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November 8, 2018

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

Dear Dr. Nasca and Distinguished Members of the ACGME,

The AAEM Resident and Student Association (RSA) is the second largest resident run group representing Emergency Medicine. As an accessible, collaborative organization that fosters innovation, education and advocacy, RSA prides itself on advocating for residents and students in emergency medicine. We represent nearly 4,000 residents and students, and as such we appreciate the opportunity to represent our constituency and comment on the proposed changes to the Common Program Requirements Section VI.

To start, we would like to express our appreciation for the time and effort that went into developing the proposal and recognize the countless hours spent on improving graduate medical education. We understand the importance of attempting to achieve standardization with program requirements for all specialties however would like to take this time to discuss potential areas for individualization as pertained to Emergency Medicine.

We as residents in emergency medicine have a different culture in regards to teaching and education. Our specialty includes around the clock coverage 365 days a year and does not universally allow for protected teaching during shifts. Often we are rushed to disposition patients or spend hours stabilizing a single patient. These conditions do not allow for time to sit aside and review cases and procedural skills with appropriate feedback. As such, in contrast to other specialties much of our core curriculum, as outlined in the EM Model, is taught outside of the clinical department.

The proposed CPR (I.A.1.) no longer provides RC-EM to protect program leadership including the director, associate program directors, and core faculty. This presents a significant threat to our education, as equating

clinical time to educational time is not applicable in the field of emergency medicine for the aforementioned reasons. This leads to the overwhelming concern that this proposition will directly lead to producing undertrained attending EM physicians. The consequences of which are limitless but most notably will be compromised patient care.

Given the known intense workload variation between Emergency Medicine training when compared to other specialties and between EM programs themselves, protected time for core faculty has allowed residents to learn aspects of diagnosing and managing cases that we may not see given our geographic location or hospital size, but are quintessential to learning the skills needed in EM practice. For example, the opportunities to perform a perimortem C-section or a surgical cricothyroidotomy are negligible during day to day shift work; yet these skills are essential to the practice of emergency medicine and require dedicated education.

Unfortunately, from a health care perspective Emergency Medicine as a specialty has been increasingly pressured to focus on increased clinical productivity to produce higher revenue generation. This is evidenced by the rise of EM residencies in community hospitals led by major healthcare systems. With these new programs it is imperative for accrediting bodies including but not limited to ACGME, ABEM, and AOBEM to defend the academic standard of residency training program and contribute to producing exemplary clinicians. Protected faculty time is essential to ensure this academic standard.

Again, we appreciate the opportunity to relay our concerns and are honored to contribute to any ongoing dialogue to improve residency education in Emergency Medicine.

With regards,

MohammedMoiz Qureshi, MD
President, AAEM/RSA