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Residency and Fellowship Program Accreditation: Effects of the Novel Coronavirus (COVID-19) Pandemic

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The US is now in the grip of the COVID-19 (SARS COV2) pandemic. As this is written (March 27, 2020), the nation is still on the very steep upslope of the curve of the number of patients diagnosed with the disease. Many sources predict that the apex of that curve will not be reached until June 2020. Surgical services have been severely disrupted and will be for at least several months. The pandemic poses unprecedented challenges to surgical residency and fellowship programs. In turn, there are unprecedented challenges to the process of accrediting those programs. This article delineates some of those challenges and the responses to them that are known, to date.

IMPACT ON SURGICAL RESIDENCY AND FELLOWSHIP PROGRAMS

The "normal" daily, weekly, monthly, and annual schedules planned by programs, which were to be in effect at this time, have been severely affected. This is certainly true in Seattle, New York City, and other cities in the vanguard of the pandemic, but it is also true in cities that have, so far, a relatively low incidence of the disease. Elective cases normally done by residents/fellows have been postponed or cancelled.[1] Clinic and office visits have been severely curtailed or eliminated. Surgical fellows are being, or will be, deployed as attending physicians in their core specialties. Residents and fellows have been, or will be, placed on rotating shifts, both consistent with current clinical demands for surgical services and to minimize their exposure to the virus. Residents and fellows have been, or will be, deployed as primary care doctors in screening facilities, emergency rooms, and medical wards, or to supplement the physician force in medical critical care units. Because of both clinical demands and the need for "social distancing," clinical and educational conferences are being held remotely, if at all. It is, or soon will be, impossible in many instances for programs to evaluate residents/fellows in anything approaching the normal curriculum of the specialty/subspecialty. Residents, fellows, and attending surgeons are being, and will be, sidelined by quarantine due to exposure to the virus or recovering from SARS COV2 infections themselves. Although to date, none have been reported, there will predictably be deaths of surgical residents, fellows, and attendings as a result of SARS COV2 infections acquired in performing their clinical duties.

ALTERATION IN ACTIVITIES TO MEET ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION (ACGME) PROGRAM REQUIREMENTS

It is clear that, at least during the remainder of the 2019–2020 academic year, most residents and fellows will not be able to accomplish clinical rotations, operative case log minima, and nonoperative patient care encounters as set forth in the requirements for program accreditation. The impact of those deficient experiences will be greatest on residents/fellows in their ultimate or penultimate years of training (as previously scheduled). And the degree of impact will be inversely correlated to the length of the training program. A few months of curtailed clinical activity for residents in a 7-year neurological surgery program might be relatively easily overcome. The period of March through June, though, constitutes one-third of a colon and rectal surgery program and all of the 1-year surgical fellowship programs.

IMPACT ON ACCREDITATION ACTIVITIES AT THE PROGRAM LEVEL

Annual ACGME resident, fellow, and faculty surveys

The ACGME's annual resident, fellow, and faculty surveys are used to monitor parameters of clinical education and provide early warning of potential noncompliance with ACGME accreditation requirements. All accredited programs are required to participate in these surveys each academic year. The surveys are administered to programs in different specialties/subspecialties in 3 roughly

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5-week "windows," from January through April. The required completion rate of the surveys for each program is 70%. In the next accreditation system,[2] programs may be site-visited as infrequently as every 10 years. The Review Committees are, therefore, heavily dependent upon the surveys as a source of information for what is happening at the program level. The "window" closed in February for the surveys in colon and rectal surgery, otolaryngology, obstetrics and gynecology, plastic surgery, and the subspecialties of each. Therefore, surveys in those programs were completed when the virus had been detected in very few cities. The "window" for surveys in orthopaedic surgery, surgery, thoracic surgery, urology, and all of their subspecialties closed on March 15, just as the pandemic began to grip a few metropolitan areas. The "window" scheduled for neurological surgery, ophthalmology, and their subspecialties was to be March 9 to April 12, clearly at a time when the pandemic began to broadly reshape the activities of surgical trainees and programs. ACGME announced March 18 that surveys would remain available for those who wished to complete them until May 15, 2020,[3] but that the normal periodic ACGME reminders to programs to complete the surveys would be suspended. The surveys have historically been analyzed in the context of all responders, nationally, regardless of specialty. As the national response pool to the 2020 surveys will predictably be quite truncated, it remains to be seen what survey data will be made available to review committees for use in their 2021 accreditation decisions.

Telesupervision

Revisions in the Common Program Requirements that allow and foster greater use of telesupervision were adopted by the ACGME Board of Directors in February 2020 and were to become effective July 1, 2020. As the pandemic unfolded in the US, it became clear that telesupervision of residents/fellows could positively affect the delivery of care to patients while mitigating the risks to those residents, fellows, and other healthcare providers. Accordingly, the Common Program Requirements regarding telesupervision were made effective as of March 18, rather than waiting for the original effective date of July 1.[3]

ACCREDITATION SITE VISITS

With the advent of the next accreditation system, "regular" (ie, every 3, 4, or 5 years) program site visits were replaced by scheduled site visits every 10 years.[2] Although somewhat reduced in number, site visits continue to play a very important role in the accreditation process. A site visit must occur with the application for a new program, and a site visit must also occur at the end of the 2-year period of initial accreditation for a new program. The most common and, perhaps, the most important site visits, are those ordered by the Review Committees when there is evidence from surveys, case logs, board scores, or some other source that there may be problems in a program.

As the footprint of the pandemic began to grow, the ACGME decided on March 9 to indefinitely postpone all scheduled and requested accreditation site visits.[4] The rationale for postponing site visits was 3-fold. The ACGME did not want to further disrupt already stressed clinical environments. The ACGME did not want its site visitors to become vectors of disease by traveling on airplanes to and from clinical environments that may be dealing with infected patients. Finally, it was important to the ACGME to protect the health of the site visitors, themselves. The necessary site visits will be scheduled once again when the clinical activity of the sponsoring institutions returns to more normal activity and when it is again safe for the site visitors to travel. Accreditation decisions for the year 2020 will be delayed for a very small minority of programs until site visits can be accomplished and Review Committee decisions can be made based on those site visits.

PANDEMIC EMERGENCY STATUS

On March 24, the ACGME announced availability of a Pandemic Emergency Status for institutions that sponsor ACGME-accredited programs.[5] That status is self-declared. It will immediately be in effect for an institution when the institution notifies the ACGME. No approval from the ACGME is necessary for the declaration to take effect. If, after 30 days, the institution wishes to continue in Pandemic Emergency Status, that continuance must be approved by the ACGME Institutional Review Committee (by a process yet to be determined). For all ACGME-accredited programs in an institution that has declared the Pandemic Emergency Status, all program requirements will be suspended except those pertaining to resident/fellow work hours, supervision, and safety.

OTHER ANNUAL ACCREDITATION ACTIVITIES

At this writing, discussions are still ongoing at the ACGME regarding the approach to such program activities as meetings of the Clinical Competence Committee, Milestones assessments, meetings of the Program Evaluation Committee, the annual program evaluation, etc. Decisions regarding those and other activities will be announced by the ACGME as they are reached.

IMPACT ON REVIEW COMMITTEE ACTIVITIES

2020 program accreditation decisions

The 2020 program accreditation decisions are based on data accumulated in 2019. Therefore, except for the small number of programs still awaiting site visits, the 2020 program accreditation decisions are not affected by the pandemic. Most programs have already received 2020 accreditation decisions reached in the December to February meetings of the Review Committees. The remaining programs are slated for accreditation decisions to be reached in the March-April meetings of the Review Committees. Those meetings are ongoing, albeit conducted remotely. Accreditation decisions have been or will be reached for most programs scheduled to be reviewed in those meetings. For a very small minority of programs, accreditation decisions will not be reached in those meetings because of the unavailability of vital information (eg a site visit report). The current accreditation status of those programs will be continued until the necessary information is acquired and reviewed by the Review Committee.

2021 program accreditation decisions

No one yet knows how severely the US will be affected by the current pandemic. Certainly, no one yet knows how severely ACGME-accredited surgical programs will be affected or for how long. The surgical Review Committees are acutely aware that the coming months will not be "business as usual" for accredited programs. In most, if not all, accredited surgical programs, residents/fellows will not have access to elective surgical cases for several months to come. In most, if not all, accredited surgical programs, residents/fellows will see and evaluate a drastically smaller than normal number of patients in clinics and offices for at least the next several months. In many accredited programs, residents/fellows have been, or will be, at times taken out of surgical settings, altogether, due to re-deployment in emergency rooms, screening centers, medical wards, medical critical care units, etc. Even residents/fellows who are assigned to surgical services are likely to be working on a rotating schedule of days on and off, both because of decreased clinical surgical demands and as a means of mitigating their exposure to the virus. Educational and clinical conferences have already been disrupted by the need for social distancing, if not by clinical demands. Programs can and should continue to hold conferences remotely whenever possible. However, the quality and penetrance of those conferences will likely suffer because few (if any) programs have previously made remote conferencing their routine, so will have many obstacles to overcome. Evaluation and feedback are critical for the continued professional growth of residents/fellows, but will be greatly impaired by clinical demands, disrupted schedules, resident/fellow redeployments, and other issues. In the same vein, program evaluation is critical for improvement but will suffer from the same obstacles as trainee evaluation. It is also clear that residents/fellows and attending surgeons will be sidelined for significant periods of time due to known exposure to the virus or becoming infected themselves. Sadly, some surgical residents, fellows, and attendings will predictably succumb to the virus.

As noted previously, many of the tools that the Review Committees use in making accreditation decisions (site visits, resident/fellow surveys, faculty surveys) will be unavailable or available only in an incomplete or modified fashion for at least the remainder of the 2019-2020 academic year. It is even possible that some programs will be unable, in the fall months, to complete their ACGME annual program updates, which are another critical tool in the accreditation process. The case log minima will remain in place for every surgical specialty and subspecialty for which they have been developed but will, necessarily, be interpreted and applied in the context of the impact of the pandemic on the 2020 graduate case logs. For all these reasons, the Review Committees will have far less information on which to base accreditation decisions in 2021 than they have had in any other year since their establishment. Three domains of program requirements will remain in effect for every program throughout the pandemic: requirements limiting resident/fellow work hours, the requirements for appropriate supervision, and the requirements for resident/fellow safety, including provision of training and equipment appropriate to the clinical circumstance. To the extent that it can be assessed, compliance with those requirements will likely comprise a major consideration of a Review Committee regarding the accreditation status of a program.

ON THE OTHER SIDE OF THE PANDEMIC

In healthcare, accreditation is one of many important safeguards of the public. Accreditation of surgical residency and fellowship programs will continue through and beyond the pandemic. The accreditation process, though, will hopefully be improved by questions asked and lessons learned in the current crisis. Must all site visits be conducted in person or might it be possible to conduct some of them remotely, therefore potentially accomplishing more "site visits" in the same period of time by eliminating travel and saving money for the organization? (Note: more than 90% of the annual income of the ACGME is derived from accreditation fees. "Saving

money for the organization" can be read as saving money for ACGME-accredited institutions and programs through controlling accreditation fees.)

Must all Review Committee meetings be held in person or might some of them be held remotely, therefore eliminating travel time for the volunteers who serve on the committees and, again, saving money for the organization? In what way(s) can the ACGME best rapidly communicate critical information to programs and institutions? In what way(s) can programs and institutions best communicate critical information to the ACGME? What requirements might the ACGME put in place that would help programs and institutions be better prepared for future destabilizing events? To what extent can current requirements be relaxed in the face of local, regional, or national crises? Put another way, compliance with which requirements is absolutely essential in accreditation decisions in order to safeguard the public? These are some of the questions that ACGME and the surgical Review Committees have asked themselves or been asked by others.

It has been said that "tough cases make bad laws." There has never been a greater challenge to the ACGME, the Review Committees, accredited programs, or, most importantly, the residents, fellows, attending surgeons, and other staff of those programs than the pandemic now being faced. In the midst of the pandemic, we should not make radical and lasting changes in a system that has generally served our country well for decades. But, on the other side of the pandemic, these and other questions must be thoughtfully addressed in order to build a more responsive, robust, and resilient system for the accreditation of surgical programs.

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