



**Accreditation Council for
Graduate Medical Education**

**ACGME Program Requirements for
Graduate Medical Education
in Pediatric Emergency Medicine**

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

Common Program Requirements are in **BOLD**

Introduction

Int.A. Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident.

The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident physician to assume personal responsibility for the care of individual patients. For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As residents gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept--graded and progressive responsibility--is one of the core tenets of American graduate medical education. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.

Int.B. 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. ^{(Core)*}

Int.C. 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). ^(Core)

Int.D. The fellows and faculty must interact with the residents in the core pediatrics residency program. ^(Core)

Int.D.1. Lines of responsibility for the pediatric residents and the fellows must be clearly defined. ^(Core)

Int.D.2. The presence of a subspecialty program should not adversely affect the education of pediatric residents. ^(Core)

Int.E. 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. ^(Core)

Int.F. Duration of Educational Experience

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

Int.G. Scope of Educational Experience

Int.G.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. ^(Core)

Int.G.1.a) This must include progressive clinical, technical, and consultative experiences that will enable the fellow to develop expertise as a consultant in the subspecialty. ^(Core)

Int.G.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. ^(Core)

Int.G.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. ^(Core)

Int.G.3.a) 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. ^(Core)

I. Institutions

I.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. ^(Core)

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. ^(Core)

I.A.1. The pediatric subspecialty program must be sponsored by the same institution that sponsors the related core pediatrics program. ^(Core)

I.A.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.

I.B. Participating Sites

I.B.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. ^(Detail)

The PLA should:

I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for fellows; ^(Detail)

I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of fellows, as specified later in this document; ^(Detail)

I.B.1.c) specify the duration and content of the educational experience; and, ^(Detail)

I.B.1.d) state the policies and procedures that will govern fellow education during the assignment. ^(Detail)

I.B.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). ^(Core)

I.B.2.a) Copies of these written arrangements, specifying administrative, organizational, and educational relationships, must accompany an application for initial accreditation. ^(Detail)

I.B.2.b) At subsequent reviews, these documents need not be submitted, but must be available for review by the site-visitor. ^(Detail)

I.B.3. 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. ^(Detail)

II. Program Personnel and Resources

II.A. Program Director

II.A.1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMC must approve a change in program director. ^(Core)

II.A.1.a) The program director must submit this change to the ACGME via the ADS. ^(Core)

- II.A.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. ^(Detail)
- II.A.3.** Qualifications of the program director must include:
- II.A.3.a)** requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee; ^(Core)
- II.A.3.b)** current certification in the specialty by the American Board of Pediatrics, or specialty qualifications that are acceptable to the Review Committee; ^(Core)
- II.A.3.b).(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. ^(Detail)
- II.A.3.c)** current medical licensure and appropriate medical staff appointment; and, ^(Core)
- II.A.3.d)** 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). ^(Detail)
- II.A.4.** The program director must administer and maintain an educational environment conducive to educating the fellows in each of the ACGME competency areas. ^(Core)
- The program director must:
- II.A.4.a)** oversee and ensure the quality of didactic and clinical education in all sites that participate in the program; ^(Core)
- II.A.4.b)** approve a local director at each participating site who is accountable for fellow education; ^(Core)
- II.A.4.c)** approve the selection of program faculty as appropriate; ^(Core)
- II.A.4.d)** evaluate program faculty; ^(Core)
- II.A.4.e)** approve the continued participation of program faculty based on evaluation; ^(Core)

- II.A.4.f)** monitor fellow supervision at all participating sites; ^(Core)
- II.A.4.g)** prepare and submit all information required and requested by the ACGME; ^(Core)
- II.A.4.g).(1)** This includes but is not limited to the program application forms and annual program fellow updates to the ADS, and ensure that the information submitted is accurate and complete. ^(Core)
- II.A.4.h)** ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution; ^(Detail)
- II.A.4.i)** provide verification of fellowship education for all fellows, including those who leave the program prior to completion; ^(Detail)
- II.A.4.j)** implement policies and procedures consistent with the institutional and program requirements for fellow duty hours and the working environment, including moonlighting. ^(Core)
- and, to that end, must:
- II.A.4.j).(1)** distribute these policies and procedures to the fellows and faculty; ^(Detail)
- II.A.4.j).(2)** monitor fellow duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements; ^(Core)
- II.A.4.j).(3)** adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and, ^(Detail)
- II.A.4.j).(4)** if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue. ^(Detail)
- II.A.4.k)** monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged; ^(Detail)
- II.A.4.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; ^(Detail)
- II.A.4.m)** be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures; ^(Detail)

- II.A.4.n)** obtain review and approval of the sponsoring institution's GMEC/DIO before submitting information or requests to the ACGME, including: ^(Core)
- II.A.4.n).(1)** all applications for ACGME accreditation of new programs; ^(Detail)
- II.A.4.n).(2)** changes in fellow complement; ^(Detail)
- II.A.4.n).(3)** major changes in program structure or length of training; ^(Detail)
- II.A.4.n).(4)** progress reports requested by the Review Committee; ^(Detail)
- II.A.4.n).(5)** responses to all proposed adverse actions; ^(Detail)
- II.A.4.n).(6)** requests for increases or any change to fellow duty hours; ^(Detail)
- II.A.4.n).(7)** voluntary withdrawals of ACGME-accredited programs; ^(Detail)
- II.A.4.n).(8)** requests for appeal of an adverse action; ^(Detail)
- II.A.4.n).(9)** appeal presentations to a Board of Appeal or the ACGME; and, ^(Detail)
- II.A.4.n).(10)** proposals to ACGME for approval of innovative educational approaches. ^(Detail)
- II.A.4.o)** obtain DIO review and co-signature on all program application forms, as well as any correspondence or document submitted to the ACGME that addresses: ^(Detail)
- II.A.4.o).(1)** program citations, and/or, ^(Detail)
- II.A.4.o).(2)** request for changes in the program that would have significant impact, including financial, on the program or institution. ^(Detail)
- II.A.4.p)** ensure that the fellows are mentored in their development of clinical, educational, and administrative skills; ^(Detail)
- II.A.4.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; and, ^(Core)
- II.A.4.q).(1)** Where appropriate, the core curriculum in scholarly activities should be a collaborative effort involving all of the

pediatric subspecialty programs in the institution; ^(Detail)

II.A.4.r) have documentation of meetings that describe ongoing interaction among pediatric subspecialty and core program directors. ^(Detail)

II.A.4.r).(1) These must take place at least semi-annually. ^(Detail)

II.A.4.r).(2) These meetings should address a departmental approach to common educational issues and concerns (e.g., core curriculum, competencies, and evaluation). ^(Detail)

II.B. Faculty

II.B.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. ^(Core)

The faculty must:

II.B.1.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 ^(Core)

II.B.1.b) administer and maintain an educational environment conducive to educating fellows in each of the ACGME competency areas. ^(Core)

II.B.2. The physician faculty must have current certification in the specialty by the American Board of Pediatrics, or possess qualifications judged acceptable to the Review Committee. ^(Core)

II.B.2.a) Acceptable qualifications for the required key subspecialty faculty include: ^(Core)

II.B.2.a).(1) certification, if eligible, by the American Board of Pediatrics (ABP) or other appropriate board of the American Board of Medical Specialties (ABMS), or ^(Core)

II.B.2.a).(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. ^(Detail)

II.B.2.b) When assessing the adequacy of the number of faculty, the total number of fellows will be considered. ^(Detail)

II.B.2.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. ^(Core)

- II.B.2.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. ^(Detail)
- II.B.2.e) Appropriate teaching and consultant faculty in the full range of pediatric subspecialties and in other related disciplines also must be available. ^(Core)
- II.B.2.e).(1) An anesthesiologist, pathologist, and a radiologist who have substantial experience with pediatric problems and who interact with the fellows are essential. ^(Detail)
- II.B.2.e).(2) 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. ^(Detail)
- II.B.3. The physician faculty must possess current medical licensure and appropriate medical staff appointment. ^(Core)**
- II.B.4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments. ^(Core)**
- II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component. ^(Core)**
- II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. ^(Detail)**
- II.B.5.b) Some members of the faculty should also demonstrate scholarship by one or more of the following:**
- II.B.5.b).(1) peer-reviewed funding; ^(Detail)**
- II.B.5.b).(2) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks; ^(Detail)**
- II.B.5.b).(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or, ^(Detail)**
- II.B.5.b).(4) participation in national committees or educational organizations. ^(Detail)**
- II.B.5.c) Faculty should encourage and support fellows in scholarly activities. ^(Core)**

- II.B.5.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; ^(Detail)
- II.B.5.e) To provide an appropriate environment for the fellows, the fellowship faculty must have a program of ongoing scholarship. ^(Core)
- II.B.5.e).(1) This should be characterized by peer reviewed funding and publications. ^(Detail)
- II.B.5.e).(2) 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. ^(Detail)
- II.B.5.e).(3) A scholarly environment outside of the training program can supplement but not replace the scholarly environment within the training program; ^(Detail)
- II.B.5.f) Although an individual faculty member may not be accomplished in all four areas of scholarship, the program faculty must exhibit all four. ^(Core)
- II.B.5.f).(1) 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. ^(Detail)
- II.B.5.f).(2) Recent productivity by the program faculty and by the fellows will be assessed at the time of each review of the program. ^(Core)
- II.B.5.f).(3) 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. ^(Core)

II.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. ^(Core)

- II.C.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. ^(Detail)

II.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. ^(Core)

- II.D.1. Adequate inpatient and outpatient facilities, as specified in the requirements for each subspecialty, must be available. ^(Core)
- II.D.1.a) These must be of sufficient size and be appropriately staffed and equipped to meet the educational needs of the subspecialty program. ^(Detail)
- II.D.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. ^(Detail)
- II.D.3. Patients should range in age from newborn through young adulthood, as appropriate. ^(Core)
- II.D.3.a) Adequate numbers of pediatric subspecialty inpatients and outpatients, both new and follow up, must be available to provide a broad experience for the fellows. ^(Core)
- II.D.3.b) 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. ^(Core)
- II.D.3.b).(1) 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. ^(Detail)

II.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. ^(Detail)

III. Fellow Appointments

III.A. Eligibility Criteria

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

III.A.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. ^(Core)

III.A.1.a) 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. ^(Detail)

III.B. Number of Fellows

The program's educational resources must be adequate to support the number of fellows appointed to the program. ^(Core)

III.B.1. **The program director may not appoint more fellows than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements.** ^(Core)

III.C. Fellow Transfers

III.C.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.** ^(Detail)

III.C.2. **A program director must provide timely verification of fellowship education and summative performance evaluations for fellows who may leave the program prior to completion.** ^(Detail)

III.D. Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed fellows' education. ^(Core)

III.D.1. **The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.** ^(Detail)

IV. Educational Program

IV.A. **The curriculum must contain the following educational components:**

- IV.A.1. Overall educational goals for the program, which the program must make available to fellows and faculty;** ^(Core)
- IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to fellows and faculty at least annually, in either written or electronic form;** ^(Core)
- IV.A.3. Regularly scheduled didactic sessions;** ^(Core)
- IV.A.4. Delineation of fellow responsibilities for patient care, progressive responsibility for patient management, and supervision of fellows over the continuum of the program; and,** ^(Core)
- IV.A.5. ACGME Competencies**
- The program must integrate the following ACGME competencies into the curriculum:** ^(Core)
- IV.A.5.a) Patient Care and Procedural Skills**
- IV.A.5.a).(1) 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:** ^(Outcome)
- IV.A.5.a).(1).(a) must 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. ^(Outcome)
- IV.A.5.a).(2) Fellows must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. Fellows:** ^(Outcome)
- IV.A.5.a).(2).(a) must demonstrate competence in performing and interpreting the results of laboratory tests and diagnostic procedures for use in patient care. ^(Outcome)
- IV.A.5.a).(2).(a).(i) Fellows must acquire the necessary procedural skills and develop an understanding of their indications, risks, and limitations. ^(Outcome)
- IV.A.5.a).(2).(a).(ii) Each fellow's experience in such procedures must be documented by the

program director and such documentation must be available for review. ^(Detail)

IV.A.5.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: ^(Outcome)

IV.A.5.b).(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. ^(Outcome)

IV.A.5.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. ^(Outcome)

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

IV.A.5.c).(1) **identify strengths, deficiencies, and limits in one's knowledge and expertise;** ^(Outcome)

IV.A.5.c).(2) **set learning and improvement goals;** ^(Outcome)

IV.A.5.c).(3) **identify and perform appropriate learning activities;** ^(Outcome)

IV.A.5.c).(4) **systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;** ^(Outcome)

IV.A.5.c).(5) **incorporate formative evaluation feedback into daily practice;** ^(Outcome)

IV.A.5.c).(6) **locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;** ^(Outcome)

IV.A.5.c).(7) **use information technology to optimize learning;** ^(Outcome)

IV.A.5.c).(8) **participate in the education of patients, families, students, fellows and other health professionals; and,**
(Outcome)

IV.A.5.c).(9) self-evaluate performance and incorporate assessments provided by faculty, peer and patients (Outcome)

IV.A.5.c).(9).(a) This should be a component of the individual learning plan. (Core)

IV.A.5.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. (Outcome)

Fellows are expected to:

IV.A.5.d).(1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; (Outcome)

IV.A.5.d).(2) communicate effectively with physicians, other health professionals, and health related agencies; (Outcome)

IV.A.5.d).(3) work effectively as a member or leader of a health care team or other professional group; (Outcome)

IV.A.5.d).(4) act in a consultative role to other physicians and health professionals; (Outcome)

IV.A.5.d).(5) maintain comprehensive, timely, and legible medical records, if applicable; and, (Outcome)

IV.A.5.d).(6) teach proficiently, understand 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. (Outcome)

IV.A.5.d).(6).(a) 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. (Outcome)

IV.A.5.e) Professionalism

Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. (Outcome)

Fellows are expected to demonstrate:

- IV.A.5.e).(1)** **compassion, integrity, and respect for others;** ^(Outcome)
- IV.A.5.e).(2)** **responsiveness to patient needs that supersedes self-interest;** ^(Outcome)
- IV.A.5.e).(3)** **respect for patient privacy and autonomy;** ^(Outcome)
- IV.A.5.e).(4)** **accountability to patients, society and the profession; and,** ^(Outcome)
- IV.A.5.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.** ^(Outcome)

IV.A.5.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.
^(Outcome)

Fellows are expected to:

- IV.A.5.f).(1)** **work effectively in various health care delivery settings and systems relevant to their clinical specialty;** ^(Outcome)
- IV.A.5.f).(2)** **coordinate patient care within the health care system relevant to their clinical specialty;** ^(Outcome)
- IV.A.5.f).(3)** **incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;** ^(Outcome)
- IV.A.5.f).(4)** **advocate for quality patient care and optimal patient care systems;** ^(Outcome)
- IV.A.5.f).(5)** **work in interprofessional teams to enhance patient safety and improve patient care quality;** ^(Outcome)
- IV.A.5.f).(6)** **participate in identifying system errors and implementing potential systems solutions;** ^(Outcome)
- IV.A.5.f).(7)** **participate in the administrative aspects of the subspecialty, including;** ^(Outcome)

- IV.A.5.f).(7).(a) an awareness of regional and national access to care, resources, workforce, and financing appropriate to their specialty through guided reading and discussion; and, ^(Outcome)
- IV.A.5.f).(7).(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: ^(Outcome)
- IV.A.5.f).(7).(b).(i) staffing a service or unit, including managing personnel and making and adhering to a schedule; ^(Outcome)
- IV.A.5.f).(7).(b).(ii) drafting policies and procedures, leading interdisciplinary meetings and conferences, providing in-service teaching sessions; ^(Outcome)
- IV.A.5.f).(7).(b).(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; ^(Outcome)
- IV.A.5.f).(7).(b).(iv) business planning and practice management that includes billing and coding, personnel management policies and professional liability; ^(Outcome)
- IV.A.5.f).(7).(b).(v) division or program development, organization, and maintenance; and, ^(Outcome)
- IV.A.5.f).(7).(b).(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. ^(Outcome)

IV.A.6. Curriculum Organization and Fellow Experiences

- IV.A.6.a) Fellows must have a formally-structured educational program in the clinical and basic sciences related to the subspecialty. ^(Core)
- IV.A.6.a).(1) The program must utilize lectures, seminars, and practical experience. ^(Detail)
- IV.A.6.a).(2) Subspecialty conferences must be regularly scheduled,

and should involve active participation by the fellows in the planning and implementation of these meetings. ^(Detail)

IV.A.6.a).(3)

Fellows 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. ^(Core)

IV.A.6.a).(4)

Fellows 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. ^(Core)

IV.A.6.a).(5)

Bioethics must be addressed in the formal curriculum. ^(Core)

IV.A.6.a).(5).(a)

This must include attention to physician-patient, physician-family, physician-physician/allied health professional, and physician-society relationships. ^(Detail)

IV.A.6.a).(6)

Fellows should 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. ^(Detail)

IV.B. Fellows' Scholarly Activities

IV.B.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. ^(Core)

IV.B.2.

Fellows should participate in scholarly activity. ^(Core)

IV.B.2.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. ^(Core)

IV.B.2.b)

The program must provide a scholarship oversight committee for each fellow to evaluate the fellow's progress as related to scholarly activity. ^(Core)

IV.B.2.c)

The scholarly experience must begin in the first year and continue for the entire period of training. ^(Detail)

IV.B.2.c).(1)

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. ^(Detail)

IV.B.2.c).(1).(a)

Where applicable, the process of establishing fellow scholarship oversight committees should be a collaborative effort involving other pediatric subspecialty programs in the institution. ^(Detail)

IV.B.3.

The sponsoring institution and program should allocate adequate educational resources to facilitate fellow involvement in scholarly activities. ^(Detail)

V. Evaluation

V.A. Fellow Evaluation

V.A.1.

The program director must appoint the Clinical Competency Committee. ^(Core)

V.A.1.a)

At a minimum the Clinical Competency Committee must be composed of three members of the program faculty. ^(Core)

V.A.1.a).(1)

Others eligible for appointment to the committee include faculty from other programs and non-physician members of the health care team. ^(Detail)

V.A.1.b)

There must be a written description of the responsibilities of the Clinical Competency Committee. ^(Core)

V.A.1.b).(1)

The Clinical Competency Committee should:

V.A.1.b).(1).(a)

review all fellow evaluations semi-annually; ^(Core)

V.A.1.b).(1).(b)

prepare and assure the reporting of Milestones evaluations of each fellow semi-annually to ACGME; and, ^(Core)

V.A.1.b).(1).(c)

advise the program director regarding fellow progress, including promotion, remediation, and dismissal. ^(Detail)

V.A.2.

Formative Evaluation

V.A.2.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. ^(Core)

V.A.2.b)

The program must:

V.A.2.b).(1)

provide objective assessments of competence in

patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the specialty-specific Milestones; ^(Core)

V.A.2.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff); ^(Detail)

V.A.2.b).(3) document progressive fellow performance improvement appropriate to educational level; and, ^(Core)

V.A.2.b).(4) provide each fellow with documented semiannual evaluation of performance with feedback. ^(Core)

V.A.2.c) The evaluations of fellow performance must be accessible for review by the fellow, in accordance with institutional policy. ^(Detail)

V.A.3. Summative Evaluation

V.A.3.a) The specialty-specific Milestones must be used as one of the tools to ensure fellows are able to practice core professional activities without supervision upon completion of the program. ^(Core)

V.A.3.b) The program director must provide a summative evaluation for each fellow upon completion of the program. ^(Core)

This evaluation must:

V.A.3.b).(1) 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; ^(Detail)

V.A.3.b).(2) document the fellow's performance during the final period of education; and, ^(Detail)

V.A.3.b).(3) verify that the fellow has demonstrated sufficient competence to enter practice without direct supervision. ^(Detail)

V.B. Faculty Evaluation

V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program. ^(Core)

V.B.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. ^(Detail)

V.B.3. This evaluation must include at least annual written confidential evaluations by the fellows. ^(Detail)

V.B.3.a) In order to maintain the confidentiality of responses from fellows in small programs, evaluations of faculty may be consolidated with the core faculty evaluations. ^(Detail)

V.B.4. Faculty should receive formal feedback from these evaluations. ^(Core)

V.C. Program Evaluation and Improvement

V.C.1. The program director must appoint the Program Evaluation Committee (PEC). ^(Core)

V.C.1.a) The Program Evaluation Committee:

V.C.1.a).(1) must be composed of at least two program faculty members and should include at least one fellow; ^(Core)

V.C.1.a).(2) must have a written description of its responsibilities; and, ^(Core)

V.C.1.a).(3) should participate actively in:

V.C.1.a).(3).(a) planning, developing, implementing, and evaluating educational activities of the program; ^(Detail)

V.C.1.a).(3).(b) reviewing and making recommendations for revision of competency-based curriculum goals and objectives; ^(Detail)

V.C.1.a).(3).(c) addressing areas of non-compliance with ACGME standards; and, ^(Detail)

V.C.1.a).(3).(d) reviewing the program annually using evaluations of faculty, fellows, and others, as specified below. ^(Detail)

V.C.2. The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written and Annual Program Evaluation (APE). ^(Core)

The program must monitor and track each of the following areas:

V.C.2.a) fellow performance; ^(Core)

V.C.2.b) faculty development; ^(Core)

- V.C.2.c) **graduate performance, including performance of program graduates on the certification examination;** ^(Core)
- V.C.2.d) **program quality; and,** ^(Core)
- V.C.2.d).(1) **Fellows and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and** ^(Detail)
- V.C.2.d).(2) **The program must use the results of fellows' and faculty members' assessments of the program together with other program evaluation results to improve the program.** ^(Detail)
- V.C.2.e) **progress on the previous year's action plan(s).** ^(Core)
- V.C.3. **The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section V.C.2., as well as delineate how they will be measured and monitored.** ^(Core)
- V.C.3.a) **The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.** ^(Detail)
- V.C.4. 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. ^(Outcome)
- V.C.4.a) 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. ^(Detail)
- V.C.5. 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. ^(Detail)

VI. Fellow Duty Hours in the Learning and Working Environment

VI.A. Professionalism, Personal Responsibility, and Patient Safety

- VI.A.1. **Programs and sponsoring institutions must educate fellows and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.** ^(Core)
- VI.A.2. **The program must be committed to and responsible for promoting patient safety and fellow well-being in a supportive educational environment.** ^(Core)

- VI.A.3.** The program director must ensure that fellows are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs. ^(Core)
- VI.A.4.** The learning objectives of the program must:
- VI.A.4.a)** be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and, ^(Core)
- VI.A.4.b)** not be compromised by excessive reliance on fellows to fulfill non-physician service obligations. ^(Core)
- VI.A.5.** The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. ^(Core)
- VI.A.6.** Fellows and faculty members must demonstrate an understanding and acceptance of their personal role in the following:
- VI.A.6.a)** assurance of the safety and welfare of patients entrusted to their care; ^(Outcome)
- VI.A.6.b)** provision of patient- and family-centered care; ^(Outcome)
- VI.A.6.c)** assurance of their fitness for duty; ^(Outcome)
- VI.A.6.d)** management of their time before, during, and after clinical assignments; ^(Outcome)
- VI.A.6.e)** recognition of impairment, including illness and fatigue, in themselves and in their peers; ^(Outcome)
- VI.A.6.f)** attention to lifelong learning; ^(Outcome)
- VI.A.6.g)** the monitoring of their patient care performance improvement indicators; and, ^(Outcome)
- VI.A.6.h)** honest and accurate reporting of duty hours, patient outcomes, and clinical experience data. ^(Outcome)
- VI.A.7.** All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. They must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider. ^(Outcome)
- VI.B.** Transitions of Care
- VI.B.1.** Programs must design clinical assignments to minimize the number of transitions in patient care. ^(Core)

- VI.B.2.** Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. ^(Core)
- VI.B.3.** Programs must ensure that fellows are competent in communicating with team members in the hand-over process. ^(Outcome)
- VI.B.4.** The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and fellows currently responsible for each patient's care. ^(Detail)
- VI.C.** Alertness Management/Fatigue Mitigation
- VI.C.1.** The program must:
- VI.C.1.a)** educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation; ^(Core)
- VI.C.1.b)** educate all faculty members and fellows in alertness management and fatigue mitigation processes; and, ^(Core)
- VI.C.1.c)** adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules. ^(Detail)
- VI.C.2.** Each program must have a process to ensure continuity of patient care in the event that a fellow may be unable to perform his/her patient care duties. ^(Core)
- VI.C.3.** The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for fellows who may be too fatigued to safely return home. ^(Core)
- VI.D.** Supervision of Fellows
- VI.D.1.** In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care. ^(Core)
- VI.D.1.a)** This information should be available to fellows, faculty members, and patients. ^(Detail)
- VI.D.1.b)** Fellows and faculty members should inform patients of their respective roles in each patient's care. ^(Detail)
- VI.D.2.** The program must demonstrate that the appropriate level of supervision is in place for all fellows who care for patients. ^(Core)

Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the fellow can be adequately supervised by the immediate availability of the supervising faculty member or fellow physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of fellow-delivered care with feedback as to the appropriateness of that care. ^(Detail)

VI.D.3. Levels of Supervision

To ensure oversight of fellow supervision and graded authority and responsibility, the program must use the following classification of supervision: ^(Core)

VI.D.3.a) Direct Supervision – the supervising physician is physically present with the fellow and patient. ^(Core)

VI.D.3.b) Indirect Supervision:

VI.D.3.b).(1) with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision. ^(Core)

VI.D.3.b).(2) with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision. ^(Core)

VI.D.3.c) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. ^(Core)

VI.D.4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members. ^(Core)

VI.D.4.a) The program director must evaluate each fellow’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria. ^(Core)

VI.D.4.b) Faculty members functioning as supervising physicians should delegate portions of care to fellows, based on the needs of the patient and the skills of the fellows. ^(Detail)

VI.D.4.c) Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. ^(Detail)

VI.D.5. Programs must set guidelines for circumstances and events in which fellows must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions. ^(Core)

VI.D.5.a) Each fellow must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence. ^(Outcome)

VI.D.5.a).(1) In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available. ^(Core)

VI.D.6. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each fellow and delegate to him/her the appropriate level of patient care authority and responsibility. ^(Detail)

VI.E. Clinical Responsibilities

The clinical responsibilities for each fellow must be based on PGY-level, patient safety, fellow education, severity and complexity of patient illness/condition and available support services. ^(Core)

VI.E.1. The program director must have the authority and responsibility to set appropriate clinical responsibilities (i.e., patient caps) for each fellow based on the PGY-level, patient safety, fellow education, severity and complexity of patient illness/condition and available support services. ^(Core)

VI.E.2. Fellows must be responsible for maintaining an appropriate patient load. Insufficient patient experiences do not meet educational needs; an excessive patient load suggests an inappropriate reliance on fellows for service obligations, which may jeopardize their educational experience. ^(Core)

VI.F. Teamwork

Fellows must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty. ^(Core)

VI.F.1. Interprofessional team members should participate in the education of fellows. ^(Detail)

VI.G. Fellow Duty Hours

VI.G.1. Maximum Hours of Work per Week

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting. ^(Core)

VI.G.1.a) Duty Hour 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. ^(Detail)

The Review Committee for Pediatrics will not consider requests for exceptions to the 80-hour limit to the fellows' work week.

VI.G.1.a).(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. ^(Detail)

VI.G.1.a).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO. ^(Detail)

VI.G.2. Moonlighting

VI.G.2.a) Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program. ^(Core)

VI.G.2.b) Time spent by fellows in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit. ^(Core)

VI.G.2.c) PGY-1 residents are not permitted to moonlight. ^(Core)

VI.G.3. Mandatory Time Free of Duty

Fellows must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days. ^(Core)

VI.G.4. Maximum Duty Period Length

VI.G.4.a) Duty periods of PGY-1 residents must not exceed 16 hours in duration. ^(Core)

VI.G.4.b) Duty periods of PGY-2 residents and above may be

scheduled to a maximum of 24 hours of continuous duty in the hospital. ^(Core)

- VI.G.4.b).(1)** Programs must encourage fellows to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested. ^(Detail)
- VI.G.4.b).(2)** It is essential for patient safety and fellow education that effective transitions in care occur. Fellows may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours. ^(Core)
- VI.G.4.b).(3)** Fellows must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty. ^(Core)
- VI.G.4.b).(4)** In unusual circumstances, fellows, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. ^(Detail)
- VI.G.4.b).(4).(a)** Under those circumstances, the fellow must:
- VI.G.4.b).(4).(a).(i)** appropriately hand over the care of all other patients to the team responsible for their continuing care; and, ^(Detail)
- VI.G.4.b).(4).(a).(ii)** document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director. ^(Detail)
- VI.G.4.b).(4).(b)** The program director must review each submission of additional service, and track both individual fellow and program-wide episodes of additional duty. ^(Detail)
- VI.G.5. Minimum Time Off between Scheduled Duty Periods**
- VI.G.5.a)** PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods. ^(Core)
- VI.G.5.b)** Intermediate-level residents should have 10 hours free of

duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty. ^(Core)

VI.G.5.c) Residents in the final years of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. ^(Outcome)

Pediatric subspecialty fellows in the PGY-4 level and beyond are considered to be in the final years of education.

VI.G.5.c).(1) This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these fellows must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. ^(Detail)

VI.G.5.c).(1).(a) Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director. ^(Detail)

VI.G.5.c).(1).(b) The Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient with whom the fellow has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.

VI.G.6. Maximum Frequency of In-House Night Float

Fellows must not be scheduled for more than six consecutive nights of night float. ^(Core)

VI.G.6.a) Fellows should not have more than one consecutive week of night float, and not more than four total weeks of night float per year. ^(Detail)

VI.G.7. Maximum In-House On-Call Frequency

PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period). ^(Core)

VI.G.8. At-Home Call

VI.G.8.a) Time spent in the hospital by fellows on at-home call must

count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks. ^(Core)

VI.G.8.a).(1)

At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each fellow. ^(Core)

VI.G.8.b)

Fellows are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”. ^(Detail)

***Core Requirements:** Statements that define structure, resource, or process elements essential to every graduate medical educational program.

Detail Requirements: Statements that describe a specific structure, resource, or process for achieving compliance with a Core Requirement. Programs in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.

ACGME Program Requirements for Graduate Medical Education in Pediatric Emergency Medicine

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

Introduction

- Int.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.
- Int.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. ^{(Core)*}
- Int.C. 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). ^(Core)
- Int.D. 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. ^(Core)

VII. Duration and Scope of Educational Experience

- VII.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. ^(Core)
- VII.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. ^(Core)
 - VII.B.1. The program should inform fellows in writing as to the length of their curriculum before they begin the fellowship. ^(Core)
- VII.C. The program must emphasize the fundamentals of assessment, diagnosis, and management. ^(Core)
 - VII.C.1. 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. ^(Detail)

VII.C.2. Fellows should also be exposed to academic debate, intensive research review, and interaction between the specialties of pediatrics and emergency medicine. ^(Detail)

VIII. Teaching Staff

VIII.A. Program Director

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 of experience as a clinician, teacher, and administrator in pediatric emergency medicine. ^(Core)

VIII.B. Faculty

VIII.B.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: ^(Core)

VIII.B.1.a) provide adequate supervision of fellows, and ^(Detail)

VIII.B.1.b) ensure the educational and research quality of the program. ^(Detail)

VIII.B.2. Two faculty members must be certified in pediatric emergency medicine or possess qualifications acceptable to the residency Review Committee. ^(Core)

VIII.B.3. The remaining faculty members must be certified in pediatrics, emergency medicine, pediatric emergency medicine or possess qualifications acceptable to the Review Committee. ^(Core)

VIII.B.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. ^(Core)

VIII.B.5. 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. ^(Detail)

VIII.B.6. 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. ^(Detail)

VIII.B.7. The pediatric emergency medicine faculty must: ^(Detail)

- VIII.B.7.a) have an active role in curriculum development and in the supervision and evaluation of fellows; ^(Detail)
- VIII.B.7.b) contribute both clinically and academically to the program; and, ^(Detail)
- VIII.B.7.c) have protected time to allow for teaching and active participation in scholarly activity. ^(Detail)

IX. Facilities

- IX.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. ^(Core)
- IX.A.1. This facility should be accredited by the Joint Commission on Accreditation of Healthcare Organizations. ^(Detail)
- IX.B. There must be comprehensive radiologic and laboratory support systems and readily available operative suites and intensive care unit beds. ^(Core)

X. Curriculum

X.A. Agreements Between Programs

- X.A.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. ^(Detail)
- X.A.1.a) 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. ^(Detail)

X.B. Program Design

- X.B.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. ^(Core)
- X.B.1.a) 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. ^(Core)
- X.B.1.b) The fellows' training must include experience with blunt and penetrating trauma, significant gynecologic and obstetrical emergencies, as well as psychiatric emergencies of the adolescent. ^(Detail)

- X.B.2. Specialty-specific content must include at least four months of training in the specialty reciprocal to the fellow's prior residency. ^(Core)
- X.B.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. ^(Detail)
- X.B.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. ^(Detail)
- X.B.4.a) One block month of that experience must be spent caring for adults with traumatic injuries, ideally on a trauma service. ^(Detail)
- X.B.4.b) During the time spent in the adult emergency department, there must be structured educational experiences in EMS and toxicology. ^(Detail)
- X.B.4.b).(1) These should include both didactic and experiential components that may be longitudinally integrated into other parts of the curriculum or designed as block rotations. ^(Detail)
- X.B.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. ^(Detail)
- X.B.6. The core content of the program must include training in EMSC, administration, legal issues, procedures, patient safety, medical errors, ethics and professionalism. ^(Detail)
- X.B.7. 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. ^(Detail)
- X.C. Patient Care
- X.C.1. Fellows must demonstrate competence in providing initial evaluation and treatment to all kinds of patients. ^(Outcome)
- X.C.2. Fellows must be able to evaluate the patient with an undifferentiated chief complaint and diagnose whether it falls in areas traditionally designated medical, surgical or subspecialty. ^(Outcome)

- X.C.3. Fellows must be able 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. ^(Outcome)
- X.C.4. Fellows must demonstrate the skills necessary to prioritize and simultaneously manage the emergency care of multiple patients. ^(Outcome)
- X.C.5. They must demonstrate competence in technical/procedural and resuscitation skills for pediatric patients of all ages. ^(Outcome)
- X.C.6. Fellows must attain competency in the following procedures: ^(Outcome)
- X.C.6.a) abscess incision and drainage; ^(Outcome)
 - X.C.6.b) arterial catheterization; ^(Outcome)
 - X.C.6.c) arthrocentesis; ^(Outcome)
 - X.C.6.d) artificial ventilation; ^(Outcome)
 - X.C.6.e) cardiac pacing, external; ^(Outcome)
 - X.C.6.f) cardiopulmonary resuscitation in all of the following groups: ^(Outcome)
 - X.C.6.f).(1) adult medical resuscitation >18 years; ^(Outcome)
 - X.C.6.f).(2) adult trauma resuscitation >18 years; ^(Outcome)
 - X.C.6.f).(3) pediatric medical resuscitation <2 years; ^(Outcome)
 - X.C.6.f).(4) pediatric medical resuscitation >2 years; ^(Outcome)
 - X.C.6.f).(5) pediatric trauma resuscitation <2 years; and, ^(Outcome)
 - X.C.6.f).(6) pediatric trauma resuscitation >2 years. ^(Outcome)
 - X.C.6.g) cardioversion/defibrillation; ^(Outcome)
 - X.C.6.h) central venous catheterization; ^(Outcome)
 - X.C.6.i) closed reduction/splinting; ^(Outcome)
 - X.C.6.j) conversion of supraventricular tachycardia; ^(Outcome)
 - X.C.6.k) cricothyrotomy - translaryngeal ventilation; ^(Outcome)
 - X.C.6.l) dislocation/reduction; ^(Outcome)
 - X.C.6.m) endotracheal intubation; ^(Outcome)

- X.C.6.n) foreign body removal; ^(Outcome)
- X.C.6.o) gastric lavage; ^(Outcome)
- X.C.6.p) gastrostomy tube replacement; ^(Outcome)
- X.C.6.q) intraosseous access; ^(Outcome)
- X.C.6.r) laceration repair; ^(Outcome)
- X.C.6.s) pericardiocentesis; ^(Outcome)
- X.C.6.t) nasal packing; ^(Outcome)
- X.C.6.u) peritoneal lavage; ^(Outcome)
- X.C.6.v) rapid sequence intubation; ^(Outcome)
- X.C.6.w) regional nerve blocks; ^(Outcome)
- X.C.6.x) sedation and analgesia; ^(Outcome)
- X.C.6.y) slit lamp examination; ^(Outcome)
- X.C.6.z) tracheostomy tube replacement; ^(Outcome)
- X.C.6.aa) tube thoracostomy; ^(Outcome)
- X.C.6.bb) umbilical vessel catheterization; and, ^(Outcome)
- X.C.6.cc) vaginal delivery. ^(Outcome)
- X.C.7. To ensure an acceptable level of resident performance and procedural and resuscitation competency, the program must: ^(Detail)
- X.C.7.a) discuss assessment tools, measurement process and outcomes with each resident; ^(Detail)
- X.C.7.b) document performance and procedural and resuscitation competency in resident files; and, ^(Detail)
- X.C.7.c) maintain documentation of these activities for review with the site visitor at the time of the site visit. ^(Detail)
- X.C.8. Fellows must be given progressive responsibility for patient care as they advance through the program. ^(Core)
- X.C.8.a) In the final year of training, fellows must demonstrate, under faculty supervision, the skills appropriate to a supervisor, teacher, and decision maker in pediatric emergencies. ^(Outcome)

- X.C.9. Fellows must assume leadership responsibility for the pediatric emergency department. ^(Outcome)
- X.C.10. Fellows should demonstrate competence when providing supervision and consultation to other residents caring for patients in the emergency department. ^(Outcome)
- X.C.11. Fellows must demonstrate 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. ^(Outcome)
- X.C.12. Discussion and appreciation of ethical issues involved in pediatric emergency medicine should be part of the educational program. ^(Detail)
- X.D. Instruction in Program Administration
- X.D.1. Fellows should have formal sessions on organizing teaching programs, medical writing, and oral presentation. ^(Detail)
- X.D.2. Fellows should develop teaching skills by conducting lectures, seminars, and clinical conferences and by preparing written reports and teaching materials. ^(Outcome)
- X.D.2.a) These efforts must be reviewed and evaluated by the supervising faculty in light of using competency-based objectives developed by the program. ^(Detail)
- X.D.3. Fellows must receive instruction and experience in administrative and management skills, including quality improvement principles, necessary to oversee a division or department. ^(Detail)
- XI. Conferences
- XI.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. ^(Detail)
- XI.B. 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. ^(Detail)
- XI.C. 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. ^(Detail)
- XI.D. Faculty and fellows' attendance must be documented, and both must participate meaningfully in the didactic activities offered by the program. ^(Detail)
- XI.E. The program should also provide education on physician wellness and stress

management. ^(Detail)

XII. Patient Population

XII.A. The available patient population should encompass the full spectrum of infants, children, adolescents, and young adults. ^(Core)

XII.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. ^(Core)

XII.B.1. The Review Committee will consider patient acuity and the total number of trainees in assessing the adequacy of the patient population. ^(Detail)

XII.B.2. 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. ^(Core)

XIII. 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. ^(Detail)

***Core Requirements:** Statements that define structure, resource, or process elements essential to every graduate medical educational program.

Detail Requirements: Statements that describe a specific structure, resource, or process for achieving compliance with a Core Requirement. Programs in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.