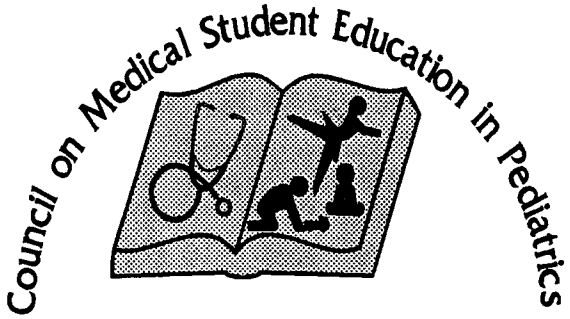
The Pediatric Educator



Volume 7 Issue 2 **Summer 2000**

EDITOR
Gary E. Freed, D.O.
Emory University School of Medicine

Comments from the President

President's Column
Richard Sarkin

Summer greetings from Western New York! I hope all goes well. I am honored to serve as COMSEP's sixth president. COMSEP is a wonderful organization. It has been my professional home for nearly 10 years. I am repeatedly impressed with the abilities, energy and vitality of the members of COMSEP. I will work hard as COMSEP's President to continue the outstanding tradition of our organization.

I want to most enthusiastically thank Mike Lawless for the superb leadership that he has provided to COMSEP over the past several years. Mike is a tireless worker who gets things done so very well with his good judgment, common sense and gentlemanly manner. He's a very tough act to follow.

I also want to thank all of those responsible for the wonderful 2000 meeting in Vancouver including Joan Fraser, David Warren and of course, Jean Bartholomew. I know all of you who attended this meeting were most impressed with the high quality of the meeting as well as the beauty of Vancouver. Well done!

Plans are well under way for the 2001 combined AMSPDC/COMSEP meeting in San Diego from March 9-12, 2001. As most of you know, a portion of this meeting will be held jointly with the Chairs. Special thanks to Nan Kaufman from UCSD for once again hosting a COMSEP meeting. David Irby from UCSF, one of the most renowned medical educators, will give a plenary address as well as a workshop on innovations in medical education. After his terrific workshop in Vancouver, Steven Wong from UBC has been invited to address our group once again on educational aspects of cutting edge technology. In addition to all of the other activities that will be packed into the meeting, free time will be set aside each day for us to enjoy the Southern California sunshine. I am eagerly

looking forward to the San Diego meeting.

Plans are also under way for the 2002 COMSEP meeting in Nashville. Bob Janco from Vanderbilt and John Estrada from Meharry are already making arrangements for this meeting. Steve Miller has begun dancing lessons in preparation for night time fun in Nashville.

Each COMSEP delegate should have already received a copy of, "Introduction to the Pediatric Physical Exam," the videotape that was developed by Jane Curtis, Mary Ann LoFromento, Steve Miller and Linda Tewksbury to help orient medical students to their first clinical experiences in Pediatrics. For additional copies of this videotape, please contact Jean Batholomew. Also, each COMSEP delegate will soon receive a copy of the new Clerkship Director's Manual that was written by members of the Alliance for Clinical Education (ACE).

I want to make sure that COMSEP continues to be as productive as it has in the past. I want to encourage every COMSEP member to get involved in some way with one of the many activities of this organization. All sorts of new projects are being initiated from the revision of the COMSEP Curriculum to overhauling the COMSEP web site (www.comsep.org). Each Task Force needs volunteers (see the individual Task Force reports). We need volunteers to write articles for the next issue of the Pediatric Educator. The call for abstracts for research presentations and posters as well as workshops at the 2001 meeting will be coming shortly. We will need volunteers to review these abstracts. In addition, we want to make sure that folks new to COMSEP can find the assistance they need by teaming up with more experienced COMSEP members. The more active each of you are within COMSEP, the more vital our organization will be.

Please send me your comments, suggestions and questions. I am looking forward to hearing from you and seeing all of you in San Diego. Have a great summer! And remember, fairways and greens - eye on the ball, back slowly, accelerate smoothly, follow through, hands high.

Richard Sarkin

The following section deals with Task Force Reports from the last COMSEP Meeting in Vancouver.

FACULTY DEVELOPMENT TASK FORCE

The Faculty Development Task Force met twice during the 2000 COMSEP meeting in Vancouver. We reviewed the activities of the past year, including the New Clerkship Director's Workshop, workshops during the meeting that had been proposed last year, the "mentoring" activities, and the status of the COMSEP Orientation Manual. There was considerable discussion regarding the next COMSEP meeting (to be held jointly with AMSPDC, and possible workshop activities there. Among the areas mentioned were residency application issues, professionalism/ humanism, creativity in education, faculty and career development, resources for medical education, recruiting, training, and retaining quality community preceptors, the AAP faculty development program, the use of technology in teaching and faculty development (including a basic workshop for those less familiar with this area), cultural awareness, assessing competency, and medical student clubs and interest groups. The role of the Faculty the next several

months. COMSEP members interested in participating in these activities but were not at the task force meeting should contact Bill Wilson at "wgw@virginia.edu".
Submitted by William Wilson

Learning Technology Task Force:

COMSEP 4/2000
Vancouver Canada
Co-Chair: Robin Deterding, MD and Bob Janco, MD
Attendance: 27 participated during the first meeting on Friday, April 14th, 2000

Agenda:

I. Web Site:

A. Draft proposal for Web site purpose, Responsibility and Ownership, Hosting and Content and Use Specifications were discussed and reviewed. Opportunities for changes to the document were provided. The plan was present to the executive committee and they are proceeding with the development of this project.

- Technology task force members universally support the funding of the web site by COMSEP. All believed it could be a significant user resource but more needed to be done.

B. Other important features to bring members to the web site were discussed. This have been incorporated into the wish list for the COMSEP website :

- Transition or announcements page for members: promotion, births, etc.
- Medical Education Journal links and Pediatric Educator - Bruce Morgenstern has already sent the links to Jim Harper for Academic Medicine, Teaching and Learning, Medical Education Online, and Medical Teacher. The Pediatric Educator can also be published here and a discussion group around journal articles could occur. Steve Miller is interested trying one of the articles he reviewed to see how this would work.
- Educational Products and web site reviews: It was suggested that members have the ability to provide their comments. Most felt it was unrealistic to assess educational quality by a committee review process and give COMSEP endorsement due to funding and time restraints.
- Clinical Cases: An extensive discussion developed around this issue. There was interest in pursuing this as a group but also concerns about the extensive time and funding required for software development. Individuals mentioned that they were pursuing grant funding with the intent to share products with COMSEP. JoAnn Harris is pursuing this with the curriculum committee.
- Web based discussion groups for the Learning Technology and other task forces.
- Web based presentations quarterly. This would draw people to the Web site and web based discussions could occur after this.
- AAMC objectives related to technology
- Grant opportunities
- Clerkship Directors resources including new clerkship directors information.
- Curriculum
- Updates about COMSEP through out the year
- Presentations and workshops and pictures for the national meeting
- E-mail notification when something new is added to the web site
- Meeting announcements, on-line registration, and PowerPoint presentations from annual meeting
- Membership Directory

with email links (Password access)
- Sharing applications of PDAs, e.g. PalmPilot use by students
- Student moderated discussion groups but most felt the site was for member development

C. All agreed that for the Web site to be used by members up to date information and discussions should occur through the site. This requires funding, which is supported by the executive committee.

D. A small group of members meet to discuss the design of the web site. This subgroup of the technology task force could be used as a subcommittee to guide design. Interested members should contact Jim Harper.

II. Interaction with other task forces:

Time was provided at the end of the Friday meeting for small groups to discuss their interests in other task forces and members attended the other task forces on Sunday.

A. Curriculum: Integration of Technology Objectives into the COMSEP curriculum (Bob Drucker, Bob Swantz, and Bob Janco)

B. Research: Developing a workshop in Evidence Based Medicine and evaluating technology use in clerkships (teaching and learning).

C. Faculty Development: Developing a workshop for the technology objectives required of medical educators and input on the planning for the upcoming COMSEP conference (2001) related to the technology demonstrations and a symposium. All felt that better planning for the technology displays is important. At the Faculty development group a needs assessment will be done via the list serve to assess the members needs related to technology and faculty development (Carol Kamin volunteered to do).

D. Evaluation: Interest in defining clinical recognition skills to be evaluated by students. A discussion will be initiated in the list serve and summarized on the web site (Robin Deterding volunteered to do). This also will need to be incorporated into the curriculum also.

III. Task force name change:

As the task force feels that we need to learn and provide learning opportunities for others to learn technology, we have changed our name to the "Learning Technology Task Force."

Co-chairs Robin Deterding and Bob Janco

COMSEP Evaluation Taskforce

The evaluation taskforce met at the recent COMSEP meeting in Vancouver. The following issues and topics were discussed:

"*Standardized Pediatric Evaluation System*" - This concept grew from a need to compare students from different medical schools who are applying for residency selection in Pediatrics. This system would develop a form asking for specific information that pediatric clerkship directors and program directors feel would help differentiate students. By being standard all programs would have access to the same information.. This "Form" would be planned to accompany the "Chairs" letter. Drs. Jim Harper (U of Nebraska)

and Stu Slavin (UCLA) volunteered to work on this project.

Essential Items for recognition: Dr. Robin Deterding (U of Colorado) has already posted a request on the COMSEP Listserv for those clinical problems felt to be essential for students to recognize. She is planning to collate these lists, and then to distribute them for comment. Once these have been reviewed the committee can continue their work with the NBME to help mold the Pediatric Subject Exam to include questions on those issues felt to be essential.

Observation and feedback: Dr. Paul Kaplowitz (MCV) will be placing the History and Physical Feedback Form on the Website. Dr. Lindsey Lane (Thomas Jefferson U) indicated that she would be willing to begin development of an Outpatient evaluation form (based on her recently published work in this area). When available and reviewed she will place this on the Website.

Dr. Ben Siegel (Boston U) reminded the group of the new APA journal, and requested submission of manuscripts regarding educational topics and research.

Workshop ideas which were discussed include:
Evaluation methods: Drs. Conrad Clemens (UNC) and Sherilyn Smith (U. Wash).

Submitted by:
Roger L. Berkow, MD
Professor and Vice-chair of Pediatrics
Division of Pediatric Hematology/Oncology
University of Alabama at Birmingham
mailto:rberkow@peds.uab.edu

COMSEP
Curriculum Task Force

The Curriculum Task Force met twice in Vancouver. The first meeting was held jointly with the Evaluation Task Force on April 14th and was attended by 46 COMSEP members. On April 16th the two groups split, with 16 members attending Curriculum meeting. This report will focus on the issues related to curriculum discussed at both sessions. A separate report will be devoted to issues of evaluation.

The major curriculum issue discussed was the plan to review and revise or renew the APA/COMSEP General Pediatric Clerkship Curriculum. This project was originally developed at the 1999 COMSEP meeting, but little progress had been made in the ensuing year. Despite the best intentions, none of the groups assigned to work on specific components of the Curriculum had completed any substantive work. Consequently, curriculum revision was the focus of the 2000 meeting.

Discussion at the first meeting in Vancouver ranged around the need for curriculum revision and what the term meant to the various members in attendance. Decisions were made at that meeting to do a topic review and make plans for revision after its completion. The second meeting focussed largely on the clinical problems and the need to expand the technological impact of the Curriculum. Approximately one third of the members in attendance at the Curriculum Task Force meetings were new clerkship directors (first or second COMSEP meeting). Only four attendees had not used the Curriculum, two from Canada. There was general agreement that the Curriculum topics are relevant but not inclusive of all that is or should be included in education about Pediatrics for students. Several viewpoints emerged from the discussions. One group emphasized the need for guidance in the

application of the Curriculum to a specific clerkship, utilizing the resources available within an institution and its surrounding community.

Another group championed the need to renew (rather than revise) the Curriculum, in order to keep the document "alive." A third group emphasized the importance of the clinical problems and requested development of expanded problem sets, sharing of locally developed problems and guidance with different ways to utilize the problems (including OSCEs). The fourth group raised the issue of the need for greater utilization of technology - the COMSEP web site, multimedia presentation of problems, and guidelines for students about information technology and information management.

The two task force sessions resulted in a plan for renewal of the Curriculum:

1. The curriculum was divided into broad topic areas, each with a volunteer from the task force as a leader. Each leader will engage a group of COMSEP members for a rapid review of selected content areas. Each group will prepare a summary of the review and will present that information in Boston. Key to the reviews will be an assessment of the validity of the current curricular material and determination of new or revised curriculum content.

2. Suggested additions or changes to the Curriculum included

* Addition of specific diseases such as diabetes mellitus
* New topic areas
  - informatics (or information technology)
  - cultural competency and gender issues
  - telephone medicine
  - ethics
* Expansion of the clinical skills section to emphasize the importance of problem solving
* Ideas, guidance or tips for implementation of the Curriculum

3. Topic groupings and leaders for topic reviews are listed below. Please contact one of the leaders in the list below if you would like to help with the revision process:

Common Illness (acute)
Lynn Manfred
Lynn.Manfred@banyan.ummed.edu

Common Illness (chronic), physical findings, and laboratory results. Kathleen McGann
mcgann_k@kids.wustl.edu

Growth & Development, Health Supervision, Behavior, and Nutrition
Jane Curtis
curtis@aecom.yu.edu

Poisoning, Emergencies, Fluids & Electrolytes
Bill Raska
wraszka@salus.med.uvm.edu

Child Abuse, Child Advocacy, and Therapeutics
Cindy Christian
christian@email.chop.edu

Adolescence, Genetics, and Newborn
Nan Kaufman
Nkaufman@ucsd.edu

Clinical Skills
Mike Giuliano
giuliano7@aol.com

Professional Attitudes and Behavior
Jerry Woodhead
jerold-woodhead@uiowa.edu

Implementation issues
Scott Davis
sdavis@tmcpop.tmc.tulane.edu

Informatics and TechnologyJo-Ann Harris
Jsharris@bu.edu

4. Information from each of the groups was discussed at the PAS meeting on May 14th, immediately preceding the APA Medical Student Education SIG. Those group leaders unable to attend the SIG sent the results of their discussions to either Ardis Olson or Jerry Woodhead. The group discussed the progress of this review and recommendations made by the working groups. Details will be included in a subsequent note to the list.

5. A meeting in the fall will be organized for more in depth discussion of the Curriculum and for work on the key issues identified in the first two rounds of the review. A proposal for funding of this meeting will be sent to both COMSEP and the AAP.

Submitted by Jerold Woodhead

The following information concerning the SIG on Medical Student Education was provided by Helen Loeser

SIG on Medical Student Education
Boston MA 02109

Participants at our lively, well-attended session had the exciting opportunity to sneak preview the brand new video: "Introduction to the Pediatric Exam" which has been produced by Mary Ann LoFrumento, Jane Curtis, Linda Tewksbury and Steve Miller with support from the APA, COMSEP, and Einstein's Department of Pediatrics. It was a smash hit! Duplication and dissemination is now underway; every clerkship director will receive a copy by the end of June, 2000.

The session then undertook to examine community- and practice–based learning. Janet Fischel presented a review of current practices; Mimi Bar-On and Pat Lye presented a review of literature; then we went to work in small groups to define the scope of the opportunities and problems, and to develop a working agenda for the future. Highlights included: the curricular challenge to prioritize what is best learned in practice setting and to develop learning objectives and evaluation criteria; the need to improve feedback skills and loops at all levels; the clarification that the longitudinal nature of this learning setting as key, as is the opportunity to contextualize teaching and learning. A full summary of this work will be posted at the COMSEP web site: www.comsep.org (and perhaps as a separate article in the Educator)

Next year's SIG topic will be on performance-based assessment, and will include standardization of evaluation across sites and clerkships. Leadership for the SIG will now pass to Steve Miller at Columbia (szm1@Columbia.edu).

Summary of small group work on Practice-Based Learning
SIG on Medical Student Education
Sunday, May 14, 2000

FACULTY RECRUITMENT

A universal problem. Part of the solution is convincing potential preceptors that it doesn't require an additional 5 hours per day, or lots of additional cost, to precept a student. Student participation in the office should add value to the practice - suggestions include quality assurance activities, audits, tracking of immunizations and well child care, home visit to a patient with chronic illness.

Inducements for preceptors should include faculty development, but can also include more tangible rewards: dinners or plaques for preceptor involvement, an annual party for preceptors and their families. AAP prioritizing of community pediatricians' important role in student teaching can be

very helpful (state level especially).

Future plans: The COMSEP resource manual and web site could include a section on ideas and suggestions for preceptor recruitment, development, retention.

COMMUNICATIONS

Getting acquainted:

A recurring theme. Ideally, the preceptor should make time initially to become acquainted with the student – identifying level of clinical experience, prior exposure to children, expectations. Providing both the preceptor and the student with background information about each other, the practice site etc. could facilitate this process.

Future plans: The COMSEP resource manual and web site could include a template for acquiring and communicating this kind of information..

Learning Objectives:

Better communication about skill level of the student and expectations of the experience, including specific tasks the student should perform, would give much better yield for the time spent in the clinical encounter.

Providing students with skills to "activate" learning in a setting that is largely observational can be helpful.

Written learning objectives, detailing what the student should learn and do during the time in the practice/community setting, should be given to, and agreed upon by, both the preceptor and the student. Subjects better taught in community and office based settings than in academic sites include: dealing with managed care, methods of arranging referral, practice management, efficient use of an office for both staffing and patient flow issues ("multitasking"). Community and office-based settings provide unique opportunities, including: increased patient exposure, especially in arenas of longitudinal, chronic illness and well child care; and for observation and feedback on student history, physical exam and communication skills.

Future plans: The COMSEP curriculum should identify objectives that are best taught in a community setting.

Teaching Skills:

We should strive to" raise the bar" of expectations for experientatial learning, observation and feedback for students and community/practice-based faculty.

Flexibility in teaching style is key for preceptors, since different students respond differently. There needs to be an interactive exchange between preceptor, student, and possibly course director.

Improved feedback is an important goal to achieve. Feedback to students and to faculty in community settings occurs rarely and is not timely

Faculty development is key to achieving all of the above, and includes peer-level problem-solving and directed learning.

Future plans: The COMSEP resource manual and web site could gather teaching modules and host a discussion site for preceptors.

Definitions for the ideal practice/community-based experience:

A. Preceptors would be paid, thereby enabling the program to choose excellent teachers, maintain their quality, and require participation in faculty development activities.

B. The experience should be longitudinal and occur continuously over along length of time - from 6 months to 4 years. This allows us to break down the barriers of the 6 to 8 week block pediatric rotation and the time and resource

constraints that accompany that model.

C. Occasionally the academic and community pediatricians should consider switching roles and locations, allowing the academics a "real world" experience while serving as locum tenens for the community physicians (especially appropriate in rural areas where coverage issues are of paramount importance).

D. Upper level students in the 4th year should "buddy" with less experienced students in the longitudinal setting described in B above. Although the newer students could pick up bad habits from the 4th years, a course in effective teaching skills for the upper level students could improve this interaction and help the new students "learn the ropes".

E. Students should be assigned a chronically ill patient and participate in their care over a long time period (1-4 years).

F. Didactic and processing session should occur to allow students to reflect on the meaning of their longitudinal community experience.

Educational and Professional Development Opportunities for COMSEP

AAMC Programs

Junior Women Faculty Development program – an excellent start

Senior Women Faculty Development program – builds nicely on the Jr. program

Executive Leadership in Academic Medicine Fellowship (AAMC) – an intense course, offered over two sessions of 9-10 days about 10 months apart. This is for women who are in or looking to enter leadership roles and requires nomination from your Dean.

(Pat Kokotailo, U. Wisconsin is a recent grad of this program)

Fellowships in Medical Education Research (FMER)

The Central Group on Educational Affairs has begun an administrative series offered as pre-meeting sessions.
(contact: Karen Wendelberger-Marcdante, Med. Coll. Wisconsin)

Web site with resources for academic faculty development: Www.aamc.org/about/progemph/wommed/edrlist/menwom.htm

Harvard Macy Institute Programs

1. For Physician-Educators: A collaboration between the School of Medicine and the School of Education : two weeks in January and a third week in May; focuses on educational philosophy, adult learning, educational administration and the change process. Each participant develops and works on a project, with small group and faculty assistance. "It was excellent - very stimulating, largely due to the eclectic nature of attendees. There is also good on-going follow-up for those involved."

(A few of the COMSEP members who have participated: Helen Loeser, UCSF; Steve Miller, Columbia; Michael Rieder, U.of Western Ontario;

2. For Leaders in Medical Student Education: A collaboration between the Office of Medical Education and the Business school; one week in June.
Contact: Elizabeth Armstrong, Ph.D. Harvard Macy Program Director: 617-432-0340; earmstrong@hms.harvard.edu

The Division of Medical Education, University of

Southern California, offers 4 different programs for Faculty Development, open to faculty members from any University.

1) Fellowship in Teaching and Learning - a 9-month program, offered as 6 separate weekend workshops designed to provide a comprehensive educational approach to teaching, learning and evaluation in medical education.

2) Fellowship in Educational Leadership - same format as above but focussed on professional effectiveness in an educational setting.

3) Master's Degree for Medical Education - a 2 year program that combines the above 2 workshop series with some additional coursework

4) Individual Workshops - offered in a weekend format.
Contact: Diane Boughton 323/442-2384 or Tracey Tierney 323/442-1504

APA's National Pediatric Faculty Development Scholars Program
Project Director: Lucy Osborn, MD

3. Tracks: Educational Scholarship, Community Based Clinical Teaching, Executive Leadership
"Outstanding small-group "train-the-trainer" workshops for academic pediatricians to become regional and national faculty development teachers and leaders" (not sure if there will be further cohorts)
Paula Algranati, U. Conn; Elizabeth Rider, Harvard; Steve Miller, Columbia

"Effective Teaching: Improving Your Skills", delivered by MCP's Office of Faculty Development (presumably now an MCP-Hahneman course). This was a week-long workshop and included components such as micro-teaching, role playing, writing curriculum. "One of the very best faculty development workshops I have taken."
Paula Algranati, U. Conn.

American Academy of Physician and Patient -AAPP offers another excellent workshop (also about a week-long) on improving communication between doctor and patient (also improved teaching of same). "The beauty of this course is that participants are able to address some of their own learning needs- and through small group work get help from peers and course leaders on same."
Paula Algranati, U. Conn.; Elizabeth Rider, Harvard

The Primary Care Faculty Development Program at MSU is a one year program at MSU that is divided out in 1 and 2-week blocks over the year: "extraordinarily valuable for primary care educators".
Contacts: Bill Anderson and Emily Zoeller
Leslie Fall , Dartmouth

The Case and Curriculum Development Course (PBL) with Dr. Howard Barrows at Southern Illinois University. "My training for was absolutely outstanding." Contact: 217-782-0795.
Jane Curtis, Einstein

The University of Illinois at Chicago (UIC) has a 2 year program that can be done onsite or online to achieve a Master of Health Professions Education (MHPE). The individuals involved are well respected such as George Bordage, Alan Schwartz, and William Reed to name a few with great credentials. Their website provides more information:
http://www.uic.edu/com/mcme/mhpeweb/Home.html
Robin Deterding, U. Colorado

"A compendium of higher education opportunities in health profession education", Academic Medicine. 1998;73:1255-1259. "A little

out of date but still a great resource".
Michael Giuliano, NYU

The following was submitted by Lorraine Basnight

Abstracts selected for Posters COMSEP 2000, Vancouver

Reflecting on Pediatrics: Memorable Experiences During the Clerkship Rotation. Lorraine Basnight, MD; Pamela Larsen PhD, DNSc, FNP
Brody School of Medicine at East Carolina University

Background: There is evidence that attitudes of medical students change over the course of their medical school training. However, little is known about how specific events are viewed by the students during their clerkships. The objective of this study was to systematically look at shat students write about when asked at the conclusion of their pediatric rotation to describe an occurrence that made a significant impact on their experience.
Method: This study analyzed 130 anonymous student narratives written at the end of their pediatric clerkship. Analysis was performed using a standard qualitative method. Common themes were identified and the writings examined again for prevalence of these themes throughout the narratives.
Results: Several thematic trends were noted, one which included descriptions of disease processes or diagnoses, some written in great detail. However, a substantial number of the students wrote about relationships – those between students and physicians, between students and patients, and between parents and their children. One student wrote *"It makes me angry that such a sweet child had to die in such an excruciating manner..."* after a child deteriorated from Steven-Johnson syndrome. After caring for a young child with behavioral problems, a student noted that *"good medicine can't replace bad parenting... Billie got good medicine here but we can't replace his mother who made promises to visit that were rarely kept..".*
Conclusions: The pediatric clerkship may be the student's first experience with pivotal situations involving very young patients. For some, this experience is difficult. *"this nibbled away at my faith in humanity"*. For others it triggers self-examination... *"it has been a long while since I thought about why I wanted to be a doctor"*. These results have generated concern about the need to debrief students for issues beyond asking for general "course feedback". Further, there is the need to educate ourselves as attendings, as well as our supervising resident physicians, about the impact of the emotional experience of Pediatrics for young emerging physicians.

Impact of a Preceptor Focused Discussion Group on the M3 Primary Care Pediatric Experience.
Mary Bozynski, MD; Pamela Castro; Larry Gruppen, PhD
University of Michigan School of Medicine.

Background: Third year students spend 10 half days in primary care. Preceptors were invited to join a Discussion Group. Preceptors' needs determined the group's agenda.
Methods: 20 preceptors were surveyed concerning students' experience. Preceptors completed an empowerment scale. Students completed surveys to characterize their experience. Responses were scored suing a 5-7 point Likert scale. The preceptor group revised the curriculum, reviewed cases and web-based materials, adult learning theory, and teaching strategies. After one year, preceptors and students were surveyed.
Results: 14/20 preceptors

(70%) and all 36/36 (100%) students responded. Pre-intervention data indicated that preceptors did not use the curriculum. 33 and 39% of students reported no mid or end of experience feedback. 21% of the preceptors reported having given no feedback. Pre-intervention data showed the preceptors valued their teaching role but gave lower ratings to departmental communication and the impact of their opinions. 11/12 preceptors (91.6%) and all 34/34 (100%) of students returned post-intervention surveys. There was no significant increase in the use of the curriculum. The time students spent in active learning increased by both student and preceptor report (ES=.37). 90% of preceptors reported giving feedback vs. only 60% of students. Post-intervention data did not show significant improvement in preceptor empowerment.
Conclusions: A focused discussion group for primary care preceptors was associated with some improvement in student learning. Further improvements require continued dialogue and support of faculty preceptors.

Computer Generated Patient Education Handouts as Tools for Enhancing Medical Student Training in Ambulatory Care Settings

Christensen, Kenneth, MD; Hanson, Janice, Ph.D.; Bush, David, MD, PhD*.
Department of Pediatrics, Uniformed Services University, Bethesda, MD
*Children's Hospital of Philadelphia

Introduction: The art of learning to educate patients in the clinical setting may be the single most important event in medical training, yet the teaching systems have not yet been developed to provide medical students with necessary skills training. Accurate, pee-reviewed, patient education materials are currently available in the form of computer software programs. This study investigated whether the incorporation of computer generated patient education handouts into a 6-week clinical rotation leads to students' increased awareness of and positive attitudes toward this method of patient education.
Methods: Two study groups identified as A) educational intervention (n=28) and B) control (n=27) participated in the study. The educational intervention group (A) was exposed throughout their 6-week pediatric clerkship to a staff physician routinely using computer generated handouts in daily patient care activities, while the control group (B) cared for patients without this direct, educational exposure. The two groups completed anonymous questionnaires at the conclusion of their 6-week clerkship assessing their awareness of and attitudes toward this form of patient education.
Results: Significant differences were observed in the educational intervention group (A) in the following attitudes toward the use of computer generated patient education materials: 1) increased confidence in accessing patient education materials (P=0.032), 2) increased awareness of handouts as vehicles improving documentation and time management skills (P=0.024), 3) improved recognition of handouts as contributors to their own education as medical student son a particular topic and/or clinical condition (P=0.002), and 4) increased ability to list the many established ways patients benefit from receiving written materials from their physician (P=0.001).
Conclusions: From the points of view of our third year medical students, consistent exposure to staff physicians using computer generated patient education handouts in daily practice leads to their improved awareness of and

positive attitudes toward this method of patient education.

COMSEP Curriculum Review by Parents.

Virginia F. Randall, MD, MPH and Janice L. Hanson, PhD.
Uniformed Services University of the Health Services

Objective: To obtain recommendations from parents of children with special needs regarding the COMSEP curriculum.
Method: A three-hour meeting was held with parents who had previously reviewed the COMSEP curriculum. They were asked to address items that they felt should change, or be added, based on their experience using health care for their children. The parents had baccalaureate or masters degrees. Of their 14 children, 6 had typical needs and 8 had special needs (autism, diabetes, cystic fibrosis, multiple severe disabilities, and ADHD.)
Results: The most forceful message from the parents to clerkship directors was, "I'll share my child with you, but only if you include me." They had specific recommendations for the chapter on adolescence that reflected their concern that the text stereotyped adolescent behavior and adolescent-parent relationships. The parents developed a list of ideas they believe are important to convey to pediatric clerks, for example, take time to listen to parents and respect their experience and fears, and ask the parent how to best proceed with the physical exam. They developed some practical advice for the students, such as, be gentle and kind, speak slowly and calmly, and greet parent and child by name.
Conclusions: The parent group was able to provide useful recommendations to the COMSEP curriculum review committee. They want to collaborate with clerkship directors in pediatric medical education, rather than be passive observers.

A Community Based Exposure to Developmentally Handicapped Individuals.

Cynthia J. Stolman, Ph.D., Gary E. Eddey, M.D., Amy L. Davidow, Ph.D., Susan G. Mautone, M.D.
UMD-New Jersey Medical School.

Objective: To provide a unique learning experience for students at a school and hospital for neurologically handicapped persons.
Methods: We introduced a one day program for third year medical students to the suburban Matheny School and Hospital for the neurologically handicapped. This institution specializes in treating children and young adults with a variety of neurodevelopmental disorders including cerebral palsy, spina bifida, muscular dystrophy and Lesch-Nyhan Disease. Students observe activities of daily living, assessments, various types of therapy and feeding techniques and interact with patients and staff. The experience is designed to increase students' knowledge of and comfort with this challenging patient population. In addition, students are given an introduction to alternative forms of communication for the non-verbal disabled individual.
Results: Evaluations of this program by 98 students, using pre-and post-experience surveys with a five point Likert scale (strongly agree to strongly disagree) show all questions significant ($p=<.001$) with students indicating their improved 1. ability to communicate with non-verbal patients; 2. comfort in taking a history; 3. understanding of the team approach to management of handicapped patients; 4. appreciation for allocation of resource decisions; 5. knowledge of procedures used to evaluate

dysphagia; and 6. ability to obtain information from patients with cognitive deficits.
Conclusion: Students view the activity as "enriching," "valuable" and "a rare opportunity to interview severely disabled patients."

Are Community-Based Practices Better than Academic Health Centers for Teaching Pediatrics to Third Year Medical Students?

CB White, R Kauff, LA Lewis.
Medical College of Georgia.

Background: In 1997 we established a teaching site in a community 200 miles from MCG where students spend their entire 6-week pediatric clerkship. Most MCG students are taught at MCG, spending 3 weeks in the inpatient setting, and 3 weeks in the outpatient setting and newborn nursery. The COMSEP pediatric curriculum is used exclusively for the clerkship.
Objective: We compared the performance of students taking their pediatric clerkship at an ambulatory practice site in a community setting (CS) versus those at the Medical College of Georgia (MCG) teaching hospital. Performance outcome was measure by students' mean performance on two standardized written examinations, clinical grade, and final clerkship grade.
Design/Methods: Baseline comparability of both group (CS, MCG), was performed by comparing the group mean scores for medical school GPA and USMLE Step 1. Performance outcome was compared by group mean scores on the written pediatric clerkship exam, the NBME Pediatric Subject examination, the clinical grade, and the final clerkship grade. Statistical significance was analyzed using *t-tests* with the significance level set at .05.
Results: During 1997-1998, 21 students completed their clerkship in the CS, versus 246 students at MCG. There was no statistical difference between the two groups in GPA or USMLE 1 scores. However, students in the CS scored significantly higher on the written examination 90.2% vs. 86%, p=0.19), clinical grade (3.47 vs. 3.24, p=.001), and final clerkship grade (3.52 vs. 3.30, p=.002), than students at MCG. Students in the CS averaged over 35 points higher on the NBME Subject exam compared to MCG students (615.5 vs. 579.8), but this did not reach statistical significance (p=.105).
Conclusion: The CS group performed better than the MCG group. Based o these findings, we feel community-based pediatricians may provide superior teaching to third year medical students compared to traditional academic health centers. Reasons for these differences warrant further study.

Thanks to Steve Miller, the follow section has become the most popular addition to the Educator. Within this section "Editor's Comments" refer to Dr. Miller and not me.
G.F.

Pediatric Educator Journal Review

The journal review has three goals. 1) To provide COMSEP members a chance to participate in scholarly review, 2) To promote collaboration among COMSEP members and 3) To promote dissemination of ideas and discussion. Once again, I want to acknowledge Karen Wendleberger-Marcdante for establishing the idea and I want to invite participation from all interested parties. Send comments to me at **szm1@columbia.edu**
Thanks. Steve Miller.(Greetings from sunny, calm and quiet NYC).

Also, I'd like to challenge the Technology Task Force to break this down into a format, which would generate more discussion on the web page.

1. Usatine RP, Tremoulet PT, Irby D: Time-efficient preceptors in ambulatory care settings. Acad Med 2000; 75:639-642.

This study analyzed 44 outpatient encounters (14 of which did not include students) in managed care settings by 4 "exemplary" family medicine preceptors. Times spent in the various parts of the encounter were compared between those visits including students and those that did not. Although the participation of the medical student did not significantly change the preceptor's time with the patient (or the preceptor's time in patient-related activities), it did increase the length of time that the patient was in the clinic. Teaching strategies used included having the student write notes in the chart and providing health education to the patient while the student was present. This study suggests that it is possible to teach medical students and maintain an efficient practice schedule for the preceptor. However, the patient's time in clinic is extended, and the "turnover" of rooms is also affected. In addition, the study was conducted prior to the new documentation guidelines that place emphasis on the attending's direct participation and personal documentation in the patient chart.
Reviewer's comments: This is an interesting study, because it does suggest that, by changing teaching and practice behaviors in the outpatient setting, it is possible to teach and still maintain good patient flow. Their strategy of having students write chart notes would need to be modified in view of the new requirements, and would decrease the efficiency of the attending.
William G. Wilson, MD
Editor's Comments: This seems to suggest that the best model for students working in the office is to have two rooms - one for the student and one for the preceptor – and that critical strategies for efficiency are a) student charting, b) teaching the student and the patient simultaneously and c) prepping the student prior to the visit. This article could be a great starting point for a workshop with community preceptors. By the way, specific feedback was given only 4/30 encounters – shame, shame, and shame. **Steve Miller, MD**

2. Grant VJ, Hawken SJ. "What do they think of it now? Medical graduates' view of earlier training in communication skills" ***Medical Teacher*** **2000; 22(3):260-265.**

No one will deny that teaching our medical students about communication skills is important or that a lot of time and effort has been spent recently on this endeavor. But has it been worth it? The authors of this paper have surveyed 6th year medical students (in New Zealand) and 1st year postgraduate physicians about their views of the mandatory communication curriculum and assessment at their school. Four types of opinions were sought: the value of the course, the utility of the content, the utility of the methods and a retrospective pre vs. post intervention comparison. Negative comments about the value and content were relatively few (< 12%). The requests for additional time on certain topics (breaking bad news and difficult interviews) suggest that once the students are involved in more of the patient care interactions they recognize just how hard some of the "basic" communication tasks are. Perhaps most encouraging is the changes in the retrospective pre/post survey. The number finding the course "not useful" dropped from 36 to 11% while the number finding it very useful increased form 17 to 64%. What great news for educators! And, it also

suggests a possible collaborative study for COMSEP. Is anyone interested in surveying non-pediatrician graduates (now out in the real world) on what they would have liked to learn in pediatrics? The methodology may also be useful in evaluating the COMSEP curriculum content and methods. What do you think?
Reviewer Comments: I'm serious about the possible topic and would be glad to coordinate it if anyone is interested... Or you could ask the research group if they want to take it on. **Karen Wendleberger – Marcdante, MD**
Editor's Comments: How many of you have been discouraged by disparaging comments from students about "touchy – feely stuff" - only to have them corner you years later to say "remember that session on breaking bad news, now I see why it was important". It's gratifying to experience this, but always makes me wonder about the timing of some of our curricula. What do you all think? As far as the study, please contact Karen with your interest. One question here is, what type of IRB approval is needed to survey graduates of other programs? **Steve Miller, MD**

3. Hafler JP, Lovejoy FH. Scholarly Activities Recorded in the Portfolios of Teacher-Clinician Faculty. *Academic Medicine* 2000;75:649-652.

This article has several excellent features that make it worth your time to read in full. The first thing that struck me was what a simple idea this was, and it resulted in a peer-reviewed article! So, don't think that your own scholarly work needs to be complex and exhaustive. Perhaps the strength of the article, however, is in the delineation of the type of scholarly activities that can be considered as evidence for your teaching dossier/portfolio. The authors do a nice job of listing various types of activities that appear in their faculty dossiers. Despite this, I have to admit that I was a bit disappointed with the article. While demonstrating that successful teacher-clinicians at Harvard include "non-traditional" products in their dossier, there is no evidence that these same products made a difference in the decision to promote. (In fact, the average number of publications especially for successful Associate Professors is quite high.) Comparing to the traditional track candidates may have given some added evidence of the importance of the educational activities. Comparing to historical controls, before the clinician-teacher track was implemented would have been even better. So, what's the bottom line. Read this article, but not in isolation. In December, 1999's *Academic Medicine* there's a nice article entitled "Making a Case for the Teaching Scholar" that would be a nice companion piece. And, in September 2000 the same journal is publishing a special edition that will focus on the various types of scholarship and include 5 case studies from schools who have implemented clinician-educator tracks. In combination, this series of articles may help you improve the quality of evidence in your own CV.
Karen Wendleberger – Marcdante, MD
Editor's Comments: I would have liked to have seen individual case studies presented, in which non-traditional scholarship (anything other than original articles) made up for limited original articles. We are lucky to have such an expert. Advocate and leader on our group as Karen and we should probably collect data on our experiences across institutions. Contact me if you are interested. **Steve Miller, MD**

4. S. Durguerian, W. Riley,

and G. O. Cowan Training in Assessment and Appraisal: Who Needs it? ***Medical Education*** **2000; 34:307-309**

This article performed a needs assessment of postgraduate medical trainees and their educational supervisors. The purpose of the assessment was to determine the areas in which the educational supervisors felt competent or not quite as competent regarding educational assessment and appraisal tasks.
Not surprisingly there were a number of fairly mundane tasks that all educational supervisors felt quite good at. However, fewer than 50% felt either moderately or fully proficient at such tasks as: 1) having knowledge of the underlying principles of assessment, 2) confirming achievement of the training agreement, 3) negotiating a training agreement with the trainee, 4) using various methods of assessment to provide evidence of competence, or 5) preparing the trainee for the annual assessment interview.
Additionally, there was a remarkable lack of admitted proficiency in helping the trainee conduct a self-assessment.
Clearly, this sort of a needs assessment is an excellent way to help focus faculty development efforts. The survey tool itself was neither fancy nor was the analysis particularly esoteric, but the data are certainly compelling.
Bruce Morgenstern, MD
Editor's Comments: The lack of confidence that medical teachers have in negotiating and confirming a training agreement may be at the core of learner dissatisfaction. Experts have difficulty describing their expertise and leave learners grasping for how to do it. Think about how good you are at describing how you drive a car. How do you convey to your learners the specific skills you want them to learn in negotiating a learning agreement – or in more plain language – in describing specific objectives. Also, keep an eye out for the APA SIG on Medical Student Education in May 2001. This will be the topic – and I hope to include more new ideas from our high tech – low maintenance assessment guru, Bill Raszka of UVM fame.
Steve Miller, MD

5. Catherine Brooker, Max Kamien, and Allison M. Ward
Differences in Teaching About the Acute Sore Throat Within One Medical Faculty
Medical Education **2000; 34:269-274**

This paper assessed, as the title indicates, differences in teaching about the diagnosis and treatment of patients with acute sore throats in one medical school. This study was performed using cross sectional survey data as well as direct observations.
The medical school, the University of Western Australia, is a six-year undergraduate curriculum, the first three years are non-clinical. The students are taught about the management of the acute sore throat by four different departments over the six years. They received information on this issue in the third year microbiology course, in the fourth year ENT and general practice courses, and in the fifth year during clinical microbiology and pediatrics. The format and teaching methods differed. Case discussions were used in the two microbiology courses, the general practice course was taught via discussion with clinical application of selected articles. In ENT there was a formal didactic lecture. In pediatrics, teaching was informal, but the topic was to be covered during general clinical teaching sessions.
In addition, the authors did an evidence-based literature search to determine whether or not the teaching was in fact consistent with generally

accepted medical evidence. The authors found a considerable difference in the teaching of the different departments with regard to the cause, the diagnosis and the management of acute pharyngitis and, in fact, were able to demonstrate therefore that in some instances the evidence for good practice was ignored.
Curiously, however, although many students were able to identify the discrepancies in their teaching, others did not feel that there were any discrepancies. One quarter of the students also noticed that there was a discrepancy between what the students were taught and what they actually saw being done clinically. The lecturers were split on whether or not it was relevant that the information was inconsistently presented.

This is a very compelling presentation of how is it that we teach medical students about the management of very common topics. The authors present the medically accepted evidence for the diagnosis and treatment of acute pharyngitis and demonstrate that in fact this is often ignored in both preclinical and clinical teaching. In addition, variations in diagnostic and treatment approaches are not explained in any detail to the students so that the students might understand why different fields are viewing the same issue differently. Once again, this offers intriguing opportunities to explore about the integration of the undergraduate medical education curriculum. **Bruce Morgenstern, MD**
Editor's Comments: I wonder how COMSEP members vary in this concrete area as well? What do you teach about the approach to sore throat? Send me your approaches to teaching this and your approach to diagnosis and treatment – I'll share the responses with the group. **Steve Miller, MD**

6. Dennis K. Faculty Behavior and Other Key Factors in Student Adjustment to Medical School, *Advances In Health Sciences Education* 5: 55-69, 2000

This is a study of one school's approach to fostering humanism and idealism through the often grueling and anti – humanistic experience of medical school. At Eastern Carolina Medical school, structured small groups, facilitated by a faculty member, were organized throughout the first year of medical school. These experiences included a workshop on the Myers-Briggs Type indicator (learning styles) and a trust building outdoor ropes course – followed by regular small group discussions. Focus groups were used to assess the intervention with the third cohort of students. I general, students felt the program enhanced their feeling of social and academic support from peers and faculty. The undertone of criticism was useful for anyone who facilitates a similar group in any year of medical school. Some students don't like to share their feelings verbally, some students resent any more structured time added to their, self perceived, busy and school controlled lives, almost all students resent preceptors who are cynical and say things like – "It'll only get worse", and success depends on facilitators who truly insure equal group participation in which the facilitator makes everyone feel that he/she is approachable and non judgmental. **Steve Miller, MD**
Editor's Comments: How many of you feel that lack of humanism is a problem in medical training? How many of you have specific sessions in the clerkship devoted to debriefing the learning experience? My sense from this and other studies of similar programs, is that we need to be flexible in giving students a lot of different

ways to express and explore their adjustment to medical training in which they can share the evolution of their professional values and ideals with us. How can we make sure that students perceive us as non-judgmental and what kind of faculty development do we need in this critical area? Further food for thought; how does the developmental stage of the student affect their readiness to participate in these discussions and in the development of their professional values. Check out Eric Marcus' article in Academic Medicine (Late summer or early fall of 2000) for more on this. Who knew that Pediatric clerkship directors could be into such heavy stuff? **Steve Miller, MD**

7. Nendaz M et al. Teaching Diagnostic Skills: Clinical Vignettes or Chief Complaints. *Advances in Health Sciences Education* 5: 3-10 2000

This study compared accuracy of diagnosis and management when participants were presented a full clinical vignette versus a single chief complaint. Accuracy was lower in the chief complaint group – pointing out that having strategies for framing hypotheses just from a chief complaint is a different skill than putting together a pattern of facts to make a diagnosis. This study includes a good discussion of the nuances of clinical reasoning and the implications for teaching. **Steve Miller, MD**
Editor's Comments: I think this is must reading for anyone who is working on developing computer cases for teaching and for anyone using SP's and OSCE's for assessment. We obviously teach and assess different things, depending on how we present the case. **Steve Miller, MD**

8. S.J. Van Luijk, J.G.E. Smeets, J. Smits, I. Wolfhagen & M.L.F. Perquin. Assessing professional behaviour and the role of academic advice at the Maastricht Medical School *Medical Teacher* Volume 22 Page 168 to 172

Comments to Authors:
s.vanluijk@EDUC.unimaas.ni
This paper deals with developments in accessing and advising students with respect to their professional behaviour. Examples of humanistic issues in professional behaviour are lack of care and empathy towards patients and others, lack of communication skills or inability to reflect on ones personal behaviour. Assessment of knowledge and skills does not provide this information as recognized by the American Association of Medical Colleges (AAMC 1999) 1

A rating scale was developed by clinical teachers for assessing professional behaviour in an educational setting; the three major sections of the scale were performing tasks, aspects of communication and personal performance. The assessment of professional behaviour take places in the clerkship years, in those situations which resemble future practice. The Maastricht assessment has focused on observable behaviours and not on values or opinions of students. I feel this makes the assessment of professional behaviour checklist worthy of use. The paper goes on to describe the assessment tool as meeting criteria of reliability, validity and acceptability. I like the way the authors have used descriptors rather than a huge amount of number crunching (which I am sure they will do eventually). Lastly, what does one do if there is unprofessional behaviour? The most important take home message is that if unprofessional behaviour

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1 American Association of Medical Colleges (1999) Teaching professionalism in undergraduate medical education, Journal of the American Medical Association, 282(9), pp830-832.

occurs it should be observed and documented. Once observed, immediate feedback needs to be given. The student needs to be given a chance to change and, if not, further action taken. My only concern is that the student needs to be seen over a period of time, which is often difficult for many of us in the ambulatory setting and with short clerkships. Often these behaviours are picked up too late in the student's undergraduate career to afford time for change. I think many of us can visualize students that have passed through our teaching and clinical services who exhibit unprofessional behaviour and a process to deal with this seems appropriate. In Maastricht they use an academic advisor who has a clear responsibility to support the student and to solve the problem between school and student. There is certainly significant manpower behind their structure and for many of us with monetary cuts I am not sure that we could reproduce this process. I agree with the authors that in dealing with unprofessional behaviour it is essential to assess this aspect of the profession as soon as students have entered medical school. Leaving this to clerkship is often too late.

Finally, I reflected on a number of faculty members that I have noted who would not meet the criteria of good professional behaviour and therefore would not be good role models or mentors for students. I did wonder if the use of this assessment could be reversed with the student rating their teachers. Just a point to ponder. **Kim Blake, MD**

Editor's Comments: This paper provides a terrific checklist of behaviours that could easily be transferred to any school. What do you all think of it? After all, specific descriptions of behaviour are the most difficult part of feedback/evaluation.

Steve Miller, MD

The following is a list of other studies worth looking at.

1. **Matthews C. Role Modeling. *Medical Education* 2000;34:443-448**

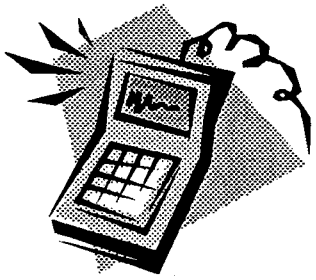
This is a good description of key components of good role modeling and bad role modeling. You could use this to trigger a discussion among colleagues, students or residents to encourage explicit role modeling behaviours. . The four keys are a) behaviour (British spelling) towards patients, b) behaviour towards colleagues, c) encourages active participation by student, and d) content of teaching well prepared. Not a bad checklist of behaviours that we should promote.

2. **Kurth R. et al. The Effects of Patient Characteristics and Practice Settings on Students' Participation. *Acad Med* 2000;75:634-638**

Look at this study in conjunction with the Usatine study for information about critical factors in structuring good outpatient experiences for our students.

3. **Boex J. et al. Measuring the Costs of Primary Care Education in the Ambulatory Setting *Acad Med.* 2000;75:419-425**

This study provides critical information for us as we plan our programs and advocate for our ambulatory preceptors.



The following "Hi-Tech" article was submitted by Steve Wong (I admire those of you who understand this!)

Using the Palm PDA:
COMSEP Vancouver, Canada
Steve Wong
s.wong@canada.com

Useful Palm software links:
http://www.palmgear.com/
http://handheldmed.com/
http://www.healthypalmpilot.com/
http://www.pdamd.com

ePocrates http://www.epocrated.com
LexiDrugs & 5 minute medical consult
http://www.skyscrape.com/palm/home.htm
http:www.handmedical.com

PalmWebpage
http://www.palm. com
Handspring Visor
http://www. handspring.com

EBM Tools:
http://www3.mtco.com/glwoods/Default.htm
http:www3.mtco/glwoods/HTML.files.htm

To Assess Featured & Recommended Applications:

1. Go to Palmgear HQ (http//www.palmgear.com/)
2. Click on the "My PGHQ" login link at the top right corner
3. To log in, enter the following (both in CAPITAL letters):
4. User Name: COMSEP
5. Password: COMSEP

Of the list you will find here with links he specifically mentioned the following as really valuable:
Back up Buddy
Date BK 3
Launcher III
Jfile Pro and Teal Doc
1 Silo for HTML files
PenDragon Browser (HTML)
He said he liked this better than Avantgo but there was debate about this.
ePocrates: LexiDrugs is coming out with Peds drugs separate from Adult drugs. He liked features of ePocrates best (it is also free but you can't add drugs).

The following was submitted by Kim Blake, Dalhousie University, Canada

OTTAWA IN AFRICA
9TH International Ottawa Conference on Medical Education
1-3 March 2000

The Ottawa Conference is held every 2 years and the venue alternates between North America and the rest of the world (often Europe).

The inaugural Conference was in 1985 (in Ottawa) and was pioneered by Professor Ian Hart, from Canada and Professor Ronald Harder, from Scotland. This first meeting concentrated on the assessment of clinical competence; assessment has always remained a theme throughout the subsequent conferences. Recent meetings have established a local theme and have always accepted general papers on all medical education issues.

An International Conference on Medical Education issues is a must for any Clerkship Director who wishes to pursue medical education with a more academic focus. Personally, I find the AAMC (Association of American Medical Colleges) -- end of October -- this year Chicago (http://www.aamc.org/meetings/annual/2000/exhibits/start.htm) rather overwhelming but very evidence based. The great advantage of the Ottawa Conference is that the organizers try and include as many presentations in small groups or poster settings, as possible. The theme/poster sessions involved 8-10 mini presentations (2 minutes maximum) that were intended to capture the essence of these posters. The posters are open for viewing by the audience. Finally, there is a group discussion. Many of

these theme/poster presentations are on new initiatives and are not structured in a research format. This means that the conference will accept work in progress, and any new educational implementations that have been successful or even unsuccessful. Therefore, if you are out there embarking on a new program think about evaluating it and bringing it to the next Ottawa Conference (in Ottawa) in just under 2 years. As many of you have ventured across the 48th parallel recently for COMSEP, a trip to Ottawa should not be too daunting. A number of you have become experts in giving workshops. As conference organizers are always interested in workshops, it may be worth e-mailing (Professor Ian Hart irhart@attglobal.net) with your ideas.

Most of the papers (oral presentations, theme presentations, posters) were grouped into one of 14 areas; Standardized Patients, Post-graduate Training, Student Learning, Distance Learning, Assessment, Problem Based Learning, Faculty Development, Community Learning, Curriculum Change, Topical Issues (for South Africa -- HIV), Multi-professionalism, Ethical Issues, Gender Issues. An outstanding Plenary on Best Evidence Medical Education (BEME) has given by Professor Ian Hart and Professor Ronald Harden. The Plenary discussed "... the implementation, by teachers and educational bodies, of methods and approaches to education based on the best evidence available" [1]

A report discussing BEME has been published [1,2] and this has recommended that:

- there should be a move towards the culture and practice of BEME, facilitating the implementation of BEME at both the individual and institutional level;
- teachers and/or teaching planners, when contemplating an education intervention, should critically appraise the existing evidence;
- the QUESTS criteria – quality, utility, extent, strength, target and setting -- should be used as a model for evaluation the reliability and relevance of the evidence in the individual's own situation; six dimensions that can be used to assess BEME. The Quality of the research evidence available – how reliable is the evidence? The Utility of the evidence – can the methods be transferred and adopted without modification, the Extent of the evidence, the Strength of the evidence, the Target or outcomes measured – how valid is the evidence? And the Setting or context – how relevant is the evidence? In the ideal situation the evidence is high on all six dimensions, but this is rarely found.
- an infrastructure for the implementation of BEME is needed.

Many ideas presented at the conference challenged existing practice. One example was the need to move away from the current emphasis on knowledge and skills to that of attitudes. As Pediatric Clerkship Directors, we have been aware of this for some time, so perhaps we can take a lead in the research that is needed on assessment of attitudes.

There were a number of educational papers on Pediatric issues that were presented and I have included the title, lead author and e-mail below but feel free to contact me if you would like any more information regarding this excellent conference (kblake@is.dal.ca). I look forward to seeing some of you at the 10TH Ottawa Conference, which will take

place in Ottawa from 30 June – 3 July 2002. The main theme there will be Assessment with a sub-theme on Faculty Development. Future meetings will be in Barcelona 2004, and New York City 2006.

Titles of Papers having Pediatric Content:

- Role of an education committee in reviewing medical students with marginal clerkship performance: 6-years experience ♦ Paul Hemmer ♦
- Establishing primary care education resource centres in east London ♦ Yvonne Carter ♦ y.h.carter@mds.qmw.ac.uk
- Patients as teachers – who benefits? Patients' experiences of home visits made by first year medical students ♦ Sue Conning ♦ susan.conning@kcl.ac.uk
- An assessment of medical students' experiences of learning about the psychosocial inquiry in their introductory course ♦ Jill Thistlethwaite ♦ j.e.thistlethwaite@leeds.ac.uk
- Learning to care for children -- a model for undergraduate students ♦ Minette Coetzec ♦ mcoetzee@uctgsh1.uct.ac.za
- Learning adolescents psychosocial interviewing using simulated patients ♦ Kim Blake ♦
- Revaluating the introduction of the "Integrated Management of Childhood Illness" approach into the medical curriculum ♦ Elmarie Malek ♦
- The impact of a new teaching strategy on medical students' competency in practical skills in neonatology ♦ Ina Treadwell ♦

I would like to thank Dr. Ian Hart, who kindly provided me with a draft of his editorial "The Ottawa Conferences: The good, the new, the controversial and the uncomfortable" to be published in Medical Teacher.

Finally, I would like to share with you the last paragraph in BEME Guide No. 1 [1] *"In medicine and in other academic areas, there is some* concern that staff activities in teaching are regarded as in some way inferior to research activities. There is a recognized need to improve the image of teaching and to value more highly the wide range of activities in which a teacher is engaged. Active engagement by teachers in the use of research through the practice of best evidence medical education may help to address this problem. Best evidence medical education has much to offer the teacher, the student, the medical profession and the public."

Kim Blake, MB, MRCP, FRCP (C)

Assistant Professor Pediatrics
Joint Appointment with
Division of Medical Education
Dalhousie University, Canada

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[1] Harden RM, Grant J, Buckley EG and Hart IR BEME Guide No. 1 Best Evidence Medical Education, Medical Teacher 21;6 (1999), Page 553-562, Dundee, Association for Medical Education in Europe (AMEC)

[2] Hart IR (1999) Editorial: Best Evidence Medical Education , Medical Teacher, 21 (5), Page 453- 454

Bozynski M, Castro P, and Gruppen L. Impact of a preceptor focused discussion group on the M3 primary care paediatric experience. University of Michigan, USA.

The conference website will run for a few more months **ottawainafrica.co.za**

As Pediatricians, I thought you might find this somewhat funny. Perhaps you can use this when you interview with "perspective" parents.

How To Know Whether Or Not You Are Ready To Have Children

MESS TEST:
Smear peanut butter on the sofa and curtains. Place a fish stick behind the couch and leave it there all summer.

TOY TEST:
Obtain a 55 gallon box of Legos (or you may substitute roofing tacks). Have a friend spread them all over the house. Put on a blindfold. Try to walk to the bathroom or kitchen. Do not scream because this would wake a child at night.

DRESSING TEST:
Obtain one large, unhappy, live octopus. Stuff into a small net bag, making sure that all the arms stay inside.

FEEDING TEST:
Obtain a large plastic milk jug. Fill halfway with water. Suspend from the ceiling with a cord. Start the jug swinging. Try to insert spoonfuls of soggy cereal into the mouth of the jug, while pretending to be an airplane. Now dump the contents of the jug on the floor.

NIGHT TEST:
Prepare by obtaining a small cloth bag and fill it with 8-12 pounds of sand. Soak it thoroughly in water. At 3:00 p.m. begin to waltz and hum with the bag until 9:00p.m. Lay down your bag and set your alarm for 10:00p.m. Get up, pick up your bag, and sing every song you have ever heard. Make up a dozen more and sing these too until 4:00 a.m. Set alarm for 5:00 a.m. Get up and make breakfast. Keep this up for 5 years. Look cheerful.

INGENUITY TEST:
Take an egg carton. Using a pair of scissors and pot of paint, turn it into an alligator. Now take a toilet paper tube and turn it into an attractive Christmas candle. Use only scotch tape and a piece of foil. Last, take a milk carton, a ping-pong ball, and an empty box of Cocoa Puffs. Make an exact replica of the Eiffel Tower.

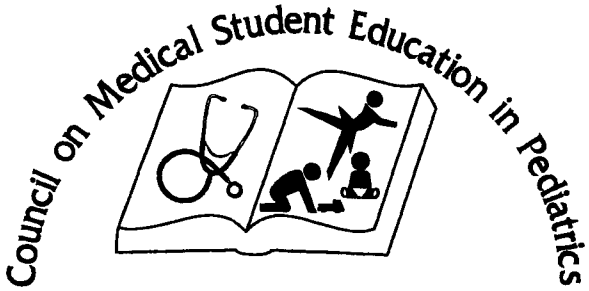
AUTOMOBILE TEST:
Forget the BMW and buy a station wagon. Buy a chocolate ice cream cone and put it in the glove compartment. Leave it there. Get a dime. Stick it into the cassette player. Take a family size package of chocolate chip cookies, mash them into the back seat. Run a garden rake along both sides of the car. There, perfect.

PHYSICAL TEST: (Women)
Obtain a large bean bag chair and attach it to the front of your clothes. Leave it there for 9 months. Now remove 10 of the beans.

PHYSICAL TEST: (Men)
Go to the nearest drug store. Set your wallet on the counter. Ask the clerk to help himself. Now proceed to the nearest food store. Go to the head office and arrange for your paycheck to be directly deposited to the store. Purchase a newspaper. Go home and read it quietly for the last time.

FINAL ASSIGNMENT:
Find a couple who already have a small child. Lecture them on how they can improve their discipline, patience, tolerance, toilet-training and child's table manners. Suggest many ways they can improve. Emphasize to them that they should never allow their children to run wild. Enjoy this experience. It will be the last time that you will have all of the answers!

The Pediatric Educator



Volume 7 Issue 1 **Spring 2000**

EDITOR
Gary E. Freed, D.O.
Emory University School of Medicine

Message from the President

Welcome to Vancouver!

I'm excited about COMSEP's 2000 Annual Meeting on many levels. My excitement began the moment we first considered the idea at least three years ago. Our Canadian colleagues unfailingly attend this meeting year after year. They have their own PUPDOCC meeting on the opening Thursday. (Be honest. How many non-Canadians really know the full name of PUPDOCC?) Then at the COMSEP meeting they lead workshops and present excellent research papers or educational innovations. We couldn't keep them coming South on this continent without ever going North to meet on their turf. The idea of COMSEP meeting for the first time outside the United States in the year 2000 in beautiful Vancouver was irresistible and here we are!

The theme of this meeting, technology in pediatric education, is exciting. The pace at which new technical innovations enhance medical education is unbelievable. We'll see many such examples at this meeting. Setting up for the meeting made it evident that technology is expensive, even displaying it. Our presenters will help us appreciate the potential of technology in education while recognizing some of its limitations. Just because we can develop some new technology doesn't mean that we should. We must consider expense, educational goals and educational outcomes to know if new technology really is an improvement over less technical ways of teaching and learning.

I'm excited about seeing Vancouver. I want to thank our Canadian hosts and particularly our University of British Columbia hosts for all the planning that goes into a meeting of this magnitude. The meeting facilities and social venues promise to be exceptional.

It's been quite a privilege to represent COMSEP these past two years. I'm proud to tell you that the academic community respects COMSEP and recognizes its valuable contributions. That makes it particularly enjoyable to represent you. I welcome Rich Sarkin as your new president. His quiet reserved manner is quite a contrast to my zany flair for excitement. HAVE A GREAT MEETING.

Mike Lawless, President

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The abstracts that follow represent the oral presentations given at the annual meeting on Saturday, April 15, 2000.

Rather than make them a separate handout for meeting participants only, we decided to include them in the newsletter to be distributed to all COMSEP members.

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ORAL PRESENTATIONS
– April 15, 2000

Learning Adolescent Psychosocial Interviewing Using Simulated Patients.

Kim Blake, K.V. Mann, D.M. Kaufman, Dalhousie University
M. Kappelaman, University of Maryland School of Medicine

Introduction: Communication shills in the area of adolescent medicine are emerging as an important part of the medical curriculum. Finding ways of exposing students to learning specific skills of dealing with adolescent interviewing is necessary. This study was a prospective randomized double blind study to assess changes in psychosocial interviewing conducted by final year medical students after they had received feedback from an adolescent and mother simulated patient team.

Methods: Data were collected on the student's prior experiences with adolescent medicine. As a pre-test, students undertook a videotaped interview with a simulated adolescent and mother, using one of four cases. Students were randomly assigned to feedback (F) or to no feedback (NF) from the simulators. The post-test was a second interview, videotaped four weeks later, using a different case. Students then received feedback. A single "blinded" psychologist scored the tapes, using a modified Calgary Cambridge Observation Guide. Data were analyzed using the SPSS statistical software program.

Results: Data collection was complete with 52 (F=31; NF=21). Regression analysis was conducted using student global scores as the dependent variable. The independent (predictor) variables were: feedback, gender, previous medical experience, self-reported comfort level in relating to adolescents, future career prospects in adolescent medicine and the score on pre-test case. Receiving feedback was the only significant ($p=0.02$) predictor of students' performance on the post-test ($R=.10$). There was no significant statistical influence due to case difference. This experience was rated by the students as one of the most positive learning initiatives of the clerkship.

Conclusion: Significant improvements in adolescent psychosocial interviewing can be achieved after only one feedback session from an adolescent simulated patient and their simulated mother.

Promoting Resilience: Pediatric Clerks Gain Skills for Health Care Encounters.

Janice L. Hanson and Virginia F. Randall, Uniformed Services University
Grotberg, Edith. University of Alabama

Objective: Previous research has identified factors that promote resilience in children and families (Grotberg, 1999) and a strategy for measuring medical students' ability to promote resilience in children and families (Hanson and Randall, 1999). The objective of this study was to measure students' growth in their ability to promote resilience after an educational session on resilience, a home visit to a family with a child with special health care needs, and a discussion of the strengths observed in home visit families.

Methods: Parents of children with special health care needs wrote scenarios depicting adversity in health care settings. Previous research identified two scenarios that students generally did not know how to respond to before the educational intervention, but could learn to handle in a way that promoted resilience. Students responded to a scenario before

and after the educational session, home visit, and discussion. They described what they would do in this situation, how they thought the parent would react, and how they thought the child would react. Their responses were scored as resilience promoting (3), mixed (2), or counterproductive (1).

Summary of results: Seventeen students received the same score before and after the home visit; 6 students received a lower score after the home visit; 30 students improved their score after the home visit.

Conclusions: Third-year medical students in their pediatric clerkship effectively learn to promote resilience in children and families after an educational session on resilience, a home visit, and a discussion of the strengths observed in families.

Grotberg, EH. (1999) The International Resilience Research Project in R. Roswith (ed.), Psychologists Facing the Challenge of a Global Culture with Human Rights and Mental Health (pp.239-256). Graz, Austria: Pabst Science Publishers, Proceedings of the 55th Annual convention, the International Council of Psychologists.
Hanson, JL and Randall, VF. (1999) Evaluating Impact on Medical Students: Home Visits in the Pediatric Clerkship. Research Day, USUHS.

The Impact of Initiating a Pediatric Hospitalist System on the Third Year Medical Student Pediatric Clerkship Educational Experience.

PR Ogershok, RS Moore, and ND Ferrari West Virginia University School of Medicine

Objective: To compare satisfaction among third year medical students regarding two forms of ward attendings: traditional vs. hospitalist.

Methods: Medical student course and attending evaluations were studied over the past three years to compare the traditional ward attending system (1997 – 1998) to the hospitalist system (1999).

Results: Improvement was seen in 11 of 13 categories evaluated when comparing both 1997 and 1998 (traditional) data to 1999 (hospitalist). The 11 areas of improvement included availability of attending, interest in teaching students, attending approachability, attendings sensitivity to needs of patients, explanation of diagnosis/management plans for patients, pathophysiology of disease, presentation of newer knowledge/recent advances, quality of didactic teaching, student involvement in patient care responsibilities, overall quality of learning experiences, and inpatient wards. The two areas that did not improve included attending punctuality and faculty review of student histories and physicals.

Conclusions: The initiation of a pediatric hospitalist system greatly improved the satisfaction among third year medical students. The new hospitalist ward attending system allows greater continuity of teaching for the students. As the hospitalist is freed from outpatient responsibilities, more time is available to concentrate on inpatient medicine and inpatient teaching for the students. Students can also look to one identifiable attending for overall patient management issues compared to multiple different attendings as in the traditional ward system. In conclusion, the first six months of data show a tremendous benefit to the pediatric clerkship under an academic pediatric hospitalist system.

Medical Ethics in the Pediatric Clerkship: Curriculum Development and Evaluation.

Sherilyn Smith[1], Kelly A Edwards[2], Douglas S Diekema[1], and Clarence H Braddock[2].
[1]Pediatrics and [2]Medical History and Ethics, University of Washington

Objective: Develop a medical ethics curriculum for a pediatric clerkship and evaluate the impact of different educational methods on moral reasoning.

Methods: Participants were University of Washington medical students doing a 6-week pediatric clerkship. Approximately ½ of the students were based at Children's Hospital in Seattle, while the remaining students rotate through community sites in a 5 state area (WWAMI). All students received 3 short ethics cases with instructions on the first day of their rotation. All students submitted written answers and received written feedback from a single evaluator. The written feedback consisted of a 5-point scale focusing on ability to: 1)identify the ethical issues; 2)weigh different viewpoints; 3) formulate a plan; and 4) justify the action plan. In addition to numerical grading, specific comments about the essays were included. All students submitted a written final exam that was graded using the same scale and evaluator. Following submission of the initial essays the Seattle students also participated in an hour-long ethics discussion group focusing on the essays they had submitted. To evaluate the incremental effectiveness of the discussion group, the average grades form each component of the initial essays and the degree of improvement on the final examination were compared between the two groups.

Results: The responses of 55 students were analyzed: 34 at Seattle and 21 at WWAMI sites. There was no significant difference between the mean scores for the two groups on the initial set of 3 essays: Seattle 3.0 vs. WWAMIO 3.0, $p=0.84$. On the final exam, Seattle students scored significantly higher than WWAMI students: 3.4 vs. 2.5 $p=0.004$. Most students improved in their ability to formulate a plan to address the dilemma regardless of the rotation site. However, students at the Seattle site improved in their ability to identify the ethical dilemmas ($p=0.01$), weigh the conflicting views ($p=0.01$), and justify their plan of action ($p<0.01$) compared to WWAMI students.

Conclusion: This pilot study demonstrates the feasibility of implementing an ethics curriculum during pediatric clerkships and evaluates two methods of teaching and evaluation. Although methodological limitations exist, our initial data suggest that discussion groups should be an integral part of medical student education about ethical issues unique to pediatrics.

Helping Students Optimize Their Use of the Internet in Clinical Medicine

Robert Swantz and Nicholas Jospe
Children's Hospital at Strong, University of Rochester

Background: The Internet has been called the "fastest growing technology in history," and a recent Harris poll showed that more than half of U.S. households own a personal computer with nearly 90% of them connected to the Internet. Increasingly, the Internet is a source of information used by patients to enhance their own health care, and by physicians, educators, and administrators to support their clinical practice.

Objectives: In April 1999, our Pediatric clerkship developed a workshop to teach Third-year medical students basic skills to manage Internet information.

Methods: During the clerkship, students attend a one-hour workshop to promote computer and Internet skills. This meeting, facilitated by the clerkship directors, is held in the medical library's computer classroom, with workstations equipped with multimedia computers and a high-intensity projector.

Results: The students submit, via e-mail, a short report identifying and critiquing a web-site relevant to pediatrics. At the workshop, students "surf the Net" and discuss their chosen web-sites, leading to an examination of the criteria used to assess the quality of information on the web – credibility, context, content, and continuity. Further discussion and demonstration focuses on directories; search and meta-search engines; e-mail and listserves; electronic textbooks, journals, and

reviews; and student learning assessment tools.

Conclusions: More than 70 Third-year medical students have participated in our Internet-based medical informatics workshop. Feedback from the students and faculty has been positive, and supports the importance of teaching the skills and knowledge to effectively use medical information technology. Our medical school has also recognized the significance of this theme by including study in information management in the first year curriculum.

Running scared: How Anxious are Medical Students about Examining Young Children?

LR Tewksbury[1], JA Curtis[2], and AL Mendelsohn[1].
[1]NYU School of Medicine, [2]Albert Einstein College of Medicine

Objective: To assess the degree and correlates of anxiety among third year medical students regarding the examination of infants and young children at the start of their pediatric clerkship.

Design/Methods: A group of faculty and medical students developed a questionnaire of eight statements reflecting feelings of anxiety regarding the examination of infants and young children. Responses were recorded on a 5 point Likert scale (+2 strongly agree, -2 strongly disagree). The questionnaire was administered to 3rd year medical students on the 1st day of their pediatric clerkship at two medical schools form June to November 1999. Information was collected on age, sex, previous experience with young children and interest in pediatrics as a career. Internal reliability was demonstrated by a Crohnbach alpha score of 0.78. An overall anxiety score was calculated by addition of the responses to the eight statements (range +16 to –16). A factor analysis was highly consistent with a three factor structure, delineating three areas of anxiety: effect of the exam on the patient/parent, effect of the experience for themselves, and their own competence.

Results: Of 145 eligible students, complete data was available for 133 (92%). Mean anxiety score was –2.8 ± 5.2. Students were more likely to report anxiety about the effect of the exam on the patient/parent (55%) than on themselves (5%) or their competence (17%) (Cochran's $Q = 92$, $p<.001$). A stepwise regression analysis demonstrated 3 significant independent correlates of the overall anxiety score: prior experience with young children ($r=-.29$, $p<.001$), age ($r=0.20$, $p=.02$), and timing of rotation (first vs later) ($r=.19$, $p=.02$). Sex, medical school, and interest in pediatrics as a career were not significantly correlated with anxiety.

Conclusions: Students who had more experience with young children were less anxious. Students were particularly concerned about the impact of their examination on the child and parents. These findings suggest that increasing medical student exposure to young children during the preclinical years might decrease anxiety about the examination of infants and young children.

--- End of Presentations –

A Web-based Conferencing System for Clinical Medical Educators

Kenneth E. Christensen, MD
Uniformed Services University of the Health Sciences

Objective: To achieve a flexible and simple Internet browser-based conference center, a WebBoard was designed.[1] The goal of this system is to foster communication and improve productivity among medical student clinical educators regardless of time or distance. Participants only need a web browser to join the

conferencing system and can be located down the hall or halfway around the world.

Description: WebBoard is a program originally designed in 1997 signaling the age of web conferencing. Like many other sections responsible for medical student education across the country, we struggle to maintain productive, quality clerkship sites at increasing, multiple outpatient settings. Unfortunately this responsibility is becoming more challenging for a variety of reasons, one of which is the inherent difficulty in maintaining communication and collaboration between the university-based faculty and the growing numbers of vital community preceptors who oversee the daily activity of our students. The WebBoard was instituted in our Education Section in April 1998 as an attempt to remove the barriers to communication that previously existed between the clerkship director and preceptors separated by time and space. Uniquely at Uniformed Services University of the Health Sciences, we have clerkship sites established across the country, maximally challenging communication on a daily basis. The following WebBoard features are ideally suited to our communication needs:

1. A user-friendly interface allows the clerkship director to communicate with preceptors anywhere and anytime regarding project collaboration, idea exchange, scheduling, or budget issues as examples.

2. With a sole system administrator overseeing all WebBoard functions, data, and users, information overload from multiple participants is avoided.

3. WebBoard's structured hierarchy and support for file attachments manages conferences logically and chronologically, making information retrieval simple and efficient.

4. The distinct advantage of the browser-based WebBoard over conventional e-mail and list-servers is that rather than "pushing" information to recipients, users become much more active participants and contributors to discussions. Access to the board is available through any Internet browser at any time.

5. The program comes with its own internal server requiring no configuration or special maintenance, so that the program is maintained locally from the clerkship director's PC. The cost of the program at $100 is not prohibitive.

Discussion: Developing a WebBoard has been a fascinating, productive, and satisfying endeavor. Given its popularity and suitability to our needs, we plan to maintain this system as the number of our educators and participating clerkship sites continues to grow. Our current active conferences include individual Clerkship site issues, educational workshop development, research projects, scheduling, budget, problem-based learning ideas, and informatics module development for students. Given the nationwide distribution of our clerkship sites and the success of our WebBoard at Uniformed Services University of the Health Sciences, it certainly implies that clerkship directors across the country may use this browser-based conference system as a convenient, simple way to communicate and collaborate with distant, quality teaching sites.

Inquiries: Kenneth E. Christensen, MD, USUHS, 4301 Jones Bridge Road, Room C1069, Bethesda, MD, 20814-4799; e-mail: kchristensen@usuhs.mil

Reference:

1. Peck SB, Scherf BM. *Building Your Own Web Conferences.* California: O'Reilly & Associates; 1997.

Once again Steve Miller has provided the COMSEP members with an outstanding literature review complete with editorial comments from COMSEP members from around the country.

***Pediatric Educator* Review**

Welcome to our fourth journal review. I'd like to acknowledge Karen Wendelberger for her role in originating the idea. The review serves three purposes. First, it acknowledges the importance of scholarship in our work. Second, it generates discussion. And finally, it gives us a chance to work together across our institutions to disseminate ideas. This is a great opportunity for everyone to participate, so let me know if you want to serve as a reviewer next year. Please, e-mail me at ***szm1@columbia.edu*** or through the COMSEP listserv with your comments.

-Steve Miller, MD

1. Papadakis, et al., A Strategy for the Detection and Evaluation of Unprofessional Behavior in Medical Students, University of California, San Francisco. *Academic Medicine,* Vol.74 No. 9, Sept 1999.

This article describes four years of experience with a new system to monitor students' professional behavior in their 3rd and 4th year clinical rotations. After collaboration and consultation among students, faculty, and deans, a system for filing a "Physicianship Report" was developed, with the goal being to identify and remediate students who had problematic evaluations in a clinical clerkship because of unprofessional behavior. This Physicianship Evaluation Form, a copy of which is included in the article, gives clear, concrete descriptions of the types and categories of behaviors that are considered unprofessional. Students who received two reports were placed on academic probation and were given counseling and mentoring to improve their professional behavior. During the four-year period that the article describes, 29 reports were filed on 24 students, with 5 of the students having two reports filed. For those five students, 4 had their difficulties cited in their Dean's Letters but did go on to residency, and one student voluntarily withdrew from the medical school. The 19 students who had one report filed had a counseling session with a dean, and in some cases were referred for ongoing counseling.

This article drew my immediate attention because it focuses on an issue that all of us have probably dealt with at some time: the student who may have adequate clinical skills, but has shown behaviors that are incompatible with appropriate professional conduct. The total number of reports filed seems in keeping with what one would estimate the size of the problem to be: 3% of the students had reports filed on them. This is about what I would estimate the percentage is at my own institution. My major criticism of the project is that while some of the criteria for unprofessional behavior are listed, the threshold for deciding that a behavior is "bad enough" to file a report is still rather arbitrary. Perhaps this is as close as it can get. In any case, it certainly gives the faculty the go ahead to address the issue head on, and legitimizes professionalism as an important component of medical education. I look forward to the next component of the project, where evaluations from the residency programs of the students who had reports filed when in school are compared to those of other students who did not have reports filed **(Shari Nethersole, M.D. Harvard Medical School).**

(This article provides an explicit program for encouraging reporting of unprofessional behavior. Do you think it picks up behavior that would otherwise be swept under the rug? How many of you have such an explicit program - and how many get input from patients, nurses,

other staff or other students? Steve Miller, MD)

2. Cohen JJ. Still seeking gender equity in health care. *Academic Medicine.* 74:1226, Nov. 1999.

AAMC President Cohen believes that, despite measurable progress, gender parity in all aspects of both the medical profession and health care has not yet been achieved. He introduces a new initiative sponsored by the AAMC Group on Educational Affairs, the Interdisciplinary Women's Health Care Special Interest Group, whose goal is to advance the understanding of women's health care issues through the development and implementation of interdisciplinary curricula for medical students. The SIG aims to formulate a comprehensive consensus statement on undergraduate core competencies in women's health, and work with the USMLE and LCME to include these competencies in student evaluation processes. This new SIG is "interdisciplinary" to emphasize that gender specific concerns extend far beyond reproductive health issues and that the entire range of specialties, including pediatrics, must actively expand women's health education in curriculum development. Other goals of the SIG focus on research and outcomes measures for women's health care provision.

As the NIH Office of Research on Women's Health seeks to partner with medical schools and academic health centers in conducting research and creating educational programs, the Interdisciplinary Women's Health Care SIG may also play a role in facilitating these partnerships. This new AAMC SIG promises to influence medical student education, and will offer yet another set of competencies to be aware of when updating Pediatric Clerkship curricula **(Janet Williams, MD, UTHSC)**

(This is a challenge to all of us. As an important corollary to the theme of Professionalism, what can we contribute as clerkship directors to insuring that gender equity is part of every student's mission and skill? Steve Miller, MD)

3. Kossoff EH, Hubbard TW, Gowen CW. Early clinical experience enhances third-year pediatrics clerkship performance *Acad Medicine* 1999;74:1238-41.

This study asks whether early clinical experience in medical school translates into improved performance in a pediatric clerkship. The authors compared the clinical performance and NBME pediatric examination scores of students who had a traditional preclinical curriculum (years 1996-1997) to students who participated in a newly designed early mentorship program (1998-1999) at Eastern Virginia Medical School. Clinical skills did not change significantly over the four years. Early clinical experience in medical school did correlate with improved clinical skills for students who took pediatrics early in the clerkship year. By the year's end, however, the advantage disappeared. The authors note a significant improvement in NBME scores over the 4 years, although the MCAT scores also increased significantly during that time, calling into question whether the students were better test takers overall! The authors note other limitations of their study, and conclude that early mentorship results in improved clinical skills for students early during the clerkship year. Whether early experience helps beyond jump-starting clinical confidence is yet to be determined. **(Cindy W. Christian, MD, CHOP)**

(Do you think that this labor-intensive program is justified? I wonder if there are other, more long-term benefits that accrue from an easier transition in the early part of the clinical year; does lower stress in medical school enhance subsequent

professional and humanistic behavior of the students? After all, easier transitions reflect a more caring attitude by the school for the students. Steve Miller, MD)

Other Comments
Incorporation of clinical experience during the first two years of medical education has been previously found to be associated with an increase of the student's general understanding of the health care delivery system and has influenced their career plans in favor of primary care. The present study insinuates that may also help the students overcome the "disadvantage" of being the first in that clerkship. Previous studies have shown that clerkship scores rise significantly after the student's second clerkship rotation. In this study the students with early clinical exposure scored as well in the first as in subsequent rotations. The institution of a clinical experience during the preclinical years requires a considerable amount of resources and a strong commitment by practicing generalists to participate in the program. In spite of that, results from this and other studies as well as my own personal experience students at the University of Hawaii, justifies the extra effort. The student entering the clerkship with prior clinical experience has a very extensive base on which to build their knowledge of clinical medicine.**(Raul Rudoy, MD, Hawaii)**

4. Edmond M et al. The Dishonest Dean's Letter *Acad Med* 1999,74: 103

The Dean's Letter is one of the tools utilized almost universally in the residents' selection process and it is assumed by the committee members to represent the actual students' performance in medical school.

Method: Comparisons were made between the Dean's Letter content and the student's actual official school transcript. The student's USMLE I score was also obtained and the Dean's Letter was reviewed to see whether the scores were recorded.

Results The study population represented 13% of all US seniors and consisted of 532 students from 99 US medical schools written by 151 Deans. Discordance between the Dean's Letter and the official transcript was noticed in 34% of the letters from students having one or more of the variables listed in the table:

Variable	% absent in Dean's Letter
Pre-clinical Course	
Failure	27
Marginal	41
Clinical Course	
Failure	33
Marginal	26
Leave of Absence	40
Repeated Year	50

In addition, the Dean's Letter reported USMLE I scores less frequently, if the score were below the 20th percentile (P=0.003)

Comments: The residency program directors view the Dean's Letter as the "official" representation of the student's performance. The results of this study are very troublesome. In 1989 the Association of American Medical Colleges (AAMC) issued recommenda-tions for the content and format to be included in the Dean's Letter. However, a study performed in 1992 determined that 37% of the letters did not comply with the AAMC guidelines. The current study once more corroborates the previous findings. The lack of important information in the Dean's Letter seriously undermines the residency selection process and unfairly prevents candidates from schools with "honest" Deans in obtaining residency positions because some Deans choose to delete negative information. Residency Selection Committee Members be warned—first, our President lied to us and now the Dean—who will be next? **(Raul Rudoy, MD, Hawaii)**

(What about grade inflation as another source of inaccuracy? How does this contribute to "professional" attitudes? Steve Miller, MD)
(By the way, I take no

responsibility for the political feelings of the reviewer.)

5. Urbina C, Voss C, Seeger K, McHarney-Brown C, Martinez M, Voelz J. Kaufman A. Interdisciplinary Ambulatory Education and Service in Primary Care at the University of New Mexico. *Acad Med* 1999;74(6):659.

This article describes experience developing three interdisciplinary primary care clinics at the University of New Mexico. The clinics were established through the efforts of a Primary Care Policy Advisory Council at the medical school, comprised of physicians, nurses, and physician assistants from primary care departments. Reported advantages of this model include "one-stop shopping" for patients, a unified voice in the medical school for primary care providers from separate departments, and cross-pollination in educational experiences for residents. Balancing commitments to primary care versus specific departments has been one of the major challenges. Currently at UNM only internal medicine and family medicine residents are training in these sites, although pediatrics is represented at the faculty level in one of the clinics.

Comment: Providers of primary care from different disciplines may have more in common with one another than with other members of their specific departments. This is particularly true where education is concerned. Integrated primary care clinics are an attractive alternative to traditional hospital-based practices for ambulatory teaching. **(John Andrews, MD, Johns Hopkins,** and soon to be of New Zealand)

(Do you all agree? How many people feel that specific Pediatric outpatient work is a better /earning experience? It probably depends on how much Pediatrics is covered within the experience and in other experiences in your program. At Columbia, there is so little Pediatrics, that it can get lost in the shuffle. Am I being defensive? Steve Miller, MD)

6. Bing-You, et al, Faculty Development of Community based Preceptors through Collegial Site-Visit Program, *Teaching and Learning in Medicine* Vol. 11, 2 1999.

This program highlights a number of unique and creative faculty development approaches. Preceptors volunteer to visit other sites in the program in order to observe their colleagues teaching and facilitate discussions about educational topics and skills. These site visitors are otherwise precepting in their offices; they undergo a short training program and embark on these visits to their colleagues. It creates a sense of honor and accomplishment for those who do the site visits. They become "champions" of teaching. This is borne out in that they seemed to get the most out of it. It emphasizes the fact that you learn something at a deeper level — when you need to teach it.

(It also highlights collegiality as a main value of teaching and teachers — a unique trait among medical educators in general — in my humble opinion. Steve Miller, MD)

7. Hatalar et al, Influence of a Single Example on Subsequent ECG interpretation, *Teaching and Learning in Medicine,* 11, 2, 1999.

This study sheds light on the complex process of diagnostic reasoning. Students seem to judge individual pieces of data -- one at a time. Residents use one piece of information-- to influence their interpretation of other pieces of information -- in putting together a pattern that they can recognize. While we usually see this is an advantage of experience -- it may make someone more experienced prone to anecdotal errors. How many of us have forced a single fact into a puzzle even when it didn't fit?

This study proves that experts do this.

(What do you think the implications for teaching are? Steve Miller, MD)

8. Tanenbaum, S. Evidence and Expertise. The challenge of the Outcomes Movement to Medical Professionalism, *Acad Med* 1999; 74:757-763.

This special article takes a critical look at the Evidence-Based Medicine (EBM) movement to delineate its theoretical shortcomings. The pro and con argument for EBM rages -- almost at the level of a religious conflict. What do you think the role of the clerkship director should be? First, we should be familiar with EBM and teach it. Second, we should be the arbiters of compromise -- evidence is only one type of "knowledge" as Tanenbaum argues -- but ignoring it -- puts all the power in the most fanatic EBM fringe. It, meaning EBM, then becomes a body of knowledge for an "elite" that places unwarranted power in their hands. On the other hand, a strong EBM stance is needed to bring it into our consciousness.

(Where do you stand on this "movement?" It can't be ignored -- in the same way that computers can't be ignored despite Tanenbaum's arguments. Steve Miller, MD)

9. Jonassen et al, The Effect of Interclerkship Collaboration on the Knowledge, Attitudes and Skills of Third Year Medical Students, *Acad Med* 74:821-828.

This is an interesting paper in two ways. First it describes how clerkships can collaborate around the teaching of universal clinical skills and topics — such as screening for domestic violence. Instead of relegating this and similar topics to the second year, for focused teaching, it places theses clinical skills into the third year where students can begin to truly practice the skills right away. In the second year, the skill lies dormant and seems abstract. Second, this is a good study design. It measures an important outcome performance of the skill by the student (using OSCEs) six months after training.

(Education research often suffers from inadequate measurement of outcomes - "the students liked it" is marginal outcome data - which is often passed off as an important outcome. Steve Miller, MD)

10. Miller SZ and Schmidt H. The Habits of Humanism: A Framework for Making Humanistic Care a Reflexive Clinical Skills, *Acad Med* 74: 800-803.

This is a shameless plug for the article that I wrote for *Academic Medicine* on Humanism. What can I really say here? **(Steve Miller, MD, Columbia)**

11. Lawrence S. et al, What Learning Outcomes Students Value in a Third-Year Ambulatory Primary Care Clerkship, *Acad. Med.* 1999; 74:715-717.

This is an interesting study; however its methodology is a bit suspect. The authors asked for self report from the students about what they learned and coded the answers. We really aren't sure that these are the things they learned. It does suggest, though, that ambulatory clerkships emphasize certain skills more than others — such as patient-doctor communication skills. **(Steve Miller, MD, Columbia)**

12. van de well, et al. The Explanation of Clinical Concepts by Expert Physicians, Clerks and Advanced Students, *Teaching and Learning in Medicine,* Vol. 11,3:153-163.

This study is important for at least two reasons. First, it confirms that experts have "encapsulated knowledge." That means that they are more likely to lump their knowledge of a specific entity together -- and make decisions -- almost

by pattern recognition *(see related article by Hatalar, et al.)*. Nonetheless, when necessary, experts can "unfold this encapsulated knowledge when they are faced with difficult problems that they can't recognize right away.

Students, on the other hand, can't see the "big picture" and must reason through the problem. Therefore, we should recognize that evaluating each tree — rather than the whole forest — is developmentally appropriate for students. And second, knowledge of this trend in reasoning points out pitfalls in each approach, as alluded to before in Hatalar's study.

(What do you think are the implications for your approach to teaching? Send me your thoughts. (Steve Miller, MD)

13. Kassebaum DO, Eaglen RH: Shortcomings in the evaluation of students' clinical skills and behaviors in medical school, *Academic Medicine* (1999) 74:841-849.

The authors report and comment on data from LCME accreditation surveys of 97 US medical schools which were reviewed between 1993-1998 regarding each school's assessment of "non-cognitive abilities, including clinical skills and behaviors." The areas receiving attention included assessments of participation and preparation in basic science courses, particularly small group sessions, and the methods by which clerkships evaluate skills and behaviors. As the title suggests, their conclusion is that US medical schools are lagging in their efforts to specifically assess these skills. The article is useful as a commentary on these educational practices during this time interval. Of greater importance is the implication that the LCME will be focusing more specifically on these areas in upcoming accreditation reviews. COMSEP members should all read this paper for its overt and hidden messages, and perhaps use this locally in your endeavors to improve our teaching and evaluation of students in these important areas. **(William G. Wilson, MD, University of Virginia)**

(This is a critical paper for those who need to convince their colleagues to adopt new evaluation methods. Steve Miller, MD)

*Finally, on a lighter note, I present "Quibble's Classification of Case Presenters:**

1. **The medical student:** Presents too much information, only half of which is relevant, and does not know what any of it means.

2. **The Intern:** Obtains most of the information and probably knows what some of it means, but falls asleep presenting it.

3. **The Resident:** Presents all of the information and knows most of what it means, but prefers arguing about the night call schedule

4. **The Chief Resident:** Obtains all of the information and knows what all of it means, but is too busy making schedules to present it.

5. **The Research Professor:** Has forgotten what a presentation is, but will find a reference on it and get back to you.

6. **The Clinical Professor:** Could obtain all of the information he wanted to, but prefers to have others do it for him. Yes, he knows what all of it means too.

7. **The Chief of Medicine:** Does not have time for case presentations. He is too busy editing the definitive text on differential diagnosis.

*Reprinted from: How to Survive a Case Presentation by Howard J Bennett, M.D. and appeared in: The Best of Medical Humor compiled and edited by Howard J. Bennett, M.D. Hanley & Belfus Publisher 1991.