



Dear ACGME Leadership and Members of the Common Program Requirements Review Committee:

On behalf of the undersigned emergency medicine organizations, we appreciate the opportunity to comment on the proposed revisions to the ACGME Common Program Requirements (Residency). We recognize the substantial work involved in reviewing and modernizing requirements across graduate medical education and appreciate the goals of reducing unnecessary complexity, promoting consistency, and allowing programs greater flexibility in meeting educational outcomes.

At the same time, we have significant concerns about the potential impact of several proposed changes on emergency medicine residency training. Emergency medicine is practiced in an environment characterized by continuous patient care, unpredictable volume and acuity, frequent interruptions, circadian disruption, and sustained high-stakes decision-making. These characteristics have appropriately informed specialty-specific accreditation standards developed by the Emergency Medicine Review Committee through extensive expertise, deliberation, and stakeholder input.

Our principal concern is not simply with individual proposed changes, but with the broader issue created when common standards are coupled with deletion of specialty-specific requirements and removal or narrowing of Review Committee authority to further specify those requirements. **We believe the Common Program Requirements should establish a floor for graduate medical education, not a ceiling that prevents Review Committees from establishing more stringent standards when warranted by the clinical and educational needs of a specialty.**

Preserve specialty-specific clinical work-hour protections

We are particularly concerned about the potential loss of emergency medicine-specific clinical work-hour protections.

The recently approved Emergency Medicine Program Requirements limit residents to no more than 12 continuous scheduled hours in the emergency department, 60 scheduled ED patient-care hours per week, 72 total hours per week, and six consecutive days in the ED, while requiring one 24-hour period free every seven days without four-week averaging. The proposed CPRs instead

permit up to 80 hours per week averaged over four weeks, up to 24 continuous hours of scheduled clinical assignments with additional time for transitions of care or education, and averaging of the required day off over four weeks. Existing specialty-specific requirements in these sections and Review Committee authority to further specify them are proposed for deletion.

Clinical hours are not necessarily equivalent across specialties. Emergency department work requires sustained attention and rapid decision-making amid unpredictable volume and acuity, frequent interruptions, and limited opportunity for predictable downtime. Specialty-specific work-hour protections appropriately recognize these differences.

We urge the ACGME to preserve Review Committee authority to establish more stringent specialty-specific limits on weekly clinical hours, continuous scheduled clinical work, consecutive days worked, and required time free from clinical responsibilities. We also encourage reconsideration of the proposed reduction in required recovery time following 24 hours of in-house call from 14 hours to 12 hours.

Preserve adequate core faculty resources

We are also concerned about proposed §2.25, which would prevent a Review Committee using a faculty-to-resident ratio from requiring more than one core faculty member for every five residents. The recently approved Emergency Medicine Program Requirements require at least one core faculty member for every three residents; the proposed CPR language would prevent the Emergency Medicine Review Committee from retaining that standard as a ratio.

Core faculty support bedside teaching, assessment, mentorship, remediation, curriculum development, simulation, scholarship, Clinical Competency Committee activities, program evaluation, and resident well-being. Reducing required faculty resources risks diminishing the educational infrastructure necessary for high-quality residency training.

Although programs may voluntarily maintain greater faculty resources, local commitments are not equivalent to accreditation standards. Accreditation requirements materially influence institutional allocation of faculty time and financial support. We therefore recommend preserving Review Committee authority to determine core faculty requirements appropriate to each specialty's educational needs.

Maintain specialty-specific standards for leadership, faculty, and supervision

The proposed CPRs also raise concerns regarding program director qualifications and continuity, physician faculty qualifications, and supervision.

The revisions would remove the explicit requirement addressing continuity of program leadership and could create pathways for program directors or physician faculty who are not eligible for specialty board certification to serve with GMEC approval. They would also remove

existing Review Committee authority to specify certain certification expectations and provide greater flexibility for cross-specialty supervision.

Flexibility may be appropriate in selected circumstances, but program leadership and faculty expertise are foundational to specialty training. We encourage the ACGME to preserve sufficient Review Committee authority to establish qualifications and supervision standards appropriate to each specialty.

Preserve specialty authority over educational outcomes and scholarship

We are concerned by the proposed changes to Patient Care, Procedural Skills, and Medical Knowledge, particularly when the shift in language toward what programs must provide instruction in and assess is combined with removal of associated specialty-specific requirements and Review Committee authority to further specify these competencies.

Determining the clinical experiences, procedural skills, and medical knowledge necessary for independent practice is a core function of specialty-based accreditation. Specialty Review Committees should retain authority to establish specific expectations necessary to ensure graduates are prepared for independent practice.

Similarly, while we appreciate greater flexibility in how residents and faculty engage in scholarship, the proposed CPRs lower the minimum accreditation threshold for faculty and resident scholarship and would remove existing Review Committee authority to further specify scholarship requirements. We encourage preservation of Review Committee authority to establish meaningful specialty-specific expectations in this area.

Recognize the professional role of program coordinators

We also encourage reconsideration of the proposed terminology replacing “program coordinator” with “GME administrative professional.” Program coordinators are skilled graduate medical education professionals whose responsibilities extend well beyond clerical or administrative assistance and include management of accreditation processes, recruitment and onboarding, scheduling, program evaluation, data management, and residency program operations.

The proposed terminology may unintentionally diminish recognition of the expertise and professional responsibilities associated with this role. We encourage the ACGME to retain a program-specific title, such as “program coordinator” or “program manager” that appropriately reflects the specialized expertise and responsibilities of these professionals, and to ensure that revisions to personnel requirements do not inadvertently reduce the administrative infrastructure necessary to support residency programs.

Common standards should be a floor, not a ceiling

Again, we support the ACGME's efforts to streamline and modernize accreditation requirements and recognize the value of clear, consistent expectations across graduate medical education. Consistency and specialty specificity, however, need not be competing goals.

The clinical environments, educational needs, and requirements for independent practice vary meaningfully among specialties. Specialty Review Committees provide the expertise necessary to translate common principles into standards appropriate to those differences.

We therefore respectfully ask the ACGME to preserve Review Committee authority to establish more stringent specialty-specific requirements when justified, particularly with respect to clinical work hours and fatigue protections, core faculty resources, program leadership and faculty qualifications, supervision, patient care and procedural competencies, medical knowledge, and scholarship.

The Common Program Requirements should establish a floor of standards shared across graduate medical education while allowing specialty Review Committees to raise that floor when necessary, not create a ceiling that prevents them from doing so.

We appreciate the ACGME's commitment to graduate medical education, its willingness to solicit stakeholder input, and its consideration of these concerns. We welcome continued dialogue toward an approach that achieves the benefits of streamlined Common Program Requirements while preserving the specialty-specific standards necessary to ensure high-quality training, resident well-being, and patient safety.

Respectfully,

Jaime Jordan MD, MA

President

Council of Residency Directors in Emergency Medicine (CORD)

On behalf of the Council of Residency Directors in Emergency Medicine and the undersigned organizations

