PROGRAM REQUIREMENTS FOR RESIDENCY EDUCATION in PEDIATRIC EMERGENCY MEDICINE

In addition to complying with the Program Requirements for Residency Education in the Subspecialties of Pediatrics or Emergency Medicine, programs in pediatric emergency medicine must comply with the following requirements.

I. Introduction

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 has an emergency medical services system.

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 and must be associated with an ACGME-accredited residency program in the corresponding discipline.

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 compose this subspecialty program. These agreements should address appropriate curriculum content, supervision of the resident, amount and distribution of clinical and nonclinical time, conferences, clinical performance criteria, and mechanisms for resolving performance problems.

Prerequisite training should include satisfactory completion of an ACGME-accredited residency program in either emergency medicine or pediatrics.

II. Duration and Scope of Training

A training period of 2 years is required for all subspecialty residents. [Note: For those planning to seek certification from the American Board of Pediatrics, three years of training is required.] [Note: If a third year is offered, it must be described when the program is reviewed by the Residency Review Committee. Those planning to seek certification should consult with the appropriate certifying board regarding the criteria for eligibility, including duration of training.]

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

III. Curriculum

The residents in pediatric emergency medicine must participate in the care of pediatric

patients of all ages, from infancy through young adulthood, 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 children, ages 21 years of age or less, are treated for the full spectrum of illnesses and injuries. To provide adequate exposure for selected problems, additional experience with anesthesiologists, intensivists, neurologists, psychiatrists, pre-hospital care providers, orthopedists, surgeons, toxicologists, traumatologists, who have training and experience in the care of children and adolescents, and other specialists must be available.

Specialty-specific content must include at least 4 months of training in the reciprocal specialty from which the resident enters the training program. Additional elective months of reciprocal training should be scheduled when deemed appropriate by the program director on the basis of the background of the resident and his/her progress in acquiring the essential skills of a pediatric emergency specialist.

For the emergency medicine graduate, the reciprocal time must include time spent in pediatric subspecialty and ambulatory clinics, inpatient management, neonatal management, and pediatric critical care in an ACGME accredited residency program in pediatrics.

For the pediatric graduate, this must include 4 months in an adult emergency department that is part of an ACGME-accredited residency program in emergency medicine. One month of that experience may occur off site as approved by the ACGME-accredited program in Emergency Medicine, in EMS, adult trauma, or toxicology.

Additional experiences may be necessary for residents from both core specialties. For example, adolescents have unique aspects of disease and injury. Experience with blunt and penetrating trauma, and with significant gynecologic and obstetrical emergencies, as well as psychiatric emergencies of the adolescent, must be a part of a resident's training if previous experience in these areas was not adequate. These experiences should be in settings best suited for the resident's training.

The core content must include training in EMS, administration, ethics, legal issues, and procedures. It must also include but not be limited to structured opportunities to develop special competence in such areas as cardiopulmonary resuscitation; trauma; disaster and environmental medicine; transport; triage; sedation; monitoring (biomedical instrumentation); 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.

In addition to achieving an understanding of the pathophysiology, epidemiology, and management of these problems, the resident must learn how to evaluate the patient with an undifferentiated chief complaint such as abdominal pain. The resident must be taught to arrive at a diagnosis, whether it falls in areas traditionally designated medical or surgical, e.g., appendicitis, ectopic pregnancy, intussusception, sickle cell anemia; to

perform the evaluation rapidly in accordance with any pathophysiologic disturbances in the patient; and to proceed with an appropriate life-saving therapy, such as endotracheal intubation or thoracostomy or administration of antibiotics, before arriving at a definitive diagnosis.

The resident must learn the skills necessary to prioritize and manage the emergency care of multiple patients. Finally, the resident must have supervised experience in a range of technical/procedural skills, as they apply to pediatric patients of all ages.

The resident must be given increasing responsibilities for patient care as she or he progresses through the program. In the final year of training, the resident must be given the opportunities to demonstrate the skills appropriate to a supervisor, teacher, and a decision maker in pediatric emergencies.

There must be an emphasis on developing a compassionate understanding of the stress associated with sudden illness, injury and death so that the resident may be responsive to the emotional needs of the patients, their families, and the staff of the emergency department. Discussion and appreciation of the many ethical issues involved in pediatric emergency medicine should be part of the educational program.

Residents should be exposed to formal sessions on organizing teaching programs, medical writing, and oral presentation. Residents should have the opportunity to 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 competency based objectives developed by the program. The resident must receive instruction and experience in the administrative and management skills necessary to oversee a division or department.

IV. Conferences

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 instruction in or other educational exposure to related basic sciences, including physiology, growth and development, pathophysiology, and epidemiology and prevention of pediatric illnesses and injuries.

The program also should provide education on physician wellness and stress management.

V. Teaching Staff

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 to provide adequate supervision of residents and to ensure the educational and research quality of the program. Two of the faculty must be certified in pediatric emergency medicine or have equivalent qualifications. 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. Conversely, for a subspecialty program based in an emergency medicine residency program, there must be adequate exposure to faculty certified by the American Board of Pediatrics.

The availability of consultant and collaborative faculty in related medical and surgical disciplines, as referred to in Section III, must be ensured.

The pediatric emergency medicine faculty must have an active role in curriculum development and in the supervision and evaluation of the subspecialty residents.

VI. Patient Population

A sufficient number of patients must be available to provide adequate opportunity for subspecialty residents to acquire competence in the management of the full spectrum of acutely ill and injured children, adolescents, and young adults. The subspecialty residents must provide the initial evaluation of and treatment to all types of patients.

To meet the educational objectives of the program and to provide both the pediatric and subspecialty residents with an adequate experience to acquire competence in clinical management, there should be a minimum of 15,000 pediatric patient visits per year in the primary emergency department that is used for the program. Patient acuity and the total number of trainees will be considered in assessing the adequacy of the patient population. These must include a sufficient number of 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.

Subspecialty residents should not serve as the only care givers for children seen in the emergency department. They should provide supervision and consultation to other residents who are assigned to the emergency department and will be caring for patients. These subspecialty residents must, however, have the opportunity to manage multiple patients at the same time, to learn the skills necessary to prioritize the evaluation and treatment of these patients. In addition, the program must provide the pediatric emergency medicine residents the opportunity to assume leadership responsibility for the pediatric emergency department.

VII. Facilities

There must be an acute care facility that receives patients via ambulance from the prehospital setting, is equipped to handle trauma, and that has a 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.

The emergency department must be adequately staffed, have appropriate bedside monitoring capability, and be capable of resuscitating medical and trauma patients. Facilities and equipment must meet the generally accepted standards of a modern emergency department and be available within the institution on a 24-hour-a-day basis.

The institution should have comprehensive radiologic and laboratory support systems and readily available operative suites and intensive care unit beds.

VIII. Board Certification

Residents seeking certification in the subspecialty of pediatric emergency medicine should consult their primary specialty board, ie, the American Board of Pediatrics or the American Board of Emergency Medicine, regarding the criteria for eligibility for certification in this subspecialty.

ACGME: June, 1998 *Effective: June, 1998*