

Principles of Pediatric Graduate Medical Education Draft

Preamble: Pediatric Graduate Medical Education should take advantage of what is known about how best to foster the development of clinical expertise and lifelong learning. It should focus on outcomes organized according to the six competencies of medical knowledge, patient care, professionalism, interpersonal skills and communication, systems-based practice and practice-based learning and improvement. Specific principles to which pediatric graduate medical education should be attentive include the following, each accompanied by comments:

1. **Changes in graduate medical education should be linked to measurable outcomes.** The importance of the link between medical education and patient outcomes is paramount. Other outcomes should also be specified and measured.
2. **Pediatric residency training should prepare future pediatricians for multiple pediatric career paths using curricula that offer opportunities for focused training.** Preparation for current and future pediatric careers is not met by “one size fits all” residency training that attempts to cover the entire breadth of child health problems. The flexibility that currently exists in the residency curriculum, with just 24 months specified by RRC requirements (17 if subspecialty rotations are electively configured), should be utilized to the maximum extent possible to serve resident career goals. Flexible time need not necessarily be a collection of 1 month, single discipline rotations. Residents should have access to curricula prioritized according to the epidemiology of the population or subpopulation for which they will care. The current curriculum, comprised largely of month-by-month goals and objectives, is unlikely to accomplish that.
3. **Pediatricians should be prepared to function as members of a pediatric healthcare team.** Transient resident participation in multidisciplinary patient care teams is limited by block rotation schedules. Participation in continuity of care experiences is limited by episodic resident availability. Neither is optimal for developing skills in teamwork, leadership and communication.
4. **Faculty must be prepared for resident teaching and assessment:** Faculty are not consistently trained to teach competencies other than medical knowledge and patient care nor are they trained to provide assessment and constructive feedback.
5. **The goals of residency education must be considered as part of a career-long continuum of medical learning.** Clarification of the goals of residency education requires consideration of other aspects of the continuum of learning. Experiences in the fourth year of medical school should be an important step in the educational progression of a pediatrician. The goals of residency training need to be examined in light what happens in the first few years after the end of residency; little is known about this important phase of learning. Residency education needs also to be considered in light of the possibilities offered by directed, monitored lifelong learning as part of a maintenance of certification program; development of a sense of personal responsibility for learning, confirmed by ongoing self- and external assessment, should begin during medical school and residency.

6. **Handicaps imposed by a fragmented system of clinical care must be minimized:** Discontinuity of resident experiences and resident-faculty interactions handicaps learning of disease progression and therapeutic response. It is not optimal for development of thematic competencies, e.g. practice-based learning and improvement, and interpersonal skills and communication. It compromises assessment of resident performance and provision of appropriate feedback. These handicaps must be acknowledged and their impact ameliorated.
7. **GME funding should track to appropriate education settings.** The traditional link of pediatric GME support to hospital-related care can eliminate valuable learning experiences. The support of hospital partners to change this is most likely in the context of proposals intended to improve patient outcome and satisfaction.
8. **The medical education workplace should be organized for maximum efficiency.** An efficient service organization assigns tasks to trained, experienced individuals. The use of inexperienced residents for tasks better done by non-medical staff in non-education settings compromises both patient care and education.
9. **The American Board of Pediatrics must be confident of candidate proficiency in each of the core competencies before awarding certification:** The test of medical knowledge is the only formal testing administered by the American Board of Pediatrics. The knowledge examination must be supplemented by rigorous assessment of other competencies.

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