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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
5-week “windows,” from January through April. The required completion rate of the surveys for each program is 70%. In the next accreditation system, 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, 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.

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. 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. 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. 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.
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ters are acutely aware that the coming months will not
accreditation programs, residents/fellows have been, or will
be “business as usual” for accredited programs. In most,
number of programs still awaiting site visits, the 2020
impact of the pandemic on the 2020 graduate case logs.
For all these reasons, the Review Committees will have
more information on which to base accreditation deci-
sions in 2021 than they have had in any other year since
their establishment. Three domains of program require-
technology for resident/fellow work hours, the requirements for appropriate supervision, and
the requirements for resident/fellow safety, including pro-
visions 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 re-
dency 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 elim-
inating travel and saving money for the organization?
(Note: more than 90% of the annual income of the
ACGME is derived from accreditation fees. “Saving

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 conduct-
ed 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 meet-
ings 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 in-
formation 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 Commit-
tees 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 dra-
stically 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 redeployment in emergency rooms, screening cen-
ters, 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 de-
mands 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 pre-
viously made remote conferencing their routine, so will
have many obstacles to overcome. Evaluation and
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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