Association of Pediatric Program Directors

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Caroline Fischer, MBA
Executive Director, Review Committee for Pediatrics
Accreditation Council for Graduate Medical Education
515 N. State St., Suite 2000
Chicago, IL 60654

Dear Caroline,

I am writing on behalf of the APPD in response to the request for comments on the latest revision of the Program Requirements for Graduate Medical Education in Pediatrics. The APPD has a process of conducting conference calls with discussion board postings and surveying that allow our organization to hear and respond to members' comments and concerns. We employed that process to gain member response to the proposed program requirements for 2013. We completed six calls over the last three weeks, with an average of 52 members registered on each call. There were some areas of the requirements that had general consensus, and those will be stated in the following detailed comments from the APPD. The APPD appreciates your willingness to clarify questions our organization had regarding the nuance of the requirements.

Overall, the APPD recognizes the effort that has been put into the revised program requirements and we appreciate that many of the recommendations from the APPD were incorporated and taken into consideration in the revision document. Thus, the collaborative manner in which they were developed is laudable. The APPD and its members strongly endorse the tenor of the document with the emphasis on flexibility and the further movement away from process requirements to competency-based education and assessment. The flexibility allows programs to use their areas of strength to their trainees' benefits. Lessening the number of requirements also encourages learners to deeply consider their learning needs and goals, thus making the individualized curriculum meaningful. We foresee innovative curricular modifications due to this philosophical shift in the requirements. Conversely, however, many members also believe that some RC requirements have, in the past, provided support and protection for programs, program directors, and trainees. Therefore, some limits and requirements as noted in the specific

APPD comments below must be reviewed for potential unintended consequences at institutions with realities of financial and service pressures. This nuance is quite important to APPD members. While being freed from prescriptive requirements has significant advantages to the educator; however, it may pose practical difficulties around institutional support and consistency for optimal program planning. In summary, the language in the requirements to provide more flexibility, to lessen the number of requirements and the length of the document, to incorporate an individualized curriculum for learners and to promote longitudinal experiences are generally viewed as a favorable development by APPD members.

We understand the ACGME's Frequently Asked Question (FAQ) section will guide and define the intent of requirements, yet these FAQs will not be completed until after the comment period is over. Therefore, it will be noted, in the attached document, the areas that the APPD membership would like to assist in informing the content of the FAQs. We understand that the FAQs can be modified and updated on a more frequent basis than the full requirements and recognize the ACGME's proposed strategy to have the FAQs inform programs of the details of the requirements. This is a new process that we have some uncertainty about, given that the FAQs may functionally serve as program requirements. We suggest that some elements of the proposed Pediatric Review Committee's Draft of the Pediatric Requirements may benefit from revision; other informational details may be clarified within the FAQ section. We look forward to assisting the committee in the construction of the FAQs.

Thank you for allowing the APPD the opportunity to comment on these important requirements that will shape medical education practices in the upcoming years.

Concerns and recommendations from APPD:

Line 94: APPD agrees with adding a requirement for larger programs. In a survey to our members that included 353 responses, many respondents were in favor of increasing the FTE needed to effectively and appropriately manage a program that adheres to all of the new requirements. There are more demands for assessment, curricular design, scheduling and administrative details in programs. More FTEs seem to be necessary. However, due to the fact that this sentiment is not a consensus with our membership, it is only mentioned here for informational purposes. If no changes upward in program FTE requirements are made with this iteration, the APPD strongly encourages the RC to carefully consider changes in the next iteration of the Pediatric Requirements. There is concern amongst many APPD members that for large programs, the 1.75 FTE does not represent a proportionate change from the smallest programs. For example, if a program of 12-30 residents gets 0.75 FTEs of program leaders (PDs and APDs) as stated in line 74, then a program of 120 should have 4 times that or 3.0 FTEs….not 1.75 FTEs. As well, it is critical that these program leaders are specified as APDs and PDs and not Primary Care Directors (formally CC directors) nor faculty that head up education in the ED, or in the NICU or other divisions, as specified in lines 317-320. Further, the APPD would suggest increasing the gradations for all of the FTEs in the future. We feel strongly that while the requirements are decreasing, the transformational change taking place in GME requires significantly increased time and effort from program leadership. Faculty development with regards to assessment of Milestones, documentation of outcomes in medical education and meeting and developing the "core faculty" will be a substantial increase in duties.

Line 354: Adding "Pediatric emergency medicine" to the list of required subspecialty faculty may pose a problem for many smaller programs, especially if "expertise" means board certification in PEM. We would favor encouraging expertise (i.e certification) in PEM with an option for programs without such an individual to prove and document expertise of another faculty member that teaches residents in an emergency room setting. While we think this could become a firm requirement, there should be time to allow for planning and recruitment of such individuals. We recommend that this requirement should be in the next iteration if the above suggestion is not allowed.

Line 429: "The number of combined positions should not exceed the number of categorical pediatric positions": The APPD would like clear direction in the FAQ on how this calculation is going to be done. That is, does it mean combined positions per year, or in the whole program? Does each combined learner count as one FTE or .5 FTE position? There was concern from a few programs that there are more Medicine-Pediatrics residents (because it is a four year program) than pediatric residents. (For example, a program with 4 categorical pediatric residents: total of 12; and 4 Medicine-Pediatrics residents per year: total of 16). We advocate that this should be calculated as number of intern slots per program. So, for example, a program with 6 categorical pediatric positions and 6 Medicine-Pediatrics positions offered in the match would be in compliance.

Line 469-478: The APPD is in agreement with this conceptual framework, however it may pose a problem for many Program Directors who do not know the concepts and literature behind Entrustable Professional Activities (EPAs). In the FAQ the APPD would appreciate the explicit listing of references regarding ten Cate's work. We suggest the following wording changes (bold shows suggested changes):

> Line 469: **The competencies should be taught and assessed in the context of the professional activities that residents will practice without direct supervision upon graduation.**
>
> Line 473: For each educational unit, the curriculum must contain competency-based goals and objectives, educational methods, and the evaluation tools that the program will use to assess each resident's **ability to perform the expected professional activities.**
>
> APPD members have been updated on the Milestones project and will be anticipating some language regarding the Milestones in this document. This area of the document seems appropriate to make mention of the Milestones.

Line 479: The term "regularly scheduled didactic sessions" as the section heading is outdated in the opinion of the APPD. It may make more sense to change this to "regularly scheduled educational activities" because many programs use self directed learning modules which residents must complete, procedural skills training, small group discussion, etc. Many activities are accomplished in these types of sessions other than "didactics".

Line 492: We agree with significant involvement of the faculty in the training programs educational activities. The APPD, however, respectfully disagrees with the concept of record keeping and documentation to prove faculty attendance. Programs have more meaningful ways to spend their time and energy. We propose that it would suffice to convey the intent of this requirement to say "The role of faculty in these educational activities is critical".

Section starting on Line 518: Understanding the complexity of gaining competence in procedural skills, the vast majority of APPD members think that endotracheal intubation of neonates and children should be in the list under patient care. Additionally, peripheral intravenous catheter placement should be in the upper list under patient care as well. Many program directors worry that if these are moved to the medical knowledge list (lower list), institutions will not fund simulation centers as vigorously, nor will real patient care experiences be made available to pediatric residents for the purpose of gaining abilities in these two key procedures for pediatricians; as these two procedures will now not be defined as "required" if they are placed under "medical knowledge".

Section starting on line 689-Line 864: Curriculum Organization and Resident Experiences: Again, the APPD applauds the efforts of the review committee to modify the requirements in an attempt to gain flexibility and better learning experiences for residents and programs. In our multiple phone conversations with membership a few themes emerged:

1. While flexibility is appreciated and endorsed, protection from loss of control of scheduling educational experiences are needed in the form of maximums.
2. Calculating the educational units is a new framework for programs, most would appreciate a guideline like we have now, of saying "a minimum of 40% of clinical training should be devoted to ambulatory experiences, and no more than 60% of the educational units, with exclusion of the 6 months individualized time should be inpatient"
3. Continue and encourage flexibility for programs regarding where they place their learners for "acute care" experiences.

More specifically:

Line 707: Individualized training is philosophically a good thing to prepare residents for their future practice, however concerns about providing core experiences to produce competent general pediatricians is a tension many APPD members have. Making this requirement clear that it needs to be heavily guided by program and faculty mentors is important. We suggest placing guidance in the FAQs: what is reasonable, how much tracking is going to be considered a positive for programs, which years of training does the RC think most of these 6 educational units will occur, etc.

Line 715: The APPD membership feels strongly that placing a maximum of "required" (i.e. exclusive of the individualized time) on the PICU and the NICU time is important. We suggest: "two educational units (with a maximum of four) of pediatric critical care" and "two educational units (with a maximum of four) of neonatal intensive care". We strongly suggest a caveat be mentioned requiring specific expectations regarding delivery room experience. Many members work within institutions that have delivery room experience during the normal newborn month or at one of many NICU locations. We would appreciate clear delineation of the expectation that graduates from a pediatric program should possess the abilities to resuscitate and stabilize a sick neonate. Some examples may be: two months of normal Newborn Care and two months of NICU if the normal newborn site is where the babies are delivered. Conversely, three months NICU experience should be required if an institution's NICU is where the recognition of sick neonates and their resuscitation takes

place. If this flexibility cannot be added we recommend three months of NICU at a minimum.

Line 723: One of the general themes commented on above of explicitly stating the percent of inpatient and outpatient time (not including the six individualized months) should be stated here. The APPD disagrees with "no more than 16 educational units of inpatient experience" for the following reasons: 1) Recognizing that the math may be done in a number of ways, but roughly, using four weeks blocks, there are 13 units per year. Over three years, there are 39 units total. Thus to keep with the current 60% allowable for inpatient learning the maximum number should be significantly higher than 16. Further, we recommend that the language should be familiar; use percentage of time vs. capping the overall inpatient educational units. For example, "a minimum of 40% and a maximum of 60% of clinical training should be accomplished in the inpatient pediatrics setting" 2) Concerns about not maintaining a service on a learning experience that erodes the residents' responsibilities. The inability for programs to schedule and provide that service in a consistent manner will decrease resident learning experience and ownership of patients, thus degrading their meaningful learning and training even further. 3) A maximum of 16 educational units as inpatient does not allow flexibility for various programs whose program design utilizes the inpatient environment for optimal resident education. While ambulatory subspecialty education may be desired, the actual educational goals may be optimally achieved in the inpatient setting in some programs.

Line 740: It is recommended that the RC should leave this section as is. The APPD agrees with this language. However, we suggest an explanation in the FAQs that encourage flexibility for programs: "programs should decide and use their institution's strengths regarding the setting of the subspecialty training. Some programs can best provide subspecialty education in the inpatient setting for some of the subspecialties, while other institutions can provide optimal resident education in subspecialty areas in the outpatient setting."

Line 802: The APPD membership is in disagreement with the section starting with: "A minimum of five educational units of ambulatory experiences, to include" because we feel that the current requirement is much more flexible and allows programs to build excellent curriculum and experiences in Acute Care by dividing up a total number of months between the emergency room and patients in outpatient acute care clinics. There was general consensus among participants on the calls that the RC should continue to mandate four months of Acute Care experience, with a minimum of two of those months being in an Emergency Room setting.

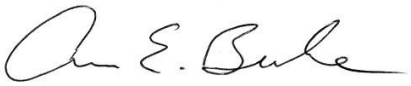
Line 816: The listing of choices in this section was somewhat confusing and unclear with regard to global health, adolescent medicine and developmental-behavioral pediatrics. We recommend placing Global Health in the second list (Line 774-800) of Subspecialty Experiences as a choice for programs and residents. Additionally, due to the requirement for both adolescent and developmental-behavioral units on line 735 and 738 under "subspecialty experiences", it is less confusing by far to not list those options under the "ambulatory experiences" section as well.

Line 828 which starts the section on longitudinal outpatient experience: Generally the APPD applauds the flexibility instilled in the intent of these requirements which allow for 36 half day sessions over a minimum of 26 weeks. Educationally, it makes sense to "count" a session two times if two sessions occurred in the same week. The resident still has the learning experience of taking care of patients in the medical home model. There was concern and tension about the lines 837-841 which seem to allow for PGY-3 to not continue in the outpatient clinic setting (formerly called continuity clinic), but rather to attend a subspecialty clinic instead. The APPD endorses a three year longitudinal experience in outpatient primary care pediatrics. Program Directors can, with the added flexibility of these requirements, schedule some residents, based on the residents individualized career goals, to participate in a longitudinal "subspecialty" clinic experience IN ADDITION to their primary care clinic. APPD members, both subspecialists and generalists, feel that the importance of three years of participation in pediatric primary care is necessary for most trainees to develop an experientially based concept of the medical home.

Additional considerations that are not related to specific lines in the document but pertain to the concept of service vs. education are of concern to APPD. The APPD strongly endorses language that defines the philosophy of balance of service and learning as less of a dichotomy but rather as a fine balance and interplay that makes a program successful to its learners. Service should not be interpreted as a negative in all situations. Service to patients is laudable and motivating for learners. Providing patient care service allows residents to feel needed and integral in the educational experience they are participating in; indeed, many valuable educational experiences occur only in the setting of providing service to patients. In this debate and question about service and education, the APPD collected 353 responses to a question about patient caps for interns and residents. Responses revealed the rich appreciation for the complex environment of graduate medical education with consensus that caps, if needed, should be locally determined and that the RC should provide program leaders the ability to determine the delicate interplay between service and education. Further, the majority of respondents agreed that there should be guidance from the RC in the FAQs on how to strike an appropriate balance.

Again, we appreciate the collaborative nature of this process and your willingness to be transparent in your interactions with the APPD. If there is any other information you would like from our members as decisions are made about the final requirements, please do not hesitate to contact us.

Sincerely,



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