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April 20, 2021

Louis Potters, MD, FASTRO  
Chair, Society of Chairs of Academic Radiation Oncology Programs  
(SCAROP)  
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Dear Dr. Potters:

The ACGME Residency Review Committee (RC) for Radiation Oncology thanks you for SCAROP's thoughtful letter dated March 31, 2021 regarding the current state of radiation oncology training. ACGME and SCAROP share a common goal of ensuring high-quality care of cancer patients through a committed and well-prepared workforce. We also share the concerns voiced by SCAROP's Executive Committee, and are similarly dedicated to improving the quality and culture of radiation oncology training.

As you are aware, the ACGME is an independent, not-for-profit organization that sets and monitors compliance with professional educational standards essential in preparing physicians to deliver safe, competent medical care.

ACGME-accredited radiation oncology residency training programs are reviewed annually (at a minimum) by the RC, which is comprised of volunteer radiation oncologists nominated by the American Board of Radiology, the American College of Radiology, and the American Medical Association's Council on Medical Education, in addition to a resident member and a non-physician public member. Beginning this year, the American Society for Radiation Oncology (ASTRO) is now also a nominating organization to the RC. All RC members undergo an extensive nomination, application, and selection process; the RC Chair and Vice Chair are internally nominated and elected positions.

Accredited programs are continuously monitored for substantial compliance with all applicable ACGME requirements using submitted annual program data indicators, which include: case logs; leadership, faculty, and resident attrition; resident and faculty scholarly activity; and certifying board exam results. The RC also monitors annual ACGME Resident and Faculty Survey results for every program. Inherent in the ACGME's role as an accreditor is achieving an optimal balance between the assurance function (regulatory focus) and the improvement function (continuous improvement) of educational programs and the outcomes of their graduates.

With respect to SCAROP's specific suggestions, the RC would like to comment and respond to each point:

1. We agree there is value in having other oncology residents and fellows at both the primary clinical site and the Sponsoring Institution, if it is not also the primary clinical site. We are already working on focused revisions of the Program Requirements to strengthen the relationship between the Sponsoring Institution and the primary clinical site, as applicable, to ensure quality training and a rich learning environment. As part of our proposed revisions, we recommend that three or more of the following ACGME-accredited residency and/or fellowship training programs be active at the Sponsoring Institution and be directly involved in radiation oncology residency training at the primary clinical site: complex general surgical oncology; gynecologic oncology; hematology and medical oncology; hospice and palliative medicine; interventional radiology; micrographic surgery and dermatologic oncology; musculoskeletal oncology; neurological surgery; otolaryngology - head and neck surgery; pediatric hematology/oncology, thoracic surgery; and urology.
  
2. As indicated in #1 above, the RC recognizes the vital role of the primary clinical site in providing a robust clinical and academic environment that supports resident education and professional development. We also recognize the value of other clinical training environments within an accredited program, and the contributions of teaching faculty and staff at these locations, which may include high-volume affiliated community hospitals, veterans' affairs hospitals, and non-primary sites with unique technologies. To improve upon the current 51%, the RC is already considering a threshold of 60% for a program with a single main site, or higher threshold for a program with two main clinical sites, with a grace period for affected programs to adjust their clinical rotations in order to meet the new threshold(s).

We appreciate the rationale of defining a clinical faculty member as someone who has at least a 0.8 full-time equivalent (FTE) clinical role. However, we are concerned that there might be unintended consequences of excluding clinical faculty with alternative work schedules or significant administrative or research duties, but who are dedicated educators and mentors. A strict FTE limitation might be counterproductive and could inadvertently penalize both faculty and trainees in these situations.

3. In previous focused revisions of the Program Requirements, the Review Committee already took steps to ensure that teaching faculty includes physics and biology faculty:

*II.B.1.b) The primary clinical site must 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. (Core)*

- II.B.1.b).(1) This must be a faculty member who is responsible for oversight and organization of an on-site didactic educational program core curriculum. (Core)*
- II.B.1.b).(2) This individual must be based at the primary clinical site or at a participating site. (Core)*
- II.B.1.c) To provide a scholarly environment of research and to participate in the teaching of radiation physics, the core faculty must include at least one full-time medical physicist (PhD level or equivalent). (Core)*
- II.B.1.c).(1) This individual must be based at the primary clinical site or at a participating site. (Core)*

The RC gives autonomy to the department chair and program director to manage faculty availability through office hours and the like.

4. The RC is committed to ensuring that residents do not have excessive clinical responsibilities that interfere with their education and work-life balance. As stated above, the metric of FTE does not account for variations in clinical practices across programs. However, the RC believes any rotation where there is a combination of coverage that exceeds 1.0 clinical FTE equivalent physician should have a clear rationale of why this is in the best interest of resident education, and have a mechanism to prevent excessive clinical work, such as use of an advanced practice provider.

It is an expectation in the Common Program Requirements for all specialties that the program director, together with members of the Clinical Competency and Program Evaluation Committees, oversee the balance of education and clinical service; ensure that goals and objectives of clinical rotations are met, and if not met, enact corrective measures; and prioritize resident education and well-being. The RC monitors program compliance in several ways annually, as noted above. To the extent that we receive accurate program information and honest survey responses, the ACGME has zero tolerance for violations of this policy.

5. The RC fully agrees that brachytherapy is an important component of resident education, and the above-mentioned proposed focused revisions to the Program Requirements include recently modified clinical case minimums to reflect the RC's assessment of this importance.

6. We agree and have already publicly shared the first step of our initiative last July, when our RC introduced recommended minimums for non-metastatic cases involving select adult disease sites. Data from this recent effort are being used to inform the development of new case log requirements forthcoming as proposed focused revisions of the Program Requirements, with sufficient time for stakeholder engagement prior to official activation.
7. The RC is also charged with reviewing new program applications and resident complement increase requests for existing programs. The ACGME has no jurisdiction or control over the geographic distribution of the new program applications or of existing residency programs. We do not solicit or sponsor such requests. As mentioned previously, the RC's role is to monitor compliance with professional educational standards, regardless of where the training is taking place. Similarly, the RC does not have any authority or role in ensuring that training programs are distributed amongst rural, urban, and suburban regions.

Additionally, we are not aware of any studies that demonstrate that large programs are less able to provide high quality education in radiation oncology. All specialty RCs assess all programs within their specialty, regardless of size, for their ability to meet educational standards and provide an excellent training environment.

Please note that all RC members who practice at an institution in the same state (or in the case of the public member, live in the same state) as a program under review, or who have any known or reported conflict of interest with a program under review, are automatically recused from any discussion on the program, and are not provided access to any information on the program or its accreditation status until the status is made public on the ACGME website.

8. The current Program Requirements for Radiation Oncology already allow for 12 months to pursue clinical projects, elective experience and the like.

*IV.C.3. The curriculum must include 48 months of education in radiation oncology. (Core)*

*IV.C.3.a) This must include a minimum of 36 months in clinical radiation oncology. (Core)*

*IV.C.3.b) The remaining 12 months may be spent performing such activities as taking elective rotations, performing research, pursuing an advanced degree, or taking other clinical rotations. (Core)*

Additionally:

*IV.D.3.b) Residents must complete an investigative project under faculty member supervision. (Core)*

Requiring a minimum of six months raises the possibility of an unintended gradual (or sudden) eroding of the 12 months that some programs are currently allotting for the above activities, and may be considered a step backwards from the flexible 12 months that the above provides. A program's decision to require rotations for the remaining 12 months is under the authority of the program director and department chair. If there are specific residents for whom additional clinical training is recommended by the Clinical Competency Committee or desired by the residents, the requirement leaves flexibility to use some of these 12 months to meet those competency goals, which is ultimately in the interest of the public stakeholders whom we all serve. If there are training programs that are uniformly not providing their residents with dedicated time for research, we would like to work with the SCAROP members who oversee those programs to better understand and help remedy those situations.

9. We agree with the addition of resources allowing for the "capability for SBRT/SRS with motion management, image fusion capabilities with PET and MRI scans, IV contrast for CT-simulation, and HDR interstitial and intracavitary brachytherapy." The RC will include this addition in the proposed focused revisions of the Program Requirements.
10. Similar to item #2 above, we recognize the vital role the primary clinical site plays in providing a robust clinical and academic environment. The RC will discuss the appropriate clinical volume at the primary clinical site to support approval of a complement increase, commensurate with time spent there, among other measures.

The focused revisions to the Program Requirements for Radiation Oncology are underway, and we anticipate posting them for the required public Review and Comment period on the ACGME website by early June. We will notify SCAROP when the proposed revisions are posted.

It appears that the SCAROP Executive Committee is particularly concerned with a potential oversupply of radiation oncology residents, and with the distribution of residents (e.g. a large proportion being trained at a limited number of large programs). As mentioned above, neither of these issues are within the authority of the ACGME.

Our RC places high levels of peer-reviewed scrutiny on each program undergoing review, as well as on new program applications and permanent complement increase requests. All ACGME specialty RCs are required to approve these requests if program requirements that are in effect at that point

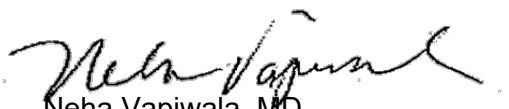
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in time are substantially met. Thus it is critically important to ensure that our training program requirements are more robust in order to better serve our trainees and in turn their future patients. This is what we are working towards, through some of the measures referenced in this letter


Obviously, new program applications and complement increase requests could not be submitted to the ACGME without the approval of the department chair, presumably in consultation with the program director and designated institutional official. Therefore, it would seem that the most appropriate forum for further discussions specifically on rotation quality (e.g. with respect to faculty FTE allotment and educational roles, allocation of elective/research time), and on program growth and diversity (e.g. with regard to geographic distribution, residency program complement size, and population density), would be SCAROP.

The Radiation Oncology RC looks forward to our continued partnership with SCAROP as it approaches these critical challenges of teaching quality, elective time, program growth, and program distribution/diversity. We sincerely appreciate your commitment to training excellence in radiation oncology residency programs nationwide.

Very truly yours,

  
Neha Vapiwala, MD  
Chair  
ACGME RC for Radiation Oncology

  
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cc: Emily Wilson, Executive Vice President, American Society for  
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