

ACGME Program Requirements for Graduate Medical 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 Graduate Medical Education in the Subspecialties of Pediatrics*, as well as the following requirements.

I. Introduction

- I.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.
- I.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).
- I.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

- II.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.
- II.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.
- II.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

III.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 experience as a clinician, teacher, and administrator in pediatric emergency medicine.

III.B. Faculty

III.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:

III.B.1.a) provide adequate supervision of fellows, and

III.B.1.b) ensure the educational and research quality of the program.

III.B.2. Two faculty members must be certified in pediatric emergency medicine or possess qualifications acceptable to the residency Review Committee.

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

III.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. 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.

III.B.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.

III.B.6. The pediatric emergency medicine faculty must:

III.B.6.a) have an active role in curriculum development and in the supervision and evaluation of fellows;

III.B.6.b) contribute both clinically and academically to the program; and,

III.B.6.c) have protected time to allow for teaching and active participation in scholarly activity.

IV. Facilities

- IV.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.
- IV.B. There must be comprehensive radiologic and laboratory support systems and readily available operative suites and intensive care unit beds.

V. Curriculum

V.A. Agreements Between Programs

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.

V.B. Program Design

- V.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. 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.
- V.B.2. Specialty-specific content must include at least four months of training in the specialty reciprocal to the fellow's prior residency.
- V.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.
- V.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. 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.

- V.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.
- V.B.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.

V.C. Patient Care

V.C.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.

V.C.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:

- V.C.2.a) abscess incision and drainage
- V.C.2.b) arterial catheterization
- V.C.2.c) arthrocentesis
- V.C.2.d) artificial ventilation
- V.C.2.e) cardiac pacing, external
- V.C.2.f) cardiopulmonary resuscitation in all of the following groups:
 - V.C.2.f).(1) adult medical resuscitation >18 years

V.C.2.f).(2)	adult trauma resuscitation >18 years
V.C.2.f).(3)	pediatric medical resuscitation <2 years
V.C.2.f).(4)	pediatric medical resuscitation >2 years
V.C.2.f).(5)	pediatric trauma resuscitation <2 years
V.C.2.f).(6)	pediatric trauma resuscitation >2 years
V.C.2.g)	cardioversion/defibrillation
V.C.2.h)	central venous catheterization
V.C.2.i)	closed reduction/splinting
V.C.2.j)	conversion of supraventricular tachycardia
V.C.2.k)	cricothyrotomy – translaryngeal ventilation
V.C.2.l)	dislocation/reduction
V.C.2.m)	endotracheal intubation
V.C.2.n)	foreign body removal
V.C.2.o)	gastric lavage
V.C.2.p)	gastrostomy tube replacement
V.C.2.q)	intraosseous access
V.C.2.r)	laceration repair
V.C.2.s)	pericardiocentesis
V.C.2.t)	nasal packing
V.C.2.u)	peritoneal lavage
V.C.2.v)	rapid sequence intubation
V.C.2.w)	regional nerve blocks
V.C.2.x)	sedation and analgesia
V.C.2.y)	slit lamp examination
V.C.2.z)	tracheostomy tube replacement
V.C.2.aa)	tube thoracostomy

- V.C.2.bb) umbilical vessel catheterization
- V.C.2.cc) vaginal delivery
- V.C.3. To ensure an acceptable level of resident performance and procedural and resuscitation competency, the program must:
 - V.C.3.a) discuss assessment tools, measurement process and outcomes with each resident;
 - V.C.3.b) document performance and procedural and resuscitation competency in resident files; and,
 - V.C.3.c) maintain documentation of these activities for review with the site visitor at the time of the site visit.
- V.C.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.
- V.C.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.
- V.C.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.
- V.D. Instruction in Program Administration

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
 - VI.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.

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

VII. Patient Population

VII.A. The available patient population should encompass the full spectrum of infants, children, adolescents, and young adults.

VII.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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