

November 6, 2018

Thomas J. Nasca, MD, MACP
Chief Executive Officer
Accreditation Council for Graduate Medical Education
401 North Michigan Avenue, Suite 2000
Chicago, IL 60611

Dear Dr. Nasca,

The American College of Emergency Physicians (ACEP), which represents 38,000 emergency physicians, appreciates the opportunity to comment again on the proposed changes to the Common Program Requirements Section VI. In our previous letter sent on March 21, 2018, we outlined our concerns with these changes, specifically the threats to faculty protected time. While we would like to again express our appreciation for the time and effort that went into developing this document, we echo that uniformity with these requirements for all specialties could have unintended consequences.

The teaching of the specialty of emergency medicine (EM) has largely blossomed due to the flexibility allowed under the ACGME's EM – RRC requirements. EM is a leader in developing innovative teaching methods and it is different than other specialties because a significant proportion of our core curriculum is taught outside of the clinical arena. Protected time for core faculty has allowed EM to teach the wide scope of its curriculum to learners who are unlikely to encounter rare conditions or presentations during their clinical training. For example, it is highly unlikely that a resident will ever be exposed to a perimortem C section or a lateral canthotomy during their training; yet these skills are essential to the practice of emergency medicine. Opportunities for learning in the emergency department (ED) are episodic due to the nature of patient flow and are driven by the volume and variety of patients seen on shift. Unpredictable workloads, limited time for in-depth discussions, and frequent interruptions create substantial challenges within the ED learning environment.¹

In a survey conducted by the Society of Academic Emergency Medicine of their Simulation Academy, a majority of respondents said that more than 10% of their program's resident educational time was dedicated to simulation-based learning outside of the ED. Simulation requires significantly more faculty time to prepare and execute than standard didactic lectures. When asked if losing dedicated protected time would impact their ability to teach residents simulation, 89% strongly agreed that it would impact them. Of the same respondents, 89% strongly agreed that having dedicated protected time was important for EM simulation-based teaching. Faculty protected time allows for development of these necessary teaching opportunities. The Society of Clinical Ultrasound

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¹ Goldman EF, Plack MM, Roche CN, Smith JP, Turley CL. Learning clinical versus leadership competencies in the emergency department: strategies, challenges, and supports of emergency medicine residents. *J Grad Med Educ.* 2011;3(3):320-5.

Fellowships (SCUF) found that the average Ultrasound Division Director worked 288 hours a year on ultrasound education and an additional 124 hours performing quality assurance, which is done for educational purposes, on top of their time working clinically in the emergency department. We feel strongly that resident education, and future patient care, would be compromised without faculty protected time to cover the scope of our core educational topics. Ensuring that residents have the procedural knowledge and skills to take care of patients with any number of acute illness or injury is a matter of patient safety.

Emergency medicine has had a consistently higher burnout rate compared to other specialties. The nature of emergency medicine is high acuity and high demand, and a 24/7 clinical commitment which is incessant. The workplace is a major contributor to burnout in this profession. A survey published in *JAMA Internal Medicine* found that emergency medicine physicians had the highest burnout rate of any medical specialty.² ED volumes have increased significantly over the past 10 years as well as patient acuity. Emergency medicine faculty are required to cover all 24/7/365 service hours during the year and still have time for teaching, scholarship and research for core faculty. Unlike most other specialties, core faculty spend the majority of their teaching time at the bedside, during the off hours of nights, evenings and weekends. As opposed to other specialties, there is also no “down time” during a clinical shift in emergency medicine. Emergency physicians have cited difficulty even finding time to eat or use the restroom during a clinical shift because of competing demands for their time and critical nature of patient care.³ While other specialties have breaks in between cases or time while on-call to perform other administrative tasks, there is no administrative time built in to our clinical schedule. While faculty are able to supervise residents, there is rarely enough time to teach them a new skill or procedure while working clinically. Most procedural skills and labs are taught independently outside of clinical time. This is in direct contrast to other specialties that have elective cases, down time between patients, and control over the volume and acuity of patients during their clinical time. We believe that an unintended consequence of ACGME’s proposed changes is increased physician burnout. Without protected core faculty time, staff physicians will be required to carve out time somewhere else, which will likely come from their own personal time, vacation days, or time that is needed to reset from a night shift to day shift. This will compromise job satisfaction, the quality of education, and the ability for faculty physicians to care appropriately for themselves and their patients.

Emergency medicine is unique in that our academic faculty time is uniquely defined by hours worked/ year and not by a threshold of RVUs/ year or % of provider data from the Medical Group Management Association (MGMA). Other specialties have built in administrative time because they can meet their required RVUs and % MGMA in less than 40 hours/ week. The remainder of their time can then be spent on teaching, research, or other administrative requirements. All clinical hours in emergency medicine are allocated 100% to patient care. Emergency medicine is an “on-demand” specialty with little control over the type of patient or procedure presenting to the ED. MGMA is much more variable for EM than for other specialties because of significant differences in department staffing, patient acuity, and patient volume between facilities. This is compounded by core faculty who may work in Children’s ED or work a higher distribution of night shifts, which generate significantly less RVUs. Using a national norm for academic emergency medicine based on RVU generation or % MGMA is simply not practical for our specialty. Without dedicated rules to reduce the number of hours of required clinical time, emergency

² Shanafelt TD, Boone S, Tan L, et al. Burnout and Satisfaction With Work-Life Balance Among US Physicians Relative to the General US Population. *Arch Intern Med.* 2012;172(18):1377–1385. doi:10.1001/archinternmed.2012.3199

³ Kamaloo A, Ahmadipour A, Labbaf A, et al. Why Do Emergency Medicine Residents Experience Burn Out? A qualitative study. *Iran J Psychiatry.* 2017;12(3):214-218.

medicine does not have the same flexibility to allow their faculty to perform administrative duties and scholarly activity.

In addition, emergency medicine has been negatively impacted by other specialties modifying or decreasing their clinical training requirements. The downstream impact of these specialties changing their requirements to improve their own learning environment, is that emergency medicine now carries the burden of ensuring these skills are taught to its own residents. Many specialties have modified the requirement for ED rotations, some removing it altogether. Other specialties have shifted some patient care responsibilities to the ED, such as critical care for ICU patients who wait hours, or sometimes days, for admission to the hospital.

We believe that these changes may also have an unintended consequence on the overall landscape of academic affiliated residency programs. Residency training programs could become a new business model, maximizing efficiency and limiting overhead costs at the expense of resident education. Without clear requirements for scholarly activity, academic productivity of all core faculty members, and the needed protected time to prioritize the academic mission, our concern is that training programs will deemphasize scholarly output and academic productivity. Training programs will be pushed to prioritize profits over preservation of the academic mission.

Ultimately, physician education is a critical part of patient safety and public health. We understand the ACGME's desire for creating standards across specialties, but we believe a one-size fits all approach is detrimental to innovation, education, and patient care. Greater flexibility within the requirements would allow each distinct specialty to best meet the educational needs of its residents and ultimately, the patients that see them.

Thank you again for the opportunity to provide feedback.

A handwritten signature in black ink, appearing to read "Vidor Friedman". The signature is fluid and cursive, with a large, sweeping flourish at the end.

Vidor Friedman, MD, FACEP
President
American College of Emergency Physicians