# ACGME Pediatric Residency Changes to Neonatology

Every 10 years, the ACGME Pediatric Review Committee is required to evaluate and revise the requirements for pediatric residency programs. The current revisions **will have profoundly negative impacts** on the education, competency, standard of future board-certified pediatricians and the ability of pediatricians to care for infants.

We can advocate for changes to these by revisions by **voicing our concern during the open comment period**. To do this we must have a massive response in which hundreds of us responded.

Please take time to:

1) Responded to the ACGME at the following link - ACGME Open Comment - Pediatrics by **April 5th 2023**
2) Read the talking points below to craft help craft your unified response
3) Amplify our response by forwarding this to colleagues, families of former patients and other allies
4) Spreading the word on social media

## Key Points

1) Significant **decrease in NICU and overall critical care time with a minimum of 4 weeks of NICU** and 12 weeks total of NICU, PICU or CCU.
#IV.C.6- IV.C.6.f).(2)

**Recommendation** - A **minimum of 8 weeks should be spent in the NICU and a minimum of 16 weeks of critical care time** is required to educate pediatric residents adequately.

a. All pediatricians must be able to have sufficient knowledge to **manage the 3.9 million infants born each year** and the large number of general pediatric patients which are infants. Only time in the NICU and delivery room can build these essential skills.
b. The majority of children who die in hospitals die in a NICU with most of the remainder dying in the PICU. Residents **can only learn to manage end of life care**, **bereavement skills, and palliative care** by having direct experiences with families and patients in ICUs.
c. Pediatricians must be able to quickly **differentiate between "normal variant", "sick" and "critically ill" infants**. With limited experience in the NICU and PICU trainees will be unable to make these critical decisions.
d. Only through time in the NICU and critical care units can **trainees build essential skills** in the course of complex disease that start at birth, understand physiology in a robust manner, develop time management & triage skills and understand collaboration teamwork.

e. **Postpartum depression and challenges with family mental health** are a frequent part of a family's experience in a critical care environment and residents will be deprived of these educational experiences without this experience.

## 2) Removal of specified, required procedures (i.e. no bag mask skills, UVC placement, LP) - #IV.B.1.b).(2).(a) – IV.B.A.B0.(2).(a).(xiii)

**Recommendation** – All pediatric residents must be competent in mag mask ventilation, umbilical catheter placement, lumbar puncture, LMA placement and NRP & PALS.

a. Respiratory causes are the leading cause of cardiac arrest in children. **Removal of required lifesaving skills** is short sighted and dangerous, will erode trust with the public and will remove the ability of pedestrians to stabilize a patient prior to transfer of care. These skills can only be learned with sufficient time in an ICU and by mandating competency through training, experience, and simulation.
b. **All pediatricians should possess the same lifesaving skills** and have had some experience in learning environments (i.e. NICU, PICU) that practically demonstrate how to deal with life-threatening emergencies.
c. The pediatric workforce is unequally distributed, and general pediatricians are often the only resource that rural and disadvantaged communities have available. Without mandated critical care procedural training **disparities in the delivery rooms, hospitals and communities will increase.**
d. Without sufficient experience in critical care, **trainees' wellness, mental health, and confidence as junior physicians will be negatively impacted**. Only providing training, measuring competency, providing direct patient experience, and faculty mentorship will allow trainees' to be mentally prepared to stabilize a child with an acute condition.
e. Residents should have the opportunity to choose to learn advanced procedural skills such as point of care ultrasound. However, **basic skills are a prerequisite to learning advanced skills**.

## 3) Removal of subspecialty faculty (i.e. board certified neonatologists) from integral parts of the clinical and instructional components of the pediatric residency program. #II.B.1.c)- II.B.1.e).(1).(f)

**Recommendation** – A board certified neonatologists and at least one other critical care physician must be part of the pediatric residencies core faculty.

a. Infants constitute the largest subset of pediatric practice and trainees require the education, expertise, and the **guidance of a board-certified neonatologist** is required to best learn how to care for infants. This experience cannot be duplicated or replaced by other physicians who lack the focus on fetal physiology, experience dealing with critical illness, team management skills, end of life care and experience as educators focused on infants.

b. As content experts Neonatologists are the **only educators capable of providing the nuance to appropriately train residents** on the physiology, pathology, and unique care of infants transitioning from fetal to infant life and the infant parent dyad that is under stress.

c. Without required certified neonatologists educating pediatrics residents there **will be inconsistent and variability in training and practice** that will lead to adverse outcomes, decrease faith from the public and lack of confidence/wellness in trainees.

**Please respond to the ACGME at the following link - ACGME Open Comment - Pediatrics by April 5th 2023 and forward to your colleagues.**

**The ONTPD YouTube channel will have a very brief "how to navigate the survey" video. ONTPD YouTube Channel**