Proposed Pediatrics 2024 Requirements

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From: Joseph W. St. Geme, III, M.D., AMSPDC President
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On behalf of the Association of Medical School Pediatric Department Chairs (AMSPDC), I am providing our organizational response to the recently disseminated ACGME Program Requirements for Graduate Medical Education in Pediatrics. We appreciate the partnership with the ACGME as we work together to achieve our goals of providing outstanding care to pediatric patients and educating the next generation of pediatricians. The training requirements for our pediatric residency programs are critical to ensuring optimal health outcomes of our diverse population of children and adolescents. We are encouraged by many components of the proposed revisions to the pediatric training requirements, including the recognition of working in interdisciplinary teams, the role of the pediatrician in the context of a health care system, and the need to respond to variation in patient volumes and acuity, as these factors affect the workload of the team, the well-being of the residents, and the safety of the patients. On the other hand, we have significant concerns about a number of the proposed changes and the likelihood of both short-term and long-term negative consequences if these changes are approved as written. In order to address a complex range of patient needs, graduates of our training programs must be able to function without supervision. This goal can best be accomplished with continued exposure to children in inpatient settings where residents can learn complex pediatric disease from subspecialty experts. Pediatric trainees must learn the intricacies of inpatient medicine in order to understand the component of care that can safely be delivered in the ambulatory setting. Core educational experiences such as exposure to acutely ill children in pediatric emergency departments and intensive care units are integral to the maturation of our pediatric workforce.

From a broader perspective, we believe the proposed requirements will add significantly to the financial burden of children's hospitals and departments of pediatrics. To compensate for the proposed reduction in inpatient time for trainees, hospitals and departments will have to recruit additional front-line providers, adding significant expense and likely falling short of the necessary person power given the inadequate pools of pediatric advanced practice providers and pediatric hospitalists. Furthermore, we are concerned that the proposed changes will compromise the concerted efforts of AMSPDC to strengthen the pediatric subspecialty workforce, a major initiative that is critical for the future health of children.

We understand that the proposed modifications are scheduled to take effect July 1, 2024. We are requesting a meeting with the ACGME Pediatric Review Committee (RC), as we think these proposed changes to our pediatric curriculum can and should be revised to meet the needs of our patients, our trainees, and the educational organizations who are responsible for supporting pediatric training.

To guide our discussions with the Pediatric RC, we offer the following critique of the proposed training requirements.

Pediatric Subspecialists and Board Certification

We are concerned that the ACGME has removed the requirement for board certification across all of our pediatric subspecialty services. We believe this change will not achieve the ACGME goals that state **"Pediatricians are physicians who provide comprehensive patient-centered preventive, acute, and chronic care for the growing and developing child from birth through the transition to adult care,"** and are **"self-directed lifelong learners who stay current with advanced and emerging technologies."** Rather, our trainees must learn from pediatric subspecialists who possess a level of expertise that is essential for ensuring the optimal education of residents. They achieve this level of expertise by board certification, and they remain current with their discipline with the American Board of Pediatrics Maintenance of Certification program. The pediatrician in training must interact with, learn from, and be educated by those who are most advanced in their discipline. To achieve excellence in our training programs and advance the next generation of pediatricians, we must recognize the importance of subspecialization and pediatric subspecialty board certification.

While we appreciate the roles of generalists and other members of our workforce, we have an obligation to have a hematologist-oncologist teach current approaches to precision medicine. Similarly, neonatologists must be available to teach perinatal care and neonatal resuscitation, and physicians who are board certified in adolescent medicine are best equipped to convey key aspects of care for transgender youth, offer advice on family planning, and discuss challenges related to adolescent health. In addition, board certification in developmental and behavioral pediatrics will identify those individuals who are best equipped to provide education regarding autism and other developmental conditions, a key aspect of the emphasis on mental and behavioral health. The best way to achieve the goal of life-long learning will be to require board certification of our pediatric workforce, including pediatric subspecialists.

Our understanding is that the removal of the requirement for board certification is specific to Pediatrics. For instance, the ACGME requirements for General Internal Medicine state, **"There must be physicians with certification in internal medicine by the ABIM or AOBIM to teach and supervise internal medicine residents while they are on internal medicine inpatient and outpatient rotations." (See Program Requirements in General Internal Medicine - II.B.1.a.(1))**

For these reasons, we strongly recommend that the Pediatric RC require subspecialty certification and that the following statement remain a part of the program requirements: **Faculty members with subspecialty board certification must function on an ongoing basis as integral parts of the clinical and instructional components of the program in both inpatient and outpatient settings.** Elimination of this requirement will negatively impact our ability to ensure that the education of our trainees is provided by faculty who have the expertise needed to provide our patients with the highest quality of care.

Core Faculty Funding Mandate

We support the concept of core faculty, but we do not agree with the requirement that core faculty **"… must be provided with support equal to an average dedicated minimum of 0.1 FTE for educational and administrative responsibilities that do not involve direct patient care. (Core)" (Section II.B.4.c).**

In our COVID pandemic environment, pediatric departments have experienced significant challenges with funding, underscored by poor Medicaid reimbursement. These challenges will likely increase with the loss of health insurance coverage for millions of children impacted by Medicaid redetermination and the withdrawal of the public health emergency. As pediatric leaders, we strongly believe that we need flexibility to determine how we provide support to core faculty without a specific effort mandate by the ACGME, in particular given that this requirement will further exacerbate the financial strain on pediatric departments.

It is our strong recommendation that the ACGME describe the expected responsibilities of core faculty and leave the complicated decision of providing salary support for core faculty to programs and institutions.

Mental Health Training

We agree that providing mental health experiences is appropriate given the current behavioral health crisis. However, the current language states that there must be a four week ambulatory mental health rotation. There are two challenges with this requirement. First, access to mental health clinicians is quite limited, and building outpatient rotations in mental health will need additional time and resources to offer this experience. Second, many of our institutions have large numbers of patients with behavioral health disorders on our inpatient services and in our emergency departments as additional or alternative settings for strong educational experiences.

We request that the Pediatric RC allow mental health training to include experiences in other settings (inpatient behavioral health units, emergency departments, etc). Many of our departments offer integrated behavioral health services in our patient-centered medical home; thus, we ask the Pediatric RC to allow our programs to meet this requirement by recognizing the mental health training that occurs in the context of the continuity clinic experience, where foundational care in behavioral health is being provided.

Critical Care Training

We believe that exposure to critical care pediatrics must be a core element of our training programs. All pediatricians must be fully capable of identifying and stabilizing a critically ill child, requiring more than limited experience in ICUs during their training. We strongly oppose any decrease in the amount of critical care experiences. We do not believe that the requirement of 12 weeks of critical care time is sufficient to meet this goal and would suggest that the requirement for training clearly state the need to have a minimum of 8 weeks of training in both the pediatric intensive care unit and the neonatal intensive care unit (for a total of at least 16 weeks), consistent with current program requirements.

Procedural Training
The elimination of required procedural experience also threatens the quality of care for children as residents continue on their career path. While we agree that the previous list of required procedures was excessive, we believe that that all pediatricians should be competent in a handful of basic procedures by the end of their training, including bag mask ventilation, neonatal and pediatric resuscitation, lumbar puncture, iv placement, and phlebotomy.

Inpatient Experiences
The dramatic increase in outpatient experience overlooks the major advantages of inpatient care vs. outpatient experiences in providing residents with opportunities for independent responsibility and decision making. The decrease in inpatient time will result in residents no longer being essential members of inpatient teams, likely diminishing the quality of the learning experience. The decrease in inpatient time by residents will require that hospitals find other healthcare providers to fill this gap, yet the pools of advanced practice providers and hospitalists as the logical replacements are likely insufficient to meet this need, thereby jeopardizing care for children.

We believe departments should have flexibility to achieve our education goals. It is time for the program requirements to allow pediatric training programs and our program directors to have the discretion to determine which settings are best for achieving specific training priorities. We believe the Pediatric RC should generate general principles and delegate to programs the responsibility for achieving these principles based on the mission of the institution and the resources available to them. This approach would allow us to accommodate the diversity in resident career interests and also meet our goals as academic pediatric programs.

We look forward to the opportunity to review our proposed changes with the leadership of the Pediatric RC.