

Program Requirements for Residency Education in Pediatric Urology (Urology)

ACGME Common Program Requirements Appear In Bold

I. Introduction

A. Scope of Education

Subspecialty education in pediatric urology involves all aspects of congenital anomalies, childhood acquired urologic problems such as tumors and trauma, and overlapping problems of adolescence. The subspecialty education in pediatric urology must provide an experience of sufficient level for the pediatric urology resident to acquire advanced skills in the management of congenital anomalies and pediatric urologic problems.

B. Duration of Education

A pediatric urology program is 1 continuous clinical year taken subsequent to the completion of an accredited residency in urology. A pediatric urology educational program can be provided only in conjunction with an ACGME accredited urology residency program.

II. Institutions

A. Sponsoring Institution

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

The pediatric urology program must be centered at a children's hospital or a medical center with pediatric medical, surgical, and radiologic subspecialties. The sponsoring institution of the pediatric urology program may seek a complementary affiliation with other institutions that offer significant educational opportunities to the residency program.

B. Participating Institutions

1. Assignment to an institution must be based on a clear educational rationale, integral to the program curriculum, with clearly stated activities and objectives. When multiple participating institutions are used, there should be assurance of the continuity of the educational experience.

2. Assignment to a participating institution requires a letter of

agreement with the sponsoring institution. Such a letter of agreement should:

- a) identify the faculty who will assume both educational and supervisory responsibilities for residents;**
- b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;**
- c) specify the duration and content of the educational experience; and**
- d) state the policies and procedures that will govern resident education during the assignment.**

III. Program Personnel and Resources

A. Program Director

- 1. There must be a single program director responsible for the program. The person designated with this authority is accountable for the operation of the program. In the event of a change of either program director or department chair, the program director should promptly notify the executive director of the Residency Review Committee (RRC) through the Web Accreditation Data System of the Accreditation Council for Graduate Medical Education (ACGME).**
- 2. The program director, together with the faculty, is responsible for the general administration of the program, and for the establishment and maintenance of a stable educational environment. Adequate lengths of appointment for both the program director and faculty are essential to maintaining such an appropriate continuity of leadership.**
- 3. Qualifications of the program director are as follows:**
 - a) The program director must possess the requisite specialty expertise, as well as documented educational and administrative abilities.**
 - b) The program director must be certified in the specialty by the American Board of *Urology*, or possess qualifications judged to be acceptable by the RRC.**
 - c) The program director must be appointed in good standing and based at the primary teaching site.**

- d) The program director must be dedicated to and actively engaged in pediatric urology education.

4. Responsibilities of the program director are as follows:

- a) **The program director must oversee and organize the activities of the educational program in all institutions that participate in the program. This includes selecting and supervising the faculty and other program personnel at each participating institution, appointing a local site director, and monitoring appropriate resident supervision at all participating institutions.**
- b) **The program director is responsible for preparing an accurate statistical and narrative description of the program as requested by the RRC, as well as updating annually both program and resident records through the ACGME's Accreditation Data System.**
- c) **The program director must ensure the implementation of fair policies, grievance procedures, and due process, as established by the sponsoring institution and in compliance with the Institutional Requirements.**
- d) **The program director must seek the prior approval of the RRC for any changes in the program that may significantly alter the educational experience of the residents. Such changes, for example, include:**
 - (1) **the addition or deletion of a participating institution;**
(Participation by any institution providing more than 2 months of education in the program must be approved by the Residency Review Committee.)
 - (2) **a change in the format of the educational program;**
 - (3) **a change in the approved resident complement for those specialties that approve resident complement.**
 - (4) All permanent or temporary increases in resident complement must be approved in advance by the RRC.

On review of a proposal for any such major change in a program, the RRC may determine that a site visit is necessary.

- e) Selection of residents for appointment to the program in accordance with institutional and departmental policies and

procedures

- f) Selection and supervision of the faculty and other program personnel at each institution participating in the program
- g) Implementation of fair procedures as established by the sponsoring institution regarding academic discipline and resident complaints or grievances
- h) Monitoring resident stress, including mental or emotional conditions inhibiting performance or learning and drug- or alcohol-related dysfunction. Program directors and faculty should be sensitive to the need for timely provision of confidential counseling and psychological support services to residents. Educational situations that consistently produce undesirable stress on residents must be evaluated and modified.

B. Faculty

- 1. At each participating institution, there must be a sufficient number of faculty with documented qualifications to instruct and supervise adequately all residents in the program.**
- 2. The faculty, furthermore, must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities. They must demonstrate a strong interest in the education of residents, and must support the goals and objectives of the educational program of which they are a member.**
- 3. Qualifications of the physician faculty are as follows:**
 - a) The physician faculty must possess the requisite specialty expertise and competence in clinical care and teaching abilities, as well as documented educational and administrative abilities and experience in their field.**
 - b) The physician faculty must be certified in the specialty by the American Board of Urology, or possess qualifications judged to be acceptable by the RRC.**
 - c) The physician faculty must be appointed in good standing to the staff of an institution participating in the program.**
- 4. The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the faculty, and an active research component must be included in each program. *Scholarship* is defined**

as the following:

- a) the scholarship of *discovery*, as evidenced by peer-reviewed funding or by publication of original research in a peer-reviewed journal;
- b) the scholarship of *dissemination*, as evidenced by review articles or chapters in textbooks;
- c) the scholarship of *application*, as evidenced by the publication or presentation of, for example, case reports or clinical series at local, regional, or national professional and scientific society meetings.

Complementary to the above scholarship is the regular participation of the teaching staff in clinical discussions, rounds, journal clubs, and research conferences in a manner that promotes a spirit of inquiry and scholarship (e.g., the offering of guidance and technical support for residents involved in research such as research design and statistical analysis); and the provision of support for residents' participation, as appropriate, in scholarly activities.

5. **Qualifications of the nonphysician faculty are as follows:**

- a) Nonphysician faculty must be appropriately qualified in their field.
- b) Nonphysician faculty must possess appropriate institutional appointments.

C. **Other Program Personnel**

Additional necessary professional, technical, and clerical personnel must be provided to support the program.

D. **Resources**

The program must ensure that adequate resources (e.g., sufficient laboratory space and equipment, computer and statistical consultation services) are available.

Diagnostic facilities should include body-imaging equipment suitable for the care of pediatric patients.

IV. **Resident Appointments**

A. **Eligibility Criteria**

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

B. Number of Residents

The RRC will approve the number of residents based upon established written criteria that include the adequacy of resources for resident education (e.g., the quality and volume of patients and related clinical material available for education), faculty-resident ratio, institutional funding, and the quality of faculty teaching.

C. Resident Transfers

To determine the appropriate level of education for residents who are transferring from another residency program, the program director must receive written verification of previous educational experiences and a statement regarding the performance evaluation of the transferring resident prior to their acceptance into the program. A program director is required to provide verification of residency education for residents who may leave the program prior to completion of their education.

D. Appointment of Fellows and Other Students

The appointment of fellows and other specialty residents or students must not dilute or detract from the educational opportunities available to regularly appointed residents.

V. Program Curriculum

A. Program Design

1. Format

The program design and sequencing of educational experiences will be approved by the RRC as part of the review process.

2. Goals and Objectives

The program must possess a written statement that outlines its educational goals with respect to the knowledge, skills, and other attributes of residents for each major assignment and for each level of the program. This statement must be distributed to residents and faculty, and must be reviewed with residents prior to their assignments.

B. Specialty Curriculum

The program must possess a well-organized and effective curriculum, both didactic and clinical. The curriculum must also provide residents with direct experience in progressive responsibility for patient management.

1. Clinical Experiences

- a) The institution sponsoring the pediatric urology program must provide a sufficient volume and variety of pediatric urology experience to meet the needs of the pediatric urology resident without compromising the quality of resident education in general urology.
- b) To be considered for accreditation, the institution should have the following resources available for resident education: a broad spectrum of urologic diseases; a sufficient volume and broad variety of pediatric urology surgical procedures consisting of 200 major, 200 intermediate, and 100 minor procedures per year; and 2000 pediatric urologic outpatient visits per year, including urology subspecialty clinics.

Representative examples of these classifications include minor: circumcision, meatotomy, diagnostic endoscopy, percutaneous aspiration or tube insertion; intermediate: therapeutic endoscopy, inguinal surgery > 2 years, distal hypospadias with no urethroplasty, diagnostic laparoscopy; major: all abdominal surgery, flank surgery, hypospadias, laparoscopic surgery, valve ablation, inguinal surgery < 2 years.

- c) The clinical component of the program must include experience in:
 - i. The surgical aspects of pediatric urology. Such experience must be documented in an accurate, comprehensive, operative log maintained by the resident and reviewed by the program director quarterly. All operative procedures in which the pediatric urology resident acts as surgeon or teaching assistant should be separately documented.
 - ii. Inpatient consultation and outpatient management of pediatric urologic disease, with graded responsibility for patient care, which must be similarly documented and maintained
 - iii. Body imaging modalities used in the care of pediatric patients
 - iv. Performance and evaluation of urodynamic studies

- v. Multidisciplinary management of patients with urologic tumors
- vi. Multidisciplinary management of patients with urologic trauma
- vii. Multidisciplinary management of nephrological disease
- viii. Neonatal and intensive care unit treatment for all pediatric ages
- ix. Multidisciplinary management of myelomeningocele and other neuropathic bladder entities
- x. Multidisciplinary management of patients with problems relating to sexual development and medical aspects of intersex states
- xi. Performance of genetic counseling for renal and genital anomalies
- xii. Pediatric infectious disease and its treatment

C. Residents Scholarly Activities

Each program must provide an opportunity for residents to participate in research or other scholarly activities, and residents must participate actively in such scholarly activities.

D. ACGME Competencies

(N.B.: Section V. D. does not apply to this subspecialty)

VI. Resident Duty Hours and the Working Environment

Providing residents with a sound didactic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energy. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

A. Supervision of Residents

- 1. All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of residents at all times. Residents must be provided with rapid, reliable**

systems for communicating with supervising faculty.

2. Faculty schedules must be structured to provide residents with continuous supervision and consultation.
3. Faculty and residents must be educated to recognize the signs of fatigue, and adopt and apply policies to prevent and counteract its potential negative effects.

B. Duty Hours

1. Duty hours are defined as all clinical and academic activities related to the residency program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities such as conferences. Duty hours do *not* include reading and preparation time spent away from the duty site.
2. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.
3. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. *One day* is defined as 1 continuous 24-hour period free from all clinical, educational, and administrative duties.
4. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

C. On-call Activities

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal workday, when residents are required to be immediately available in the assigned institution.

1. In-house call must occur no more frequently than every third night, averaged over a 4-week period.
2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.

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

A new patient is defined as any patient to whom the resident has not previously provided care.

4. ***At-home call (or pager call)* is defined as a call taken from outside the assigned institution.**

- a) **The frequency of at-home call is not subject to the every-third-night limitation. At-home call, however, must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.**
- b) **When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.**
- c) **The program director and the faculty must monitor the demands of at-home call in their programs, and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.**

D. Moonlighting

1. **Because residency education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.**
2. **The program director must comply with the sponsoring institution's written policies and procedures regarding moonlighting, in compliance with the ACGME Institutional Requirements.**
3. **Any hours a resident works for compensation at the sponsoring institution or any of the sponsor's primary clinical sites must be considered part of the 80-hour weekly limit on duty hours. This refers to the practice of *internal moonlighting*.**

E. Oversight

1. **Each program must have written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours and the working environment. These policies must be distributed to the residents and the faculty. Duty hours must be monitored with a frequency sufficient to ensure an appropriate**

balance between education and service.

- 2. Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.**

F. Duty Hours Exceptions

An RRC may grant exceptions for up to 10% of the 80-hour limit to individual programs based on a sound educational rationale. Prior permission of the institution's GMEC, however, is required.

VII. Evaluation

A. Resident

1. Formative Evaluation

The faculty must evaluate in a timely manner the residents whom they supervise. In addition, the residency program must demonstrate that it has an effective mechanism for assessing resident performance throughout the program, and for utilizing the results to improve resident performance.

- a) Assessment should include the use of methods that produce an accurate assessment of residents' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.**
- b) Assessment should include the regular and timely performance feedback to residents that includes at least semiannual written evaluations. Such evaluations are to be communicated to each resident in a timely manner, and maintained in a record that is accessible to each resident.**
- c) Assessment should include the use of assessment results, including evaluation by faculty, patients, peers, self, and other professional staff, to achieve progressive improvements in residents' competence and performance.**

2. Final Evaluation

The program director must provide a final evaluation for each resident who completes the program. This evaluation must include a review of the resident's performance during the final period of

education, and should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. The final evaluation must be part of the resident's permanent record maintained by the institution.

B. Faculty

The performance of the faculty must be evaluated by the program no less frequently than at the midpoint of the accreditation cycle, and again prior to the next site visit. The evaluations should include a review of their teaching abilities, commitment to the educational program, clinical knowledge, and scholarly activities. This evaluation must include annual written confidential evaluations by residents.

C. Program

The educational effectiveness of a program must be evaluated at least annually in a systematic manner.

- 1. Representative program personnel (i.e., at least the program director, representative faculty, and one resident) must be organized to review program goals and objectives, and the effectiveness with which they are achieved. This group must conduct a formal documented meeting at least annually for this purpose. In the evaluation process, the group must take into consideration written comments from the faculty, the most recent report of the GMCEC of the sponsoring institution, and the residents' confidential written evaluations. If deficiencies are found, the group should prepare an explicit plan of action, which should be approved by the faculty and documented in the minutes of the meeting.**
- 2. The program should use resident performance and outcome assessment in its evaluation of the educational effectiveness of the residency program. Performance of program graduates on the certification examination should be used as one measure of evaluating program effectiveness. The program should maintain a process for using assessment results together with other program evaluation results to improve the residency program.**

VIII. Experimentation and Innovation

Since responsible innovation and experimentation are essential to improving professional education, experimental projects along sound educational principles are encouraged. Requests for experimentation or innovative projects that may deviate from the program requirements must be approved in advance by the RRC, and must include the educational rationale and method of evaluation. The sponsoring institution and program are jointly responsible for the quality of

education offered to residents for the duration of such a project.

IX. Certification

Residents who plan to seek certification by the American Board of Urology should communicate with the office of the board regarding the full requirements for certification.

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