20]*
Beyond year 3 (e.g. Research Fellows): [*drop down menu 0-20 and >20]*

# of Fellows		0	1	2	3	4	5	6	7	8	9
Year 1	2019	3 (2.8%)	6 (5.6%)	16 (14.8%)	19 (17.6%)	18 (16.7%)	14 (13%)	6 (5.6%)	9 (8.3%)	11 (10.2 %)	4 (3.7%)
	2020	2 (1.8%)	5 (4.5%)	12 (11.6%)	12 (15.2%	25 (22.3%)	15 (13.4%)	11 (9.8%)	9 (8%)	9 (8%)	3 (2.7%)
	2021	2 (1.7%)	7 (5.8%)	16 (13.3%)	19 (5.8%)	26 (21.7%)	12 (10%)	13 (10.8%)	5 (4.2%)	10 (8.3%)	1 (0.8%)
Year 2	2019	3 (2.8%)	5 (4.7%)	18 (17%)	17 (16.0%)	20 (18.9%)	10 (9.4%)	9 (8.5%)	12 (11.3%)	9 (8.5%)	0
	2020	5 (4.6%)	5 (4.6%)	12 (11%)	20 (18.3%)	27 (24.8%)	12 (11%)	10 (9.2%)	5 (4.6%)	8 (7.3%)	4 (3.7%)
	2021	6 (5.1%)	3 (2.6%)	15 (12.8%)	20 (17.1%)	26 (22.2%)	19 (16.2%)	6 (5.1%)	5 (4.3%)	8 (6.8% 0	4 (3.4%)
Year 3	2019	7 (7.5%)	5 (5.4%)	13 (14%)	16 (17.2%)	18 (19.4%)	11 (11.8%)	12 (12.9%)	7 (7.5%)	4 (4.3%)	0
	2020	9 (9.4%)	2 (2.1%)	11 (11.5%)	12 (12.5%)	26 (27.1%)	9 (9.4%)	13 (13.5%)	6 (6.3%)	5 (5.2%)	2 (2.1%)
	2021	7 (7.1%)	1 (1%)	9 (9.2%)	18 (18.4%)	25 (25.5%)	9 (9.2%)	15 (15.3%)	8 (8.2%)	2 (2%)	1 (1%)
Beyond Year 3 (e.g Research Fellows)	2019	45 (69.2%)	8 (12.3%)	6 (9.2%)	1 (1.5%)	0	2 (3.1%)	1 (1.5%)	0	0	0
	2020	47 (77%)	3 (4.9%)	2 (3.3%)	2 (3.3%)	4 (6.6%)	2 (3.3%)	0	0	0	0
	2021	41 (69.5%	10 (16.9%)	0	5 (8.5%)	0	1 (1.7%)	0	0	1 (1.7%)	0

# of Fellows		10	11	12	13	14	15	16	17	18	19	20	>21
Year 1	2019	1 (0.9%)	1 (0.9%)	0	0	0	0	0	0	0	0	0	0
	2020	1 (0.9%)	1 (0.9%)	0	1 (0.9%)	0	0	0	0	0	0	0	0
	2021	7 (5.8%)	2 (1.7%)	0	0	0	0	0	0	0	0	0	0
Year 2	2019	3 (2.8%)	0	0	0	0	0	0	0	0	0	0	0
	2020	1 (0.9%)	1 (1%)	0	0	0	0	0	0	0	0	0	0
	2021	3 (2.6%)	2(1.7%)	0	0	0	0	0	0	0	0	0	0
Year 3	2019	0	0	0	0	0	0	0	0	0	0	0	0

	2020	O	0	0	0	0	0	0	0	0	0	0	0
	2021	2 (2%)	1 (1%)	0	0	0	0	0	0	0	0	0	0
Beyond Year 3 (e.g Research Fellows)	**2019**	1 (1.5%)	0	1 (1.5%)	0	0	0	0	0	0	0	0	0
	2020	0	1 (1.6%)	0	0	0	0	0	0	0	0	0	0
	2021	0	0	0	0	1 (1.7 %)	0	0	0	0	0	0	0

5. Mark the one response that best reflects your allocated salary support (also referred to as release or protected time) as Program Director for non-clinical, administration of the fellowship program?

	2019	**2020**	**2021**
	N=106 (100%)	N= 113 (100%)	N= 120 (100%)
a. None (0 hours per week)	4 (3.8%)	5 (4.4%)	7 (5.8%)
b. 1-5% (less than 2 hours per week)	1 (0.9%)	7 (6.2%)	5 (4.2%)
c. 6-10% (>2-4 hours per week)	14 (13.2%)	7 (6.2%)	40 (33.3%)
d. 11-20% (>4-8 hours per week)	29 (27.4%)	33 (29.2%)	43 (35.8%)
e. 21-30% (>8-12 hours per week)	39 (36.8%)	47 (41.6%)	12 (10.0%)
f. 31- 40% (>12-16 hours per week)	15 (14.2%)	10 (8.8%)	6 (5.0%)
g. 41-50% (>16-20 hours per week)	4 (3.8%)	4 (3.5%)	6 (5.0%)
h. >50% (>20 hours per wee)	0	0	1 (0.8%)

6. Regarding your response to the previous item (question 5), to what extent do you agree that the allocated support is sufficient for the scope of Program Director responsibilities?

	Response	**Strongly Disagree**	**Disagree**	**Neither Disagree or Agree**	**Agree**	**Strongly Agree**
2019	106 (100%)	16 (15.1%)	33 (31.1%)	16 (15.1%)	28 (26.4%)	13 (12.3%)
2020	113 (100%)	15 (13.3%)	31 (27.4%)	19 (16.8%)	38 (33.6%)	10 (8.8%)
2021	120 (100%)	35 (29.2%)	35 (29.2%)	15 (12.5%)	38 (31.7%)	13 (10.8%)

7. Indicate the number of Assistant and/or Associate Program Directors for your fellowship?

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	2019	**2020**	**2021**
	106 (100%)	113 (100%)	120 (100%)
0	17 (16.0%)	15 (13.3%)	14 (11.7%)
1	53 (50.0%)	59 (52.2%)	55 (45.8%)
2	19 (17.9%)	22 (19.5%)	30 (25.0%)
3	9 (8.5%)	9 (8%)	10 (8.3%)
4	6 (5.7%)	3 (2.7%)	9 (7.5%)
5	1 (0.9%)	4 (3.5%)	0.0%
>5	1 (0.9%)	1 (0.9%)	2 (1.7%)

8. Mark the one response that best reflects the total allocated salary support (also referred to as protected or released time) for all Associate Program and/or Assistant Director for non-clinical, administrative responsibilities for the fellowship program?

	2019	**2020**	**2021**
	89 (100%)	95 (100%)	100 (100%)
a. None (0 hours per week)	31 (34.8%)	31 (32.6%)	29 (29.0%)
b. 1-5% (less than 2 hours per week)	21 (23.6%)	24 (24.3%)	23 (23.0%)
c. 6-10% (>2-4 hours per week)	21 (23.6%)	23 (24.2%)	25 (25.0%)
d. 11-20% (>4-8 hours per week)	8 (9.0%)	11 (11.6%)	13 (13.0%)
e. 21-30% (>8-12 hours per week)	3 (3.4%)	4 (4.2%)	5 (5.0%)
f. >30% (>12 hours per week)	4 (4.5%)	2 (2.1%)	5 (5.0%)
g. I do not have an APD	1 (1.1%)	0	0.0%

9. Regarding your response to the previous item (question 8), to what extent is the allocated support sufficient for the scope of APD responsibilities?

	Response	**Strongly Disagree**	**Disagree**	**Neither Disagree or Agree**	**Agree**	**Strongly Agree**
2019	89 (100%)	29 (32.6%)	23 (25.8%)	20 (22.5%)	13 (14.6%)	4 (4.5%)
2020	95 (100%)	25 (26.3%)	30 (31.6%)	17 (17.9%)	18 (18.9%)	5 (5.3%)
2021	100 (100%)	26 (26.0%)	31 (31.0%)	13 (13.0%)	20 (20.0%)	10 (10.0%)

10. Mark the one response that best reflects the source of support for the Associate Program Director's administrative responsibilities.

	2019	2020	2021
	89 (100%)	95 (100%)	100 (100%)
a. No salary, protected or release time support	9 (10.1%)	32 (33.7%)	34 (34.0%)
b. Salary support allocated to Program Director, with a portion allocated to the Associate/Assistant Program Director, at the PDs discretion.	26 (29.2%)	20 (21.1%)	12 (12.0%)
c. Separate source allocated to Associate Program Director, independent of that allocated to Program Director	18 (20.2%)	35 (36.8%)	44 (44.0%)
d. I don't know.	36 (40.4%)	8 (8.4%)	10 (10.0%)

11. Do your Core Faculty receive salary/protected or time support for fellowship responsibilities (e.g., teaching, supervision, advising)?

	2019	2020	2021
	105 (100%)	110 (100%)	113 (100%)
a. No	80 (76.2%)	89 (80.9%)	86 (76.1%)
b. Yes	21 (20%)	20 (18.2%)	24 (21.2%)
c. I don't know	4 (3.8%)	1 (.9%)	3 (2.7%)

12. To what extent do you agree that recruiting and retaining effective Core Faculty for your fellowship program is difficult because of insufficient support (e.g., salary and/or protected or release time) for carrying out fellowship responsibilities?

	Response	Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
2019	105 (100%)	6 (5.7%)	17 (16.2%)	32 (30.5%)	36 (34.3%)	14 (13.3%)
2020	110 (100%)	6 (5.5%)	24 (21.8%)	33 (30%)	30 (27.3%)	17 (15.5%)
2021	113 (100%)	13 (11.5%)	19 (16.8%)	40 (35.4%)	33 (29.2%)	8 (7.1%)

13. What is range of total months of protected research time does your program provide fellows for the duration of their training program, excluding an extra research year?

Min [Drop down menu with, 0 Months – 18 Months and >18 Months]
Max [Drop down menu with, 0 Months – 18 Months and >18 Months]

	2019		2020		2021	
Number of Months	**Min**	**Max**	**Min**	**Max**	**Min**	**Max**
0	10 (9.5%)	6 (5.7%)	10 (9.1%)	5 (4.5%)	8 (7.2%)	2 (1.8%)
1	8 (7.6%)	1 (1.0%)	13 (11.8%)	1 (.9%)	4 (3.6%)	1 (0.9%)
2	0	3 (2.9%)	0	4 (3.6%)	9 (8.1%)	3 (2.7%)
3	15 (14.3%)	4 (3.8%)	21 (19.1%)	9 (8.2 %)	12 (10.8%)	4 (3.6%)
4	8 (7.6%)	2 (1.9%)	4 (3.6%)	3 (2.7%)	11 (9.9%)	5 (4.5%)
5	5 (4.8%)	3 (2.9%)	3 (2.7%)	5 (4.5%)	1 (0.9%)	2 (1.8%)
6	15 (14.3%)	12 (11.4%)	18 (16.4%)	17 (15.5%)	25 (22.5%)	16 (14.5%)
7	1 (1.0%)	5 (4.8%)	3 (2.7%)	2 (1.8%)	2 (1.8%)	3 (2.7%)
8	6 (5.7%)	7 (6.7%)	5 (4.5%)	5 (4.5%)	4 (3.6%)	8 (7.3%)
9	3 (2.9%)	8 (7.6%)	4 (3.6%)	4 (3.6%)	4 (3.6%)	7 (6.4%)
10	5 (4.8%)	3 (2.9%)	3 (2.7%)	3 (2.7%)	6 (5.4%)	5 (4.5%)
11	0	2 (1.9%)	2 (1.8%)	2 (1.8%)	4 (3.6%)	1 (0.9%)
12	15 (14.3%)	11 (10.5%)	12 (10.9%)	12 (10.9%)	12 (10.8%)	15 (13.6%)
13	0	1 (1.0%)	3 (2.7%)	3 (2.7%)	0	3 (2.7%)
14	1 (1.0%)	5 (4.8%)	3 (2.7%)	5 (4.5%)	1 (0.9%)	3 (2.7%)
15	1 (1.0%)	1 (1.0%)	2 (1.8%)	2 (1.8%)	0	2 (1.8%)
16	3 (2.9%)	4 (3.8%)	1 (.9%)	1 (.9%)	1 (0.9%)	0.0%
17	2 (1.9%)	0	1 (.9%)	1 (.9%)	8 (7.2%)	2 (1.8%)
18	7 (6.7%)	21 (20.0%)	22 (20%)	22 (20%)	4 (3.6%)	2 (1.8%)
>18	0	6 (5.7%)	4 (3.6%)	4 (3.6%)	0	6 (5.5%)
Total	**105 (100%)**	**105 (100%)**	**110 (100%)**	**110 (100%)**	**111 (100%)**	**110 (100%)**

14. What % of fellows extend their fellowship beyond three years for additional research training.

	2019	2020	2021

Total	**105 (100%)**	**110 (100%)**	**113 (100%)**
a. None	69 (65.7%)	71 (64.5%)	72 (63.7%)
b. 1-25%	26 (24.8%)	28 (25.5%)	32 (28.3%)
c. 26-50%	3 (2.9%)	2 (1.8%)	2 (1.8%)
d. 50-75%	2 (1.9%)	4 (3.6%)	4 (3.5%)
e. 76-99%	5 (4.8%)	4 (3.6%)	1 (0.9%)
f. 100%	0	1 (.9%)	1 (0.9%)
g. All fellows are required to do an additional research year	0	0	1 (0.9%)

SECTION 2: ICU STAFFING

The items in this section pertain to required, in-house ICU responsibilities, excluding any elective moonlighting.

15. For each training year, select the response that best estimates the typical <u>total</u> nights of fellows' <u>required in-house</u> ICU coverage.

Fellowship Year		0	1-7	8-14	15-21	22-28	29-35	36-42	43-48	>48	Total
1	**2019**	35 (33.3%)	11 (10.5%)	15 (14.3%)	7 (6.7%)	9 (8.6%)	8 (7.6%)	9 (8.6%)	3 (2.9%)	8 (7.6%)	105 (100%)
	2020	28 (25.7%)	12 (11%)	9 (8.3%)	12 (11%)	13 (11.9%)	12 (11%)	12 (11%)	4 (3.7%)	7 (6.4%)	109 (100%)
	2021	29 (25.9%)	8 (7.1%)	11 (9.8%)	14 (14.3%)	8 (7.1%)	16 (14.3%)	15 (13.4%)	3 (2.7%)	6 (5.4%)	112 (100%)
2	**2019**	28 (26.7%)	12 (11.4%)	16 (15.2%)	12 (11.4%)	12 (13.3%)	10 (9.5%)	7 (6.7%)	1 (1%)	5 (4.8%)	105 (100%)
	2020	33 (30.3%)	11 (10.1%)	10 (9.2%)	13 (11.9%)	11 (10.1%)	13 (11.9%)	12 (11%)	2 (1.8%)	4 (3.7%)	109 (100%)
	2021	28 (25%)	12 (10.7%)	11 (9.8%)	19 (17%)	16 (14.3%)	15 (13.4%)	9 (8%)	2 (1.8%)	0	112 (100%)
3	**2019**	44 (41.9%)	8 (7.6%)	20 (19%)	11 (10.5%)	11 (10.5%)	10 (9.5%)	2 (1.9%)	1 (1%)	3 (2.9%)	105 (100%)
	2020	43 (39.4%)	12 (11%)	14 (12.8 %)	11 (10.1%)	11 (10.1%)	9 (8.3%)	6 (5.5%)	1 (.9%)	2 (1.8%)	109 (100%)
	2021	48 (42.9%)	12 (10.7%)	10 (8.9%)	15 (13.4%)	10 (8.9%)	11 (9.8%)	5 (4.5%)	1 (0.9%)	0	112 (100%)

16. Do fellows receive an hourly wage beyond their standard salary for staffing required in-house shifts?

	2019	**2020**	**2021**
Total	105 (100%)	109 (100%)	112 (100%)
a. Not Applicable, my fellows are not required to perform in-house nights. (skip to question 19)	24 (22.9%)	23 (21.1%)	22 (19.6%)
b. No	73 (69.5%)	75 (68.8%)	80 (71.4%)
c. Yes	8 (7.6%)	11 (10.1%)	10 (8.9%)

17. How do faculty supervise fellows during a required in-house shift?

Supervision Method		a. Not Supervised	b. Faculty in-house for supervision	c. Faculty supervise by telephone ONLY	d. Faculty supervise by phone (and come in-house as needed based upon this supervision)	e. Not applicable	Total
Year 1	**2019**	0	34 (38.6%)	4 (4.5%)	39 (44.3%	11 (12.5%)	89
	2020	1 (1.1%)	44 (47.3%)	4 (4.3%)	39 (41.9%)	5 (5.4%)	93

	2021	0	50 (50%)	5 (5%)	42 (42%)	3 (3%)	100
Year 2	**2019**	0	39 (43.8%)	3 (3.4%)	43 (48.3%)	4 (4.5%)	89
	2020	0	44 (48.9%)	2 (2.2%)	36 (40%)	8 (8.9%)	90
	2021	0	50 (50%)	5.00%	42.00%	3.00%	100
Year 3	**2019**	0	28 (32.2%)	3 (3.4%)	39 (44.8%)	17 (19.5%)	79
	2020	0	36 (40.4%)	2 (2.2%)	35 (39.3%)	16 (18%)	89
	2021	0	34 (34.7%)	6 (6.1%)	37 (37.8%)	21 (21.4%)	98

18. Do faculty receive additional compensation for supervising fellows during required in-house shifts?

	2019	**2020**	**2021**
Total	80 (100%)	86 (100%)	90 (100%)
a. No	70 (87.5%)	74 (86%)	74 (82.2%)
b. Yes	10 (12.5%)	12 (14%)	16 (17.8%)

SECTION 3: PROCEDURAL COMPETENCY

19. Of your 2019 final-year class, how many fellows met program standards performing each of the following procedures independently and competently by graduation? *(Choose one per row)*

Procedure		**0**	**1-25%**	**26-50%**	**51-75%**	**76-99%**	**100%**	**Total**
19.1. Bedside Tracheostomy	**2019**	51 (63.7%)	8 (10.0%)	3 (3.8%)	1 (1.3%)	4 (5.0%)	13 (16.3%)	80
	2020	46 (51.7%)	15 (16.9%)	2 (2.2%)	7 (7.9%)	3 (3.4%)	16 (18%)	89
	2021	54 (62.1%)	6 (6.9%)	2 (2.3%)	3 (3.4%)	4 (4.6%)	18 (20.7%)	87
19.2. Critical care ultrasound	**2019**	13 (14.8%)	8 (9.1%)	9 (10.2%)	2 (2.3%)	4 (4.5%)	52 (59.1%)	88
	2020	14 (15.4%)	6 (6.6%)	5 (5.5%)	4 (4.4%)	4 (4.4%)	58 (63.7%)	91
	2021	14 (17.1%)	4 (4.9%)	9 (11%)	4 (4.9%)	4 (4.9%)	47 (57.3%)	82
19.3. EBUS (Display only if PCCM or Pulmonary is selected in Q1)	**2019**	15 (16.5%)	5 (5.5%)	8 (8.8%)	4 (4.4%)	5 (5.5%)	54 (59.3%)	91
	2020	17 (17.2%)	7 (7.1%)	4 (4%)	6 (6.1%)	12 (12.1%)	53 (53.5%)	99
	2021	7 (8.3%)	7 (8.3%)	6 (7.1%)	4 (4.8%)	10 (11.9%)	50 (59.5%)	84
19.4. Insertion of indwelling pleural catheters (i.e. PleurX catheter)	**2019**	27 (32.1%)	14 (16.7%)	5 (6.0%)	4 (4.8%)	6 (7.1%)	28 (33.3%)	84
	2020	33 (36.3%)	6 (6.6%)	6 (8.8%)	7 (7.7%)	8 (8.8%)	29 (31.9%)	91
	2021	19 (24.4%)	5 (6.4%)	10 (12.8%)	4 (5.1%)	10 (12.8%)	30 (38.5%)	78

20. For each procedure listed below, mark whether each assessment method (columns) is consistently used to assess fellow competency. Remove yes no and on check all that apply in

		Minimum number of procedures performed	Global assessment via reported impressions without direct observation	Global assessment based on a direct observation	Written Knowledge Test	Itemized Observed Performance Checklist
20.1. Bedside Tracheostomy	**2019**	NA	6 (8.2%)	55 (75.3%)	1 (1.4%)	11 (15.1%)
	2020	52 (34.7%)	6 (4%)	71 (47.3%)	2 (1.3%)	12.7%)
	2021	43 (32.3%)	14 (10.5%)	1 (0.8%)	1 (0.8%)	12 (9%)
20.2. Critical care ultrasound	**2019**	NA	21 (13.8%)	84 (54.5%)	18 (11.7%)	31 (20.1%)
	2020	48 (22.2%)	15 (6.9%)	90 (47.7%)	23 (10.6%)	40 (18.5%)
	2021	42 (20.1%)	27 (12.9%)	87 (41.6%)	17 (8.1%)	36 (17.2%)
	2019	NA	13 (9.4%)	80 (57.2%)	7 (5%)	39 (28.1%)

20.3. EBUS(Display only if PCCM or Pulmonary is selected in Q1)	**2020**	68 (29.8%)	14 (6.1%)	91 (39.9%)	15 (6.6%)	14 (6.1%)
	2021	58 (30.4%)	13 (6.8%)	78 (40.8%)	9 (4.7%)	33 (17.3%)
20.4. Insertion of indwelling pleural catheters (i.e. PleurX catheter)	**2019**	NA	13 (12.9%)	65 (64.4%)	3 (3%)	20 (19.8%)
	2020	54 (32.3%)	12 (7.2%)	77 (46.1%)	3 (1.8%)	12 (7.2%)
	2021	47 (32.2%)	9 (6.2%)	69 (47.3%)	1 (0.7%)	20 (13.7%)

21. For each of the procedures listed below, to what extent do you have:
1) sufficient faculty expertise and
2) sufficient dedicated time to teach and supervise your fellows to achieve competent, independent performance by graduation?
(For each row, mark one, best response for Expertise and for Time.) Make this a yes no only.

Procedure		**Expertise**		**Time**		**Total**
		No	**Yes**	**No**	**Yes**	
21.1. Bedside Tracheostomy	**2019**	33 (31.7%)	71 (68.3%)	104 (100%)	50 (49.0%)	104 (100%)
	2020	20 (18.3%)	89 (81.7%)	43 (39.4%)	66 (60.6%)	109 (100%)
	2021	30 (27.3%)	80 (72.7%)	45 (40.9%)	65 (59.1%)	110
21.2. Critical care ultrasound	**2019**	7 (6.7%)	97 (93.3%)	27 (26%)	77 (75%)	104 (100%)
	2020	10 (9,2%)	99 (90.8%)	23 (21.1%)	86 (78.9%)	109 (100%)
	2021	12 (10.9%)	98 (89.1%)	29 (26.4%)	81 (73.6%)	110
21.3. EBUS (Display only is PCCM or Pulmonary if selected in Q1)	**2019**	8 (7.7%)	96 (92.3%)	15 (14.4%)	89 (85.6%)	104 (100%)
	2020	11 (10.1%)	98 (89.9%)	17 (15.6%)	92 (84.4%)	109 (100%)
	2021	3 (3.2%)	90 (96.8%)	8 (8.6%)	85 (91.4%)	93
21. 4. Insertion of indwelling pleural catheters (i.e. PleurX catheter)	**2019**	13 (12.5%)	91 (87.5%)	34 (32.7%)	70 (67.3%)	104 (100%)
	2020	17 (15.6%)	92 (84.4%)	28 (25.7%)	81 (74.3%)	109 (100%)
	2021	12 (12.9%)	81 (87.1%)	21 (22.6%)	72 (77.4%)	93

22. To what extent do you agree that the ABIM should include Endobronchial Ultrasound –guided biopsy as a required procedure for Pulmonary board eligibility. (Display only if PCCM or Pulmonary is selected in Q1)

	Response	**Strongly Disagree**	**Disagree**	**Neither Disagree or Agree**	**Agree**	**Strongly Agree**
2019	104 (100%)	89 (8.7%)	21 (20.2%)	31 (29.6%)	27 (26%)	16 (15.4%)
2020	109 (100%)	14 (12.8%)	29 (26.6%)	24 (22%)	28 (25.7%	14 (12.8%)
2021	93 (100%)	9 (9.7%)	19 (20.4%)	21 (22.6%)	23 (24.7%)	21 (22.6%)

SECTION 4: EBUS SPECIFIC QUESTIONS (Display only if 1-100% is selected in 19.3)

23. Who trains your fellows in EBUS? (choose one)

	2020	**2021**
Total Response	81 (100%)	77 (100%)
23.1. A board-certified interventional pulmonologist	25 (30.9%)	26 (33.8%)
23.2. A non-IP Trained faculty member	16 (19.8%)	12 (15.6%)
23.3. Both	40 (49.4%)	39 (50.6%)

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24. Who assess competency for certification of your fellows in EBUS?

	2020	2021
Total Response	81 (100%)	77 (100%)
24.1. A board-certified interventional pulmonologist	30 (37%)	30 (39.0%)
24.2. A non-IP Trained faculty member	15 (18.5%)	12 (15.6%)
24.3. Both	36 (44.4%)	35 (45.5%)

25. Do you certify fellow in: (Choose one)

	2020	2021
Total Response	81 (100%)	77 (100%)
25.1. Staging EBUS	2 (2.5%)	2 (2.6%)
25.2. Diagnostic EBUS	16 (19.8%)	14 (18.2%)
25.3. Both	63 (77.8%)	61 (79.2%)

26. Do you certify fellow in peripheral/radial EBUS?

	2020	2021
Total Response	81 (100%)	77 (100%)
26.1. Yes	31 (38.3%)	30 (39.0%)
26.2. No	50 (61.7%)	47 (61.0%)

SECTION 5: PULMONARY ARTERY CATHETERIZATION SPECIFIC QUESTIONS

27. Within each of the fellowship programs listed below, how should be competence to INSERT a pulmonary artery catheter be addressed?

Fellowship Program		a. Do not teach or assess	b. Teach, but do not assess	c. Teach and assess	d. Teach and assess and require competence	Total
27.1. Pulmonary	2019	14 (13.5%)	39 (37.5%)	38 (36.5%)	13 (12.5%)	104 (100%)
	2020	18 (16.7%)	41 (38%)	30 (27.8%)	19 (17.6%)	108 (100%)
	2021	15 (13.8%)	38 (34.9%)	39 (35.8%)	17 (15.6%)	109 (100%)
27.2. Combined PCCM	2019	8 (7.7%)	20 (19.2%)	46 (44.2%)	30 (28.8%)	104 (100%)
	2020	4 (3.7%)	26 (24.1%)	45 (41.7%)	33 (30.6%)	108 (100%)
	2021	6 (5.5%)	28 (25.7%)	46 (42.2%)	29 (26.6%)	109 (100%)
27.2. CCM	2019	7 (6.7%)	20 (19.2%)	46 (44.2%)	31 (29.8%)	104 (100%)
	2020	5 (4.6%)	26 (24.1%)	44 (40.8%)	33 (30.6%)	108 (100%)
	2021	7 (6.4%)	26 (23.9%)	45 (41.3%)	31 (28.4%)	109 (100%)

28. Within each of the fellowship programs listed below, how should competence to INTERPRET and APPLY findings from a pulmonary artery catheter be addressed?

Fellowship Program		a. Do not teach or assess	b. Teach, but do not assess	c. Teach and assess	d. Teach and assess and require competence	Total
28.1. Pulmonary	**2019**	6 (5.9%)	9 (8.8%)	42 (41.2%)	45 (41.2%)	104 (100%)
	2020	11 (10.2%)	12 (11.1%)	40 (37%)	45 (41.7%)	108 (100%)
	2021	2 (1.8%)	13 (11.9%)	35 (32.1%)	59 (54.1%)	109 (100%)(100%)
28.2. Combined PCCM	**2019**	3 (2.9%)	7 (6.9%)	36 (35.3%)	56 (35.3%)	104 (100%)
	2020	0	9 (8.3%)	42 (38.9%)	57 (52.8%)	108 (100%)
	2021	0	5 (4.6%)	32 (29.4%0	72 (66.1%)	109 (100%)
28.3. CCM	**2019**	3 (2.9%)	8 (7.8%)	35 34.3%)	104 (34.3%)	104 (100%)
	2020	2 (1.9%)	6 (5.6%)	42 (38.9%)	58 (53.7%)	108 (100%)
	2021	0	5 (4.6%)	34 (31.2%)	70 (64.2%)	109 (100%)

29. Of your last graduating class, how many fellows consistently demonstrated competent and independent performance by year-end for each ability listed below.

Ability		0	1-25%	26-50%	51-75%	76-99%	100%	Total
29.1. Insert a pulmonary artery catheter	**2019**	28 (26.9%)	12 (11.5%)	19 (18.3%)	10 (9.6%)	12 (11.5%)	23 (22.1%)	104 (100%)
	2020	21 (19.4%)	22 (20.4%)	23 (21.3%)	8 (7.4%)	6 (5.6%)	28 (25.9%)	108 (100%)
	2021	29 (26.6%)	18 (16.5%)	16 (14.7%)	12 (11%)	12 (11%)	22 (20.2%)	109 (100%)

29.2. Interpret and apply findings from a pulmonary artery catheter	**2019**	10 (9.6%)	2 (1.9%)	6 (5.8%)	11 (10.6%)	11 (10.6%)	64 (61.5%)	104 (100%)
	2020	12 (11.1%)	4 (3.7%)	8 (7.4%)	11 (10.2%)	16 (14.8%)	57 (52,8%)	108 (100%)
	2021	9 (8.3%)	4 (3.7%)	8 (7.3%)	15 (13.8%)	10 (9.2%)	63 (57.8%)	109 (100%)

30. For each of the following clinical/education settings, to what extent do Fellows learn to insert OR interpret pulmonary artery catheters?

Setting		Insert PA catheters	Interpret and apply findings from PA catheters	Not Applicable
30.1 Medical ICU	**2019**	45	76	17
	2020	63	83	15
	2021	57	88	14
30.2 Cardiac ICU	**2019**	30	56	36
	2020	38	66	31
	2021	32	63	35
30.3 Cardiothoracic or other ICU	**2019**	42	71	26
	2020	41	72	28
	2021	38	78	21
30.4 Cath lab or other setting where PH is evaluated	**2019**	54	68	27
	2020	52	66	27
	2021	53	69	27
30.5 Didactic teaching sessions	**2019**	30	89	10
	2020	35	89	7
	2021	32	96	5
30.6 Simulation-based education	**2019**	14	25	52
	2020	20	30	48
	2021	15	29	53
30.7 Other, please describe any other settings in which fellows learn about PA catheters and indicate the frequency of learning opportunities for each setting.	**2019**	4	6	55
	2020	1	7	50
	2021	2	5	53
30.8 None	**2019**	1	0	49
	2020	1	1	47
	2021	4	1	49
Other Specified	**2019**	• PH clinic and PH rotation • Cardiac OR • Subspecialty clinic (PH) • Our fellows go to the Cardiac Surgery OR • pHTN clinic	• Our fellows go to the Cardiac Surgery OR • pHTN clinic • Subspecialty clinic (PH) • Cardiac OR • PH clinic and PH rotation	
	2020	• clinical PH conference (weekly for fellows who elect to attend) • Outpatient right heart cath with PH specialist • ph clinic • pHTN clinic, consults • CT Surgical Operating Room	• CT Surgical Operating Room • pHTN clinic, consults • ph clinic • Outpatient right heart cath with PH specialist • clinical PH conference (weekly for fellows who elect to attend)	
	2021	• ECMO • Heart Failure consults • PH clinic • Pulmonary Vascular Disease Clinics	• Heart Failure consults • PH clinic • Pulmonary Vascular Disease Clinics	

SECTION 6: SLEEP EDUCATION **(Display only if PCCM or Pulmonary is selected in Q1)**

31, Indicate which settings/methods listed below fellows receive clinical training in sleep medicine **(Display only if PCCM or Pulmonary is selected in Q1)**

Educational Setting/Method	2019	2020	2021

a. Didactic teaching (classroom)	85 (29.5%)	84 (28.7%)	81 (30.2%)
b. Sleep lab time, reading sleep studies	56 (19.3%)	61 (20.8%)	54 (20.1%)
c. Sleep patients in longitudinal clinic	66 (22.5%)	61 (20.8%)	57 (21.3%)
d. Dedicated sleep medicine blocks	61 (21.1%)	63 (21.5%)	11 (4.1%)
e. Other: Please describe setting and typically frequency for fellows:	13 (4.6%)	12 (4.1%)	64 (23.9%)
f. None	10 (3.2%)	12 (4.1%)	1 (0.4%)

2019 Other Responses

- 2 dedicated sleep medicine blocks are in the 3-year schedule for fellows
- Multidisciplinary Sleep Journal Club
- 2-3 weeks per year=6-8 week total
- 1 month during fellowship, 6 didactic sessions per year
- Weekly conference
- 1-2 weeks per year
- One week in sleep clinic and lab
- 10 sleep clinics during one rotation
- Sleep elective
- Sleep clinic, 1-2x/week during 4-week clinic block
- Sleep patients in dedicated sleep clinic
- Not applicable
- Attend 6 sleep conferences per

2020 Other Responses

- weekly sleep clinic during two VA rotations during F1 year-8 clinics total
- Attend sleep clinic during subspecialty clinics block
- fellow sleep clinics at the VA
- 1 month sleep rotation
- 1 month
- required sleep medicine rotation
- weekly review
- Outpatient Clinic during their month-long outpatient rotations
- Sleep clinic ~10 sessions with sleep faculty
- 2-week blocks/year
- multidisciplinary sleep grand rounds
- sleep elective, up to 2 weeks

2022 Other Responses

- Outpatient sleep clinic during clinic subspecialty block x 1 month
- 1-2 months, depending on interest
- Elective in sleep medicine
- Sleep clinic included in VA rotation
- Required sleep clinics
- Attend sleep clinic during subspecialty clinics block
- Outpatient sleep clinic, not longitudinal
- Multidisciplinary sleep grand rounds
- Sleep patients in non-longitudinal clinic; 10-12 sessions over 2 years
- Sleep elective, up to 2 weeks

32. What is the typical number of total months of sleep training that fellows complete by the end of their required program? (Display only if PCCM or Pulmonary is selected in Q1)

Drop down menu with:**0 <1, 1, 2, 3, 4, 5, >5**

	2019	2020	2021
Total Responses	**104 (100%)**		93 (100%)
0	14 (13.5%)	14 (14%)	1 (1.1%)
less than 1	23 (22.1%)	20 (18.7%)	24 (25.8%)
1	33 (31.7%)	38 (35.5%)	35 (37.6%)
2	19 (18.3%)	20 (18.7%)	23 (24.7%)
3	12 (11.5%)	11 (10.3%)	7 (7.5%)
4	2 (1.9%)	1 (.9%)	2 (2.2%)
5	1 (1.0%)	1 (.9%)	0
>5	0	1 (.9%)	1 (1.1%)

SECTION 7: FELLOWSHIP APPLICATION and ORIENTATION

33.Which of the following best describes how you review applicants for your fellowship program?

	2019	2020	2021
Total Responses	**104 (100%)**	**107 (100%)**	109 (100%)
a. Universal Application form through ERAS only	99 (95.2%)	100 (93.5%)	107 (98.2%)
b. Institution-specific application form only	2 (1.9%)	4 (3.7%)	0
c. Universal Application and Institution-specific (supplemental) application form	3 (2.9%)	3 (2.8%)	2 (1.8%)

34. Check the appropriate box if either your institution or program has orientation activities starting before July 1:

Orientation		On-line	In person	No orientation before July 1	Total
Institution	**2019**	9 (8.7%)	33 (32%)	61 (59.2%)	103 (100%)
	2020	19 (17.8%)	34 (31.8%)	54 (50.4%)	107 (100%)
	2021	25 (22.9%)	17 (15.6%)	67 (61.5%)	109 (100%)
Program	**2019**	1 (1.0%)	17 (16.5%)	85 (82.2%)	103 (100%)
	2020	5 (4.7%)	23 (21.5%)	79 (73.8%)	107 (100%)
	2021	5 (4.6%)	11 (10.1%)	93 (85.3%)	109 (100%)

35. Which of the following start dates do you most favor?

	2019	2020	2021
a. July 1st, with no changes in IM residency start and end dates	48 (42.5%)	57 (51.4%)	61 (51.7%)
b. July 1st- only if an earlier universal IM residency start date is set, so residents graduate by June 16 or 23	44 (38.9%)	42 (37.8%)	38 (32.2%)
c. July 7	17 (15%)	7 (6.3%)	15 (12.7%)
d. July 14	3 (3.5%)	5 (4.5%)	4 (3.4%)

36. Please provide any comments on the potential benefits or difficulties associated with a mandatory start date for fellowship programs after July 1st

2019 Comments

- Benefits--time for orientation, fellows to relocate; difficulties--visa holders have to leave country
- Would prefer that new fellows start at the same time as new residents. I think this would be the best for both classes
- I favor later start if that also means pushing back the end date to July 3 years later for the full 36 months. I would be willing to start as late as Aug 1. My concerns would be for the incoming fellow ensuring that they have budgeted for the gap of up to two weeks where they are unlikely to be paid for that time or have healthcare coverage. Alternatively, advocating that for this gap time either the new or old institution cover those things.
- Not realistic
- This is most fair to IM residencies
- Would take three years plus to phase in creating increased workload
- Will need to time in advance so that current fellows know they will need a later stop date (later than 6/30)
- Cross coverage issues
- Extended coverage time until the new fellows start which is already a burden. We orient from July 1-7.
- We continuously encounter problems with incoming fellows that don't get paid for orientation activities because of J1 visa and they are still under contract from their residency until June 30.
- Services would get uncovered as 3 yr fellows are leaving.
- Thus far, we have had no issues with fellows arriving a few days prior to July 1, but if we do, we would simply push back the start/orientation date as needed.
- Orientation and workshops/simulation are needed. I think the first week of starting fellowship should be dedicated for that.
- Avoid July 4th, additional moving time for new fellows
- Manpower issues
- May be issues with h1 visas
- Just the incoming fellows having time to move and get settled before starting.
- Orientation will run later in to the month- we have a 2 week "boot camp" for critical care
- Clinical care during the gap between the end of residency and beginning of fellowship
- Many residents are committed to residency program until June 31st, making a July 1 start date challenging especially if they are moving.
- We are not a large program and once graduating fellows leave, there is "missed opportunities for education". Also, a gap in pay could be extremely hard for fellows as well as potential visa issues
- Fellows starting the F3 year often enroll in classes that start in the first week of July, so aren't available to cover if new fellows haven't yet started.
- Graduating fellows expect to finish and leave by June 30. Need new fellows to replace them so patient care can continue.
- Coverage from graduating classes.
- Burden of coverage on other fellows.
- July 1st is just predictable and everyone is on the lookout for new trainees. If the starting date is different between programs then we will just stretch the headache for longer.
- July 1st makes it easy to transition from other programs. Before July 1st is unfair to previous program.
- I would have problems with coverage by my upper years who start classes in early July if the start date for first years gets pushed back too late.
- We still need to orient fellows and it would shorten the amount of time we have to train them.
- As long as fellowship end dates correlate with the start dates - i.e. fellowship end date extended to July 6 if start date is July 7 - much like surgical fellowships - even an Aug 1 start date would be fine as long as end dates are July 31).
- I prefer July 1 start date; don't care if IM residencies end early or not
- Lapses in training for international medical graduates are an issue; if this were not the case then July 14th would allow residents to finish their residencies on June 30th with time to move and get oriented for fellowships. They would then graduate later in July but not a problem if all fellowships follow the same schedule.
- I explained to the newly matched fellows that they should expect to find coverage the week before to July for hospital wide orientation. But I have found that this is getting more lengthy and it may be more difficult to do before July 1.
- None of the first-year fellows can be on an MICU or consult rotation prior to completing their orientation
- None
- We are already starting on July 6
- The residencies are in position to start earlier, I favor that so that fellows have time to move and be ready to start fellowship July 1
- Equal treatment of fellows
- Perhaps allow medical licensure to go through
- There will be problems with fellows on J1 visas as there cannot be a break between the end of residency and start of fellowship
- Visa applicants will have difficulty anytime there is any gap whatsoever in residency completion and fellowship start. Federal grants often become effective July 1, which is important for fellows supported by NRSA or T32, etc.

2020 Comments

- I think a move would support wellness for our incoming trainees. Moving, learning a new system(s) within 24 hours is incredibly stressful. I think it would also improve efficiency within the program. Our current first week of July is basically an extension of the year prior while the incoming fellows complete orientation.
- We would be severely hampered by time without fellows from June 30 - July xx when fellows arrive.
- Schedule
- Fellows May not have enough time to re-energize adjust to new role, to adapt
- There is no benefit to starting after July 1st. Important to finish orientation before application season starts.
- For us would mainly affect when they actually get onto the services as we do a 3-week boot camp
- potential issues for those who have j-1 visas
- Little benefit; would require overhaul of contracts w GME office to require graduating fellows to graduate later than June 30.
- We barely have enough time to get fellows all the training they need, this just limits it more
- Research fellows often have coursework that starts the first week in July, so could run into trouble covering services that week
- Lack of manpower for patient care
- better to have in person orientation before start day.
- Difficulty as it would extend an already extended rotation by the existing fellows.
- This would conflict with many funding sources, including NIH, that begin funding years on July 1.
- There is not a way to orient new fellows by July 1 unless they come at least one week prior preferably 2 weeks
- I strongly believe ABIM-IM Residents should take their Board Exam in June of their final year, so it is not hanging over them while they start a new job or training program. Similarly, I favor some staggered start/finish for ABIM-IM Residencies and Fellowships.
- A later start date would be a big problem for trainees on H-1b visas, and could become a deterrent to programs who might otherwise consider them as fellowship candidates.
- There would be hardship covering the gap in the first year of implementation if the start date was moved back. All orientation courses would have to be rescheduled which would be disruptive. The biggest issue regards VISA status and what the legalities are regarding start dates. Internal medicine programs often start their orientation earlier than July 1 but then give their interns time off at the end of the year to make that up. It would seem they could delay that compensation time until the 3rd year.
- It will be better to keep starting date as July 1st because our academic year for Fellowship and for Int Medicine will be the same
- foreign students and visas if too late after July 1 and they finish June 24 at previous training programs
- Our orientation starts on July 1st. Delaying the start date will just delay the orientation and start of the clinical activities
- Fellows don't get trained in EMR to do clinics and in-patient rotations. A few days are just wasted in the paper work and system-based activities. It would be so beneficial if they all can come a week in advance.
- We need time for orientation; and the prior fellows have extended rotations
- Throws off the "block" schedule if starting off cycle
- difficulty-staffing shortage
- Would favor later start date if that was the only way to provide a stretch of time (at least 2 weeks) for transition to fellowship.
- we are a small program, so when our fellows leave and new fellows haven't started, we have 2-3 fellows available for to staff our service lines
- My second years start classes first week of July so if first years start late. I have a coverage gap
- We do a 3-week orientation for procedures, etc. Starting after 7/1 would make that difficult. However, if there was a move to put ABIM testing into July, I'd be supportive of a later start date
- Benefits: Gives fellows more time to move in, more time to study and perhaps even take the boards before starting fellowship. Difficulty: if on Visa no gaps allowed. Surgery does an August 1st start date. It works well.
- Would advocate for a later start date if fellows would finish their training exactly three years from then. Otherwise, a yearly gap of 1-2 weeks would make clinical operations difficult yearly
- Starting in July seems the best strategy in that all residents transitioning to fellowship will have completed their training. Furthermore, there is more flexibility for our fellows to graduate from the program in July in terms of maintaining insurance while they transition to work with a start afterwards,
- Visa
- Must be accompanied by earlier IM residency completion date. Very stressful to move across the country and start a new job with no time off in between.
- Issues with physicians on visas - must have contiguous employment dates

2021 Comments

- The benefits to having trainees available a week or 2 prior to starting fellowship would be to allow for orientation/preparatory events to be truly independent of clinical activities that would reduce strain on fellows/programs and faculty on service.
- shortened time for training
- there is time needed for orientation, so that doesn't start until the official start date. Also, consider continuity for J-1 VISA holders; they need to have no gaps in time.
- If later start, potential for orientation teaching and activities to conflict with opening of ERAS for application review, which would be somewhat overwhelming.
- interference in continuity of starting work week due to Jul 4th holiday
- Starting on a day other than July 1 has implications for fellows on VISA approvals and is off-cycle for NIH grant funding that would support research years.
- We run a regional fellow bootcamp. Our system's fellows start July 7 or later but all other's July 1 so schedule bootcamp tough. In additional so participating fellows are surgical-cc and they start August 1, so their new fellows miss the basics course in July
- Starting later than end of residency will necessitate residents/fellows to purchase health insurance by COBRA which is very expensive
- Start dates after July 1st create problems with end dates. Fellows rental leases generally end June 30th and many visas also end on June 30th. This forces fellows to use a week of vacation at the end of their fellowship to avoid an extra month of rent, or visa holders have to end a week early. This leaves a gap between the completing class and the new starting class which is difficult to staff. It also means the fellows can't take a week of vacation during the year.
- Changing the fellowship start date to later in July would put a substantial strain on the program to cover the necessary services. Those on a VISA can't have break between completing one job and starting another. The only way to make this work for those on VISAs is to have IM programs plan on a terminal vacation to allow their graduates to move. This promotes diversity within programs. Currently some IM programs don't take this into account and those on VISA suffer undue stress and fear of INS.
- The first two weeks of training are usurped by orientation activities. Would prefer a 1-2 week late start where fellows can graduate, take care of personal needs (relocating, etc) and virtual orientation activities can occur. The caveat being completion of training also being pushed to July.

- need time for onboarding and sim/workshops. Start clinical duties July 16th
- We have not encountered any difficulties
- fellowships are smaller programs and already take 2-3 weeks of orientation with graduated fellows already gone; starting after July 1 delays that even more fellowships are smaller programs and already take 2-3 weeks of orientation with graduated fellows already gone; starting after July 1 delays that even more
- Less fellows present on clinical service to cover services; added strain on rising 2nd and 3rd years; delays start of research time. Less fellows present on clinical service to cover services; added strain on rising 2nd and 3rd years; delays start of research time.
- Benefits: Time for fellows transitioning from residency to re-locate prior to their start date.
- Coursework and other research fellow obligations starts July 1, so may not have available fellows to cover clinical services much further into July
- Most medical schools have graduation in May or early June. Can start residency earlier.
- I'd actually be okay with it but in my opinion, it would be August 1st and boards would be taken in July! This would provide dedicated study time as passing boards so important
- timeline crunch on application downloads and review - already time crunch for bootcamps/onboarding and applications - if they overlap it will cause huge amounts of distress for program directors, and will results in trainee harm. Worse experience in beginning of program - less involvement of program leadership. Not to mention burnout to PDs, who deserve to have a break in the summer like everyone else does..
- staffing, orientation which would be delayed
- Too close to opening of ERAS and review of applications which typically occurs on the 15th. It is nice to have first year fellows start 7/1- have boot camp training in first two weeks and settled before application review for next class starts.
- A later start date may have challenges with benefits; also moves back the end date of terminal training. A later start date may have challenges with benefits; also moves back the end date of terminal training.
- Difficulty in providing simulation/procedural workshops across multiple specialties
- Hard to train both fellow and house staff initially
- I like the benefit of allowing trainees to have some time to move and get settled in before starting their fellowship. One barrier to start dates after July 1st is managing the different start dates for our various Critical Care fellowships that train and work together (Surgical Critical Care, Anesthesiology Critical Care, etc).
- Interruption of benefits (eg, especially health insurance). Would suggest polling trainees.
- visa issues
- orientation for fellows coming from outside institutional programs
- one year we would have to make everyone's training program longer or else be short of fellows for the time between July 1 and the new start date, which would pose difficulty caring for patients and supervising new residents
- Potential Benefits are after July 1st all Fellows and Faculty are present at the institution
- Benefits include allowing time for relocation following residency, avoiding the 4th of July holiday for orientation activities or clinical coverage by new fellows. Challenge would be the proximity to fellowship recruitment begins at the same time the new fellows are being oriented to the program.

SECTION 8: DEMOGRAPHICS

37.What is your gender? *(Choose one)*

	2019	2020	2021
Total	103 (100%)	107 (100%)	109 (100%)
a. Male	61 (59.2%)	62 (57.9%)	61 (56.0%)
b. Female	39 (37.9%)	42 (39.3%)	46 (42.2%)
c. Prefer not to say	3 (2.9%)	3 (2.8%)	2 (1.8%)
d. Prefer to self-describe as: _____	0	0	0

38. What is your current academic rank? *(Choose one)*

	2019	2020	2021
Total	103 (100%)	107 (100%)	109 (100%)
a. Instructor	2 (1.9%)	1 (.9%)	0
b. Assistant Professor or equivalent	23 (22.3%)	19 (17.8%)	24 (22.0%)
c. Associate Professor or equivalent	50 (48.5%)	56 (52.3%)	56 (51.4%)
d. Professor or equivalent	28 (27.2%)	29 (27.1%)	29 (26.6%)
e. Other (please specify)	0	2 (1.9%)	0
f. Not applicable	0		0

2020 Other Response

- Program Director, pending promotion to professor

2021 Other Response

39. As of June 30, 2019, how complete years have been program director? *Drop down menu with 0-20 and >20*

Years as PD	2019	2020	2021
Total responses	103 (100%)	107 (100%)	109 (100%)
0	14 (13.6%)	11 (10.3%)	15 (13.8%)
1	11 (10.7%)	18 (16.8%)	10 (9.2%)
2	7 (6.8%)	12 (11.2%)	10 (9.2%)
3	11 (10.7%)	8 (7.5%)	7 (6.4%)
4	5 (4.9%)	7 (6.5%)	5 (4.6%)
5	10 (9.7%)	6 (5.6%)	8 (7.3%)
6	10 (9.7%)	8 (7.5%)	9 (8.3%)
7	3 (2.9%)	7 (6.5%)	5 (4.6%)
8	6 (5.8%)	8 (2.8%)	12 (11.0%)
9	3 (2.9%)	1 (.9%)	5 (4.6%)
10	2 (2.0%)	5 (4.7%)	3 (2.8%)
11	1 (1.0%)	0	1 (0.9%)
12	1 (1.0%)	0	3 (2.8%)
13	4 (3.9%)	3 (2.8%)	1 (0.9%)
14	3 (3.0%)	0	2 (1.8%)
15	1 (1.0%)	5 (4.7%)	2 (1.8%)
16	4 (4.0%)	1 (.9%)	3 (2.8%)
17	2 (2.0%)	1 (.9%)	2 (1.8%)
18	0	1 (.9%)	2 (1.8%)
19	1 (1.0%)	3 (2.8%)	0
20	2 (2.0%)	1 (.9%)	2 (1.8%)
> 20	2 (2.0%)	6 (5.6%)	2 (1.8%)

40.. Prior to being program director, how many complete years did you serve as an assistant and/or associate program director?

Years as APD, Prior to PD	**2019**	**2020**	**2021**
Total Responses	103 (100%)	107 (100%)	109 (100%)
0	33 (32.0%)	34 (31.8%)	26 (23.9%)
1	10 (9.7%)	11 (10.3%)	17 (15.6%)
2	10 (9.7%)	17 (5.9%)	11 (10.1%)
3	12 (11.7%)	7 (6.5%)	10 (9.2%)
4	8 (7.8%)	4 (3.7%)	18 (16.5%)
5	14 (13.6%)	19 (17.8%)	11 (10.1%)
6	4 (3.9%)	2 (1.9%)	6 (5.5%)
7	6 (5.8%)	2 (1.9%)	1 (0.9%)
8	4 (3.9%)	3 (2.8%)	4 (3.7%)

9	0	2 (1.9%)	2 (1.8%)
10	1 (1.0%)	4 (3.7%)	1 (0.9%)
11	1 (1.0%)	1 (.9%)	0
12	0	0	1 (0.9%)
13	0	0	0
14	0	0	0
15	0	0	0
16	0	1 (.9%)	1 (0.9%)
17	0	0	0
18	0	0	0
19	0	0	0
20	0	0	0
> 20	0	0	0

41. What is your self-identified race/ethnicity? *(Choose one)*

	2019	**2020**	**2021**
Total Responses	103 (100%)	107 (100%)	109 (100%)
a. American Indian or Alaska Native	0.0%	1 (.9%)	0
b. Asian	14 (13.6%)	17 (15.9%)	13 (11.9%)
c. Black or African American	2 (1.9%)	2 (1.9%)	4 (3.7%)
d. Hispanic, Latino, or of Spanish Origin	4 (3.9%)	5 (4.7%)	5 (4.6%)
e. Native Hawaiian or Other Pacific Islander	0.0%	0	0
f. Caucasian/White	70 (68%)	72 (67.3%)	76 (69.7%)
g. Multiple Race/Ethnicity	4 (3.9%)	1 (.9%)	3 (2.8%)
h. Other (Please specify)	4 (3.9%)	3 (2.8%)	3 (2.8%)
i. Prefer not to disclose	5 (4.9%)	6 (5.6%)	5 (4.6%)

2019 Other Responses:

- South Asian
- Indian
- Middle Eastern
- South Asian

2020 Other Responses:

- Middle Eastern
- South Asian

2021 Other Responses:

- Mediterranean
- South Asian
- Mediterranean