

SCAROP

March 31, 2021

Neha Vapiwala
Chair, Radiation Oncology Review Committee
Cheryl Gross
Executive Director, Radiation Oncology Review Committee

Dear Dr. Vapiwala and Ms. Gross,

As the Society for Chairs at Academic Radiation Oncology Programs (SCAROP), we are deeply concerned about the current state of the field and the training environments at some of the residency training programs in the United States. For us to lead our field, grow our faculty, and, most importantly, care for our patients, we believe the standards for ACGME accredited programs should be reconsidered.

Specifically, SCAROP believes that resident training requires an appropriate culture for learning in order to create lifelong learners that are able adapt to a rapidly changing specialty. Please consider our 10 points to address training in radiation oncology.

1. The sponsoring institution's primary clinical site (not inclusive of participating sites) should sponsor more than three other oncology-related training programs as defined and accredited by the ACGME. This allows trainees to participate in tumor boards for other specialties and the opportunity to learn with other oncology trainees in a multidisciplinary care setting, which is the cornerstone of oncology care.
2. We propose to change from 50 percent to 75 percent of the residents' educational experiences to take place at the primary clinical site for 27 of the 36 months of required core clinical radiation oncology rotations.
3. Any program must demonstrate at least a one-to-one clinical radiation oncology faculty to resident ratio at the sponsoring institution's primary clinical site.
 - a. The primary clinical site should include the program director radiation oncologists plus have a minimum of four physician clinical faculty radiation oncologists defined as ≥ 0.8 clinical FTE each at the primary clinical site, scaling 1:1 or more with resident complement.
 - b. The Program Director should work primarily (as defined by $>80\%$ clinical time) at the institution's primary clinical site.
 - c. Teaching faculty should include physics and biology faculty who is, either a member of the department or a member of the cancer center of the primary institution that are available to provide personal teaching (such as office hours) to residents as necessary, even if the classwork is online or recorded.

4. Residents should not cover more than one faculty physicians during a rotation unless that combination of coverage represents no more than 1.0 clinical FTE equivalent physician (i.e. coverage of multiple faculty with documented research or administration time would be acceptable provided that the clinical time does not exceed that of 1.0 clinical FTE). Simultaneous coverage of multiple physicians leads to dilution of experience and interference with managing patients under treatment.
5. The primary clinical site must support a majority of the mandatory procedures and brachytherapy cases needed to meet current requirements where teaching of the procedure allows for semi-autonomous competencies. We believe it is imperative that residents see brachytherapy patients throughout the full continuum of care: in consultation, during the procedure, and in follow-up.
6. Minimum case numbers for common sites such as breast, prostate, gynecologic, gastrointestinal, lymphoma, CNS, sarcoma, and thoracic cancer should be considered, as is currently done with pediatrics cases. We agree with the steps that the RRC is taking in this direction.
7. Radiation oncology residency is enhanced by having many different and diverse programs in varying practices and differing geographies. Therefore, no one program should have a disproportionately large share of residents. We believe this is important so that the future workforce is trained to meet the needs of patients from diverse areas (ie, urban, suburban, rural areas). If programs become too large, this should be viewed as a negative quality factor.
8. Based on a resident achieving clinical competencies, a minimum of 6 months of protected time will be provided for residents to pursue elective clinical experience, research projects, or other professional pursuits that will support the resident's specific career goals.
9. Technology requirements at the primary clinical site currently defined as "Two or more megavoltage machines, a machine with a broad range of electron beam capabilities, CT-simulation capability and 3-dimensional computerized treatment planning including IMRT" will include 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.
10. Changes in minimum cases from the current of 600 patients receiving EBRT per year cumulatively at the primary clinical site and any participating sites be modified to 600 patients receiving EBRT per year at the primary clinical site only for a program of 4 residents, and concomitantly increased with resident complement (150 patients receiving EBRT per year per resident).

As board-certified physicians, who have participated in the ACGME process, we are deeply indebted to the work done by our RRC and the ACGME volunteers. We share a common goal of improving the health care of cancer patients through education and research. Please feel free to reach out to us to discuss these items in more detail.

Sincerely,

Louis Potters, MD, FASTRO
on behalf of the [SCAROP Executive Committee](#)