

ACGME Program Requirements for Graduate Medical Education in the Subspecialties of Pediatrics

Common Program Requirements are in BOLD

Effective: July 1, 2007

Introduction

In addition to complying with the requirements in this document, each program must comply with the program requirements for the respective subspecialty, which may exceed the minimum requirements set forth here.

An accredited pediatric subspecialty program must exist in conjunction with and be an integral part of a core pediatric residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME). The fellows and faculty must interact with the residents in the core pediatrics residency program. Lines of responsibility for the pediatric residents and the fellows must be clearly defined. The presence of a subspecialty program should not adversely affect the education of pediatric residents.

This document includes the ACGME Common Program Requirements which incorporate the competencies into fellowship training. Core and subspecialty program directors should work together to achieve this goal. Close coordination among core and subspecialty program directors will foster consistent expectations in regard to fellows' achievement of competencies, and for faculty with regard to evaluation processes.

A. Duration of Educational Experience

Unless specified otherwise in the program requirements, pediatric subspecialty programs must provide three years of training.

B. Scope of Educational Experience

1. Each subspecialty program must be organized and conducted in a way that ensures an appropriate environment for the well-being and care of the patients, and provides adequate training for fellows in the diagnosis and management of those subspecialty patients. This must include progressive clinical, technical, and consultative experiences that will enable the fellow to develop expertise as a consultant in the subspecialty.
2. Fellows in the subspecialty program must develop a commitment to lifelong learning, and the program must emphasize scholarship, self-instruction, development of critical analysis of clinical problems, and the ability to make appropriate decisions. Progressive acquisition of skill in investigative efforts related to the subspecialty

is essential.

3. The program must provide fellows with instruction and opportunities to interact effectively with patients, patients' families, professional associates, and others in carrying out their responsibilities as physicians in the specialty. Fellows must learn to create and sustain a therapeutic relationship with patients, and how to work effectively as members or leaders of patient care teams or other groups in which they participate as a researcher, educator, health advocate, or manager.

I. Institutions

A. Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to fellow assignments at all participating sites.

The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program.

1. The pediatric subspecialty program must be sponsored by the same institution that sponsors the related core pediatrics program.
2. Each subspecialty program will be evaluated by the Review Committee at regular intervals, in conjunction with a review of the related core pediatrics program when possible.

B. Participating Sites

1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years.

The PLA should:

- a) **identify the faculty who will assume both educational and supervisory responsibilities for fellows;**
- b) **specify their responsibilities for teaching, supervision, and formal evaluation of fellows, as specified later in this document;**
- c) **specify the duration and content of the educational experience; and,**

- d) **state the policies and procedures that will govern fellow education during the assignment.**
2. **The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all fellows, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).**
3. Copies of these written arrangements, specifying administrative, organizational, and educational relationships, must accompany an application for initial accreditation. At subsequent reviews, these documents need not be submitted, but must be available for review by the site-visitor.
4. An accredited program may occur in one or more sites. The Review Committee must approve any site providing six months or more of the inpatient and/or outpatient training

II. Program Personnel and Resources

A. Program Director

1. **There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.**
2. **The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.**
3. **Qualifications of the program director must include:**
 - a) **requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;**
 - b) **current certification in the specialty by the American Board of Pediatrics, or specialty qualifications that are acceptable to the Review Committee; and,**
 - (1) Qualifications other than subspecialty certification by the American Board of Pediatrics will be considered only in exceptional circumstances. Qualifications

would include subspecialty training in the subspecialty area, active participation in national societies, evidence of on-going scholarship documented by contributions to the peer-reviewed literature in the subspecialty, and presentations at national meetings in the subspecialty.

c) current medical licensure and appropriate medical staff appointment.

d) The program director should have a record of ongoing involvement in scholarly activities, including peer review publications, and mentoring (i.e., guiding fellows in the acquisition of competence in the clinical, teaching, research and advocacy skills pertinent to the discipline).

4. The program director must administer and maintain an educational environment conducive to educating the fellows in each of the ACGME competency areas. The program director must:

a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;

b) approve a local director at each participating site who is accountable for fellow education;

c) approve the selection of program faculty as appropriate;

d) evaluate program faculty and approve the continued participation of program faculty based on evaluation;

e) monitor fellow supervision at all participating sites;

f) prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program fellow updates to the ADS, and ensure that the information submitted is accurate and complete;

g) provide each fellow with documented semiannual evaluation of performance with feedback;

h) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;

i) provide verification of fellowship education for all

fellows, including those who leave the program prior to completion;

- j) implement policies and procedures consistent with the institutional and program requirements for fellow duty hours and the working environment, including moonlighting, and, to that end, must:**
 - (1) distribute these policies and procedures to the fellows and faculty;**
 - (2) monitor fellow duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;**
 - (3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,**
 - (4) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.**
- k) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;**
- l) comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of fellows, disciplinary action, and supervision of fellows;**
- m) be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;**
- n) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:**
 - (1) all applications for ACGME accreditation of new programs;**
 - (2) changes in fellow complement;**
 - (3) major changes in program structure or length of training;**

- (4) progress reports requested by the Review Committee;**
 - (5) responses to all proposed adverse actions;**
 - (6) requests for increases or any change to fellow duty hours;**
 - (7) voluntary withdrawals of ACGME-accredited programs;**
 - (8) requests for appeal of an adverse action;**
 - (9) appeal presentations to a Board of Appeal or the ACGME; and,**
 - (10) proposals to ACGME for approval of innovative educational approaches.**
- o) obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:**
- (1) program citations, and/or**
 - (2) request for changes in the program that would have significant impact, including financial, on the program or institution.**
- p) ensure that the fellows are mentored in their development of clinical, educational, and administrative skills;**
- q) be responsible for the creation of a core curriculum in scholarly activities, the identification of a mentor, and the identification and monitoring of a scholarship oversight committee responsible for overseeing and assessing the progress of each fellow. Where appropriate, the core curriculum in scholarly activities should be a collaborative effort involving all of the pediatric subspecialty programs in the institution;**
- r) ensure that explicit written guidelines identify that appropriate back-up exists. Such guidelines must be communicated to all members of the program staff. Fellows must be provided with prompt, reliable systems for communication and interaction with supervisory physicians;**

- s) monitor and document the procedural skills of the fellows; and,
- t) have documentation of meetings that describe ongoing interaction among pediatric subspecialty and core program directors. These must take place at least semi-annually. These meetings should address a departmental approach to common educational issues and concerns (e.g., core curriculum, competencies, and evaluation).

B. Faculty

- 1. At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all fellows at that location.**

The faculty must:

- a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of fellows, and**
- b) administer and maintain an educational environment conducive to educating fellows in each of the ACGME competency areas.**

- 2. The physician faculty must have current certification in the specialty by the American Board of Pediatrics, or possess qualifications acceptable to the Review Committee.**

- a) Acceptable qualifications for the required key subspecialty faculty include:
 - (1) certification, if eligible, by the American Board of Pediatrics (ABP) or other appropriate board of the American Board of Medical Specialties (ABMS), or
 - (2) if trained elsewhere and not eligible for certification, documented subspecialty training and peer-reviewed publications in the field with evidence of active participation in applicable local and national professional societies.
- b) When assessing the adequacy of the number of faculty, the total number of fellows will be considered.
- c) In addition to the subspecialty program director, there must be at least one other member of the teaching staff qualified

in the subspecialty. In some of the subspecialties, two or more additional subspecialists are required. Specific details are included in the related specialty-specific section of the requirements.

- d) If the program is conducted at more than one institution, a member of the teaching staff of each participating site must be designated to assume responsibility for the day-to-day activities of the program at that site, with overall coordination by the program director
- e) Appropriate teaching and consultant faculty in the full range of pediatric subspecialties and in other related disciplines also must be available. An anesthesiologist, pathologist, and a radiologist who have substantial experience with pediatric problems and who interact with the fellows are essential. The other related disciplines should include medical genetics, child neurology, child and adolescent psychiatry, as well as pediatric surgery and surgical subspecialties, as appropriate to the subspecialty.

- 3. The physician faculty must possess current medical licensure and appropriate medical staff appointment.**
- 4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.**
- 5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.**
 - a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.**
 - b) Some members of the faculty should also demonstrate scholarship by one or more of the following:**
 - (1) peer-reviewed funding;**
 - (2) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;**
 - (3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,**
 - (4) participation in national committees or**

educational organizations.

- c) **Faculty should encourage and support fellows in scholarly activities.**
- d) Research may be in a variety of fields related to the subspecialty (e.g., basic science, clinical, health services, health policy, or educational research). This should include the mentoring of fellows as they apply scientific principles, epidemiology, biostatistics, and evidence-based medicine to the clinical care of patients;
- e) To provide an appropriate environment for the fellows, the fellowship faculty must have a program of ongoing scholarship characterized by peer reviewed funding and publications. The teaching faculty must play a substantial role in conceiving and writing the funding application(s), conducting the project, collecting and analyzing data, and publishing results. A scholarly environment outside of the training program can supplement but not replace the scholarly environment within the training program;
- f) Although an individual faculty member may not be accomplished in all three areas of scholarship, the program faculty must exhibit all three. In particular, a program must provide evidence of an ongoing commitment to, and productivity in, the scholarship of discovery in the relevant pediatric subspecialty area. Recent productivity by the program faculty and by the fellows will be assessed at the time of each review of the program. Activity in the following is required as evidence of the commitment to scholarship: projects with peer review for funding, and publications of original research and/or critical meta-analyses, systematic reviews of clinical practice, critical analyses of public policy, or curricular development projects in peer-reviewed journals.

C. Other Program Personnel

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program.

1. The professional personnel should include nutritionists, social workers, respiratory therapists, pharmacists, subspecialty nurses, physical and occupational therapists, child life therapists, and speech therapists with pediatric focus and experience, as appropriate to the subspecialty.

D. Resources

The institution and the program must jointly ensure the availability of adequate resources for fellow education, as defined in the specialty program requirements.

1. Adequate inpatient and outpatient facilities, as specified in the requirements for each subspecialty, must be available. These must be of sufficient size and be appropriately staffed and equipped to meet the educational needs of the subspecialty program.
2. Support services must include the clinical laboratories, intensive care, nutrition, occupational and physical therapy, pathology, pharmacology, mental health, diagnostic imaging, respiratory therapy, and social services.
3. Patients should range in age from newborn through young adulthood, as appropriate. Adequate numbers of pediatric subspecialty inpatients and outpatients, both new and follow up, must be available to provide a broad experience for the fellows. The program must maintain an appropriate balance among the number and variety of patients, the number of preceptors, and the number of fellows in the program. Occasionally programs may use defined clinical experiences at participating sites to supplement the clinical experience and patient population at the primary clinical site. Where that is the case, the program director must submit detailed information to demonstrate that the clinical exposure to the population(s) in question is sufficiently consistent to provide each fellow with an adequate experience during the limited time at the affiliated site(s); e.g., if a fellow is spending two months at an affiliated site to meet required exposure to patients with congenital heart disease, annual data regarding numbers and types of patients in this category must be provided.

E. Medical Information Access

Fellows must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available.

III. Fellow Appointments

A. Eligibility Criteria

The program director must comply with the criteria for fellow eligibility as specified in the Institutional Requirements.

1. Prerequisite training for entry into a pediatric subspecialty program should include the satisfactory completion of an ACGME-accredited pediatric residency or other training suitable to the program director. N.B.: Candidates who do not meet this criterion must be advised in writing by the program director to consult the American Board of Pediatrics or other appropriate board regarding their eligibility for subspecialty certification.

B. Number of Fellows

The program director may not appoint more fellows than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. The program's educational resources must be adequate to support the number of fellows appointed to the program.

1. Programs planning to implement a modest increase in fellow complement between formal reviews should follow the directions provided on the Pediatrics home page of the ACGME website.

C. Fellow Transfers

1. **Before accepting a fellow who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring fellow.**
2. **A program director must provide timely verification of fellowship education and summative performance evaluations for fellows who leave the program prior to completion.**

D. Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, fellows from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed fellows' education. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.

IV. Educational Program

A. The curriculum must contain the following educational components:

1. **Overall educational goals for the program, which the program must distribute to fellows and faculty annually;**
2. **Competency-based goals and objectives for each assignment**

at each educational level, which the program must distribute to fellows and faculty annually, in either written or electronic form. These should be reviewed by the fellow at the start of each rotation;

- 3. Regularly scheduled didactic sessions;**
- 4. Delineation of fellow responsibilities for patient care, progressive responsibility for patient management, and supervision of fellows over the continuum of the program; and,**
- 5. ACGME Competencies**

The program must integrate the following ACGME competencies into the curriculum:

a) Patient Care

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

- (1) must have supervised training to acquire the necessary clinical skills used in the subspecialty. These skills include development of expertise in the ability to perform a history and physical examination, make diagnostic and therapeutic decisions, develop and carry out management plans, counsel patients and families, and use information technology to optimize patient care, and**
- (2) must have supervised experience performing and interpreting the results of laboratory tests and diagnostic procedures for use in patient care. Instruction and experience must be sufficient for the fellow to acquire the necessary procedural skills and develop an understanding of their indications, risks, and limitations. Each fellow's experience in such procedures must be documented by the program director and such documentation must be available for review.**

b) Medical Knowledge

Fellows 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. Fellows:

- (1) must have a working understanding of biostatistics, clinical and laboratory research methodology, study design, preparation of applications for funding and/or approval of clinical research protocols, critical literature review, principles of evidence-based medicine, ethical principles involving clinical research, and the achievement of proficiency in teaching for all subspecialty fellows. The curriculum should lead to an understanding of the principles of adult learning, and provide skills to participate effectively in curriculum development, delivery of information, provision of feedback to learners, and assessment of educational outcomes. Graduates should be effective in teaching both individuals and groups of learners in clinical settings, classrooms, lectures, and seminars, and also by electronic and print modalities;
- (2) must have a formally-structured educational program in the clinical and basic sciences related to the subspecialty that utilizes lectures, seminars, and practical experience. Subspecialty conferences must be regularly scheduled, and should involve active participation by the fellows in the planning and implementation of these meetings;
- (3) should have an education in basic and fundamental disciplines related to each subspecialty, as appropriate, such as anatomy, physiology, biochemistry, embryology, pathology, microbiology, pharmacology, immunology, genetics, and nutrition/metabolism; and,
- (4) should have instruction that includes pathophysiology of disease, reviews of recent advances in clinical medicine and biomedical research, conferences dealing with complications and death, and instruction in the scientific, ethical, and legal implications of confidentiality and of informed consent.

c) Practice-based Learning and Improvement

Fellows 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. Fellows are expected to develop skills and habits to be able to meet the following goals:

- (1) identify strengths, deficiencies, and limits in one's knowledge and expertise;**
- (2) set learning and improvement goals;**
- (3) identify and perform appropriate learning activities;**
- (4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;**
 - (a) Fellows are expected to participate in a quality improvement project.
- (5) incorporate formative evaluation feedback into daily practice;**
- (6) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;**
- (7) use information technology to optimize learning;**
 - (a) This includes the ability to appraise and assimilate evidence from scientific studies related to their patients' health problems.
- (8) participate in the education of patients, families, students, fellows and other health professionals.**
- (9) self-evaluate performance and incorporate assessments provided by faculty, peer and patients in the development of his or her individual learning plan; and,
- (10) assume some departmental administrative responsibilities. The program should also provide fellows with instruction in curriculum design, information delivery in clinical settings and classrooms, provision of feedback to learners, assessment of educational outcomes, and the development of teaching materials.

d) Interpersonal and Communication Skills

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

- (1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;**
- (2) communicate effectively with physicians, other health professionals, and health related agencies;**
- (3) work effectively as a member or leader of a health care team or other professional group;**
- (4) act in a consultative role to other physicians and health professionals; and,**
- (5) maintain comprehensive, timely, and legible medical records, if applicable.**

e) Professionalism

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

- (1) compassion, integrity, and respect for others;**
- (2) responsiveness to patient needs that supersedes self-interest;**
- (3) respect for patient privacy and autonomy;**
- (4) accountability to patients, society and the profession; and,**
- (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.**
- (6) professionalism throughout training. Bioethics must be addressed in the formal curriculum, including attention to physician-patient, physician-family,**

physician-physician/allied health professional, and physician-society relationships.

f) Systems-based Practice

Fellows 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. Fellows are expected to:

- (1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;**
- (2) coordinate patient care within the health care system relevant to their clinical specialty;**
- (3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;**
- (4) advocate for quality patient care and optimal patient care systems;**
- (5) work in interprofessional teams to enhance patient safety and improve patient care quality; and,**
- (6) participate in identifying system errors and implementing potential systems solutions.**
- (7) have instruction in such topics as the economics of health care and current health care management issues, such as cost-effective patient care, practice management, preventive care, quality improvement, resource allocation, and clinical outcomes. Programs must provide didactics and experience in the prevention of medical errors, and
- (8) have instruction in the following areas of administration:
 - (a) an awareness of regional and national access to care, resources, workforce, and financing appropriate to their specialty through guided reading and discussion, and

- (b) organization and management of a subspecialty service within one's own delivery system by engaging fellows as active participants in discussions (e.g., through already scheduled division activities/meetings) that involve:
 - (i) staffing a service or unit, including managing personnel and making and adhering to a schedule;
 - (ii) drafting policies and procedures, leading interdisciplinary meetings and conferences, providing in-service teaching sessions;
 - (iii) discussions/proposals for hospital and community resources including clinical, laboratory and research space, equipment and technology necessary for the program to provide state-of-the-art care while advancing knowledge in the field;
 - (iv) business planning and practice management that includes billing and coding, personnel management policies and professional liability;
 - (v) division or program development, organization, and maintenance; and,
 - (vi) necessary collaborations within (e.g., pathology, radiology, surgery) and beyond the institution (e.g., participation in national specialty societies, cooperative care groups, multi-center research collaboratives) as appropriate to their specialty.

B. Fellows' Scholarly Activities

- 1. The curriculum must advance fellows' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.**
- 2. Fellows should participate in scholarly activity.**

- a) Each fellow must design and conduct a scholarly project in his or her subspecialty area with the guidance of the fellowship director and a designated mentor. The program must provide a scholarship oversight committee for each fellow to evaluate the fellow's progress as related to scholarly activity. The scholarly experience must begin in the first year and continue for the entire period of training. Time must be adequate to allow for the development of requisite skills, project completion, and presentation of results to a local scholarship oversight committee established for this review. Where applicable, the process of establishing fellow scholarship oversight committees should be a collaborative effort involving other pediatric subspecialty programs in the institution.

3. **The sponsoring institution and program should allocate adequate educational resources to facilitate fellow involvement in scholarly activities.**

V. Evaluation

A. Fellow Evaluation

1. Formative Evaluation

- a) **The faculty must evaluate fellow performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.**
- b) **The program must:**
 - (1) **provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;**
 - (2) **use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);**
 - (3) **document progressive fellow performance improvement appropriate to educational level; and,**
 - (4) **provide each fellow with documented semiannual evaluation of performance with feedback.**

- c) **The evaluations of fellow performance must be accessible for review by the fellow, in accordance with institutional policy.**

2. Summative Evaluation

The program director must provide a summative evaluation for each fellow upon completion of the program. This evaluation must become part of the fellow's permanent record maintained by the institution, and must be accessible for review by the fellow in accordance with institutional policy. This evaluation must:

- a) **document the fellow's performance during the final period of education, and**
- b) **verify that the fellow has demonstrated sufficient competence to enter practice without direct supervision.**

B. Faculty Evaluation

- 1. At least annually, the program must evaluate faculty performance as it relates to the educational program.**
- 2. These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.**
- 3. This evaluation must include at least annual written confidential evaluations by the fellows.**
4. Faculty should receive formal feedback from these evaluations.

C. Program Evaluation and Improvement

- 1. The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:**
 - a) **fellow performance;**
 - b) **faculty development;**
 - c) **graduate performance, including performance of program graduates on the certification examination; and,**

- d) **program quality. Specifically:**
 - (1) **Fellows and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and**
 - (2) **The program must use the results of fellows' assessments of the program together with other program evaluation results to improve the program.**
- 2. **If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.**
- 3. A program will be judged deficient if, over a six year period, fewer than 75% of fellows eligible for the certifying examination take it and of those who take it, fewer than 75% pass it on the first attempt. The Review Committee will take into consideration noticeable improvements or declines during this same period. An exception may be made for programs with small numbers of fellows. A subspecialty program director will be expected to provide the requested information at the time of each review.
- 4. The same evaluation mechanisms used in the related pediatrics residency program must be adapted for and implemented in all of the pediatric subspecialty programs that function with it. In order to maintain the confidentiality of responses from fellows in small programs, evaluations of faculty may be consolidated with the core faculty evaluations.

VI. Fellow Duty Hours in the Learning and Working Environment

A. Principles

- 1. **The program must be committed to and be responsible for promoting patient safety and fellow well-being and to providing a supportive educational environment.**
- 2. **The learning objectives of the program must not be compromised by excessive reliance on fellows to fulfill service obligations.**
- 3. **Didactic and clinical education must have priority in the allotment of fellows' time and energy.**

4. **Duty hour assignments must recognize that faculty and fellows collectively have responsibility for the safety and welfare of patients.**

B. Supervision of Fellows

The program must ensure that qualified faculty provide appropriate supervision of fellows in patient care activities.

C. Fatigue

Faculty and fellows must be educated to recognize the signs of fatigue and sleep deprivation and must adopt and apply policies to prevent and counteract its potential negative effects on patient care and learning.

D. Duty Hours (the terms in this section are defined in the ACGME Glossary and apply to all programs)

Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours do *not* include reading and preparation time spent away from the duty site.

1. **Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.**
2. **Fellows must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call.**
3. **Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.**
 - a) **The Review Committee will not consider requests for a rest period that is less than 10 hours.**

E. On-call Activities

1. **In-house call must occur no more frequently than every third night, averaged over a four-week period.**
2. **Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Fellows may remain on duty for up to six additional hours to participate in didactic activities,**

transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.

- a) Post-call fellows may not attend any outpatient clinics other than continuity clinics.

3. No new patients may be accepted after 24 hours of continuous duty.

- a) A new patient is defined as any patient for whom the fellow has not provided care during the previous 24 hour period or who is not a part of the fellow's continuity panel or the panel of the fellow's continuity team, if such exists.

4. At-home call (or pager call)

- a) **The frequency of at-home call is not subject to the every-third-night, or 24+6 limitation. However at-home call must not be so frequent as to preclude rest and reasonable personal time for each fellow.**
- b) **Fellows taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.**
- c) **When fellows are called into the hospital from home, the hours fellows spend in-house are counted toward the 80-hour limit.**
- d) When evaluating the acceptability of a program's schedule for at-home call, the Review Committee will take into consideration the number and frequency of calls taken by the fellows, the number of consecutive nights fellows have such call, and include the number of times the fellow comes into the hospital.

F. Moonlighting

- 1. **Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program.**
- 2. **Internal moonlighting must be considered part of the 80-hour weekly limit on duty hours.**

G. Duty Hours Exceptions

A Review Committee may grant exceptions for up to 10% or a

maximum of 88 hours to individual programs based on a sound educational rationale.

- 1. In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.**
- 2. Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.**
- 3. The Review Committee for Pediatrics will not consider requests for exceptions to the 80 hour limit to a fellow's work week.**

VII. Experimentation and Innovation

Requests for experimentation or innovative projects that may deviate from the institutional, common and/or specialty specific program requirements must be approved in advance by the Review Committee. In preparing requests, the program director must follow Procedures for Approving Proposals for Experimentation or Innovative Projects located in the ACGME Manual on Policies and Procedures. Once a Review Committee approves a project, the sponsoring institution and program are jointly responsible for the quality of education offered to fellows for the duration of such a project.

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Revised Common Program Requirements Effective: July 1, 2007

ACGME Program Requirements for Fellowship Education in Pediatric Emergency Medicine

Effective: July 1, 2007

Programs in pediatric emergency medicine must comply with either the *General Program Requirements for the Subspecialties of Emergency Medicine* or the *Program Requirements for Residency Education in the Subspecialties of Pediatrics*, as well as the following requirements.

I. Introduction

- A. The goal of a residency program in pediatric emergency medicine is to produce physicians who are clinically proficient in the practice of pediatric emergency medicine, especially in the management of the acutely ill or injured child, in the setting of an emergency department that is approved as a 911-receiving facility or its equivalent and that has an emergency medical services system.
- B. A program in pediatric emergency medicine must be administered by, and be an integral part of, an Accreditation Council for Graduate Medical Education (ACGME) accredited program in either emergency medicine or pediatrics. The program must also be affiliated with an ACGME-accredited residency program in the reciprocal discipline (i.e., pediatrics for those programs administered by an emergency medicine program; emergency medicine for those administered by pediatrics).
- C. Prerequisite training should include satisfactory completion of an ACGME or Royal College of Physicians and Surgeons of Canada accredited residency program in either emergency medicine or pediatrics.

II. Duration and Scope of Educational Experience

- A. All fellows must receive at least two years of training. Pediatrics graduates must be provided with a third year of training to meet the American Board of Pediatrics (ABP) requirements for scholarly activity.
- B. Emergency medicine sponsored programs that wish to accept pediatrics trained graduates must specify two residency curricula: a two year curriculum for emergency medicine graduates and a three year curriculum for pediatrics graduates. Emergency medicine programs must provide a third year of training so that pediatrics graduates may complete the ABP requirements for scholarly activity. Pediatrics sponsored programs that wish to accept emergency medicine trained graduates must provide a two year residency curriculum. The program should inform fellows in writing as to the length of their curriculum before they begin the fellowship.

- C. The educational program must be organized and conducted in a way that ensures an appropriate environment for the well-being and care of patients and their families, while providing fellows the opportunity to become skilled clinicians, competent teachers, and knowledgeable investigators. The program must emphasize the fundamentals of assessment, diagnosis, and management. Fellows should also be exposed to academic debate, intensive research review, and interaction between the specialties of pediatrics and emergency medicine.

III. Teaching Staff

A. Program Director

- 1. The program director must be a member of the core teaching faculty, be American Board of Medical Specialties board certified in pediatric emergency medicine, and have three years experience as a clinician, teacher, and administrator in pediatric emergency medicine.

B. Faculty

- 1. There must be at least four members of the teaching staff who have experience and knowledge of the care of acute pediatric illness and injuries so as to:
 - a) provide adequate supervision of fellows, and
 - b) ensure the educational and research quality of the program.
- 2. Two faculty members must be certified in pediatric emergency medicine or possess qualifications acceptable to the residency Review Committee.
- 3. The remaining faculty members must be certified in pediatrics, emergency medicine, pediatric emergency medicine or possess qualifications acceptable to the Review Committee.
- 4. For a subspecialty program that functions as an integral part of a pediatric residency program, there must be adequate exposure to faculty who are certified by the American Board of Emergency Medicine (ABEM). Conversely, for a subspecialty program based in an emergency medicine residency program, there must be adequate exposure to faculty certified by the ABP. Fellows must be exposed to both ABEM-certified faculty and ABP-certified faculty over the course of the residency, both didactically and in the clinical management of acutely ill and injured patients.

5. The program must ensure that fellows have access to consultants and collaborative faculty in related medical and surgical disciplines who have training and experience in the care of children and adolescents.
6. The pediatric emergency medicine faculty must:
 - a) have an active role in curriculum development and in the supervision and evaluation of fellows;
 - b) contribute both clinically and academically to the program; and,
 - c) have protected time to allow for teaching and active participation in scholarly activity.

IV. Facilities

- A. There must be an acute care facility that receives patients via ambulance from the pre-hospital setting, is equipped to handle trauma, and has the full range of services associated with residencies in pediatrics and emergency medicine. This facility should be accredited by the Joint Commission on Accreditation of Healthcare Organizations.
- B. There must be comprehensive radiologic and laboratory support systems and readily available operative suites and intensive care unit beds.

V. Curriculum

A. Agreements Between Programs

1. There must be written agreements between the director of the program in pediatric emergency medicine and the directors of the participating residencies in pediatrics and emergency medicine specifying the experiences that will comprise this subspecialty program. These agreements should address appropriate curriculum content, supervision of fellows, amount and distribution of clinical and non-clinical time, conferences, clinical performance criteria, and mechanisms for resolving performance problems.

B. Program Design

1. Fellows in pediatric emergency medicine must participate in the care of pediatric patients of all ages, from infancy through young adulthood, and with a broad spectrum of illnesses and injuries of all severities. At least 12 months of the clinical experience must be obtained seeing children in an emergency department where patients, ages 21 years of age or younger, are treated for the full

spectrum of illnesses and injuries. The fellows' training must include experience with blunt and penetrating trauma, significant gynecologic and obstetrical emergencies, as well as psychiatric emergencies of the adolescent.

2. Specialty-specific content must include at least four months of training in the specialty reciprocal to the fellow's prior residency.
3. For the emergency medicine graduate, reciprocal time must include four months spent in pediatric subspecialty and ambulatory clinics and in the management of critically ill neonates and children in an ACGME-accredited pediatric residency program.
4. For the pediatrics graduate, reciprocal time must include four months spent in an adult emergency department that is part of an ACGME-accredited emergency medicine residency program. One block month of that experience must be spent caring for adults with traumatic injuries, ideally on a trauma service. During the time spent in the adult emergency department, there must be structured educational experiences in EMS and toxicology. These should include both didactic and experiential components that may be longitudinally integrated into other parts of the curriculum or designed as block rotations.
5. Additional elective months of reciprocal training should be scheduled when deemed necessary by the program director to ensure fellows acquire the essential skills of a pediatric emergency specialist.
6. The core content of the program must include training in EMSC, administration, legal issues, procedures, patient safety, medical errors, ethics and professionalism. The curriculum must also include experiences in cardiopulmonary resuscitation; trauma; disaster and environmental medicine; transport; triage; sedation; emergencies arising from toxicologic, obstetric, gynecologic, allergic/immunologic, cardiovascular, congenital, dermatologic, dental, endocrine/metabolic, gastrointestinal, hematologic/oncologic, infectious, musculoskeletal, neurologic, ophthalmic, psychosocial, and pulmonary causes; renal/genitourinary and surgical disorders; and physical and sexual abuse.

C. Patient Care

1. Fellows must have the opportunity to provide initial evaluation and treatment to all kinds of patients. Fellows must learn to evaluate the patient with an undifferentiated chief complaint and diagnose whether it falls in areas traditionally designated medical, surgical or

subspecialty. Fellows must learn to perform such evaluations rapidly, with simultaneous stabilization of any life threatening process, and to proceed with appropriate life-saving interventions before arriving at a definitive diagnosis.

2. Fellows must learn the skills necessary to prioritize and simultaneously manage the emergency care of multiple patients. They must have supervised experience using their technical/procedural and resuscitation competency skills as those skills apply to pediatric patients of all ages. Accordingly, the program must demonstrate that fellows have been provided didactic training and clinical exposure to attain competency in the following procedures:

- a) abscess incision and drainage
- b) arterial catheterization
- c) arthrocentesis
- d) artificial ventilation
- e) cardiac pacing, external
- f) cardiopulmonary resuscitation in all of the following groups:
 - (1) adult medical resuscitation >18 years
 - (2) adult trauma resuscitation >18 years
 - (3) pediatric medical resuscitation <2 years
 - (4) pediatric medical resuscitation >2 years
 - (5) pediatric trauma resuscitation <2 years
 - (6) pediatric trauma resuscitation >2 years
- g) cardioversion/defibrillation
- h) central venous catheterization
- i) closed reduction/splinting
- j) conversion of supraventricular tachycardia
- k) cricothyrotomy – translaryngeal ventilation

- l) dislocation/reduction
- m) endotracheal intubation
- n) foreign body removal
- o) gastric lavage
- p) gastrostomy tube replacement
- q) intraosseous access
- r) laceration repair
- s) pericardiocentesis
- t) nasal packing
- u) peritoneal lavage
- v) rapid sequence intubation
- w) regional nerve blocks
- x) sedation and analgesia
- y) slit lamp examination
- z) tracheostomy tube replacement
- aa) tube thoracostomy
- bb) umbilical vessel catheterization
- cc) vaginal delivery

3. To ensure an acceptable level of resident performance and procedural and resuscitation competency, the program must:
- a) discuss assessment tools, measurement process and outcomes with each resident;
 - b) document performance and procedural and resuscitation competency in resident files; and,
 - c) maintain documentation of these activities for review with the site visitor at the time of the site visit.

4. Fellows must be given progressive responsibility for patient care as they advance through the program. In the final year of training, fellows must be given the opportunity to demonstrate, under faculty supervision, the skills appropriate to a supervisor, teacher, and decision maker in pediatric emergencies.
5. The program must provide fellows the opportunity to assume leadership responsibility for the pediatric emergency department. Fellows should provide supervision and consultation to other residents caring for patients in the emergency department.
6. Fellows must develop a compassionate understanding of the stress associated with sudden illness, injury and death so that they are responsive to the emotional needs of patients, their families, and the emergency department staff. Discussion and appreciation of ethical issues involved in pediatric emergency medicine should be part of the educational program.

D. Instruction in Program Administration

1. Fellows should have formal sessions on organizing teaching programs, medical writing, and oral presentation. Fellows should develop teaching skills by conducting lectures, seminars, and clinical conferences and by preparing written reports and teaching materials. These efforts must be reviewed and evaluated by the supervising faculty in light of using competency-based objectives developed by the program. Fellows must receive instruction and experience in administrative and management skills, including quality improvement principles, necessary to oversee a division or department.

VI. Conferences

- A. There should be opportunities to participate in regularly scheduled, multi-disciplinary conferences that include lectures, morbidity and mortality conferences, case conferences, general reviews, and research seminars. The program must include education in related basic sciences, including physiology, growth and development, pathophysiology, and the epidemiology and prevention of pediatric illnesses and injuries. Fellows should attend conferences related to understanding diversity, family presence during resuscitations, cultural competence, professionalism, communication skills, the giving and receiving of feedback, and self-directed assessment and learning. Faculty and fellows' attendance must be documented, and both must participate meaningfully in the didactic activities offered by the program.
- B. The program should also provide education on physician wellness and stress management.

VII. Patient Population

- A. The available patient population should encompass the full spectrum of infants, children, adolescents, and young adults.
- B. To meet the educational objectives of the program, there should be a minimum of 20,000 pediatric patient visits per year in the program's primary emergency department. The Review Committee will consider patient acuity and the total number of trainees in assessing the adequacy of the patient population. The population must include a sufficient number of acutely ill patients with major and minor trauma, airway insufficiency, ingestions, obstetric and gynecologic disorders, psychosocial disturbances, and emergent problems from all pediatric medical and surgical subspecialties.

VIII. Board Certification

Fellows seeking certification in the subspecialty of pediatric emergency medicine should consult their primary specialty board, i.e., the ABP or the ABEM, regarding the criteria for certification eligibility in this subspecialty.

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Companion Document (Guidelines for Subspecialty PIF Documentation)

The revised Program Requirements document for the Subspecialties of Pediatrics reflects a transition from a process orientation to one of outcomes. In order to provide assistance to Program Directors, this Companion Document includes some explanation and guidelines for the types of documentation that will be expected. The numeric designations refer to sections of the Program Requirements.

Goals and Objectives (Section IV.A.2)

Written goals and objectives are required for each learning experience. These must be level specific since you would expect more expertise as learners progress through fellowship training. Goals are broad statements of what the learner is expected to accomplish over time. Objectives are specific statements about what the learner is expected to do. Learning objectives should begin with a verb. The choice of verbs is important as the verb gives an indication of the level of complexity of the task. For example, it is easier to “identify” or “explain” than it is to “apply” and “evaluate.” The verb that one chooses also needs to be one that describes a measurable behavior. So verbs like learn or understand are not useful for writing learning objectives because it is difficult for an evaluator to directly observe whether the objective has been met. Responsibilities should not be confused with learning objectives and should not be included here. For example, “respond to the arrest team pager when you are on the ICU and ED rotations” is a responsibility and not a true learning objective. The level of detail of the learning objectives should be such that an evaluator would be able to say that a goal has been reached because the requisite set of behaviors needed to reach the goal have all been witnessed. The goals and objectives for each learning experience must be distributed to and reviewed with each learner.

Collaboration Between Programs (Section II.A.4.t.)

For departments/institutions with more than one pediatric subspecialty fellowship program, there should be evidence of a collaborative effort among the fellowship directors in: 1) the preparation and delivery of required general curricular content areas (e.g., biostatistics, critical literature review, preparation of grant applications, etc.), 2) the formation and implementation of the scholarship oversight committees such that, to the extent possible, each fellow’s committee is consistent in function, level of responsibility and expectations of fellow accountability. Written guidelines for the operation of the scholarship oversight committee should be developed as a collaborative effort among subspecialty program directors. A mechanism for fellows to document their research progress is available through the American Academy of Pediatrics (AAP) “Fellow Center” of PediaLink (www.PediaLink.org),

ACGME Competencies (Section IV.A.5.)

Practice-based Learning and Improvement (Section IV.A.5.c.)

In order for fellows to adopt this competency as a life-long habit of practice, they should be guided in the process of reflection with the intent of identifying strengths, needed areas for improvement, and plans to implement strategies that will lead to practice improvement. Fellows should be paired with a faculty mentor with whom they can develop a meaningful relationship to guide them in this process. Faculty development is necessary to ensure that mentors have the needed skills to address the full scope of their responsibilities and function as a valuable resource to fellows. Mentors should meet with mentees a minimum of twice per year along with ongoing interaction via email, phone conversations, etc., during these intervals.

The process of self-assessment is most valuable when discussed with a mentor. The mentor should guide the fellow in reviewing evaluations from health care team members and patients to understand: 1) how one's performance /behavior can impact others, and 2) how to incorporate this feedback into future practice improvement. The fellow can then build on this self-assessment and reflective process by developing an individualized learning plan (e.g., documenting a minimum of three personal learning objectives to address identified areas of needed improvement and strategies to achieve the objectives). This plan should be updated at least annually with the final plan focusing on transition to the next phase of one's career and a plan for life-long learning. The "Fellow Center" of PediaLink provides a mechanism to guide fellows through a self-assessment and reflective process that culminates in documentation of their learning plan.

In addition to knowledge content, it is critical that fellows demonstrate their ability to use technology to access scientific evidence, interpret the evidence they uncover, and then apply it to the care of their patients. The program must document that a fellow is able to perform these skills and that the faculty have a structured way of teaching and evaluating such skill. Having the fellows present at Journal Club or complete a critically-appraised topic are examples of ideal ways of teaching and assessing skills. Necessary components include faculty guidance, criteria for demonstrating competence that are transparent to both fellows and faculty, and documented achievement of competence using the established criteria.

The program must also document that fellows acquire the skills needed to analyze and improve the quality of their practice. Each fellow should engage in a quality improvement project/activity under the guidance of the faculty. The Plan-Do-Study-Act (PDSA) cycle, as described by Berwick, which can be completed in a minimum of two week cycles, provides a practical method for engaging fellows in this process. This requirement may also be met through fellow membership on a QI Committee. In this case there must be evidence of the fellow's active participation in the planning, implementation and analysis of an intervention on a practice outcome.

Programs must provide skilled teachers as role models who demonstrate the value of teaching students, residents, patients and families. Structured learning activities that address teaching skills should be incorporated into the curriculum. Fellows should have opportunities to practice these skills and in turn be evaluated in so doing so that feedback can be used to bring about ongoing improvement.

Interpersonal and Communication Skills (Section IV.A.5.d.)

Effective written and verbal communication is critical to practicing the science of medicine; style and content of communication is critical to practicing the art of medicine.

Providing fellows a structured curriculum to address the needed skills as well as engaging them in interactive methods of learning, such as role modeling, role playing, direct observation and feedback, etc., are necessary to enable them to become competent in this area. Based on the need for subspecialists to engage in the delivery of critical/complex and sometimes devastating information regarding diagnosis, process and treatment, particular attention must be given to teaching and assessing competence in conducting family meetings for these purposes. “On-the-job” training without structured teaching and feedback is not sufficient.

Effective communication is a requisite skill for optimal functioning of the health care team. The ability to function as both a member and leader of a team are critical skills for the subspecialist who works with referring physicians and agencies, patient and families, as well as other members of the health care system.

One effective way of evaluating communication is through review of the fellow’s correspondence with other health care professionals. A structured process for review of written communication, particularly consults and letters to referring physicians is required. Ad hoc review of written communication does not meet this requirement. Timeliness of completion as well as quality of information provided should be assessed and a mechanism for delivering feedback to the fellow must be ensured. Documentation of competence should be included as part of the written evaluation process.

Professionalism (Section IV.A.5.e.)

Medical ethics and professionalism should be emphasized in the didactic curriculum and modeled by the faculty in all aspects of their practice. A structured curriculum with meaningful venues for teaching that extend beyond the traditional lecture to include interactive learning (e.g., small group discussions of vignettes or case studies, computer-based modules, role plays, etc.) will meet this requirement.

Multi-source feedback that includes patients/families and allied health professionals is critical to the professional formation of fellows. Since the fellow will relate to each

individual in a unique way it is important to have team members (including the patient and family as part of the team) contribute to the assessment of a fellow's professionalism. The program should provide a mechanism to ensure that patients/families and representatives of the health care team assess appropriate aspects of the fellow's professionalism and that this feedback is given to the fellows, preferably as aggregate data, that preserves the anonymity of the evaluators. These evaluations should supplement the evaluations of faculty and peers. A structured mechanism for dissemination and collection of evaluations as well as delivery of feedback to the fellows is required. Timeliness of feedback is also important particularly when there has been a breach of professionalism. A structured mechanism for timely documentation, such as the use of critical incidents or instant evaluations, should be in place. In cases where remediation is needed, the steps should include immediate feedback, the development of an action plan with the fellow that specifically addresses the infraction, ongoing monitoring of behavior, and an identified consequence if improvement is not demonstrated.

Systems-Based Practice (Section IV.A.5.f..)

In order to best serve a patient population, one must develop a familiarity with the natural history and epidemiology of major health problems in the community. A background understanding of the health literacy of the community, along with knowledge of the cultural norms and health beliefs, will improve care delivery. This information becomes helpful in improving patient/family compliance as well. The program must provide a structured curriculum to address all of the elements of this competency as well as opportunities to apply this learning. Particularly relevant to subspecialty fellows is their ability to apply the elements of this competency (e.g., preventive care, resource allocation, cost-effective care, etc.) to help patients navigate the complexities of the health care delivery system. A clinical setting that particularly lends itself to experiential learning and demonstration of the requisite skills is a continuity clinic setting where the fellow has an ongoing therapeutic relationship with patients.

In addition, for three year fellowship programs, fellows must have exposure to the administrative aspects of the delivery of care appropriate to their subspecialty discipline. The required elements may be addressed by having fellows be active participants in division meetings and division conferences where these issues are discussed and solutions to identified problems developed and/or by participating with designated faculty in carrying out administrative responsibilities within the division.

Programs must provide a safe environment that encourages practitioners to identify weaknesses, deficiencies, and errors. The program must ensure that each fellow is actively engaged in activities, under the guidance of experienced faculty, to identify system problems/errors, and to develop and implement system solutions. Morbidity and mortality conference provides an ideal venue for a structured approach to the examination of system errors and the development of system solutions provided the

interdisciplinary team that represents the system is involved and the fellow is an active participant in identifying and addressing the problems/errors.

Evaluation (Section V)

An important consideration in the evaluation of competence is that multiple methods of assessment provide a more comprehensive and valid assessment of the learner. Global evaluations are helpful when used in conjunction with other methods but should not be used as the only method of assessment. The type of assessment methods/tools should be paired in a meaningful way to the tasks of real world practice to be evaluated. For example, if it is important for learners to demonstrate competence as evidence-based practitioners then they need to demonstrate competence in systematically accessing, analyzing and applying evidence which can be accomplished in activities like journal club and care delivery in the clinical setting. The former task may be assessed using direct observation of performance in delivering an evidence-based journal club while the latter may be best assessed using a global assessment of the learner by a faculty member directly interacting with the fellow over some period of time such as a block rotation or several months of a longitudinal experience. The learner and the evaluator should be clear about the criteria on which the judgment of competence will be based. Formative feedback is critical in helping the learner meet the bar that has been set to define competence. Faculty development becomes important for those who will serve as evaluators, ensuring that they understand how to use the assessment tools. Training evaluators has been shown to improve the consistency of the assessment process. Self-assessment is critical in the evaluation of competence. Multi source feedback from various stakeholders such as peers, patients, families and other health care professionals provides valuable feedback to the learner and should be used to inform the process of self-assessment.