Frequently Asked Questions: Anatomic Pathology and Clinical Pathology
(FAQs related to Pathology Program Requirements effective July 1, 2023)
Review Committee for Pathology
ACGME

Question	Answer
Introduction	
Can residents leave in the middle of their program to complete a fellowship and then return to finish their pathology residency? *[Program Requirement: Int.C.1.]*	Yes, as the American Board of Pathology allows residents to enter a pathology fellowship program (except dermatopathology) after 24 months of residency, the Review Committee allows this as well. Residents must meet eligibility requirements for the applicable accredited fellowship. The expectation is that once the fellowship is completed, residents return to the pathology residency program to complete their education. Programs do not need to notify the Review Committee or request exceptions for residents to pursue this pathway. In the Accreditation Data System (ADS) these residents should be listed as “In Program but Doing Research/Other Training” while they are in a fellowship program, and reset to “Active Full time” status once the fellowship is completed and they have returned to the pathology residency program.
If a resident wishes to focus only on anatomic pathology or clinical pathology, must the Sponsoring Institution apply for a separate program or does the existing program need any other approval from the Review Committee? *[Program Requirements: Int.C.2.-3.]*	No. All pathology programs are accredited as APCP-4, with anatomic pathology only (AP-3) and clinical pathology only (CP-3) offered as tracks within the program, not as separately accredited programs. There is no separate application process, as programs are free to offer these tracks to residents if they choose. The Educational Program section of the Program Requirements clearly denotes tracks so that programs can understand the expectations for residents in any of the tracks.
Oversight	
What are some examples of relevant certifications or accreditations at the state and/or national level that participating sites must maintain? *[Program Requirement: I.B.6.]*	Relevant certifications and accreditation will vary depending on the focus of the site and the state regulations applicable to that site. Examples include: Association for the Advancement of Blood and Biotherapies, Clinical Laboratory Improvement Amendments, College of American Pathologists, Food and Drug Administration, or Joint Commission.
Personnel	

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What qualifications and responsibilities are expected of the Autopsy Service Director? *[Program Requirement: II.B.1.a)]*	An Autopsy Service Director is needed at each teaching hospital to oversee and participate in teaching, service, and scholarly and administrative duties pertaining to the service. It is desirable that the Autopsy Service Director be a strong educator and mentor, be board certified in anatomic pathology and experienced in autopsy performance, and have sufficient time to oversee and advocate for the autopsy service. The Autopsy Service Director assesses residents' competence in performance of all steps of the autopsy and reports those assessments to the Clinical Competency Committee and program director.
Resident Appointments	
What are the most common circumstances for temporary complement increase requests? *[Program Requirement: III.B.1.]*	1. When a resident needs to take medical leave/maternity leave from a program. Example: During the course of the residency, a resident needs to take extended medical leave. In order to complete the required 48 months of pathology residency, the resident's matriculation from the program will need to be extended by three months. An additional position made available through the temporary increase in complement would accommodate this three-month extension. The program explains the situation and documents that it has sufficient resources to accommodate this additional resident position. 2. When a resident requires remediation. Example: Toward the end of the first year in the program, the program determined that a resident was not ready to be promoted to the second year and two months of remedial education and training were required. Based on the resident's performance during this remediation period, the program promoted the resident to the second year of education. Because the two months of remedial education and training do not count toward the required 48 months of pathology residency, the resident's matriculation from the program will need to be extended by two months. An additional resident position made available through the temporary increase in complement would accommodate this two-month extension. The program explains the situation and documents that it has sufficient resources to accommodate this additional resident position. 3. When a resident is on an extended leave from a program, or if a resident starts the program outside of the July 1-June 30 academic year cycle.

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	Example: One resident in the program is in the military and is currently on active duty. The resident does not know the exact date of separation from the military but expects it to be sometime in the first half of the current academic year. Both the resident and the program would like to hold the space for the resident in the residency program. An additional resident position made available through the temporary increase in complement would maintain the same number of residents in all years of the program. The program explains the situation and documents that it has sufficient resources to accommodate this additional resident position. 4. When the request for a temporary increase in complement will be followed immediately by a request for a permanent increase in complement, as the educational resources of a program (most commonly a fellowship) have significantly expanded and will support an additional position. Example: A cytopathology service has grown significantly in clinical volumes, specialized techniques, and clinical sites, thereby enabling a more diverse fellow experience, including different practice settings. This expansion provides an excellent educational experience for an additional fellow, while not compromising the educational experience of the current learners (residents and/or fellows). Funding and all other resources (e.g., dedicated office space, computer) are available for this additional position. Temporary complement increases of less than three months in duration do not need to be submitted to the Review Committee for review, regardless of the reason for the increase, and can instead just be explained in the “Major Changes” section of ADS. These and other circumstances for a temporary increase in complement are considered on a case-by-case basis. Sequential temporary complement increases as a means to avoid submitting a request for a permanent complement increase are not acceptable.
Educational Program	
Why are autopsies included in pathology residency?	The autopsy experience remains an important part of pathology residency education. As an educational tool, it serves to integrate medical clinical and scientific knowledge,

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[Program Requirements: IV.B.1.b).(2).(a)(.i),(a); IV.C.11.b)-h)]	and provides a basis for understanding the disease process in the context of anatomic and clinical laboratory data and procedures. While autopsy performance rates have declined nationally and subspecialization has shifted professional practice patterns, pathologists entering practice do need to be able to perform medical autopsies and understand their role in current practice.
What should be included in autopsy education and training? *[Program Requirements: IV.B.1.b).(2).(a).(i).(a); IV.C.11.a)]*	Autopsy education and training requires knowledge of pre-autopsy tasks (medical examiner jurisdiction, appropriate consent, communication with clinicians and sometimes family members, review of the medical record, and preparation for safety issues) in addition to the technical performance of the case, including proper dissection and sampling for a range of adult and pediatric cases. Accurate assessment of histologic and other studies is essential, as is the integration of findings in preliminary and final reports, which need to be communicated clearly to health care providers and family members. Clinical laboratory testing is also an integral part of autopsy education and training, including for anatomic pathology-only tracks; its role in the review of the patient's medical or surgical history cannot be overlooked.
How should resident competence in performance of an autopsy be assessed? *[Program Requirements: IV.B.1.b).(2).(a).(i).(a)]*	Resident competence in all steps of autopsy preparation, performance, and reporting for different types of autopsies is assessed as part of formative and summative evaluations, with input from the attending pathologists involved with the cases. Performance and competence evaluations may currently be amalgamated for this assessment by the program director at some institutions; designation of an Autopsy Service Director who has more direct experience with autopsies with the residents will facilitate both education and performance/competence evaluation.
What are the Review Committee's expectations for the faculty member responsible for the educational experience of each rotation? *[Program Requirement: IV.C.1.a)]*	The Review Committee expects that each rotation has one faculty member who is responsible for the longitudinal oversight of the experience on the rotation. This faculty member will ensure supervisory continuity as faculty members and residents come on and off the rotation. This requirement does not mean that only one faculty member should provide day-to-day teaching of residents, as that can still be shared among faculty members in a particular specialty/subspecialty area; however, one individual must take charge of the overall, longitudinal experience on that rotation to ensure continuity.
How can residents be expected to perform independent sign-out when other requirements stipulate that residents must always have some form of supervision?	The intent of this requirement is not that residents perform independent sign-out during their residency program, but rather that residents gain experiences during their residency that enable them to perform independent sign-out once they complete the program. The program must be designed to allow residents to progress appropriately

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[Program Requirement: IV.C.3.]	through the levels of supervision, ultimately working under oversight supervision so they may gain confidence and experience in independent decision-making with minimal faculty member oversight.
Why are 30 autopsies required, and what types of autopsies count? *[Program Requirement: IV.C.11.b).(2)]*	While the requirement for 30 autopsies does not ensure resident competence, it does ensure a certain level of exposure to case material. The 30-autopsy requirement will remain until a competency-based system can be validated and implemented to potentially replace it. The eight components of the autopsy, as appropriate to the case, are integral to the autopsy process.
How can sharing of cases be implemented when available numbers of cases are limited? *[Program Requirement: IV.C.11.b)]*	Sharing of cases is permissible; however, no more than two residents may share a case. To count toward a required case, each resident's experience must include the aspects of an autopsy listed in Program Requirements IV.A.6.f).(1)-(8). Each resident's involvement in every aspect of a shared case, however, must be different. A more experienced resident may teach or even supervise a less experienced resident, if qualified to do so. In formulating a written report, one resident might write a first draft and the second resident might edit the draft. It would not be acceptable for both residents to engage in the prosection of the case; only one may review the microscopic slides and write the description. The American Board of Pathology has additional information on autopsies that should be reviewed as relates to board eligibility.
What constitutes a shared autopsy? *[Program Requirement: IV.C.11.b)]*	In a shared autopsy, each resident participates in some manner in all components of the case (listed below). While it is understood that certain cases may not include all eight components (hence the qualifier, "as appropriate to the case"), no component should be skipped on a routine basis. • Review of history and circumstances of death • External examination of the body • Gross dissection, including organ evisceration • Review of microscopic and laboratory findings appropriate to the case • Preparation of written description of gross and microscopic findings • Development of opinion on cause of death • Clinicopathological correlation, as appropriate to the case • Review of autopsy report with a faculty member

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	A shared autopsy must be a collaborative process, even if one resident assumes a more primary role in the work-up of the case. Example: Two residents participate in the prosection of an autopsy, but only one performs the microscopic examination. This is **not acceptable** as this compromises the experience of the second resident. Example: A senior resident assists and supervises a junior resident in performing and completing an autopsy as part of his/her graduated responsibility. This is **acceptable** as this is practice is a beneficial, though different, autopsy experience for both residents. The American Board of Pathology has additional information on autopsies that should be reviewed as relates to board eligibility.
Can a limited autopsy count toward meeting the requirement for 30 autopsies? *[Program Requirement: IV.C.11.b)]*	Yes. However, the program director and the Autopsy Service Director should monitor to ensure that the number of limited autopsies does not compromise any resident's overall autopsy experience or attainment of competence and learning with regard to the full autopsy procedure. In addition, the majority of a resident's experience in autopsies should involve all components. The American Board of Pathology has additional information on autopsies that should be reviewed as relates to board eligibility.
How many forensic autopsies can count toward meeting the requirement for 30 autopsies? *[Program Requirement: IV.C.11.b)]*	The Review Committee has not established a maximum number of forensic autopsies, but as with limited autopsies, as noted above, these should not compromise any resident's overall autopsy experience or attainment of competence and learning with regard to the full autopsy procedure.
To what extent must residents have exposure to fetal autopsies? *[Program Requirement: IV.C.11.c)]*	The Review Committee considers the requirements set forth by the American Board of Pathology adequate with regards to fetal autopsies. For fetal autopsies to count toward meeting the requirement of 30 autopsies, the fetus must be intact, and gross and microscopic examination of the placenta must be part of the report. Receipt of a separate accession number by the placenta does not preclude review by the resident and inclusion of the gross and microscopic findings in the autopsy report of the fetus.

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	Furthermore, the American Board of Pathology also limits the number of unexplained fetal demise cases (5) and cases in which maceration of the fetus precludes a diagnosis (2) that can count toward the resident's minimum of 50 autopsies; it is the responsibility of the program director to ensure that each resident can meet these requirements. The American Board of Pathology has additional information on autopsies that should be reviewed as relates to board eligibility.
Can a fetal demise count as an autopsy? *[Program Requirement: IV.C.11.c)]*	Yes. A fetal demise may count as an autopsy provided it has an autopsy permit. The American Board of Pathology has additional information on autopsies that should be reviewed as relates to board eligibility.
Why should residents participate in scholarship? *[Program Requirement: IV.D.3.a)]*	Scholarly activity by residents is a quality indicator reported annually to the ACGME as a marker for an environment of inquiry and scholarship within the program, and as an indicator of ongoing self-directed learning and practice improvement. It is evaluated, along with other markers, such as scholarly activity by core faculty members and responses to the annual Resident/Fellow and Faculty Survey questions related to the learning environment, in assessing program quality. As scholarly activity is a longitudinal process, it is not required that every resident produce formal evidence of scholarly activity during each year of the program. However, the annual data submitted by the program should demonstrate scholarly activity by at least a subset of residents to convincingly reflect compliance with the requirements for ongoing scholarly activity by each resident. The broad definition of scholarly activity should make this possible. Examples of scholarly activity include, but are not limited to, research, evidence-based presentations at journal clubs or meetings (local, regional, or national), or preparation/submission of articles for peer-reviewed publication. Completeness and accuracy of reporting resident scholarly activity by the program is essential to the accurate assessment of program compliance. Programs in which ongoing scholarly activity by all residents cannot be extrapolated from the Annual Update may be considered for more in-depth review by the Committee to investigate the quality of the learning environment.
The Learning and Working Environment	

Question	Answer
Can pathologist's assistants supervise residents? *[Program Requirement: VI.A.2.a).(2)]*	Although pathologist's assistants are not licensed independent practitioners, they may be authorized by a department to provide supervision or oversight of dissection of surgical specimens and autopsies.
When can a PGY-1 resident be indirectly supervised? *[Program Requirement: VI.A.2.b).(1).(a).(i).(a)]*	In order for PGY-1 residents to be indirectly supervised, they must have performed the requisite procedures in the categories specified in the requirements *[apheresis, autopsies (complete or limited), bone marrow biopsies and aspirates, fine needle aspirations and interpretation of the aspirate, frozen sections, gross dissection of surgical pathology specimens by organ system]*. A resident who has met the requirement for indirect supervision may be indirectly supervised by a more senior resident, a fellow, a pathology assistant, or an attending physician. The identified supervisor must be available for consultation and assistance but does not need to be immediately available or in the hospital.
Who is qualified to supervise residents in bone marrow biopsies? *[Program Requirement: VI.A.2.b).(1).(a).(i).(a).(iii)]*	Residents at the PGY-2 level or above in a clinical pathology-only track, residents at the PGY-3 level or above in an anatomical pathology/clinical pathology track, hematology-oncology fellows, hematopathology fellows, hematologist-oncologists, and attending pathologists may supervise the performance of bone marrow biopsies.
Who is qualified to supervise residents in apheresis procedures? *[Program Requirement: VI.A.2.b).(1).(a).(i).(a).(i)]*	Residents at the PGY-2 level or above in a clinical pathology-only track, residents at the PGY-3 level or above in an anatomical pathology/clinical pathology track, blood banking/transfusion medicine fellows, and attending pathologists may supervise the performance of apheresis procedures. Hematopathology fellows may also supervise apheresis procedures if approved to do so by their respective program directors.
Who is qualified to supervise residents in gross dissection of surgical pathology specimens and/or autopsies? *[Program Requirement: VI.A.2.b).(1).(a).(i).(a).(vi)]*	Residents in the PGY-2 level or above in an anatomic pathology/neuropathology or anatomic pathology-only track, residents in the PGY-3 or -4 level, fellows, pathology assistants, other faculty members certified by the American Board of Pathology in blood banking/transfusion medicine, or attending pathologists may supervise gross dissection of surgical pathology specimens and/or autopsies.

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What is the optimal clinical workload for residents? *[Program Requirement: VI.E.1.]*	The program director must make an assessment of the learning environment with input from faculty members and residents. There must be an adequate clinical workload to develop competency in all areas specified in the Program Requirements. Optimal workload may vary from program to program, and will depend on the patients, patient material, program resources, and testing/consultations/procedures done in the primary and participating sites. Clinical workload should include patients and patient material for testing, while additional educational materials should include study sets and other case-based teaching tools.
Other	
When are autopsy permits required?	Autopsy permits are required for all autopsies, with the exception of forensic cases.
In ADS, how should programs report residents who are doing the anatomic pathology/neuropathology certification pathway offered by the American Board of Pathology?	Residents in the anatomic pathology/neuropathology pathway should have their specialty track in ADS noted as “AP/NP Track.” Additionally, once these residents have completed their two years of anatomic pathology education they should <u>not</u> be marked as “Transferred to Another Program,” but rather as “In Program, but Doing Research/Other Training,” which will allow the program to make such residents “Active Full time” after completion of the neuropathology program to enter/modify the autopsies reported in the Case Log System. Alternatively, if the program has confirmed that a resident logged autopsies prior to completing the two years of neuropathology pathology education, the program can mark such a resident as “Completed All Accredited Training.”
What are the Review Committee’s expectations regarding block diagrams for pathology programs?	The Review Committee understands that block diagrams present some unique challenges for pathology programs given how pathology education is often structured. Programs must submit a diagram representing all four years of the educational program so the Review Committee can gather an understanding of what types of experiences residents would have in a particular program and how frequently they might have those experiences. The block diagram is not meant to be indicative of any one resident’s experience, but rather a high-level representation of what the educational program could look like. Even if rotations can be interchanged across the four years of education, the block diagram should give a general idea of what rotations would occur and how often they would occur. Block diagrams should not include resident names but should include descriptions of the type of rotation/experience (for example, “Anatomic Pathology” is not enough

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	information; however, “Breast Pathology” is sufficient). There are further instructions provided in ADS regarding required and suggested components of the block diagram.