

ACGME Requirements Review and Comment Form

Title of Requirements	Program Requirements for GME in Radiation Oncology
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Organizations submitting comments should indicate whether the comments represent a consensus opinion of its membership or whether they are a compilation of individual comments.

Select [X] only one	
Organization (consensus opinion of membership)	X
Organization (compilation of individual comments)	
Review Committee	
Designated Institutional Official	
Program Director in the Specialty	
Resident/Fellow	
Other (specify):	

Name	ARRO Executive Committee
Title	
Organization	Association of Residents in Radiation Oncology (ARRO)

As part of the ongoing effort to encourage the participation of the graduate medical education community in the process of revising requirements, the ACGME may publish some or all of the comments it receives on the ACGME website. By submitting your comments, the ACGME will consider your consent granted. If you or your organization does not consent to the publication of any comments, please indicate such below.

The ACGME welcomes comments, including support, concerns, or other feedback, regarding the proposed requirements. For focused revisions, only submit comments on those requirements being revised. Comments must be submitted electronically and must reference the requirement(s) by both line number and requirement number. Add rows as necessary.

	Line Number(s)	Requirement Number	Comment(s)/Rationale
1	405	II.B.1.a)	<p>We agree with the proposed change to increase the minimum number of FTE radiation oncologists on faculty to a minimum of six, in addition to the program director.</p> <p>We also agree with the proposed change to increase the minimum number of FTE radiation oncologists on faculty at the primary clinical site to a minimum of four.</p> <p>We would like to suggest consideration of the following proposals:</p> <ul style="list-style-type: none"> ○ We propose that the program director be required to be on faculty at the <u>primary clinical site</u>. ○ We propose that each of the six FTE radiation oncologists be required to be <u>core faculty</u>. ○ We propose that any increase in faculty requirements be accompanied by a specification of the maximum number of participating sites that can partner with a program (see comments to Section III.B.2 (#6)). <p>The 2017-2018 ACGME data resource reports the mean number of physician faculty per program to be 11.4 (range: 3-58) and core faculty per program to be 8.2 (range: 3-39). We would recommend that further granular data be obtained and considered regarding the current number of FTE core faculty at the primary clinical site and participating sites, with consideration of the rationale and potential effects of any proposed change(s).</p>
2	409-414	II.B.1.b)	<p>We agree with the recommendation that the primary clinical site have a cancer or radiation biologist who is either a member of the department or a member of the cancer center of the Sponsoring Institution, and whose job description includes responsibility for resident education in radiation oncology.</p>
3	415-419	II.B.1.b).(1)	<p>While we agree that each radiation oncology program should have high quality didactic education in radiation and cancer biology, we also recognize that many programs rely on (and benefit from) <u>remote learning</u> (such as the UNC/Wake Forest/Duke course) or <u>pooling of resources</u> with other programs (such as with the New York programs or the University of Maryland course that is attended by residents across the country). We do not want to discourage or disincentivize programs from participating and/or investing in collaborative resources that enhance radiation and cancer biology education.</p> <p>As a result, we would suggest that the wording be more flexible, perhaps by recommending that the cancer or radiation biologist be responsible <u>for facilitation of an on-site, collaborative, or remote didactic educational program</u>.</p> <p>We do not agree with the requirement for a radiation biologist to lead a minimum of four cancer and/or radiation biology journal</p>

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		clubs or conferences. The quality of these sessions will likely be quite heterogeneous across programs; the rationale for this requirement is unclear.
4	506-509	<p>II.B.4.b.)(1)</p> <p>We agree that the faculty-to-resident ratio should be determined based on <u>core</u>, <u>FTE</u> faculty members.</p> <p>We would suggest clarification of whether this ratio should include only physician/clinical faculty that are board certified/board eligible in radiation oncology or would also include other faculty (i.e. a cancer or radiation biologist and medical physicist as per II.B.4.b.)(2).</p> <p>We would like also to propose that core faculty members be required to participate in and meet the requirements for the <u>Maintenance of Certification (MOC) program</u>.</p>
5	511-512	<p>II.B.4.b.)(2)</p> <p>We agree with the recommendation that core faculty should include a cancer or radiation biologist and a medical physicist.</p>
6	598	<p>III.B.2</p> <p>We do not agree with the recommendation of increasing the minimum size of the resident cohort. There is concern that the size of a program's resident cohort may be a poor surrogate for program quality; there are certainly small residency programs with 4 or 5 residents that provide high quality training. This proposed change may result either in the <u>unnecessary expansion of programs</u> that do provide excellent clinical training and didactic education or, perhaps worse, <u>the closure of strong smaller programs unable or unwilling to expand</u>. Unnecessary expansion of small programs that have the resources to do so for the sole purpose of maintaining ACGME accreditation would be unlikely to improve the quality of resident training and could even <i>worsen</i> it due to the dilution of clinical cases.</p> <p>On the other hand, the lack of stability of several of these smaller programs has caused us concern. Closure (or persistent threat of closure) of a program, a high level of faculty turnover, and resident dissatisfaction can compromise resident education and cause a not insignificant amount of stress. Furthermore, we are concerned that there are some training programs (of a variety of sizes) that may not provide satisfactory clinical or didactic training. Several residents have conveyed to us their personal concerns regarding the rigor and quality of their <i>own</i> training in anticipation of board qualification/certification and the transition to independent practice.</p> <p>The 2017-2018 ACGME data resource reports the mean number of participating sites to be 2.7 (std: 1.4, range: 1-7). Currently, residents are required to spend at least 50% of We would like to propose consideration of the following suggestions that we believe may facilitate an enhanced educational environment that</p>

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		<p>can more effectively foster academic collaboration as well as resident camaraderie and support:</p> <ul style="list-style-type: none"> ○ We propose the specification of a <u>maximum number of participating sites</u> (in addition to the primary clinical site) with which a training program may partner (<i>i.e. 3 total participating sites in addition to the primary clinical site</i>). ○ We propose <u>increasing the minimum amount of time that a resident is required to spend at the primary clinical site</u> (<i>i.e. from 50% to 60%</i>). <p>We would favor that any data utilized in the development of this recommendation be published in a peer-reviewed format, and appropriately cited, to allow for consideration by the radiation oncology community. ACGME criteria for program accreditation have significant influence on residency training and, in the long-term, on the specialty as a whole. These high stakes suggest that a more formal analysis using high quality and comprehensive data available from the ACGME, the ABR, and programs themselves may represent a more optimal method of establishing which characteristics inherent to residency programs and clinical training are associated with the successful development of competent and independent board-certified radiation oncologists.</p>
7	872-873	<p>IV.C.1.a-c)</p> <p>While we agree that rotations should be structured to minimize the frequency of rotational transitions and, ideally, should be a minimum length of two months, we are hesitant that this should be made a requirement. Indeed, we have received feedback from senior residents that they elect one-month rotations in order to maximize exposure prior to graduation. Similarly, it may be in a resident cohort's best interests to have a certain amount of flexibility as schedules are developed. <u>Perhaps the review committee could consider specifying a minimum number of rotations that must be of a minimum length of two months.</u></p>
8	917-925	<p>IV.C.5.b)</p> <p>We do not agree with raising the maximum number of cases to 350 per year. The rationale for this change, as stated, is unclear to us; hypofractionation of a treatment course does not necessarily translate into decreased time required for consultation, simulation, or treatment planning that is required for a single case. Allowing such an increase in workload may unintentionally detract from resident education.</p> <p>According to the ACGME data regarding national case logs reported per graduating resident, the median number of procedures (all cases) logged per resident was 663 (10th-90th percentiles: 535-844), while the number of definitive non-metastatic cases logged per resident was 338 (10th-90th percentiles: 267-435).</p> <p>We propose that the ACGME/RRC consider the following:</p>

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		<ul style="list-style-type: none"> ○ We suggest specification of a <u>minimum</u> number of <u>definitive</u> cases that must be performed as part of the 450 simulations required for graduation. ○ In addition to minimum numbers of SRS, SBRT, and brachytherapy cases, we suggest specification of a <u>minimum</u> number of certain core <u>site-specific definitive</u> external beam simulations that must be performed by graduation. <p>These suggestions may help to ensure that ACGME accreditation is granted only to those programs that can provide sufficiently rigorous training across core disease sites and techniques.</p>
9	927-936	IV.C.6 We certainly agree with the proposal to <u>increase the minimum numbers of interstitial and intracavitary brachytherapy procedures</u> as well as to set a minimum number of required tandem-based insertions and a maximum for cylinder insertions. We are concerned, however, that an increase from a minimum of 5 to 7 cases will have a minimal impact on resident competence in brachytherapy. Per the ACGME case logs, the median number of interstitial brachytherapy cases that a resident performs is 15 (mean: 20.6, std: 17); indeed, over 90% of residents perform 6 or more interstitial brachytherapy cases. In a recent resident survey, however, 59% of survey respondents reported that caseload was the greatest barrier to achieving independence in brachytherapy (Marcrom et al, IJROBP, 2019). We therefore suggest that ensuring competence in these procedures be considered a priority at this time. We recommend that there be a more formal determination of the number of both gynecologic and prostate brachytherapy cases that should be required for the demonstration of competence.
11	992-994	IV.C.12 We very strongly agree with <u>site-specific rotations</u> in gastrointestinal, gynecologic, genitourinary, lymphoma/leukemia, head/neck, breast, adult CNS, and thoracic malignancies. We believe that a well-trained radiation oncologist must demonstrate competence in each of these disease sites. Site-specific rotations will help ensure each accredited residency program is able to provide broad-based clinical exposure as well as disease site-specific expertise.
12	1036-1041	IV.C.16 We agree with the inclusion of the specified topics as part of a department's clinical oncology conference series. We would, however, suggest that this may be achieved through an <u>interdepartmental oncology conference series</u> as opposed to mandating this occur within each department.
13	1123-1125	IV.D.3.b We agree that residencies should require scholarly work that is <u>submitted</u> to peer-reviewed journals or presentation at scientific meetings.

General Comments:

On behalf of radiation oncology residents nationwide, the Association of Residents in Radiation Oncology (ARRO) Executive Committee would like to sincerely thank the ACGME and the radiation oncology Residency Review Committee (RRC) for undertaking this effort. We appreciate the complexity of these decisions and are mindful of the influence these recommendations may have on residents, programs, as well as the specialty as a whole.

In this response, we have attempted to represent the broad base of opinions of our resident constituents. For this purpose, we queried residents regarding their opinion of these proposed changes; 97 residents from submitted comments that comprise over 7 single-spaced pages. These compiled, anonymous comments will be separately submitted.

We believe this review process represents an opportunity for stakeholders to thoughtfully consider the characteristics of a residency program that should represent the national standard for an accredited radiation oncology residency program. We believe that this exercise represents what we hope are a series of conversations and data-driven analyses.

We appreciate that each of our comments seems to elaborate on one of the following two central themes:

- We would suggest that any proposed change(s) to the ACGME Program Requirements be considered in the context of relevant data (i.e. ACGME case logs; association with relevant outcomes such as job procurement or board performance). In addition, we would suggest that a “simulation” be performed in order to estimate the actual effects of each recommendation individually and in toto.
- We would suggest that any proposed change to the ACGME Program Requirements should prioritize resident education and transition to independence (i.e. radiation oncology milestones; demonstration of competence).

We hope that as further revisions are considered these themes may be kept in mind.

We would like to reiterate our sincere gratitude to the ACGME and the RRC for taking the time to propose these revisions and to so proactively seek summary feedback from individuals as well as stakeholder organizations. We are also grateful to each organization and each individual who has taken the time to provide this feedback. Please do not hesitate to contact the ARRO Executive Committee if we can be of any help moving forward.