

Programmed to Fail: The Decline of Protected Time for Training Program Administration

Christina M. Yuan¹, MD

Brian Y. Young, MD

Maura A. Watson², DO, MPH

Amy N. Sussman, MD

The Accreditation Council for Graduate Medical Education (ACGME) accredits specialty and subspecialty training programs in the United States.¹ In 2019, the ACGME began to decrease requirements for protected time that program directors and core faculty are to receive from their institutions for program administration—the non-clinical teaching and administrative activities necessary for training program management.^{2–4} As an example, changes in requirements for internal medicine subspecialties are shown in the TABLE, presented from a fellow perspective. Before July 2019, a 6-fellow program had available 20 hours a week of dedicated time from the program director, and 10 hours a week from each of the 4 required core faculty.² The aggregate 60 hours per week averages 10 hours/fellow/week of effort, in addition to direct clinical supervision. As of July 2023, the aggregate had shrunk to 12 hours total (2 hours of effort per fellow), comprising 8 hours for the program director and 4 hours total shared between the 3 required core faculty.⁵ This is an 80% decrease within 4 years.

These changes were undertaken without fanfare, based on findings of an ACGME taskforce convened in mid-2020 (the height of the COVID-19 pandemic) “to quantify the effort required to participate in the educational program of residents and fellows.”⁶ The stated goal was to establish equitable standards across specialties and subspecialties. Input was solicited at “stakeholder” congresses, but the findings have not been published.^{6–8} Some specialty organizations (eg, emergency medicine, pathology, and family medicine) responded by recommending pre-2019 levels of protected time be retained.^{9–11} The Alliance for Academic Internal Medicine proposed that minimum subspecialty program director administrative time be 10 hours per week, yet this was reduced to 8 hours in 2022.⁸

For internal medicine subspecialties, including our own (nephrology), these changes may result in fellowship training being focused even more on the

apprenticeship model—direct clinical “bedside” teaching and supervision. Fellows will likely experience a decrease in faculty time devoted to teaching conferences, assessment, and mentoring, from approximately 10 hours to 2–3 hours per week, out of their maximum 80-hour workweek. The impact of these decreases on trainee education and board performance has not been assessed.

Graduate medical education (GME) programs must meet ACGME standards, including trainee work hours, supervision, and the necessary qualifications and functions of the faculty and program director.^{12,13} In addition to patient care, program directors and core faculty not only perform direct (bedside) clinical teaching and supervision, but also didactic teaching activities, and program-related administrative tasks. Protected time, per the ACGME, is for all vital program activities not reimbursed through patient care. This includes preparation and delivery of teaching sessions, curriculum development, resident assessment, mentoring required scholarship, faculty development, recruitment, program performance improvement, ensuring resident well-being, and promoting a culture of safety, diversity, equity, and inclusion. Program directors must also ensure the accuracy and timeliness of program record-keeping and submit data to their institutions and the ACGME. This data underlies accreditation decisions and documents resident progress toward graduation.

How much time do program directors and core faculty need for program administration? Annually, the ACGME surveys programs regarding how much time their program director and core faculty “devote” to program administration tasks. Only specialty data is available. For example, in 2021–2022, family medicine, internal medicine, and emergency medicine programs reported time devoted to program administration averaged 26 to 28 hours per week for program directors and 11 to 13 hours per week for core faculty.¹⁴ The survey does not ask how much of this time is protected, or if program directors and faculty feel it is sufficient. These specialty programs average 20 to 50 residents per program, with maximum program director protected time of 20 hours per week.¹⁴

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TABLE

Hours per Week per Fellow for Didactic Teaching and Program Administration for Internal Medicine Subspecialty Programs (2019 to 2024) Stipulated by the ACGME^{2-5,16}

Fellows per Program	Before July 1, 2019 ^a			July 1, 2019-June 30, 2022 ^b			July 1, 2022-June 30, 2023 ^c (Paused)			July 1, 2023-June 30, 2024 ^{d,e}		
	Minimum Core Faculty	Minimum Aggregate Program Hrs	Hrs/Wk/Fellow	Minimum Core Faculty	Minimum Aggregate Program Hours	Hrs/Wk/Fellow	Minimum Core Faculty	Minimum Aggregate Program Hrs	Hrs/Wk/Fellow	Minimum Core Faculty	Minimum Aggregate Program Hrs	Hrs/Wk/Fellow
4	2	40	10	2	10	2.5	2	8	2	3	12	3
5	4	60	12	4	10	2	4	8	1.6	3	12	2.4
6	4	60	10	4	10	1.7	4	8	1.3	3	12	2
7	5	70	10	5	10	1.4	5	10	1.4	4	21	3
8	6	80	10	6	10	1.3	6	10	1.3	4	21	2.7
9	6	80	8.9	6	10	1.1	6	10	1.1	4	21	2.3
10	7	90	9	7	10	1	7	12	1.2	6	23.6	2.4
11	8	100	9.1	8	10	0.9	8	12	1.1	6	23.6	2.1
12	8	100	8.3	8	10	0.8	8	12	1.0	6	23.6	2

Abbreviations: ACGME, Accreditation Council for Graduate Medical Education; hrs, hours; wk, week.

^a 20 hours/week for the program director; 10 hours/week for core faculty.

^b 10-20 hours/week (25-50%) for the program director, with no time stipulated for core faculty.

^c 6 or fewer fellows, program director receives 8 hours; 7-9 fellows, program director receives 10 hours; 10-12 fellows; program director receives 12 hours. Protected time for faculty and associate program director (now required) paused.

^d 6 or fewer fellows; 12 hours total (8 hours for program director and 4 hours divided between core faculty/associate program director; 7-9 fellows, 21 hours total (10 hours for program director, 6 hours divided among core faculty, 5.2 hours for associate program director); 10-12 fellow programs, 23.6 hours total (12 hours for program director, 5.6 hours for the associate program director, 6 hours divided among core faculty).

^e In 2023-2024, the number of required core faculty decreased from 2 faculty/3 trainees to 1 faculty/2 trainees.

Small 2-year subspecialty programs (nephrology, endocrinology, rheumatology, and infectious disease), which average 4 to 6 fellows, will be particularly hard hit.¹⁵ They fall below an arbitrary 7-fellow threshold (TABLE).^{4,5,15,16} Programs with fewer than 7 fellows receive 12 hours per week of protected time between the program director, associate program director, and core faculty. Fellows in a 6-fellow program have 2 hours per week available to each personally. Adding only 1 fellow increases protected time to a little over 21 hours per week—3 hours per fellow. This is achieved by requiring the associate program director in a 7-fellow program specifically to receive 5.2 hours of protected time, while in 6-fellow programs they receive none.

The effective erosion of protected time began before 2019-2020. In a 2022 survey, 84% of nephrology program directors in their positions before 2019-2020 reported that they had not received the required 20 hours per week of protected time.¹⁷ By 2021-2022, they were receiving only a median 10 hours per week, and those with fewer than 7 fellows were receiving only 8 hours per week.¹⁷ At that time, the ACGME minimum was 10 hours per week. Overall, 73% reported needing more time—a median 5 hours per week more than they were receiving. Thirty-nine percent indicated that faculty received no protected time.¹⁷

In 2022-2023, the ACGME proposed that internal medicine core faculty receive 4 hours per week of protected time.¹⁶ This was paused because of the projected financial burden to institutions, despite the

requirement for 10 hours per week before 2019-2020. The Alliance for Academic Internal Medicine expressed concern that the “unintended consequences” of resuming protected time for faculty (only in abeyance for 3 years) would result in increased direct costs in the climate of “large operating losses.”¹⁸ The 2023-2024 protected time proposals appear to try to minimize the impact by cutting the number of core faculty and decreasing time to 4 hours per week for the faculty in aggregate (1 hour for each faculty member in a 4-faculty program).^{5,12,13}

The Centers for Medicare & Medicaid Services (CMS) provides institutions with GME support payments (approximately \$140,000 per resident FTE in 2015).¹⁹ Some have argued that this is insufficient, as there is a longstanding cap on resident numbers (“direct cost”), and increased funding for GME is the result of increases in “indirect cost” payments.²⁰⁻²³ Trainee numbers have increased beyond the CMS cap, presumably because it makes fiscal sense for training institutions. A bill has been recently introduced in Congress to increase CMS funding of GME, both for trainee numbers and funding per resident.²⁴ However, the way these payments have been used by institutions and shared with individual training programs is not transparent.^{19,22}

From a financial perspective, sponsoring institutions benefit from supporting only the ACGME-stipulated minimum protected time and lobbying for the smallest minimum. This would be an injustice to trainees and to GME educators, who are specialists

in medical education and should be recognized and remunerated as such. Trainees require educational support beyond bedside rounds, procedural oversight, and clinic staffing by faculty. Education leaders must pay attention to these changes, support the need for protected time, and insist that the ACGME provide objective evidence to support these changes, including the data presented at the 2020-2021 congresses. The ACGME should minimize the time burden of administrative processes and assess the impact of new requirements.¹¹ CMS payments to institutions should be transparent to individual training program leadership, including the clinical revenue attributable to program faculty and trainees. If funding is inadequate, lobbying activities need to be directed to Congress, but there must be a clear accounting of the use of CMS funding. Lastly, the impact on trainee outcomes, including board pass rates and competency milestone attainment, should be assessed prospectively.

Early this year, one of us and another nephrology faculty walked a first-year fellow through the physiology of the water deprivation test. We calculated hourly osmolar clearance, discussed the differential diagnosis of polyuria, vasopressin and thirst, and the electrolyte free water clearance. We spent a happy 30 minutes—nephrology nerds reveling in fluid and electrolyte calculations. The fellow had just expended half of his 2-hour per week allotment of faculty protected time.

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Christina M. Yuan, MD, is Associate Program Director, Nephrology SVC, Walter Reed National Military Medical Center; **Brian Y. Young, MD**, is Program Director, Division of Nephrology, University of California at Davis; **Maura A. Watson, DO, MPH**, is Program Director, Nephrology SVC, Walter Reed National Military Medical Center; and **Amy N. Sussman, MD**, is Program Director, Division of Nephrology, Department of Medicine, University of Arizona Health Sciences Center.

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Corresponding author: Christina M. Yuan, MD, Walter Reed National Military Medical Center, christina.m.yuan.civ@health.mil