



ACGME International

**Advanced Specialty Program Requirements for
Graduate Medical Education
In Pediatrics**

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Graduate Medical Education
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I. Introduction

I.A. Definition and Scope of Specialty

Pediatric residency programs provide training through which residents acquire competency in general pediatrics, including the ability to provide comprehensive and coordinated care to a broad range of pediatric patients. Pediatrics residents also become sufficiently familiar with the subspecialty fields of pediatrics to enable them to participate as team members in the care of patients with chronic and complex disorders.

I.B. Duration of Education

I.B.1. The educational program in pediatrics must be 36 or 48 months in length.

II. Institutions

II.A. Sponsoring Institution

See International Foundational Requirement, Section I.A.

II.B. Participating Sites

The program must be structured to provide at least 30 months of required residency education at the primary clinical site and other participating sites.

III. Program Personnel and Resources

III.A. Program Director

See International Foundational Requirement, Section II.A.

III.B. Faculty

III.B.1. For each required educational unit (four-week or one-month block, or longitudinal experience), a core faculty member must be responsible for curriculum development and for ensuring orientation, supervision, teaching, and timely feedback and evaluation.

III.B.2. Faculty Development

III.B.2.a) At least annually, program leadership and core faculty members must participate in faculty or leadership development programs relevant to their roles in the program.

III.B.2.b) All faculty members involved in the education of residents should participate in programs to enhance the effectiveness of their skills as educators, based on their roles in the program.

III.B.3. General Pediatrics

III.B.3.a) There must be faculty members with expertise in general pediatrics who have ongoing responsibility for the care of general pediatric patients. These faculty members must:

III.B.3.a).(1) participate actively in formal teaching sessions; and,

III.B.3.a).(2) serve as attending physicians for inpatients, outpatients and term newborns.

III.B.4. Subspecialty Faculty

III.B.4.a) Faculty members with subspecialty certification must function on an ongoing basis as integral parts of the clinical and instructional components of the program in both inpatient and outpatient settings, including a faculty member in each of the following subspecialty areas of pediatrics:

III.B.4.a).(1) adolescent medicine;

III.B.4.a).(2) developmental-behavioral pediatrics;

III.B.4.a).(3) neonatal-perinatal medicine;

III.B.4.a).(4) pediatric critical care;

III.B.4.a).(5) pediatric emergency medicine; and,

III.B.4.a).(6) the five other distinct pediatric medical disciplines.

III.B.5. Other Faculty

III.B.5.a) At the primary clinical site, there must be at least one physician, available for clinical consultation and teaching of residents, who is certified in each of the following areas:

III.B.5.a).(1) diagnostic radiology;

III.B.5.a).(2) pathology; and,

III.B.5.a).(3) surgery.

III.C. Other Program Personnel

See International Foundational Requirement, Section II.C.

III.D. Resources

III.D.1. Facilities

III.D.1.a) The program must have an intensive care facility that is appropriately equipped and staffed for the care of a sufficient number of critically-ill pediatric patients.

III.D.1.b) There must be an emergency facility that specializes in the care of pediatric patients and that receives pediatric patients who, if it is available in the country or jurisdiction, have been transported via the Emergency Medical Services system.

III.D.2. There must be a sufficient number of patients being treated in the intensive care unit to support the required experiences for the number of residents in the program.

IV. Resident Appointments

IV.A. Eligibility Criteria

See International Foundational Requirement, Section III.A.

IV.B. Number of Residents

IV.B.1. There should be at least four residents at each level of education.

IV.B.2. Resident attrition must not have a negative impact on the stability of the educational environment.

V. Specialty-Specific Educational Program

V.A. Regularly Scheduled Didactic Sessions

V.A.1. The core curriculum must include a didactic program that is based upon the core knowledge content in pediatrics.

V.A.2. All required core conferences should have at least one faculty member present and be scheduled to ensure peer-peer and peer-faculty interaction.

V.A.3. Patient-based teaching must include direct interaction between residents and attending physicians, bedside teaching, discussion of pathophysiology, and the use of current evidence in diagnostic and therapeutic decisions. The teaching must be:

V.A.3.a) formally conducted on all inpatient and consultative services; and,

V.A.3.b) conducted with a frequency and duration sufficient to ensure a meaningful and continuous teaching relationship between the assigned supervising faculty member(s) and residents.

V.B. Clinical Experiences

V.B.1. The curriculum must be organized in educational units.

V.B.1.a) An educational unit should be a block of at least four weeks or one month, or a longitudinal experience.

V.B.1.a).(1) An outpatient educational unit should be a minimum of 32 half-day sessions.

V.B.1.a).(2) An inpatient educational unit should be a minimum of 200 hours.

V.B.1.b) Residents must act in a supervisory role, under faculty guidance for a minimum of five educational units during the last 24 months of education.

- V.B.2. The overall structure of the program must include:
- V.B.2.a) a minimum of six educational units of an individualized curriculum determined by the learning needs and career plans of each resident, and developed through the guidance of a faculty mentor.
 - V.B.2.b) a minimum of 10 educational units of inpatient care experiences, including:
 - V.B.2.b).(1) five educational units in inpatient pediatrics;
 - V.B.2.b).(1).(a) No more than one of the five required educational units should be devoted to the care of patients in a single subspecialty.
 - V.B.2.b).(2) two educational units in the neonatal intensive care unit (NICU);
 - V.B.2.b).(3) two educational units in the pediatric critical care unit (PICU); and,
 - V.B.2.b).(4) a minimum of one educational unit in term newborn care.
 - V.B.2.c) critical care experience in the NICU and PICU;
 - V.B.2.c).(1). For a 36-month program, critical care experience cannot exceed six educational units.
 - V.B.2.c).(2). For a 48-month program, critical care experience cannot exceed eight educational units.
 - V.B.2.d) a minimum of nine educational units of additional subspecialty experiences, including:
 - V.B.2.d).(1) adolescent medicine;
 - V.B.2.d).(1).(a) There should be at least one educational unit in adolescent medicine.
 - V.B.2.d).(2) one educational unit in developmental-behavioral pediatrics;
 - V.B.2.d).(3) four educational units of four key subspecialties from among the following:

- V.B.2.d).(3).(a) child abuse;
- V.B.2.d).(3).(b) medical genetics;
- V.B.2.d).(3).(c) pediatric allergy and immunology;
- V.B.2.d).(3).(d) pediatric cardiology;
- V.B.2.d).(3).(e) pediatric dermatology;
- V.B.2.d).(3).(f) pediatric endocrinology;
- V.B.2.d).(3).(g) pediatric gastroenterology;
- V.B.2.d).(3).(h) pediatric hematology-oncology;
- V.B.2.d).(3).(i) pediatric infectious diseases;
- V.B.2.d).(3).(j) pediatric nephrology;
- V.B.2.d).(3).(k) pediatric neurology;
- V.B.2.d).(3).(l) pediatric pulmonology; or,
- V.B.2.d).(3).(m) pediatric rheumatology.
- V.B.2.d).(4) three educational units consisting of single subspecialties or combinations of subspecialties, consisting of experiences from either the list above or from the following:
 - V.B.2.d).(4).(a) child and adolescent psychiatry;
 - V.B.2.d).(4).(b) hospice and palliative medicine;
 - V.B.2.d).(4).(c) neurodevelopmental disabilities;
 - V.B.2.d).(4).(d) pediatric anesthesiology;
 - V.B.2.d).(4).(e) pediatric dentistry;
 - V.B.2.d).(4).(f) pediatric ophthalmology;
 - V.B.2.d).(4).(g) pediatric orthopaedic surgery;
 - V.B.2.d).(4).(h) pediatric otolaryngology;

- V.B.2.d).(4).(i) pediatric rehabilitation medicine;
 - V.B.2.d).(4).(j) pediatric radiology;
 - V.B.2.d).(4).(k) pediatric surgery;
 - V.B.2.d).(4).(l) sleep medicine; or,
 - V.B.2.d).(4).(m) sports medicine.
- V.B.2.e) a minimum of five educational units of ambulatory experiences, including:
- V.B.2.e).(1) two educational units of the ambulatory experience that include elements of community pediatrics and child advocacy; and,
 - V.B.2.e).(1).(a) Ambulatory experiences should include a children's Emergency Department setting where residents provide care for children with non-serious acute illnesses with supervision provided by general pediatricians.
 - V.B.2.e).(2) three educational units in pediatric emergency medicine and acute illness.
 - V.B.2.e).(2).(a) At least two of these educational units must be in the Emergency Department.
 - V.B.2.e).(2).(b) Residents must have first-contact evaluation of pediatric patients in the Emergency Department.
- V.B.3. Residents should have real or simulated experience in the following procedures if they are important for a resident's post-residency position as defined in the resident's individualized learning plan:
- V.B.3.a) arterial line placement;
 - V.B.3.b) arterial puncture;
 - V.B.3.c) chest tube placement;
 - V.B.3.d) endotracheal intubation of non-neonates;

- V.B.3.e) procedural sedation; and,
- V.B.3.f) thoracentesis.
- V.B.4. Each resident should have a minimum of 36 half-day sessions per year of a longitudinal outpatient experience over a three-year period.
 - V.B.4.a) These sessions must not be scheduled for fewer than 26 weeks per year.
 - V.B.4.b) There must be an adequate volume of patients to ensure exposure to the spectrum of normal development at all age levels, as well as the longitudinal management of children with special health care needs and chronic conditions.
 - V.B.4.c) There must be a longitudinal working experience between each resident and a single or core group of faculty members with expertise in primary care pediatrics and the principles of the medical home.
 - V.B.4.d) PGY-1 and PGY-2 residents must have a longitudinal general pediatric outpatient experience in a setting that provides a medical home for the spectrum of pediatric patients.
 - V.B.4.e) PGY-3 residents should continue this experience at the same clinical site or, if appropriate for an individual resident's career goals, in a longitudinal subspecialty clinic or alternate primary care site.
 - V.B.4.e).(1) The medical home model of care must focus on wellness and prevention, coordination of care, and longitudinal management of children with special health care needs and chronic conditions, and provide a patient- and family-centered approach to care.
 - V.B.4.e).(2) Consistent with the concept of the medical home, residents must care for a panel of patients that identify the resident as their primary care provider.
- V.B.5. Residents must maintain certification in Pediatric Advanced Life Support, including simulated placement of an intraosseous line and Neonatal Resuscitation.

V.C. Residents' Scholarly Activities

See International Foundational Requirement, Section IV.B.

V.D. Resident Duty Hour and Work Limitations

See International Foundational Requirement, Section VI.

VI. ACGME-I Competencies

VI.A. Patient Care

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents must demonstrate proficiency in:

- VI.A.1. gathering essential and accurate information about the patient;
- VI.A.2. organizing and prioritizing responsibilities to provide patient care that is safe, effective, and efficient;
- VI.A.3. providing transfer of care that ensures seamless transitions;
- VI.A.4. interviewing patients and families about the particulars of the medical condition for which they seek care, with specific attention to behavioral, psychosocial, environmental, and family unit correlates of disease;
- VI.A.5. performing complete and accurate physical examinations;
- VI.A.6. making informed diagnostic and therapeutic decisions that result in optimal clinical judgment;
- VI.A.7. developing and implementing management plans;
- VI.A.8. counseling patients and families;
- VI.A.9. providing effective health maintenance and anticipatory guidance;
- VI.A.10. providing appropriate role modeling;
- VI.A.11. providing appropriate supervision;
- VI.A.12. performing procedures used by a pediatrician in general practice, including being able to describe the steps in the procedure, indications, contraindications, complications, pain management, post-procedure care, and interpretation of applicable results; and,

VI.A.13. performing all medical, diagnostic, and therapeutic procedures considered essential for pediatric practice, including:

- VI.A.13.a) bag-mask ventilation;
- VI.A.13.b) bladder catheterization;
- VI.A.13.c) developmental screening
- VI.A.13.d) giving immunizations;
- VI.A.13.e) lumbar puncture;
- VI.A.13.f) neonatal endotracheal intubation;
- VI.A.13.g) peripheral intravenous catheter placement;
- VI.A.13.h) procedural sedation and pain management;
- VI.A.13.i) reduction of simple dislocation;
- VI.A.13.j) simple laceration repair;
- VI.A.13.k) simple removal of foreign body;
- VI.A.13.l) temporary splinting of fracture;
- VI.A.13.m) tympanometry and audiometry interpretation;
- VI.A.13.n) venipuncture; and,
- VI.A.13.o) vision screening.

VI.B. Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Residents must demonstrate proficiency in their knowledge of:

- VI.B.1. indications, contraindications, limitations, complications, techniques, and interpretation of results of those diagnostic and therapeutic procedures integral to the discipline, including the appropriate indication for and use of screening tests/procedures;

- VI.B.2. presentation and management of isolated and multi-organ system failure and assessment of its reversibility;
- VI.B.3. variations in organ system dysfunction by age of patient;
- VI.B.4. invasive and non-invasive techniques for monitoring and supporting pulmonary, cardiovascular, cerebral, and metabolic functions;
- VI.B.5. understanding of the appropriate roles of the generalist pediatrician and the intensivist/neonatologist;
- VI.B.6. resuscitation and care of newborns in the delivery room;
- VI.B.7. evaluation and management of patients following traumatic injury during the pediatric intensive care experience;
- VI.B.8. normal and abnormal child behavior and development, including cognitive, language, motor, social, and emotional components;
- VI.B.9. evaluation and management of adolescent patients;
- VI.B.10. family structure, adoption, and foster care;
- VI.B.11. interviewing parents and children;
- VI.B.12. psychosocial and developmental screening techniques;
- VI.B.13. behavioral counseling and referral;
- VI.B.14. management strategies for children with developmental disabilities or special needs;
- VI.B.15. needs of children at risk (e.g., those in poverty, from fragmented or substance abusing families, or victims of child abuse/neglect); and,
- VI.B.16. impact of chronic diseases, terminal conditions, and death on patients and their families.

VI.C. Practice-based Learning and Improvement

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:

- VI.C.1. identify strengths, deficiencies, and limits in one's knowledge and expertise;
- VI.C.2. set learning and improvement goals;
- VI.C.3. identify and perform appropriate learning activities;
- VI.C.4. systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;
- VI.C.5. incorporate formative evaluation feedback into daily practice;
- VI.C.6. locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;
- VI.C.7. use information technology to optimize learning;
- VI.C.8. participate in the education of patients, families, students, residents, and other health professionals;
- VI.C.9. be an effective teacher;
- VI.C.10. participate in the education of students, residents, and other health professionals;
- VI.C.11. take primary responsibility for lifelong learning to improve knowledge, skills, and practice performance through familiarity with general and experience-specific goals and objectives and attendance at conferences;
- VI.C.12. obtain procedure-specific informed consent by competently educating patients about the rationale, technique, and complications of procedures; and,
- VI.C.13. apply new knowledge to the management and care of their patients.

VI.D. Interpersonal and Communication Skills

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents must:

- VI.D.1. communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
- VI.D.2. communicate effectively with physicians, other health professionals, and health-related agencies;
- VI.D.3. work effectively as a member or leader of a health care team or other professional group;
- VI.D.4. act in a consultative role to other physicians and health professionals;
- VI.D.5. maintain comprehensive, timely, and legible medical records, if applicable; and,
- VI.D.6. demonstrate the insight and understanding into emotion and human response to emotion that allows one to appropriately develop and manage human interactions.

VI.E. Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents must demonstrate:

- VI.E.1. compassion, integrity, and respect for others;
- VI.E.2. responsiveness to patient needs that supersedes self-interest;
- VI.E.3. respect for patient privacy and autonomy;
- VI.E.4. accountability to patients, society, and the profession;
- VI.E.5. sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation;
- VI.E.6. a commitment to engage in personal and professional development that will sustain them in balancing a commitment to their profession with a

healthy and productive personal life, including:

- VI.E.6.a) self-awareness of one's own knowledge, skill, and emotional limitations that leads to appropriate help-seeking behaviors
- VI.E.6.b) healthy responses to stressors;
- VI.E.6.c) manage conflict between one's personal and professional responsibilities;
- VI.E.6.d) flexibility and maturity in adjusting to change with the capacity to alter one's own behaviors;
- VI.E.6.e) trustworthiness that makes colleagues feel secure when one is responsible for the care of patients;
- VI.E.6.f) leadership skills that enhance team function, the learning environment and/or the health care delivery system/environment with the ultimate intent of improving care of patients;
- VI.E.6.g) self-confidence that puts patients, families, and members of the health care team at ease; and,
- VI.E.6.h) the capacity to accept that ambiguity is part of clinical medicine and to recognize the need for and to utilize appropriate resources in dealing with uncertainty.
- VI.E.7. high standards of ethical behavior, including maintaining appropriate professional boundaries and relationships with other physicians, and avoiding conflicts of interest; and,
- VI.E.8. a commitment to lifelong learning, and an attitude of caring derived from humanistic and professional values.

VI.F. Systems-based Practice

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents must:

- VI.F.1. work effectively in various health care delivery settings and systems relevant to their clinical specialty;
- VI.F.2. coordinate patient care within the health care system relevant to

their clinical specialty;

- VI.F.3. incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
- VI.F.4. advocate for quality patient care and optimal patient care systems;
- VI.F.5. work in interprofessional teams to enhance patient safety and improve patient care quality;
- VI.F.6. participate in identifying system errors and implementing potential systems solutions; and,
- VI.F.7. advocate for the promotion of health and the prevention of disease and injury in populations.