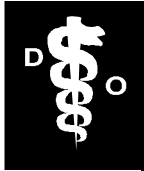

BASIC STANDARDS FOR RESIDENCY TRAINING IN PEDIATRICS

American Osteopathic Association

and the

American College of Osteopathic Pediatricians

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BASIC STANDARDS
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ARTICLE I - INTRODUCTION

These are the basic standards for residency training in pediatrics as approved by the American Osteopathic Association (AOA) and the American College of Osteopathic Pediatricians (ACOP). These standards are designed to provide the osteopathic resident with advanced and concentrated training in pediatrics and to prepare the resident for the examination for certification in pediatrics.

ARTICLE II - DEFINITION AND PURPOSES

The specialty of pediatrics consists of the study and management of care of newborns, infants, children and adolescents, as well as the diagnosis and treatment of their diseases. The purposes of an osteopathic pediatric training program are to:

A. Provide training and experience to enable the resident to care for the whole patient, incorporating the osteopathic concept of the integrated function between the musculoskeletal and nervous systems in the practice of pediatrics.

B. Provide continuity of advanced educational experience and increased patient care responsibilities to prepare the resident for the complete medical care of the pediatric patient, and to broaden his/her understanding of the fundamentals of pediatric medicine, behavioral sciences and basic sciences related to the specialty.

C. Provide a structured educational program that will enable the resident, upon completion of training, to demonstrate expertise in clinical proficiency and in the technical skills required to perform at a level expected by a peer group of qualified pediatricians.

ARTICLE III - INSTITUTIONAL REQUIREMENTS

A. To be approved by the AOA for residency training in pediatrics, an institution must meet all the requirements as formulated in the Residency Training Requirements of the AOA and documents that the program meets the policies and procedures of the OPTI of which it is affiliated.

B. The institution must provide sufficient patient load to properly train a minimum of three (3) residents in pediatrics. No program may accept a new resident unless at least two (2) other residents are also in the program. New programs shall require a minimum of three (3) residents to begin.

C. The institution shall maintain an adequate medical library containing carefully selected texts, the latest editions of medical journals and other appropriate publications, in various branches pertaining to pediatrics. The library shall be in the charge of a qualified person who shall act as custodian of its contents and arrange for the proper cataloging and indexing that will facilitate investigative work by the residents. Access to Med-Line searches and inter-library loans should also be available. Interactive learning and/or other computerized learning resources should be available.

D. The institution shall develop and maintain an evaluation mechanism for rating residents, program directors and the training program to ensure ongoing quality.

E. The institution shall provide for the interaction between the pediatric service and other departments including, but not limited to, obstetrics, medicine, pathology, radiology, emergency medicine, and surgery.

F. The teaching staff shall be composed of qualified physicians with diversified experience in clinical pediatrics, basic and behavioral sciences and allied health fields. The competence and availability of the teaching staff must provide supervision of daily clinical care and teaching experiences. The role models set by the teaching staff in their dedication to patient care are essential to the excellence of the training program.

G. The institution must provide an opportunity for exposure in a supervised ambulatory site for continuity of care training that will suit the needs of the tracks offered. Institutional clinics or pediatricians' offices may be used. The residents must function as the patients' primary care providers.

H. The institution must provide a written policy and procedure for the selection of residents.

   1. The department of pediatrics shall make resident selections in compliance with the regulations of the governing body of the institution.

   2 Each applicant shall be notified of the decision made on his/her appointment in writing.

   3. Applicants that are selected shall be notified that their appointment is for one (1) year, subject to annual renewal for the term of the residency.

I. The institution shall execute a contract with each resident in accordance with the Residency Training Requirements of the AOA.

J. Upon satisfactory completion of the training program, the institution shall award the resident an appropriate certificate. The certificate shall confirm the fulfillment of the program requirements, starting and completion dates of the program and the name(s) of the training institution(s) and the program director(s).

ARTICLE IV - PROGRAM REQUIREMENTS

A. The residency training program shall commence only after it has received the recommendation of the Council on Postdoctoral Training (COPT) and the approval of the AOA Board of Trustees.

B. The residency training program in pediatrics shall be three (3) years (thirty-six (36) months) in duration. The training shall consist of: three (3) years (thirty-six (36) months) of general pediatric medicine, the first year of which may be an AOA-approved specialty track internship with concentration in pediatric medicine and its subspecialties taken in an institution in which an AOA-approved pediatric residency exists and which meets the criteria for approval of the ACOP and the AOA; or, three (3) years (thirty-six (36) months) of general pediatric medicine after a traditional, AOA-approved internship.

C. At least twenty-four (24) months of the required thirty-six (36) months must be served at the same institution unless exemption is granted by the ACOP.

D. The general educational content of the residency training program shall include:

1. The neuromuscular component of disease and the osteopathic concept of evaluating and treating the whole patient in inpatient care and ambulatory care settings.

2. Development of basic cognitive skills and knowledge pertaining to normal physiology and pathophysiology of the body systems and the correlating clinical applications of medical diagnosis and management.

3. Sufficient experience and training in the following procedures and development of respective interpretation skills. Verification by the program director of experience and competency in required procedures is necessary.

   a. Required: Lumbar puncture, intravenous access, endotracheal intubation, umbilical artery lines, umbilical venous lines, arterial blood gas sampling, suturing of lacerations, suprapubic aspiration, bladder catheterization, phlebotomy, newborn resuscitation, intraosseous access, exchange transfusion, conscious sedation, management of ventilators, pelvic examinations, interpretation of pulmonary function tests, and pediatric advanced life support (PALS) and neonatal resuscitation program (NRP).

   b. Recommended: Tympanocentesis, electrocardiograms, bone marrow aspiration, circumcision, thoracentesis, chest tube insertion, central venous pressure/peripherally inserted central lines, pericardiocentesis, central venous pressure lines, and skin testing.

c. Optional: Endoscopy and casting of fractures.

4. Bio-psychosocial knowledge and skills shall be taught in both formal and informal settings throughout the residency. These shall include such factors as medical sociology, doctor/patient/parent/guardian/family communication, crisis recognition and intervention, the effects of psychological components of health states, interviewing skills, recognition and management of uncomplicated behavioral disorders, substance abuse care, and death and dying.

5. Elective training may be included and can be offered as inpatient or ambulatory experience in general pediatrics, pediatric subspecialty or certain non-medical specialties in accordance with the requirements for content (Article V). All elective training must be approved by the program director.

6. Ambulatory Care: To include the traditional care of the well child and also the child with acute illness, trauma, poisoning and chronic disorders. Training must enable the resident to develop skills in counseling and guidance, developmental appraisal, referral, consultation, health maintenance assessment and the management of a practice as well as to prepare the resident to assist in the continuing care of the developmentally disabled child. Participation in the activities of the outpatient department and the emergency medicine department are important, as they pertain to the pediatric patient including child abuse evaluations, treatment and reporting.

7. Inpatient Care: To include the management and understanding of functional and organic diseases of newborns, infants, children and adolescents. Training shall enable the resident to appraise and react to the rapidly changing clinical status of the patient as well as to handle multiple or conflicting consultations and coordinate services for individual patients requiring multidisciplinary care.

8. Experience in the delivery room with newborn care and resuscitation, enabling the resident to become skilled in the process of infant stabilization when specialized facilities are not available prior to transfer. The resident must be capable of managing the seriously ill newborn.

9. Experience in the newborn nursery to enable the resident to become proficient in the management of such conditions as asphyxia, hypoglycemia, jaundice, respiratory distress syndrome, sepsis and other conditions inherent in the management of a neonate. The resident shall demonstrate knowledge of the normal growth and development of the fetus and the effects of drugs, infection and malnutrition.

10. The training program shall make available pediatric board review opportunities to each resident, either in the form of weekly programs (such as Nelson's Club or Journal Club), or by sponsoring the resident's attendance at a pediatric board review course. Residents must attend at least one ACOP meeting prior to completing their residency.

11. Training in both the inpatient and ambulatory practice of pediatrics shall be provided to enable the resident to do complete histories and physicals, plan comprehensive care and mobilize available community resources in the holistic care of the patient.

12. Provide training to make sound medical judgments with an understanding of ethical and legal considerations as well as cultural diversities and the care of the patient.

E. Advanced Placement

1. Advanced placement into osteopathic pediatric medicine from non-pediatric medicine fields or after traditional osteopathic internships. One (1) month of credit may be awarded for each month of training in general pediatrics or its subspecialties taken under the direction of a pediatrician in an AOA- or ACGME-approved program. In addition, elective credit may be granted in non-pediatric medicine specialties to include radiology, pathology, emergency medicine and ambulatory surgical specialties (gynecology, orthopedics, ENT) up to a maximum of two (2) months credit towards a total program. Total advance placement cannot exceed twelve (12) months towards the entire program.

2. Mechanism to request advanced placement.

   A request for advanced placement must be received from both the resident and the current pediatric program director and must include:

   A. Letter requesting advanced placement standing from resident.
   B. Letter requesting advanced placement standing from program director. (The resident's academic level in comparison to other residents at the training level if advanced placement were to occur.) Determination of advanced placement within these guidelines shall be made by the ACOP GME committee based on the concept of equivalency and approved through the COPT and Board of Trustees of the AOA.
   C. ACOP resident annual report for previous training.
   D. AOA program director report for previous training.

F. If necessary, the program must provide suitable arrangements for outside rotations to ensure the complete education of the resident and for broadening the scope of training. All rotations must meet standards as formulated in the Residency Training Requirements of the AOA.

G. At least twenty-four (24) months of training must include actual clinical pediatric patient responsibility, and no more than six (6) months of the thirty-six (36) months of training can be assigned in non-pediatric services.

H. The program shall provide adequate exposure to medical research/review skills and methods of presentation, including information relating to changes in the healthcare delivery system. Options for meeting the above requirement shall be determined by the program director and may include, but not be limited to, any of the following:

1. Original research studies (basic science, clinical studies, health services research) and writing, once per training program;

2. Retrospective studies (medical records analysis), once per training program;

3. Entry into an annual resident medical writing competition, once per training program;

4. Presentation of a scientific poster/abstract, once per training program;

5. Resident education program on research types and methodology, ongoing;

6. Resident education program on biostatistics, ongoing;

7. Formal written critique of resident presentations of journal club articles/literature review (i.e., credibility of material, data, statistics and study design), twice annually;

8. Educational program for residents in health services research, policies, administration (i.e., access of population groups to healthcare, compliance issues, public policies, managed care, etc.), ongoing;

9. Educational program on "How to read and understand the medical literature," ongoing;

10. Formal written critique of medical resident lecture presentation of researched topic, twice annually.

I. The program faculty must complete and review a performance evaluation with each resident at the conclusion of each rotation.

These activities must be documented and available for inspection.

J. An ongoing document showing residents mastery of ACOP competencies must be maintained by program director (See Appendix F).

ARTICLE V - CURRICULUM

A. Introduction

Each component of the curriculum must be a structured educational experience that reflects an appropriate balance between clinical and didactic activities. Goals and objectives and a method of evaluation must exist for these curricular components. These goals must be distributed to residents and members of the teaching staff and should be available for review.

B. General Pediatric Training

1. Ambulatory

The curriculum must include at least six (6) months in general ambulatory settings, including general pediatric clinic, acute illness clinic, emergency department, private practice settings, adolescent clinics and behavioral-developmental clinics, in addition to the required time spent in the continuity clinic.

The following requirements pertain to ambulatory general pediatric care:

a. Continuity Clinic

To develop an understanding of the longitudinal aspects of growth, development, diseases and problems, continuing care of a group of patients throughout the three (3) years of training is essential. Residents must have an assignment of at least one half-day per week in a continuity clinic throughout the first two years of training—Two half days are required during the third year of the residency. This assignment should receive priority over other duties and may be interrupted only for vacations and outside rotations located at too great a distance to allow the residents to return for the clinic.

The continuity patient population includes well patients together with those with complex and chronic problems. The teaching staff must monitor the appointment system to ensure the adequacy of the patient numbers and type of problems for each resident. A system within the continuity clinic should be in place to arrange for the care of continuity patients when residents are not available. (See Appendix C for further guidelines.)

b. Office-based assignments

Office electives or assignments may constitute up to two (2) months in each of the second and third years of the pediatric residency. Assignments may be solid blocks of time or may run concurrently with other assignments on a part-time basis. Preceptors using this educational method must submit to the program director adequate descriptions of the content of these educational experiences each time the program is reviewed. Logs of all patients seen must be kept by residents. Preceptors must be designated specifically by the director and chosen for their willingness and ability to teach. Residents must be involved in decision-making processes and not function merely as observers. Participation in hospital preceptorships is encouraged. The role of the resident in the management of inpatients should not, however, conflict with that of other house officers assigned to inpatient duty. A resident may not be employed to substitute for a pediatrician temporarily absent from the office. A preceptor must be physically present to supervise the resident and ensure a continuing educational experience.

A resident in an office-based assignment should be responsible for the maintenance of office records as well as for the management of patients assigned to him or her. The program director is responsible for the documentation of the preceptor's activities, including verification of the qualifications of the preceptor, written evaluation of the resident by the preceptor, and evaluation of the preceptor by the resident.

c. Emergency and acute illness experiences

In addition to their experience with acutely ill pediatric patients in the continuity clinics, residents must have at least three (3) months of experience managing pediatric patients with acute problems, such as respiratory infections, dehydration, coma, seizures, poisoning, trauma, lacerations, burns, shock and status asthmaticus. At least one of these months must be a block rotation in an department during which the residents have the opportunity to function as the physician of first contact for pediatric patients with the problems mentioned above. It is not a sufficient educational experience if the pediatric residents function only on a consultative basis.

Residents in these settings must be supervised by pediatric teaching staff members or by other attending staff who have extensive experience in and knowledge of the care of pediatric emergencies. These individuals must participate with the members of the pediatric teaching staff in the establishment of educational goals for this experience and in the evaluation of the pediatric residents.

d. Adolescent Medicine

There must be a structured experience in adolescent medicine involving didactic and clinical components and inpatient and ambulatory experience. It must be under the direction of a teaching staff member with expertise in adolescent medicine. Residents must have patient care experiences in the following: health maintenance examinations, family planning, sexually transmitted diseases and gynecology.

Experiences in chemical dependency, sports medicine, health needs of incarcerated youth, and college health issues are strongly recommended. A separate clinic for adolescent patients is desirable. Also recommended is experience with healthcare for adolescents provided in schools, group homes, family planning clinics, and inpatient psychiatric facilities.

e Behavioral Developmental Pediatrics

Residents must participate in a structured experience in normal and abnormal behavior and development involving didactic and clinical components. Experience must include the care of patients from newborn through young adulthood.

Special attention should be given to anticipatory guidance and developmental and behavioral issues. Pediatric patients with chronic diseases and multiple problems, including physical and emotional disabilities, are in great need of comprehensive, coordinated care. Residents must learn how to serve as care managers for these patients and to function as a part of a healthcare team. Subspecialty consultants and ancillary personnel must be available to the residents as they care for these patients.

2. Inpatient Care

The list of diagnoses and patient data requested in the program information forms must show evidence of a sufficient number and variety of complex and diverse pathologic conditions to ensure that the residents have adequate experience with patients who have acute and chronic illnesses as well as those with life-threatening conditions in the pediatric age groups. Residents at more than one level of training must interact in the care of inpatients, typically by having the second and third year residents acting in a supervisory capacity.

The patient load for each first-year resident should allow time for close and effective management and detailed study of patients, yet should challenge the resident with diverse and complex problems. A first-year resident should be responsible for a sufficient number of patients, depending on the average length of stay and the nature and severity of illness. Second- and third-year residents may be involved in the care of more patients than first-year residents. Pediatric faculty with broad experience in primary care pediatrics should actively participate in the education of residents in the inpatient settings through inpatient rounds. Inpatient pediatric rotations must be a minimum of three (3) months and a maximum of six (6) months.

3. Newborn nursery Care

There must be at least two (2) months that include care of newborns in the newborn nursery setting. This experience must include routine physical examination of the newborns, attendance at routine and high risk deliveries and C-Sections (alternatively, may be included to IN NICU rotations), counseling of the parents on the care, and comprehensive issues of the neonatal period. This rotation may be combined or included with other rotations.

C. Electives

1. Subspecialty Electives

The total amount of time committed to all subspecialty elective rotations must be at least eleven (11) but not more than fifteen (15) months. No more than six (6) months may be spent on any one subspecialty during the three (3)-year residency. The subspecialty rotations should occur primarily in the second and third years of training.

2. Critical Care

A. There must be a rotation in neonatal critical care (Levels II and III) for a minimum of three (3) months, exclusive of experience with the normal newborn. Residents must have the opportunity to participate in the resuscitation of newborns in the delivery room. Subspecialty rotations may include the following: allergy/immunology, cardiology, child psychiatry, critical care, dermatology, endocrinology/metabolism, gastroenterology, genetics, hematology/oncology, infectious disease, nephrology, neurology, pediatric radiology, pediatric rheumatology, pediatric surgery, pulmonology
B. There must be a rotation in the pediatric intensive care unit for a minimum of one (1) month.

C. The maximum number of required rotations in both critical care areas combined may not exceed six months

3. Subspecialty Supervision

Subspecialty experience must be supervised by pediatricians who have been certified in their pediatric subspecialty areas by the appropriate sub-boards of the American Osteopathic Board of Pediatrics (AOBP) or by another specialty board or who possess suitable equivalent qualifications. The acceptability of equivalent qualifications will be determined by the program director. These individuals must be directly involved in the supervision of residents during their training in the subspecialties.

4. Content of Required and Elective Subspecialty Experiences

All subspecialty rotations must have an adequate number and variety of patients to provide each resident with an appropriately broad experience in the subspecialty. These experiences also must include attending subspecialty conferences, appropriate reading assignments, and acquainting the residents with techniques used by subspecialists.

Each resident must have patient care responsibilities as a supervised consultant on the inpatient and outpatient services in each of his or her subspecialty experiences. As a supervised consultant the resident must have the opportunity to evaluate and to formulate management plans for subspecialty patients. Instances in which a resident functions solely as an observer will not fulfill this requirement.

ARTICLE VI - QUALIFICATIONS AND RESPONSIBILITIES OF PROGRAM DIRECTOR

A. Qualifications

The program director of a residency program shall possess the following qualifications:

1. Be certified in pediatrics by the AOA through the AOBP;

2. Have practiced in pediatrics or a pediatric subspecialty for a minimum of three (3) years;

3. Be a practicing specialist in pediatrics or a pediatric subspecialty;

4. Be educationally and attitudinally suited to conduct a training program;

5. Meet the continuing medical education requirements of the AOA;

6. Meet the standards of the position as formulated in the Residency Training Requirements of the AOA;

7. Understand and fulfill the basic requirements of the AOA and ACOP; and

8. Be a member in good standing of the ACOP and attend an ACOP chairmans/program directors meeting at least once every three years.

B. Responsibilities

1. The program director's authority in directing the residency training program must be defined in the program documents of the institution.

2. The program director shall be directly responsible to the director of medical education to verify that each resident is meeting or exceeding the minimum standards of the program.

3. The program director shall arrange affiliations and/or outside rotations necessary to meet the program objectives.

4. The program director shall, in cooperation with the AOA Department of Education, prepare required materials for inspections.

5. The program director shall provide the resident with all documents pertaining to the training program as well as the requirements for the satisfactory completion of the program.

6. The program director shall evaluate the resident's progress in the program, documenting the resident's performance, and review these with the resident at regular intervals.

7. The program director must provide the ACOP with yearly evaluation reports of the residents in the training program within thirty (30) days of completion of the contract year.

8. The program director shall encourage the resident to apply for Candidate-in-Training status with the ACOP during the training program.

ARTICLE VII - RESIDENT REQUIREMENTS

A. Applicants for residency training in pediatrics must:

1. Have graduated from an AOA-accredited college of osteopathic medicine;

2. Have completed a one (1)-year AOA-approved internship (unless applying for the specialty track internship in pediatrics);

3. Be and remain members of both the AOA and the ACOP during residency training; and

4. Be appropriately licensed in the state in which training is conducted.

B. During the training program the resident must:

1. Submit residents Annual Report to the ACOP within thirty (30) days of completion of each contract year;

2. Perform scientific research and scholarly writing with the oversight and approval of the program director;

3. Attend all meetings as directed by the program director, including the educational portion of the department/division of pediatric medicine, and participate in major committee meetings.

4. Complete a comprehensive reading program as assigned by the program director, including participation in a journal club;

5. Assist in the instruction of interns, externs, clinical clerks and allied health professionals in the care of pediatric patients as well as participate with other residents in the care of patients;

6. Maintain a record of educational and postgraduate work completed outside the training institution, listing dates, locations, subjects and speakers.

7. Complete an evaluation after each rotational assignment; and

8. Attend at least one ACOP CME meeting during 36 months of pediatrics residency.

APPENDIX A

WORK HOURS AND SUPERVISION POLICIES

It is recognized that excessive numbers of hours worked by resident physicians can lead to errors in judgment and clinical decision-making. These can impact on patient safety through medical errors, as well as the safety of the physician trainees through increased motor vehicle accidents, stress, depression and illness related complications. The training institution, director of medical education (DME) and residency program director must maintain a high degree of sensitivity to the physical and mental well being of residents and make every attempt to avoid scheduling excessive work hours leading to sleep deprivation

A. Work Hours

1. The following work hours policy will apply to all residents in all specialties.
    - a. The resident shall not be assigned to work physically on duty in excess of eighty hours (80) per week averaged for each month, inclusive of night call.
    - b. The resident shall not work in excess of twenty-four (24) consecutive hours inclusive of morning and noon educational programs. Allowance for, but not to exceed up to six (6) hours for inpatient and outpatient continuity, transfer of care, educational debriefing and formal didactic activities may occur. Residents may not assume responsibility for a new patient after twenty-four (24) hours.
    - c. If moonlighting is permitted in the same institution as contracted for residency, the eighty (80) hour per week limit and moonlighting shall be inclusive.
    - d. The resident shall have alternate forty-eight (48) hour weekends (Saturday and Sunday) off or at least one (1) twenty-four (24) hour period off each weekend (Saturday or Sunday).
    - e. Upon conclusion of a twenty-four (24) hour duty shift, residents shall have a minimum of twelve (12) hours off before being required to be on duty again.
    - F. Those rotations requiring the resident to be assigned to emergency department duty shall not be assigned longer than twelve (12) hour shifts.
    - G. The resident and training institution must always remember the patient care responsibility is not precluded by this policy. In the case where a resident is engaged in patient responsibility which cannot be interrupted, additional coverage should be provided to relieve the resident involved as soon as possible.
    - H. The resident may not be assigned to call more often than every third night.

2. The training institution shall provide an on-call room for residents, which is clean, quiet and comfortable, so to permit rest during call. A telephone shall be present in the on-call room. Toilet and shower facilities should be present in or convenient to the room. Nourishment shall be available during the on-call hours of the night,

B. Supervision Of Residents

1 The residency is an educational experience and must be designed by the institution to offer structured and supervised exposure to promote learning rather than service. An opportunity must exist for residents to be supervised and evaluated throughout their training with availability of teaching staff scheduled within the program. During daytime hours, residents will be responsible to attending physicians for assignment, of responsibility.

APPENDIX B

THREE-YEAR MODEL CURRICULUM

[1]First Year as AOA-Approved Specialty Track Internship in Pediatrics (in Months)
and
[2]First Year Residency After Completion of AOA-Approved Non-Specialty Track Internship in Pediatrics

	Year 1 Specialty Track	Year 1	Year 2 Specialty Track	Year 2	Year 3 Specialty Track	Year 3
Surgery						
OR PEDS Surgery	1					
IM	1					
OB-GYN	1					
ER						
OR PEDS ER	1	1	1	1		
Ambulatory	2	2	2	2	2	2
Newborn Nursery	1	1	1	1		
General In-Patient	2	2	2	2	2	2
PICU	0	1	1	1	1	1
NICU	1	2	1	1	1	1
Electives	2	3	4	4	6	6
Total	12	12	12	12	12	12

*May be combined with other rotations (ie., Newborn nursery a.m. and ambulatory pediatric p.m.)

APPENDIX C

GUIDELINES FOR CONTINUITY AMBULATORY TRAINING SITES FOR RESIDENTS IN OSTEOPATHIC PEDIATRIC MEDICINE

1. The ambulatory site should provide for comprehensive continuous general pediatric patient care where residents can function as the primary care giver for the patient. The site may be in a clinic (free-standing or in-hospital) or in a private practice setting.

2. The training site must have the presence of an attending pediatrician for supervision of residents. If the supervisor is also seeing patients, he/she should not be so busy with patient care that supervision and training cannot be provided. The supervisor should not supervise more than four (4) residents per clinic.

3. Residents must be scheduled a minimum of one half (1/2)-day per week during the first and second training years and 2 ½ days ~~a~~ per week during the third year. Residents must be scheduled for continuity clinic for a minimum forty-six (46) out of fifty-two (52) weeks per year.

4. An educational program must be scheduled in the clinic with active participation between the supervisor and the resident. Cases should be discussed and all charts should be reviewed and signed by the supervising pediatrician.

5. The resident should be exposed to the broad spectrum of medical diagnoses in pediatric and adolescent patients, as well as to demonstrate the ability to integrate the concepts of disease prevention and health maintenance.

6. A minimum of fifty (50) patients per year should be accrued into each resident panel of patients, or a minimum total of one hundred fifty (150) patients per resident by the end of three (3) years. The greater emphasis on development of the panel (practice) should occur during the first and second years.

7. Separate resident performance evaluations should be conducted by the ambulatory supervisor at least quarterly and reviewed between the resident, ambulatory supervisor and program director.

8. In addition to clinical exposure in the ambulatory training site, the resident should also be exposed to osteopathic concepts, behavioral and psycho-social aspects of medical care, medical ethics, medical-legal implications and practice management.

9. An opportunity must exist for the resident to be involved and participate in the ongoing care of his/her clinic patients when they are hospitalized at the base hospital facility and through all phases of their care (under supervision).

9. A resident in a teaching ambulatory setting should see an average of four (4) to eight (8) patients per half (1/2)-day period, to be gauged by the level and progress of the resident and the nature of the patient (new physical or repeat visit, etc.).

APPENDIX D

MODEL INTERNSHIP CURRICULUM: PEDIATRIC INTERNSHIP YEAR

A. If an intern year is utilized as the first year of a pediatric residency, the intern must participate in the specialty track internship in an institution which has an AOA-approved pediatric residency program which contains the following components:

1. Four (4) weeks or one (1) month of general internal medicine.

2. Twenty-four (24) weeks or six (6) months of pediatrics with a minimum of eight (8) weeks or two (2) months in ambulatory pediatrics. This may include newborn nursery, inpatient care, NICU or PICU.

3. Four (4) weeks or one (1) month of hospital-based general or pediatric surgery.

4. One (1) month or four (4) weeks in ED or pediatric ER or at the base or an affiliate training center site.

5. Continuity of Care Clinic will be required and will be a priority extending throughout the entire year. It will occupy 10% or one-half day of the total time of the internship and shall be present in all internship training programs a minimum of forty-six (46) weeks out of the year in pediatrics.

8. The pediatric internship shall be under the direction of the director of medical education or osteopathic training in concert with the pediatric residency program director at the sponsoring institution.

9. The intern who is training at a pediatric internship shall be required to submit a resident's annual report no later than 30 days after the completion of a contract year. A program director's report must also be submitted for the pediatric portion of the training year.

B. The number of specialty interns and residents in pediatrics that an institution is permitted to accept into training may not exceed 150% of it’s approved pediatric residency positions without prior approval of the AOA.

C. The inspection of the pediatric program will be conducted by a physician who is certified in pediatrics by the AOA. This physician will be assigned as a part of AOA's intern training inspection team. However, the specialty internship will also be routinely inspected as part of the institution's Pediatric Residency Program.

APPENDIX E

MODEL HOSPITAL POLICY ON ACADEMIC AND DISCIPLINARY DISMISSALS

In July 1993, the Board of Trustees of the American Osteopathic Association adopted the following policy:

The hospital and department have clearly defined procedures for academic and disciplinary action. Academic dismissals result from a failure to attain a proper level of scholarship or non-cognitive skills, including clinical abilities, interpersonal relations, and/or personal and professional characteristics. Institutional standards of conduct include such issues as cheating, plagiarism, falsifying records, stealing, alcohol and/or substance abuse, or any other inappropriate actions or activities.

In cases of academic dismissal, the hospital and department will inform trainees, orally and in writing, of inadequacies and their effects on academic standing. The trainee will be provided a specified period in which to implement specified actions required to resolve academic deficiencies. Following this period, if academic deficiencies persist, the trainee may be placed on probation for a period of three (3) to six (6) months. The trainee may be dismissed following this period, if deficiencies remain and are judged to be irredeemable. In accordance with institutional policy, the trainee will be provided an opportunity to meet with evaluators to appeal decisions regarding probation of dismissal. Legal counsel at hearings concerning academic issues will not be allowed.

In cases of disciplinary infractions that are judged irredeemable, the hospital and department will provide the trainee with adequate notice, in writing, of specific ground(s) and the nature of the evidence on which the disciplinary action is based. The trainee will be given an opportunity for a hearing in which the disciplinary authority will provide a fair opportunity for the trainee's position, explanations and evidence. Finally, no disciplinary action will be taken on grounds that are not supported by substantial evidence. The department and/or hospital intern training committee, or house staff education committee, or other appropriate committees will act as the disciplinary authority. Trainees may be allowed counsel at hearings concerning disciplinary issues. Pending proceedings on such disciplinary action, the hospital in its sole discretion may suspend the trainee, when it is believed that such suspension is in the best interests of the hospital or of patient care.

APPENDIX F

Core Competency # 1: Osteopathic Philosophy And OMT

Pediatric residents are expected to demonstrate and apply knowledge of accepted standards in osteopathic manipulative treatment (OMT) appropriate to their specialty. The educational goal is to train a skilled and competent osteopathic practitioner who remains dedicated to life long learning.

1) Demonstrate competency in the understanding and application of omt appropriate to pediatrics.

Suggested Educational Content/Topics To Achieve Compliance

- Provide active training opportunities for OMT in both hospital and ambulatory settings.
- Teach residents to perform a critical appraisal of medical literature related to OMT.
- Observe and credential residents in the performance of OMT by assessing their diagnostic skills, medical knowledge, and problem-solving abilities.

2) Integrate osteopathic concepts and OMT into the medical care provided to patients as appropriate.

Suggested Educational Content/Topics To Achieve Compliance

- Have residents assume increasing responsibility for the incorporation of osteopathic concepts in patient management.
- Participate in activities that provide educational programs at the student and intern levels.
- Participate in CME programs provided by the specialty colleges or other AOA organizations

3) Understand and integrate osteopathic principles and philosophy into all clinical and patient care activities.

Suggested Educational Content/Topics To Achieve Compliance:

- Utilize caring, compassionate behavior with patients.
- Demonstrate always the treatment of people rather than symptoms.
- Demonstrate understanding of somato-visceral relationships and the role of the musculoskeletal system in disease.
- Demonstrate listening skills in interaction with patients.
- Knowledge of and behavior in accordance with the osteopathic oath and AOA code of ethics.

Suggested Methods For Evaluation

1. Direct Observation
2. Global Rating (360 Degree)
3. Standardized Patient
4. Peer Review
5. Simulations And Models
6. Procedures Or Case Logs
7. OSCE

Core Competency # 2: Medical Knowledge

Pediatric residents are expected to demonstrate and apply knowledge of accepted standards of clinical pediatrics, remain current with new developments in pediatrics, and participate in life-long learning activities, including research.

1) Demonstrate competency in the understanding and application of clinical pediatrics to patient care.

Suggested Educational Content/Topics To Achieve Compliance

- Performance on COMLEX-USA level 3 and in-service examinations.
- Supervised observation of the clinical decision-making abilities of pediatric residents.
- Seminars or CME
- Participation in a directed readings program and journal club.
- Periodic assessment of resident critical thinking and problem-solving abilities.

2) Know and apply the foundations of clinical and behavioral pediatrics.

Suggested Educational Content/Topics To Achieve Compliance

- Participate in activities that critically evaluate medical information and scientific evidence.
- Develop as a medical educator by giving presentations before peers, faculty, and participating in the instruction of medical students and other professionals.
- Routinely assess the skill and outcomes of residents in their performance of medical procedures.
- Programmatic education in life long learning.

Suggested Methods For Evaluation

1. Chart Stimulated Recall Oral Examinations (CSR)
2. Simulations And Models
3. Ratings From Patients, Staff, Supervisors And Professionals (360 Degrees)
4. Oral Examinations
5. Written Examinations
6. Direct Observation

Core Competency # 3: Patient Care

Pediatric residents must demonstrate the ability to effectively treat patients, provide medical care that incorporates the osteopathic philosophy, patient empathy, awareness of behavioral issues, the incorporation of preventive medicine and health promotion.

1)Gather accurate, essential information for all sources, including medical interviews, physical examinations, medical records, and diagnostic/therapeutic plans and treatments.

Suggested Educational Content/Topics To Achieve Compliance

- Supervise the performance of medical interviewing techniques.
- Provide instruction on developing and implementing of effective patient management plans.
- Teach proper methods for requesting and sequencing diagnostic tests and consultative services.
- Instill the need to provide a caring attitude that is mindful of cultural sensitivities, patient apprehensions, and accuracy of information.

2) Validate competency in the performance of diagnosis, treatments and appropriate procedures.

Suggested Educational Content/Topics To Achieve Compliance

- Provide instructional programs for the performance of medical procedures where appropriate.
- Develop a credentialing program for pediatric residents to validate their procedural competency.
- Instruct residents the performance of procedures, including any potential complications and known risks to the patient (informed consent).

3) Provide health care services consistent with osteopathic philosophy, including preventative medicine and health promotion that are based on current scientific evidence and understanding of behavioral medicine.

Suggested Educational Content/Topics To Achieve Compliance

- Counsel patients and families on health promotion and lifestyle activities related to good health maintenance.
- Refer patients to non-for-profit and community service organizations that support health promotion and behavioral modification programs.
- Work with professionals from varied disciplines as a team to provide effective medical care to patients that address their diverse healthcare needs.

Suggested Methods For Evaluation

1. Checklists
2. Simulations And Models
3. Patient Surveys
4. OSCE
5. Standardized Patient
6. Procedure Or Case Logs
7. Oral Examination
8. Record Review
9. Ratings From Patients, Staff, Supervisors And Professionals (360 Degrees)

Core Competency # 4: Interpersonal And Communication Skills

Pediatric residents are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.

1) Demonstrate effectiveness in developing appropriate doctor-patient relationships.

Suggested Educational Content/Topics To Achieve Compliance

- Interviewing Techniques
- Health Assessment Of Non English-Speaking And Deaf Patients
- Involvement Of Patients And Families In Decision-Making
- Appropriate Verbal And Non-Verbal Skills
- Understanding Of Cultural And Religious Issues And Sensitivities In The Doctor-Patient Relationship

2) Exhibit effective listening, written and oral communication skills in professional interactions with patients and health professionals.

Suggested Educational Content/Topics To Achieve Compliance

- Communicating medical problems and patient options at appropriate levels of understanding
- Maintain comprehensive, timely, and legible medical records
- Respectful interactions with health practitioners, patients, and families of patients
- Eliciting medical information in effective ways
- Work effectively with others as a member or leader of a healthcare team

Suggested Methods For Evaluation

1. Standardized Patients
2. OSCE
3. Ratings From Patients, Staff, Supervisors And Professionals (360 Degrees)
4. Patient Surveys
5. Checklist
6. Case/Chart Review
7. Videotaping

Core Competency # 5: Professionalism

Pediatric residents are expected to uphold the osteopathic oath in the conduct of their professional activities that promote advocacy of patient welfare, adherence to ethical principles, and collaboration with health professionals, life-long learning, and sensitivity to a diverse patient population. Pediatric residents should be cognizant of their own physical and mental health in order to effectively care for patients.

1) Demonstrate respect for patients and families and advocate for the primacy of patient's welfare and autonomy.

Suggested Educational Content/Topics To Achieve Compliance

- Honest representation of patient's medical status and the implications of informed consent.
- Maintenance of patient confidentiality and proper fulfillment of doctor-patient relationship
- Inform patients accurately of the risks associated with medical research projects, the potential consequences of treatment plans, and the realities of medical errors in medicine.
- Treat the terminally ill with compassion in the management of pain, palliative care, and preparation for death
- Course/program participation (e.g. Compliance, end of life, etc)

2) Adhere to ethical principles in the practice of pediatrics.

Suggested Educational Content/Topics To Achieve Compliance

- Understand conflicts of interest inherent in medicine and the appropriate responses to societal, community, and healthcare industry pressures.
- Use medical resources effectively and avoid the utilization of unnecessary tests and procedures.
- Recognize the inherent vulnerability and trust accorded by patients (and families) to physicians and uphold moral principles that avoid exploitation for sexual, financial, or other private gain.
- Pursue life-long learning goals in clinical medicine, humanism, ethics, and gain insight into the understanding of patient concerns and the proper relationship with the medical industry.

3) Demonstrate awareness and proper attention to issues of culture, religion, age, gender, sexual orientation, and mental and physical disabilities.

Suggested Educational Content/Topics To Achieve Compliance

- Become knowledgeable and responsive to the special needs and cultural origins of patients.

- Advocate for continuous quality of care for all patients.
- Prevent the discrimination of patients based on defined characteristics.
- Understand the legal obligations of physicians in the care of patients.

Suggested Methods Of Evaluation

1. Standardized Patients
2. OSCE
3. Ratings From Patients, Staff, Supervisors And Professionals (360 Degrees)
4. Patient Surveys
5. Checklist
6. Lectures/Seminars
7. Competency Cards
8. Sensitivity Seminars/Programs
9. Videotaping

Core Competency # 6: Practice-Based Learning And Improvement

Pediatric residents must demonstrate the ability to critically evaluate their methods of clinical practice, integrate evidence-based medicine into patient care, show an understanding of research methods, and improve patient care practices.

1) Treat patients with the most current information on diagnostic and therapeutic effectiveness.

Suggested Educational Content/Topics To Achieve Compliance

- Use reliable and current information in diagnosis and treatment.
- Understand how to use the medical library and electronically mediated resources.
- Demonstrate the ability to extract and apply evidence from scientific studies to patient care.

2) Perform self-evaluations of clinical practice patterns and practice-based improvement activities using a systematic methodology.

Suggested Educational Content/Topics To Achieve Compliance

- Understand and participate in quality assurance activities at the hospital and at ambulatory sites.
- Apply the principles of evidence-based medicine in the diagnosis and treatment of patients.
- Measure the effectiveness of resident practice patterns against results obtained with other population groups in terms of effectiveness and outcomes.

3) Understand research methods, medical informatics, and the application of technology as applied to medicine.

Suggested Educational Content/Topics To Achieve Compliance

- Participate in research activities and/or scholarly activities as required by the ACOP.
- Demonstrate computer literacy, information retrieval skills, and an understanding of computer technology applied to patient care and hospital systems.
- Apply study designs and statistical methods to the appraisal of clinical studies.

Suggested Methods For Evaluation

1. Written Examinations
2. OSCE
3. Chart Stimulated Oral Examinations (CSR)
4. Standardized Patients

5. Record Reviews
6. Self Study
7. Procedure Or Case Logs
8. Resident Initiated Research

Core Competency # 7: Systems-Based Practice

Pediatric residents are expected to demonstrate an understanding of health care delivery systems, provide effective and qualitative patient care within the system, and practice cost-effective medicine.

1) Understand national and local health care delivery systems and how they impact on patient care and professional practice.

Suggested Educational Content/Topics To Achieve Compliance

- Instruction in health policy and structure
- Understand business applications in a medical practice
- Show operational knowledge of health care organizations, state and federal programs
- Understand the role of the resident as member of the health care team in the hospital, ambulatory clinic, and community.
- Guest lectures/seminars with policy makers

2) Advocate for quality health care on behalf of patients and assist them in their interactions with the complexities of the medical system

Suggested Educational Content/Topics To Achieve Compliance

- Understand local medical resources available to patients for treatment and referral
- Participate in advocacy activities that enhance the quality of care provided to patients
- Practice clinical decision-making in the context of cost, allocation of resources, and outcomes.

Suggested Methods For Evaluation

1. OSCE
2. Ratings From Patients, Staff, Supervisors And Professionals (360 Degrees)
3. Chart Stimulated Recall (CSR)
4. Oral Exams
5. Seminars
6. Record Review
7. Patient Surveys
8. Checklist