April 29, 2025

Setting Our Frame of Reference

On behalf of the Society for Academic Emergency Medicine (SAEM), representing our more than 9,700 members, including members from the Association of Academic Chairs of Emergency Medicine (AACEM), Clerkship Directors in Emergency Medicine Academy (CDEM), and Residents and Medical Students (RAMS), we thank you for the opportunity to comment on the most recent proposed specialty-specific changes to the Common Program Requirements (CPR) put forth by the ACGME Review Committee for Emergency Medicine.

SAEM is deeply committed to the training, mentorship, and professional development of the next generation of emergency physicians. We recognize and appreciate the ACGME's efforts to advance graduate medical education. However, we are concerned that several proposed changes are being implemented on an accelerated timeline without sufficient consensus or clarity.

Many within our community feel these changes are being introduced too quickly, with limited opportunity for thoughtful, inclusive stakeholder engagement. While the intent behind the revisions is commendable, the rapid pace of implementation risks creating unintended disruptions to emergency medicine training programs across the country. To that end, we respectfully request a pause in the implementation process to allow for broader engagement, more transparent communication, and deliberate consideration of the long-term impact on our specialty.

We also urge the ACGME to conduct a new, transparent survey with clearly articulated objectives and methodology. The prior survey, which has played a significant role in informing these revisions, has raised concerns among many educators and program leaders who felt the questions lacked clarity and may have led to misinterpretation. A rigorous, purpose-driven assessment—conducted with complete transparency—would help restore confidence in the decision-making process.

SAEM | 1111 East Touhy Avenue, Suite 540 | Des Plaines, IL 60018
Tel: (847) 813-9823 | Fax: (847) 813-5450
www.saem.org | info@saem.org

Specifically, it is not clear that program directors understood that they were voting for new program requirements that would have far-reaching implications on program duration and required resources.

In addition, if an extension in the duration of training is required, it should be accompanied by a meaningful expansion in the scholarly expectations of our trainees with appropriate space to complete these expectations. SAEM strongly supports scholarship as a core competency of emergency medicine training, and any increase in training time should correlate with measurable increases in academic productivity and impact.

Competency-Based Education

Competency-based medical education (CBME) is rapidly emerging as a best practice at all levels of medical education, and program requirements should reflect this shift in pedagogy. While the rationale for changes is described in competency-based language, the requirements themselves focus on numeric and time-based requirements, and often fail to specify the desired competencies to be gained from additional educational experiences. To truly meet the needs of our patients for decades to come, the paradigm for training should seek to ensure competency and entrustment rather than rote time requirements..

For example, revision 4.11.d.2.c stipulates that residents must spend four weeks in a "low-resource" ED. The benefit of this new requirement is described only as providing a balanced experience that will prepare residents for autonomous practice in any setting. However, in the absence of specific competencies to be gained from such an experience, it is entirely possible - in fact, likely - that resident experience on these rotations will be highly variable, and in many cases will not meet the desired goals. Rather than stipulating new rotation requirements, we believe the better way forward is to clearly define the competencies that new rotations are intended to support residents in achieving. This would allow program directors latitude to identify the best educational experiences available within their individual contexts to foster competency in the desired domains.

While we appreciate that the proposed program requirements intentionally do not incorporate time-variable educational models, we emphasize that, even with careful tailoring to objectives, time-based rotations do not ensure competency for all learners. Program directors need to have the flexibility to account for the individual learning styles and speeds by adjusting curricula in accordance with needs. This would allow graduated

responsibility for residents who achieve competency more quickly, and additional learning experiences for those who require more time. Replacing time-based requirements with clearly defined competencies would better support all residents in their progression towards mastery of key EM knowledge and skills.

With the nuanced nature of bedside emergency sonography, we concur with the joint statement from the Emergency Ultrasound Community.

We hope our recommendations below will be received in the spirit of collaboration with which they are offered. SAEM is eager to partner with the ACGME in refining these proposals to advance educational excellence while preserving the **flexibility** and **innovation** that have long been hallmarks of emergency medicine training and are highlighted as central to the specialty within the new proposed program requirements. We recognize that there are many proposed changes that are not addressed below. **These specific recommendations represent areas in which SAEM and its constituents have reached clear consensus.**

1.6.F	SAEM **opposes** this change
Programs must utilize at least one high-resource emergency department and at least one low-resource emergency department for training in emergency medicine	The proposed requirement of a mandatory rotation at a low-resource emergency department as part of residency training is not in alignment with P.R. 1.6.c.2 and the longstanding requirement that emergency medicine residents must be supervised by board-certified emergency physicians when rotating in an emergency department. Requirement 1.6.c.2 reads "The program should ensure that residents are not unduly burdened by required rotations at geographically distant sites." Geographically distant is defined as a site that requires extended travel (consistently more than half an hour each way) or if the distance between the site and the primary clinical site exceeds 60 miles. In addition, the program requirements state that programs will seek locations that mitigate excessive burden on residents (e.g., support for travel, accommodations) and include consideration of safety, financial impact, removal from family/life, and social impact. For many, this new P.R. will mean travel and time away from family, as well as potentially having a financial impact on the sponsoring programs and trainees, given travel. P.R.2.10.b. states that faculty members supervising emergency medicine residents seeing patients in an emergency department must be certified in emergency medicine by the ABEM or the AOBEM. Many under-resourced emergency departments, especially in rural areas, are not staffed 24/7 with board-certified emergency medicine physicians. (See reference below) We recommend that rather than a required rotation in a low-resource emergency department, the RRC stress required outcomes or a structured

	experience where residents must demonstrate before graduation their 1) ability to care for patients in a variety of emergent care settings, 2) understanding of the capabilities and limitations of these settings, 3) ability to arrange appropriate transfer of patients to higher-resource setting, including document preparation (4.9.k and 4.11.f.11.), and 4) ability to communicate with consultants to assure patients are dispositioned appropriately to get the care that is warranted for their presenting condition.

1.8.H	SAEM **opposes** this change
The aggregate annual volume of patients in the emergency department at the primary and participating emergency department sites must total at least 3,000 patient visits per approved resident position in the program, determined via a calculation defined by the Review Committee.	The number of patients seen in any department does not guarantee any particular number of patients available to be seen by a particular resident. The variability in ED staffing models among EDs nationally (Ex: variance in hours worked per resident in the ED per year, number of other learners in the department, patient volume cared for without resident involvement, the care of boarding patients) prevents this number from being meaningfully applied to the residency experience. The ACGME RRC-EM acknowledges that the number of patient encounters needed to achieve competency is unknown. Therefore, incorporating a minimum number becomes arbitrary. Rather, we suggest a defined and transparent process (such as reporting requirements, etc) to help the ACGME determine the needed number of encounters before imposing a minimum, especially one that would require multiple programs to close.

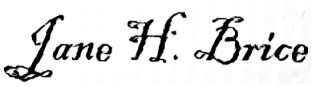
4.11.D.6.	SAEM **opposes** this change
Residents must have at least a two-week experience in administration/quality assurance. (Core) and 4.11.d.6.a. Residents must participate in an emergency department quality improvement project. (Detail)	These are already performed in many departments as part of the ongoing didactic curriculum or administrative requirements of the program. Additionally, Administration and quality assurance ebb and flow throughout the calendar year; limiting participation to a fixed period would likely hamper instead of improve residents' experiences/exposure, and competency development. We suggest changing this to a Structured Experience. Inclusion of the QI project as one of the types of disseminated scholarly projects (4.15.a) would allow residency programs to put residents on a 2-week QI rotation, have them complete their “scholarly project” during this time, and then not require any other scholarly work during their residency. This diminishes and could even eliminate actual research experience time in residency for programs not willing to invest the resources here.

4.11.D.2.F.	SAEM **opposes** this change

Residents should have no less than eight weeks of experience in a practice setting designated for low-acuity patients, such as an emergency department fast track or urgent care center. Time Requires the above. spent in a low-resource emergency department does not count toward this experience. (Detail)	This is a time-based, not competency-based, requirement. Additionally, all departments (low resource and high resource) include low acuity patients. We recommend setting a target total number of patients evaluated with an ESI of Level 4 or 5 throughout their training.

Sincerely,

Ali S. Raja, MD, DBA, MPH
SAEM President



Jane Brice, MD, MPH
AACEM President

Keme Carter, MD
CDEM President

Ly Cloessner, MD, MSPH
RAMS President