APDEM
ASSOCIATION OF PROGRAM DIRECTORS IN ENDOCRINOLOGY • DIABETES • METABOLISM

September 19, 2019

Sima S. Desai, MD
Chair, ACGME Review Committee for Internal Medicine

RE: APDEM response to Program Requirements Review and Comment – Endocrinology, Diabetes, and Metabolism

Dear Dr. Desai:

When we in Council for the Association of Program Directors in Endocrinology, Diabetes, and Metabolism (APDEM) learned about the open comment period related to the proposed changes to program requirements, we elected to perform a survey of APDEM members related to the proposed changes. Our primary goal was to assess whether important themes emerged, with the idea being that APDEM Council could potentially lend additional support to the most important concerns raised by APDEM members.

After our review of APDEM member responses (see appendix), and after more careful consideration of proposed changes, we in APDEM Council concluded that we could also provide *unique* commentary for ACGME consideration. That is, while this letter was informed by a survey of APDEM members, the letter includes additional considerations raised by APDEM Council members.

We offer the following comments in a constructive and collaborative spirit.

---------- Line numbers 47-54 ----------

Int.B. Definition of Subspecialty

Endocrinology, diabetes, and metabolism is the subspecialty of internal medicine that focuses on the diagnosis and care of disorders of the endocrine (glandular) system and the associated metabolic dysfunction. ~~Endocrinology, diabetes, and metabolism fellowships provide advanced education to allow a fellow to acquire competency in the subspecialty with sufficient expertise to act as an independent consultant.~~

Some of our survey respondents had suggestions to improve this definition (see appendix). However, since it seems unlikely to us that this definition will materially impact the well-being of APDEM members or endocrinology fellows, we in APDEM Council won't advocate for specific changes at this time.[1]

---------- Line numbers 247-256 ----------

II.A.2. The program director must be provided with support adequate for administration of the program based upon its size and configuration. (Core)

II.A.2.a) The program director must not be required to generate clinical or other income to provide this administrative support. (Core)

II.A.2.b) This support ~~should~~ must be in the range of 20 ~~25~~ to 50 percent of the program director's salary, or protected time, for administration of the program, depending on the size of the program. (~~Detail~~ Core)

The topic of program director (and associate program director) support is of substantial interest to APDEM members, and it generated the most robust survey response.

[1] If the ACGME would like specific APDEM input in this regard, we would be happy to provide it.

APDEM has advocated on this topic previously. In a 1/31/2019 letter from APDEM to the ACGME, we described survey data suggesting that an unacceptably high number of endocrine program directors believe that effort/salary support provided by their institution is inadequate vis-à-vis current program requirements; and many program directors believe that their institution's incentive to maximize the program director's revenue-generating activities often supersedes the institution's incentive to ensure a program director's ability to fulfill her/his obligations as outlined in the ACGME program requirements. *These views were reinforced in the current survey.* In particular, our recent survey responses almost uniformly voiced opposition to the reduction of minimum program director support from 25% to 20%.

We very much appreciated the IM-RC's 3/13/2019 response to our 1/31/2019 letter, which included an explanation that "[t]he RC lowered the range to 20 percent so there is parity with the residency common program requirement (CPR) related to this issue"; and that "the RC-IM will consider all facets of this very important issue during the major revision of the subspecialty requirements." When the time comes, we will be eager to engage in continued collaborative and meaningful discussions about this topic.

In the meantime, we want to reiterate our strong beliefs that (a) many institutions will provide the bare minimum mandated support, regardless of true need; and (b) all institutions have a financial incentive to underestimate a program director's true support needs. As you know, the bulk of administrative requirements are pertinent to all programs regardless of size. In addition, faculty support is highly variable among programs, the supportive ability of program coordinators is highly variable, etc. Moreover, we worry that administrative requirements may be increasing (e.g., 2019 ADS), and an emphasis has been placed on continuous program improvement. Thus, we believe that program directors for small programs will often need more than 20% support. The bottom line: we implore the ACGME once again to provide clear and strong requirements related to program director (and associate program director) support, and we ask the ACGME to incorporate factors other than size alone.

---------- Line numbers 258-267 ----------

II.A.3. Qualifications of the program director:

II.A.3.a) must include subspecialty expertise and qualifications acceptable to the Review Committee; and, (Core)

II.A.3.a).(1) The program director must have <u>administrative experience and</u> at least ~~five~~ <u>three</u> years of participation as an active faculty member in an ACGME-accredited internal medicine residency or endocrinology, diabetes, and metabolism fellowship. (~~Detail~~ <u>Core</u>)

We believe that the "must have administrative experience" requirement is too vague; as written, we're not sure that this would effectively exclude any potential candidate for program director.

Regarding the change from five to three years, our survey responses were mixed: some members approved the change because it would offer more flexibility, while a number of others expressed concern that three years may not provide enough foundational experience for the role.

We in APDEM Council are curious about why this particular change (five to three years) is being proposed.[2] We acknowledge that some faculty members with only three years of active program participation may be well-suited for the program director role (e.g., those with a longer-history of non-GME-related leadership and/or administrative experience). This change could also be desirable if a program's best overall candidate has only three and five years of active program participation. However, our strong intuition is that some faculty members with three years of active program participation will be unprepared for the program director role. We are particularly concerned about junior faculty members who are only three years out of fellowship. Such faculty members may be less

[2] This change is not addressed in the accompanying summary/impact document, and there is no accompanying "Background and Intent section" in the proposed new program requirements document.

able to provide strong mentorship to fellows; may be less able and/or less willing to strongly defend the interests of fellows against the competing interests of senior faculty; etc.

We also offer a potential unintended consequence: this change could exacerbate problems if a division has an incentive to "dump" program director responsibilities on the most junior faculty members. We don't know how often this situation occurs, but such situations would be especially problematic if such junior faculty members are ill-equipped. It would also be problematic if institutional (salary, effort, and administrative) support is poor, as junior faculty members may be less able to navigate the rigorous requirements of the program director role without strong institutional support.[3]

---------- Line numbers 461-468 ----------

II.B.4.c) In addition to the program director, there must be at least one core faculty member certified in endocrinology, diabetes, and metabolism by the ABIM or the AOBIM. (Core)

II.B.4.d) For programs approved for more than three fellows, there must be at least one core faculty member certified in endocrinology, diabetes, and metabolism by the ABIM or the AOBIM for every 1.5 fellows. (Core)

A number of our survey respondents found the language of these particular requirements to be confusing. We request that the ACGME consider revising for clarity or providing clarifying examples.

As a group, APDEM Council has mixed feelings about this requirement.

According to V.C.1.c).(6).(c), assessments of program quality are to include aggregate fellow board pass and certification rates. In essence, board pass rates (imperfectly) reflect graduate quality and, by inference, board pass rates (imperfectly) reflect program quality. In light of this, it seems reasonable that the ACGME might similarly address board certification requirements on the part of a program's physician teaching faculty members. Presumably, the ACGME's intent is to ensure the quality of a program's teaching faculty.[4] If this presumption is correct, we are somewhat surprised that this new requirement for physician teaching faculty doesn't parallel requirements for graduated fellows. Indeed, the proposed requirements could still allow a large majority of a program's physician teaching faculty to lack board certification. For example, if a four-fellow program has 10 core faculty members, up to eight (80%) of those core faculty members could lack board certification. Similarly, if a four-fellow program has 10 core physician faculty members and 10 non-core physician faculty members, up to 18 (90%) of the program's clinical teaching faculty members could lack board certification.

We sympathize with one program director who highlighted a potential dilemma related to the fact that some of his outstanding faculty members decided to let their board certification lapse. Given the potentially negative impact such a regulation could have on programs and individual faculty members,[5] we request that the ACGME communicate its rationale for these new regulations.

---------- Line numbers 849-863 ----------

IV.C.1. The curriculum must be structured to optimize fellow educational experiences, the length of these experiences, and supervisory continuity. (Core)

IV.C.1.a) Assignment of rotations must be structured to minimize the frequency of rotational transitions, and rotations must be of sufficient length to provide a

[3] We believe that poor institutional support would also make it more likely that a division (led by senior faculty) would "dump" the poorly-supported program director role on a junior faculty member.

[4] The accompanying summary/impact document does not clearly explain the rationale for this change; it only states "The Committee is supplementing the "Core Faculty" section of the Common Program Requirements with its long-standing requirements that there be a minimum number of faculty members who are certified in the subspecialty." Similarly, there is no accompanying "Background and Intent section" in the proposed new program requirements document.

[5] Maintenance of board certification is both expensive and time consuming, and our understanding is that not all academic institutions require it.

quality educational experience, defined by continuity of patient care, ongoing supervision, longitudinal relationships with faculty members, and meaningful assessment and feedback. (Core)

IV.C.1.b) Clinical experiences should be structured to facilitate learning in a manner that allows fellows to function as part of an effective interprofessional team that works together towards the shared goals of patient safety and quality improvement. (Core)

We agree that the concepts incorporated into these additions are important, and we like that the statements aren't overly prescriptive. That said, we believe that many APDEM members would benefit from some examples highlighting what kinds of rotation structures (IV.C.1.a) would be acceptable vs. unacceptable. Since programs will be held accountable, we advocate for additional clarity in this regard.

---------- Line numbers 1017-1021 ----------

IV.D.2.b).(2) At least 50 percent of the core faculty members who are certified in endocrinology, diabetes, and metabolism by the ABIM or AOBIM (see Program Requirements II.B.4.c-d) must annually engage in a variety of scholarly activities, as listed in Program Requirement IV.D.2.b).(1). (Core)

None of our survey responses implied opposition to this requirement.

In contrast to scholarly activity for fellows (IV.D.3.a), this regulation is somewhat vague in the sense that it does not describe what constitutes acceptable scholarly activity for faculty.

It's unclear to us in APDEM Council why 50% of ABIM-/AOBIM-certified core faculty members must participate in scholarly activities while, in contrast, core faculty members who aren't ABIM-/AOBIM-certified are not required to participate in scholarly activities at all. With regard to the benefit that faculty scholarly activities may have for fellows and/or for the fellowship program, is there a fundamental difference between board-certified and non-board-certified faculty members? We can understand how board-certification might be pertinent for clinical training/guidance, but we fail to see how board-certification relates to academic/scholarly training and guidance.

---------- Line numbers 1023-1048 ----------

IV.D.3. Fellow Scholarly Activity

IV.D.3.a) While in the program, at least 50 percent of a program's fellows must have engaged in more than one of the following scholarly activities: participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor. (Outcome)

IV.D.3.b) ~~The majority of fellows must demonstrate evidence of scholarship conducted during the fellowship.~~ (Outcome)

~~This should be achieved through one or more of the following:~~

~~IV.D.3.b).(1) publication of articles, book chapters, abstracts or case reports in peer-reviewed journals;~~ (Detail)

~~IV.D.3.b).(2) publication of peer-reviewed performance improvement or education research;~~ (Detail)

~~IV.D.3.b).(3) peer-reviewed funding; or,~~ (Detail)

~~IV.D.3.b).(4) peer-reviewed abstracts presented at regional, state or national specialty meetings.~~ (Detail)

In our view, this proposed change introduces two important conceptual inconsistencies.

1. This requirement suggests that substantive scholarly activity is critically important for some fellows (i.e., important enough to be mandated), but at the same time it suggests that scholarly activity is not at all important for other fellows. The rationale for this discordance is unclear. If scholarly activity is not important for up to 50% of fellows, we question why it should be mandatory for other fellows. Similarly, if it is not uniformly important for all fellows, then the 50% threshold seems entirely arbitrary. What makes it important for one fellow and unimportant for another?
2. The proposed change seems incongruous with the inclusion of a scholarship item in the current milestones.[6] Inclusion of a scholarship milestone implies that related activities and characteristics are important for all fellows. We believe that program requirements and milestones should be harmonized.

Some of our survey respondents suggested that *all* fellows should participate in scholarly activity while in fellowship. We members of APDEM Council—each of whom is an academic endocrinologist—are certainly tempted to advocate that some form of scholarly activity should be required of all fellows. Nonetheless, instead of advocating for a specific position, we simply request that the ACGME carefully consider (and explain) these scholarly activity requirements in the context of the overall purpose of the ACGME's program requirements. Presumably, the overarching purpose of the program requirements is to ensure that every fellow becomes a competent, independent clinical endocrinologist. Is scholarly activity during fellowship required to become a competent clinical endocrinologist, or does it somehow enhance the capabilities of the clinical endocrinologist?[7] If so, we would advocate that scholarly activity should be required of all fellows. If not, we aren't sure how scholarly activity requirements can be defended. (We note that individual programs—e.g., those specifically designed to train academic endocrinologists—could still require scholarly activity as appropriate.)

Similarly, we suggest that the academic skills required of a clinical endocrinologist are not materially different from the academic skills required of a clinical internist. Thus, if additional development in scholarship is required for endocrinology fellows, does this imply that development in scholarship was inadequate or imperfect for general internists? Similar concerns could be expressed for numerous other fellowship training requirements.[8]

We in APDEM Council agree with a survey respondent who highlighted that some of the items in the new list seem conspicuously out of place (e.g., serving as a journal reviewer, journal editorial board member, or editor). Our intuition is that very few fellows are provided with the opportunity to engage in these particular activities.

We in Council like that additional examples of acceptable scholarly activities have been added. However, we suggest that this limited and concrete list may be too constraining. We suggest that the ACGME should instead provide an operational definition of "scholarly activity," accompanied by an explicitly non-comprehensive list of examples that would be acceptable to the ACGME.

Final note: "IV.D.3.b)" on line 1034 can now be removed.

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[6] "Ready for unsupervised practice" in Scholarship includes the following items: Collaborates with other investigators to design and complete a project related to clinical practice, quality improvement, patient safety, education, or research; Presents scholarly activity at local or regional meetings, and/or submits an abstract summarizing scholarly work to regional/state/ national meetings, and/or publishes non-peer-reviewed manuscript(s) (reviews, book chapters).

[7] We are not willing to say that scholarly activity during fellowship is *essential* for clinical competence. However, we believe that scholarly activity does in fact *enhance* the capabilities of the clinician.

[8] We offer IV.A.5. as another example. We maintain that professionalism in endocrinology is not materially different than professionalism in internal medicine, and most fellows satisfactorily demonstrated adequate professional development during their internal medicine residency programs. If additional training is required for endocrinology fellows, does this imply that professionalism training has been inadequate for general internists?

APDEM Council was involved in the construction of this letter, and Council unanimously approved this final version.

We offer this in a constructive and collaborative spirit.

Sincerely, and on behalf of APDEM Council,

Christopher R. McCartney, MD
APDEM President

Attachment: APPENDIX - APDEM member survey responses

CC: APDEM Council (Drs. Charitou, Cooper, Gianoukakis, Salvatori, Samson, Torres, and Yaqib)
APDEM Staff (Alexa Stout, Amanda Perl)

APPENDIX - APDEM member survey responses

The following are individual APDEM member comments (verbatim) related to the proposed changes. Note that blank survey responses were omitted from this appendix.

Definition of subspecialty (lines 47-54)

- No comments
- The way this is written I would question if either nutrition or metabolic bone disease would be included in endocrinology. Perhaps take out the term glandular.
- Agree
- i'd take out glandular and add diabetes: "Endocrinology, diabetes, and metabolism is the subspecialty of internal medicine that focuses on the diagnosis and care of disorders of the endocrine system and of metabolic dysfunction, including but not limited to, diabetes mellitus."
- Agree
- The definition is worded awkwardly. In addition, it seems odd to comment on "endocrine" and "metabolism" and not "diabetes" in the definition.
- Why is the goal of the fellowship training crossed out? This seems like it should be an important inclusion as a follow-up to the definition.
- no comment
- Agree with the definition.
- Fine with this
- Agree with it
- I think 'evaluation and management of disorders…' appears more accurate than diagnosis and care.

Program director support (lines 247-256)

- No comments
- It would be helpful to have a ratio here similar to the ratio of number of core faculty per fellow. 20% might be an appropriate minimum for a 2 fellow program. It is not enough for a larger program. Perhaps increasing this floor by 5% admin support for each additional fellow over 2 (25% for 3 fellows, 30% if 4 fellows...)
- 20-50% is big range It may be good to suggest this by the number of fellows
- Agree with the wording change to "MUST" but would like the range be from 25-50% rather than 20-50%
- I don't think it's a good signal to institutions to reduce the lower limit of this range. I would recommend leaving the lower limit at 25%. If anything, 50% seem like too high an upper limit. I believe more reasonable is 25-35%.
- Could not agree more that the effort for fellowship support should be higher and (frankly) mandated. It should be split if there is an APD with respect to effort divide. Effort should be at least 30%. This is the most important element that needs approval.
- Who is to determine what program size warrants 20% and what program size warrants 50%?
- I understand the need to be concise. However, limiting the time involved to "administration" could be interpreted by some in ways that underestimates requirements of PDs. I am thinking in particular of attending regularly scheduled learning activities of fellows which consumes "free time" like noon hours and time in the morning before clinic or hospital service begins.
- Agree with the level of support, which may vary depending on the size of the program.
- The minimum percent of required protected time for the PD for administration of the program should remain 25-50% (and should not be changed to 20-50%). Regardless of program size, 25% protected time, at minimum, is required to adequately complete the multitude of tasks required of the PD (for a program of any size) and to ensure that the fellowship is providing an

adequate training and educational experience to the fellows. Even for smaller programs, 25% can be an underestimate of the true time commitment required.

- This requirement is too vague and requires clarification. There should be clear minimum requirements for program director salary support and protected time based on the number of fellows in a training program.
- I am concerned about the minimum dedicated time for administration of the program, please can you maintain at 25%. Ours is a community hospital with scant resources, hence I have been putting in a lot of personal time towards the fellowship. I am concerned that if the lower bar is 20% for the work, I will be spending even more of my personal time to complete the needed activities to maintain the fellowship.
- 20% is too little, advocate for the minimum to be 25%
- Program directors work a lot on administrative issues regarding the program. All the work that a PD need to do is very similar if you have 2 or 10 fellows. The administrative work including training your faculties and dealing with the sponsor institutions is a lot. I am worried that if they decrease the time then some programs will get 4 days of clinic and one day for PD time and as you know this is not enough for all the things that we need to do.
- I do not agree with changing the range of support from 25-50% down to 20-50%. At my institution the default is to give program directors the bare minimum salary support allowed (even when more is justified) and this new language will worsen this problem.
- I liked 25% better as the low end as it can be very time consuming to do well. Should also consider administrative support and experience.
- In my opinion, we should insist (with recollection of the previous conversations) that ACGME offer more clarity re: PD protected time. If they can require 1 ABIM certified faculty per 1.5 fellows, why can't they require 5% additional protected time/per additional fellow above the minimum 20% (for programs with 1-2 fellows) and up to a maximum of 50% protected time. The ACGME continues to pile on the admin requirements as we are all feeling this week heading into the 8/30 deadline. The least they can do is put some teeth behind the support for PDs.
- I do think that even with a small program, 25% is the minimum.
- 60-80% of the administrative work load is very similar irrespective of the number of fellows and so if we can get a higher base salary for PD it would be ideal. However it seems the ACGME is worried about cost to parent institutions and since many PD don’t even get 20% salary support at this time.
- I recommend 25 to 50% rather than 20 to 50%. I think ACGME should specify and include the effort calculation formula and that this protected time is a composite for both PD/APD combined to clarify.

Qualifications of the program director (lines 258-267)

- No comments
- This is a reasonable change.
- i'm not sure 3 years is enough time to have significant administrative experience to be a program director. i'd recommend leaving a 5 years.
- Agree
- What "administrative experience" must a prospective PD possess to ascend to the role? This should be more clearly spelled out.
- This is the most important change in the standards, which I strongly support. It allows small fellowship programs to engage and select the faculty members most passionate about medical education. The previous requirement for five years of faculty experience to qualify as a program director was a barrier, and the proposed three year requirement is a major improvement in the core standards.
- I prefer the requirement of five years of administrative experience and status as an active faculty member to serve as a program director.
- glad that the 5 years is reduced to 3 years

- I have a lot of experience involves with ACGME in multiple levels and a master in medical education, but because of my experience as a young program director, I really believe that PD should have at least 5 years of faculty experience to really understand the administrative part of being a PD. It is not only the knowledge of the medical educator part but is the maturity in leadership and leadership skills that you get with time involve in the program. 3 years are not enough.
- Is “experience” defined somewhere? If not, it needs to be.
- The PD should have at least 5 years experience instead of 3. That will help prevent junior faculty from being drawn into PD role too early in their academic career.
- Program requirements (I.e. QI projects, milestones based feedback, scholarship, etc.) warrants an experienced PD requiring higher salary support but also skill level. It would be ideal for PD appointment to occur at least 5yrs after training (and maybe the APD 3yrs after training).
- It should stay as at least five years. 3 years is certainly not enough.

Core faculty members (lines 461-468)

- No comments
- The formula for core faculty is a bit confusing. If a program has 4 fellows, does it need to have 2 or 3 core faculty?
- Agree
- i feel there should be at least 2 core faculty members, not one, in addition to the program director
- Agree
- Fine
- All of the core physician faculties should be ABIM certified in endocrinology
- I’m not clear on this – if 1 or 2 fellows, then need to have the PD and one core endo faculty and if 3 fellows, need to have the PD and two core endo faculty? May be obvious to others.
- Faculty requirements should be qualified. My interpretation is that if you are required 4 faculty that are ABim cerfified, two of them should have scholarly activities but I might be confused.
- If a program has 4 fellows, then the program needs 3 core faculty plus PD. Only 2 of the faculty need to be board certified or have any scholarship? Does adding more core faculty (example: 10 core faculty) if the minimum requirement is only 3 change the calculation for the number of faculty who need to have board certification or scholarship (i.e. 2 vs. 5)?
- I know that in my program there are outstanding endocrinologists who did not think it was worth their time to re-certify in Endo. As of now, our Institution does not require maintenance of certification. How should we behave? Should the PD’s go to the ABIM website to check for current certifications? Should not re-certified people be removed from core faculty?
- ACGME should specify and further define this statement. It should state something like ‘..50% of the minimum required core faculty members..must engage in a variety of scholarly activities…’

Curriculum (lines 849-863)

- Would consider inquiring about removing Section IV.C.1.a), specifically "rotations must be structured to minimize the frequency of rotational transitions, and rotations must be of sufficient length....". It is possible that even one-week long rotations that recur would provide the fellows with a quality educational experience, continuity of patient care, ongoing supervision and relationships with faculty members, and meaningful assessment and feedback.
- This is reasonable
- Agree
- seems fine
- Agree
- does this replace that longitudinal clinics must be at least 6 month rotations? I hope so, this gives more flexibility
- agree

- This is difficult to quantify. We do try to include our fellows in MD/RN collaborative meetings and operational meetings for clinics in order to involve fellows in these goals. So these types of experiences may be able to answer that question, in the future.

Faculty scholarly activity (lines 1017-1021)

- No comments
- This is reasonable - could argue to all should participate in these items but I am okay with a 50% minimum.
- seems fine
- Agree
- fine
- I believe that 50% of the goal faculty (depending on fellows) should have some scholarly activities To clarify not 50% of the entire faculty listed in the roster just the one that is the standard for that fellow
- Can we clarify what counts as scholarship for faculty? Same as what counts for fellows?
- Perhaps we can propose to remove the part of "ABIM certified" for scholarly activity to avoid being too restrictive on # of faculty?
- Is it 50% of the number of ABIM certified faculty you have or 50% of the minimum number of ABIM faculty you are supposed to have? In re-reading, the ACGME may want to clarify the language. For example, if you only need 4 certified faculty for the number of fellows you have, but have 14, should it be 2 faculty that have scholarly activities or 7? This may become important as institutions move to RVU based compensation and hire 100% clinical faculty with $\geq$9 clinics who work with fellows clinically and are ABIM certified but do not have a mandate or the time to produce scholarly activity.

Fellow scholarly activity (lines 1023-1048)

- No comments
- This again is reasonable although could argue that all should participate in at least one of these items. I am okay with a 50% minimum.
- This is a fairly broad definition of scholarly activity. I think that ALL fellows should be required to engage in scholarly activity (not merely 50% of fellows), as this is highly valuable for learning and career development. I think this is highly feasible from a programmatic perspective since the definition of scholarly activity as described here is very broad.
- seems fine
- These expectations need to be more realistic. Including that a trainee be an editor or on an editorial board is stretching. Even presenting at grand rounds is beyond reasonable. The previous guidelines regarding scholarly activity should remain unchanged.
- Agree
- I like that the definition of scholarly activity is broadened for fellows as it was for core faculty in the past. Demonstration of leadership growth (such as committee involvement) should be recognized.
- Should not 100% of fellows do at least two things in the course of two years especially when participation is the bar to reach for some like workshops and QI projects?
- fine
- Fellow scholarly activities are excellent, they include poster, cases, publication, etc. and not just focus on publications. I think that it should also be added to be involved in regional or national organizations or leadership position.
- is this really at least two? if so, favor saying that. Also not sure why two specific rather than the prior at least one of the following. I also find at least 50% confusing as many programs are small and for 1 fellow only, how is that counted?