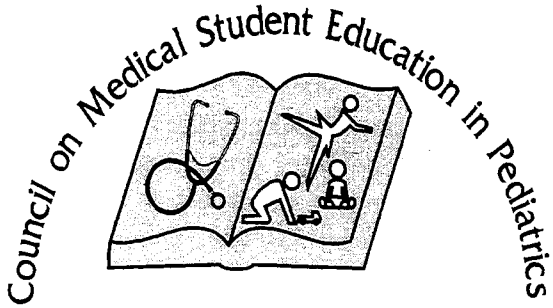
The Pediatric Educator



Volume 6 Issue 2 **Summer 1999**

EDITOR
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Comments from the President

As this edition of the Educator is published in July, it doesn't seem possible that it's been over three months since COMSEP's annual meeting in Galveston. We are greatly indebted to Mark Malloy, our local host from UTMB, and Marie Carr, CME coordinator at UTMB,for the outstanding facilities, arrangements and social events that made the meeting one of our most successful. Thanks also to our own coordinator, Jean Bartholomew, who plays a significant role in the plans for each of our meetings. Jean inherited COMSEP through her role as coordinator of AMSPDC, the organization of pediatric department chairs. To use a pediatric metaphor, Jean took to our organization in its infancy as the best adoptive mother you can imagine. Jean's knowledgeable support contributes greatly to the progress and maturity COMSEP has experienced. Like many similar beneficiaries we don't say thank you as often as we should. THANKS, JEAN!

The energy and enthusiasm displayed by each task force at the March meeting is exciting. The task force reports in this newsletter give an idea of some of the projects they are undertaking. Apparently some first-time attendees at the 1999 meeting did not realize that the task force meetings were open to anyone, both at the annual meeting and any other time you wish to participate. This is another reminder to the COMSEP leadership that new members may not be aware of what has become common knowledge to veteran members. Some task force groups have their own listserv that can also keep you informed. Please be quick to participate in the work of the Curriculum and Evaluation Task Force as they undertake the very

important task of revising the flagship achievement of COMSEP, The General Pediatric Clerkship Curriculum.

I find the topics discussed on the COMSEP listserv to be of great interest. I may get an idea from someone else's approach to an issue and I sometimes find a colleague with similar interests. At other times I find it affirming that respected colleagues also use some of the educational and evaluation methods that we use in our clerkship. I always find it comforting to see that we share many of the same struggles. Before e-mail we usually had to wait an entire year for our annual meeting to have those kinds of exchanges and discoveries. I've seen some folks get some excellent suggestions and resources in a very short time. There's a lot of expertise in our membership. Your ideas and questions are most welcome. If you are not on the listserv and would like to be, just e-mail your request to subscribe to: rcf-lists@mayo.edu.

I had the opportunity to recommend two excellent members of COMSEP as nominees to serve as our representative on the Advisory Board of Genetics in Primary Care: A Faculty Development Initiative. The goal of the project is to enhance the ability of faculty to incorporate the clinical application of genetic information into undergraduate and graduate primary care medical education. This is a much-needed effort given the important and voluminous flow of genetic information. At the time of the newsletter, I've not heard which of our nominees has been selected. I will inform you as soon as I hear.

Plans are well underway for the 2000 Annual Meeting, April 13-16 in Vancouver, British Columbia. Joan Fraser, University of British Columbia, who will be our local host for the meeting, and David Warren, University of Western Ontario who represents PUPDOCC on our Executive Committee, are already laying the groundwork for another great meeting. (See report in the Educator.) This will be COMSEP's first international meeting and our first meeting of the millennium. Don't miss this historic meeting.

Enjoy your family and vacation time this summer. After getting a new academic year underway, we all can use some recreation. My thanks to our members for your responsiveness when a when a need arises.

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The following was graciously submitted by one of the "senior" members of COMSEP, Dr. Larrie Greenberg.

Educational Activities for the Clinician Educator

The new environment mandates that each of us as clerkship director demonstrates accountability

for all of our activities under the general heading of education. In doing this, we need not undersell what we do in our periodic reports to our chairs and/or section chiefs. My concern is that we indeed do just that; i.e., we don't give ourselves credit for those things we do nor do we try to collect qualitative data that would address the importance/impact of our work.

As a 'senior' member of COMSEP, I have had the great pleasure to write supportive letters for promotion for many of my colleagues in COMSEP. What I have often noted is the absence in CVs of critical documentation of educational activities of the individual seeking promotion. Therefore, I have created a list of educational endeavors that I think would be reasonable to include in an educator's portfolio for schools that have a clinician/educator track. The list is not complete, I'm sure, nor may all these activities be credible in every school. However, I encourage COMSEP colleagues to use this list as a guide and just as importantly, attempt to get evaluation data on these activities to add a qualitative piece to the numbers.

TEACHING:

- Basic science years- lecture, small group facilitating(PBL), precepting in an office
- Clinical years- ward attending, ambulatory teaching, lecturing, precepting(bedside rounds, case presentations), group facilitation(PBL, workshops), mentoring
- Residency/Fellowships- lecture, small group facilitating, workshops, mentoring, ward attending, ambulatory teaching, precepting
- CME activities- local, regional and national
- Patient education- classes, special interest groups
- Awards- student and resident teaching

DEPARTMENTAL:

- Committee work (educational strategic plan, APT, Grand Rounds, medical student education, curriculum, graduate education, search committees, pathway development
- Faculty development efforts
- Educational innovations- evaluation methodology, teaching process, making something more efficient/effective
- Leadership issues- planning retreats, chairing committees
- Mentoring- students, residents, fellows

MEDICAL SCHOOL ACTIVITIES

- Committee work (APT, curriculum)
- Leadership- chair committee

NATIONAL

- Committee work (AAP, APA, COMSEP, subspecialty group)
- Leadership- election to board or office
- Participation in task forces
- Awards- research, program, leadership
- Visiting professorship

COMMUNITY

- Committee work- CME, disease-specific community group(SIDS, Lamplighters)
- Advocacy- patient and parent education, media events
- Camp physician (Diabetes)
- Preparation of educational materials (anti-smoking, safety)
- Education in the schools

It would be terrific if this piece stimulated other ideas and we expanded this list. Looking forward to hearing your comments.

Larrie Greenberg, M.D.
Director, Office of Medical Education
Children's National Medical Center
Washington, D.C.

Back by popular demand is Steve Miller and Raul Rudoy and their literature review.

PEDIATRIC EDUCATOR/JOURNAL REVIEW

Steven Z. Miller, MD;
Raul Rudoy, MD, MPH

The following is meant as an "appetizer," for the next installment of the Journal Review. The next installment will have longer commentaries by members of the Journal Review Group. I must admit, these choices reflect my own interest in feedback and problem solving; I look forward to any comments on these topics specifically (S Miller):

1. Brukner et al. Giving Effective Feedback to Medical Students' Medical Teacher, Vol. 21, No.2, 1999.

This is a description of the workshop given by the author at the University of Chicago. This paper adds two important points to the generic feedback workshop. It explores specific scenarios and anticipates the type of behaviors one might see in these scenarios. It highlights the importance of developing expertise in giving feedback in various situations as opposed to developing generic expertise. (Steve Miller, MD)

2. Schuwirth et al. How to Write Short Cases for Assessing Problem Solving Skills, Medical Teacher, Vol. 21, No.2, 1999.

This article offers a helpful framework for writing cases, both for assessment and teaching. Unfortunately, it doesn't shed light on how to actually score the responses. This remains a big challenge in medical education. The article offers good general principles for case writing. (Steve Miller, MD)

3. Alderson, et al. Electronic Log of Clinical Experiences, MedicalEducation, 1999; 22:429-433.

This paper addresses an issue that many of us face; how we know what students are actually doing. The literature on this topic seems to be split between the usefulness of logs for us as teachers as opposed to the usefulness for learners. We identify gaps in our learners' experiences -- but the learners don't seem to have high use in identifying these gaps. How many of you use a patient log and to what effects? (Steve Miller, MD)

4. Duggan et al. Evaluating One to One Teaching in General Practice, Medical Teacher, Vol. 21, No.1, 1999.

This article describes an interesting method for feedback and evaluation of teaching. The preceptor and the learner each fill out a checklist that rates different aspects of a teaching session. The information is used to promote improved sessions. The checklist is a useful and detailed account of the characteristics of a good session. How many of us would be open to this type of feedback? (Steve Miller, MD)

5. Hunt et al. Medical Students' Education in the Ambulatory Care Setting: Background Paper 1 of the Medical School Objectives Project, Acad. Med. 1999; 74:289-296.

This is an important paper for two reasons. First, it articulates the vision of the AAMC for the future of medical school education (whether you agree with it or not). Second, it describes three important trends that we as clerkship directors, may soon, if we are not already, be involved in. These are 1) Longitudinal Preceptorships, 2) Multispecialty Clerkships and 3) Community-oriented, Population-based Experiences. The paper describes what these initiatives look like at different schools. How many of you are involved in any of these experiences? (Steve Miller, MD)

6. Veloski, Jon et al Patients don't present with five choices: An Alternative to Multiple-Choice Tests in Assessing Physician Competence. Acad. Med. 74:539, 1999

Written examination utilized to evaluate student's and resident's performance are frequently in the category of Multiple Choice Questions (MCQ) or open ended Essay Questions (MEQ). The MCQ's are easy to score but introduce the possibility of guessing the correct answer. The MEQ's provide a better way to evaluate the students, but it's scoring is labor intensive.

The authors of this paper propose a new type of examination called The Uncued Format (UNQ). This format presents only the test questions to the examiner who needs to find the answer from a given list of possible responses and then transcribe the code for that response in the answer sheet, which can be read by a computer. The UNQ exam was given to 7036 residents. It contained 40 open ended uncued questions and a list of 500 possible responses. Similar items were administered using a standard multiple choice exam. Also 40 UNQ test items dealing with core content were given to 7138 Family Practice residents. The scores achieved were higher for the MEQ than for the UNQ, perhaps indicating sight recognition or random guessing of the correct answer. The differences were even greater at the lower levels of clinical experience suggesting that the less capable examinees obtained the greatest benefit from cueing in the MEQ format. The UNQ test for core content was able to discriminate well among the three resident levels (?x% correct, 1st Year: 78, 2nd Year: 86, 3rd Year: 90 $P<0.001$) Comments. The results of this study support the concept of having an open ended exam that is both accurate and easy to score. The UNQ limits the possibility of random guessing and permits to discriminate more accurately among the student's level of knowledge. The UNQ cannot replace completely the MEQ format, particularly when certain MCQ's contain lengthy answers that cannot be easily adapted to the UNQ format.

An exam combining MCQ and UNQ questions will have the advantage of providing open ended questions that can be scored mechanically and also will

decrease the possibility that the final score will be based in part
on test taking techniques. (Raul Rudoy, MD, MPH)

E-mail me with your comments at szm1@Columbia.Edu or through the COMSEP Listserve.

Speaking of listserve, the following was complied by Randy Rockney of Brown University after he asked a question on listserve re: the NBMEshelf exam and clerkship grading.

An Analysis of a COMSEP Listserv Exchange: The NBME Shelf Exam and Clerkship Grading

Randy Rockney
Brown University

The Questions

On March 14 of this year I posted two queries on the COMSEP listserv:

What % of pediatric clerkships in US medical schools require passage of the NBME Pediatric Subject Examination to pass the pediatric clerkship? [I apologize to my Canadian colleagues for my provincialism.]

and

What % of pediatric clerkships in US medical schools include score on NBME Pediatric Subject Examination in students' final grade for clerkship?

My posting these questions resulted from a simple need to obtain information for a research presentation. The Brown clerkship dropped the NBME shelf exam as the final written exam in 1997 and I am looking into the impact of not taking the shelf exam on students' ultimate performance on the pediatric portion of the USMLE.

So What's all the fuss about?

Now less than one month and 49 emails later (I may have missed a few in my retrospective collection and/or deleted a few that seemed redundant or noncontributory as they came in), I am trying to make sense of it all. What started as questions about the use of the NBME shelf exam quickly evolved into a discussion of evaluation and grading of pediatric clerkship students.

The flurry of emails witnessed by all who tune into the COMSEP listserv is in itself a phenomenon worthy of comment. Many emails, indeed, did just that. I think the reasons for such a response are many, not the least of which was the fact that the posting preceded the most recent COMSEP meeting in Galveston by less than two weeks and members' minds were likely concentrating on issues of medical student education and especially evaluation. I think, too, that some of the reasons for the response are captured in some of the emails themselves.

Scott Davis of Tulane wrote, "Irwin warned me about this part of the job. During the 8 months I have been clerkship director, assigning grades has easily been the most disagreeable part of the job [I used to tell people at Brown the exact same thing]...The recent postings regarding the use of the shelf exam and the variety of responses leads me to feel that the ideal form of evaluation is a "Holy Grail" for which others besides me are searching."

Roger Berkow of Alabama is someone who has put a lot of thought into this issue:

"The questions raised about standardizing clinical

grading [bring up an] issue that I have been concerned about for the last eight years. Regardless of what we do and how much we talk to faculty and housestaff there does not seem to be a good way to standardize the clinical grades. When you add in multiple sites this gets even more difficult."

And finally, Bob Janco wrote, "We will struggle forever with trying to find the most reproducible and fairest way to validly evaluate and rank our students."

The Answers

The answers to my original questions were readily obtained. In regard to the percentage of clerkships that require passage of the NBME shelf exam, Roger Berkow wrote:

"In 1993 a survey of pediatric clerkship directors was done by the evaluation task force on evaluation methods. This survey covered about 90 medical schools. 60% used the shelf exam."

Ashir Kumar of Michigan State University wrote:

"We are in the process of collecting a variety of data related to student evaluation during pediatric clerkships in US and Canadian schools. So far 60% of clerkship directors have returned the surveys. Eye balling the data it appears that about 80% of responders are using the NBME shelf exam."

60-80% of clerkships use the NBME shelf exam and I am sure that number fluctuates year by year. Interestingly, in a 1980 study only one third of U.S. and Canadian schools used "shelf exams" obtained from the NBME. (Sahler OJZ: Pediatric Medical Student Education. Arch Pediatr Adolesc Med. 1999; 133: 223-225). This increasing use of the shelf exam, surprising to me, may not be a bad thing if another phenomenon is kept in mind. Again, Roger Berkow:

"For the last three-four years the NBME have distributed several "forms" of the exam to a group of Clerkship directors from COMSEP. Each clerkship director is requested to review all questions on the exam and rank them as appropriate for use, probably ok to use, and definitely not appropriate to use. Questions getting two or more "not appropriate" responses are likely to be removed from the test. The clerkship directors have been very good in their review to stay within the competencies described in the COMSEP curriculum...[T]he exam has gotten closer to the COMSEP curricular goals. The NBME has said that they will continue with the approach of having the clerkship directors review the exam about once a year."

For those who, like me, were surprised that use of the NBME pediatrics subject exam seems to be increasing rather than decreasing, there is an interesting article Andy Spooner mentioned on the listserv exchange. (Tamblyn R et al: Association between licensing examination scores and resource use and quality of primary care practice. JAMA. 1998; 280: 989-996). This study from Quebec supports the validity of licensing examination as a measure of clinical competence. Licensing examination scores were found to be predictive of resource use (specialty consultation, symptom-relief prescribing compared with disease-specific prescribing) and quality of care

(inappropriate prescribing, mammography screening). Quebec, it should be pointed out, "was the first jurisdiction to include an objective structured clinical examination (OSCE) in its licensure process." As we heard from Paula Algranati at a meeting of the Curriculum and Evaluation Task Force in Galveston, the NBME is moving in the same direction.

My second question, what percentage of clerkships include score on NBME shelf exam in students' final grade, prompted the greatest number of email responses, with many clerkship directors giving the exact portion of any students' grade that was determined by the shelf examination. In the 1993 survey of clerkship directors mentioned above, the shelf exam accounted for a mean of17% of the grades. Of those who administer the shelf examination, the weight given to the results when the final clerkship grade is calculated varied from not at all (exam given as practice for "the real thing") to 50% of the grade with just about every number in between in use someplace. In many cases, the shelf exam score could not be assigned a specific percentage contribution to the grade but is instead used as a "gateway" to the clinically recommended grade. In all honesty, I could never begin to convey the huge variety and ways of calculating the results of the shelf exam in the final grade that are used at all the clerkships and so I won't even try. The whole concept of assigning an exact percentage of the grade to the shelf exam was called into question by some. Bob Janco wrote: "At VUMC, we arbitrarily say 20% of grade is from the final exam, but, I analyzed this in years past, and fewer than 5% have their final letter grade changed due to a[n] exceptionally superior or poor exam grade."

Where do we go from here?

Another recent article I learned about while in Galveston (Hunt CE et. al: Trends in Clinical Education of Medical Students: Implications for Pediatrics. Arch Pediatr Adolesc Med. 1999; 153:297-302) looked at the major observed clinical curricular changes at 26 US medical via site visit. One of the conclusions of that study relevant to this discussion is "assessment strategies did drive the curriculum to some extent; students tended to focus their learning and their examination preparation on what was being tested." Maybe a standardized evaluation approach that includes an examination derived from a sensible curriculum and with demonstrated predictive value for residency or eventual clinical practice might be a worthy goal of COMSEP. Something of this idea was conveyed in one message from Bob Janco, who went on to say, "Imagine residency directors being able to know what an A really means." To which our former president, Larrie Greenberg replied, and I'll let him have the last word here, "Sounds like an ambitious but wonderful project for a task force. It would require a review of the literature and a 'new approach' based on input from NA schools. It should be publishable."

The following summary of research presentations from the COMSEP meeting in Galveston was furnished by Nicholas Jospe at the University of Rochester.

The following is a compendium of the oral and poster research presentations at the meeting in Galveston.

1) Adolescents: the forgotten patients and the curricular fix.

In this presentation, Dr. Deterding shared preliminary data regarding a school-based health clinic where third-year Pediatric clerks are exposed to adolescent health issues. She discussed that students who participate in these school-based health clinics are exposed to significantly more adolescent medicine than in the traditional curriculum. This exposure has included high risk behavior, routine sports physical exams, acute infections, sexually transmitted disease, psychosocial issues such as anxiety, depression or eating disorders, and contraception. She concluded that this exposure results in a far better learning experience for students.

2) Using manikins for learning clinical skills and for objective structured clinical examinations.

In this presentation, Dr. Estrada gave a clear demonstration of how medical students were made to become comfortable with a host of procedures to which they do not have ready access. Dr. Estrada has been working for a long time to improve these manikins and develop various stations. These include performing a complete physical examination, performing cannulations and IV infusions, lumbar puncture, endotracheal intubation, pelvic, breast and testicular examinations, heart and breath sounds, stomach and nasogastric tubing procedures and blood sampling from neonates. Dr. Estrada concluded that these manikins realistically simulate hospital patients and offer students a comprehensive learning of clinical skills.

3) Initiation of pathway system for senior medical students.

In this presentation, Dr. Foster reviewed the pathway system for students in the middle of their third-year medical school, to choose the pathway of interest. Students are assigned an adviser and guided through an individualized curriculum for the fourth year. The conclusion from this is that the pathway system is acceptable to students but labor-intensive for faculty. It is also a testimonial to the quality of the faculty involved in this project and their ability to mentor students.

4) Current practices regarding patient write-ups by medical students; results of an online survey by Pediatric clerkship directors.

In this presentation by Dr. Kaplowitz, it was pointed out that during inpatient Pediatric rotations, medical students spent a significant amount of time writing patient histories and physical exams with the assessment and plans. Importantly, little is known about requirements across different clerkships and problems encountered by both students and clerkship directors. Dr. Kaplowitz reported results of a survey in which the major concern regarding write-ups is that of inconsistent faculty feedback to students. The development of a standardized evaluation form has begun in order to address this problem.

5) Current validity of the COMSEP clerkship examination with National Board Shelf Examination.

This was a pilot study presented by Dr. Levi in

which the two different evaluation tools were compared. The authors found that both examinations are indeed significantly correlated. Dr. Levi reported that the COMSEP exam is gaining better acceptance by his faculty.

6) Impact of managed care on faculty, teaching, and morale.

Dr. McCurdy reported data from a survey given to Pediatric clerkship directors concerning the impact of managed care on their teaching programs as well as their own attitudes about managed care. Data indicate that managed care has caused statistically significant decreases in full-time and volunteer faculty teaching, individual supervision of students, clerkship training sites, and increased administrative and educational duties. Managed care has also reduced professionalism. The authors conclude that managed care has negatively impacted medical education programs and had not improved the health care of most Americans.

7) Evaluation of student performance by faculty during a Pediatric clinical clerkship: why bother?

In this presentation, Dr. Reider presented data comparing the ability of different types of evaluations to identify marginal students. Dr. Reider contrasted evaluations based on subjective feedback from preceptors to the objective grades on structured oral examinations and OSCEs. The provisional conclusion is that faculty evaluation of student performances is not a good discriminator of the actual performance as measured by objective means, particularly for the marginal student.

8) Combining Pediatric and Obstetrics and Gynecology clerkships: the impact on student performance.

Dr. Sharkey presented data about the newly combined Pediatric and Obstetrics and Gynecology clerkship into a single twelve week block. The components of the clerkship themselves have been reorganized and a core lecture series has been created. Data were presented on the results of the USMLE shelf examinations administered prior to and after the combination. The conclusion is that the major revision in the now combined Women and Children's health clerkship has occurred without significant change in objective measurements of student performance.

Presumably due to the threats of Richard Sarkin at the meeting, all of the Task Forces have submitted reports!

The Curriculum and Evaluation Task Force

The Curriculum and Evaluation Task Force has decided to review the APA/COMSEP General Pediatric Clerkship Curriculum with an eye to developing a revised version. This process will be carried out by members of the task force over the next year. We plan to bring a report to the general membership at the COMSEP meeting in Vancouver, BC.

Three groups have been established.

(1) review the objectives and competencies to determine relevancy, current utility, teachability, and the need for revision, addition or deletion.
(2) review and update clinical cases with the goal

of expanding both the number and types of cases -- this will include development of more detailed cases (Hx, PE, Lab etc)
(3) address interdisciplinary issues, including cultural competency, ethics and advocacy -- plus the need to include these issues into cases for the curricular objectives and competencies.

Each of the groups will contact task force members to engage their participation in the work of curriculum revision.

Any COMSEP member who did not attend the task force meetings on Friday or Sunday, but who has an interest in a particular are being addressed by one of the 3 groups mentioned above, may send me a note, which I will pass on to the appropriate person.

A summary of the Task Force meetings will be posted on the listserv and sent for inclusion in the Pediatric Educator within the next week.

Jerry Woodhead, MD, Co-Chair, Curriculum and Evaluation Task Force
email: jerold-woodhead@uiowa.edu

Technology Task Force

Nineteen people attended to discuss the charge, potential structure, and issues. While no one recalled a written charge to the group, the specific notion of technology applied to pediatric medical education remained the central focus of a wide-ranging discussion of ideas, projects, concepts, needs, and funding.

A common thread to the discussion was the usefulness of technology in dealing with problems of distant sites. This focused discussion on distant learning-- anytime, anywhere learning by student groups. Several people discussed their interests in web site development, case simulations, and sharing of ideas. Funding for projects and how to enlist COMSEP to support proposals seeking funding from other agencies engendered some concern. Several commented that curriculum reform was driving the development and implementation of new technology for teaching and learning.

Discussion of the roles and purposes of the COMSEP web site occupied much of the first hour. Following discussion members agreed that the site should fit members needs, include more useful material, be kept up to date, and support the activities of COMSEP members, committees, and task forces between meetings. A partnership with an existing organization would offer several benefits for esthetics and maintenance of links. The American Board of Pediatrics reportedly has volunteered to host a site.

Later discussion centered around what technology is, what it can or should be used for, and what needs for student learning should drive the development and deployment of new technologies.

Specific Projects:

1)A survey of COMSEP members for web site needs will be circulated Saturday

2) Bob Janco will draft the TTF recommendation for the web site: location, roles and maintenance needs for the Executive Committee NLT 1 Jun 99.

3)Harold Levine will draft a white paper on learning needs that may be solved by technology with assistance of Bob Janco.

4)Robin Deterding, MD will author a draft of a recommendation to the Executive Committee on COMSEP support of innovative funding.

5) TTF structure and relationship to other Task Forces was discussed.

Further discussion will need to take place at the Sunday meeting (March 28) chaired by Dr. Andy Spooner (separate report to follow)

6)A joint Curriculum and Technology Task Force group should be charged to develop criteria to evaluate new learning modules that use technology, e.g. CD-ROMs, web sites virtual reality learning, etc.

7) TTF encouraged the use of workshops next year for the creation of web sites and demo of how to productively use the COMSEP site (Dr. David Warren).

8) Encouraged the promotion of a computer project bazaar for people to demonstrate their computer-based projects at the next meeting in Vancouver (Dr. Warren).

9) Maintain the listserv as a real-time reminder and 'wake up' for timely presentation and discussion of ideas relevant to the whole membership (Dr. Morgenstern).

10)Enlist a small group from the TTF to address DLOs for informatics in pediatrics not listed in the Core Curriculum (Drs. Deterding and Janco).

11) Encourage demo of state of the art technology in telemedicine and video conferencing as it may be applied to student education in pediatrics

Recommendations:

1) The charge and roles of the Task Force should be more clearly defined by the Executive Committee
2) A more permanent structure would enable continuity of projects.
3) Executive Committee should discuss and facilitate ways to support grant projects in principle by letters of support

4) COMSEP should address the feasibility of scale-up for easily adapted technology projects that enhance efficiency, decrease costs, and improve learning. Collateral issues include copyright, academic attribution, recovery of development costs, and user fees.

Bob Janco, M.D.
Chair, Technology Task Force e-mail: bob.janco@mcmail.vanderbilt.edu

Research Task Force

The Research Task force sponsored a collaborative study during the 1997-1998 academic year which involved 5 schools (U of Nebraska, Indiana U, U of Rochester, Thomas Jefferson U, and Medical College of Va) and which surveyed 700 medical students about their community preceptorship. These experiences have become an increasingly important part of many clerkship ambulatory rotations, and we were interested to see how students perceived them, and how it affected their thinking about a pediatrics career. There was very strong agreement with the statement that the office preceptor was a good role model and that the preceptorship was an excellent learning experience. Interestingly, the office preceptor received a higher mean rating from students at these

five schools than did the ward attending and the ward residents. Nick Jospe and I, who co-authored the survey, had postulated that the question which would correlate best with a high rating of the office experience was "I examined patients on my own much of the time and presented them to my preceptor", but to our surprise, the best predictor was instead the statement "I was exposed to a wide spectrum of diseases of children". Nick will be presenting the results of this project in a poster at the APA on May 3rd, and we hope to get this written up for publication. We would like to thank Fred McCurdy, Mitch Harris, and Ruth Gottlieb for administering the survey at their schools and getting their data keyed in.

The focus this year will be on patient write-ups on the inpatient service, and what we can do to make them a better learning experience for students. The online survey of clerkship directors, which was done this past year and presented in the research session, documented that poor or inconsistent feedback to the students is perceived as a frequent problem. Some of us believe that if attendings and residents who read and comment on student write-ups had a structured form for providing feedback, students would get more benefit from doing them and show greater improvement. Starting with a form that Karen Wendelberger developed at MCW, we worked for 2 ½ hours at our Sunday morning session to trim this down to something which would fit on one side of a page. It was very instructive to see that the 12 of us at this session agreed about many aspects of what makes a good write-up, but disagreed (sometimes passionately) about others. We think the resultant product represents a good compromise, and we plan to share it with all of you on the listserv very soon. We struggled with the issue of how to best demonstrate from a research point of view that this new form achieves it's stated purpose. One aspect is to see how faculty and residents at our schools feel about the ease of using the form and its usefulness in standardizing the feedback process. Jan Hanson at Uniformed Services University, is working on a survey we can administer to faculty after they review the form and before they start to use it. In addition, some of us are administering to students a survey this year on their attitudes towards write ups, including the feedback issue, and these surveys can serve as a baseline if the same schools would agree to pilot the survey in their clerkship next year. Once we get some clerkship directors to share this with their faculty and we get some comments, we can further modify the form to make it as clear and user-friendly as possible.

Our task force will be meeting by teleconference 2-3 times during the year to move our work ahead, and we are hoping to have a workshop in Vancouver at which COMSEP members may bring ideas for collaborative research studies. Our group can then make suggestions and give feedback as to how to move these ideas forward.

Paul Kaplowitz, MD
Chair, Research Task Force

Faculty Development Task Force

The Faculty Development Task Force meetings on Friday, March 26, and Sunday, March 28 were attended by a total of 34 COMSEP members and conference attendees. Activities of COMSEP and COMSEP members in other organizations were

highlighted. Larrie Greenberg discussed the AAP faculty development program that is underway. Several COMSEP members are participating. Fred McCurdy described the ACE orientation manual that is being finalized and may be available later this year. The possibility of a COMSEP appendix which might cover issues of interest to our membership which may not be covered in the ACE manual was discussed.

There was considerable discussion regarding the needs of new clerkship directors. Several ideas mentioned included developing mentoring activities, encouraging contact between new members and "veteran" members, CV reviews for those members entering the promotions and tenure process, presenting "core" workshops on a recurring basis, and developing a "needs assessment" for our membership, including new 3. members. The possibility of having the "New Clerkship Directors Workshop" annually was discussed and endorsed.

The importance of the "Pediatric Educator" as a faculty development tool was discussed. Steve Miller will undertake a renewed effort to organize the journal review activity and to coordinate this with the "Educator."

Plans for the upcoming year:

1. Reinstate the journal review. This will be coordinated by Steve Miller, with a group of enthusiastic reviewers who will assist in this process.
2. A COMSEP resource/orientation manual will be developed. Fred McCurdy has volunteered to head this effort. The possibility of having this material accessible via the web site was raised.
3. Activities designed to facilitate mentoring and interactions among COMSEP members, particularly those who are new to our organization, their positions as clerkship directors, or to our meetings will be planned for the next meeting. Helen Loeser and Joe Stavola will head this effort.
4. Task force members will strive to participate in workshop development and presentation, to focus on a "core curriculum" of workshops. Members are encouraged to use the "buddy system" of planning and directing workshops in which an experienced member and a newer member share these responsibilities. Possible workshop topics include feedback, professionalism, residency advising, career development, adult learning, teaching methods, outcomes measures, and preparing and presenting workshops.
4. The "New Clerkship Directors Workshop" should be offered at the next meeting.

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University of Virginia
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COMSEP 2000 --- VANCOUVER

COMSEP makes its first move in a Northerly direction to the world-class city of Vancouver, British Columbia, just north of the 49 parallel. The dates of the 2000 meeting , April 21-23, a little later than usual, were selected to give visitors the advantage of enjoying

spring on the West Coast plus still including the possibility of skiing.

The conference hotel, The Sheraton Wall Street Centre is in the heart of downtown Vancouver, a modern hotel with breathtaking views of the city and surroundings, and within walking distance of most of the city centre activities. These include the historic Gastown area, Chinatown, shopping in several malls such as the Pacific centre, Sinclair centre and Robson Street, the Art Gallery, the theatres and the famous Stanley Park, round which you can walk, jog, roller-blade or cycle. Vancouver's multicultural population will give you flavours from around the world and the downtown area has restaurant choices for everyone.

Vancouver is a city built on a small peninsula and is therefore surrounded by both water and mountains, the latter covered with rain forests. This environment creates endless possibilities of activities, April being the time of year when you can ski on the local mountains in the morning (visible from your hotel room) and play tennis or go sailing in the afternoon. Even non-skiers can ride the Ski-ride up Grouse mountain for the view and dinner at the top!

If you wish to consider an extended stay beyond Vancouver there is of course Whistler ski resort, a 110 km road trip north of Vancouver. Whistler is now a number 1 world-class resort with many lovely hotels and restaurants to complement its wonderful downhill skiing on the 2 mountains, Whistler and Blackcomb.

Vancouver Island, a short ferry trip away, with the city of Victoria, makes a lovely day trip and for those of you interested in gardens, don't miss a trip to the Butchart Gardens. The ferry trip itself is beautiful, through the Gulf Islands with the possibility of seeing dolphins or even a whale.

With all these wonderful activities I hope you all find time to come to the conference! Or at least take your family with you. Don't forget to take your waterproof jacket, shoes and an umbrella, our beautiful scenery reflects our moist climate and, although it is likely to be mild, it may be damp. I look forward immensely to being your host and I am sure it will be a memorable conference and visit.

The next selection was taken from an essay published in JAMA's weekly column, "A Piece of My Mind."

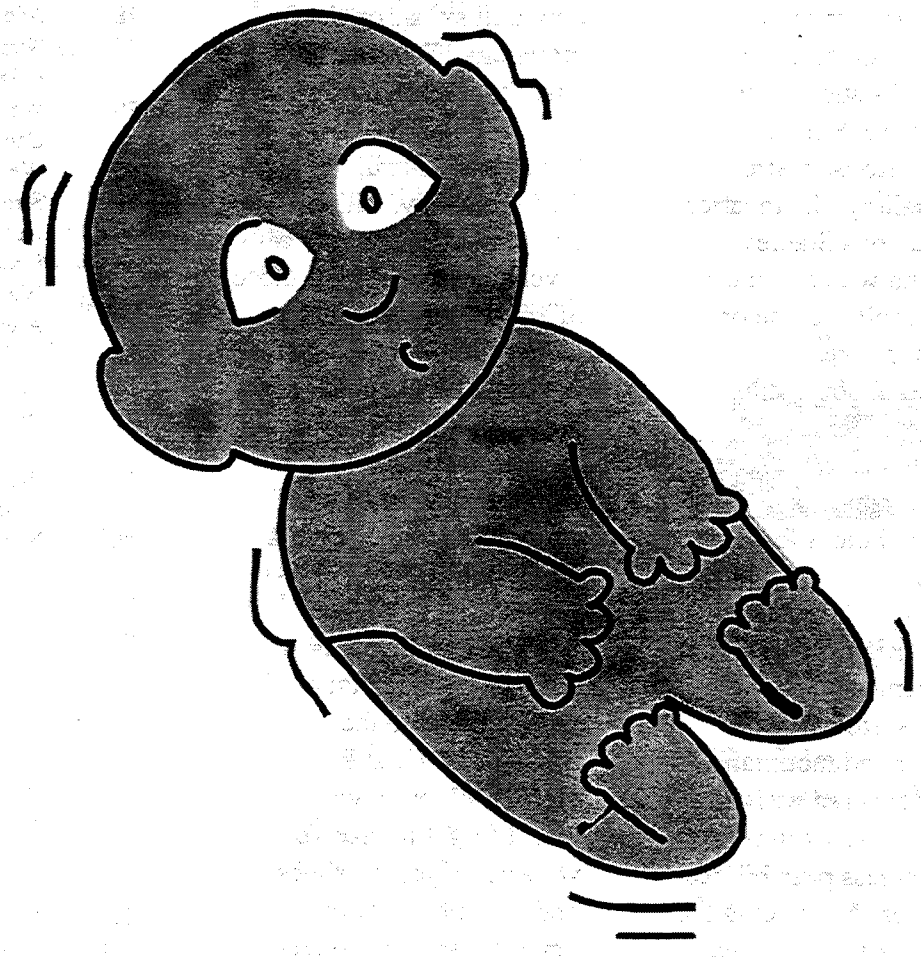
Performance Percentile	Descriptor
99	Magnificent
98	Superlative
93	Extraordinary Strong
88	Notable
83	Wonderful
80	Terrific, radiant,and humble
78	Accomplished
75	Nonsteroidal anti-inflammatory
70	Well read
65	Capable
55	Well above the mean
50	Strong
45	Hearty
40	Friendly
35	Well groomed
30	Attentive and respectful
25	Pleasant
20	Punctual
15	Imminently about to blossom
12	Present and fully continent of all excreta
10	Normocephalic and nonfelonious
8	Claudicative
6	English Speaking
5	Ambulatory
3	Respirating and well perfused
1	Charmingly fresh in outlook
0	Eukaryotic and possibly diploid

Henry Schneiderman, MD
Farmington, Conn
Taken from JAMA 1988; 259(1):87.
Appeared in: The Best of Medical Humor; Howard J. Bennett, MD 1991

COMSEP

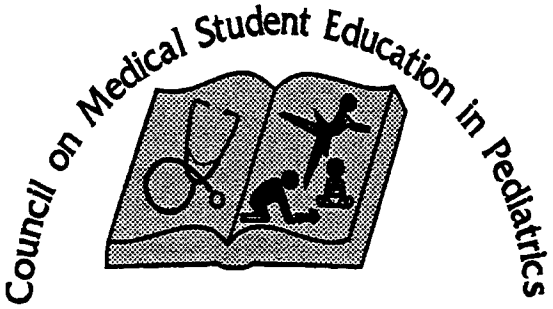
Vancouver, British Columbia

April 21-23, 2000



CROSSING BOUNDARIES IN THE NEW MILLENNIUM

The Pediatric Educator



Volume 6 Issue 1 **Winter 1999**

EDITOR
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Comments from the President

After receiving the program for the COMSEP Annual meeting in March, I'm looking forward even more to being in Galveston. The array of workshops is so attractive that I had a very difficult time selecting only three to attend. Thanks to all who are willing to lead workshops and contribute to the meeting in such an important way.

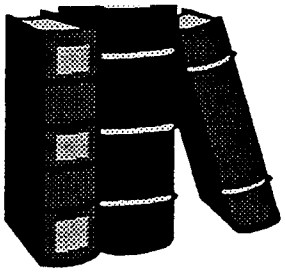
The Executive Committee at the suggestion of Jim Harper is exploring the feasibility of videotaping some selected workshops which can then be on the web for anyone to utilize. By the way, if you haven't visited the pediatrics home page of the University of Nebraska Medical Center and Creighton University developed by webmaster par excellence, Jim Harper, you should do so. It is found at www.unmc.edu/Pediatrics/educ. You can see among many other things the recording of presentations such as Pediatric Grand Rounds. Fine work, Jim.

Nan Kaufman, UC-San Diego, is replacing Ardis Olson as COMSEP's representative on the UME-21 Project. Ardis' own Dartmouth Medical School was selected as one of the Project medical schools, thus she was required to resign from the Advisory Committee. The Committee next meets the first weekend in March, so Nan will be up to speed by the time of COMSEP's meeting.

As you can see from the report sent by Pat Kokotailo on the listserv, there is great progress toward the American Academy of Pediatrics having a membership category for medical students. This should be a very helpful in giving medical students a glimpse of who pediatricians are and what they do on behalf of children. It should also be a very promising link to State AAP chapters and thus to pediatricians who may be role models and preceptors for students in their practices.

I look forward to seeing every one on Galveston Island in a few weeks.

Mike Lawless



As promised at last year's COMSEP meeting, Steve Miller from Columbia has reviewed the literature and has provided us with a brief synopsis of relevant articles.

Haists S. et al, Comparing Fourth–Year Students with Faculty in the Teaching of Physical Examination Skills to First Year Students, *Acad. Med.* 1998; 73: 198-200.

This study offers solid proof that senior students can be an excellent resource in teaching junior students. As we all continue to compete with other courses to find

preceptors for first, second and third year students, this can be a benefit. Of interest, senior students were paid for their time and faculty was not paid. This might explain why senior students were considered to be more enthusiastic than the faculty.

Salterwhite W. et al, Medical Students' Perceptions of Unethical Conduct at One Medical School, *Acad. Med.* 1998; 73: 529-531.

This study suggests that 90 percent of students witness unethical acts during their third year of school. This certainly implies that this is a pervasive problem; speaking about patients in a derogatory fashion is among the most pervasive issues. How are you all "teaching" and evaluating professionalism in your clerkship? Do you think there are differences across fields of medicine (surgery vs. medicine)? The data from this study cuts across all specialties.

Dunnington, G and De Rosa, D: A Prospective Randomized Trial of a Residents-as-teachers Training Program, *Acad. Med.* 1998, 73: 696-700.

This study has a number of interesting features. First, it proves the efficacy of a faculty development program to enhance teaching skills up to seven months later. Second, it uses a spin off of the OSCE to evaluate teaching skills – the so called OSTE (Objective Structured Teaching Evaluation). And third, it demonstrates the difficulty of enhancing feedback skills – as the experimental group improved in all areas except feedback.

Van de Wiel, et al: A Failure to Reproduce the Intermediate Effect in Clinical Case Recall, Acad. Me. 1998, 73: 894-900.

This study is another installment on the clinical reasoning of experts compared to novices. Most of the data suggests that medical experts solve problems by pattern recognition. That is, experts may have difficulty elaborating how they got to the correct answer – they just know it when they see it. This study suggests that experts can elaborate their reasoning more so than has been shown earlier especially for more difficult cases. What are the implications for us? We must help our faculty teach differently than they reason – that is explain the answers rather than just giving the answers. This has implications for faculty development.

Martin, D. et al: Using Videotaped Benchmarks to Improve the Self-assessment Ability of Family Practice Residents, *Acad. Med.* 1998; 73:1201-1206.

This paper describes an important approach to improving what has been until now, an extremely inaccurate assessment tool. It is a fairly labor intensive approach, yet the potential power of accurate self-assessment is great.

Bing-Yoon et al: A Randomized Multicenter Trial to Improve Residents Teaching with Written Feedback, Teaching and Learning in Medicine 1997, Vol. 9, No. 1, 10-13.

This is an excellent description of a relatively simple intervention to improve resident teaching skills. It highlights that faculty development can take many forms and that some of the most powerful are not necessarily the most labor intensive. It is also another example of the many contributions for our past president and mentor Larrie Greenberg, M.D. who co-authored the article.

Beecher et al: Use of the Educator's Portfolio to Stimulate Reflective Practice among Medical Educators, Teaching and Learning in Medicine 1997, Vol.9, No.1, 56-59.

This article deals with two very important issues. First, there is a good description of the process of putting together an educator's portfolio using the well publicized and validated template from the Medical College of Wisconsin. Second, there is a good discussion of the process of reflection and its benefits. This is worth looking at for anyone who wants to base their academic promotions on work in education.

McLeod P, et al: Are Ambulatory Care-Based Learning Experiences Different from those on Hospital Clinical Teaching Units, Teaching and Learning in Medicine, 1997, Vol. 9, No. 2, 125-130.

This is an interesting study, which shows that students perceived greater opportunities for learning in their inpatient experience because they were exposed to more unfamiliar issues. Of note, students felt they learned more about basic skills such as eliciting histories and performing physical examination on the inpatient unit. In general, the authors conclude that the inpatient learning for students and residents around major illnesses is superior to ambulatory experiences around minor illnesses, One important caveat to the conclusions is that the ambulatory experience was only a half day per week with one preceptor teaching five to seven residents and one to three students at a time. This may not be a fair comparison to a much longer inpatient experience.

Wear D: On White Coats and Professional Development: The Formal and Hidden Curricula, *Ann Intern Med.* 1998;129: 734 – 737

This is an interesting discussion of the "hidden curriculum" in medical training. Dr. Wear discusses the implicit unintended messages of the White Coat Ceremony; even though its stated intention is to promote compassion and humanism, it potentially sends contrary messages about physician privilege and hierarchy. This points out one of the most challenging aspects of medical education; that is, what you think you are teaching may not be what is being learned.

Review by Dr. Kim Blake '98

Michael H. Malloy, MD, MS and Alice Speer, MD
A Comparison of Performance Between Third-Year Students Completing a Paediatric Ambulatory Rotation on Campus Vs in the Community
The objective of this study was to compare the performance of third year medical students who completed a 12 week multidisciplinary (family, paediatrics, internal medicine) ambulatory clerkship (MAC) with those who attended the on-site campus clerkship.

The students on campus received a higher mean grade in their paediatric performance, on examination ($p < .0007$). There was also an increased failure rate of MAC students of 18% compared to 3.9%. There was, however, no difference noted between the two groups from a clinical performance, evaluations for their ambulatory or inpatient experiences. The data, therefore, suggests differences in the learning experience between students receiving their paediatric experience in the community vs. on campus. The authors suggest that exposure to structured learning experience occurred more frequently on campus, this may have accounted for some of the differences in the final examination results.

One of the concerns of the study is that the students elect to enter the community setting, therefore, there was no randomisation. These students may have their strengths in interpersonal skills and communication as they may be considering future careers within community settings/family practitioners. From The Association of American Medical Colleges - *Physicians for the Twenty-First Century*: although fewer than 5 percent of all physician-patient contacts result in hospitalisation, clinical clerkships are predominantly based on hospital inpatient services. This report, however, does not make specific recommendations to move clerkships into the community. The report concludes that developing and maintaining hospital inpatient and outpatient and community settings appropriate for required medical student clerkships in the major clinical disciplines will require both ingenuity and the expenditure of resources. The paper concludes that the movement of students into the community for economic reasons and because that is where the patients are may be practical, but will not ensure an optimal education.

On a personal note, different community settings offer different experiences and community pediatricians who are in group practices and undertake regular CME may offer a better experience, especially if they have visiting clinics and residents attached to their practices.

Please send any comments that you may have about this literature review to Steven Miller M.D. at szm@Columbia.edu

The following article about "standard setting" for standardized patients is a synopsis of a workshop at the Ottawa Conference on medical Education and Assessment. It was written by Ms. Lisa Doyle, M.Ed., who is coordinator of the standardized patient program at the University of Virginia.

Scoring and Standard Setting Issues for a Standardized Patient Examination: A Summary

At the recent Eighth International Ottawa Conference on Medical Education and Assessment, a special session titled, *Scoring and Standard Setting Issues for a Standardized Patient Examination*, was led by representatives of the National Board of Medical Examiners (NBME) and the Educational Commission for Foreign Medical Graduates (ECFMG). The session opened with a general description of the standardized patient examination format and the

tools utilized by these formats. After this general introduction, Boulet went on to discuss the clinical skills assessment process at ECFMG. Each foreign candidate completes ten patient encounters consisting of three components: 1) data gathering; 2) verbal communication; 3) written communication. The standardized patients document the history-taking and physical examination techniques of each candidate. Items on these checklists are scored equally and accrued. The verbal communication component is also evaluated by the SP and is documented with a holistic rating scale. Finally, the written communication component is assessed through a patient note, which is holistically scored by a physician. Expert raters are used to set standards for each of the three components.

Various standard setting methods were described by Champlain. Most notable were the popular Angoff Procedure (1971)[1] and the Contrasting Groups Method (Zieky and Livingstone, 1977)[2]. The Angoff Procedure is the most common method of creating criterion-referenced standards for written assessments. A judge or group of judges is asked to imagine the minimally competent student and estimate that person's answers, item by item, on a given test. This minimum standard is used as a reference for assessing the group's performance. Several modifications have been made to this approach in order to improve the process and make it applicable for performance assessments; however, many shortcomings still remain, such as the assumption of locally independent item performances. The Contrasting Groups Approach was described as an adequate method for performance assessments. In this approach, a group of experts are asked to define a qualified, borderline and unqualified examinee and classify several examinees into these three categories. The cut-off score is established at the point of intersection for the qualified and unqualified distributions. The limitation with this approach is the halo effect or the difficulty for judges to restrict their judgements to case constructs and not overall performances.

The NBME standardized patient exam format and standard-setting processes were briefly discussed. Because the NBME is still in the preliminary stages of development, specific scoring procedures have yet to be established. However, the Expert-Judgement Approach was described in detail and demonstrated in a small group exercise. This approach was described as a feasible and valid method for setting standards on performance assessments. Qualified judges are used to rate a sample of performances and provide skill and case level ratings for each. These sample ratings are then used to generalize to the test population.

This session supports the literature and clearly demonstrated that there is currently no definitive method for establishing cut-off scores for standardized patient assessments. However, a defensible and reasonable cut-off score must meets three criteria. It must first set a standard of competence that is high enough to ensure that examinees in need of remediation are identified. It must not, however, be so high that it falsely and unfairly identifies examinees. Finally, though cut-off scores are inherently arbitrary and dependent upon the purpose of the assessment, a good standard is one which can be defended by a consensus, and which is neither capricious nor inappropriate.

For an up-to-date summary of the NBME's scoring and standard setting plans, see www.nbme.org/new.version/a

amc99.pdf. For a more general review of scoring and standard setting issues, see Cusimano MD (1996)[3].

1. Angoff, WH. *Educational Measurement* 1971. Washington: American Council on Education.
2. Zieky, MJ, Livingston SA *Basic Skills Assessment. A Manual for Setting Standards on the Basic Skills Assessment Tests* 1977. New Jersey: Educational Testing Services.
3.Cusimano, MD. Standard setting in medical education. *Academic Medicine* 1996; 71: (October Supplement) S112-120.

The following Update on ACE was submitted by Fred McCurdy

The Alliance for Clinical Education is a consortium of required clerkship director organizations. Those organizations who have representatives to ACE are: The Association of Surgical Educators (ASE), Association of Directors of Medical Student Education in Psychiatry (ADMSEP), Association of Professors of Gynecology and Obstetrics (APGO), The Clerkship Directors in Internal Medicine (CDIM), Consortium of Neurology Clerkship Directors (CNCD), Society of Teachers of Family Medicine (STFM), and COMSEP.
ACE came into existence in 1992 under the leadership of O.J. Sahler, the first President of COMSEP. The second convener of ACE was Fred McCurdy who is also a past president of COMSEP and is currently the Alternate Delegate from the University of Nebraska. Fred served as the convener for ACE for two years , but has remained active on the Board of Directors. As fate would have it, Fred has been reelected to be the leader of ACE. The title has now changed to "President". The term of office is three years.

ACE came into existence around the issue of financing of health education for undergraduates. O.J. felt that there was strength in numbers and she organized the leadership from all of the aforementioned clerkship directors organization into ACE for the purposes of raising the consciousness of medicine's leadership (principally the Association for American Medical Colleges - AAMC) to the need for consistent and guaranteed funding for medical student education as well as other concerns clerkship directors had about the same. Since coming into existence, ACE has carried this message to the AAMC through workshops and plenary sessions at the annual meeting of the AAMC; through New Clerkship Directors Workshops held in conjunction with the AAMC annual meeting; and through publication of a very popular New Clerkship Directors Handbook. This handbook is currently undergoing revision and will become a permanent publication of the AAMC.

COMSEP is well represented on ACE by Mary Ellen Bozynski, Roger Berkow, and Nan Kaufman. Current efforts on the part of the ACE Board are directed toward better defining the role of ACE and it's relationship with organizations such as the AAMC; better defining the future direction for ACE in an era of tremendous change both within medicine as well as within graduate and undergraduate medical education; and, better defining a collaborative research agenda for the

organization. There have been two collaborative research efforts by ACE. The first was a survey of clerkship directors asking them to describe themselves, their clerkships and their opinions of their careers; the second was a survey of the impact managed care has had on the clinical teaching enterprise. Both surveys have resulted in a number of publications either already printed or in process.

What matters the most now to ACE is to develop a long term strategic plan.
To that end, the membership of COMSEP is strongly encouraged to send suggestions to the Executive Committee so that they can craft a written proposal to the ACE Executive Board for inclusion in the ACE Strategic Plan. It would appear through the time that ACE has been in existence that the same issues of time, space, career enhancement, teaching skills, and a host of other matters are common to all clerkship directors. ACE wishes to be a vehicle through which these issues can gain national clarity and be solved through national debate and discussion.

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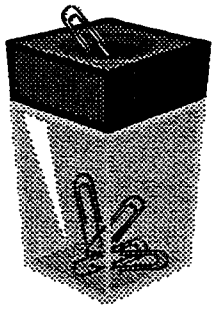

A special request from Jerry Woodhead

I invite any COMSEP member to bring a poster that addresses implementation of the COMSEP Curriculum to the Curriculum Task Force meeting in Galveston.
If anyone has had particular success (or lack of success) with the objectives and/or competencies or has added new objectives or competencies, please consider presenting your experience. The posters may be of work in progress and do not have to be fancy. Please let me know ASAP so that I may arrange for poster boards at the task force meeting.

Jerry Woodhead
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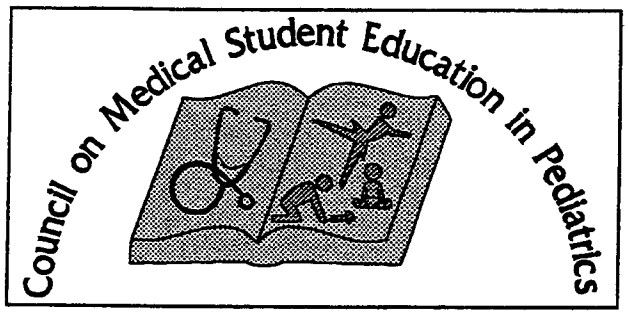
Telephone: 319-356-4964
Fax: 319-356-4855

From the editor's personal dictonary

The Redneck Dictionary of Medical Terms: Part I

>Benign: What you be after you be eight
>Artery: The study of paintings
>Bacteria: Back door to cafeteria
>Barium: What doctor do when patients die
>Cesarean Section: A neighborhood in Rome
>CAT scan: Searching for kitty
>Cauterize: Made eye contact with her
>Colic: A sheep dog
>Coma: A punctuation mark
>D & C: Where Washington is
>Dilate: To live long
>Enema: Not a friend
>Fester: Quicker than someone else
>Fibula: A little white lie
>Genital: Non-Jewish person
>G. I. Series: World Series of military baseball
>Hangnail: What you hang your coat on
Impotent: Distinguished, well known
>Labor Pain: Getting hurt at work
>Medical Staff: A doctor's cane

To be continued in next issue



Role of Pediatrics in Interdisciplinary Education and Cultural Issues

COMSEP Annual Meeting
March 25-28, 1999
San Luis Resort and Conference Center
Galveston. Texas

Thursday, March 25, 1999

9:00-12:00	PUPDOCC Meeting
1:00-5:15	Pre-Conference Workshops
6:30-9:30	Executive Committee Dinner Meeting

Friday, March 26, 1999

8:00-8:15	Welcome
8:15-9:30	Plenary Session
9:45-11:45	Task Force Meetings
1:00-3:00	Workshops
3:30-5:30	Workshops
6:00-8:00	Poster Session and Reception

Saturday, March 27, 1999

8:00-9:00	Business Meeting
9:00-10:15	Plenary Session
10:30-12:00	Research Presentations
1:30-3:30	Workshops
5:45-9:00	Reception, Tour and Dinner at Moody Gardens

Sunday, March 28, 1999

7:00-8:30	Executive Committee Meeting
8:30-11:00	Task Force Meetings