Review and Comment Form

The ACGME invites comments from the community of interest regarding the proposed requirements. Comments must be submitted electronically and must reference the requirements by line number and requirement number. For focused revisions, only the section(s) of the requirements that is being revised is open for review and comment.

Organizations submitting comments should indicate whether the comments represent a consensus opinion of its membership or whether they are a compilation of individual comments.

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<th>Title of Program Requirements</th>
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Name: Errol Alden, MD, FAAP
Title: Executive Director/CEO
Organization: American Academy of Pediatrics

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General Comments:

All general comments refer to lines 277–305 (Requirement III.A.) of the Common Program Requirements.
The AAP opposes the implementation of these new program requirements. As worded, the AAP is concerned that the requirements allow significant room for interpretation and misinterpretation. Overall, AAP member groups felt this change would apply to pediatric residents who wished to transfer from an osteopathic residency program to an allopathic program, and to fellowship applicants who had previously completed a residency program abroad.

The Academy maintains that these new requirements may have a harmful impact on pediatrics and pediatric fellowship training programs. Furthermore, and perhaps more importantly, the Academy believes that it is not the prerogative of the ACGME to accredit individuals, nor is it within that organization’s purview. The role of the ACGME is to evaluate and accredit medical residency programs in the United States. It is the role of the specialty boards (i.e., the American Board of Pediatrics [ABP]), through their certification process, to attest to the competence of individual physicians. The ACGME has established requirements for those who hold the position of program/fellowship director. Therefore, the ACGME must allow those individuals to exercise their professional, considered opinion as to whether or not an individual can successfully complete an ACGME-accredited residency or fellowship program, and to take all necessary steps/interventions to enable residents from non-ACGME programs to attain the required competencies. Through the issuance of citations to programs that do not follow these new program requirements, the ACGME is effectively usurping part of the program directors’ judgment and the ABP’s authority. Furthermore, at a time when this country is facing a physician workforce shortage, particularly in primary care, and pediatrics is dealing with a paucity of subspecialists, it is counterintuitive to introduce a requirement that has the potential to reduce the number of residents entering pediatric specialty training.

These changes may have the potential for denying the United States many outstanding physicians. The ACGME should limit its role to accreditation of programs within the US, and not be involved in accrediting individuals from foreign programs.

This change would mainly affect people who had residency training in foreign countries, and sometimes experience as specialist attendings in addition, who seek specialty fellowships in the US. It would re-route this group to apply either first to residency programs, or first to the American Board of Pediatrics for credit for foreign residency training, which is usually, if any credit at all, only partial (i.e. one year). It is logical in that if a person wants to be board-certified and stay in the US, this would be the route to take given current requirements. One question would be the effect on filling specialty fellowship positions if there is a shortage, but if the person illogically has to do a residency after fellowship to stay here, it is only the global supply of specialists that might ultimately be affected.

This seems to primarily affect two groups.

1) Some residencies require 2 years of preliminary pediatrics prior to joining the specialty residency. For example, child neurology is a residency in which the resident completes 2 years of preliminary pediatrics, 1 year of adult neurology and 2 years of child neurology. It is possible in this scheme, and happens regularly, that someone will do their 2 years of pediatrics in one program and the remaining 3 years in another. So it is possible that a person could do 2 years of pediatrics in another country and then come to the US to do the remaining 3 years. What the ACGME seems to be saying is that the 2 years of preliminary pediatrics must be done at an ACGME accredited program.
2) The American Board of Pediatrics allows IMGs to do a fellowship prior to doing a residency. For example, if a person does a pediatric residency in another country, they could come to the US, do a 3-year fellowship (neonatology seems to be a common one), and then, after doing the fellowship, do a 2-year residency with the 3rd year waived. Then they sit for general pediatrics boards, then their fellowship boards. This is all quite common. Every year we see several applicants to our program who are completing their fellowships and want a residency position. It seems that the ACGME is saying that those preliminary residency years before doing a residency must be done in an ACGME-accredited program.

The ACGME is primarily responsible for accrediting programs and not individuals, and the ACGME is coming close to—if not actually crossing—that line.

**SECTION ON CRITICAL CARE (SOCC)**
Several senior members of the Section, all of whom are recognized national and international leaders in the subspecialty, have contributed to this commentary.

It is the consensus of the AAP SOCC that these changes should not be adopted. We submit that these changes are unwarranted, will be counter-productive, and address an area that is out of the purview of the ACGME.

Currently, there are workforce shortages in many pediatric subspecialties, including our own subspecialty of critical care, due in part a shortage of trainees entering subspecialty fellowship training. It is worth noting that more than 20% of all pediatric critical care fellowship positions went unfilled in the most recent (2011) NRMP match; more than 40% of pediatric critical care training programs did not completely fill their positions.

Since the proposed changes will work to reduce the available applicant pool, they will further worsen current workforce shortages, and therefore seem unconscionable at this time. Additionally, these proposed changes do not appear to be based on any data, and there are no problems identified that the changes are supposed to solve. There are better ways to evaluate an individual's readiness for specialty training than just noting the country in which he or she trained. In any case, the role of the ACGME is to accredit programs, not trainees, as evaluation of the latter is the role of the subspecialty boards.

We therefore strongly object to the proposed changes and urge that they not be adopted.

**SECTION ON HOSPITAL MEDICINE (SOHM)**
The Section on Hospital Medicine Executive Committee feels strongly that the AAP should oppose the changes suggested in the document from the ACGME.

It is our understanding that it is not the prerogative of the ACGME to accredit individuals, nor is it within that organization’s purview.

In addition, and perhaps more concerning is that the change is given without any data to support why programs other than those approved by the ACGME and RCPSC are inadequate training. As written, this excludes those trained in the United Kingdom. We wonder if we are truly “better” than the U.K. system that requires many more years of training for registrars than are required for residents in the U.S.? It also is a disservice to children in other countries as we have an obligation to assist with international medical training needs.

Finally, in regards to the specific population of children we specialize in, hospitalized children, we fear that these changes will result in fewer subspecialists to meet their increasing complex needs both outside and inside the hospital. This would lead to increased and prolonged stays, increased error and cost. As the
field looks towards possible board certification, this would also affect the influx of physicians into hospital medicine, exacerbating shortages.

The AAP should speak out against the proposed changes.

**SECTION ON INFECTIOUS DISEASE**
This is a difficult issue to solve. We want to have well trained residents in the fellowship programs, but we need to fill programs as there are shortages across the country in many specialty areas. The best situation is to have some mechanism to assure all residents are knowledgeable for the fellowship training they choose.

**SECTION ON MEDICAL STUDENTS, RESIDENTS, AND FELLOWSHIP TRAINEES (SOMSRFT)**
The Section on Medical Students, Residents, and Fellowship Trainees has reviewed the Accreditation Council for Graduate Medical Education’s (ACGME) proposed amendments to Section III.A. of its Common Program Requirements. In brief, we agree and support proposed amendment III.A.2; we also agree with the spirit but have significant apprehension regarding proposed amendments III.A.3.a) & III.A.3.b) on the basis of numerous concerns outlined below.

Regarding proposed amendment III.A.2, we support this requirement that all physicians perform pre-requisite clinical education at programs accredited by the ACGME/RCPSC. Such “transitional” training years lay a critical foundation for young physicians’ aptitude in practicing medicine. We agree that physicians entering US residency programs that require pre-requisite clinical education should perform that training in ACGME or RSPSC-accredited programs.

Our Section’s primary concern revolves around the proposal to require all incoming fellows to have completed pre-requisite clinical education at ACGME or RSPSC-accredited institutions. Given that the majority of our constituents are residents, we are personally aware of the significant impact that fellows have on resident and medical student education. Thus, we agree with the spirit of trying to procure qualified fellows to train and actively participate in residency education in the US. However, this proposal has vast impact on global education and the practice of medicine. Per the ACGME impact statement, ~7% of current US and Canadian fellows would be affected by this amendment. Those 7% are training in the US to attain a superior medical education with the ultimate goal of returning to their native country. This proposed amendment would place a significant barrier to those physicians, with a resultant educational and clinical impact in other countries, with a presumably disproportionate impact in countries lacking sophisticated subspecialty medical education programs. Though we understand that the ACGME’s mission is to accredit US medical education institutions, the impact of its proposals should be considered as well.

Another concern is that the accreditation of a physician’s educational institution does not necessarily correlate with that physician’s aptitude in educating other trainees. We do understand that each physician can only transfer the knowledge they have personally attained. We could infer that the ACGME’s intent with this amendment is to maximize US resident education by ensuring that internationally-trained fellows have attained up-to-date educations. To the best of our knowledge, a thorough search of PubMed failed to demonstrate any data in this regard. In addition, we believe that other opportunities—such as requiring passage of medical specialty certification exams—could achieve this goal without the same degree of obstruction to internationally-trained physicians.

Overall our Section supports the spirit of both amendments in their attempt to optimize the education of our nation’s future physicians. We are concerned that burdens of proposed amendments III.A.3.a) & III.A.3.b) outweigh their potential benefits, and we would strongly urge the ACGME to evaluate other
avenues—such as requiring certification in medical specialty exams—which would achieve the same goals.

**SECTION ON NEPHROLOGY (SONp) EXECUTIVE COMMITTEE**

We strongly oppose the ACGME proposal to prohibit training of pediatric subspecialists who have not previously completed an ACGME approved pediatric residency.

There is a lack of evidence that the current subspecialty training paradigm in the U.S., which has included physicians who have not completed an ACGME approved residency, has impaired the quality of care of pediatric nephrology patients at United States hospitals. Pediatric nephrology program directors have considerable experience with critical evaluation of applicants who have completed ACGME and non-ACGME approved pediatric residencies alike and acceptances are based upon the individual’s experience and merit. By limiting the applicant pool, this proposal could potentially lead to more borderline candidates being accepted into fellowship programs given the grave manpower needs in pediatric nephrology (see below).

We acknowledge that pediatric nephrology fellows who have never trained at a United States hospital may be less familiar with the United States medical system. However, fellows are closely supervised directly by an attending physician and training program directors supervise from 1-6 fellows, providing for much more direct interaction on that level than often occurs in a residency program. Finally, we believe that the fellows without prior ACGME approved training are often the best of the best (see below), making it likely that these trainees will quickly adapt to any subtle differences in the practice of medicine. Many have years of prior experience, as both trainees and practicing physicians.

There are a number of potential negative consequences of this proposal:

1. Workforce issues: Pediatric nephrology currently faces a profound long-term workforce shortage. We currently have the oldest workforce in pediatrics and yet there remains a shortage of pediatric nephrologists. We anticipate a worsening of this situation, since more than half of American Board certified pediatric nephrologists are over 56 years old and will soon be aging out of the workforce. We are gravely concerned with any proposal that is likely to reduce the number of trainees in pediatric nephrology.

2. International training: The United States offers the premier training environment for pediatric nephrologists in the world. For this reason, we have attracted trainees from a variety of countries, including Australia, Israel, South Africa, numerous European countries, and many less developed countries. The United States has an important role in training physicians who return to their native countries. This is an important service for the rest of the world. In addition, the relationships forged during United States based training are important for fostering international collegiality and collaboration. This proposal would eliminate this training opportunity, and thus diminish the leadership role of the United States in pediatric nephrology training. In a world where globalization and international partnership are so important, this initiative sends our field in the wrong direction.

The trainees that would be excluded by this proposal often bring unique benefits to the United States. Some come with extensive prior research training and those skills are invaluable in advancing our field. As previously mentioned, some return to their native country, but continue to collaborate with pediatric nephrologists in the United States. A few return periodically to engage in ongoing research projects. Other trainees remain in the United States and meet critical workforce needs.

These trainees are often the best and brightest. Here are some examples:
Faculty and Division Directors at prestigious United States medical schools, many of whom have made seminal contributions to academic medicine and have received funding from the National Institutes of Health

- The current president of the International Pediatric Nephrology Association, a longtime United States-based pediatric nephrologist
- The head of pediatric nephrology in Sydney Australia
- A leading pediatric nephrologist at Great Ormond Street Hospital (the premier pediatric facility in Great Britain).

We believe that this proposal is addressing a problem that does not exist, and will have several extremely negative consequences.

**SECTION ON ORTHOPAEDICS (SOOr)**
This may not affect the manpower workforce in pediatric orthopaedics significantly. Currently, orthopaedics is a popular specialty and the great majority of US orthopaedic residents come from US medical schools. Pediatric orthopaedics, in the past, has not been as popular, mostly due to lower reimbursements in pediatric patients, perceived lower operative rates and difficulty caring for children with chronic conditions. However, there has been a recent surge in pediatric orthopaedic fellowship applications and this year saw a record 55 graduating from US pediatric orthopaedic fellowship programs (it is unclear how many of these fellowships are ACGME accredited). At this time, most fellows have come from US residency programs, and a few from Canada or other Commonwealth countries. Many of the foreign fellows return to their home countries, so it’s unlikely that they contribute significantly to our pediatric orthopaedic workforce. Our position on peds ortho fellowships has been to emphasize quality before quantity, and this ACGME revision is going in that direction.

**SECTION ON RHEUMATOLOGY (SORh)**
The Section on Rheumatology (SORh) Executive Committee reviewed the ACGME proposed revisions and agreed that the proposal will have detrimental effects on subspecialty training [for the reasons outlined in the AAP overview above]. These new requirements may have a harmful impact on pediatrics and, ultimately, on pediatric fellowship training programs.