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September 10, 2020

Lynn M. Kirk, MD MACP
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Dear Dr. Kirk:

The American Academy of Emergency Medicine (AAEM) appreciates this opportunity to share our position on faculty protected time with the ACGME.

Graduate medical training in Emergency Medicine (EM) depends on residency program faculty members making substantial contributions of non-clinical work. This work provides crucial educational opportunities which cannot be accomplished during the "on-shift" course of clinical care, and range from traditional classroom-based didactics, to individualized hands-on procedural and simulation training.

The heaviest administrative burden is assumed by a residency's program director, assistant/associate program director(s), and program coordinator(s). Without sufficient support, this can quickly lead to burnout and rapid turnover, further compromising the quality of supervision and teaching.[1,2,3,4] Core faculty also play an essential role in fulfilling the educational and administrative needs of graduate medical education.[5] Likewise, supported time for program administration and resident education helps to sustain these faculty, allowing residency programs to successfully train residents and meet accreditation standards.

Non-Clinical Administrative Time for All Specialties

We believe the ACGME must require specific support for faculty administrative and educational work. Without such requirements, expected faculty efforts may come to be defined solely by clinical productivity. This would essentially require non-clinical contributions to graduate medical education to depend on the altruism of teaching faculty, a practice which would be neither ethical nor sustainable. Just as the ACGME restricts resident work hours in order to ensure resident wellness, healthcare quality, and patient safety, so too must it regulate faculty clinical time and non-clinical effort to ensure the quality of residency education.

Given the variability in how different specialties and institutions define 1.0 FTE, we believe it is important for the ACGME to define non-clinical protected time for program administration or resident education and/or maximum clinical time in a way that standardizes expectations across programs.

With respect to non-clinical administrative time for all specialties:

- The ACGME should establish requirements for supported time for the non-clinical work of program directors, assistant/associate program directors, core faculty, and program coordinators.
- To account for specialty-specific differences, the supported non-clinical time requirements should include a minimum base for all specialties with scaled increases for larger programs with more trainees.
- Individual review committees should be granted discretion to further specify additional detail, in consideration of the unique educational needs and clinical environment of each specialty.

Non-Clinical Administrative Time in Emergency Medicine

Emergency physicians must be knowledgeable about a wide range of conditions, including those which are infrequently encountered in clinical practice, but are nonetheless life-threatening. Didactic education outside the clinical realm, specifically through simulation, is necessary to ensure that residency graduates are equipped to handle any presenting complaint. Furthermore, certain skills, such as emergency ultrasound, require extensive direct supervision, often exceeding the boundaries of what can be demonstrated and practiced within routine clinical encounters within the ED.

The breadth of pathology in EM specifically requires extensive education, but it has been estimated that clinical shifts allow residents to encounter only 47% of the Model of Clinical Practice[6]; given that emergency physicians must be facile even with rare diseases and procedures, didactic education outside of the clinical environment -- specifically including simulation training, which now comprises approximately 10-30% of total EM residency educational time -- is crucial.[7]

Proficiency in ultrasound imaging acquisition and interpretation requires hundreds of hours annually of direct supervision of residents and hands-on training by faculty (preliminary data, ACEP internal survey of Ultrasound Section). But faculty working Emergency Department (ED) clinical shifts already face a heavy cognitive load, characterized by high patient loads compared with other outpatient or inpatient settings, frequent interruptions which are estimated to range from 6-12 per hour, and constant task switching, which seriously limit the amount of formal education that can be provided on shift.[8–12] The continuous clinical demands and constant direct faculty supervision of clinical care on shift in the ED means that didactics cannot occur during scheduled clinical work, but must be additive to faculty clinical time.[13]

Additionally, it is especially challenging to integrate EM clinical work-- which causes constant circadian disruption-- with non-clinical administrative and educational work, which generally strictly conforms to a diurnal rhythm.[14] Working night shifts and the concomitant sleep deprivation have been associated with fatigue, irritability, and decreased cognitive performance, limiting faculty's ability to work a night shift and then engage in administrative or educational work the following day.[15,16]

The 2018 Academy of Administrators in Academic Emergency Medicine (AAAEM)/Association of Academic Chairs in Emergency Medicine (AACEM) benchmark survey reported mean annual clinical hours of 942 for academic emergency physicians and mean non-clinical work hours of 922. (S. Bird, MD, September 2020).

A recent survey of the Council of Residency Directors in Emergency Medicine members found that the majority of PDs report working 711-735 clinical hours per year, with APDs working a median of 936-1159 hours per year. Average administrative time per week was estimated at an additional 31-40 hours per week (J. Smith, MD, unpublished data, August 2020).

A FTE can be defined as 2080 hours/ year, which includes 160 hours of paid time for vacation, conference attendance, and continued medical education. This leaves 1920 hours dedicated to clinical and non-clinical work in the emergency department.

Given the administrative and nonclinical education needs of EM residency training, we believe that the ACGME should require that:

- Program directors must be provided with the required salary support to devote at least 0.6 FTE non-clinical time to program administration, with clinical shift hours not to exceed 768 hours per year.
- Assistant/Associate program directors must be provided with the required salary support to devote at least 0.4 FTE non-clinical time to program administration, with clinical shift hours not to exceed 1152 hours per year.
- Core faculty must be provided with the required salary support to devote an average of at least 0.3 FTE non-clinical time each to fulfilling the program requirements, with average clinical shift hours not to exceed 1344 hours per year each. The specific distribution of non-clinical time for education and administration may be determined by the program director, with each faculty member receiving a minimum of 0.1 FTE of support for non-clinical education or residency administration effort.
- At least one program coordinator must be provided with 1.0 FTE support for administration of the program.
- Required support for administrative and educational effort should be scaled up as the size of the program increases.

Scaling of administrative and educational effort

- We support the current ACGME requirement in emergency medicine (II.A.2.) for a minimum of 1 Assistant of Associate Program Directors (APD) for a program of 18-35 residents, 2 APDs for a program of 36-53, and 3 APDs for a program of 54 or more.
- We would request further scaling expectations of 3 APDs for a program of 54-71, 4 APDs for a program of 72-89, and 5 APDs for a program of 90 or more to address large training programs. This would ensure residents from larger training programs receive equivalent support from their program leadership to promote resident well-being.
- We support the current ACGME requirement in emergency medicine (II.C.2.a.) of a minimum of 1.5 FTE support personnel including at least 1.0 FTE coordinator for programs of 31-45 residents, 2.0 FTE support personnel including at least 1.0 FTE coordinator for programs of 46-60 residents, 2.5 FTE support personnel including at least 1.0 FTE coordinator for programs of 61-75 residents, and 3.0 FTE support personnel including at least 1.0 FTE coordinator for programs of 76 or more.
- We would request clarifying 3.0 FTE support personnel including at least 1.0 FTE coordinator for programs of 76-90 with additional scaling for 3.5 FTE support personnel including at least 1.0 FTE coordinator for programs with 91 or more residents.

Characteristics of Residency Programs that Affect Workload

Specific factors that may affect the workload of program faculty and staff, and, thus, the required administrative time and effort include:

- Size of the program
- Affiliation with a medical school
- Number of other resident learners and medical students rotating in the emergency department

- Total number of clinical sites
- Number of other residency programs and overall graduate medical education resources available within the institution
- Financial resources dedicated to the program
- Institutional and local regulatory requirements
- Ratio of the total numbers of program APDs, core faculty, and program coordinators relative to the number of residents

Recommendations for How the ACGME Can Support Residency Program Leadership

In addition to requiring adequate support for program administration and resident education, the ACGME can lessen the administrative burden on program directors, core faculty, and program coordinators by reducing the effort required to comply with accreditation requirements.[17,18,19,20] Recent events have demonstrated that many tasks can actually be completed online and asynchronously with equal fidelity and superior efficiency.[21,22]

We propose that the ACGME eliminate site visits and the self study. The ACGME monitors program compliance through the annual WebADS update, but this is often duplicative with the Annual Program Evaluation and other local institutional requirements. To offload program directors, the responsibilities of monitoring program compliance, assuring the quality of training, and reporting to the ACGME should be shifted from individual programs to the institution. Similarly, since faculty development and faculty wellness are multifactorial and generally not controlled by residency program administration, oversight of these areas should fall within the purview of the institution rather than of the residency program director. The ACGME might also utilize existing learning management systems or develop a dual-purpose universal learning management system that would allow the ACGME to track necessary quality assurance data while also serving programs' educational and training needs. This would eliminate the need for programs or institutions to prepare and submit annual reports containing this data. The ACGME could redefine expectations for academic faculty broadly to encourage a more equitable distribution of workload among all faculty rather than a limited few.

Additional Considerations

In addition to changes in the accreditation and compliance process to reduce reporting effort required of program directors, AAEM believes required support for non-clinical effort remains of paramount importance. Faculty need to teach and train future generations of physicians. Rapid advances in science and technology, increased demands of clinical care due to an aging population, and more onerous documentation requirements, contribute to an increasingly challenging work environment. It has become increasingly challenging to provide sufficient education in the clinical environment to allow trainees to develop the knowledge and procedural competency required for independent practice.[23] The ACGME has placed great emphasis on safety of residents and patients: protected time allows for better resident education, which in turn translates to better patient safety and better quality of care.

The COVID-19 pandemic has highlighted that the work that faculty and residents do daily is essential and matters. It has also demonstrated the risks of a system that is already stretched to its limits at baseline and the importance of having sufficient faculty and staff bandwidth to allow for unexpected challenges.

Emotional exhaustion and burnout previously have been positively associated with total weekly work hours and negatively associated with supported non-clinical time for academic faculty.[24,25,26] There has been growing recognition of burnout in program coordinators as well.[27] COVID-19 seems to have exacerbated the existing problems with burnout

in graduate medical education.[28] Physician burnout feeds forward and affects patient care: studies have demonstrated negative effects of physician burnout on communication with patients, transfer of information during handoffs, pain management, ordering of tests, patient satisfaction, and unprofessional behavior.[29,30] Another important negative association with burnout is physician turnover.[31-35] Turnover of a residency program director or key education faculty impacts not just the physician, but the residency program and residents in it.

Faculty burnout negatively impacts resident education, as the current ACGME Common Program Requirements recognize: "Faculty members create an effective learning environment by acting in a professional member and attending to the well-being of residents and themselves."[36] COVID has disrupted traditional training processes, thereby increasing the workload associated with residency education and administration.[37,38,39] The ACGME has demonstrated consistent concern for resident well-being and has prioritized quality and safety in patient care, but the dangers of physician burnout and the importance of physician well-being don't end upon graduation from residency. The recent suicide of Dr. Lorna Breen in New York is a reminder that faculty have finite limits on how much time and effort they can and should expend on clinical and administrative work.[40] Protecting medical education faculty from harm by prohibiting excessive workloads parallels job safety requirements established by regulatory agencies within other industries. Most importantly, it is necessary for the functioning of our graduate medical education system, and it is the right thing to do.

Summary Recommendations

It is imperative that academic medicine carves out dedicated non-clinical time for education. AAEM would be pleased to participate in the proposed congress in November. We firmly believe that our residents' education, faculty wellness, and current and future patients' quality of care depend upon supported non-clinical time, so we can't afford not to provide it.

We strongly urge the ACGME to establish minimum requirements for supporting faculty non-clinical time for residency administration and education. Now more than ever, we must maintain standards of excellence in physician training, promote well-being for residents and faculty, and ensure the quality of future patient care.

Thank you for inviting AAEM to provide this information and for your commitment to high standards in residency training.

Sincerely,

Lisa A. Moreno, MD MS MSCR FAAEM FIFEM
President, AAEM

Joshua W. Joseph, MD MS FAAEM
Chair, AAEM Academic Affairs Committee

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