

Program Requirements for Residency Education in Colon and Rectal Surgery Revision

Impact Statement

Background

In the prior set of PRs there was almost nothing that was specific to the specialty of Colon and Rectal Surgery. The discipline has evolved considerably over the past few decades as evidenced by the breadth and depth of material presented at the annual meeting of the American Society of Colon and Rectal Surgery, by the curriculum developed by the Program Directors for CRS and by the outline of topics tested by the American Board of Colon and Rectal Surgery. In addition, a Blue Ribbon Commission of the ABCRS, including members of the ASCRS and Review Committee (RC), has proposed minimum case numbers for entry to the ABCRS examinations which are anticipated to become effective in 2011. Therefore, the RC believes that a significant revision of the PRs is in order to more specifically address what is necessary to train a colon and rectal surgeon. It is the intent of the RC to encourage a high level of expertise in graduates of colon and rectal surgery residency programs. Additionally, the RC wishes to assure that each program provides a minimum standard of didactic and clinical experiences leading to 1) defined resident competencies, and 2) consistency in curricular content and educational training across programs.

1. Impact on Resident Education:

How will the proposed changes improve the quality of resident education?

Overview

The proposed revisions include more specialty specific language which focuses on linking didactic and clinical experiences with outcomes. This proposed revision will also shift significantly from process requirements to requirements which focus on assessment of resident competencies.

A number of specific requirements have been added to assure adequate and consistent training in the diagnoses and procedures that constitute the specialty of colon and rectal surgery:

- Specific requirements have been added to require education leading to proficiency in all of the essential components of colon and rectal surgery.
- The essential components are defined and listed. Required exposure to patients with the essential diagnoses treated by colon and rectal surgeons will be required – IV.A.5.a).(1).(a); Lines 517-623.
- Training leading to proficiency in the essential procedures performed by colon and rectal surgeons will be required – IV.A.5.a).(2); Lines 625-698.
- In addition, programs must provide education and experience so that residents will be able to demonstrate substantial familiarity with the defined additional colon and rectal surgery-related issues and procedures – IV.A.5.a).(3) & IV A.5.b).(3); Lines 700-742 & 765-809.

- Training in specified settings such as inpatient/hospital, outpatient/ambulatory surgery, clinics/offices, endoscopy centers, emergency departments, and physiology laboratory will be required – IV.A.6.a); Lines 938-951.
- Programs will be required to provide residents with a minimum number of patients with specific colon and rectal surgery diagnoses and specific procedures – IV.A.6.f) & IV.A.6.g); Lines 995-1025 and Minimum Case Requirements for Training in Colon and Rectal Surgery FAQs Sheet.

Specific changes

Introduction – The wording in the “Introduction” section was split into separate paragraphs to define the specialty of Colon and Rectal Surgery and to specify the duration of education in colon and rectal surgery training programs – Introduction; Lines 23-34.

I.A. Sponsoring Institution - The requirements have been enhanced to include institutional support for program directors – I.A.1-3; Lines 48-56.

II.A. Program Director - The program director qualifications were rewritten to specify the RC's expectations for the minimum number of years in practice and teaching prior to assuming the role of program director – II.A.3; Lines 126-133.

II.B. Faculty - The faculty requirements were revised to require a minimum level of faculty involvement in regional and national specialty societies and scholastic inquiry. A minimum number of full-time equivalent faculty required to maintain the program was set at 3 – II.B.5. & 6; Lines 321-330.

II.D. Resources – Several specific requirements were added to ensure the necessary volume and variety of cases, adequate office workspace and reliable communication systems – II.D.1-3; Lines 344-359.

II.E. The rewrite of the “Medical Information Access” section reflects the rapid evolution of electronic reference materials and need for resident access to these materials – II.E.1; Lines 367-369.

III.A. Resident Appointments – Eligibility Criteria - The requirements for resident appointment was improved to define specific resident eligibility criteria. This reflects the long-standing agreement between the American Board of Surgery and the American Board of Colon and Rectal Surgery that defines the pathway for entry into Colon and Rectal Surgery programs – III.A.; Lines 378-392.

IV.A. Educational Program – This section was extensively rewritten and supplemented to specify the education that each program must provide their residents and to link training to competency. This is an evolving process, but the additions in this section are quite comprehensive and specific. In addition to the comments noted in the above bulleted list, the following changes have been made.

IV.A.1. Overall educational goals – This overview section was rewritten to reflect the general categories of the educational program including a comprehensive curriculum, need for a minimum standard breadth and depth of education, and development of an appropriate fund of knowledge and clinical and technical skills – IV.A.1.a)-c); Lines 429-441.

IV.A.2. Requires delineation of specific goals and objectives for each assignment and rotation to 1) be reviewed at the beginning of the rotation, and 2) set expectations for assessment at the end of the rotation – IV.A.2.a) & b); Lines 449-455.

IV.A.3. Didactic sessions – the didactic sessions types, frequency and attendance requirements are specified – IV.A.3.a)-e); Lines 460-499.

IV.A.5. ACGME Competencies - These have been extensively upgraded to reflect the specific educational content of each of the Competencies. Specific requirements have been added regarding education leading to proficiency in all of the essential components of colon and rectal surgery as well as to provide exposure to all of the areas of required substantial familiarity.

IV.A.5.a).(1) - The essential components are defined and listed. Required exposure to patients with the essential diagnoses treated by colon and rectal surgeons will be required; Lines 524-623.

IV.A.5.a).(2) - Training leading to proficiency in the essential procedures performed by colon and rectal surgeons will be required; Lines 625-698.

IV.A.5.a).(3) & IV.A.5.b).(3) - Programs must provide education and experience so that residents will be able to demonstrate substantial didactic and clinical knowledge of the defined additional colon and rectal surgery-related issues and procedures; Lines 700-742 & 765-809.

IV.A.6. - An additional section was added detailing Curriculum Organization and Resident Experiences.

Highlights:

IV.A.6.a) - Training in specified settings such as inpatient/hospital, outpatient/ambulatory surgery, clinics/offices, endoscopy centers, emergency departments, and physiology laboratory will be required; Lines 938-951.

IV.A.6.f) & IV.A.6.g) - Programs will be required to educate residents to at least a minimum number of patients with specific colon and rectal surgery diagnoses and specific procedures; Lines 995-1025 & Minimum Case Requirements for Training in Colon and Rectal Surgery FAQs Sheet.

IV.B.2. - The requirement for residents' scholarly activity was rewritten to include specific types of activities for resident scholarship; Lines 1042-1055.

V. Evaluation - In the 2007 requirements, there were no Colon and Rectal Surgery specialty-specific requirements for resident evaluation, summative evaluation, faculty evaluation and program evaluation and improvement. Standards were added to specify these requirements. The RC has also established benchmarks for graduate performance on the examinations of the ABCRS; Lines 1073-1115, 1138-1149 & 1200-1209.

IV. Resident Duty Hours - Criteria have been established to define a new patient, and moonlighting is no longer allowed during colon and rectal surgery training. IV.E.3; Lines 1279-1281 & IV.F.3; Line 1306.

2. Impact on Patient Care:

How will the proposed changes affect the way the resident, the service, and the staff provide patients with continuing care?

The proposed changes will not adversely affect, and may improve, patient care. Continuity of care should be improved through required team rounds, improved communication capabilities, increased staff to resident ratios, rapid access to medical literature via electronic means and a comprehensive educational curriculum.

3. Impact on Faculty Resources:

Will an increase in number of faculty from within the discipline or other disciplines be required? If so, please explain.

A small set of programs may need to increase colorectal faculty staffing to reach the required 3 FTEs level, but review of the current programs shows that that number is very small. Provision of adequate educational material in terms of patients and case volumes, particularly in certain disease categories, is anticipated and this is a specific goal of the new PRs in order to provide a standard level of education. No increases in non-colorectal staffing are anticipated.

4. Impact on the Institutional Facilities, Services, and Faculty:

a. Will there be required institutional resources for the educational or service unit as a result of the proposed change?

Increased funding may be required of some programs to comply with the requirements for the program director and/or the program coordinator, depending on the setting and current arrangements. However, for those programs that incur added costs, the RC with the support of program directors has determined that this is an essential cost necessary to support residency programs. Required case volumes may dictate the need for additional faculty or for additional rotations.

b. Will there be any additional cost to the institution in this regard?

Costs for these requirements are difficult to predict. It is anticipated that programs will not be adversely impacted.

5. Impact on the Other Services and Educational Program in the Institution:

a. If these changes are implemented will there be adequate volume and variety of patients to provide proper educational resources in the institution?

Each program will need to assess the adequacy of institutional case volume in light of the new PRs and Minimum Numbers. In some cases, additional faculty or rotations may be needed. For programs without these resources, it may be necessary to match the number of approved resident positions with the resources available to support each trainee.

b. How will other services in the department of the institution be affected by the changes?

Other services in the department of the institution should not be affected by these changes.

6. Implementation:

What is the effective date of this proposed change? Please justify the requested effective date based upon the need for faculty, institutional services, financial, or other support.

The proposed effective date of the revised PRs is January 1, 2011.

Program directors have been informed of these changes as they evolved, and have had substantial opportunity for input through the process starting in June, 2008. Additional input from the leadership of the ASCRS and the ABCRS has also been sought throughout the process.

In most cases, the proposed revisions do not require any major changes in the faculty, financial support or other support for the programs.

Therefore, since the RC feels that these revisions are critical and it has been difficult to function with the current set of PRs, the RC respectfully requests an expedited review and implementation by January 1, 2011.