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Caroline Fischer, MBA

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

Dear Ms. Fischer:

I am writing to you on behalf of the Academic Pediatric Association (APA) to provide comments regarding the latest revision of the Program Requirements for Graduate Medical Education in Pediatrics. Although many APA members are involved in research, child advocacy, public policy, and innovations in health care delivery, almost all APA members are educators and are actively involved with pediatric residency education. Many are in leadership positions in medical education and/or are involved in educational scholarship. In preparation for responding to the revised program requirements, we surveyed our membership in late July and early August with specific questions related to the proposed revision as well as solicitation of comments on the changes. Over 350 members responded. We also separately solicited comments from members of our Education Committee and from members of our Special Interest Groups that are focused on medical education. The comments that follow represent our members' reaction to the proposed revision to program requirements, rather than the specific point of view of the APA leadership.

The APA is a member organization of the Federation of Pediatric Organizations (FOPO), and was actively involved, along with other member organizations, in crafting FOPO's comments and response to the revision of the Program Requirements. We strongly support the recommendations included in FOPO's response.

We want to first make clear our recognition of the thoughtful deliberations of the ad hoc committee that led to these proposed changes, as well as the general approval of our membership for the move towards flexibility, innovation, and individualized curriculum that is evident in the revisions to the program requirements. It is our intention that the comments that follow stress the positive reactions of our members as well as their concerns. Nevertheless, it is the nature of commentary on change to more heavily focus on areas of concern or the need for clarity, than on agreement. We appreciate this opportunity to provide comments on the proposed revision and hope that you recognize the important perspective that our membership brings to this deliberation of requirements for pediatric residency education and the future of pediatrics.

Specific Comments:

Lines 512-583: Patient Care (competence in performing procedures) and Medical Knowledge (competence in the understanding of the indications, contraindications and complications of procedures).

The large majority of APA members who responded felt that intravenous line placement and endotracheal intubation, especially of neonates, should remain as procedures requiring training for competence. A majority also felt that arterial puncture and umbilical artery catheterization should remain as procedures requiring training for competence. In addition, a majority expressed concern regarding the change of wording for those procedures for which competence is not required. While recognizing the importance of an “understanding of the indications, contraindications, and complications” of those procedures, there was concern that “exposure” was no longer required. Members’ comments revealed a general concern about several factors:

- Differentiation of skills and value of pediatricians vs. other pediatric providers such as nurse practitioners and physician assistants.
- The need for such skills in community and rural settings.
- The need for such skills for pediatric hospitalists.
- Actual exposure to procedures, including observation of performance of those procedures or supervised performance of a few procedures, leads to a different level of knowledge than just reading or learning without such exposure.

Lines 704-710: A minimum of six educational units of an individualized curriculum.

The majority of APA members’ comments were positive about this innovation. Members thought this was a change that would lead towards needed flexibility in training and would allow residents to explore and differentiate their career pathways. However, even those members expressing strong approval frequently had concerns about implementation. These concerns included:

- Concerns that six units may be too long and perhaps could be limited to four units or “a minimum of four and up to six units”.
- Resultant unpredictability of schedule due to this change may lead to variation in the number of residents available on standard rotations. This may cause difficulties in planning the educational program and to concerns that residents will lose their status as an integral part of the health care system in which they are training. While this is not an educational concern, it could have the “unintended consequence” of affecting the number of pediatric resident lines supported by hospitals and lead to pediatric workforce shortages.
- Concerns about availability of mentorship, quality of mentorship, and burden on the mentors if there was no financial reimbursement.
- Concerns that without clear structure and effective mentorship/guidance, this individualized time could be “wasted” or just become additional electives and not lead to a meaningful individualized career focus.
- Concerns that some residents will be encouraged to make career decisions too early in their training.
- Concerns about the compression of the “core curriculum” for all residents.
- Lack of clarity regarding the ability of residency programs to create “tracks” as part of this individualized curriculum. Such tracks could alleviate concerns about variation in resident availability and lack of clear structure for the individual curriculum.

Therefore, while the APA supports the innovation of individualized curriculum for residents, we would recommend more detailed focus on and clearer guidance regarding implementation strategies.

Lines 712-730: Inpatient Care Experiences.

A significant minority of APA members were concerned about the limit of a maximum of 16 educational units of inpatient experience. Those concerned felt that either a larger number of units (perhaps 19 to 20) or a specific percentage of total experience (50-60% of training time including subspecialty rotations but not including the individualized curriculum) would provide greater flexibility to programs as well as important educational benefits in knowledge and skills in the care of sick patients.

A large majority of APA members were concerned that the new requirements do not have a maximum number of educational units in intensive care (apart from the individualized curriculum) and that the proposed guidelines could lead to 10 units of intensive care in some programs. A consensus was that approximately seven units of intensive care should be the maximum.

Lines 828-863: Longitudinal Outpatient Experience.

The APA appreciates the Review Committee's inclusion of the concept of the "medical home" as an important aspect of the longitudinal ambulatory care experience. However, APA members feel that all three years of the longitudinal ambulatory care experience should be in primary care pediatrics. Many members were also in favor of the possibility of offering a longitudinal subspecialty experience to interested residents, but felt that this experience should be in addition to the primary care pediatrics longitudinal care experience. Their concerns were:

- The third year of continuity clinic is when residents "consolidate their advanced skills in outpatient independent decision-making," especially about complex patients. The third year is also when therapeutic relationships between residents and families come to fruition. Learning to be responsible for patients in the medical home model, an important educational goal for future pediatricians, whether generalists or subspecialists, requires both the acquisition of independent decision-making regarding complex outpatients and the development of therapeutic relationships with families, and is likely to be negatively impacted by this change. The third year also provides an opportunity for third year residents to be teachers for more junior residents and this educational opportunity will be lost.
- Even those going into subspecialties need a firm grounding in general pediatrics, especially regarding issues of development, behavior, mental health.
- Subspecialty training programs will provide this type of experience for most residents going into subspecialty fellowships.

APA members recognized that requiring only 26 weeks of longitudinal ambulatory experience will allow programs more flexibility, but a majority felt that having a longitudinal ambulatory experience only half of the year would significantly impact even the imperfect continuity already provided in such clinics. They felt that approximately 34 weeks was more appropriate.

Additional Comments:

Two-thirds of the responders expressed concern regarding the lack of a percentage of training in ambulatory care (previously 40%) as well as the lack of emphasis on general pediatrics in both the inpatient and outpatient care experiences. While recognizing the importance of the flexibility and individualized training in the proposed revision, members believed that the lack of focus on general pediatric training may cause a downstream reduction of the workforce in general pediatrics. They also stressed the importance of excellence in training in general pediatrics for subspecialists as well as generalists.

Summary:

The APA recommends the following for consideration by the Review Committee for Pediatrics of the ACGME:

1. Intravenous line placement and endotracheal intubation, especially of neonates, as well as arterial puncture and umbilical artery catheterization, should remain as procedures requiring training for competence.
2. Limitation of inpatient care experiences to 16 educational units should be reconsidered. We suggest either increasing the number of units (perhaps to 19 or 20) or adding wording regarding the overall percentage of inpatient time to 50-60% (to include inpatient time in subspecialty rotations but not inpatient time during the individualized curriculum).
3. Clearly stating a limit to the number of units of intensive care experience during training. We would suggest a limit of six to eight educational units.
4. Maintaining the requirement of a three year longitudinal ambulatory experience in primary care pediatrics and offering a subspecialty longitudinal ambulatory experience in addition to the primary care pediatrics experience. We would also recommend extending the number of weeks per year of the longitudinal ambulatory experience beyond the proposed 26 weeks, perhaps to 34 weeks.
5. The APA supports the innovation of individualized curriculum for residents, but would recommend more detailed focus on and clearer guidance regarding implementation strategies.

The APA appreciates the ability to provide these comments and recommendations to the Review Committee for Pediatrics. We are happy to participate in any ongoing conversations about this critically important topic.

Respectfully submitted,



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President, Academic Pediatric Association.