International Advanced Specialty Program Requirements
Summary of Revisions and Rationale

Advanced Specialty Requirements for: **Pediatrics**
Proposed Effective Date of revised requirements: **1 July 2026**

Comments are currently being solicited on revisions to the International Advanced Specialty Program Requirements for the specialty listed above. To aid those providing comment, the following table summarizes and provides a rationale for the revisions.

Submitted comments are used by the Review Committee-International to determine the final revision of the Requirements that will be posted on the ACGME-I website.

Deleted Requirements

Requirement Number	Line Number	Rationale
IV.A.1.c).(1). Residents must demonstrate knowledge of **(c)** variations in organ system dysfunction by patient age;**(d)** invasive and non-invasive techniques for monitoring and supporting pulmonary, cardiovascular, cerebral, and metabolic functions;	364-369	This was moved to the Patient Care and Procedural Skills competency section (now IV.A.1.b).(1).(q)) and was generalized to cover all skills related to resuscitating, stabilizing, and triaging patients to align care with the severity of illness.
IV.A.1.c).(1).(e) Residents must demonstrate knowledge of understanding of the appropriate roles of the generalist pediatrician and the intensivist/ neonatologist;	371-373	This is redundant with requirements IV.A.1.e).(1).(b) and (c) related to working effectively as a member or leader of the health care team and acting in a consultative role to other physicians.
IV.A.1.c).(1).(f) Residents must demonstrate knowledge of resuscitation and care of newborns in the delivery room;	375-376	This was moved to the Patient Care and Procedural Skills competency section (now IV.A.1.b).(1).(r).(vi)).
IV.A.1.c).(1).(m) Residents must demonstrate knowledge of behavioral counselling and referral	395	This was moved to the Patient Care and Procedural Skills competency section (now IV.A.1.b).(1).(o)).
IV.A.1.d).(1).(b) Residents are expected to develop skills and habits to be able to meet the following goals: be an effective teacher	430	This is redundant with IV.A.1.d).(1).(f).
IV.A.1.d).(1).(c) Residents are expected to develop skills and habits to be able to meet the following goals: identify and perform appropriate learning	432	This is redundant with IV.A.1.d).(1).(g),

activities		

Added Requirements

Requirement Number	Line Number	Rationale
II.B.7. Faculty members must maintain awareness of and respond to patient volumes and acuity as they affect the workload and well-being of the residents, and safety of the patients.	93-95	Faculty members have responsibility to help ensure resident well-being and patient safety. Programs are encouraged to develop policies and procedures for faculty members to respond to patient volumes and acuity to help them meet this responsibility.
II.B.8. Faculty members with expertise in adolescent medicine and developmental-behavioral pediatrics should be available for education and consultation.	97-99	This revision replaces a 'must' requirement, where the faculty members with certification in these two subspecialty areas is mandatory, with a 'should' statement. The change provides programs with flexibility to develop alternatives provided the intent of the requirement is met—that expertise in these two subspecialties is available to residents.
IV.A.1.b).(1). Residents must demonstrate the ability to… **(c)** provide comprehensive medical care to infants, children and adolescents including conducting health supervision, minor sick and acute severe illness encounters, in addition to managing complex or chronic conditions; **h)** incorporating consideration of the impacts of social determinants of health and advocating for social justice; **j)** recognizing normal variations in growth, development, and wellness, and anticipating, preventing and detecting disruptions in health and well-being **l)** assessing growth and development from birth through the transition to adult practitioners; **(m)** providing medical care that addresses concerns of groups of patients;	228-230 248-250 256-258 262-263 267-268	The addition of these requirements outlines the specific ways that graduates are expected to deliver comprehensive medical care and helps ensure that a resident's ability in each area will be assessed. This includes routine well-child visits; minor inter-current sick visits; acute, more severe illness encounters; and management of chronic conditions. It also includes recognizing and managing common mental health and behavioral issues in childhood and referring patients who need surgical care. These additional requirements also describe a wider scope of practice, including needed attention to environmental concerns and clear expectations about the transition to adult care and end-of-life care.

(n) participating in real or simulated end-of-life care coordination and grief and bereavement management; **(o)** identifying and managing common behavioral/mental health conditions of childhood; **(p)** referring patients who require consultation, including those with surgical problems; **(q)** resuscitating, stabilizing and triaging patients to align care with severity of illness;	270-271 273-274 276-277 279-280	
IV.A.1.c).(1) Residents must demonstrate knowledge of... **(b)** the selection and interpretation of screening tools and tests; **(c)** the full spectrum of inpatient and outpatient care of well and sick infants, children, and adolescents through the transition to adult care, in addition to the diagnosis and management of common presentations, **(n)** evidence-based guidelines that inform care; **(o)** the components of quality improvement and patient safety; **(p)** medication side effects and identification of adverse events; **(q)** psychosocial and developmental screening techniques.	 351-352 354-358 407 409-410 412-413 415-416	Pediatricians must be mindful of the many dimensions of the outcomes of their care. They must monitor patient safety, patient cost, patient access, and effectiveness of treatment in single patients and in populations. Pediatricians are cognizant of their role in preventive care and health maintenance through transitioning a child's care to an adult practitioner.
IV.A.1.f).(1).(g) Residents must collaborate with community organizations, including schools and/or leaders in health care systems, in order to improve health care and wellbeing of patients;	529-531	The addition of this requirement recognizes the role that schools and communities play in child wellness.

IV.C.2. Assignment of rotations must be structured to minimize the frequency of rotational transitions, and rotations must be of sufficient length to provide a quality educational experience, defined by continuity of patient care, ongoing supervision, longitudinal relationships with faculty members, and meaningful assessment and feedback.	565-569	Education and patient safety are impacted by the length of clinical rotations. Programs must consider the appropriate length of a rotation when planning educational experiences.

Requirements with Major Revisions. Additions are underlined and deletions are ~~crossed out~~.

Requirement Number	Line Number	Rationale
II.B.5. Faculty members with ~~subspecialty certification~~ expertise in the following subspecialty areas of pediatrics 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: ~~a) adolescent medicine;~~ ~~b) developmental-behavioral pediatrics;~~ **a)** neonatal-perinatal medicine; **b)** pediatric critical care; **c)** pediatric emergency medicine; and, **d)** at least five other distinct pediatric medical disciplines.	65-69	This revision requires expertise in subspecialty areas of pediatrics, acknowledging that certification may not be available in all countries or jurisdictions. Programs are encouraged to develop policies and procedures to assess faculty members' expertise, which may include review of their current practice, research interests, and additional training and education in the subspecialty. The requirement for subspecialists in adolescent medicine and developmental-behavioral pediatrics was separated out as requirement II.B.8. to allow programs flexibility in obtaining faculty expertise in areas where there may not be sufficient physicians with subspecialty qualifications. See rationale for this additional requirement above.
IV.A.1.b).(1).(r) Residents must demonstrate the ability to provide comprehensive medical care to infants, children and adolescents, including performing all medical, diagnostic, and therapeutic procedures considered essential for pediatric practice in the country or jurisdiction, including: (i) ~~arterial line placement;~~ (i) bag-mask ventilation;	288-330	Procedures for which residents must develop competence will vary by country and are subject to change. The requirement was revised to reflect this reality while still requiring those procedures that are universally recognized as necessary for pediatrics practice. Programs are encouraged to determine the specific procedures required in their country or jurisdiction, taking into consideration current and future practice in pediatrics and each resident's individual career plans.

~~(iii) arterial puncture;~~ ~~(iv) bladder catheterization;~~ ~~(v) chest tube placement;~~ (ii) developmental screening (iii) ~~giving~~ immunizations; (iv) lumbar puncture; (v) neonatal ~~endotracheal intubation;~~ delivery room stabilization and (vi) peripheral intravenous catheter placement. ~~(xi) procedural sedation and pain management;~~ ~~(xii) thoracentesis~~ ~~(xii) reduction of simple dislocation;~~ ~~(x) simple laceration repair;~~ ~~xi) simple removal of foreign body;~~ ~~xii) temporary splinting of fracture;~~ ~~xiii) tympanometry and audiometry interpretation;~~ ~~(xiv) venipuncture.~~ ~~(xv) vision screening.~~		
IV.C.3. The ~~overall structure of the program curriculum~~ must be organized in educational units. **IV.C.4.** The overall structure of the program must include: 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 member. b) a minimum of 10 educational units of inpatient care experiences, ~~including~~ to include: (1) ~~five educational units in inpatient pediatrics;~~ six educational units of inpatient medicine, with a minimum of four educational units of	571-572 587 589-591 593-594 596-600	The time it takes for residents to acquire competence may vary. The requirement was revised to allow greater flexibility in determining the length of an educational unit and to improve continuity experiences for residents. The requirement for inpatient pediatrics was revised to provide more information on the time to be spent in general inpatient pediatrics and in subspecialty pediatrics.

general pediatrics or pediatric hospital medicine service. The remaining time must be on the general pediatrics or pediatric hospital medicine service or other subspecialty services; and,		
(a) No more than one educational unit ~~of the five required educational units~~ should be devoted to the care of patients in a single subspecialty.	604-606	
~~(2) two educational units in the neonatal intensive care unit (NICU);~~	608-609	
~~(3) two educational units in the pediatric critical care unit (PICU); and,~~	611-612	
(2) ~~a minimum of~~ one educational unit in term newborn care.	614-615	
(3) 3 educational units of critical care experience ~~in the NICU and PICU~~ to include: a minimum of one educational unit in the PICU; and, a minimum of one educational unit in the NICU.	617-619	
IV.C.4.d) a minimum of 10 educational units ~~five educational units~~ of primarily ambulatory care experiences, including elements of community pediatrics and child advocacy, to include a minimum of:	694-696	The requirement was revised to allow for flexibility in how the program provides experiences in community pediatrics and child advocacy. These experiences can now be part of any ambulatory care experience. By eliminating the requirement for non-serious care in the emergency department, the revision also recognizes differences in treatment of children in emergency departments.
(1) two educational units of general ambulatory pediatric clinic experience; and ~~two educational units of the~~	698-699	

~~ambulatory experience that include elements of community pediatrics and child advocacy; and,~~ (2) <u>one educational unit of subspecialty outpatient experience, composed of not fewer than two subspecialties.</u> ~~IV.C.3.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.~~	703-705 707-711	
IV.C.6. <u>Each resident should have a minimum of 36 half-day sessions per year of a longitudinal outpatient experience.</u> ~~over a three-year period.~~ ~~a) These sessions must not be scheduled for fewer than 26 weeks per year.~~ ~~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 to the longitudinal management of children with special health care needs and chronic conditions.~~ ~~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.~~ ~~d) PGY-1 and PGY-2 residents must have a longitudinal general pediatric outpatient experience in a setting that provides primary care a medical home for the spectrum of pediatric patients.~~ ~~e) PGY-3 residents should continue~~	738-771	The revision provides flexibility in how the longitudinal care experience is structured, recognizing that not all countries will have a highly developed longitudinal care model that provides a medical home. However, the requirement maintains a continuity experience as a major component of pediatrics education and training. Programs are encouraged to develop longitudinal experiences that expose residents to the spectrum of normal development at all ages, as well as to the longitudinal management of children with special health care needs and chronic conditions.

~~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.~~ ~~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.~~ ~~(2) Consistent with the concept of the medical home, Residents must care for a panel of patients who identify the resident as their primary care provider.~~		