May 2019

Society for Academic Emergency Medicine

SAEM Responds to RRC-EM Proposed Changes that Reduce Required and Dedicated Protected Time for Key Faculty

The Society for Academic Emergency Medicine (SAEM), during an invited open commentary period, responded recently to Thomas J. Nasca, MD, MACP, CEO of the Accreditation Council for Graduate Medical Education (ACGME), regarding newly proposed changes to the Residency Review Committee for Emergency Medicine (RRC-EM) that would reduce required and dedicated protected time for key faculty. The SAEM response is reproduced below in its entirety.

Dear Dr. Nasca,

Thank you for the opportunity to respond regarding recent changes to the Residency Review Committee for Emergency Medicine (RRC-EM). As you know, the Society for Academic Emergency Medicine (SAEM) is an organization representing nearly 7,000 members from the academic emergency medicine (EM) community. Our members primarily come from academic departments, divisions, and community-based hospitals that have ACGME-accredited EM residency training programs. The proposed changes to the RRC-EM requirements have tremendous implications for our education, training, research, and clinical work environments and will impact the workforce of future EM physicians for years to come.

The newly-proposed changes to reduce required and dedicated protected time for key faculty represent an unmitigated real and existential threat to our specialty. As you know, our clinical operations, by necessity, are fully operational 24 hours a day, seven days a week. More than half of EM faculty clinical hours take place outside of usual business hours, making any efforts in non-bedside instruction and meaningful scholarly pursuits more challenging. The existence of required protected time for key faculty ensures that faculty have at least some time during typical business hours to pursue scholarly work and contribute to the education and training missions that serve the development of medical students, residents, and fellows. The sheer scope of content inherent to EM training also makes protected time for faculty critically important. The breadth of the EM Model requires both traditional and less traditional methods of instruction. For instance, the utilization of ultrasound and simulation in EM training is significant. It has been determined that clinical ultrasound faculty spend nearly 600 hours a 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. Time spent by emergency ultrasound faculty also enhances the training of residents, fellows, and faculty in other specialties (e.g., internal medicine, family medicine, pediatrics, etc.). Similarly, the broad scope of the EM Model requires significant education using simulation. This is due to the time-sensitive, rare, and unusual presentations of some conditions and procedures that must (by necessity) be taught utilizing simulation. Simulation is a faculty-intensive learning environment. On average, roughly 300 hours of simulation are taught every year to students, EM residents, and fellows by each EM simulation faculty.

Furthermore, the tremendous strain experienced in our clinical environments has led EM physicians to hold the ignominious title of most burned-out physicians. Recent surveys demonstrate that more than 70 percent of EM faculty meet Maslach criteria for burnout. Patient-boarding within the emergency department is further stretching the clinical and education environments to a breaking point. Resident education suffers when faculty are overly stressed and burned out. We believe the protected time for key faculty, which allows them a modicum of support to realize academic goals beyond bedside teaching, serves as a minimum-level buffer or safety net to burnout.

SAEM also has concerns about newly-proposed scholarly activity determination from the RRC-EM. Historically, all key faculty as *individuals* have been held responsible for contributing scholarly activity as part of the educational mission of their departments and residency programs. The benchmark of scholarly activity has always been grant funding and peer-reviewed manuscripts. What the RRC-EM is proposing is a step backward for EM as a specialty. After decades of hard work to justify our position as an innovative and impactful specialty in research and education, these changes over time will diminish the impact of our resident graduates to lead in research and healthcare change. We feel that the methods to quantify scholarly activities for residency programs should not change. The proposed changes will allow a small number of faculty to meet requirements and result in a reduction in diversity of novel thought exploration and scientific investigation in training programs. Fewer faculty doing scholarly work will result in fewer faculty to mentor residents. Residency training is a defined period during which residents learn to critically appraise literature, participate in research, and build a foundation for one's career. Working closely with many faculty who have academic interests and peer-reviewed productivity across the broad spectrum of emergency care is critical to a resident's education. Allowing the faculty scholarly productivity metrics to change such that a single person can contribute solely to that effort is misguided and fraught with consequences — both intended and unintended. Current RRC-EM requirements have met the needs of our learners, faculty, and departments for many years. The proposed changes to the RRC-EM requirements would have serious negative consequences to the education, training, and research missions of our residencies.

Concomitant with the relaxing of academic standards now proposed for all EM residencies has been a surge in non-academic residencies sponsored by contract management groups. Is it merely a coincidence that the RRC-EM proposed changes are occurring at the same time? Is this the future of residency training – decreasing academic standards, increased key physician clinical hours, and assuming that nearly all education will be done at the bedside save for a small number of dedicated faculty who become increasingly taxed with more mentorship expectations, less internal support, and diminishing volunteerism in the decades to come? We implore the RRC-EM to ensure protected time for EM key faculty and not change how scholarly activities are quantified among faculty. This appears to be a tipping point in the future of EM training. The legacy of the current RRC-EM is also at stake. Will you be the RRC-EM that looks to the future and ensures that residents are provided the best possible training, or will you be the RRC-EM that compromises our academic departments, our faculty, our residents, and our patients?

Sincerely,

Steven B Bird, MD
SAEM President

November 2018

SAEM and AACEM Respond to the New ACGME Common Program Requirements and Proposed Requirement Changes to the RRC for EM

The Society for Academic Emergency Medicine (SAEM) and the Association of Academic Chairs of Emergency Medicine (AACEM) today issued a response to the Accreditation Council for Graduate Medical Education (ACGME) regarding the ACGME's new Common Program Requirements (CPR) and upcoming changes to the Residency Review Committee for Emergency Medicine (RRC-EM) requirements. Read the full SAEM and AACEM statements.

Of particular concern to SAEM and AACEM are 1) how scholarly activities are determined by the ACGME and 2) that possible changes to the RRC–EM requirements would reduce required and dedicated protected time for core faculty.

The ACGME Common Program Requirements are a basic set of standards (requirements) in training and preparing resident and fellow physicians. These requirements set the context within clinical learning environments for development of the skills, knowledge, and attitudes necessary to take personal responsibility for the individual care of patients. In addition, they facilitate an environment where residents and fellows can interact with patients under the guidance and supervision of qualified faculty members who give value, context, and meaning to those interactions.

Please view official responses to the ACGME from other EM organizations:

American Academy of Emergency Medicine (AAEM)

American Academy of Emergency Medicine Resident and Student Association (AAEM/RSA)

American College of Emergency Physicians (ACEP)

Council of Residency Directors in Emergency Medicine (CORD)

Emergency Medicine Residents' Association (EMRA)