



COUNCIL OF RESIDENCY DIRECTORS IN EMERGENCY MEDICINE

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Dear Dr. Nasca,

We are writing this letter on behalf of the Council of Residency Directors in Emergency Medicine (CORD-EM). Our organization represents 100% of the 237 ACGME-accredited emergency medicine (EM) residency programs and is comprised of residency program directors, a total of over 2100 educators in EM, and approximately 7384 residents.¹ We are respectfully writing in response to the recently distributed common program requirements. Our concern lies with section II. B. 4. b) where there is no ability for the EM Residency Review Committee (RRC) to specify requirements specific to core faculty. This change will limit the EM RRC's ability to create limitations on clinical hours for core educational faculty in the specialty of emergency medicine. We are extremely concerned about this change and the adverse effect it will have on core faculty and on the educational learning environment of our trainees.

While there may be a desire to create commonality in processes among training in all specialties, there are some unique qualities of each specialty that we believe require individualization. Specifically, EM has shift scheduling challenges, increasing patient volumes with frequent emergency department (ED) overcrowding, and an increased burden of clerical work. These factors pose some unique challenges in educating and training residents without the provision for protected time for clinician-educators. Additionally, changes in other specialties and decreased availability of specialists has led to increased workload on EM physicians and an increased need for education in areas that were previously not in the purview of our specialty.

The ED is open and available 168 hours per week, all weekends, and all holidays. In fact, the ED is often the only point of care accessible to patients outside of the usual 40-hour business week. ED providers are frequently busiest when other specialists are less available or not available at all. It has been demonstrated that when EDs are busy, EM physicians need to be able to distribute the work of procedures to admitting services in order to continue to serve the patients.² The current ED trends demonstrate increasing volumes and complexity each year which further challenge EM educators to teach during clinical shifts.³

Several changes in other specialty requirements to control the learning environment in compliance with ACGME rules have had downstream effects leading to a negative impact on the training of emergency physicians, as well as increasing ED workload. Examples and how they affect the learning environment include:

- Patient capping: There are no caps on the number of patients that can be seen in the ED. The doors are open 24/7 and many times the most critical patients are walking in and not being transported by ambulance. While divert may give reprieve from the ambulance traffic, it does not decrease the volume of walk-ins.

Contrary to EM, some other specialties have caps on the number of patients that can be cared for by a single provider. The effect of capping patient volumes to admitting services has increased ED crowding.⁴ ED crowding has potential to increase the cognitive load on the providers working in the ED. Such additional stress may have significant effects on empathy, ability to educate for teachers, and openness to receiving that education for learners.

- Procedural requirements: As other specialties make changes to their procedural requirements, decreasing their scope of practice, the responsibility for these procedures frequently shifts to the ED providers thus increasing the workload in the ED. One such example is the recent removal from the ACGME requirements for nephrology fellows to be trained in the placement of dialysis catheters. This has effectively shifted the responsibility for these catheters to be placed by critical care or ED teams for critically ill patients. There are few other specialties other than EM whose procedural scope of practice is determined by the attrition of responsibility by other specialties. This further increases the complexity of the learning environment and the cognitive load on education faculty.
- Rotation requirements: Recent decreases in requirements for EM rotations by multiple specialties has led to less understanding of the ED environment by these consultants and admitting teams, leading to an acceptance of delaying admitting orders until it is either convenient for that service (after rounds, after sign-outs, etc.) or the patient has been vetted by multiple hierarchical members within the specialty or the patient is discussed at length between the possible admitting services. This leads to delay in patient care, increased cognitive load on the ED providers as they are unable to finish the patient work-up, and decreased patient satisfaction scores which all can have negative effects on the provider's and patient's well-being.

The scope of practice of EM is very broad. One of the critical aspects of EM training is preparing learners for low frequency, high stakes clinical scenarios. As the scope of practice for procedures continues to evolve in an ever-expanding trajectory, the amount that needs to be taught and learned in environments other than the clinical setting increases as well. Post-mortem C-sections, emergent cricothyrotomies, acute resuscitations of massive gastrointestinal bleeds or ruptured ectopic pregnancies are not very common scenarios, but an excellent EM resident must be prepared and competent to perform these rare clinical cases as if they saw them every day. What allows drilling of these cases is increased use of high and low fidelity simulators and task trainers. Proper preparation of learners for these cases requires innovative teaching strategies that leverage technology, simulation, blended learning, and traditional teaching. In order to guarantee exposure of all residents to these procedures, procedural experiences and other teaching must be scheduled outside of the ED. It has been identified as a best practice for EM education to occur “beyond the shift” given the frequency of ED crowding which limits the time available for teaching due to immediate care needs of patients.⁵ Suggestions include that faculty send articles after shifts and create teaching files outside the shifts in order to best educate residents training in the ED. For procedural training, simulation education is increasingly necessary to ensure quality and a standardized training environment. The number of procedures and self-report of comfort does not equate to procedural competence.⁶ “Rigorous simulation-based education is a natural fit with the ACGME milestone framework because it provides standardization, deliberate practice, feedback, translation of outcomes to improved patient care, and reliable formative evaluation until a mastery standard is met.”⁶

While EM faculty are pleased to provide these styles of blending teaching methods and experiential learning environments, faculty require protected time for preparation and teaching. Such examples from EM educational faculty in ultrasound and simulation

demonstrate the time commitment of these training modalities outside of the clinical environment.

- The Society for Clinical Ultrasound Fellowships has performed benchmarking surveys as part of its application for American Board of Medical Specialties (ABMS) accreditation. As part of this application, it was determined that clinical ultrasound faculty spend, on average, 590 hours per year on ultrasound activities. Specifically, they spend, on average, 288 hours on ultrasound education alone, which is more than six hours per week, per faculty member. In addition, ultrasound faculty spend an additional 124 hours every year on quality assurance of ultrasound examinations that are performed by residents, fellows, and faculty as part of the education mission.
- Data from the Society for Academic Emergency Medicine's Simulation Academy demonstrates that, on average, 300 hours of simulation are taught every year to students, EM residents, and fellows by each EM simulation faculty. This survey also demonstrated that most programs are using simulation to educate EM residents with up to 30% of curriculum being taught via simulation and faculty report spending up to 50 hours per month on simulation education.
- Results from a recent internal CORD survey queried Program Directors, Assistant Program Directors, and Core Faculty in US EM training programs. There were almost 200 respondents. These core faculty reported that removal or decrease of core faculty protected time would be "job threatening" or "career threatening" in more than 95% of respondents. Likewise, over 96% of respondents reported that a loss of protected time would impede their ability to perform their academic duties to a large extent. Additionally, more than 99% of core faculty responding felt there would be a distinct negative impact from the loss of academic protected time.

EM has been on the forefront of innovative teaching solutions using sound andragogical theory. Without clear delineation of educational protected time for faculty, we will experience a decrease in educational innovation and effort. This will degrade the educational experience for the residents and have an adverse effect on patient safety. It has been demonstrated that the quality of the training environment impacts patient outcomes during training but also that this effect remains stable after graduation.⁷ Without the explicit requirement of protected time for EM faculty to teach, there will be a loss of that time secondary to the market forces described below. It should be clearly noted that the inability to train EM residents for rare, but high-risk clinical situations will not only have a profound negative impact on their training, but that impact will then be transmitted to the public as the population of inadequately-prepared residents grows with each graduating class.

We must also consider how the proposed rule changes will impact physician burnout. According to Medscape's Annual National Burnout and Depression Report 2018⁸, EM has one of the highest burnout rates. A study published in Archives of Internal Medicine in 2012 reported that EM physicians were three times more likely to develop burnout than the average physician.⁹ The following factors have been identified as drivers of burnout and engagement: workload/job demands, efficiency/resources, meaning in work, culture/values, control/flexibility, social support/community work, and work-life integration.¹⁰ The changes in the support for faculty time in academic settings will have significant impact on the workload/job demands and meaning in work categories. Increasing ED volumes, charting demands, and emphasis on throughput metrics have negatively impacted the teaching environment. Faculty at institutions with residency programs consider it part of their mission to educate the next generation of EM physicians. If the balance is shifted with increasing workload and decreasing time to

educate while maintaining the same challenging expectations to produce exceptional EM graduates well prepared to care for patients safely in any ED, there will be a negative impact on physician wellness and an increase in burnout. Our internal survey described above found that over 95% of respondents felt that removal of protections for academic time would be “job threatening” or “career threatening”.

Additionally, the practice of EM is becoming ever-more privatized and consolidated into large contracted medical groups (CMG). These corporations are large, for-profit companies that are incentivized to have their employees (EM physicians) see patients and generate revenue rather than spend time on educational or academic pursuits. This market pressure will begin to force CMGs that wish to remain lean and competitive to disincentivize academic and education time. This will absolutely and inevitably degrade the high standards EM educators hold their learners to and endanger patients both at those training sites as well as beyond.⁷

In this time when there is increased focus on physician wellness and improving the educational environment for residents, removing boundaries on clinical time for EM teaching faculty to engage in education is a step backwards and will have a negative impact on our specialty. We need the ACGME to continue to allow provisions for faculty to engage in education away from the bedside. This will allow for continued innovation, prevent the erosion of the educational learning environment, support the continued pursuit of wellness, and most importantly, ensure well trained graduates in EM ready to provide high quality of care for their patients.

Thank you for your consideration of our concerns,



Christopher Doty, MD, FAAEM, FACEP
President

on behalf of the Board of Directors

Council of Residency Directors in Emergency Medicine (CORD EM)

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